COMBATING THE OPIOID CRISIS

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM HOUSE OF REPRESENTATIVES

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COMBATING THE OPIOID CRISIS

Tuesday, November 28, 2017

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

The Committee met, pursuant to call, at 12:42 p.m., in the Chevy Chase Auditorium, Johns Hopkins Hospital, 1800 Orleans Street, Baltimore, MD, 21287, Hon. Trey Gowdy [Chairman of the Committee] presiding.

Members present: Representatives Gowdy, Grothman, Palmer, Comer, Cummings, Norton, Clay, Lawrence, Raskin, and Welch.

Also present: Representatives Sarbanes and Ruppersberger.

Chairman GOWDY. Thank you, Governor, thank you, Mayor Pew, thank you, Johns Hopkins for pardoning the inconvenience of having a Committee of Congress come, and appreciating the seriousness of the issue that brings us here. The Committee will come to order. Without objection, the Chair is authorized to declare recesses at any time. I am going to break from protocol a little bit because we are in Mr. Cummings's hometown, and because he cares so passionately about this issue, we are going to recognize you first for your opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and I want to first of all, take a—just to mention one thing that is so important to me, Mr. Chairman, and to the members of this panel.

I cannot come into this hospital without saying thank you to Hopkins for saving my life, and spent 60 days here this summer, a lot of it in this building. And so I want to thank—I see a lot of white coats out there and others, but pass the word. I thank you for what you have done for me and my family.

I want to begin by thanking Chairman Gowdy for calling today's very important hearing, and for bringing the Oversight Committee to Baltimore. I also thank my colleagues for coming to Baltimore, and certainly my colleagues who represent Baltimore along with me as Dutch Ruppersberger and John Sarbanes. I thank you for being here.

I have been in Congress now for 20 years and I have been through and seen a lot of field hearings. I have never seen as many members attend any field hearing since I have been in Congress. I believe today's remarkable turnout reflects the fact that the opioid crisis is truly a national emergency that does not discriminate based on politics. It affects the red states and blue states, and every state in between. So I am extremely grateful that the Chairman agreed to my request to bring the Committee to—on the road to investigate the devastating effects of this very difficult problem.

I also want to thank Dr. Miller and Johns Hopkins for your warm welcome and your hospitality. The work that you do makes a huge difference in our community and around the globe. I also thank our esteemed guests, Governor Hogan and Mayor Pew, for joining us. We are honored to have you in our presence. And of course, I thank our witnesses, Governor Chris Christie, Commissioner Wen, Dr. Alexander, and Mr. Baum. Thank you for testifying and for all that you are doing to help us combat opioids and save lives.

A year and a half ago at our Committee's first hearing on this issue, I warned that so many people were dying in communities across America and that we could no longer ignore this emergency. Today, the Centers for Disease Control and Prevention estimates that more than 64,000 Americans died from drug overdoses in 2016, an increase of more than 20 percent over the year before.

To put this in perspective, the death toll from drug overdoses last year alone was higher than all U.S. military casualties in Vietnam and Iraq wars combined. Every 20 minutes someone does from an opioid overdose. If today's hearing lasts for two hours, half a dozen families will have lost a parent, a sibling, or a child to opioids. We have the reports. We have had years of talk. Now it is time for action. The American people are looking for us to take action. They are looking to the President and the Congress, and they are asking what are you going to do?

Governor Christie and the other members of the President's Commission on Drug Addiction have given us an excellent blueprint for action with dozens of recommendations. Now it is up to us, Republicans and Democrats, Federal, State, and local officials, researchers, policymakers, doctors, drug companies, health providers on the ground, and families of the faith communities. We need to work together to end this epidemic.

There are some things that we can do right now to help prevent addiction and save those who already have this disease. For example, we can ensure that every single person who needs naloxone has it. The Commission's report highlights the importance of equipping first responders with naloxone, including police officers, fire departments, and public health officials. But here is a challenge. Drug companies have continued to hike the price of this 45-year-old drug and communities have been forced to ration it. In September, I led 50 Members of the House of Representatives in sending a letter urging President Donald Trump to negotiate lower prices for naloxone, just as the Commission recommended. Unfortunately, we never received a response. The President should act now to ensure that naloxone is available at a reasonable price wherever and whenever it is needed.

We also need to ensure that every affected person has access to effective treatment. According to the Commission, and I quote, "Today, only 10.6 percent of youth and adults who need treatment for substance use disorder receive that treatment." Only 10 percent. There is simply no way to end this crisis if 90 percent of those affected are not being treated if we do not act now. To do this, we need funding.

Last month, President Trump declared this epidemic a public health emergency, but he did not propose any additional funding

to combat it. We cannot fight this epidemic without funds equal to the challenge we face. This is a sad but stark truth.

So finally, we must recognize and acknowledge the many factors that put people at risk: woefully inadequate support for our children and our vulnerable residents, worsening economic inequality, lack of opportunity, and profound disparities in the criminal justice system. We cannot solve this crisis until these risk factors are addressed.

With that, Mr. Chairman, again, I thank you for convening this critical hearing, and I look forward to the testimony and taking action on it, and I ask, Mr. Chairman, with unanimous consent, that Representatives Ruppersberger from the State of Maryland and Representative Sarbanes from the State of Maryland be permitted to sit in with the Committee and participate in this hearing today.

And with that, I yield back.

Chairman GOWDY. Without objection, welcome to our colleagues. I also want to thank the Johns Hopkins community for taking such great care of our friend and colleague over the summer. You sent him back stronger than ever, so thank you all for whoever had a role in that. You didn't send him back quite that strong, but you sent him back stronger than ever.

Governor Christie, Governor Hogan, recent past and present governors have witnessed the most devastating drug epidemic in our Nation's history. Since 1999, more than half a million Americans have died from a drug overdose, and the epidemic is escalating. Over the span of nearly 20 years, the death toll has quadrupled with the emergence of even more potent drugs and an ever-expanding online marking for illicit distribution.

Today, drug overdoses kill more Americans than gun homicides and car crashes combined. That is a staggering reality. Two out of three daily deaths from drug overdoses in the United States involve an opioid, a class of drugs commonly prescribed to relieve and manage pain. And actually, over 33,000 Americans died from an opioid-related overdose in 2015, which is an 11 percent increase from the year before.

In South Carolina where I come from, Greenville and Spartanburg Counties in particular, suffered more than 100 opioid-related overdoses in 2015, and while the numbers in the upstate of South Carolina are fewer when compared with cities like Baltimore, behind every number and every statistic is a life with loved ones and friends and potential and aspirations. We have a tendency to use numbers in government and in our line of work, but the victims aren't numbers. The victims are fellow human beings ravaged by the consequences of drug addiction, including the abuse of prescription painkillers.

We are a remarkable country of progress and innovation, community and charity. We can cure diseases that past generations lived in fear of. We can put people on the Moon and we can split atoms. Yet we are struggling with how to respond to this epidemic. I guess we need to start with how did we get here? There are more illicit users for these drugs, and there are illicit users for these drugs and there are licit users for these drugs. One is unlawful, of course, the other is legal, but with the potential for abuse and misuse remaining.

Physicians have a role to play for certain. These drugs are not available legally without a prescription. What are the pharmaceutical alternatives? Is there overprescribing? Is there sufficient information shared with patients to avoid misuse and abuse?

Frequent exposure and easy access to painkillers has led to dependency and tolerance, which drives those with a substance abuse disorder to intensify doses or methods with out without the help of a physician. Addiction to prescription painkillers is growing exponentially. On the illicit side of the equation, the level and actors are diverting high potent pills to the black market to be laced with heroin, resulting in drugs so lethal they have been called Gray Death, a term used to describe the high risk associated with every single injection. Opioid-related overdoses are now deadlier than the HIV–AIDS epidemic at its peak, more insidious that the cocaine base, cocaine powder epidemic that predated it.

So there are a plethora of questions to be asked, such as whether we are being as effective as possible in the diversion of these highly toxic substances? I actually like doctors. I happen to be the son of one. But, I also prosecuted doctors. And I want to make sure the DEA and DOJ are effectively going to the source of prescriptions issued outside the course of a professional medical practice. Is HHS monitoring insurers, placing pricier but less addictive opioids out of reach for patients with acute pain? Are states regulating so-called sober homes, which can move vulnerable patients in and out of treatment, typically for profit? These are the questions our Committee and the American people want answers to. The health and safety of our communities all across the Nation are at risk. Although almost everything seems capable of being reduced to political exercise in our current environment, I genuinely hope that this epidemic is above that. I hope it is about protecting those susceptible to addiction and punishing those fueling the epidemic. Death, especially among the premature—especially the premature death of a young life has no political or ideological bet. Victims are victims. Perpetrators are perpetrators. Addiction is addiction. Heartache is heartache.

The issue, to me, comes down to those of good conscience earnestly seeking a solution and those of a malevolent conscience bent for profit off of other people's addiction and pain. It is not just the deaths that devastate our families and communities across the healthcare system; it is also the disease of addiction that is permeating and threatening in some places within our country the very fabric of those communities.

At the same time, pain is real. It is real for a homebuilder in Mr. Cummings' district or mine with immense back pain who can't otherwise get out of bed in the morning without his physician-prescribed pain medication.

So how do we solve this epidemic? There is a prevention aspect, there is a treatment aspect, there is an education aspect, there is an enforcement aspect, there is a punishment aspect, and there is an oversight aspect. In March, the President signed an Executive Order creating a Commission consisting of governors and attorney general mental health advocates, and a professor of psychobiology to recommend policies for the Federal response to this epidemic. Earlier this month, the Commission finalized recommendations for

how the Federal Government can help states and stakeholders tackle the evolving crisis and stave off emerging threats. Today, we will have an opportunity to highlight the report, and in Baltimore, and appropriately so. We will also examine Baltimore's state and Federal partners and how they can assist with and learn from the efforts that are occurring here. The devastating statistics may leave us feeling like we have just left the start line, but our country is resilient and we have resources. We have compassion. I think we have the commitment to win this battle with opioid and opioid addiction.

Chairman GOWDY. So I want to thank all of our witnesses. Governor Christie, you are the governor of the great State of New Jersey. As I mentioned to you in the ante room, you are also a former United States attorney, so you are uniquely well-suited and we cannot thank you enough, not just for your presence today, but for your willingness to undertake this vitally important responsibility and role, and with that, you are recognized.

PANEL I

WITNESS STATEMENTS

STATEMENT OF THE HONORABLE CHRIS CHRISTIE, GOVERNOR OF NEW JERSEY

Governor CHRISTIE. Thank you, Mr. Chairman. Ranking Member Cummings, thank you for your work in this area, and thanks to all members of the Committee for inviting us today.

As the Chairman mentioned, in March the President asked me to chair his Commission on Opioid and Drug Addiction in our country. We worked together to name a bipartisan group of people to join that Commission. I think that is an important place to start. I can tell you, as the Chairman referenced in his remarks and Mr. Cummings in his, I am acutely aware as a Republican governor in the State of New Jersey that there is much that divides political dialogue in our country right now that makes it very difficult for us to get things done. This cannot be one of them.

I read the obituaries that are happening regularly in our state, and in none of the obituaries do they designate whether the person that died was a Republican or a Democrat. They are a son or a daughter, a husband or a wife, a mother or a father. And so I hope that what we try to do in the Commission and this Committee is trying to do today will help to rise—give this problem the ability to rise above the partisanship that we have in our country today.

It is true, this is the greatest and broadest public health epidemic of our lifetime. Everything else pales in comparison to the breadth of this problem. It is everywhere in America. One hundred seventy-five people are dying per day, which for someone who comes from where I come from, the most powerful analogy is that this means that we have a September 11 every two and a half weeks. Every two and a half weeks.

Now I want to ask all of you and ask this Committee, if we had a terrorist organization that was invading our country and killing 175 of our citizens every day, what would you be willing to pay to make it stop? We don't ask that question in this country, and the reason we don't ask this question, in my view, is because we still

believe that this addition is a moral failing. We are making moral judgments on the people who are suffering and dying, and we are making moral judgments on their families.

Every time I go to a drug treatment center in my state and I ask someone who is in the midst of treatment, tell me your story. Within the first two minutes, they say to me but Governor, I am from a good family. And my response to that is why would you think I would think otherwise? The reason why they believe that is because the stigma that is attached to this disease each and every day makes people believe that they have to defend their very upbringing, their performance as parents, their role as a child. That somehow we believe that this is a choice.

I would love to see a show of hands in this audience of who has not made a bad decision in their life. Usually works. The fact is, we all have. Many of us in this room are fortunate that bad decision was not to abuse opioids or heroin, because if it had been, we might be in a very different judgment position than some people are today. Addiction is a disease. It is a chronic disease, and it needs to be treated as such and viewed as such. That is why I am proud the President declared this a national public health emergency.

Now, as Mr. Cummings mentioned, we need to fund the Public Health Emergency Fund, which by my last check was at $66,000. I don't think that is going to make it, everybody, in combating this problem. We need to fund the Public Health Emergency Fund to make sure that the Administration has at their disposal the resources that they need to implement the recommendations that the Commission has made.

We had lots of discussion in the opening remarks about the role of physicians and healthcare providers in all of this. Let me be very clear. This is a drug epidemic that did not start on the corners of Baltimore or the corners of my hometown in Mendham. They started in doctor's offices and in hospitals across this Nation. And while some of it, as Chairman Gowdy implied in his remarks, are done by folks who have bad intent, most of these done by folks who have no intent. Why do physicians and healthcare providers have no intent on this issue? Because they are not educated on this issue. Broadly across our country in medical schools in every state in the union, we are not educating our future doctors and nurses, dentists, on the dangers of these drugs.

We grant DEA licenses to write prescriptions for these drugs without requiring continuing medical education on opioid addiction and how it can lead to heroin addiction. I, as a lawyer—a recovering lawyer, but a lawyer nonetheless—I have to—even as governor today, I have to take continuing legal education every year to maintain my license. And I'm not practicing. How is it that physicians can have a DEA license and not be required to have continuing medical education on this very problem when 64,000 people died last year? The Commission recommends that we do that. And if you don't believe that limits on opioid prescription length as an initial prescription work, with exceptions, obviously, for people who are terminal from cancer and in hospice.

Let me tell you what is happening in New Jersey just since we put a five-day limit on opioid prescriptions beginning on March 1

of this year. Opioid prescriptions in New Jersey are down 15 percent from March to October, and the number of pills are down 20 percent that have been prescribed in just that seven-month period of time. Those restrictions work, and they should be instituted in every state across this Nation, and that is also in the report.

I want to commend the President for granting waivers to states now for the old-fashioned, antiquated, and ridiculous IMD restriction, Institutes of Mental Disease. It says that if there is any hospital healthcare provider that has more than 16 beds, 16, that those folks cannot be reimbursed for the federal share of Medicaid because they are a state psychiatric hospital. What that means is there are literally thousands of beds that could provide the treatment that Chairman—that Ranking Member Cummings recommended in his remarks that could begin to take that 10.6 percent number up significantly, but are not opened because of this antiquated waiver. States have been asking for this ability to waive this for years. I commend the President for ordering that to be done, and tomorrow in New Jersey, the head of CMS will be coming to New Jersey with me to announce that New Jersey has received a waiver, and that hundreds of beds will open within the next six months for people who need drug treatment. And these are folks who are the neediest in our society, those folks who qualify for Medicaid.

We need to increase physician education across the Nation, and we need to decrease the influence of the pharmaceutical industry on that education. See, right now most doctors only get their education from the very companies that are producing the pills that they want them to prescribe.

Now as Chairman Gowdy said, I am a former prosecutor, and that makes me a little bit skeptical, and I am from New Jersey, which makes me completely cynical. And so what that tells me is if the only education physicians are getting are from those people who want them to prescribe these pills, and then in 2015 259 million prescriptions for opioids were written in this country, enough to give every adult in this country their own bottle of 30 pills, 259 million. We are four percent of the world's population, and we consume 85 percent of the world's opioids. If you don't think that that is where this problem started, listen to the CDC who says that four of every five new heroin addicts began with prescription opioids.

We need to have alternatives to opioids, because as the Chairman said, pain is real for many people in this country. But that is what pharmaceutical companies should be spending their money on, not on paying doctors to write more prescriptions for opioids. And so that is why we as a Commission brought together Dr. Francis Collins, the head of NIH, and all of the executives of the major pharma companies in this country in New Jersey and got them to agree to a partnership where they will now work with NIH to come up with two different solutions to this problem. First, more non-opioid painkillers to be put on the market and be affordable, and second, more alternatives to medication-assisted treatment for those who are already addicted. Right now we have three in this country. There should be more.

Those pharma companies said they have 43 different compounds among them that could address either or both of these issues. If

they are not moving forward, we need NIH to be the accelerant for moving them forward, and I would urge this Committee to look at additional funding for NIH specifically for that program to make sure that we work in partnership with the pharma companies to get these things to market, along with the FDA, as quickly as possible. If people have an alternative to opioids, both the physicians who prescribe these things for pain, and the consumer who wants to avoid addiction, to have non-opioid alternatives, that would be enormously helpful in stemming the tide here.

The insurance companies play a large role in this as well. Now as a governor, I get folks all the time saying to me well, why don't you change the regulation of insurance companies to make sure that they are covering drug treatment, so that middle class folks in our country who have employer-provided health insurance can get treatment, when right now most of them do not. And I say well, remember this. Only 30 percent in my state of the health insurance policies, employer-based health insurance policies, are regulated by the State of New Jersey. Seventy percent are regulated by the Federal Government under ERISA. So we say why doesn't the Department of Labor step in? Well, they don't have the authority to do it. Under the statute that Congress passed in the Mental Health Parity Act, they do not allow the Department of Labor to fine an insurance company or an employer who is not treating mental health and addiction with parity, and they do not allow the Department of Labor to investigate individual insurance companies. They must go employer by employer. How ridiculous is that?

We urge the Congress and the Commission to give the Secretary of Labor both the authority and the responsibility to fine insurance companies that are not treating addiction with parity to all other diseases, and to give the Secretary of Labor the authority and the responsibility to be able to investigate insurance companies directly, and not have to go employer by employer by employer, when we know that we have a number of very large insurance companies in this Nation that cover thousands of employers. As a former prosecutor, I can tell you, one robust investigation is a lot easier to staff than 2,000 little ones, and much more effective.

Lastly, and then I will leave it for questions, because I can go on for a long time. Drug court is a very important part of this. We need alternatives to incarceration. We have put forward in New Jersey the largest criminal justice reform in the last two years of any state in America, and one of the things we have done is institute drug court in every county in our state.

What does it mean exactly? When you come in, not as a dealer, not as a violent actor, but as a non-violent possessor, an addict, you are now in New Jersey required by law to go to drug court and you are diverted to treatment, not to jail. Now if you don't take your treatment seriously and the judge decides that you are not utilizing the opportunity that is being given to you, they will then send you to jail. But you are going to get a chance first to go to treatment. We should have drug court, and the Commission recommends this as well, in every federal district in this Nation. One judge in every federal district committed to dealing with the drug problem in this country, to diverting people into treatment and to giving those families and those addicts who are suffering from this disease hope

and opportunity to get better. I am a former prosecutor. I am all for jailing people who profit from this poison, and I am in favor of putting them in jail whether they are standing on a street corner in any town or city in this country, or whether they are standing in a hospital or in a doctor's office. If you run a pill mill and you have a physician, you should go to jail just as soon as this drug dealer on the corner should go to jail, but we will not solve this problem by incarcerating addicts. And we must get them the treatment that they need to be able to have the tools to recover.

In New Jersey, we have now been the first state in the country to convert a state prison into a drug treatment facility, and so now, state prisoners who are in their final year of incarceration who have a demonstrated drug problem transfer from a standard state prison to the state prison treatment facility that we have on the property of Fort Dix in New Jersey run by a certified addiction treatment company that works in conjunction with our Department of Corrections to give people the tools to deal with their addiction before they leave prison, so that when they get back on the street, we lower their chance for recidivism. All these things are in the report recommended for states and the rest of this country. We are proud of Governor Baker, Governor Cooper, Attorney General Bondi, Congressman Kennedy, and Professor Madras who joins me on the Commission and worked in a completely nonpartisan manner to make these recommendations to the President, and I hope that the members of Congress work with the President and hold the Administration and each other responsible for getting something done on this issue.

Thank you, and I am happy to take questions.

[The prepared statement of Governor Christie follows:]

HEARING ON THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION

AND THE OPIOID CRISIS

Tuesday, November 28, 2017, 12:30 p.m., Johns Hopkins Hospital, Baltimore Maryland

Written Statement of:

GOVERNOR CHRIS CHRISTIE

CHAIRMAN, PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS

Chairman Gowdy, Ranking Member Cummings, and members of the Committee, thank you for inviting me to testify today about the critical public health emergency of opioid addiction.

I am pleased to see that this Committee is focusing on this issue. I appreciate the opportunity to play a role in your efforts today, and I offer you my full commitment to providing any assistance I can going forward. I come before you today as Governor of the State of New Jersey and Chairman of the President's Commission on Combating Drug Addiction and the Opioid Crisis; but most importantly I am also here as a concerned citizen and a father.

In my testimony I will give an overview of the breadth this crisis, what my Administration has done in New Jersey to combat opioid addiction, briefly touch on key recommendations put forth to the President in the Commission's report as well as federal action thus far, and appeal to this Committee that Congress should put this public health emergency front and center.

Let me be clear right from the start: this epidemic is the greatest public health issue of our time. And it deserves the *full* attention of the federal government, state and local governments, private industry, and individual citizens. Without that, we cannot beat this. We cannot wish it away, and goodwill will only take us so far. We need a fully coordinated attack with all our forces behind us.

Our people are dying. More than 175 lives are lost every day. If a terrorist organization was killing 175 Americans a day on American soil, what would we do to stop them? We would do anything and everything. We must do the same to stop the dying caused from within.

It is time we all say what we know is true: addiction is a disease. However, we do not treat addiction in this country like we treat other diseases. Neither government nor the private sector has committed the support necessary for research, prevention, and treatment like we do for other diseases. Today, only 10.6% of youth and adults who need treatment for a substance use disorder receive that treatment. This is unacceptable. Too many people who could be helped are falling through the cracks and losing their lives as a result.

Although many of us at the state and local level have been undertaking this battle for many years, the President has now taken it to the next level by declaring the opioid crisis a national public health emergency under federal law. Through this one act, the President signaled to the country that the force of the federal government should and will mobilize to reverse the rising tide of overdose deaths. Now, Congress must play its role and provide the funding that this country needs to do just that.

I am encouraged that there is a growing national focus on this epidemic: starting with the President's formation of the Commission that I am proud to Chair, followed by the President's bold and decisive action in declaring a national public health emergency, and now the work of this Committee and hopefully all of Congress soon.

I am proud to say that in my home state of New Jersey, we have set the tone for this national focus. As Governor, my Administration has committed not only historic funding for this effort, but also a comprehensive, robust, and coordinated approach to providing programs and supports for addiction prevention, treatment, and recovery. There are addiction specific programs throughout the state agencies in New Jersey - everything from housing supports to educational programs; physician education initiatives to criminal justice reforms.

In the beginning of this year, I dedicated nearly all my State of the State address to the issue of addiction. I laid out an aggressive plan including the development of a website and hotline where individuals have access to information on opioids, available treatment providers, and other critical resources. ReachNJ.gov and 1-844-REACH-NJ have literally been lifesavers for our citizens, and they can serve as a model for other states.

I also set forth a plan to develop a full-scale marketing and public outreach campaign designed not only to inform our citizens about the new resources available to them, but also to fight the stigma of addiction and let those suffering know that they are not alone; help is within reach. We put significant funding behind this campaign, which has allowed us to blanket our communities with our message on TV, radio, social media, and billboards.

In my State of the State, I also announced the formation of the Drug Abuse Control Task Force, which pulled together several members of my Cabinet, all of whom head up departments that have a significant role to play in combating this epidemic. I charged this Task Force with developing a multi-pronged, multi-agency attack on the addiction crisis, and it did just that. My Administration is working to implement the 40 recommendations set forth by the Task Force that touch on education, prevention, intervention, treatment, recovery, and reentry.

The work of the Task Force also inspired a broad initiative in New Jersey through which my Administration has committed approximately $200 million to implement and expand 25 groundbreaking programs that aid the diverse population that suffers from addiction, including new and expecting mothers, high school and college students, those in need of housing, parents struggling to keep their families together, and individuals who are re-entering society from incarceration. One thing we know for sure about addiction is that it does not discriminate so we need a multi-faceted approach to help all those affected.

It is time now for the federal government to follow the lead of my state, and many other state and local governments who have begun to face this challenge head-on. In New Jersey, we are committing resources across all agencies and the federal government must do so as well if we are going to have a chance to win this battle. This cannot be just a health matter, just a criminal justice matter, or just a matter of educating kids about drugs; we need a robust and inclusive response.

As Chairman of the President's Commission on Combating Drug Addiction and the Opioid Crisis, I am proud to say that we have laid out a comprehensive, aggressive, and evidence-based plan for success. Our interim report set forth several practical recommendations, including the recommendation to declare addiction a national public health emergency which, as discussed, the President has already

implemented. Our final report, which the bi-partisan Commission approved unanimously on November 1, 2017, incorporates our interim recommendations and sets forth dozens more, all of which are designed to treat addiction as a national priority.

The Commission's recommendations will help doctors, addiction treatment providers, parents, schools, patients, faith-based leaders, law enforcement, insurers, the medical industry, and researchers fight opioid abuse and misuse by reducing federal barriers and increasing support to effective programs and innovation.

In addition to the national public health emergency declaration, the Trump Administration has already taken several other significant actions:

- The President has acted to remove one of the biggest federal barriers to treatment by announcing the launch of a new policy to tamper down the restrictive, decades-old federal rule that prevents states from providing more access to care at treatment facilities with more than 16 beds. These CMS waivers will take people in crisis off waiting lists and put them into a treatment bed and on the path to recovery. I am proud to say that New Jersey has received a waiver, and I urge all Governors to apply to CMS for their own waiver. This policy will – without any doubt – save lives. Governors across this nation are thankful that the President listened to our call for help.

- In the interim report, the Commission called for prescriber education and enhanced access to medication-assisted treatment for those already suffering from addiction. The President acknowledged the need for these recommendations and directed all federally employed prescribers to receive special training to fight this epidemic. This was a bold step to deal with this issue.

- The Commission recommended that the Department of Justice, which has already acted forcefully to stop the flow of illicit synthetic drugs into this country through the U.S. Postal Service, continue its efforts. The aggressive enforcement action being taken by the Trump Administration is critical in our efforts to reduce the rise of overdose deaths in this country.

- National Institutes of Health (NIH) Director Dr. Francis Collins has been partnering with pharmaceutical companies to develop non-addictive pain medication and new treatments for addiction and overdose. The Commission worked with Dr. Collins to convene a meeting with industry leadership to discuss innovative ways to combat the opioid crisis. The Commission also held a public meeting to highlight the progress and innovation occurring today resulting from the NIH's work. This type of scientific progress is a positive step to stem the flow and help free the next generation from the widespread suffering addiction is causing today.

These actions demonstrate a clear commitment to combating the scourge of addiction, but they are just a start. The Commission's interim recommendations called for more data sharing among state-based prescription drug monitoring programs and recognized the need to address patient privacy regulations that make it difficult for health providers to access information and make informed healthcare decisions

for someone who has a substance use disorder. We also recommended that all law enforcement officers across the country be equipped with life-saving naloxone.

Further, and here is an area where we need Congress to act, we recommended full enforcement of the Mental Health Parity and Addiction Equity Act to ensure that health plans cannot provide less favorable benefits for mental health and substance use diagnoses than physical health ailments. Statutory changes are needed for the Department of Labor to have enhanced penalty and enforcement powers directly against insurers failing those who depend on them for life-saving treatment. The Secretary of Labor testified he needs the ability to fine violators and to individually investigate insurers not just employers. The Commission agreed with Secretary Acosta. If Congress does not give him these tools, we will be failing our mission as badly as health insurance companies are failing their subscribers on this issue today leading to deaths.

The Commission also recommended an expansive national multi-media campaign to fight this national health emergency.

This campaign, including aggressive television and social media outreach, must focus on telling our children of the dangers of these drugs and addiction, and on removing stigma as a barrier to treatment by emphasizing that addiction is not a moral failing, but rather a chronic brain disease with evidence-based treatment options. People need to be aware of the health risks associated with opioid use, and they must stop being afraid or ashamed of seeking help when facing their addiction.

As I mentioned, my State of New Jersey has joined many other states to undertake this media strategy with significant positive results. However, having a nation-wide campaign will serve to reinforce the message and ensure, for example, that youth and young adults no longer believe that experimenting with pills from a doctor is safer than experimenting with illegal substances from a drug dealer.

As part of its prevention recommendations, the Commission also called for better educating middle school, high school, and college students with the help of trained professionals such as nurses and counselors who can assess at-risk kids. Children have not escaped the consequences of addiction and our efforts to reduce overdose deaths must start early. The First Lady's dedication and leadership in helping our nation's children will make this a top priority and help save innocent young lives.

One of the most important recommendations in the Commission's final report is getting federal funding support more quickly and effectively to state governments, who are on the front lines of fighting this addiction battle every day. Bureaucracy, departmental silos, and red tape must not be accepted as the norm when dealing with funding to combat this epidemic.

Accordingly, we have urged Congress and the Administration to block grant federal funding for opioid-related and SUD-related activities to the states. There are multiple federal agencies and multiple grants within those agencies that cause states a significant administrative burden from an application and reporting perspective. Money is being wasted and accountability for results is not as intense as it should be. Block granting them would allow more resources to be spent on administering life-saving programs. This was a request shared with me by nearly every Governor, regardless of party, across the country. And as a Commission that has three governors as members, all of whom know the frustration of jumping through multiple hoops to receive the funding we need, we wholeheartedly agreed.

Throughout the comprehensive recommendations of its final report, the Commission also identified the need to focus on, deploy and assess evidence-based programs that can be funded through these

proposed block grants. Many of the recommendations acknowledge a need for better data analysis and accountability to ensure that any critical dollars are spent on what works best to fight this disease.

From its review of the federal budget aimed at addressing the opioid epidemic, the Commission identified a disturbing trend in federal health care reimbursement policies that incentivizes the wide-spread prescribing of opioids and limits access to other non-addictive treatments for pain, as well as addiction treatment and medication-assisted treatment.

First, individuals with acute or chronic pain must have access to non-opioid pain management options. Everything from physical therapy, to non-opioid medications, should be easily accessible as an alternative to opioids. The Commission heard from many innovative life sciences firms with new and promising products to treat patients' pain in non-addictive, safer ways; but they have trouble competing with cheap, generic opioids that are so widely used. We should incentivize insurers and the government to pay for non-opioid treatments for pain beginning right in the operating room and at every treatment step along the way.

In some cases, non-addictive pain medications are bundled in federal reimbursement policies so that hospitals and doctors are essentially not covered to prescribe non-opioid pain management alternatives. These types of policies, which the federal government can fix with the large entitlement programs, are a significant deterrent to turning the tide on the health crisis we are facing. The Commission has urged the President to direct HHS to fix it.

Second, as a condition of full reimbursement of hospitals, CMS requires that hospitals randomly survey discharged patients. HHS previously included pain question response information in calculations of incentive payment, but in 2017 thankfully abandoned this practice. However, all pain survey questions were not withdrawn from the surveys. The Commission recommended that CMS remove pain questions entirely when assessing consumers so that providers won't ever use opioids inappropriately to raise their survey scores. We urged the President to order HHS to do this immediately.

The expectation of eliminating a patient's pain as an indication of successful treatment, and seeing pain as the fifth vital sign, which has been stated by some medical professionals as unique to the United States, was cited as a core cause of the culture of overprescribing in this country that led to the current health crisis. This must end immediately.

Also contributing to this problem is the fact that HHS/CMS, the Indian Health Service, Tricare, and the VA still have reimbursement barriers to substance abuse treatment, including limiting access to certain FDA-approved medication-assisted treatment, counseling, and inpatient/residential treatment.

It's imperative that federal treatment providers lead the way to treating addiction as a disease and remove these barriers. Each primary care provider employed by the above-mentioned federal health systems should screen for SUDs and, directly or through referral, provide treatment within 24-to-48 hours. Each physician employee should be able to prescribe buprenorphine (if that is the most appropriate treatment for the patient) in primary care settings. The Commission urged the President to make this happen immediately.

A good example of this federal leadership occurred when Department of Veterans Affairs Secretary Shulkin, in response to the Commission's interim report release, immediately launched eight best practices for pain management in the VA health-care system. These guidelines included everything from alternatives and complimentary care, counseling and patient monitoring to peer education for front-line

providers, informed consent of patients and naloxone distribution for veterans on long-term opioid therapy. I had the opportunity to visit with doctors and patients at the Louis Stokes Northeast Ohio VA Healthcare System and witnessed first-hand the positive results of a hospital that has embraced a different continuum of care for pain management. The VA doctors, which included behavioral health specialists, acknowledge and treat those with addiction in the full complement of ways the medical community would tackle other chronic diseases. Let's use these VA practices as an example for our entire healthcare system.

As was made clear in the Commission's recommendations, the Federal Government, including Congress, has a number of avenues through which it can ensure that individuals with addiction disorders get the help they need; including changing CMS reimbursement policies, enforcing parity laws against non-compliant insurers, promoting access to rural communities through such tools as telemedicine, and incenting a larger treatment workforce to address the broad scope of the crisis.

For individuals with a substance use disorder, ensuring life-saving access to affordable health care benefits is an essential tool in fighting the opioid epidemic. Let that sink in.

Look at Indiana as an example. After Indiana used an insurance access program to rapidly respond to a rural, opioid-related health crisis, the Indiana Department of Health reported that such a program opened the door to life changing medical treatment.

The Commission recommended that a drug court be increased at the state level and established in every one of the 93 federal district courts in America. It is working in our states and can work in our federal system to help treat those who need it and lower the federal prison population. For many people, being arrested and sent to a drug court is what saved their lives, allowed them to get treatment, and gave them a second chance.

Drug Courts are known to be significantly more effective than incarceration, but 44% of U.S. Counties do not have an adult drug court. DOJ should urge states to establish state drug courts in every county.

Further, drug courts need to embrace the use of medication-assisted treatment for their populations, as it clearly improves outcomes. The criminal justice system should accept that medication, when clinically appropriate, can lead to lasting recovery; abstinence-only sobriety is not the only path to recovery.

Lastly, the Commission's recommendations identified multiple ways to reduce the supply of licit and illicit opioids and enhanced enforcement strategies. Recognizing the growing threat of synthetic opioids such as fentanyl, the Commission recommended enhanced penalties for trafficking of fentanyl and fentanyl analogues and called for additional technologies and drug detection methods to expand efforts to intercept fentanyl before entering the country.

Many other thoughtful, vital recommendations were included in the Commission's final report. These recommendations were informed by expert testimony provided during the Commission's public meetings, which included treatment providers and experts, pharmaceutical innovators and insurers. They also were informed by thousands of written submissions accepted by the Commission as part of its public process.

The Commission is confident that, if enacted quickly, our recommendations will strengthen the federal government, state, and local response to this crisis. But it will take all invested parties to step up and play a role: the federal executive branch, Congress, states, the pharmaceutical industry, doctors,

pharmacists, academia, and insurers. The responsibility is all of ours. We must come together for the collective good and acknowledge that this disease requires a coordinated and comprehensive attack from all of us.

The time to wait is over. The time for talk is passed. 175 deaths a day can no longer be tolerated.

Obviously, many of the Commission's recommendations will require appropriations from Congress into the Public Health Emergency Fund, for block grants to states and to DOJ for enforcement and judicial improvements. It was not the Commission's charge to quantify the amount of these resources, so we did not do so in our report.

The President has made fighting the opioid epidemic a national priority, and the country is ready to follow his lead. On behalf of the Commission, my state, my family, and our country, I urge Congress to do their constitutionally delegated duty and appropriate sufficient funds (as soon as possible) to implement the Commission's recommendations.

If at any point, you question the urgency and severity of this national crisis, I encourage you to watch the video of the Commission's final public meeting on November 1, 2017. At that meeting, the Commission was honored to be joined by individuals who have suffered through this crisis either personally or through a loved one. The Commission members and others in attendance listened with tears in our eyes to the heart-wrenching stories of personal suffering and the devastating loss of children to the ravages of this disease. If you are at all uncertain about the need for change, the importance of making this a national priority, and the absolute necessity of funding, you must experience the stories that we experienced. And when you do, remember that, unfortunately, they are just a mere fraction of the heartbreaking scenarios that are playing out each day in our country because of this disease. And remember: there but for the grace of God, go I.

I want to thank this Committee again for providing me the opportunity to join you today to discuss this critical issue, and I am happy to take any questions.

Chairman GOWDY. Thank you, Governor Christie. I will now recognize the gentleman from Maryland for his questions.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and thank you, Governor Christie. I want to—and as I said to you before the hearing and now, an excellent report.

I want to talk about naloxone a little bit. I had a situation, Governor, where not very long ago I was at an event for the Maryland Legislative, my caucus, and I walked outside coming out of the event and somebody just dropped a man right in front of the hotel. And I said well what's going on? They said well this happens all the time. We see people who may be at a party and they don't know—the person has an overdose and they don't know what to do. And I use that as an introduction with regards to naloxone, because of course, as you well know, it has been—it is a drug that has been used to save lives with regard to overdoses. And in your report, you are saying—this is what you said. Price increases of the various forms of naloxone continue to create affordability issues, preventing state and local governments, as well as community organizations from stocking naloxone at the levels necessary to rescue more people from the overdose. Is that correct, Governor?

Governor CHRISTIE. That is true, sir, yes, and what we recommend in the report is that governments, starting with the Federal Government, should band together to use their purchasing power to make bulk purchases of naloxone at lower prices, and then there is no reason why—we do this in many other areas of bulk purchasing, whether it is through the GSA, as you know, or through other entities, to be able to do this. And there is no reason we shouldn't be able to do this with naloxone.

And one of the things we are doing in New Jersey, which we are also recommending in the report, is co-prescribing. When you are a physician, you prescribe an opioid, to prescribe at the same time naloxone to go to the home, because some of these overdoses are not intentional. They are accidental. Someone is in severe pain, thinks well if two pills every four hours is good, four pills might be better. So it is not just for the person who is suffering from addiction, it is also for the person who unintentionally misuses this, to have naloxone available in the home so that—in an easy form so that the folks who live with them, if they have an overdose like the one you mentioned outside the hotel, it is—in its nasal form now it is very easy. It is two pushes of a button. One in one nostril, push the button, one in the other nostril, push the button, and you save a life.

Mr. CUMMINGS. You know, our health commissioner will be testifying in a few minutes. It is one who has been very strong, Dr. Wen here in Baltimore. You know, but the thing that I think bothers me so much about naloxone is that the price was jacked up, I mean, big time, when—at the very time when first responders and others were trying to get it because they saw the effectiveness of it.

Did you have discussions with any of the manufacturers or drug companies with regard to naloxone?

Governor CHRISTIE. We did not in terms of the pricing issues——

Mr. CUMMINGS. Okay.

Governor CHRISTIE. —Congressman. What we did, though, talk about was the concept of bulk purchasing and their willingness to

consider the idea of bulk purchasing lowering prices. And so we did talk about that with the manufacturer—with a few of the manufacturers, and that is why we urged it in the report. We believe it is something that can be done, and that these manufacturers recognize. And the Commission emphasized to them their social responsibility.

Mr. CUMMINGS. And that negotiation recommendation that you just talked about was in—I noticed it was in the interim report, but I didn't see it in the final report.

Governor CHRISTIE. This is some confusion. The way the Executive Order was written, Mr. Chairman, was that the President wanted first an interim report and then a final report. They should not be read as mutually exclusive, they should be read together. And so if there is, I think, 56 recommendations in the final report, there is nine in the interim report. We have made 65 recommendations. So the nine interim recommendations remain fully enforced and in effect and should be added to the final report. So——

Mr. CUMMINGS. Good. Well I am glad you clarified that. I thought you just kind of changed your mind.

Governor CHRISTIE. No, sir. I think you know me well enough to know that changing my mind would be a difficult thing.

Listen, I reminded the White House on a regular basis, and you need to know this.

Mr. CUMMINGS. My last question——

Governor CHRISTIE. This was our report.

Mr. CUMMINGS. My last question is this. Have you discussed this report at length with the President? In particular, have you discussed this naloxone recommendation?

Governor CHRISTIE. Yes, I have discussed it with——

Mr. CUMMINGS. And which response did you get?

Governor CHRISTIE. I did not—let me fully answer this, sir. I didn't—we have discussed the report at length. I have not discussed the specific pricing issue of naloxone. My conversation with the President was more on how important it was for all law enforcement officers and first responders to have it, but we did not get into the pricing part of it in my conversation directly with the President. But I have had that conversation with other members of the Administration.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Governor CHRISTIE. Thank you, sir.

Chairman GOWDY. The gentleman from Maryland yields back. The gentleman from Wisconsin is recognized.

Mr. GROTHMAN. Sure, a couple questions.

This is really a horrible thing, and I think it is a very publicized problem and it is still underpublicized. Did you look at other countries who perhaps did not have the opioid problems we have? I was in Taiwan like 10 years ago and they had almost no problem. Could—I think England has a big problem. Could you comment on the criminal justice systems and how they deal with possession or sale of opioids in other countries?

Governor CHRISTIE. Yeah, we didn't look at it from a criminal justice perspective. What we looked at it from was an availability perspective, and the biggest difference we see between our country and the others is the extraordinary overprescribing of these drugs.

We believe that part of it was caused by the Federal Government, quite frankly, with this, you know, pain as a vital sign requirement where everybody who leaves the hospital has to have the smiley face, you know, on their lack of pain. And the hospitals were evaluated on this basis, and so what was going on was hospitals were like heck, if we are going to be evaluated on this basis, you are going to leave with no pain, and the best way to leave with no pain is to give you a whole bottle of Percocet and get you taking it.

And so the difference is the way at the very base of this problem we are dealing with the availability of this medication.

Mr. GROTHMAN. Okay. Do you know anywhere where I would even be able to get access to how they treat possession or sale of opiates in other countries that don't have this problem?

Governor CHRISTIE. Sure. We—and the Commission can be very helpful in that regard, because we dealt with a lot of other countries on those issues but not on the particular one you are talking about. But we would be happy to help. Could you get your staff in touch with ours? We would be happy to help.

Mr. GROTHMAN. Yeah. Next question I have, what percentage of people who are arrested for opiates, heroin or whatever, are addicted and what percentage are just using it?

Governor CHRISTIE. I don't know the exact numbers, Congressman. What I will tell you is that the rate of addiction in terms of the amount of time that it takes someone to get addicted to these, according to the CDC, is as little as three days. So if you have a predisposition to this, within three days of your use you could become addicted. Which is why the CDC says their recommendation is to limit prescriptions to no more than three days on initial prescription, because they think beyond three days you can become addicted.

Mr. GROTHMAN. Have you talked to anybody who—when you talk to people who are arrested for heroin, do they say they were addicted in one or two days?

Governor CHRISTIE. I will tell you that this young woman—yes. The answer is yes, and I have spoken to literally hundreds of people across my state in treatment centers about this who say that the time for addiction is very brief. I will tell you that young—one young woman who is part of our public advertising campaign on this issue in New Jersey, it is a young woman who suffered an injury, knee injury. She used her first bottle of pills. This young woman, who was a college graduate, cheerleader in college, went out, had her first job, and she was addicted within the first week that she was on these drugs. She went from being employed, having her own place to live, supporting herself, to within 60 days having lost her job, moved out of her apartment, and was living on the streets of Atlantic City in New Jersey and prostituting herself to get heroin.

Mr. GROTHMAN. Okay, I will give you one more question because I don't see—normally, as you know, on these Committee hearings have a clock, but I don't—in Vietnam, as I understand, heroin was somewhat widely used, and something has been said about how quickly it was not used by the troops once they got back in the United States, which would be a little bit inconsistent with the idea that heroin is always addicting. Can you comment on that?

Governor CHRISTIE. Yeah, I don't think anything is always addictive to anybody. I don't think it is always addictive, sir. I think there are people, as we know, who use prescription opioids and some who use heroin who use it and can use it recreationally and not become addicted. So I think we have to be very careful about using the phrase always or never in this context, because you are dealing with human beings who have different genetic backgrounds and make-ups, different psychological make-ups, and different physiological make-ups, and I think any of the physicians who are here at Johns Hopkins would tell you this is what makes what they do an art, as well as a science.

And so no, there is no always on this, sir, but what I would tell you is that when CDC says that four out of every five heroin addicts start with prescription opioids—and we are talking about the same compound—this is something that is lethal in terms of its ability to become addictive.

Mr. GROTHMAN. I will give you one more question.

Governor CHRISTIE. Sure.

Chairman GOWDY. The red light—if you are wondering where the lighting system is, it is right there in front of the Governor. Although I am in such a charitable mood, if you do have one more short question, emphasis on short.

Mr. GROTHMAN. Sure. One of the questions—or one of the things on treatment is, of course, some people feel that treatment is frequently ineffective. Could you give us your opinion on what constitutes ineffective treatment or how we can avoid ineffective treatment?

Governor CHRISTIE. Well what constitutes ineffective treatment is anything that's not evidence-based. And so we should not be operating theoretically here, and there is no reason to because there is sufficient information across this country in the medical community about what works and what doesn't, and medication-assisted treatment works for most people who try it. The fact is, though, that the way to make sure the ineffective treatment isn't happening is through the state regulatory bodies who regulate the Departments of Health across this country need to be very vigilant about regulating what happens in treatment centers. And there are places in this country where you have a lot of fallacious treatment.

I don't want to be the first to shock you and say that there is fraud in all different areas of our country when there is money to be made. That does not discount the value of treatment. What it does is it increases the need for regulatory bodies and prosecutors to go after those people who are ripping off people by giving them false hope and fake treatment.

Chairman GOWDY. The gentlelady from the District of Columbia is recognized.

Ms. NORTON. I thank you very much, and I want to thank you, Mr. Chairman, and the Ranking Member for this very important hearing, and I want to thank you, Governor Christie, for coming and for your very forthright report which minces no words.

The last Congress and the last Administration did come forward with a billion dollars, but we have seen no slowing in this epidemic. Indeed, my own district, which is not considered one of the

most serious districts, the District of Columbia, tripled in this opioid crisis in just two years.

This notion of a national emergency versus a public health emergency has emerged, and I note, Governor Christie, that the report indicated that this was a national emergency. Is that not the case?

Governor CHRISTIE. Well no, what the report indicates is we believe it is a national emergency that can be addressed one of two ways, either through the calling of a public health emergency under the Public Health Safety Act, which was our preferred method, or on the declaring of an emergency under the Stafford Act.

Ms. NORTON. Now which—and why did you prefer one to the other?

Governor CHRISTIE. Because of who would administer the funds. If it is under the Public Health Safety Act, the funds will be administered by the Department of Health and Human Services. If it was under the Stafford Act, it would be administered by FEMA. Having had a little experience with FEMA during a small storm in New Jersey, I would just tell you that I don't believe, based on my experience, that FEMA would be necessarily the best folks to administer these funds, and that the folks at Health and Human Services would be better. That is why we made that. We gave the President an alternative because our—we felt our job was to present alternatives, but I can tell you that my recommendation to the President was to do it under the Public Health Safety Act so the funds would be in the Public Health Emergency Fund; therefore, administered by folks who I think—no apparent disrespect to FEMA—that would have a greater sense of expertise on how to deal with this issue at HHS rather than at FEMA.

Ms. NORTON. You know, I can see that bureaucratic difference may make a difference otherwise.

Governor CHRISTIE. Especially if you are a governor who dealt with FEMA, it makes a big difference.

Ms. NORTON. You—the region—this region where we are now, Maryland, Virginia, the District of Columbia, just had a summit on this issue. Governor Hogan has declared a national emergency or a state emergency here. I am trying to find whether the declaration of a national emergency would encourage Congress to, in fact, come forward with farther funding that you indicate that you thought was necessary. I mean, your remarks were replete with versions of funding one way or the other. You asked at the beginning of your testimony what would we pay a terrorist, for example, who invaded our country and making that analogy to what opioid has done. You have called in your testimony for funding the Public Health Emergency Fund for funding, NIH, but we sit here and Congress is, frankly, lost focus here. In fact, we are not sure whether the government is going to be kept open and therefore, nobody is thinking about this issue.

Would declaration of some kind of emergency force this back to the front burner of the Congress of the United States, which has not funded anything since last Administration funded $1 billion in additional funding for this emergency?

Governor CHRISTIE. Well with all due respect, I think if Congress needs different wording to focus its attention, then we need——

Ms. NORTON. Then what would you suggest?

Governor CHRISTIE. —a new Congress because if you can't tell from 64,000 Americans dying a day that this is an emergency because the President did it under the Public Health Safety Act as opposed to Stafford Act, then I would say to members of Congress on both sides of the aisle that you need to reassess from a Governor's perspective what you are doing. And I recognize the billion dollars that the last Administration, the last Congress put in. Let me put that into some context of what is needed.

In New Jersey this year, in New Jersey, we are spending $500 million.

Ms. NORTON. Of their own money?

Governor CHRISTIE. Yes, state money, $500 million. And so I am not, quite frankly, impressed with a billion dollars from the Federal Government for the Nation, when the State of New Jersey is dedicating from—in a $34 billion budget, we are dedicating half a billion dollars just to increasing availability for opioid treatment, training, naloxone. All of that is being supplied by the state to localities.

Now we need help from the Federal Government, and I want to be clear about the public health emergency. It is a national emergency. It is just two different ways of doing it. Whether it is under the Public Health Safety Act or the Stafford Act, and my recommendation was the Public Health Safety Act to keep this away from people who don't know about this problem. There is confusion about all this, and you want to see real confusion? Let's put FEMA in charge of naloxone. As somebody who was, you know, waiting for blankets and food and water in Sandy, I don't want to be waiting for FEMA to give me naloxone.

Ms. NORTON. Thank you very much.

Governor CHRISTIE. Thank you.

Ms. NORTON. I see the red light.

Governor CHRISTIE. Thank you, ma'am.

Chairman GOWDY. The gentleman from Alabama is recognized.

Mr. PALMER. Thank you, Mr. Chairman.

Is this on?

Chairman GOWDY. There you go. Now we can hear you.

Mr. PALMER. Is the clock started now, or did it——

Mr. CUMMINGS. It just started.

Mr. PALMER. No, or did it start after my colleague turned on the microphone?

Chairman GOWDY. I would ask me to—yes, I am restarting. Look into the Iron Bowl and how upset you are.

Mr. PALMER. Don't go there.

Governor CHRISTIE. It is worth at least 15 seconds.

Mr. PALMER. All right. I just wanted to go back to something that was brought up by my colleague from Wisconsin about heroin, and as an initiator versus the over-prescription of painkillers. And what we found is that in opioid addiction as initiated by painkillers like oxycodone and hydrocodone has actually gone down from 42.4 percent for oxycodone to 27.8—I mean, to 24.1 and from 42.3 percent for hydrocodone to 27.8, but in terms of heroin as an initiator, it has gone from 8.7 percent in 2005 to 33.3 percent in 2015. So I think we are on two tracks here, Governor, that I think that the

medical community has to address, but also the law enforcement community has to address.

Governor CHRISTIE. Oh, no question.

Mr. PALMER. There needs to be a tandem effort.

Governor CHRISTIE. Right, the report talks about that. There is no question that we need to make sure that enforcement against those—I think I said this in my opening statement, that as a former prosecutor, enforcement against those who are profiting from the poison that they are spreading throughout our communities has to continue, and has to continue aggressively. And so I don't think there is any—there is no reason you can't chew gum and walk at the same time. The fact is that we also need to acknowledge that treatment as a part of what our overall spend is across the national government and state governments is a fraction of what we spent on enforcement.

And so I want the three-legged stool to operate. I want there to be education prevention, interdiction, and law enforcement and treatment. But right now, the prevention education part of the treatment part are shorter legs of that stool, and as long as that continues, we are going to continue to have this problem. But you will not find me being opposed to stricter enforcement. I am against those who are profiting from this, but we must draw a distinction, in my view, between those who are profiting from it and committing violent acts in support of it, and those who are addicted, and without those other elements. Those people I think, in the criminal justice system, need to be dealt with differently than those who are profiting from it.

Mr. PALMER. I also think we need to look at this in a holistic manner. There is—I don't know anyone who doesn't know someone, either a friend who has a family member who hasn't lost someone to an opioid overdose. It crosses every boundary that you can think of: race, gender, income level, profession. But one of the interesting things is—that doesn't get talked about is family structure. When you take a look at that, 68 percent of the population is either married or widowed. Yet that only represents 28 percent of the overdose deaths. Whereas the never married and divorced population is about 32 percent, but they represent 71 percent of the opioid overdoses.

I would like to see us do a deeper dive into that to start looking at the ages in those categories, but I think that has got to be part of the discussion is the overall breakdown of the family and how that has contributed to this.

Governor CHRISTIE. You know, I think as a father of four, married for 31 years, I believe we are doing something right, at least, we are trying to. But I also want to be very careful about this as well, because there are plenty of folks who are in the situation I am who wind up having children who wind up addicted. And so there is—part of what we said in the report is there is not one silver bullet to fix this problem. There just isn't, and whether it is treatment or interdiction, so I think all of those things have to be considered and looked at as part of what is leading our country to consume 85 percent of the world's opioids with four percent of the population. So something happened all across our country that is encouraging this. But there is no question that all those things

have to be things that are considered, but I don't want to mislead anyone that there is one silver bullet to fix this, because there is not.

Mr. PALMER. Well——

Governor CHRISTIE. I am confident of that.

Mr. PALMER. —for my own personal experience, one of my children's classmates, a tremendously talented young African American artist died of an overdose, and then one of my board members of the think tank that I ran, I literally sat in their living room with them while the local authorities removed the body of his son in his bedroom who had died.

My last point, Mr. Chairman, if I may, is taking a look at the drugs prescribed through Tricare and through the VA. I have gotten information from different people about the tremendous numbers of drugs and—that are sent out that these people don't need. This is a huge issue in Alabama. It gets back to where we started—or where I started with the overprescribing of medicine. If you would like to address that?

Governor CHRISTIE. That is a large part of the diversion problem, right, so that that is why we have advocated in the report and it is happening, and it is a good partnership with the private sector as well. Places like Rite-Aid and Walgreens and other major national pharmaceutical—pharmacy chains that are setting up kiosks in all their stores for people to safely dispose of these unwanted or unused medicines. A lot of times what happens is that a young man or young woman in their own home, their parents get a prescription for this. They don't use the entire prescription and it stays there, and they decide heck, I might as well try this. Or worse, they take it out and they go to sell it because there is great value on the streets for this.

So the over-prescription of this in every way impacts this crisis in an enormous extent, and that is people who overuse it themselves, and it is also people who are—don't use it but don't know how to get rid of it safely, and as a result it winds up hanging around and is available for diversion to either other users directly in their home or to be sold outside of the home.

Mr. PALMER. Thank you, Mr.——

Governor CHRISTIE. I do want to mention one other thing, if I could, on the VA. We took a field visit as a Commission to the Louis Stokes Veterans Hospital in Cleveland, and they are doing some extraordinary things in lowering the opioid use by veterans with alternative therapies and other ways to deal with this issue with our vets, and we versed in the report that Secretary Shulkin expand that throughout all the veterans hospitals for the very reason you talked about. There are a lot of these vets who know they don't want to take this stuff, but are in real pain from the war wounds that they have suffered defending our country, and they are coming up with alternatives that are really helping the veterans community in Cleveland, and we think would help the entire country.

Mr. PALMER. Thank you, Mr. Chairman. I yield back.

Chairman GOWDY. The gentleman from Missouri is recognized.

Mr. CLAY. Thank you, Governor Christie, for your testimony today. You know, while we have made critical gains in coverage as

a result of the ACA, we still have work to do. We need to make sure that they ACA's parity requirement, which requires that insurance benefits for our mental healthcare be comparable to those for physical healthcare. I guess that is why you recommend that the DOL must have authority to investigate insurance companies.

Let me quote the report. It says "The Commission found that there are commercial insurance barriers to Medicaid and assisted treatment, despite the fact that such treatment is evidence-based and largely successful." Would you agree that all insurers, both public and private, should work to remove barriers?

Governor CHRISTIE. Sure, and that is the law in the country. I mean, this is the frustrating thing. Congress passed the Mental Health and Addiction Parity Act, but for reasons that are beyond me, gave the Executive Branch no ability to enforce it. And so we are—I don't want to be, again, New Jersey cynical, but we are counting on the goodwill of the insurance industry to cover this treatment that is required, but there is no penalty for not doing it.

So my view is as a former prosecutor, the law should be followed, and if Congress's will and the President's will at that time is to make sure that mental health and addiction is treated with parity and physical ailments, then the law should be enforced.

Mr. CLAY. So we need to put more teeth in the——

Governor CHRISTIE. You got it. And listen, we had Secretary Costa at a hearing of the Commission, and he asked for this authority. He said if you give me this authority, I will use it. And Chairman Gowdy I think knows that Secretary Costa is also a former U.S. attorney who served with me during the Bush 43 Administration. I know Alex well and I am convinced that somebody with his background and experience as a prosecutor in Miami on this issue will be very, very aggressive if the tools were given to him, and I urge Congress to give him the tools.

Mr. CLAY. Thank you for that response. I represent the State of Missouri and I am proud of a lot of things, but one issue that I am not that proud of is that we have a patchwork for a PDMP in Missouri. It may go by county or by city, but it is not really statewide and it is not effective. Talking to law enforcement in Missouri, they tell me that it is really becoming pill mill, and that is an attraction for users as well as physicians who want to make profit off of that.

Tell me how is Missouri—how do they compare to the rest of the Nation as far as being a PNA problem for law enforcement?

Governor CHRISTIE. It pains me to say this to you, sir, but it is the worst state in the Nation.

Mr. CLAY. Yeah.

Governor CHRISTIE. It is the only state in the Nation without——

Mr. CLAY. No, I appreciate——

Governor CHRISTIE. —a comprehensive——

Mr. CLAY. We need to be critical of our state.

Governor CHRISTIE. It is stunning to me that there is a state in this Nation any longer that doesn't have a comprehensive prescription drug monitoring program, and that they are not sharing that information with their neighbors. We know there are people who go from state to state to be able to fuel this addiction, and one of the—not only effective law enforcement tools, but it is also an effective healthcare tool predominantly for our physicians. They can use

the PDMP, be able to see when someone comes in presenting with symptoms that might induce them to prescribe, but if they go the PDMP and see that this patient has had a dozen, two dozen, three dozen from other doctors prescriptions for this, they can stop adding to the problem then.

So Missouri is a state that is the sole outlier on this issue, and one that is damaging the health and the safety and welfare, in my view, of the people of Missouri.

Mr. CLAY. And I appreciate hearing that, and I will make the effort with our legislature and governor to reinforce it and tell him how much we need to get our act together.

Governor CHRISTIE. Yes, sir.

Mr. CLAY. Final question. HHS and CMS now get down to the tough work of implementing some of your Commission's report, and I understand that hey are calling for states to apply for waivers from the IMD exclusion. New Jersey and Utah just got a waiver approved, but as I understand it, CMS has insisted that waivers are budget neutral, so CMS is asking for states to fund—to find cuts elsewhere in underfunded behavioral health systems to pay for SUD treatment and residential settings. To me, that doesn't reflect the urgency of this epidemic.

Can you talk to us about how New Jersey dealt with it?

Governor CHRISTIE. Yeah, I think that we are finding areas—and this is part of, I think, each governor's responsibility, is to find places within the Medicaid program where spending is not being effective. And so I think it is a good start. I think once we become convinced at the state level that we have done what we need to do in terms of cost savings, that then the Administration is going to have to make the next decision, which is to lift budget neutrality requirements from it.

You will notice in our report we do not ask for a waiver of IMD with budget neutrality, we just ask for a waiver of IMD exclusions. That is our ultimate recommendation, but I can tell you in New Jersey that governing is about choosing, and I do believe that given the level of this crisis, I can make the choices as governor that are necessary to make those beds available almost immediately. But there will come a moment when you are cutting into bone and not fat, and when that happens, then I think the broader IMD exclusion is something without budget neutrality that needs to be considered by the Administration.

Mr. CLAY. Thank you for your responses. My time is up.

Chairman GOWDY. The gentleman from Kentucky is recognized.

Mr. COMER. Thank you, Chairman Gowdy, and Governor Christie, thank you for being here today to discuss the growing crisis of substance abuse in our country.

The opioid epidemic is a particular challenge for my State of Kentucky where overdose deaths rose by 12–1/2 percent last year alone. I appreciate your work as chairman of the President's Commission on Combating Drug Addiction, and look forward to working together to make progress on this issue for all the American people.

My first question is I would like to discuss the issue of fentanyl, which accounted for nearly half of the overdose deaths in Kentucky last year. Can you briefly discuss the Commission's findings and recommendations related to this especially lethal drug?

Governor CHRISTIE. Yes. Fentanyl and carfentanil is what will take this crisis to its next geometric explosion, because the strength of fentanyl and carfentanil is so beyond normal street heroin that the first usage of it can lead to death, and often does. It is so lethal that law enforcement officers who come to crime scenes where this is have to be careful in terms of the way they deal with the crime scene so they don't contaminate themselves and wind up overdosing. And in the report, we make it very clear that this is a Chinese problem, and we have urged the President and the Secretary of State to make this a priority with the Chinese and the negotiations that they are undergoing right now. China is where most of the fentanyl and carfentanil is coming from, sometimes—more times than not, we found—and this is why we recommend an increase in border security, not just at the Mexican border, but with the United States Postal Service. The United States Postal Service is delinquent in stopping these drugs. These drugs are being mailed in to the United States, and as are with the other carriers like FedEx and UPS and others, we are not having the level of enforcement that we need.

And to your point before, Congressman, you know, this is one of those areas where I think we need to be able to step up our efforts at the Postal Service and at DOJ through the DEA to make sure that we are stopping this stuff from coming into the country, but we also need to make very clear to the Chinese that this is an act of war. You are sending this into our country to kill our people. There is no other purpose for this drug. This drug will kill people, and any foreign country, in my view, who is wilfully allowing this to be done is committing an act of extraordinary aggression on our country and it needs to be met with the right type of diplomatic response by the Administration and the Secretary of State, and we have urged that in the report.

Mr. COMER. And I appreciate the work that you have done, along with the Administration, on seeing a recent crackdown in the Chinese manufacturers, and look forward to working with the Committee to see what more we can do through the Internet and postal systems to try to prevent that.

My last question, through legislation like the 21st Century Cures Act, Congress has worked to provide more support and flexibility to states who are on the frontlines of this battle. From your experience as governor, as well as your work on the Commission, what advice do you have for Congress on how best to support state and local efforts to combat opioid epidemic both now and over the long term. And I know you mentioned the billion dollars didn't go very far when you divide it up among the 50 States, but as you know, we are in a financial crisis as well in this country so what advice do you have for Congress?

Governor CHRISTIE. Well first off, I think if this battle is going to be won, it is going to be won with the Federal Government and the state governments acting as partners, but with the state governments taking the lead. We are the ones who are on the ground, and as you said, the problem in Kentucky is different than the problem in New Jersey, and the problem here in Maryland is different than the problem in Missouri. These are state circumstances depending upon all the different ways that you go about enforce-

ment in your state, the ways you go about treatment in your state and its availability. So our view is that there is—there should be accountability block grants that block grants should be sent to the states for dealing with this crisis, and that Congress should be demanding accountability in return for the block grant. If I am given a block grant as a governor, and I say in New Jersey the best way for me to spend this money is X, and it will show a decrease in deaths, if I show that decrease in deaths, I should continue to get my funding. And if I don't, my funding should be reduced. To force me as a governor to be accountable for what I am doing.

With all due respect to Congress, you know, it is a very difficult job to be able to determine individual programs that are necessary and effective in all 50 states, and so I really believe we have to trust the governors. And because I don't believe this is a partisan issue, I don't think there is a Republican or a Democratic way to combat this. So I think part of this is going to have to be a leap of faith between Congress and the governors to be able to sit down, and I really do believe that if Congress is serious about doing this—and the President—they need to sit down with the governors. They all come to Washington in February. I won't be there, but the rest of them will be. And the fact is that we need to sit down and say listen to the governors as to what they need and Congress then needs to make demands on the governors and say okay, if we are going to be partners in this and we are going to help you fund this, then what accountability measures are you willing to give us so that we can be accountable in the financial situation we are in, that this money is being spent in a way that is effective to save lives? And that should—in my view should be the determining factor. If that number, that 64,000 continues to go up, we are failing. When it starts to go down, we are succeeding.

Mr. COMER. Well thank you, Governor, and I yield back.

Chairman GOWDY. I have not gone yet either, so let me share this with my colleagues. We want to be a good steward of the Governor's time. We also want to be a good steward of the next panel's time, so to the extent we can get it done before the red light comes on, that would be great for everyone.

And with that, I would recognize my friend from Michigan, Ms. Lawrence.

Ms. LAWRENCE. Thank you, Mr. Chairman and Ranking Member Cummings, and thank you, Governor, for being here.

You know, there is a saying that in government, if you want to know my priorities, follow my budget. Many of the organizations receiving funding through the Community Mental Health Block Grant through the Substance Abuse and Mental Health Services, and these fundings provide the wraparound services. We are talking about the access to the drug, but those of in this room and those who have been on the ground with this know putting those services to transition and nurture a person out of addiction back to a healthy life, training, rehabilitation, case management, comes through the Substance Abuse and Mental Health Services.

Unfortunately, the House Appropriation bills which we will vote on this month proposes cutting funding for the Community Health Mental Health Services Block Grant by $141 million, and our President's budget proposed cutting it by 116. Now the Commis-

sion—and I read your report. Thank you for it, but you strongly recommend and urge Congress to do their constitutionally delegated duty and appropriate sufficient funds. It is—being in Congress and being a former mayor and being in local government, sir, being held accountable for my budgetary decisions, I find I am perplexed how we can have this Commission have—you being appointed, doing all this work, yet still what we do in our budget would just cut the legs from under this program.

I need you to know in your leadership and in your recommendations to this bipartisan body, this agenda of this budget that cuts the thing that we are saying that we are so passionate about—we have statistics. I wanted to say in Michigan we have enough drugs, like you said, in the United States to give every person in the State of Michigan 1.8 prescriptions, 1.1 prescriptions, which is 84 opioid pills for every resident in my state. That is how many prescriptions we write.

So—but if we really want to make a difference, if they live, we want to get them off of it. So I need you to comment on that.

Governor CHRISTIE. Well yes, and I think we are very clear in the report. We believe there needs to be a greater financial commitment at all levels of government to this problem.

Now, you know, the fact is there are lots of other things that we can do as well and should be doing that won't cost us anything, so increased medical education, increased requirements of continuing medical education for DEA licensees. There are a lot of good things we can do that don't, but please, what we said in the report, we mean, which is that we do not sufficiently fund these programs now and we also recommend in the report that there needs to be an evaluation of all the different programs, and you just mentioned one of them, and there are literally dozens and dozens of programs we looked at that are being funded. How effective are they? I can tell you that GAO did two reports during the Obama Administration that said that these programs were not being effective in stemming the tide. We know that from the sign that is behind all of you, the number of deaths.

So I think there are a couple of things that need to be done. One is to—for us to hold ourselves accountable for all the good ideas we have had in the past. Some of them were good and some of them weren't. Let's reevaluate it and reassign that money to places that we think can be effective, and then there is going to have to be additional funds given. And I—we made that very clear. I made it clear to the President in my direct conversations with him, and every member of Congress who has asked me about this, I have said there is no avoiding having to increase funding to deal with this problem. The question is how and you guys get to make that call.

Ms. LAWRENCE. Mr. Governor and to the panel, we often hear the thing of repeal and replace the Affordable Care Act, and I equate that to you having a Cadillac and you don't change the oil or you don't rotate the tires, and then when the car doesn't operate, you say that the car is inefficient and you just throw it away.

The Affordable Healthcare Act is—provides essential health benefit services that actually directly go to the mental health parity part, but all we talk about is repeal and replace, and I don't know

if you are comfortable talking about this, but I am very comfortable. It is a time for us to have real discussion on this. We talk about the lives that we are losing, and we are so compassionate and our hearts break when we read the obituaries, but we must do the work. And I want to be that voice in the room while we are talking about this, the action that needs to be taken needs to happen. It is not good enough to get a Commission together, write an excellent report, if you don't fund it. If you don't look at the Affordable Healthcare Act that had those essential services that we are saying eliminate, how are we going to get to where we need to go?

Thank you so much. My red light is on.

Governor CHRISTIE. One thing I would just quickly in response to that say to you is we need to remember that no matter—my position on the Affordable Healthcare Act is pretty clear over time, but I won't get into all of that. I will just tell you this. The Affordable Healthcare Act insures a fraction of the number of people that private health insurance in this country insures, and yet, Congress is not permitting mental health and addiction parity to be enforced for them. And so, you know, the fact is that we have tens of millions of Americans who work hard every day and are able to obtain health insurance through their employer and pay for a good part of that as well, and they are not getting the benefit of the law and parity either.

And so I don't think it is just in talking about the Affordable Healthcare Act, we are not enforcing that as the Affordable Healthcare Act. We are not enforcing that as to private insurers. You want to talk about a feel good piece of legislation, okay, the Mental Health and Addiction Parity Act is a feel good piece of legislation, because when all you do is ask would you please do this, and if you don't, there is no penalty, we know what happens in those circumstances.

And so I think we have to have even a broader discussion about it, because it is not just for those people who are covered now under ACA, it is also those people who have been covered under private insurance for a very long time who are not getting the benefit of that law that is now a decade old. We have not been enforcing that law since the day we passed it. So it seems to be we got to have an even broader discussion that I think includes all of that.

Ms. LAWRENCE. We have to do the work.

Governor CHRISTIE. Right.

Chairman GOWDY. Professor Raskin?

Mr. RASKIN. Mr. Chairman, thank you. Governor Christie, again welcome to Maryland. I want to, first of all, salute you for the passionate intensity of your leadership of this Commission and the way that you have clearly absorbed all of the lessons of it in a powerful way. And I also want to thank you for the comprehensive nature of the recommendations that are in the report, which have—which include messages for us in Congress, and I very much take your point about empowering the Secretary of Labor to act, and I hope that is one of the things that will come out very concretely from today's session. But also, there are a whole series of recommendations across the Federal Government, the Department of Education, the Department of Justice, the National Highway Traffic Safety Administration, HHS, and so on.

So I know you are a big Bruce Springsteen fan. Who is the boss now? In other words, who is in charge of implementing all these recommendations across the Federal Government and being the leader and making sure that these things comes to fruition?

Governor CHRISTIE. Well first and foremost, the President has to be the leader. He is the person who empowered this Commission, and he is the leader of the Executive Branch of government and it is his responsibility under the Constitution to make sure that the laws are duly executed. So the buck stops with the President of the United States, and I am confident that the President is serious about this effort and will put the resources that are necessary to do it.

Mr. RASKIN. Can I just follow up on that point? So I was following your work very closely. You came out with the Commission report on November the 1st, I think it was. It was just——

Governor CHRISTIE. Yes, it was.

Mr. RASKIN. —earlier this month. Did you come down and have a session with the President and his advisors about everything that is in this report and talk about what the next steps are?

Governor CHRISTIE. Yes, sir.

Mr. RASKIN. Okay, and what came of that meeting? I mean, has he appointed—is there an opioid crisis czar in the White House now?

Governor CHRISTIE. Not to the best of my knowledge.

Mr. RASKIN. Should there be one?

Governor CHRISTIE. Listen, I think as a governor, you know, the czar I think sometimes gets a little overplayed. I think the fact is the President needs to give direction to his new HHS Secretary. Because if you look at the recommendations, you are right that they are all across government. That is why at every one of the Commission hearings, we had the Deputy Attorney General, we had the Secretary of HHS until there was a change there, and then the Acting Secretary. We had Secretary of Labor. We had the Secretary of Veterans Affairs. All of those individual cabinet officers I think need to be empowered to take the section of the report that is theirs and report back to the President on what they are doing on a regular basis to implement it.

Mr. RASKIN. But you—but as a governor, you also know if everyone is responsible, no one is responsible.

Governor CHRISTIE. The President is responsible.

Mr. RASKIN. Okay, well——

Governor CHRISTIE. It is——

Mr. RASKIN. —with no respect to the President then, I mean, we have tweets about people kneeling during the playing of the National Anthem. We have tweets about who got the Americans out of China from shoplifting charges. I haven't seen any tweets about the opioid crisis, and I don't see the kind of passionate intensity of leadership that we need to deal with what you described as the equivalent of a 9–11 every two weeks in the United States of America.

Governor CHRISTIE. Well let me respectfully say this. Before this President, you didn't see a national Commission on this problem. This problem didn't just start on January 20 of 2017. This problem was building for years before this, and neither President Obama

nor President Bush empowered a national Commission to come up with recommendations, put absolutely no restrictions on that national Commission on what restrictions—what recommendations I could make. This President is the President who has declared a national emergency. This President is the one who has begun to grant IMD waivers. This President is the one who is taking the leadership on this.

So listen——

Mr. RASKIN. I am just asking about constructively moving forward——

Governor CHRISTIE. But that is——

Mr. RASKIN. —how do we make sure that—you know, there are dozens of recommendations in here. How do we make sure that they actually get into practice at every level of government?

Governor CHRISTIE. Well there are a few ways. First of all, the President of the United States is the Chief Executive and he should require of those men and woman who serve in the Cabinet offices that he has appointed them to that are covered in this report to report to him on the progress they are making in implementing the report. I don't think that requires another person sitting in the office in the executive office building, you know, sending out emails, with all due respect. I, as a governor, I hire cabinet people. Those cabinet people are supposed to run those departments and I think that is what the President is going to require of them, but more importantly, what they have seen is that this President is the first President who has elevated this to this level, and he deserves great credit for that. And I know it is very fashionable right now in lots of different corners to be critical of all those different things, and I have been critical of some of it myself, but I don't believe it is right at this moment in time to be critical of the President's efforts in this regard, and he will be held to account for what he produces.

But I would also say that Congress has to step up as well, and this is not just the President's responsibility, but every person sitting up here and every other member of the 535 of you know about this problem. You didn't need my report. Our report gives you some good recommendations, but what you know is that people are dying in your district every day. And so I would say what are members of Congress doing as well to demand that this be done? If that happens, then there will be a cacophony in that city which will force action from both the Executive and the Legislative branch.

Mr. RASKIN. Thank you, Mr. Chairman.

Chairman GOWDY. Gentleman from Vermont, Mr. Welch.

Mr. WELCH. I will try to be quick in light of your admonition.

Number one, Governor Christie, greetings from Governor Shumlin. He gave the State of the State in 2014 where it was totally dedicated to opiate crisis, and I remember many of my colleagues wondered why in the world would you do that, and then started acknowledging that this is a huge problem in their states.

Second, we need concrete actions. There is bipartisan concern about this issue. There is bipartisan conflict about spending on just about anything. But you outlined some concrete things we could do. For instance, if we can't appropriate money, which I would be in favor of, many people here would be, we can at least deal with the drug company rip-offs, and you acknowledged that cost increase

that is really becoming an enormous burden on our local communities that are on the frontlines of trying to address this.

So my—I want to ask you this question and then I will stop. The ideal outcome here is that Congress would step up and find the areas where we can act that it would make a difference, like addressing the cost issue, like the prescription issue. And my question to you is what would be your advice to this Committee, knowing that we are divided on many issues, but we have a common concern about this horrible scourge in our communities. What are the three things you would recommend for us to do?

Governor CHRISTIE. You know, you are asking me to take 65 recommendations and boil it down to three. I am pretty good, but I am not that good.

I would just tell you this, that the first thing we need to make sure we do on the supply side is to nip this fentanyl and carfentanil problem in the bud. If we don't, 64,000 is going to look like the good old days. And so our interaction with the Chinese on this needs to be unequivocal, and our ability to invest in making sure that we are stopping this as best we can from coming into our country is going to be enormously important, because fentanyl and carfentanil is going to make heroin and prescription opioids look like child's play.

Secondly, I would say that the issue of education of our medical community, and I include the pharmaceutical companies in this, about the danger of these drugs and having a real national conversation on the cost benefit of using these drugs has to happen. With this many deaths—and I understand pain is real and the Chairman is right in his recommendation on that, that we need to deal with those folks who need to get to work every day and suffer from chronic pain, but I can tell you we are losing that fight. We are losing that fight because that homebuilder can't go to work if he is dead. And so, you know, we need to try to have a conversation about that with our medical community and get them more tuned to the fact that this is killing people.

Third, I would say we have to fund greater treatment in this country. We just have to. And so if you made me come down to three, I would say fentanyl and carfentanil and the interaction with the Chinese and our own law enforcement has to be strengthened, and our communications with the Chinese on this has to be unequivocal and see it as an attack on our country and its people. Secondly, we need to work on medical education because our medical community is not educated enough at this time on this issue across the country, and that is why we also recommend things like, you know, distance, you know, treatment of folks who are in rural areas, can't get to a physician, being able to do that stuff in different ways is very important to do. And then lastly, we have underfunded treatment in this country and we need to make treatment more available to folks. I think it was as Member Cummings said in his remarks quoting the report, "When 10.6 percent of the people who need treatment are getting treatment, we need to do better." And I think if you maybe boiled down 65 to three, I would go with those three. And I am sure when I leave, I will kick myself for not having picked a different one.

Mr. WELCH. Thank you very much.

Mr. CUMMINGS. Yield?

Mr. WELCH. I yield back. I yield to——

Mr. CUMMINGS. Just one question. I told the Chairman just a moment ago that this is one of your finest moments, and I really mean that. And I got to ask this question, because I think it is critical.

How can you, Governor, with your passion and your full understanding and embracing of this issue, how can you help us bridge the gap between Republicans and Democrats so that we can get something done on this? And I mean—I don't mean to put you on the spot, but I mean, it is a critical moment. And when you just said what you said about fentanyl, we got to do something, and you seem to have pulled it all together and come out with a very balanced report so that we can be effective and efficient, and that is all.

Governor CHRISTIE. Well I appreciate the opportunity. I don't feel burdened by it at all, by your question.

The fact is that I will play any role that leaders of both the Congress and Administration want me to play as a private citizen in 49 days to be able to continue this fight. Mr. Cummings, this is something that began to be passionate for me in 1995 when as a local county official, I was brought to a drug treatment center in my county for adolescents, and I saw what was going on there. And the priest who started this treatment facility said to me at the end of my visit, Chris, this is something you are going to want to be involved in for the rest of your life. Now in 1995 I was 32 years old. The rest of my life seemed a lot longer than it does right now, but I said to him Father, with all due respect, I mean, why am I the one being involved in this the rest of my life? And he said because you just walked out of a place where God makes miracles happen on Earth.

And from that moment on, Mr. Cummings, I have been hooked on this problem and on saving lives. And so you can see what happened in New Jersey. I have worked as a Republican governor every one of my 2,920 days with a Democratic legislature, and with broad majorities, yet the package that we have done on this twice has passed overwhelmingly bipartisan majorities. And I gave my State of the State in 2016 on this with a package of reforms to insurance, to pharmaceutical companies. All things that are difficult things to do, they passed within 30 days and were signed.

I am happy at any time, sir, at the encouragement of the chairman or of you to come and speak and meet with anyone and to use my relationship with the President, which goes back 15 years, to encourage people to say this is the new water's edge in our Nation's conversation. We have to end the politics here. We have to compromise with each other. There are going to be some things that people on my side of the aisle are going to have to vote to fund that they may have some concerns about, and there is some flexibility and trust that folks on your side of the aisle may have to give to governors that you are not normally accustomed to doing. But I think I can speak to that directly, and you have my word that I will not only speak out and continue to speak out publicly, but I am cool with every role you two gentlemen want me to play in helping you to do this, and the President knows I that I feel exactly

the same way. And I am one of the folks who has known him for 15 years, so when he needs to hear some truth, he comes to New Jersey not just to play golf. Let's put it that way.

Chairman GOWDY. Gentleman from Maryland is recognized.

Mr. SARBANES. Thank you, Mr. Chairman, and thanks for the opportunity to sit in on the hearing today. Governor, thank you for your testimony and thank you for the report of the Commission, which I think is outstanding and has a myriad of very positive recommendations that we need to—probably need to prioritize so that we can make forward progress. But I think a lot of the building blocks are there.

We are very proud of the efforts here in Baltimore that our health commissioner, Leana Wen, who we will hear from shortly, has undertaken that healthcare providers, institutions like Johns Hopkins and others, are undertaking to change the trajectory on this. It is obviously a heavy lift. But these recommendations will help.

I want to echo Congressman Cummings' concern about making sure that naloxone is available in a way that it should be and there is not price gouging going on around that. I think that does need a closer look. I was able—and I want to thank you for the recommendation around co-prescribing of naloxone. We were able to get included in one of the bills that was passed last year, the Comprehensive Addiction Recovery Act, a proposal for demonstration project on co-prescribing of naloxone, to examine best practices around that, your recommendations, in a sense, are running along side that in a very positive way, so we thank you for that.

My question is this. I would imagine that you don't think yet that the sense of urgency that needs to be in the country around this issue is there, but it is changing. And as I move around in my district—and I am sure this is the experience of others—not only are you hearing about these tragedies that raise your awareness, but you are also hearing people say things like, you know, I went to my doctor the other day. I went to the dentist, and they gave me a prescription for this Oxycontin or something like that, and all I really needed was Tylenol. So patients are starting to step back from this, so something is getting to them. There is beginning to be a level of public awareness around this.

When will you look at the situation, based on your experience and being involved with this Commission, and what will you see? What will be the indications to you that the level of urgency is where it needs to be among policymakers that the level of education and awareness out in the public is where it needs to be? Is it PSAs coming across the airwaves in a way that matches, you know, election time in a swing election somewhere? Is it the President getting a briefing every Monday morning on what the status is with all the steps that are being taken with respect to addressing this crisis? What are the indicators that you are looking for to say to yourself we are starting to get it here?

Governor CHRISTIE. That is a really good question, Congressman. Thank you.

So I have been asked this before. Someone in their remarks, I forget which member said it, talked about this epidemic being in greater numbers of deaths now than the AIDS crisis at the peak

of the AIDS crisis in the mid-1980s. I was alive then, and a young adult, and here is what I think. Were are the marches?

See, I remember the AIDS epidemic and I remember marches in every major city in this country, and in Washington, D.C., with people marching to say the government must do something to find a way to stem the deaths. In this crisis, there are many, many, many more people impacted than were impacted in the AIDS crisis, yet we have no marching. And I will tell you that I think we will have seen that we have begun to remove the stigma of this disease when the people who are impacted are willing to show their face and march and demand from their government a response. And I believe they don't march today because they are ashamed to march, because they don't want to be identified—I am not talking about everybody, but I am talking about mass numbers. They don't want to march. They don't want to be identified as this having happened in their family to their loved one. And I think that that is why we recommended a national advertising campaign beyond PSAs.

I will tell you, in New Jersey in this year, we will spend $50 million on an advertising campaign in my state to remove stigma and to let people know how to get treatment, $50 million of state money. And the reason we are doing it is because I don't want people to be stigmatized anymore for this and to avoid treatment and avoid asking for help and avoid demanding that there be something done about this.

I will tell you one quick story. My mother was an addict. She was addicted to nicotine. She began smoking when she was 16 years old, and she smoked for 55 years and she tried everything that she could to quit, and she couldn't. And when she inevitably, it seemed, was diagnosed with lung cancer at the age of 71, nobody said to me well, your mother was smoking for 55 years. She has known since 1964 that it could cause cancer. She is getting what she deserved. No one said that. People said oh, we are so sorry for your mom. What can we do to help? Let's recommend doctors or treatments, that she go to this hospital or that hospital. We are praying for you. They came and visited her. They consoled her. They encouraged her. And I felt no shame in telling people that my mother had lung cancer and that her lung cancer was caused by smoking. I want to ask you, sir, if my mother was a heroin addict, would I have done the same thing? And would all those people have come to her aid and recommended treatments and help? Would my dad have been willing to ask for that?

I will know that we are at the brink of the urgency to this when those barriers go away, when people march to demand that Congress and the President and their government along with our private sector find treatments to treat people who are addicted and to find ways for them not to get addicted in the first place by alternative medicines. I will believe it when people are marching and showing their faces. And when that happens, we will know that we are on our way to a solution, and that is why I firmly believe in my heart and I believe the stigma is causing death every day, almost as much as the drug is itself.

Mr. SARBANES. Thank you. I yield back.

Chairman GOWDY. The gentleman from Maryland is recognized.

Mr. RUPPERSBERGER. Yes. Thank you, Chairman Gowdy and Ranking Member Cummings, thank you for having this hearing in Baltimore. It is such an important area, and to all our members on both sides of the aisle, welcome to Baltimore.

Governor—and I want to acknowledge Dr. Wen, who has done a lot in the Baltimore area.

Governor, I think you are at the right place at the right time. You were in local government. You were a prosecutor. You managed a major jurisdiction. That is kind of my life, local government and managing a jurisdiction, except I am in Congress and you are a governor. And I really appreciate the fact that you have made this one of your highest priorities. When you leave office, probably it will dominate your life for a while.

Now there are a couple suggestions that I do have, though, and to make sure that we pull all this together. The first thing when you have a major crisis, you have got to identify the problem, and I think these hearings—we understand it with the deaths throughout the country, it is a national issue. It is not just in urban areas, rural areas, everywhere. But the part that I am interested in—I am an appropriator, and you know, one of the issues that we have to deal with is clearly money, and you know, we have to have that. There has been a lot of money put into this. There are other areas as far as treatment and drug—doctors, nurses, treatment centers, all those types of things. But I know in your report, which is a good report—I haven't read it, but I have heard and I have been briefed on it. There are a lot of recommendations, and when you have that many recommendations, you have to pick priorities. But I think for us to get to the level—those of us who are appropriators, we are going to have to find out what your recommendations are for money, especially from the Federal Government. We have to have a number, and I would hope that your Committee or your staff on your Committee to start putting together a report.

The second thing is there is no question you said that Congress maintains the power of the purse. But in this situation, the President who has within his power as President to free up funding as well. And I am glad the President has made this a priority, but everything in life you have to have follow through. And what your relationship—I didn't know you knew the President for 15 years, that is even better—and with your tenacity, with your experience in all the areas that I talked about, I would like to know what your plan would be to work with his advisors, his Administration, to make sure we find out where we are as far as the money.

Our governor, and I praise him, has—Governor Hogan has dedicated $10 million per year for the next five years to fight this epidemic. I think other governors throughout the country need to do that too, whether Republican or Democrat. And this is not a partisan issue. If there is anything that is partisan, this can't be the case.

So my question to you is, first thing, can you decide what the recommendations would be as far as funding is concerned? When we find that number, we will work with you. I will pledge to work with you as other appropriators, Democrats and Republicans, to find a way to get Congress to fund this issue and also to get the President.

You know, Congresswoman Brenda Lawrence made a comment about certain cuts that are already there, so if the President has made this such a high priority, we are going to have to influence it. We are going to have to find a way to get him to make this a high priority to go forward in what we need to do.

Governor CHRISTIE. Sure, a few things. I think when you say the Commission or my staff, I want to be clear. My staff is sitting right over there. My chief of staff in the governor's office was the main staffer. We were not given staff on this. We had some support from ONDCP, but I will tell you that the work that you see in that report is the product of the Commissioners, and so we did not get into an amount of money, and quite frankly, I didn't think it was our province to do that. We laid out the priorities that we believe are very important, and we believe that every one of those are important priorities.

Now I know from personal experience that governing is choosing, but the choosing now needs to be done by the President and the Congress, not by an unelected Commission. We have laid out all the things that we think need to be done in both near term and long term. Now I really believe it is up to the leadership of the Congress and the President, along with the appropriate Cabinet members, to sit down and to say how do we implement this plan? How do we want to do that? And I don't think—listen. I have done this stuff as a governor, but no one elected me to do this. And I really believe that all of you are the ones who have both the authority and the responsibility to do it. I am happy to identify the problem and identify solutions and bring a practical opinion to it, but I don't believe it is my realm to talk about how much.

Mr. RUPPERSBERGER. I respect you, what you have done, but you are the man and if you can't do it, nobody can.

Governor CHRISTIE. I am going to have you call my wife and tell her that.

Mr. RUPPERSBERGER. You have the expertise, you are an advocate, you have committed. But if you don't have the money, it is not going to work.

Governor CHRISTIE. I agree with you.

Mr. RUPPERSBERGER. So we need you to be not only the advocate, we need you to be the lobbyist. We will work with you. We will—I will—Democratic and Republican staff, I guarantee you on the Appropriations Committee on the House will come together. But we need your expertise and your advocacy, especially when it comes to this President.

Governor CHRISTIE. Sure. Listen, I—as I said to both Mr. Cummings and Chairman Gowdy, I am and will continue to be available to all the folks on this Committee and other members of Congress who care passionately about this issue to give you my advice, my counsel, my opinions, and to be an advocate. I am going to continue to be an advocate no matter who is in the Congress, no matter who is in the White House. I have been an advocate on this issue for 22 years. I am going to continue to be an advocate on this issue because in my heart, I believe that the most important role of government is to protect the health, safety, and welfare of its citizens. And this is right at the core of that, so—I don't know

if I like the phrase lobbyist that you threw in there at the end, but I will certainly be——

Mr. RUPPERSBERGER. Persuader.

Governor CHRISTIE. Yeah, I will be an advocate for this and I have been an advocate with the President all along, and I will continue to be.

Mr. RUPPERSBERGER. My time is up, but my staff—I want to reach out to your staff to find a way how we can start working on the numbers.

Governor CHRISTIE. Excellent.

Mr. RUPPERSBERGER. That is end game.

Governor CHRISTIE. I look forward to it, sir.

Chairman GOWDY. Gentleman from Maryland yields back. Governor, I want to thank you on behalf of everybody for—not just for being here and sharing your perspective today, but for the hard work the Commission did.

I go last when it comes to questioning, and I want you to—while we appreciate the audience that is here, they would be the upper echelon in terms of engagement and education. I want you to think of broader audience, broader jury, our fellow citizens that have heard about the epidemic, perhaps someone close to their family has been touched by it, but they don't live and breathe it every day.

As I listened to your opening, you can put physicians, I guess, in one of three categories. The vast majority of physicians are incredibly well-intentioned and they are well trained and they are well educated and they do it the right way for the right reasons. And then you have a group that is equally well-intentioned, but they lack the education on it, and you made reference to continuing legal education, continuing medical education. There is that group, and I don't know how big it is. Our perspective is swayed by being prosecutors. There is that group that is profiting from people's addiction, and I don't see the diversion cases being prosecuted like I did in olden days. Am I missing it? Did you all find it?

Governor CHRISTIE. No, I don't think you are missing it. I do think that there has been over the course of the last decade or so a de-emphasis on that priority, and I think it is a mistake. It is—I often think, Mr. Chairman, that folks believe that to emphasize one issue is to deemphasize another.

So in New Jersey, for instance, we have done broad criminal justice reform that has lowered our prison population more than any state in the country. During my time as governor, we have closed two state prisons. Yet our crime rate is down significantly in our state. That doesn't mean that I don't want to see my attorney general continuing—and he has—to continually aggressively pursue the drug dealers in our state who are killing our people.

I think that sometimes justice departments, which we have both been members of, think that if you are in favor of criminal justice reform, you can't be in favor of aggressive prosecution of criminals. Or if you are in favor of aggressive prosecution of criminals, you can't be for criminal justice reform. I don't believe that, and I think as governor it has taught me even more than as a prosecutor, the Federal Government, in my view, over the last decade has dropped the ball on these cases. And I think that it is contributing—not causing, but contributing to the problem that we have today. And

that is why I am not in favor of shortening the leg on the stool of enforcement interdiction. We need to continue to do that and do it aggressively. I have shared that opinion with General Sessions, and I believe he understands that piece of it. But that message has to get out to the U.S. attorneys, and that can only come from the attorney general and the deputy attorney general. You and I both know, and when you were a U.S. attorney, it is kind of like being the captain of a ship out at sea, you know. Sometime the radio works from the shore, and sometimes maybe you can't hear it quite as loudly. We need to make sure the radio is working on this one, and that U.S. attorneys are not given an option, but are given a directive from their boss, the Attorney General of the United States, that these are important cases to do. That doesn't lessen our commitment to providing more treatment. It doesn't lessen our commitment to confronting the Chinese on what they are doing and using our foreign policy tools in addition to law enforcement in doing that, and it doesn't mean that we don't believe that education and prevention are really important. We didn't talk about that today, but let me say in conclusion here, from my perspective that if we don't start talking to our children in the middle school about this issue, we will lose them. And it is frightening to me as a father to think that my 11 and 12-year-old daughter or son needs to be spoken to about this issue in stark terms, but they do.

And we can't do it anymore. I saw from the Department of Education they were very proud. They showed me when I first came to—oh, we have this new pamphlet that we are going to be giving out in schools on this issue. And I looked at it and I said so listen, it is a great pamphlet. I read it. There is a lot of good information. I said if my kids got this pamphlet, it would go in their backpack. By the end of the school year, it would be all the way at the bottom of their backpack, and they would never read it. Because if it is not on here, they don't read it. We need to modernize the way we are educating our children. We should be demanding of companies like Google and Facebook who are such predominant players in communication today to our young people, that they step up to the plate and start educating our kids on the things that we need to do.

So what I am saying to you is we have dropped the ball in my view in the last decade since I have left the Justice Department in 2008 in doing these cases. We need to do them to slow the supply, but we also need to make sure that we are doing those other things as well. And this is the bipartisan nature of it, and I believe that Mr. Cummings agrees with this as well. We have got to get rid of our old barriers on this issue, to think that if you are for one thing, you must be reflexively against the other, and vice versa. We can do both and we must do both. And there are people of goodwill and great experience who are ready to help to do this, and I hope that they are called upon to do it, and I count myself as one of them, and I will allow myself to be called upon to do it.

And so I think you make a very good point, Mr. Chairman, and I think we need to make sure that we don't get caught in the trap of mutual exclusivity. It is a trap that will lead to failure, and failure we can't afford.

Chairman GOWDY. Well I want to finish up with drug courts, because we agree on that. If you want to not only have your own life

change, but see other people's lives change, attend a graduation for a drug court. That graduation ceremony will be with you for the rest of your life. And I want to mention one kind of a niche issue there at the end. I also want you to address what barriers did you find, if any, for the pharmaceutical alternatives, non-habitual aiding, non-addictive pharmaceutical alternative. What are the barriers to either having them researched, developed, or to market?

Governor CHRISTIE. They don't believe they are going to be profitable. I think that is the single biggest barrier to it, and that is why I believe bring NIH in as a partner to be a fair broker of the compounds and say which ones are most effective, and let's move those most effective ones to the front of the line and allow them to go to market, and let's see how it goes.

What I say—and listen, you know that New Jersey has more pharmaceutical companies than any state in the country, and so I am very sensitive to the importance of the pharmaceutical industry, the role that they play in our country as an economic driver, in addition to being a healer. And I am an advocate for the pharmaceutical industry. But what I reminded my friends in the pharmaceutical industry is they have a social responsibility that goes along with that, and that to stand by and not develop these compounds purely on the basis of concern about profitability is to, in my view, walk away from part of your social responsibility as a corporate citizen in this country.

Now NIH needs, I think, to be a fair broker in all this so that the right compounds get the right money spent on them to develop them, but what I heard from them was the biggest concern was an issue of—with the R&D money that they have available, is this the best way to spend that money for our shareholders? And that is an absolutely legitimate fiduciary concern that they need to have under our laws and our system of—our economic system, but they also have a social responsibility as well.

And so what I would say and what we did say to pharmaceutical companies is would you trust NIH to be a fair broker on, say, okay, all 43 of these compounds don't need to be developed, but these five have real potential to be non-addictive pain relief and/or great medication assisted treatment to help those who are already addicted. And the pharmaceutical companies at that meeting in New Jersey agreed to submit their compounds to NIH. What we need to make sure of now is that NIH has the funding to make sure that they complete that job. If they do—I know Dr. Collins is really committed to this. If they do, we are going to get some of those compounds onto the market, and that is going to help significantly. Because I know physicians would much rather prescribe a pain reliever that is non-addictive but effective, rather than one that is addictive.

Chairman GOWDY. You mentioned though the phrase social responsibility—this will be my last point.

In addition to being a colleague, one of my favorite colleagues in the entire body, Peter Welch, is also a former public defender, and his clients would have been incredibly fortunate to have him. In South Carolina, I saw sometimes in the state system, public defenders would opt for straight probation as opposed to drug court because it was easier. Now that is not in their client's best interest.

Their client will remain an addict. But they are right. Straight probation is easier than drug court. How do we develop around the grant strategy in sending the defense attorney, the public defender to encourage their client to go get help as opposed to just being on probation for the next 12 months and remaining an addict?

Governor CHRISTIE. Well let me tell you, in New Jersey what we did was we took away the option. You don't have the option of probation anymore. Your option is this: go to treatment or go to jail. Now when given that option, it is kind of the gentle encouragement I am known for, Mr. Chairman. You know, it is—and where a lot of people absolutely opposed that, said how dare you do that. If they are not ready, they shouldn't go. I said I have never met an addict who is ready. I have never met an addict who is ready. I have done interventions. I have never seen a—I had a great friend of mine who sat there and argued with me that I was wrong that he was addicted, he didn't need treatment. He was fine. Well he is dead now, and the fact is I have never met an addict who was ready.

So I think one of the things that you could work on from a grant structure perspective is to say that we want to encourage those programs that don't give an option, that your option—you don't have a probation option, because I know. I know exactly what you are talking about. That was happening in my state before we passed this law. Now defense attorneys have a really easy equation to give their clients. You can go to drug court and go into treatment, or you can go to state prison. And what we are finding is most people are choosing treatment. And even when they don't think they are ready and what has happened—you talked about drug court graduations. The miracle of those drug court graduations is, in my mind, not the young men and women and older men and women that I am sitting with on stage, it is looking out in the audience at their families. Their lives are hopeful again. Their eyes are lit with joy for the restoration of a life that they initially brought onto the earth, and which they had almost given up on.

So from my perspective, the drug court and why I advocate it for every federal district in this country is because I have watched it change lives, and so have you. And there is no reason—even though there are fewer cases on the Federal Government than would be appropriate than on the state level, there is no reason that we should have our federal prisons filled with people who would be better off being treated, for themselves and for us as a society. Because the recidivism rate, as you know, for drug court graduates goes down significantly, and that is what we all want anyway. We would much rather spend less money on corrections, on BOP, than we would on other issues that are confronting our country in a time of limited resources. If we can lower the prison population like we have done in New Jersey and close two state prisons in eight years—I defy you to find any other state in America that is closing state prisons with a decline reduction, and it is because we are treating folks who have this problem like they have a disease, not like they have a moral failing.

Chairman GOWDY. Well thank you for your passion and your expertise, and I know Mr. Cummings would want to thank you also

as we transition from your panel to the next panel. Thank you on behalf of all of us.

Governor CHRISTIE. Mr. Chairman, thank you very much. Mr. Cummings, thank you for inviting me.

Mr. CUMMINGS. Mr. Governor, thank you very much. Just one thing being our good colleague from Maryland, Mr. Delaney, has a phrase that I wish I had invented. He said "The cost of doing nothing is never nothing." And you have given us a broad blueprint, and now we have got to act. Thank you very much.

Governor CHRISTIE. Thank you, sir. I appreciate that very much.

[Recess.]

Chairman GOWDY. The Committee would like to welcome our second panel of witnesses. We have Dr. Richard Baum, Acting Director of the Office of National Drug Control Policy; Dr. Leana Wen, the Health Commissioner for the Baltimore City Health Department; and Dr. Caleb Alexander, Co-Director of the Center for Drug Safety and Effectiveness at Johns Hopkins Bloomberg School of Public Health.

Welcome to you all. I am not going to swear you because I didn't swear the first witness, so I will violate Committee rules there and hope that nobody knows that I have done it. We are going to call on you sequentially for your opening statements. To the extent possible, I will limit those to five minutes, just understanding that we have the full body of your opening statement in the record, and then we will—once Dr. Alexander gives his opening statement, we will then recognize the members for their questions.

With that, Dr. Baum, you are recognized.

PANEL II

STATEMENT OF RICHARD BAUM

Mr. BAUM. Well I thank you, Mr. Chairman, Mr. Cummings. Thanks so much for inviting me and for the Committee, I am really honored and pleased to be here in Baltimore for this important hearing.

You are all familiar with the problem we face because you see it in your districts. This epidemic knows no geographic, political, socioeconomic, or racial bounds. We are very mindful of the fact that your constituents share heartbreaking stories with you about the loss of too many of our country's sons and daughters. ONDCP is committed to working with you to turn this awful crisis around. This truly is the worst epidemic in American history.

As has been referenced in earlier testimony, we have seen over 60,000 drug overdoses in 2016, mostly caused by opioids such as heroin, illicit fentanyl, and prescription pain medications. Now listen, fentanyl is being added to heroin, cocaine, and other drugs, increasing their lethality. It is often being pressed into counterfeit prescription pills, complete with fraudulent manufacturer logos. We are not getting enough people with addiction into evidence-based treatment. Our whole system through response to overdoses and other outreach efforts has to be faster to go out and find the people that need help. Once people go through detox or treatment, they need ongoing recovery support, as well as help with sober housing and employment so they can fully rebuild their lives and re-

integrate into society. We also need to ensure that law enforcement agencies have the tools they need to reduce the drug supply and disrupt and dismantle the drug trafficking organizations that threaten the safety and health of our people.

The Administration is working hard on multiple fronts to address this crisis. As you know, President Trump has been vocal about the drug crisis, both during the campaign and since taking office. When the President established the Commission, he directed it to look at additional actions the government can take to address this epidemic. ONDCP was tasked with providing policy and administrative support to the Commission. I had the honor to serve as the executive director of the Commission, and ONDCP staff contributed their expertise and time to assist the Commission with its work, totaling more than 5,500 total staff hours. On November 1, the Commission released its final report, which included 56 recommendations, as Governor Christie just described. The recommendations have now been circulated to all the agencies in the Administration for careful consideration. I am glad to say that the Administration is already working on a number of them.

President Trump declared the opiate crisis a national public health emergency as the Commission recommended in its interim report, and he has mobilized the entire Administration to address the crisis. HHS has announced a proactive policy to allow states to waive the decades-old ban on Medicaid reimbursement for patients receiving inpatient treatment at facilities with 16 or more beds, known as the IMD exclusion. Utah and New Jersey have already received approvals under the new policy, and we hope to have many more requests for waivers in the coming months.

In terms of reducing the availability of these illicit drugs, the Administration has also taken a number of steps. We are working with the Chinese government to reduce the flow of fentanyl and its add-alongs to the United States. This includes getting additional advanced electronic data from China on packages mailed into the U.S. This summer, DOJ took down the dark web marketplace, AlphaBay, and other sustained actions like this over time will reduce trade over the Internet that has been threatening the health of our citizens.

The Heroin Response Strategy, which is an initiative of our ONDCP-run HIDTA program, is bringing law enforcement and public health together to quickly respond to overdose at the local level, and to increase law enforcement and—efforts. And the FDA is working to make prescription opioids safer and lend the effort to remove the opioid medication Opana extended release from the market, since it was frequently being diverted and abused.

The Administration has provided significant resources to address this crisis. For fiscal year 2018, the President proposed a $28.7 billion drug budget overall, including $10.8 billion for drug treatment. This year, we have already sent $800 million out to states for intervention, treatment, first responders, prescription drug monitoring programs, and recovery services. The President has requested $500 million additionally to help states expand access to opioid treatment in the fiscal year 2018 budget. And at ONDCP, as you know, we are developing the Trump Administration National Drug Control Strategy, which will be out early next year. So we are using

all the tools in the toolbox to make headway against this enormous problem which is affecting every state and many of your constituents in some way, shape, or form.

I have not yet had the privilege to visit South Carolina as acting director, but I have visited Anne Arundel and Cecil Counties in Maryland and I have seen how people in these communities are coming together to address this crisis at a local level. This is a critical part of our country's response to the epidemic.

As I said, this crisis is unlike anything we have seen before and have been working hard to address it, but we have a lot more to do. I thank Governor Christie and the Commission for their recommendations which will help to this end. I also want to thank the dedicated ONDCP career staff for so skillfully supporting the Commission's work. And I thank the Committee for holding today's hearing on this important matter, and I look forward to more discussion and dialogue. Thank you very much.

[The prepared statement of Mr. Baum follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Hearing on the President's Commission on Combating Drug Addiction and the Opioid Crisis

Committee on Oversight and Government Reform
United States House of Representatives

Tuesday, November 28, 2017
12:30 p.m.
Johns Hopkins Hospital
Baltimore, Maryland

Written Statement of:
Richard J. Baum
Acting Director of National Drug Control Policy

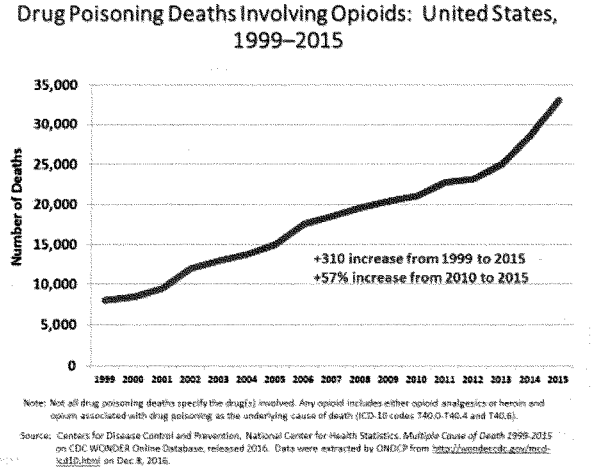
Chairman Gowdy, Ranking Member Cummings, and Members of the Committee, I am pleased to appear before you today to discuss the President's Commission on Combating Drug Addiction and the Opioid Crisis. As a long-term civil servant with over 20 years' experience at ONDCP addressing our Nation's drug abuse problem, it is a tremendous honor for me to serve as Acting Director of the agency. The strong support of President Trump, Vice President Pence, and the Members of the President's Cabinet for our vital work addressing the opioid crisis is deeply appreciated by the dedicated expert staff at ONDCP. This testimony discusses the support provided to the Commission by ONDCP, the Administration's preliminary response to the Commission's recommendations, and ongoing efforts to address the crisis.

Background: Opioid-Involved Deaths

Opioids are a class of drugs that include heroin, which has no recognized medical use and is an illicit drug, and numerous pain medications available via prescription, including morphine, codeine, and semi-synthetic medications such as oxycodone and hydrocodone. In addition to pain relief, opioids can produce a strong sense of euphoria that can lead to chronic misuse and addiction.

The Government has maintained data on deaths involving opioids since 1999. Between 1999 and 2015, the most recent year for which we have final estimates, over 300,000 people have died from drug overdoses involving opioids. Throughout this period such deaths increased each year, rising from 8,050 in 1999 to 33,091 in 2015 (See Figure), to the point that in 2015 an average of 91 people per day died from a drug overdose involving an opioid. Preliminary data from 2016 suggests this rise continues. Perhaps more troubling is the sharp increase in the number of deaths involving synthetic opioids other than methadone, a category that is dominated by illicit fentanyl—since 2013, such deaths have more than tripled, from 3,105 in 2013 to 9,580 in 2015.

Figure



The President's Opioid Commission

In response to these troubling trends and other indicators of the extent and scope of the opioid crisis, on March 29, 2017, the President issued an Executive Order establishing The President's Commission on Combating Drug Addiction and the Opioid Crisis. The Commission was tasked with the accomplishing the following projects:

(a) Identify and describe existing Federal funding used to combat drug addiction and the opioid crisis;

(b) Assess the availability and accessibility of drug addiction treatment services and overdose reversal throughout the country and identify areas that are underserved;

(c) Identify and report on best practices for addiction prevention, including healthcare provider education and evaluation of prescription practices, and the use and effectiveness of State prescription drug monitoring programs;

(d) Review the literature evaluating the effectiveness of educational messages for youth and adults with respect to prescription and illicit opioids;

(e) Identify and evaluate existing Federal programs to prevent and treat drug addiction for their scope and effectiveness, and make recommendations for improving these programs; and

(f) Make recommendations to the President for improving the Federal response to drug addiction and the opioid crisis.

The Commission's charter charged ONDCP with providing an Executive Director and Designated Federal Officer for the Commission. As the Executive Director for the Commission, I was responsible for assigning and supervising ONDCP staff to conduct work for the Commission. As of the beginning of this month, 68 ONDCP staff, detailees, contractors and interns worked over 5,500 hours (nearly 3 full time staff equivalents) conducting tasks for the Commission, including providing research and fact checking in support of the development of the Interim and Final Report recommendations, legal guidance, and logistical and information technology support for Commission meetings and travel. ONDCP's Deputy General Counsel served as the Designated Federal Officer and was responsible for approving or calling all of the Commission's meetings, preparing all meeting agendas, and attending all meetings. It was a pleasure and an honor to work with Governor Christie and the other Commission members. I am proud of the high-quality and professional work that my staff did to support the Commission while continuing to perform their regular duties. The Administration appreciates the dedication and hard work of the Commission members in producing their reports. We are committed to working with Congress; state, local and tribal governments; and non-governmental organizations to combat this crisis.

The Commission was required to submit an Interim and Final Report to the President with their recommendations for combating drug addiction and the opioid crisis. The Interim Report was

submitted to the President on July 31, 2017. The central recommendation called for the Administration to declare the opioid crisis a public health emergency. The President directed the declaration of a national public health emergency on October 26.

The Commission submitted its Final Report on November 1, 2017. It provides a detailed discussion of the history of the opioid crisis and its current status. The heart of the Report is its 56 recommendations for addressing the crisis, which are grouped into the following four categories:

- Federal Funding and Programs;
- Opioid Addiction Prevention, which includes the following three subsections:
  - Prescribing guidelines, regulation, and education;
  - Prescription drug monitoring program enhancements;
  - Supply reduction and enforcement strategies;
- Opioid Addiction Treatment, Overdose Reversal and Recovery; and
- Research and Development.

The Administration is currently reviewing the Commission's recommendations in detail, but our preliminary assessment suggests that we are in broad agreement with much of what the recommendations seek to attain.

Preliminary Assessment of Commission Recommendations

In reviewing the Commission's recommendations there are several that stand out as having especially great potential for impacting the crisis in the near term. The following nine goals are the Administration's summary of the themes of several of the recommendations and a brief discussion of steps that can be taken to achieve each of them.

- *Break down silos and bureaucratic barriers to distributing funding quickly and efficiently to states and those who are on the front lines of fighting this epidemic to deploy evidence-based programs that will save lives.* The Government distributes funding, including funding for drug control programs, via block grants and discretionary grants. The former provide states and localities with maximum flexibility in the use of the funds, which lets them target the problems and populations they deem as top priorities. Funds are distributed based on a formula driven largely by population size. Discretionary grants are competitive and can more accurately target specific problems and populations based upon need. The Government can improve coordination among various agencies providing drug control funding so that they can more accurately target need.

- *Collaborate with states, private sector partners, and other stakeholders to enhance awareness and screening efforts to prevent inappropriate use of opioids and other drugs.* All Federal agencies directly providing addiction treatment use quality metrics to routinely identify and correct program deficiencies (including screening programs), while some fund measure development and collaborate with external stakeholders to assure their validity and meaningfulness to clinical care and good outcomes.

- *Enhance education and training for medical professionals to reduce inappropriate prescribing.* The Government can initiate several steps to achieve this goal, including finalizing the national curriculum on immediate release and extended release/long acting opioids discussed in the Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy and consider other ways to enhance education on opioid prescribing and addiction for prescribers, pharmacists, and emergency medical services workers.

- *Maximize the use of Prescription Drug Monitoring Programs (PDMPs) through better data integration and utilization.* PDMPs have great potential to aid in reducing the misuse and diversion of pain medications. The Government can maximize their use by continued support for federal programs like the Harold Rogers PDMP Grant Program and consider ways to increase PDMP participation by prescribers and pharmacists, and improve data integration and sharing.

- *Strengthen law enforcement efforts to target and take down individuals and organizations that produce and sell counterfeit or illicit drugs.* To achieve this goal the Government can take steps to integrate public safety and public health efforts, enhance intelligence sharing among law enforcement agencies, and revise regulations addressing the distribution of pill presses.

- *Enhance efforts to detect and intercept illicit drugs coming across our borders.* The Government is working to develop enhanced detection capabilities, especially for synthetic opioids such as fentanyl and its analogues, to include technology and canine teams. The United States has made progress in working with China, the primary source country for illicitly manufactured fentanyl and other synthetic opioids; we expect this cooperation will increase. We also are working with Mexico, the source country for the majority of heroin consumed in the United States, on issues including eradication, interdiction, and intelligence sharing.

- *Expand access to evidence-based treatment and recovery services by revising payment policies for federal payers and ensuring private payers are complying with the law.* This year, the Centers for Medicare & Medicaid Services (CMS) solicited "Requests for Information" through Medicare payment rules and the Centers for Medicare & Medicaid Innovation to welcome continued feedback from stakeholders on flexibilities and efficiencies that could improve the availability of high-value and efficiently-provided care for beneficiaries. In response to these Requests for Information, commenters made many suggestions, and those comments are under review. The Department of Labor is committed to vigorously enforcing the Mental Health Parity and Addiction Equity Act. The Commission has recommended that the Department of Labor be given additional enforcement authority, including authority to assess civil monetary penalties to deter bad actors from violating the law, authority to enforce directly against health insurance issuers to obtain widespread correction on their noncompliant policies sold to numerous employers, and additional funding to reach a larger universe of group health plans for enforcement and compliance assistance. ONDCP supports these recommendations.

- *Expand access to overdose-reversing drugs and support services, including housing and employment services by identifying and disseminating best practices for evidence-based programs*. States can enact laws permitting standing orders issued by a prescriber or public health authority that allow naloxone to be dispensed to parties they have not examined, providing they meet certain conditions. State laws can also provide liability protections to health professionals who prescribe naloxone and/or to lay persons who administer it. The Government supports programs that encourage entry into treatment and provision of needed support services.

- *Improve coordination among research funding agencies to identify gaps and expand research related to finding more alternatives to opioids and treatment for addiction, and getting these to patients faster*. The Government can consider developing a national research action plan to survey, assess, plan, and coordinate efforts on research for alternatives to opioids and treatment for addiction. It could conduct a review of regulatory and payer issues concurrently and include payers and regulators in the review process. The Government also can consider funding a public-private partnership to invest in addiction and pain treatments that reduce our reliance on the riskiest opioids.

ONDCP Efforts

While the Commission has recommended a comprehensive set of recommendations to address the opioid crisis, the Administration has continued to implement a wide range of activities to achieve the same goal. For instance, ONDCP is currently undertaking efforts to reduce the opioid problem through its High Intensity Drug Trafficking Areas program and the National Heroin Coordination Group to address the opioid crisis through coordination of law enforcement and public health initiatives and enhanced coordination of intelligence, and public health and safety efforts among Federal, state, local and tribal partners.

High Intensity Drug Trafficking Areas Heroin Response Strategy

ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program is a locally-based program that responds to the drug trafficking issues facing specific areas of the country. Law enforcement agencies at all levels of government share information and implement coordinated enforcement activities; enhance intelligence sharing among Federal, state, local, and tribal law enforcement agencies; provide reliable intelligence to law enforcement agencies to develop effective enforcement strategies and operations; and support coordinated law enforcement strategies to maximize available resources and reduce the supply of illegal drugs.

Currently, there are 28 regional HIDTAs covering 49 states, Puerto Rico, the U.S. Virgin Islands, and Washington, D.C. Regional HIDTAs facilitate cooperation among law enforcement to share intelligence and implement coordinated enforcement activities and support law enforcement strategies that leverage available resources to reduce the supply of illegal drugs in the United States. The HIDTA program includes more than 6,000 Federal agents and analysts and more than 15,000 state, local, and tribal officers and analysts. HIDTA initiatives (task forces) and investigative support centers in each of the regional HIDTA programs disrupt and dismantle organizations that transport and distribute heroin, illicit fentanyl, and other opioids that are either illicitly produced or diverted from legal distribution channels. In addition, the regional HIDTA

programs have a number of initiatives as described below that specifically target heroin and other opioids.

In October 2017, I committed $4.8 million in HIDTA funds to support the Heroin Response Strategy (HRS) to address the heroin and opioid epidemic by coordinating the efforts of 10 regional HIDTA programs across 22 states and the District of Columbia.[1] The HRS was first launched in 2015 with an initial investment of $2.5 million to fund operations in 17 states. In 2016, the initiative received an additional $3.9 million in HIDTA funds and was expanded to three more states. At present, the HRS brings together the following regional HIDTA programs: Appalachia, Atlanta/Carolinas, Chicago, Indiana, Michigan, New England, New York/New Jersey, Ohio, Philadelphia/Camden, and Washington/Baltimore. Earlier this month, I spoke at the HRS annual symposium and witnessed firsthand the innovation and sense of urgency this initiative has brought to our broader effort to curtail the opioid epidemic.

The HRS has an ambitious goal: to leverage its strategic partnerships to target the organizations and individuals trafficking deadly drugs like heroin and illicit fentanyl so that overdoses are reduced and lives are saved. The HRS is achieving this goal by creating a human network spanning the law enforcement and public health communities to share actionable information. For example, drug intelligence officers track and relay drug-related felony arrests of out-of-state residents and then report this information to the individual's home law enforcement agency. Since January 2016, drug intelligence officers have shared more than 22,000 of these felony arrest notifications. In multiple instances, the sharing of drug intelligence across the HRS network has resulted in the identification and arrest of heroin/fentanyl distributors linked to outbreaks of fatal and non-fatal overdoses.

Shortly, the HRS will support the implementation of pilot projects that will identify opioid overdose "hot spots" to serve as testing grounds for targeted efforts. In partnership with the Centers for Disease Control and Prevention (CDC), the HRS will launch interventions designed to address the specific needs of the communities they are situated in and will evaluate these efforts to determine their efficacy and the feasibility of implementing them in other communities facing similar overdose challenges. The participating regional HIDTA programs will monitor the progress of the pilot projects as well as the HRS overall. As in 2016, the HRS participants will prepare a report outlining the initiative's achievements.

National Heroin Coordination Group

ONDCP, in coordination with the National Security Council staff, established the National Heroin Coordination Group (NHCG) in October 2015. The NHCG serves as the hub of a network of interagency partners and coordinates Federal Government activities to address the heroin problem and reduce the availability of heroin, illicit fentanyl, and fentanyl analogues in the United States. The NHCG's first task was to write, staff, and oversee the implementation of a Heroin Availability Reduction Plan (HARP), a five-year plan to synchronize existing efforts and strengthen the partnerships already in place to address this problem, focused on a clearly

[1] The HIDTA Heroin Response Strategy covers the following states: Connecticut, Delaware, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and West Virginia.

defined result: *a significant reduction in the number of heroin-involved deaths in the United States due to a disruption in the heroin and fentanyl supply chains, a detectable decrease in the availability of those drugs in the U.S. market, and the complementary effects of international engagement, law enforcement, and public health efforts.*

The NHCG continues to implement the HARP. Eight times each month the NHCG leads forums for sharing information, lessons learned, and identifying gaps and redundancies among Federal Government partners, state, local, and tribal partners, and the Intelligence Community. A monthly Public Health Webinar provides public health professionals from across the country a forum to share information on the opioid crisis from the state perspective. A monthly Federal Law Enforcement Secure Video Teleconference allows Federal law enforcement agencies to discuss case-related data and law enforcement trends in a small, classified environment. A weekly Intelligence Core Group Secure Video Teleconference includes interagency intelligence analysts from across the Intelligence Community and law enforcement officers, and maintains the Intelligence Community's awareness of heroin and fentanyl trafficking patterns around the world.

Integrating these three webinars is a monthly "Big Tent" Webinar that brings together the public health and public safety communities to share information on trends, new developments, lessons learned, and best practices in addressing the opioid crisis nationwide. Additionally, the NHCG conducts a monthly video teleconference with interagency partners and elements of the U.S. Embassy staff in Mexico City who are involved in heroin and fentanyl coordination efforts with their Government of Mexico counterparts. In all cases, these forums allow participants to share the most current information on the opioid crisis, from actions taken to interrupt the supply chain to addressing effective public health initiatives, and allows ONDCP to quickly identify gaps and redundancies that can be addressed to more effectively align efforts and resources.

Other Federal Efforts

The Administration hit the ground running with respect to the opioid crisis. Within his first 100 days, President Trump engaged in critical ways on the opioid issue. He signed an Executive Order directing the creation of the Commission. He convened a roundtable with stakeholders, which included affected individuals and families and showcased to the American public that people can and do recover. Then, based on the Commission interim report's recommendations, he directed the declaration of a national public health emergency, which offers new options and opportunities for HHS to coordinate response. In conjunction with this effort, HHS's Office of Civil Rights issued important guidance on how medical professionals can communicate with patient family members to help them get their loved ones the addiction treatment help they need. In September, First Lady Melania Trump held a listening session with families and spoke publically about her intent to shine a spotlight on this issue moving forward. Afterward, the President gave a major speech highlighting how addiction has affected him personally and the ways he intends to address the crisis.

I have never seen the Federal staff so mobilized to address drug related issues as I have seen under President Trump, and we are starting to see real progress. Highlights include:

- The National Institutes of Health has taken the first steps of a public-private partnership with industry to expand addiction treatment and pain research.

- Federal law enforcement have announced a number of major activities against both prescription opioid and illicit traffickers, including regional and national multi-agency strategic initiatives; targeted intelligence sharing and data exploitation of heroin and opioid overdoses and deaths; increased deployment of tactical diversion squads; increased engagement between criminal health care fraud investigators and prosecutors and those with expertise in drug and violent crime investigations and prosecutions; pilot projects addressing the choke points for entry of fentanyls and novel psychoactive substances into the United States; two of the largest dark web takedowns in history; multiple indictments against Chinese illicit fentanyl manufacturers, Mexican and South American cartels, and North American traffickers; and an indictment of a pharmaceutical company CEO under Racketeer Influenced and Corrupt Organizations (RICO) conspiracy charges for bribing doctors and pharmacists to prescribe fentanyl products, as well as actions across the controlled drug supply chain industry, including wholesalers/distributors, pharmacies, and practitioners.

- HHS has published draft revisions of the FDA Blueprint for Prescriber Education, which is part of the Risk Evaluation and Mitigation Strategies now for immediate release and long acting opioids, to make pain treatment safer and has circulated for public comment a new curriculum for provider training for both short- and long-acting opioids. These and other new tools will help train providers and help them use those guidelines.

- CMS issued guidance to state Medicaid Directors to improve access to and quality of opioid treatment and other substance abuse treatment that includes section 1115 waivers to the Institutes for Mental Diseases exclusion as part of comprehensive opioid/substance abuse strategy, so states can offer the entire continuum of care for addiction, including inpatient treatment for substance use disorder in a residential treatment facility. We anticipate this streamlined guidance will encourage states to follow the lead of those who are already using this process to make medication-assisted treatment more available.

- Our colleagues at FDA have intensified their efforts to make prescription opioids safer by recommending removal of the dangerous opioid Opana from the market, and I am pleased to say that the manufacturer quickly complied. FDA also decided to expand the classes of opioids which have additional risk safeguards, including provider and patient information requirements to include the most frequently prescribed opioids, the short-acting ones.

- We continue to work to expand opioid addiction prevention and treatment with new grants to states, which include funding for medication-assisted treatment, $485 million of which went to states this year. We also awarded several grants for drug courts, veterans' courts, and treatment alternatives to incarceration and diversion programs, so we do not lose an important chance to help people get care through the law enforcement and the criminal justice systems.

- And because prevention is vitally important, we are working with colleagues across the Executive Office of the President to formulate a new media campaign based on the scientific evidence concerning what works to change young people's attitudes and beliefs about these drugs.

- At the same time CDC has expanded its efforts to target opioid policies at the state level to all 50 states, including expanding and improving PDMPs and the training of providers.

- This month, a collaboration between colleagues in the Department of Transportation, HHS, and the Department of Defense produced a much-needed revision to EMS Clinic Guidelines and the EMS model scope of practice for all levels of emergency medicine staff. This will provide staff who work on ambulance crews with information about overdose reversal and will ensure states have a model to design their policies, to help ensure that crew members can use naloxone regardless of their level of medical specialization, like law enforcement has been doing for some time now in many parts of the country.

- HHS's Office of Inspector General (OIG) is focusing on preventing opioid misuse in federally-funded health care programs. In July 2017, in collaboration with state and local law enforcement partners, HHS OIG and Department of Justice (DOJ) components conducted the largest health care fraud takedown to date, in which 120 defendants were charged with prescription opioid-related crimes. Also in July 2017, HHS OIG released a report identifying 401 Medicare providers who are most responsible for prescribing questionable amounts of opioids to beneficiaries at serious risk for overdose. These providers are now being further evaluated for possible action by HHS OIG, DOJ, CMS, and other partners with enforcement and administrative authorities to address prescription drug fraud and diversion.

Several Federal agencies worked with the international community to schedule important fentanyl precursors and other synthetic opioids responsible for many overdose deaths, and recently I learned more first-hand about how Customs and Border Protection is training dogs to detect opioids.

Conclusion

The current opioid crisis is the deadliest drug epidemic on record to ever hit the United States. It has devastated families and communities across the Nation, ignoring economic, social, and racial/ethnic distinctions. It affects the Nation's economic productivity, public health and safety, and national security. In response, the President has directed the declaration of a public health emergency coordinating, implementing, and promoting Federal, state, local and tribal public health and safety efforts to: (1) reduce the availability of illicit opioids and diverted opioid pain medications from reaching the U.S. market; (2) disrupt and dismantle drug trafficking organizations; (3) launch evidence-based prevention programs; (4) expand access to opioid overdose reversal medication to save lives; (5) provide access to opioid treatment programs to enable sustained recovery from opioid addiction; and (6) improve coordination among research funding agencies to improve the efficiency of developing and delivering alternative pain medications.

I appreciate the Committee's ongoing interest in working with ONDCP on drug policy matters, and I look forward to having ONDCP continue to work with Members of this Committee on combating the opioid crisis.

Chairman GOWDY. Thank you. Dr. Wen?

STATEMENT OF LEANA WEN

Dr. WEN. Chairman Gowdy, Ranking Member Cummings, thank you for calling this hearing in our city of Baltimore where today, two residents will die from overdose.

Our aggressive approach to this epidemic has three pillars. First, we save lives by making the opioid antidote, naloxone, available to everyone. Not only have we equipped paramedics and the police, I issued a blanket prescription to all 620,000 residents. Since 2015, everyday individuals have saved the lives of 1,500 people. But our city is out of funds to purchase naloxone, as Congressman Cummings mentioned, forcing us to ration and make decisions about who can receive this antidote. And at the time of a public health crisis, it is unconscionable that we are being limited in our ability to save lives.

Second, we aim for on demand addiction treatment, because the science is clear that addiction is a disease and treatment works. But nationwide, only 1 in 10 people with addiction get treatment. Imagine if only 1 in 10 patients with cancer get chemotherapy?

As an emergency physician, I see patients coming to the ER all the time asking for help, but I tell them they have to wait weeks or months. My patients have overdosed and died while they are waiting, because our system failed them. Here we are starting a stabilization center, which is the beginning of a 24/7 ER for addiction and mental health. We are expanding medication assisted treatment, which is the gold standard for helping people to recover from opioid addiction.

Third, we reduce stigma and prevent addiction. Treating addiction as a crime is unscientific, inhumane, and ineffective. That is why our public health and public safety agencies collaborate closely, including to pilot law enforcement assisted diversion where individuals caught with small amounts of drugs are offered treatment instead of prosecution. Recognizing that it has hurt people who hurt people. We are working to prevent the next generation of addiction by addressing trauma and providing mental health services in our schools.

My written testimony has point-by-point analyses of the President's Commission's recommendations, and I agree with many of them, but they do not go nearly far enough in four areas.

First, the Commission did not identify substantial additional federal funding. We on the frontlines know what works, and we desperately need new resources, not repurposed funding that will divert from other critical priorities. These funds should also be given directly to communities of greatest need. Cities have been fighting the epidemic for years, and we shouldn't have to jump through additional hoops. Competing for grants and having funding passed from the states to cities will cost time and many more lives.

Second, the Commission failed to advocate for taking on necessary steps to expand health insurance. One in three patients with addiction depend on Medicaid. If Medicaid were gutted and they were to lose coverage, many more would overdose and die. Other patients on private insurance could find themselves without treatment if addiction is no longer required to be part of their

health plan. It is estimated that ACA repeal could result in three million people losing access to addiction treatment. Block grants should not replace insurance coverage, because no disease can be treated through grants alone.

Third, the Commissions' recommendations did not guarantee access to treatment for addiction. Medication-assisted treatment reduces the likelihood of death, incidents of other illness, and criminal behavior. At the very least, medication-assisted treatment should be the standard of care for all treatment centers, and we can go further. If doctors can prescribe opioids that lead to addiction, why shouldn't hospitals all be required to treat this disease?

Fourth, the Commission ignored evidence-based harm reduction practices. In Baltimore, needle exchange has resulted in the percentage of individuals with HIV from injection drug used decrease from 63 percent in 1994 to seven percent in 2014. Our programs are staffed by people in recovery themselves who help patients connect to treatment.

Here in Baltimore, we know what works. We need support from the Federal Government in three ways: number one, urgently allocate additional funding to areas hardest hit by the opiate epidemic; number two, directly negotiate with the manufacturers of naloxone so that communities no longer have to ration; number three, protect and expand insurance coverage to get to on demand treatment for the disease of addiction.

Here in Baltimore, we have done a lot with very little. We can do so much more if we had more resources, and I urge Congress to commit these resources so that we can save lives and reclaim our futures.

I thank you for coming to our city and for calling this hearing.

[The prepared statement of Dr. Wen follows:]

CITY OF BALTIMORE
CATHERINE E. PUGH, Mayor

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November 28, 2017

TO: Members of the House Oversight Committee

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Testimony for the Record

Chairman Gowdy, Ranking Member Cummings, and Members of the Committee:

Thank you for inviting me to testify on the epidemic of opioid addiction that is sweeping across our country. Opioid addiction is a public health emergency that is claiming the lives and livelihoods of our citizens. It affects the entire life course, and touches upon every aspect of our communities, from public safety to the workforce to children and families.

As an emergency physician, I have witnessed firsthand the effects of substance addiction, including treating hundreds of patients who have overdosed on opioids. I remember well my patient, a 24-year old mother of two who came to the emergency room (ER) nearly every week requesting addiction treatment. She would be told there was nowhere for her to go that day or the next, and would be offered an appointment in three weeks' time. Because she lacked housing and other supportive services, she would relapse. One day, her family found her unresponsive and not breathing. By the time she arrived in the ER, it was too late for us to save her, and she died.

I always think back to my patient now: she had come to us requesting help, not once, not twice, but over and over again, dozens of times. Because we do not have the treatment capacity, people looking to us for help fall through the cracks, overdose, and die. Why has our system failed her, just as it is failing so many others who wish to get help for their addictions? How does our system continue to fail her family? Nationwide, 2.5 million children are raised by grandparents and other relatives, with parents missing—and that number is rising, in part because of the epidemic of opioid addiction. After a long period of decline, the number of children in foster care is rising for the same reason.

My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, society had missed significant opportunities to intervene further upstream in that individual's life. We treat addiction differently than we treat any other illness. Would we ever tell someone who has had a heart attack to wait three weeks to get treatment? Despite scientific studies showing that addiction is a disease, many still question why people "choose" a lifestyle of using drugs. Would we impose such stigma on any other disease? How can we intervene early—not just when someone is dying from an overdose, but much earlier, to prevent addiction in the first place or to provide treatment for people the moment they need it? These are the experiences that drove me to public health: a desire to tackle the epidemic of

addiction at a community-level, saving lives while also redefining our societal approach to the treatment of addiction.

With over 21,000 active heroin users in Baltimore and more who misuse and abuse prescription opioid medications, opioid addiction and overdose is a critical health priority in our city. In 2016, 694 people died from drug and alcohol overdose, which is more than twice the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city, including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us—our neighbors, our friends, and our family.

As the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Health Department and partners across our city to prevent overdose and stem the tide of addiction. These partners include our local behavioral health authority, Behavioral Health System Baltimore, whose board of directors I chair.

I am encouraged that the approach to the opioid epidemic is shifting away from the rhetoric of the "war on drugs" and instead focusing on treating addiction as a disease. But while our rhetoric is changing, funding for treatment lags behind. Of the more than 25 million people who abuse some form of drug, only about 1 in 10 receives treatment. Ensuring those struggling with addiction can access treatment on-demand requires urgent funding and support from the federal government.

In this testimony, I describe Baltimore's three-pillar approach to addressing opioid addiction. I include our responses to the President's Commission on Combating Drug Addiction and the Opioid Crisis as well as our recommendations to Congress.

A. Baltimore's Response to Addiction and Overdose

Our work in Baltimore is built on three pillars:

- First, we have to prevent deaths from overdose and save the lives of people suffering from addiction.
- Second, we must increase access to quality and effective on-demand treatment and provide long-term recovery support.
- Third, we need to increase education and awareness in order to reduce stigma and encourage prevention and treatment.

1. Preventing deaths from overdose

In 2015, I declared opioid overdose a public health emergency and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country.

a. The most critical part of the opioid overdose prevention campaign is expanding access to naloxone—the lifesaving drug that reverses the effect of an opioid drug overdose. Naloxone is safe, easily administered, not addictive, and nearly 100% effective at reversing an overdose. In my clinical practice as an emergency physician, I have

administered naloxone to hundreds of patients and have seen how someone who is unresponsive and about to die will be walking and talking within seconds.

Since 2003, Baltimore City has been training drug users on using naloxone through our Staying Alive Program. In 2015, we successfully advocated for a change in State law so that we can train not only individuals who use drugs, but also their family and friends, and anyone who wishes to learn how to save a life. This is critical because someone who is overdosing will be unresponsive and friends and family members are most likely to help.

In 2017, we further amended the state law to eliminate the training requirement for obtaining naloxone. Today, naloxone is now essentially available over the counter in Baltimore. Anyone can walk into any pharmacy and obtain naloxone under my blanket prescription.

Our naloxone education efforts are extensive. Since 2015, we have trained nearly 30,000 people to use naloxone: in jails, public housing, bus shelters, street corners, and markets. We work with businesses, libraries, restaurants, and other entities to conduct outreach and education, and go to where people are.

We were one of the first jurisdictions to require naloxone training as part of court-mandated time in Drug Treatment Court. We have trained federal, state, and city legislators so that they can not only save lives, but also serve as ambassadors to and champions for their constituents.

b. We use up-to-date epidemiological data to target our training to "hotspots," taking naloxone directly into the most at-risk communities and putting it in the hands of those most in need. This was put into effect in 2015, when 39 people died from overdose of the opioid Fentanyl between January and March of 2015. In 2016 we lost 419 people to Fentanyl overdoses; the numbers continue to escalate, and there are now 50 times the number of people dying from Fentanyl than there were in 2013. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. These data led us to target our messaging so that we could save the lives of those who were at immediate risk. Through our citywide Fentanyl Taskforce, we coordinate our data with agencies across the city, including the police department, fire department, and hospitals, to ensure our information is complete and our efforts are unified.

c. In order to train even more people in the use of naloxone, we have launched an online platform that now allows residents to get trained online and immediately receive a prescription for naloxone. This online platform, which is the first-of-its-kind around the country and the world, is the next step to reduce barriers to the use of naloxone.

d. Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to train police officers, who have saved 182

lives since 2015. The initial trainings were met with resistance from the officers, who were hesitant to apply medical interventions that some did not see as part of their job description. However, in the first month of carrying naloxone, four police officers used it to save the lives of four citizens. After those involved acclimated to the change, I attended a training where I asked the officers what they would look for if they were called to the scene for an overdose. In the past, I would have received answers about looking for drug paraphernalia and other evidence. This time, officers answered that their job was to find out what drugs the person might have taken, call an ambulance, and administer naloxone, because their duty is to save a life. By no means is naloxone training the panacea for repairing police and community relations. However, it is one step in the right direction as we make clear that addiction is a disease and overdose can be deadly. We are changing the conversation so that all of our partners can join in encouraging prevention, education, and treatment.

e. We successfully advocated for Good Samaritan legislation, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone.

f. Our state Medicaid program has agreed to set the co-pay for naloxone at $1. While we still struggle with the pricing for naloxone (see below), this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life—which we believe is each and every one of us.

Some people falsely believe that providing naloxone will only encourage a drug user by providing a safety net. This dangerous myth is rooted not in science but in stigma. Would we ever say to someone whose throat is closing from an allergic reaction that they shouldn't get epinephrine because it might encourage them to eat peanuts or shellfish? An Epi-Pen saves lives; so does naloxone, and it should be just as readily available. Our mantra is that we must save a life today in order for there to be a better tomorrow.

2. Increasing access to on-demand treatment and long-term recovery support

Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure that there is adequate access to on-demand treatment. Nationwide, only 10 percent of patients with addiction get the treatment they need. There is no physical ailment for which this would be acceptable—imagine if only 10 percent of cancer patients or 10 percent of patients with diabetes were being treated. If we do not increase access to quality treatment options we are merely treading water, waiting for the person who has overdosed to use drugs and overdose again.

The evidence is clear: addiction treatment requires a combination of medication-assisted treatment, psychosocial support, and wrap-around services, including supportive housing. All of these must be in place for individuals suffering from addiction to recover, and they must be available at the time the individual is seeking these services—the same as for any medical

condition. There are three FDA-approved medications for the treatment of opioid use disorder (methadone, buprenorphine, and naltrexone). All three should be available and covered by insurance equally in all places where people are seeking treatment.

a. In Baltimore, we have started a 24/7 "crisis, information, and referral" phone hotline that connects people in need to a variety of services, including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services. This hotline is not just for addiction but for mental health issues; behavioral health issues are closely related, and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line receives approximately 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by schoolteachers and family members seeking resources and by police and providers looking to connect their patients to treatment.

b. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. SBIRT is now being implemented in nine of our eleven hospitals and in our city clinics to ensure delivery of early intervention and treatment services for those with or at-risk for substance use disorders.

c. We have piloted a real-time treatment dashboard to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard is being connected to our 24/7 hotline that will immediately connect people to the level of treatment that they require—on-demand, at the time that they need it.

d. We have secured $3.6 million in capital funds and $2 million in operating funds for a "stabilization center"—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 "Urgent Care" for addiction and mental health disorders—a comprehensive, community-based "ER" dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must also be able to seek treatment on-demand. The center will provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings and connect patients to case management and other necessary services such as housing and job training.

e. We are expanding and promoting medication-assisted treatment, which is the gold standard for helping people recover from opioid addiction. This combines behavioral therapy with FDA-approved medications. Taking medication for opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction. Rather, it manages a patient's addiction so that they can successfully achieve recovery. Baltimore has been at the cutting edge of

innovation for incorporating medication-assisted treatment, including providing medications in structured clinical settings. We have expanded access to buprenorphine treatment by offering services in low-barrier settings, such as recovery centers, emergency shelters, and mental health facilities. The majority of our emergency departments are now able to start buprenorphine treatment before a patient is even discharged. This year, we are building a "hub-and-spokes" treatment network to increase the number of physicians throughout the City's healthcare institutions that are prescribing buprenorphine. Providing access to buprenorphine services allows us to engage more people into much needed treatment.

f. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. To build trust, these individuals have been recruited from the same neighborhoods as individuals with addiction, and are trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services. To date, eight of eleven hospitals participate in our Overdose Survivors Outreach Program, in which overdose survivors in the emergency room are linked with peer recovery coaches in the community. These peers work with patients after they are discharged to provide a "warm hand-off" into treatment and other support services.

g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, more than 75,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an addiction.

   Baltimore already has highly-effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts. At the start of 2017, we began a Law Enforcement Assisted Diversion (LEAD) pilot, a model that has been adopted by a select group of cities. LEAD establishes criteria for police officers to identify eligible users and take them to a case manager who connects them to necessary services such as drug treatment, peer supports, and housing—rather than to central booking. Cross agency partnerships are key in making these programs successful. LEAD implementation in Baltimore involves not only the Health Department, Behavioral Health System Baltimore, and our behavioral health providers, but also the Police Department, State's Attorney's Office, Public Defender's Office, and many more entities that together recognize the importance of addiction treatment.

3. Providing education to reduce stigma and prevent addiction

In addition to treating patients, we must also change the dialogue around the nature of substance use disorders while we work towards preventing addiction. This effort has multiple components, including educating doctors and the public, and providing prevention and early intervention services throughout the life course.

a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign, "DontDie.org," to educate citizens about the fact that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches, all coordinated with neighborhood leaders. We work with restaurants and bar owners to post "Don't Die" posters in their establishments. "DontDie.org" has also become our portal for online trainings and for the dispensing of naloxone through the Standing Order mentioned above. Any resident can watch a short (4 minute) video, take a four-question quiz, and have completed the training.

b. We have established permanent prescription drug drop boxes at all nine of the city's police stations and have conducted educational awareness campaigns the address safe storage and disposal. Anyone can drop off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. More than half of 12 to 17 year-olds who misuse prescription opioids say they got them from a friend or family member. Despite this, half of all patients prescribed opioids report receiving no instructions about safe storage and disposal.

c. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control and Prevention (CDC), there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid bottle for every American adult. Every day, people overdose on or become addicted to their prescription opioids.

   To address this, I have sent "best practice" letters to every doctor in the city. These letters addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first-line medication for acute pain, and emphasizing the risk of addiction and overdose with opioids. We emphasize adherence to CDC guidelines. Importantly, this best practice requires co-prescribing of naloxone for any individual taking opioids or at-risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone if they are to be discharged with opioid medications that can result in overdose.

   These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds and medical society conferences and have also launched physician "detailing," where we deploy teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We have convened pharmacists to set pharmacy best practices, and have supported statewide legislation to require the use of Prescription Drug Monitoring Programs by physicians

and pharmacists. All of us—as providers, patients, and family members—must play our part to prevent addiction and overdose.

d. We recognize that education must begin as early as possible and that our schools are a critical part of our efforts. We launched a concerted effort to target prevention among our teens and youth through a campaign called "BMore in Control." We are also incorporating prevention into the public school curriculum. As of 2017, Maryland state law requires schools to teach on addiction. We are working with our school district to implement evidence-based educational curricula.

e. We have trained all of our nurses in our 180 public schools to save lives with naloxone. We now have addiction and mental health services in 120 of our schools. These efforts are a good start, but are limited for two reasons. First is the issue of billing: certain critical services such as case management and care coordination are not reimbursable, yet these are key to serving children in need. Second is that there must be a focus on a true prevention intervention model. Substance use is often not the problem but a response to trauma, and there must be a more comprehensive approach to social and emotional learning and to addressing intersecting issues such as poverty, violence, racism, and trauma.

B. Response to the President's Commission on Combating Drug Addiction and the Opioid Crisis

The final report issued by the President's Commission on Combating Drug Addiction and the Opioid Crisis addresses critical aspects of the fight against the nation's opioid epidemic. I agree with the major recommendations, but they do not go nearly far enough. As was the case with the President's declaration of a limited public health emergency instead of a full national state of emergency, these recommendations stop short of providing the resources needed to urgently combat this national tragedy.

Specifically, I would have looked to the report to address the following four points:

1. **The Commission failed to advocate for taking all necessary steps to expand health insurance.** This includes protecting Medicaid, which covers 1 in 3 patients who receive treatment for substance use disorder, as well as ensuring that essential health benefits covering addiction and mental health treatment remain part of every insurance plan. There should also be coverage for other wraparound services that are critical for treating addiction, such as connections to treatment, coverage for supportive housing, and reimbursement for peer recovery specialists. The Commission recommended block grants, but grants alone cannot be depended upon for treatment of such a widespread disease as opioid addiction.

2. **The Commission does not adequately address the issue of treatment for the disease of addiction.** The Commission provides recommendations to support medication-assisted treatment, but it needs to go beyond that by requiring the integration of substance use treatment into medical practice. That could include requiring all eligible physicians to obtain the waiver to prescribe buprenorphine and approving state-level pilots for integrating primary care and behavioral health treatment. At the very least, medication-

assisted treatment should be the standard of care for all treatment centers that offer addiction services.

3. **The Commission failed to identify substantial increases in federal funding that may be employed in the fight against the opioid epidemic.** National state of emergency declarations come with commitments for funding. When hurricanes devastate communities, it's understood that billions of dollars are required to rebuild homes and repair infrastructure. The same understanding applies for stopping an epidemic. In Baltimore and across the country, we desperately need these resources. Studies show that only 1 in 10 people with addiction receive the treatment that they need—a statistic we would not find acceptable for any other disease. The President needs to announce a specific dollar amount for new funding, not repurposed dollars that take away from other key health priorities. We know what works to overcome this crisis. We just need the resources and the will to get there.

4. **The Commission does not provide recommendations around evidence-based harm-reduction practices, most notably needle and syringe exchange.** There are dozens of studies showing that needle exchange programs reduce HIV and hepatitis transmission, and do not increase drug use. In Baltimore City, implementation of needle exchange has resulted in the percentage of individuals with HIV from injection drug use decreasing from 63% in 1994 to 7% in 2014. Our needle exchange vans are staffed by individuals in recovery themselves, who are credible messengers and serve as counselors to help connect patients to treatment. Furthermore, these outreach workers teach on naloxone usage to a high-risk population; it is estimated that for every 11 units of naloxone handed out on our vans, one unit is used to save someone's life. Attention should be paid to the omission of this evidence-based practice that has been successful in Baltimore and in many locations across the country and internationally. There is also growing evidence from other countries about other harm-reduction practices such as safe injection facilities. Such evidence should be referenced by the Commission report, if only to call attention to the need for further study.

Below is my analysis of each of the Commission's recommendations:

Federal Funding and Programs

1. The Commission urges Congress and the Administration to block grant federal funding for opioid-related and SUD-related activities to the states, where the battle is happening every day. There are multiple federal agencies and multiple grants within those agencies that cause states a significant administrative burden from an application and reporting perspective. Creating uniform block grants would allow more resources to be spent on administering life-saving programs. This was a request to the Commission by nearly every Governor, regardless of party, across the country.
    a. **Agree, but this doesn't go far enough**. Combining grants allows more flexibility but 1) these grants need to come directly to local jurisdictions and 2) we need more funding, not just streamlined funding.
    b. The Commission fails to identify substantial increases in federal funding that may be employed in the fight against the opioid epidemic. National state of emergency

declarations come with commitments for funding. When hurricanes devastate communities, billions of dollars are required to rebuild homes and repair infrastructure. The same understanding applies for stopping an epidemic.

2. The Commission believes that ONDCP must establish a coordinated system for tracking all federally-funded initiatives, through support from HHS and DOJ. If we are to invest in combating this epidemic, we must invest in only those programs that achieve quantifiable goals and metrics. We are operating blindly today; ONDCP must establish a system of tracking and accountability.
    a. **Agree, with reservations**. More opioid work needs to be evidence-based. The tracking system should not, however, impose bureaucratic burdens on local jurisdictions implementing programs that we already know work.

3. To achieve accountability in federal programs, the Commission recommends that ONDCP review is a component of every federal program and that necessary funding is provided for implementation. Cooperation by federal agencies and the states must be mandated.
    a. **Agree, but this does not far enough**. Maximizing the efficacy of existing resources is a worthy goal, but it will not come close to eliminating the need for new funding. Existing funding is inadequate—and it will remain inadequate no matter how efficiently it is used.
    b. While cooperation between federal agencies and the states sounds good in theory, federal funding should be allocated directly to local jurisdictions with greatest need without going through the states. State governments do not know the challenges that cities face on the ground. Cities like Baltimore have been dealing with the epidemic for many years; we know what works.

Opioid Addiction Prevention

4. The Commission recommends that Department of Education (DOE) collaborate with states on student assessment programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a program that uses a screening tool by trained staff to identify at-risk youth who may need treatment. This should be deployed for adolescents in middle school, high school and college levels. This is a significant prevention tool.
    a. **Agree, but this does not go far enough**. SBIRT is evidence-based—much more so than "just say no"-style abstinence curricula. But its implementation requires funding—as do projects to ensure that treatment is available for those who screen positive for substance use disorder.

5. The Commission recommends the Administration fund and collaborate with private sector and non-profit partners to design and implement a wide-reaching, national multi-platform media campaign addressing the hazards of substance use, the danger of opioids, and stigma. A similar mass media/educational campaign was launched during the AIDs public health crisis.

a. **Agree, but this does not go far enough**. The anti-stigma messaging needs to address not just the stigma that applies to addiction but also the stigma that applies to medication-assisted treatment—the gold standard.
b. "Just Say No" campaigns are insufficient without addressing general well-being. The best way to deter individuals from drug use is to ensure that the life they have is one that they do not wish to escape from. There must also be equal attention to preventing trauma and addressing "upstream" factors including poverty, housing, and the workforce.

Prescribing Guidelines, Regulations, Education

6. The Commission recommends HHS, the Department of Labor (DOL), VA/DOD, FDA, and ONDCP work with stakeholders to develop model statutes, regulations, and policies that ensure informed patient consent prior to an opioid prescription for chronic pain. Patients need to understand the risks, benefits and alternatives to taking opioids. This is not the standard today.
    a. **Agree.** While it's not clear that these "opioid contracts" have a significant effect on outcomes, it's certainly worth pursuing—more information about risks and alternatives is helpful.

7. The Commission recommends that HHS coordinate the development of a national curriculum and standard of care for opioid prescribers. An updated set of guidelines for prescription pain medications should be established by an expert committee composed of various specialty 13 practices to supplement the CDC guideline that are specifically targeted to primary care physicians.
    a. **Agree, but this does not go far enough**. It's important to establish national safety standards for opioid prescribing in all settings. But guidelines are not enough unless they are accompanied by regulatory changes. HHS can go much further to tie reimbursement and licensing to compliance with the guidelines.

8. The Commission recommends that federal agencies work to collect participation data. Data on prescribing patterns should be matched with participation in continuing medical education data to determine program effectiveness and such analytics shared with clinicians and stakeholders such as state licensing boards.
    a. **Agree, with reservations.** This sounds good in theory, but I urge federal officials to seek input from local partners on the ground. In Baltimore City and across the country, we already work closely with law enforcement partners and others to share and collaborate on data. Making federal data available to locals on the ground, and learning from our experiences, will be critical to ensuring the usefulness of such analytics.

9. The Commission recommends that the Administration develop a model training program to be disseminated to all levels of medical education (including all prescribers) on screening for substance use and mental health status to identify at risk patients.

a. **Agree, but this does not go far enough.** Screenings for substance use disorder should be universal—a part of every routine medical encounter.
b. Once screenings are done, there must be place for on-demand treatment. There should also be required training for how to treat patients with substance use disorder. Doctors are required to treat patients with all kinds of illnesses, and the disease of addiction should be no exception.

10. The Commission recommends the Administration work with Congress to amend the Controlled Substances Act to allow the DEA to require that all prescribers desiring to be relicensed to prescribe opioids show participation in an approved continuing medical education program on opioid prescribing.
    a. **Agree.** More should be required of providers before they prescribe opioid analgesics—and less before they prescribe medications to treat the use disorder that those analgesics can cause.

11. The Commission recommends that HHS, DOJ/DEA, ONDCP, and pharmacy associations train pharmacists on best practices to evaluate legitimacy of opioid prescriptions, and not penalize pharmacists for denying inappropriate prescriptions.
    a. Agree, but this does not go far enough. Pharmacists play an important role in preventing overprescription, but we also need their help in distributing naloxone. Many states and local jurisdictions have issued "standing orders" that allow residents to purchase naloxone from a pharmacy without an individualized prescription. The efficacy of these standing orders, however, is contingent on pharmacists: if they are unaware of the standing order, they may inappropriately deny individuals' requests for naloxone. The federal government should work with pharmacy associations and states/local jurisdictions to educate pharmacists about relevant standing order laws. The federal government should also work with pharmacy associations to ensure that pharmacists are trained to dispense naloxone when filling opioid prescriptions, as appropriate.

PDMP Enhancements

12. The Commission recommends the Administration's support of the Prescription Drug Monitoring (PDMP) Act to mandate states that receive grant funds to comply with PDMP requirements, including data sharing. This Act directs DOJ to fund the establishment and maintenance of a data-sharing hub.
    a. **Agree, but this does not go far enough**. We should be aiming for a nationally integrated PDMP that is checked, at a minimum, before every opioid prescription.
    b. There should also be a recommendation to co-prescribe naloxone for every patient receiving opioids or at-risk for an opioid use disorder.

13. The Commission recommends federal agencies mandate PDMP checks, and consider amending requirements under the Emergency Medical Treatment and Labor Act

(EMTALA), which requires hospitals to screen and stabilize patients in an emergency department, regardless of insurance status or ability to pay.

a. **Agree.** PDMP checks should be mandated. If the emendation of EMTALA recommended here consists of defining the "stabilization" of substance use disorder patients to include initiating medication-assisted treatment, per recommendation 45, then we support the change.

14. The Commission recommends that PDMP data integration with electronic health records, overdose episodes, and SUD-related decision support tools for providers is necessary to increase effectiveness.
    a. **Agree**. Lack of integration with EHRs is a major barrier preventing increased PDMP use.

15. The Commission recommends ONDCP and DEA increase electronic prescribing to prevent diversion and forgery. The DEA should revise regulations regarding electronic prescribing for controlled substances.
    a. **Agree, but this does not go far enough**. ONDCP and DEA should require electronic prescribing.

16. The Commission recommends that the Federal Government work with states to remove legal barriers and ensure PDMPs incorporate available overdose/naloxone deployment data, including the Department of Transportation's (DOT) Emergency Medical Technician (EMT) overdose database. It is necessary to have overdose data/naloxone deployment data in the PDMP to allow users of the PDMP to assist patients.
    a. **Agree.** This would help providers identify high-risk patients. Physicians should be provided with the tools they need to appropriately treat these high-risk patients—including education about alternative treatments, tapering, and referrals to a specialty provider. (This is endorsed elsewhere in the report.)

Supply Reduction and Enforcement Strategies

17. The Commission recommends community-based stakeholders utilize Take Back Day to inform the public about drug screening and treatment services. The Commission encourages more hospitals/clinics and retail pharmacies to become year-round authorized collectors and explore the use of drug deactivation bags.
    a. **Agree, with reservations.** Take-back days are important, and they do provide opportunities to educate the public about treatment services, but it would be much better if local jurisdictions were provided funding that could be used to refer individuals into treatment services (e.g., through peer recovery specialists) year-round.
    b. Baltimore City, for example, has 24/7 drop boxes at nine locations around the city. These are available every day of the year, not just on one designated day.

18. The Commission recommends that CMS remove pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids

to raise their survey score. ONDCP and HHS should establish a policy to prevent hospital administrators from using patient ratings from CMS surveys improperly.

a. **Agree, but this does not go far enough.** Elimination of the pain survey question would remove a major structural incentive for overprescribing. CMS can consider going further by tying reimbursements to judicious prescribing of opioids and evidence-based treatments of opioid use disorders.

19. The Commission recommends CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.
    a. **Agree, but this does not go far enough.** Rate-setting policies should also be used to incentivize provision of the gold standard of care, which is medication-assisted treatment.

20. The Commission recommends a federal effort to strengthen data collection activities enabling real-time surveillance of the opioid crisis at the national, state, local, and tribal levels.
    a. **Agree, with reservations.** Surveillance data needs to be shared with the local jurisdictions responding to this epidemic on the frontlines.

21. The Commission recommends the Federal Government work with the states to develop and implement standardized rigorous drug testing procedures, forensic methods, and use of appropriate toxicology instrumentation in the investigation of drug-related deaths. We do not have sufficiently accurate and systematic data from medical examiners around the country to determine overdose deaths, both in their cause and the actual number of deaths.
    a. **Agree.**

22. The Commission recommends reinstituting the Arrestee Drug Abuse Monitoring (ADAM) program and the Drug Abuse Warning Network (DAWN) to improve data collection and provide resources for other promising surveillance systems.
    a. **Agree.** These are important data collection mechanisms. The report is correct that the NSDUH alone is inadequate.

23. The Commission recommends the enhancement of federal sentencing penalties for the trafficking of Fentanyl and Fentanyl analogues.
    a. **No position.** While efforts to limit supply are important, it's not at all clear—based on the historical record—that increased penalties will limit distribution. And it's very important that we take a public health approach, rather than a criminal justice approach—from people who use drugs to low-level traffickers.
    b. Law enforcement is important to stem the flow of illicit drugs, including the synthetic opioid Fentanyl. However, we must acknowledge the evidence that

arrest is not the answer to the opioid crisis. Some individuals who sell Fentanyl and other drugs also have the disease of addiction. Treating addiction as a crime is ineffective, unscientific, and inhumane. Communities like ours in Baltimore—already hit hard by decades of systemic racism and the mass incarceration of predominantly poor, minority populations—would suffer greatly under a new War on Drugs.

c. Addressing the supply of drugs is critical, but as long as there are millions with addiction who do not have access to treatment, their demand will continue to fuel supply.

24. The Commission recommends that federal law enforcement agencies expressly target Drug Trafficking Organizations and other individuals who produce and sell counterfeit pills, including through the internet.
    a. **No position**. This should be happening already.

25. The Commission recommends that the Administration work with Congress to amend the law to give the DEA the authority to regulate the use of pill presses/tableting machines with requirements for the maintenance of records, inspections for verifying location and stated use, and security provisions.
    a. **Agree**.

26. The Commission recommends U.S. Customs and Border Protection (CBP) and the U.S. Postal Inspection Service (USPIS) use additional technologies and drug detection canines to expand efforts to intercept Fentanyl (and other synthetic opioids) in envelopes and packages at international mail processing distribution centers.
    a. **Agree**.

27. The Commission recommends Congress and the Federal Government use advanced electronic data on international shipments from high-risk areas to identify international suppliers and their U.S.-based distributors.
    a. **Agree**.

28. The Commission recommends support of the Synthetics Trafficking and Overdose Prevention (STOP) Act and recommends the Federal Government work with the international community to implement the STOP Act in accordance with international laws and treaties.
    a. **Agree.**

29. The Commission recommends a coordinated federal/DEA effort to prevent, monitor and detect the diversion of prescription opioids, including licit Fentanyl, for illicit distribution or use.
    a. **Agree, with qualifications**. It is important to prevent diversion of opioid analgesics. For some opioids—and in particular buprenorphine—the risk can be overstated. (Diverted buprenorphine is often used merely to treat withdrawal.)

30. The Commission recommends the White House develop a national outreach plan for the Fentanyl Safety Recommendations for First Responders. Federal departments and agencies should partner with Governors and state fusion centers to develop and standardize data collection, analytics, and information-sharing related to first responder opioid-intoxication incidents.
    a. **Agree, with qualifications**. The safety of our first responders is of course important, but we should also be careful not to scare citizens away from responding to an overdose by exaggerating the risks involved or perpetuating myths about, e.g., cutaneous Fentanyl overdose.

Opioid Addiction Treatment, Overdose Reversal, and Recovery

31. The Commission recommends HHS, CMS, Substance Abuse and Mental Health Services Administration, the VA, and other federal agencies incorporate quality measures that address addiction screenings and treatment referrals. There is a great need to ensure that health care providers are screening for SUDs and know how to appropriately counsel, or refer a patient. HHS should review the scientific evidence on the latest OUD and SUD treatment options and collaborate with the U.S. Preventive Services Task Force (USPSTF) on provider recommendations.
    a. **Agree, but this does not go far enough.** Guidelines are a good way to increase the use of screenings and referrals. But we shouldn't need to review the scientific evidence on OUD treatment options; we know what works. These guidelines should also be tied to regulatory action and/or reimbursement to be maximally effective.

32. The Commission recommends the adoption of process, outcome, and prognostic measures of treatment services as presented by the National Outcome Measurement and the American Society of Addiction Medicine (ASAM). Addiction is a chronic relapsing disease of the brain which affects multiple aspects of a person's life. Providers, practitioners, and funders often face challenges in helping individuals achieve positive long-term outcomes without relapse.
    a. **Agree.**

33. The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours.
    a. **Agree, but this does not go far enough**. All insurance plans (public, marketplace, small group, large group) should be required to reimburse for all

forms of MAT. Prior authorization requirements and other non-reimbursement barriers should be eliminated. As noted above, all doctors should be required to treat patients with SUD.

34. The Commission recommends HHS review and modify rate-setting (including policies that indirectly impact reimbursement) to better cover the true costs of providing SUD treatment, including inpatient psychiatric facility rates and outpatient provider rates.
    a. **Agree.**

35. Because the Department of Labor (DOL) regulates health care coverage provided by many large employers, the Commission recommends that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations.
    a. **Agree, but this does not go far enough.** All insurance plans (public, marketplace, small group, large group) should be required to reimburse for all forms of MAT (even if not doing so doesn't constitute a parity violation). Prior authorization requirements and other non-reimbursement barriers should be eliminated.

36. The Commission recommends that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity. NQTLs include stringent prior authorization and medical necessity requirements. HHS, in consultation with DOL and Treasury, should review clinical guidelines and standards to support NQTL parity requirements. Private sector insurers, including employers, should review rate-setting strategies and revise rates when necessary to increase their network of addiction treatment professionals.
    a. **Agree.**

37. The Commission recommends the National Institute on Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national, state, local, and tribal stakeholders use medication-assisted treatment (MAT) with pre-trial detainees and continuing treatment upon release.
    a. **Agree, but this does not nearly far enough.** All forms of MAT must be made available in all jails and prisons at all times—not just before trial.

38. The Commission recommends DOJ broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with an SUD who violate probation terms with substance use should be diverted into drug court, rather than prison.

a. **Agree, but this does not go far enough**. The recommendation needs to explicitly require that all drug courts offer MAT, the gold standard of opioid use disorder treatment; drug courts cannot be used to steer individuals into treatment that does not work. In addition, bolder action is required to ensure that drug courts are established beyond the federal district court system, which accounts for only a small fraction of the nation's drug cases.

39. The Commission recommends the Federal Government partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas. Insurance companies, federal health systems, and state payers should expand programs for hospital and primary case-based SUD treatment and referral services. Recovery coach programs have been extraordinarily effective in states that have them to help direct patients in crisis to appropriate treatment. Addiction and recovery specialists can also work with patients through technology and telemedicine, to expand their reach to underserved areas.
    a. **Agree, but this does not go far enough**. Recovery coach programs have indeed been extraordinarily effective—which is why local jurisdictions need additional funding to support them.

40. The Commission recommends the Health Resources and Services Administration (HRSA) prioritize addiction treatment knowledge across all health disciplines. Adequate resources are needed to recruit and increase the number of addiction-trained psychiatrists and other physicians, nurses, psychologists, social workers, physician assistants, and community health workers and facilitate deployment in needed regions and facilities.
    a. **Agree.**

41. The Commission recommends that federal agencies revise regulations and reimbursement policies to allow for SUD treatment via telemedicine.
    a. **Agree.**

42. The Commission recommends further use of the National Health Service Corp to supply needed health care workers to states and localities with higher than average opioid use and abuse.
    a. **Yes, but with amendment**. The issue in many places is not number of healthcare workers—it is number of healthcare workers who can treat SUD. One solution is to have all healthcare workers be trained to treat SUD.

43. The Commission recommends the National Highway Traffic Safety Administration (NHTSA) review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of Fentanyl overdoses.

a. **Agree, but this does not go far enough.** Local jurisdictions need more funding for naloxone, including for first responders.

44. The Commission recommends HHS implement naloxone co-prescribing pilot programs to confirm initial research and identify best practices. ONDCP should, in coordination with HHS, disseminate a summary of existing research on co-prescribing to stakeholders.
    a. **Agree, but this does not go far enough.** We cannot delay actions while waiting on the results of further research. We already know that naloxone saves lives.
    b. Also, it is not enough simply to recommend that naloxone be co-prescribed. It should be required for high-risk patients.

45. The Commission recommends HHS develop new guidance for Emergency Medical Treatment and Labor Act (EMTALA) compliance with regard to treating and stabilizing SUD patients and provide resources to incentivize hospitals to hire appropriate staff for their emergency rooms.
    a. **Agree**. This would ensure that "stabilizing" OUD patients is understood as initiating MAT, where possible.

46. The Commission recommends that HHS implement guidelines and reimbursement policies for Recovery Support Services, including peer-to-peer programs, jobs and life skills training, supportive housing, and recovery housing.
    a. **Agree**. Reimbursing for these services is absolutely essential for allowing states and local jurisdictions to make progress toward ending the opioid epidemic.

47. The Commission recommends that HHS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration on Children, Youth and Families (ACYF) should disseminate best practices for states regarding interventions and strategies to keep families together, when it can be done safely (e.g., using a relative for kinship care). These practices should include utilizing comprehensive family centered approaches and should ensure families have access to drug screening, substance use treatment, and parental support. Further, federal agencies should research promising models for pregnant and post-partum women with SUDs and their newborns, including screenings, treatment interventions, supportive housing, non-pharmacologic interventions for children born with neonatal abstinence syndrome, medication-assisted treatment (MAT) and other recovery supports.
    a. **Agree, but this does not go far enough.** Recommendations and guidelines do not go far enough when there are effective incentive and regulatory mechanisms.

48. The Commission recommends ONDCP, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Department of Education (DOE) identify successful college recovery programs, including "sober housing" on college campuses, and provide support and technical assistance to increase the number and capacity of high-quality programs to help students in recovery.

a. **Agree, but this does not go far enough.** There should be funding to support evidence-based programs.

49. The Commission recommends that ONDCP, federal partners, including DOL, large employers, employee assistance programs, and recovery support organizations develop best practices on SUDs and the workplace. Employers need information for addressing employee alcohol and drug use, ensure that employees are able to seek help for SUDs through employee assistance programs or other means, supporting health and wellness, including SUD recovery, for employees, and hiring those in recovery.
    a. **Agree, but this does not go far enough.** All employer-sponsored plans should treat SUD, as indicated in above recommendations.

50. The Commission recommends that ONDCP work with the DOJ, DOL, the National Alliance for Model State Drug Laws, the National Conference of State Legislatures, and other stakeholders to develop model state legislation/regulation for states to decouple felony convictions and eligibility for business/occupational licenses, where appropriate.
    a. **Agree, but this does not go far enough**. This should extend to pressuring (or requiring) that employers respond differently to employees who test positive for drugs. The response should be to offer help getting the employee treatment, not termination.

51. The Commission recommends that ONDCP, federal agencies, the National Alliance for Recovery Residents (NARR), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and housing stakeholders should work collaboratively to develop quality standards and best practices for recovery residences, including model state and local policies. These partners should identify barriers (such as zoning restrictions and discrimination against MAT patients) and develop strategies to address these issues.
    a. **Agree**.

Research and Development

52. The Commission recommends federal agencies, including HHS (National Institutes of Health, CDC, CMS, FDA, and the Substance Abuse and Mental Health Services Administration), DOJ, the Department of Defense (DOD), the VA, and ONDCP, should engage in a comprehensive review of existing research programs and establish goals for pain management and addiction research (both prevention and treatment).
    a. **Agree, with reservations.** We cannot let further research into treatment modalities delay funding for what we already know works.

53. The Commission recommends Congress and the Federal Government provide additional resources to the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) to fund the research areas cited above. NIDA should continue research in concert with the pharmaceutical industry to develop and test innovative medications for

SUDs and OUDs, including long-acting injectables, more potent opioid antagonists to reverse overdose, drugs used for detoxification, and opioid vaccines.

a. **Agree, with reservations.** We cannot let further research into treatment modalities delay funding for what we already know works.

54. The Commission recommends further research of Technology-Assisted Monitoring and Treatment for high-risk patients and SUD patients. CMS, FDA, and the United States Preventative Services Task Force (USPSTF) should implement a fast-track review process for any new evidence-based technology supporting SUD prevention and treatments.

a. **Agree, with reservations.** We cannot let further research into treatment modalities delay funding for what we already know works.

55. The Commission recommends that commercial insurers and CMS fast-track creation of Healthcare Common Procedure Coding System (HCPCS) codes for FDA-approved technology-based treatments, digital interventions, and biomarker-based interventions. NIH should develop a means to evaluate behavior modification apps for effectiveness.

a. **Agree.**

56. The Commission recommends that the FDA establish guidelines for post-market surveillance related to diversion, addiction, and other adverse consequences of controlled substances.

b. **Agree, with reservations.** If there are particular concerns about adverse consequences (e.g., abuse potential), these should be addressed before approval—pre-market, not post-market.

C. Recommendations for Congress and the Federal Government

The Baltimore City Health Department, together with our partners across the city and state, has made significant progress in tackling the opioid epidemic. However, there are some areas where we face continued challenges. Though there is much that can be done on the city and state levels, the federal government also plays a critical role.

Congress has shown clear concern for this pressing tragedy, including through the passage last year of the Comprehensive Addiction and Recovery Act. There is also increased recent attention to the crisis by President Trump's declaration of a limited public health emergency and his Commission's recommendations.

There are four specific areas that we urge for this Committee to consider:

1. Congress can request for the federal government to negotiate directly with drug manufacturers of naloxone so that communities can afford this life-saving medication

Naloxone, the opioid overdose antidote, is part of the World Health Organization's (WHO) list of essential medications. Naloxone is available as a generic, yet both the generic version as well as brand-name versions are too expensive for local jurisdictions to afford with their limited budgets.

In Baltimore, not only have we equipped paramedics, EMTs, and the police with naloxone, my blanket prescription equips every resident in our city to carry naloxone. Since 2015, we have trained 30,000 people, and everyday people have saved the lives of nearly 1,500 of their fellow residents.

But we have a problem: our city is out of funds to purchase naloxone, forcing us to ration and make decisions every day about who can receive this antidote. This issue is particularly acute because of Fentanyl. The number of people dying from Fentanyl has increased 50-times since 2013, and because of how strong Fentanyl is, we need more naloxone to revive individuals who are overdosing.

Earlier this year, Representative Elijah Cummings led a coalition of 51 Members to call for the President to negotiate directly with manufacturers of naloxone. We urge for these negotiations to occur. Imagine how many more lives we can save if we had the resources to do so.

2. Congress can allocate new funding directly to local jurisdictions hardest hit by the opioid epidemic

While states have traditionally received block grants from the federal government, local jurisdictions are the closest to the ground in service delivery, and understand the needs of residents the best. We urge Congress to consider direct support for local jurisdictions, particularly those in areas of greatest need, by providing cities and counties with the autonomy to innovate and provide real-time care for our residents.

For years, we on the frontlines have been able to do a lot with very little. We need resources from the federal government to help us—new resources, not repurposed funding that will divert from other critical health priorities. These funds should be directly given to communities of greatest need. Cities and counties have been fighting the epidemic for years. We know what works, and local officials should not have to jump through additional hoops to obtain the resources we need. Issuing grants and having local jurisdictions compete for them will cause months if not years of delay, as would funding that passes through the states before getting to cities and counties.

3. Congress can protect and expand insurance coverage for on-demand addiction treatment

The federal government needs to protect and expand Medicaid (see attached article from PLoS). One in three patients receiving substance use disorder treatment depend on the program. There is no margin of error: if Medicaid were gutted and they were to lose coverage, their only way to stave off the pain of withdrawal could be to use illicit drugs, potentially leading to overdose and death.

Protecting Medicaid is not enough. Private insurance coverage of addiction treatment is often inadequate. While the combination of the ACA's essential health benefits and the requirements of the Mental Health Parity and Addiction Equity Act should mean that most insurance plans include coverage for addiction treatment, some plans specifically exclude the gold standard of opioid use disorder treatment: medication-assisted treatment. Even when medication-assisted treatment is covered, other barriers—like prior authorization requirements and duration limits—can stand between individuals and their recovery. These problems also plague some state's Medicaid plans.

Essential health benefits are called essential for a reason. In the midst of an epidemic, the federal government must ensure universal coverage for medication-assisted treatment, with no inappropriate prior authorization requirements or duration limits. There should also be coverage for preventive care, mental health treatment, and the wraparound services that are critical for treating addiction, including supportive housing and targeted case management.

Block grants should not replace insurance coverage, because no disease can be treated through grants alone.

4. Congress can require hospitals and doctors to treat patients with addiction

Our efforts in Baltimore would be enhanced if the federal government took action to ensure that addiction treatment is incorporated into the traditional health care setting, where it belongs. This could include requiring all eligible physicians to obtain the waiver required to prescribe buprenorphine, if not eliminating this waiver requirement altogether, and mandating that all hospitals, healthcare systems, and federally-qualified health centers (FQHCs) treat patients with opioid addiction. If doctors can prescribe the opioids that lead to addiction, why shouldn't we be required to treat the disease of addiction?

Conclusion

While some of the challenges facing Baltimore are unique, we join our counterparts around the country in addressing the epidemic of opioid abuse and addiction. According to the CDC, the number of people dying from overdose has quadrupled over less than two decades. In many states, there are more people dying from overdose than from car accidents or suicide. This crisis extends far beyond the individual suffering from addiction; it ties into the very fabric of society and has impacts across the life course and for generations to come.

There are some who say the opioid problem is too big and too complicated—that it cannot be solved. It is true that treating the opioid epidemic requires many approaches. However, this is a problem with a solution—if only we have the will and commit the resources. Treating addiction is not only the humane thing to do, it is also cost-effective. According to the NIH, treating opioid addiction saves society $12 for every $1 spent on treatment. Treatment also impacts communities by reducing excess healthcare utilization, increasing productivity and employment rates, and

decreasing poverty and unnecessary cost to the criminal justice system. Furthermore, treating addiction is a moral imperative and a matter of life and death.

I'd like to end with one final point: imagine if a natural disaster like a hurricane were claiming 142 lives a day. No one would question the resources required to repair houses and rebuild infrastructure. Billions of dollars would immediately be appropriated. The opioid epidemic can be solved if we commit a similar level of resources with urgency, compassion, and action. I urge Congress to put the full weight of the federal government to stem the tide of this epidemic, and to join those of us on the frontlines to commit the necessary resources to save lives and reclaim our communities.

I want to thank you for calling this important hearing. I look forward to working with you to stop the epidemic of opioid addiction in the United States.

Chairman GOWDY. Thank you, Dr. Wen. Dr. Alexander?

STATEMENT OF CALEB ALEXANDER

Dr. ALEXANDER. Good afternoon, Chairman Gowdy, Ranking Member Cummings, and members of the Committee. I appreciate the opportunity to speak today.

I am a practicing primary care physician and co-director of the Johns Hopkins Center for Drug Safety and Effectiveness at the Johns Hopkins Bloomberg School of Health. My research focused on identifying political and policy solutions to the opioid epidemic, but as a practicing physician, I also know the power of stories to compel action, and I would like to share with you a brief one now.

In 2011, Judy Rummler lost her son Steve from an overdose. I work with Judy on policy reform and I asked her if I could share his story. She said, I am always happy to share Steve's story if it helps the cause. Steve's journey began like so many with a lower back injury that led to chronic opioid use and subsequent addiction. Years before his death, he wrote presciently of opioids, "At first they were a lifeline, and they became a noose around my neck." Steve tried as best he could to get well and he didn't want to die, but he ultimately succumbed from an overdose after discharge from a rehab facility. Now, Judy keeps a picture of Steve along with a note, "If love could have saved you, you would have lived forever."

Steve's story, and his family's resolve to ensure that other families don't have to experience what they have, is a reminder to me of what is at stake here, and of the loss that so many have endured.

During the past year, my colleagues at Johns Hopkins and I have reviewed hundreds of scientific studies and other data points on the epidemic. Last month, we released this report, "From Evidence to Impact", that has been provided with my written testimony, and that synthesizes the field and provides recommendations to address the epidemic. Ranking Member Cummings, we were so honored that you participated in the release of this report.

In the remainder of my time, I would like to highlight two points regarding how the Commission's report can best drive change. First the Commission's findings provide a comprehensive framework for action. Simply put, the science is the science, and the Commission's report gets it right. It is based on evidence and lines up closely with our own appraisal in most areas. For example, both assessments agree that providers should be required to use prescription drug monitoring programs, that the CDC's guidelines should be standard practice nationwide, and that high quality evidenced-based addiction treatment should be available on demand.

In my written testimony, I make specific recommendations regarding steps Congress can take, such as passage of the Prescription Drug Monitoring Act of 2017, and I also highlight areas where the Commission might have increased the comprehensiveness or impact of their review.

Second, as we have already heard urged by some of you this afternoon, it is now critical for the Administration to develop a strategy to support the implementation of its recommendations. It is one thing to say we are going to send a man to the moon, and it is totally a different thing to have a plan in place to do so. In

my humble opinion, the Commission's two most important recommendations are that we need to reduce over-prescribing and provide high quality evidence-based treatment for addiction upon demand, although I think reducing the supply of fentanyl in the country is a very close third.

But I am left asking the questions that some of you may be, which is what specific steps is the Federal Government going to take to reduce, for example, opioid over-prescribing? What resources are required? Which agencies are responsible? What timeline will be followed? And how will we know when we have been successful? In short, we urgently need an implementation plan, and this Committee could support this effort by asking for and reviewing such a plan for the Commission's most important recommendations. This Committee can also exercise oversight capacity to ensure that other federal agencies act on the Committee's recommendations.

Esteemed representatives, we are missing more than half a million Americans from overdose that should be with us today, people like Steve Rummler and so many others. Incredibly, more deaths from opioids are expected in 2017 than ever before; yet as we look to 2018, there are reasons for hope. Providers are increasingly using safer and more effective treatments for pain. There is growing awareness that addiction is a disease and treatable, and more Americans are living fulfilling lives in recovery. Communities are increasingly mobilized, demanding affordable naloxone, reliable access to addiction treatment, stronger FDA regulation, and coordinated federal action. This is a fixable crisis, but not without an implementation plan to accompany the Commission's recent recommendations.

Thank you again for the opportunity to testify. I look forward to your questions.

[The prepared statement of Dr. Alexander follows:]

Testimony for the Record
Submitted to the
House Committee on Oversight and Government Reform
for the Hearing
"Combating the Opioid Crisis"

November 28, 2017

G. Caleb Alexander, MD, MS
Co-Director, Center for Drug Safety and Effectiveness
The Johns Hopkins Bloomberg School of Public Health

Good afternoon Chairman Gowdy, Ranking Member Cummings and Members of the Committee. Thank you for the opportunity to speak today.

My name is Caleb Alexander and I am a practicing primary care physician and prescription drug expert at the Johns Hopkins Bloomberg School of Public Health, where I co-direct the Johns Hopkins Center for Drug Safety and Effectiveness. I am honoured to speak with you today. Much of my research is focused on identifying clinical and policy solutions to the opioid epidemic, and I will highlight two key points regarding the report from the President's Commission. However, as a physician, I know the power of stories to compel action, and I would first like to share a short one with you.

In 2011, Judy Rummler lost her son Steve to a heroin overdose. I work with Judy on policy reform and I asked her if I could share his story. She said "I am always happy to share Steve's story if it helps the cause." Steve's journey began with a lower back injury that evolved into chronic opioid use and addiction. Years before his death, he wrote of opioids, "At first they were a lifeline. Now they are a noose around my neck." Steve tried as best he could to get well and he did not want to die, but he ultimately succumbed from an overdose shortly after being discharged from a rehabilitation facility. Now, Judy keeps a picture of Steve along with a note, "If love could have saved you, you would have lived forever." Steve's story, and his family's resolve to ensure that other families don't have to experience what they have, is a reminder to me of what is at stake here, and of the loss that so many have endured.

During the past year, my colleagues at the Johns Hopkins Bloomberg School of Public Health and I have been reviewing hundreds of scientific studies and other data points on the epidemic. Last month, we released a report, entitled "From Evidence to Impact", in which we synthesize work from the field and provide a comprehensive set of evidence-based recommendations. Congressman Cummings, we were so honoured that you participated in the event marking the release of our report, and I have included our findings as part of my written testimony for the Committee's consideration.

In the remainder of my time, I would like to highlight two points regarding how the President's Commission can best be used to drive change.

First, the Commission's report provides a comprehensive framework for action. Simply put, the science is the science, and the report is based on evidence and lines up closely with our own appraisal in most areas. For example, both assessments agree that providers should be required to use prescription drug monitoring program (PDMP) databases, that the Center for Disease Control and Prevention's (CDCs) prescribing guidelines should be standard practice nationwide, and that high-quality, evidence-based addiction treatment should be available to those who seek it.

To enhance the use of PDMPs, Congress should pass the Prescription Drug Monitoring (PDMP) Act of 2017, which incentivizes states to mandate PDMP use by linking such mandates to the receipt of federal funding to fight the opioid epidemic. To promote the CDC's opioid guidelines, Congress should require that DEA licensure include mandatory, evidence-based training in the safe prescribing of controlled substances, and the federal government should also ensure that the CDC guidelines are consistently implemented in CMS and other federal delivery systems. There are many steps that Congress can take to improve the accessibility of high-quality, evidence-based addiction treatment, not the least of which is substantially expanding funding for these programs. The costs of the opioid epidemic are enormous, with estimates ranging from $80 to as high as $500 billion dollars per year. I believe it is Congressman John Delaney who has reminded us, "The cost of doing nothing is not nothing." Investments in addiction treatment are sound ones not only because of the incredible human toll that addiction

takes, but also because these short-term expenditures more than pay for themselves by reducing long-term direct and indirect costs associated with untreated opioid use disorder.

While the Commissions' report is remarkably thorough, there were a few areas that I believe were either underemphasized or not covered at all. For example, the Commission did not discuss harm reduction initiatives, yet the science is clear that providing sterile needles and syringes to people who inject drugs reduces HIV and Hepatitis C transmission and increases treatment seeking among those with substance use disorders. Similarly, while the Commission emphasized the importance of access to medication assisted therapy and the potential barriers posed by "fail-first" protocols or prior authorization requirements, they provided less discussion of the important role that health care insurance plays in promoting access to these treatments in the first place. Finally, while the Commission identified regulatory failures and called for the FDA to establish new guidelines for post-market surveillance, there are more immediate and effective steps they could have endorsed, such as calling upon the FDA to remove the most dangerous opioid formulations from the market and to revise the FDA label so that it better aligns with the science regarding the safety and effectiveness of these products.

Second, it is now critical for Congress and the Administration to develop a strategy to support the implementation of its recommendations. It is one thing to say we are going to send a man to the moon, it's quite another have a plan in place to do so. Of the 56 recommendations, arguably the two most important are that we need to: (1) reduce prescription opioid over-prescribing; and (2) provide high quality, evidenced-based treatment for addiction upon demand (disrupting the illicit fentanyl supply is also crucial). But how do we accomplish these goals? Let's just take the goal of reducing opioid over-prescribing. What specific steps is the federal government going to take to achieve this? What resources are required? Which agencies are responsible, what timeline will be followed and how will we know when we have been successful?

In short, we urgently need an action plan. I can't emphasize enough how important such a plan is if we are to make real progress. The Committee on Government Oversight could support this by asking for and reviewing the implementation plan for the Commission's most

important recommendations. My colleagues and I at Johns Hopkins are available to work with the Commission on such plans should we be able to be of service. This Committee can also exercise oversight capacity to ensure that other federal agencies act on the Commission's recommendations, especially the Department of Health and Human Services, the Drug Enforcement Agency and the Food and Drug Administration.

Chairman Gowdy, Ranking Member Cummings and Members of the Committee, we are missing more than *half a million* Americans from overdose that should be with us today. People like Steve Rummler and so many others. Incredibly, more deaths from opioids are expected in 2017 than ever before. As the Commission's Report makes clear, the origins of the epidemic are multiple but arise from within the healthcare system, including unsubstantiated claims about the safety and effectiveness of opioids, multifaceted campaigns by pharmaceutical companies and the failure of the FDA and DEA to regulate these products appropriately. Because of this, solutions will require involvement from patients, providers, regulators, industry, policymakers and other stakeholders.

As we look to 2018, there are reasons for hope. Patients and providers are increasingly using safer and more effective treatments for chronic, non-cancer pain. There is growing awareness that addiction is a treatable disease, and more and more Americans are living healthy and fulfilling lives in recovery. There is increasing consensus regarding evidence-based strategies that should be urgently scaled. Communities are increasingly mobilized, demanding affordable naloxone, reliable access to addiction treatment, stronger regulation by the FDA and DEA, and coordinated action by the federal government. This is a fixable crisis. But not without an implementation plan to accompany the Commission's recent recommendations.

Thank you for the opportunity to testify today. I look forward to your questions.

The opinions expressed herein are my own and do not necessarily reflect the views of Johns Hopkins University.

Chairman GOWDY. Thank you, Dr. Alexander. The gentleman from Maryland is recognized.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Dr. Wen, on June 18, 2017, the Baltimore Sun published an article on naloxone entitled "Baltimore City Running Low on Opioid Overdose Remedy." The article stated that "The city has about 4,000 doses left to last until next May." You were quoted in that same article as stating that, and I quote, "We are rationing. We are deciding who is the highest risk and giving it to them." How many doses of naloxone does the city have left now, and is that number adequate to meet the city's needs?

Dr. WEN. Thank you, Congressman. We—I have people——

Mr. CUMMINGS. And who are the highest priority people?

Dr. WEN. The highest priority individuals that we allocate this lifesaving medication to are the individuals who are clients of our needle exchange plan. These are individuals who we know are actively using drugs.

Now, I will say that we do not in any way condone drug use, but we do believe in saving someone's life. If it is a question of preventing the spread of hepatitis and HIV we need to do that, and if someone had died today, there is no chance for them to get into treatment tomorrow. So for 11 unit of naloxone given out on the needle exchange plan, one unit is used to save someone's life.

Now I don't know how many medical advances there are out there that have a number needed to save someone's life as 1 in 11. I have to answer your question. I have about 8,000 units left between now and July of 2018. Now we are grateful for the work of our state. Clay Stamp is here from the state. They have been gracious in providing additional funding for naloxone once they saw the need in Baltimore City. But if I got 8,000 more units today, I could distribute them all by this weekend, and then we can calculate how many more lives are going to be able to be saved. That is the very definition of rationing. In the middle of an epidemic, I shouldn't have to be forced to decide who gets to carry a medication that could save their lives or their family's lives.

Mr. CUMMINGS. So how many doses do you need? I mean, let me—to adequately distribute enough to be effective? In other words, what is your goal?

Dr. WEN. I want——

Mr. CUMMINGS. What would be your goal amount?

Dr. WEN. I would like for everyone in our city to carry naloxone in their medicine cabinet or their first aid kit. Imagine if we had the remedy—if Ebola had hit our city or some other horrible contagious illness were to hit our city, we would want to make sure that every single person carried the antidote. I have community members, neighborhood faith leaders calling me every day asking for naloxone. Why shouldn't it be available everywhere in every public place in a way that we have defibrillators available in public places?

Mr. CUMMINGS. Now that Baltimore Sun article in February of this year said, and I quote, "The price of a popular injectable version jumped 500 percent in the past two years, and the cost of a nasal spray used in Baltimore has increased nearly 63 percent."

One auto-injector can now cost about $4,500 for just two doses, is that correct?

Dr. WEN. That is correct.

Mr. CUMMINGS. So Dr. Wen, what formulation of naloxone is your office using? I mean, what do you——

Dr. WEN. We use nasal Narcan, which is manufactured by a company called Adapt Pharma. It is one of the FDA-approved versions of the medication, and we would hope that in this epidemic the Federal Government can directly negotiate the price so that we can get this at a much discounted one.

Mr. CUMMINGS. Some kind of way—we have spent a lot of time dealing with this issue of drug pricing and over-drug pricing, and it seems sad—and this is my conclusion—that a lot of these price hikes are about greed, not about cost of research, R&D, but greed. And at the same time, we know that we have something here that works.

Are there other things coming down the pike that you know of that might be just as effective as naloxone? Have you heard of any of those things?

Dr. WEN. I have not. There are very few antidotes available in modern medicine. This is one of them. Naloxone is on the World Health Organization's list of essential medications. It is available by the pennies in other countries.

Mr. CUMMINGS. By the pennies?

Dr. WEN. In other countries.

Mr. CUMMINGS. Wow. Thank you very much.

Chairman GOWDY. The gentleman from Wisconsin.

Mr. GROTHMAN. First question for all of you, on the break I ran into a woman down here—it was very interesting—who had a relative who had been through treatment dozens of times, which kind of obviously means that treatment doesn't always work. I would like you folks to comment on percentage-wise how often in your experience in programs you deal with treatment works, and what distinguishes the programs that treat—that are successful and those programs that are not successful? And also, what percentage of admissions do you expect to be successful with regard to treatment?

Dr. ALEXANDER. Well I could begin and say that there is no question that opioid use disorders are really, really serious, and the individuals that have opioid addiction remain with a lifelong vulnerability to the products, and this is one the reasons that it is so important that we reduce the overprescribing of prescription opioids in the first place.

Mr. GROTHMAN. They only give me so much time. Can you tell me percentage-wise in the treatment programs you are familiar with, percentage-wise how many times people go into treatment, percentage-wise how often are they successful?

Dr. ALEXANDER. I don't——

Dr. WEN. The data that I have seen are about 40 to 60 percent rate of recovery, recognizing that addiction is a complex disease and that we need to be ready for people whenever they want to go into treatment.

Governor Christie had mentioned that he had not met people who were ready for treatment. I meet them all the time, and the problem is that we need to be ready for people at that moment, not

have them wait weeks or months, and then recognize that relapses are part of recovery because that is the nature of the disease.

Mr. GROTHMAN. So you expect a treatment program to be successful half the time? Whether it is half the time of a heroin addict or an opiate addict goes in, they will never do it again? Is that what your expectation is?

Dr. WEN. They may not be successful that first time, but they may be successful that second time, and recognizing that there are forms of treatment that are evidence-based and some that are not, and so we need to be promoting these evidence-based treatments which include medication-assisted treatment.

Mr. GROTHMAN. Well just when you get on the Internet, it implies that, you know, these are wildly unsuccessful, that is why I am asking.

Mr. BAUM. Yeah, I just want to add to that. It is true that relapse rates are a challenge, but I think that if we move away from this sort of isolated episodic treatment model to an ongoing, continuing care, we can drive down relapse rates. Sometimes we have a detox program that is separate from an inpatient that is separate from ongoing recovery supports, and we have to stop doing it that way. The system has to evolve to have ongoing recovery support so that relapse rates are driven down.

And just in summary, I would say we shouldn't accept the level of relapse rates. I think we can drive them lower if we work harder and work smarter.

Mr. GROTHMAN. Okay. I asked Governor Christie and I will ask you as well. Some of you made about the fact that heroin was fairly apparently common in Vietnam. I don't know. And when people came home, almost all the troops stopped using heroin. Could you comment on that?

Mr. BAUM. Yeah, it is a very interesting point in history. In Vietnam was when they had the first drug testing program, and people weren't cleared to go home from Vietnam until they tested negative for drugs. And so there was—people in Vietnam were highly motivated to get home. They had to step using drugs, they had to test negative, and then they went home.

I mean, I do—I don't dispute the point that you changed the environment and you changed the behavior, but it was also part of a program to test people and to encourage them to get off heroin before they came back.

Dr. WEN. Part of it, too, is why it is that people are using drugs? Part of it may be overprescribing because of treating physical pain, but people are also treating other types of pain too. We know that the same communities facing high rates of overdose are also facing poverty and homelessness and unemployment, and in order for us to break that cycle of addiction, we also have to be addressing those underlying factors and helping those communities thrive too.

Mr. GROTHMAN. Okay, you are touching on something that I think Governor Christie wanted to stay away from, but do you find that sometimes family background is a correlation with abuse?

Mr. BAUM. I mean, I think that there is evidence that people on all walks of life and all type of background, of every level of wealth and every racial group are affected by the drug problem.

Mr. GROTHMAN. That goes without saying, but I mean percentage-wise.

Mr. BAUM. No, I think if you look at the percentage breakdown by socioeconomic group there is a little bit of variation, but really, everyone is being affected by this problem. Everyone with the disease of addiction needs and deserves treatment and ongoing recovery support.

Mr. GROTHMAN. Okay, that is it. On to the next.

Chairman GOWDY. The gentleman yields back. The gentlelady from the District of Columbia is recognized.

Ms. NORTON. I think you can hear me now.

I think it is fair to say that both Democrats and Republicans underestimated the standing of the Affordable Healthcare Act until the most recent election where we saw governor-to-be—governor elect Northam win an election and the polls say that a lead indicator was the Affordable Healthcare Act, and they don't even have that in Virginia. People apparently are very, very afraid for their healthcare, and they chose that election, which is considered a kind of herald election for the coming elections to express themselves, even though they knew that Northam would have a hard time getting them the Affordable Healthcare Act.

So I—my question is about what role the Affordable Healthcare Act can play or is playing in this crisis? I know that Governor Christie indicated that the Affordable Healthcare Act, unlike, by the way, the plans that many Americans have, does require that substance abuse be afforded in the same way as other healthcare. That is an important gain for healthcare in the United States, at least for those who have the Affordable Healthcare Act. One of the figures that interested me was the one on Medicaid expansion and who, in fact, has benefitted from it? It appears that 3 in 10 nonelderly adults with substance abuse disorders nationwide get Medicaid expansion. It says to me it is being used by the very people that we are discussing here today.

So I need to know from you, perhaps Dr. Wen, Dr. Alexander, what you think would—what you believe would occur if, in fact, those states that have Medicaid expansion—this is one of them, New Jersey, Governor Christie's state, is another—suppose that was no longer available? What would that do to the crisis under discussion here this afternoon?

Dr. WEN. More people would die. Because of Medicaid expansion, 1.6 million people who have substance abuse disorders are now able to have access to treatment. Prior to the ACA, one-third of the individual market plans did not cover substance abuse disorders, and for people who have the disease of addiction, there is no margin of error. If you are to take away their treatment today, their only option may be to overdose and die. And so studies have shown that it will take $180 billion over a decade to provide healthcare to those who lose coverage.

So back to the point that Ranking Member Cummings made that the cost of doing nothing isn't nothing, we are spending that money anyway. We are spending the money now on medical costs and cost of incarceration. We can choose to invest it in treatment instead.

Ms. NORTON. Is the Affordable Healthcare Act being used to prevent opioid addiction and not simply to intervene once it occurs?

Dr. WEN. We need to do a lot more when it comes to prevention, including stopping the overprescribing of drugs, stopping the trafficking of drugs, but also, things like investing in nutrition, in family literacy, in home visiting. All those things also help to boost family structure and reduce poverty, which ultimately also reduces addiction.

Dr. ALEXANDER. I would just add that there are several provisions—although the ACA wasn't designed for the treatment of patients with opioid use disorders alone, there are several provisions within it that have been very important for those seeking treatment for opioid addiction. And that is not just the parity provision, but also the requirement that treatments for addiction be considered an essential health benefit. So this is something that—the Commission speaks—the Commission's report speaks to ways that there may be insurance barriers to accessing, for example, medication-assisted treatment, but is—does not directly address the role of insurance in the first place. And as a colleague of mine has, I think, eloquently put it, until you make it easier for patients to access high quality addiction treatment than it is to find their next bag of heroin or their next bottle of Oxycontin, they aren't going to flock towards treatment. So it is vital that treatment is expanded.

Ms. NORTON. Could you give us some insights on why some jurisdictions are so much worse off in this crisis than others? For example, the District of Columbia is a big city. They have taken—they have used the Affordable Healthcare Act and done a lot of prevention. The crisis, I think, over the last three years tripled. Are there characteristics of a jurisdiction that will predict the opioid crisis that you could speak about, Dr. Alexander?

Dr. ALEXANDER. Well it is an outstanding question, and indeed, if you look at maps of the country, county maps, it is stunning the variation county to county, both in terms of opioid prescribing as well as injuries and deaths from opioids.

The first point I would make is that these are highly correlated. That is, if I showed you plots, you don't have to have a degree in biostatistics to see that there is a very high correlation between the volume of opioids that is being prescribed in a given area and injuries and deaths from these products. We do know that there are a variety of different state policies and county policies that can make a difference in the volume of opioids that are prescribed, and in rates of heroin and illicit fentanyl use.

But I think that there is a lot more that we have to learn, not only in why it is so bad in some countries, but also why we have seen counties that have had remarkable gains in terms of reducing both volume of overprescribing, but also injuries and deaths from these products. And state policies like prescription drug monitoring programs ensure policies and state policies like caps on the volume of prescription opioids that are prescribed, investments that cities and states are making and addiction treatment services, all of these can play an important role.

Ms. NORTON. Thank you.

Chairman GOWDY. Gentleman from Alabama, Mr. Palmer, is recognized.

Mr. PALMER. Thank you, Mr. Chairman.

Mr. Baum, there was a report in the November 2017 Journal Addictive Behavior that noted that there has been a shift in drug—opioid abusers first use. According to the report, in 2005 8.7 percent of individuals who began abusing opioids in 2005 began with heroin. By 2015, that had changed to 33 percent. Has your office been able to determine what caused this shift?

Mr. BAUM. You know, thank you for the question. I don't have a definitive answer, but I would say that the epidemic continues to evolve rapidly. We know—and I won't repeat what was discussed what has caused this epidemic, which was the overprescribing of narcotic painkillers. As more people have been using heroin, there has been a spread of heroin shared between family members, boyfriends, girlfriends, and others, and so I have seen those reports and it is concerning.

And let me just emphasize, we need to get out the message about the incredible lethality of the drug supply. When someone consumes heroin, it could contain fentanyl. It might contain other substances as well. Same with these prescription pills that people buy. The drug supply is more lethal than ever before, and really people are taking their lives in their own hands when they are using these drugs.

Mr. PALMER. Dr. Alexander, it has been reported that there were 64,000 deaths in 2016. Is that an accurate number?

Dr. ALEXANDER. Yes, correct, from all overdoses.

Mr. PALMER. The information that I have indicates that it might be reported—underreported by as much as 20 percent, and each of you have touched on this a little bit because the reluctance of family members to have that cited as the cause of death would—is that 20 percent underreporting—does that—is that real?

Dr. ALEXANDER. Well I don't have a—I am not sure of the precise degree to which there is underreporting, but there is no doubt you raise a very good point. And any underreporting would mean that the epidemic is even more worse than the 64,000 number would suggest.

Mr. PALMER. Well that is my point. The epidemic is at a point now where it has literally reduced the life expectancy of Americans. We—for the first time in I forget how many years, but it has been at least a couple of decades, our life expectancy in the United States has declined, and there are some studies indicating it is related to the number of people dying from drug overdoses, drug poisoning.

Dr. ALEXANDER. Yeah, that is correct, and we see manifestations in many different sectors of the economy. The labor force—I think the Commission's report did a good job of outlining many of the ripple effects. We have heard about strains on the foster care system, and so there are effects manifested throughout.

And the other point to make is that the deaths are tragic, and I know many of you have met with constituents and, you know, you'll never forget those stories and those days, and yet the deaths are the tip of the iceberg. For every patient that has died, there are dozens or more that have opioid addiction. There are hundreds that are experiencing the effects of going to emergency departments or having a chaotic household where someone has an opioid use disorder.

Mr. PALMER. I want to touch on something my colleague from Wisconsin brought up, and that is about the efficacy of the treatment using medication assisted treatment. I think the number—it is not effective for about 40 percent of the population. We talked a good bit about—but there is another drug out there, Vivitrol, that does not give the same impact as opioids. It is not—it is a once a month type pill, but it literally requires that people go into withdrawal for—I mean, it takes three to ten days for someone to become clean and use that. Have you used that, Dr. Wen? I guess that would be more appropriate to address that to you.

Dr. WEN. Yes, we believe that all three forms of FDA-approved medications, which are methadone, buprenorphine, and naltrexone, also called Vivitrol, that all three should be available in all settings without there being prior authorization for insurance, without only one form being available at some places. Because just like for other illnesses, some patients may do well with one medication, some may not do well with that medication but may do well with another one. And so we believe that all three should be available. And methadone and buprenorphine have had a bag reputation because they can be abused and misused, but so can many medications. And we have to follow the signs and evidence which show that medications as a treatment is the gold standard and that it reduces illness and death and even criminal behavior.

Mr. PALMER. I see my time is expired. I appreciate your responses to this.

I just want to point out, though, this is not a political issue. This is—it is, in my opinion, a public emergency and to bring the politics into it, I think, is inappropriate. We have seen a major increase in deaths from drug overdoses since 2010, so I just want to encourage folks to not look at this as a political issue. This is a national crisis.

I yield back.

Chairman GOWDY. Gentleman yields back. Gentleman from Missouri is recognized.

Mr. CLAY. Thank you, Mr. Chairman.

If we are to be successful, I am a firm believer that we must first remove the stigma traditionally associated with drug use. For far too long, society has deemed drug users criminals in need of incarceration rather than patients in need of treatment, as we saw so clearly during the 1980s and '90s.

Dr. Wen, you summarize that change back in January stating, and I quote, "Traditionally, it has been seen that if you have an addiction, it is a moral failing. It is a personal choice. Now we are calling it a disease."

Drs. Wen and Alexander, how important is it that we as a society are finally recognizing addiction for what it is, a disease?

Dr. ALEXANDER. Well I think it is vital, and I think we heard this question posed which is can you imagine if we told people with diabetes that 10 out of 100 will get treatment or that we told people with kidney cancer we will take 100 of you and we are going to offer 10 of you the best treatment that we have. And it is when you look at settings like that where one realizes the role that stigma has. Another very pervasive and under-appreciated point is that all too often, we discuss abuse. And I was heartened by the Commissions' report, the word addiction is throughout. It is in the first

sentence, I believe. It is in the title and the charge to the Commission. This is an epidemic of addiction. It is not an epidemic of abuse. There is non-medical use that takes place, but for far too long, we have suggested that there are sort of two populations of individuals. We have the drug abusers that we need to do everything we can to prevent them from accessing the medicine, and then, you know, when I was a resident, I was taught that we need not worry about the addictive potential of opioids if a patient had "true or legitimate pain." And nothing could be further from the truth.

So I think that the issue of stigmas is really front and center, and I think that this will take resources of massive scale, really, to continue to educate individuals. Who would choose a life of addiction? It is on anybody who has really understood and met somebody that has addiction knows that this isn't a choice that people are making any more than it is a choice of a 10-year-old to have Type I diabetes.

Dr. WEN. We would never say to somebody with diabetes that they should go to jail, and if—they should not get treatment in jail, but once they return, they should be cured. Which is the type of stigma that we continue to put on people and—who have the disease of addiction.

I think one of the questions I would ask was about the communities that are the most heavily affected. Our community here in Baltimore has been affected for decades. This is not a new issue, and Congressman Cummings has spoken very eloquently about this in many talks past that we owe an apology to generations we have incarcerated. And we owe an apology because we knew the signs but didn't speak up then.

Mr. CLAY. Mr. Baum?

Mr. BAUM. Thank you, Congressman, for the question.

Police chiefs and sheriffs, they are doing an incredible job around this country. They know the difference between someone who is a drug user who needs treatment and someone who is a drug trafficker, a major drug dealer who deserves punishment. It is no question that someone whose criminal activity is limited to buying and using drugs should be diverted to treatment. I have been really encouraged with the police diversion that is happening now around the country pre-arrest, working very closely with the police assisted addiction recovery initiative parry. Over 300 precincts and sheriff offices allow you to walk into a police department or sheriff's office 24 hours a day and get diverted right to treatment. They do a quick intake, they put you in the front seat of the police car, and they drive you to treatment. This program is expanding rapidly. So we are doing more police pre-arrest diversion than ever before.

On the other hand, if somebody is selling heroin laced with fentanyl to our citizens and causing overdoses that are killing people, that is a serious crime and they deserve prosecution for that.

So I think we are able to tell the difference between those who need to be diverted to treatment and those who deserve prosecution.

Mr. CLAY. As well as those physicians who turn their offices into pill mills.

Mr. BAUM. No question there have been some abusive doctors who have been incredibly reckless and they deserve prosecution for those crimes as well.

Mr. CLAY. Now not to put you on the spot, but is it—is that the official position of the U.S. Department of Justice, or can you share with us that——

Mr. BAUM. The Department of Justice wants to prosecute traffickers and criminals and those that are killing our citizens with these deadly drugs. There is no conflict at all for diversion for minor, non-violent offenders for treatment.

Mr. CLAY. Thank you for your responses, and I yield back, Mr. Chairman.

Chairman GOWDY. Gentleman from Missouri yields back. The Chair will now recognize himself.

Dr. Alexander, you mentioned overprescribing as being one of the—kind of the dual things that you would address first. What are the causes of over-prescription? Is it a misdiagnosis? Is it a failure to consider alternatives? What are the root causes of the over-prescription?

Dr. ALEXANDER. Well thank you for the question, Mr. Chairman, and the Commission's report discusses these in some detail. And here again, I think that they hit most of the high points. Misinformation, as I noted from my own training, when we were taught in the late 1990s that we had overestimated the addictive potential of prescription opioids. Labeling that is inconsistent with the totality of evidence regarding the safety and effectiveness of these products, and of course, the labeling, as you know, in turn affects the ways that pharmaceutical companies can market and promote the products. The widespread prevalence of pain and a notion that pain needs to be fully abated and that people should, you know, get to a zero on a scale of 1 to 10, rather than in many countries, cultures where pain is something to be managed. I think many pain experts would say pain is something to be managed and lived with, not just grin and bear it, but not expect that you are going to be taking enough opioids that you get down to a zero.

There are many, many, many causes that have contributed to the overprescribing.

Chairman GOWDY. Are there certain specialties or subspecialties where you have identified where the overprescribing is more prevalent?

Dr. ALEXANDER. Well it is a terrific question. It would be a privilege to share with the Committee some of our own data and own analyses in this regard. The point that I would make is that the prescribing volume of opioids is highly skewed so that if you look, for example, within primary care physicians, it is a small subset of primary care physicians that account for the lion's share of opioids that are prescribed.

With that being said, these are not primarily rogue prescribers that are down on Main Street seeing 300 patients in a day and only accepting cash. I think that there is a very important point here, and in fact, Governor Christie spoke to it when he said that most prescribers that are contributing to this epidemic aren't doing so out of ill intent. They are doing so out of non-intent. So it is important to recognize that while opioid prescribing is highly skewed,

that the prescribers that are prescribing in such enormous volumes are not necessarily, you know, just flouting any standard of best medical practice.

Chairman GOWDY. Now when you say primary care physicians, I am thinking pediatricians, internists, and GPs. What am I missing?

Dr. ALEXANDER. Family docs, internists are the big two. Pediatricians are lower volume only because fortunately, not many kids are prescribed opioids.

Chairman GOWDY. So we can take pediatricians out of it. Internists——

Dr. ALEXANDER. Sure.

Chairman GOWDY. —or would you—internists and GP——

Dr. ALEXANDER. Yeah.

Chairman GOWDY. —or what used to be GPs, family doctors.

Dr. ALEXANDER. Um-hum.

Chairman GOWDY. Two questions in this realm. Has there been any analysis of physicians who write prescriptions for opioids after a patient has been declined a prescription from another physician? In other words, doctor shopping?

Dr. ALEXANDER. Yeah, that is a terrific question, and here again, as with the rogue prescribers, when we look at the data we reach a very interesting conclusion, which is that opioid shoppers are exceedingly rare, and almost around the era in importance relative to other populations of high risk patients. That is not to suggest that it is not vital that we identify and intervene upon opioid shoppers, but there are other populations of chronic opioid users that are much higher risk when you look at a population level, a public health level than opioid shoppers. And so I am speaking about individuals that are on chronic high-dose opioids and also individuals that are on the combination of prescription opioids and benzodiazepines.

Chairman GOWDY. I have a couple more questions. I am going to try to fit them in so I don't violate my own rules.

In terms of alternatives—well let me ask you this. We can test blood pressure, we can test cholesterol, we can check somebody's temperature. How close are we to having a diagnostic test for pain?

Dr. ALEXANDER. It is, you know, nowhere in our lifetimes would be my best guess, and I think it is one of the other factors that has contributed to the epidemic because it is really—because pain is so inter-subjective. It varies a lot person to person, and it is very difficult—there is no objective test for it.

This is one of the reasons that I think it is so important that we teach the next generation of professionals and those currently in practice, there are lots of tools in the toolbox. We don't need to just wait for the FDA to bring new drugs down the pipeline 10 or 20 years from now. We already have dozens of different treatments, both pharmacologic and non-pharmacologic for pain. And I think one of the things that is happening with the opioid epidemic is that we are shining such a bright light on opioids that we are neglecting to consider all of the alternatives that, in many cases, are safer and more effective.

Chairman GOWDY. The gentlelady from Michigan, Ms. Lawrence.

Ms. LAWRENCE. Thank you.

I am going to ask this question to Ms. Wen and anyone else who can answer. You spoke about the Baltimore schools having addiction screening. We have approximately, as reported, about 430,000 foster children in America. I sit on the Foster Care Caucus, and it is a high priority for me. Mental health for our foster children in that alarming rate they suffer five times more likely from PTSD and from trauma.

With that being said—and we talked about the priority groups based on the socioeconomics. Is there any focus on foster children as far as education, screening, and support?

Dr. WEN. That is an excellent question. We know from studies that children who experience trauma, which losing their family certainly would be that trauma, or growing up in families with high rates of addiction would also be traumatic too, that these children have higher rates of addiction themselves. And that is this vicious cycle then of poverty, trauma, and addiction, and addiction begins to beget addiction too.

So from our standpoint, we absolutely need to provide services for those children experiencing trauma, but critically, we also have to provide treatment for their parents and caregivers, because unless we do that, we are going to have issues like we have a tripling of the number of children born with neonatal abstinence syndrome. Some studies show that 40 percent of neonatal ICU days are because of their—the child being born with and with the opiate addiction themselves. That is a dangerous cycle, and we can stop it by providing treatment for the mother, for the parent, for the caregiver.

Ms. LAWRENCE. I am told by the Department of Human Services that the fastest growing contributor to foster children growth in America is from opioid addiction, because children are being taken away.

The last thing I want to say is that I did enter a bill that would—the Timely Mental Health for Foster Youth, which would require all children to be mandated, like they get a physical health assessment. They need to get a mental health assessment because we know these children have experienced the first level of trauma, that is being separated from their family, and I really hope that as we continue of targeting and addressing addiction screening, that we keep a focus on our foster children in America.

Thank you.

Chairman GOWDY. Gentlelady yields back. The Chair would now recognize the gentleman from Vermont, Mr. Welch.

Mr. WELCH. Thank you, Mr. Chairman, and Mr. Gowdy and Mr. Cummings, I thank you for organizing this hearing. I think all of us should leave this hearing with some significant amount of humility. You know, as I see it, the Federal Government primarily has to be a partner to the local communities that are doing all the frontline work, and when I look at what you have done here in Baltimore, just the training of the number of people who are capable of administering lifesaving medication, a kind of all-in approach that the city has taken, and also Johns Hopkins has taken as well. Our role, as I see it, is to try to get resources back to the communities so that you can your job, because this appears to me to be fundamentally an issue that can only be dressed—be addressed at

the very local institutional individual level. I mean, that story, Dr. Wen, about your 24-year-old patient was—it really says it all. So I want to thank you—all of you, really, Dr. Alexander and Mr. Baum. Thank you for your work.

We are going to have a tough time in Congress on money. You need more and when we don't provide it, our local first responders are put in a jam, our police officers, the hospitals. But we can do something about the cost of these drugs that have gone way up, and it is my hope that this Committee—there has been a lot of interest by many of our members in trying to take practical steps to contain the cost. Both Mr. Gowdy and Mr. Cummings have been leaders in this.

What has the cost of these lifesaving drugs, Dr. Wen, done to your budget in your health department or in Baltimore?

Dr. WEN. We have redirected—given the scope of the opioid epidemic, we have redirected funds from other critical programs in order to fund this. So we—I have to choose all the time, do we fund asthma programs for children, lead poisoning reduction, or do we fund the opioid epidemic? And we had to——

Mr. WELCH. I will ask all of you. On these drugs like naloxone and these others, have the changes that have been made largely, in my view, to extend intellectual property protection and allow additional price increases, have they made a significant different in the benefit to the lifesaving qualities given to the patient, or is it just the higher price? And you can all address that.

Dr. WEN. Hard to say except that, again, this is available in other countries for very little, and I would love to see us get the broad access that this epidemic requires.

Mr. WELCH. Mr. Baum, is that an issue?

Mr. BAUM. Yeah, I don't know if that is an issue. I have met with all the manufacturers of these medications and talked to them about pricing, and they have talked about how if you have insurance, either public or private, they have a very low copayment, sometimes——

Mr. WELCH. Can I interrupt?

Mr. BAUM. Please.

Mr. WELCH. I hear that all the time.

Mr. BAUM. Yes.

Mr. WELCH. It is so corrupt. I mean, what is the problem—and I am not directing this at you, I am directing it at them. What is the problem with being able to go on the internet and finding out what it costs without all the convoluted obfuscation that occurs in drug pricing? I mean, is that as frustrating to you as it must be to practitioners?

Mr. BAUM. I guess where I am is naloxone saves lives. We want everyone who needs access to it to get access to it. I was trained on how to use it. I want it out available——

Mr. WELCH. What happens when the drug companies hold hostage your desire to save lives with a stick up price that bankrupts your operation?

Mr. BAUM. You know, I think that the story is more complicated than that, and they are getting a lot of this product out at discounted prices. I think we need to continue to work with them and need to continue to find resources to fund naloxone, because I——

Mr. WELCH. Explain to me why the price has gone up so much when it is basically the same product?

Mr. BAUM. Well I really—I don't want to speak for the manufacturers, but my understanding is they had a list price but the actual price at the retail level that is paid by consumers is much less.

Mr. WELCH. See, that again is gobblygook, because it is a price—you know, if you went and bought a car and paid $15,000, and the same car a year later was $25,000, you would be able to figure out that is a $10,000 difference. You can't figure that out now.

Mr. BAUM. All I can say is, you know, we are committed to keep working to getting naloxone at a fair price.

Mr. WELCH. Well we would love to work with you. You know, President Trump has said that he wants—he said that the pharma companies on pricing are getting away with murder.

And by the way, all of us acknowledge that pharma does fantastic things, life extending and pain relieving drugs. But if the price kills us, we are not really getting ahead. So we really need the President and all of us to get involved in trying to do legitimate things to contain this, in my view, price gouging.

I yield back.

Chairman GOWDY. Gentleman from Vermont yields back.

I want to thank our panel. We have votes back in Washington that they expect us to be there for, whether we want to be there or not. They expect us to be there. So I want to thank all three of you not just for your time and your expertise today, but for the dedication of your lives in helping other people. It has been very instructive. I think we are—all the members—I want to thank again the good folks at Johns Hopkins and the mayor and the governor and Governor Christie, and I want to thank you, Mr. Cummings, for being such a phenomenal host to all of your colleagues.

Mr. CUMMINGS. Again, I want to thank you, Mr. Chairman. You didn't have to do this, but you did, and you made a commitment to me right after you became Chairman that you were going to do this hearing, and you kept your word. And I really do appreciate that.

And to all of our witnesses and to Johns Hopkins, we thank you, and to the members, I want to thank every member. People in the audience, this is a little bit of a sacrifice for members to come here. I know it is close to D.C., but they literally have to come in earlier than they normally would have, probably catch some earlier flights than they would have to be with us. And so I want to thank all of our members for being here.

I just have one quick unanimous consent request, Mr. Chairman, and that is that the letter dated November 21, 2017, from the Association for Behavioral Health and Wellness be entered into the record, and that the testimony of the National Healthcare for the Homeless Council be admitted into the record, and it is dated November 28, 2017.

Chairman GOWDY. Without objection.

Chairman GOWDY. The gentleman from Alabama looks like he seeks recognition.

Mr. PALMER. We will have the opportunity to submit questions in writing?

Chairman GOWDY. You may. Let me get to that part of it.

The hearing record will remain open for two weeks for any member to submit a written opening statement or questions for the record. If there are no further questions, no further business, we want to thank our second panel again, particularly for your patience in that the first panel was super important, but it also maybe went a little bit longer. So we appreciate your patience and your expertise and your comity, with a t, with the Committee.

With that, we are adjourned.

[Whereupon, at 3:53 p.m., the Committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

"The Opioid Epidemic From Evidence to Impact" October 2017 submitted by Dr. Alexander can be accessed here:

https://www.jhsph.edu/events/2017/americas-opioid-epidemic/report/2017-JohnsHopkins-Opioid-digital.pdf

Combating the Opioid Crisis
House Committee on Oversight and Government Reform
12:30 PM, Tuesday, November 28, 2017
Johns Hopkins Hospital's Chevy Chase Auditorium, Baltimore, Maryland
Rep. Gerald E. Connolly (D-VA)

Thank you, Chairman Gowdy and Ranking Member Cummings for holding this hearing, which continues the Committee's examination of the opioid epidemic. Every day, 91 Americans die from an opioid overdose. Since 2000, the opioid and heroin epidemic has claimed more than 200,000 lives across America, more than three times the number of Americans killed in the Vietnam War. There are no signs that this epidemic is slowing down or will end soon.

According to the National Center for Health Statistics, more than 64,000 Americans died from drug overdoses in 2016. That represents an increase of more than 20 percent over the number of drug overdose deaths in 2015. Opioid-involved deaths have quadrupled since 2000 and now account for more than 60 percent of drug overdose deaths in the United States. These data also show that synthetic opioids, like fentanyl, now cause more deaths than any other type of drug. Deaths from synthetic opioids more than doubled from 2015 to 2016 to just over 20,000. Deaths from fentanyl have increased by 540 percent in just three years. This epidemic is destroying families, overwhelming first responders, and straining public health, criminal justice and child welfare resources.

We are now beginning to understand that the opioid epidemic is actually two distinct, but inter-related epidemics: one of prescription opioid abuse, and another of illicit heroin and synthetic opioids like fentanyl. However, at the root of both of these epidemics is the devastating disease of addiction, enabled by a combination of biological, psychological, and social factors. As a society, we must reject the notion that those who succumb to opioid addiction are guilty of some sort of moral failure. The stigma surrounding addiction and mental health has only exacerbated the problem and prevented those who are suffering from accessing treatment.

These epidemics do not care where you live or what political party you belong to. The crisis has touched every corner of this country. In Virginia, opioid overdose deaths spiked by about 40 percent to 1,133 people from 2015 to 2016, and deaths from synthetic opioids rose from 263 to 692 during that period. Northern Virginia and some of the country's wealthiest counties are not immune. Fairfax County reported an increase from 67 to 97 opioid-related deaths from 2015 to 2016. Deaths from opioid overdoses in Prince William County increased from 26 to 59 during that period.

One of the contributing factors to the opioid crisis is the actions of unscrupulous pharmaceutical distributers who are preying on our communities. For example, in Williamson, West Virginia, population 2,924, one distributer provided a pharmacy with 258,000 hydrocodone pills in one month, more than ten times the normal amount. There were more than 300 million opioid prescriptions written in the United States last year, about 30 percent of the global supply. That is enough for each man, woman, and child in America to have their own bottle of powerful painkillers.

Last month, an investigation by *The Washington Post* and CBS 60 Minutes exposed the potential crippling effect that the Ensuring Patient Access and Effective Drug Enforcement Act

of 2016 (P.L. 114-145) had on the Drug Enforcement Agency's (DEA) ability to combat suspicious sales of prescription narcotics. The next day, I introduced legislation that would begin to restore the ability of the Department of Justice to respond to the growing opioid crisis. The Opioid Immediate Suspension Order Act (H.R. 4073) would restore the DEA's authority to suspend a pharmaceutical distributor's license if the Attorney General, based on longstanding agency practice, found there was an imminent danger to the public health and safety. The DEA's Chief Administrative Law Judge John J. Mulrooney wrote: "It is equally remarkable that...Congress determined that the "imminent danger to public health and safety" standard required a statutory definition that imposed a dramatic diminution of the Agency's authority to issue Immediate Suspension Orders at a time when, by all accounts, opioid abuse, addiction, and deaths were increasing markedly."

Abuse of prescription opioids is also a precursor for 75 percent of new heroin users, according to the Centers for Disease Control and Prevention (CDC), but this phenomenon does not explain the full picture. In a separate study, the CDC also found that increases in synthetic opioid deaths are strongly correlated with increases in law enforcement seizures of illicitly-manufactured fentanyl. As the supply of heroin and synthetic opioids like fentanyl floods our communities, many young people are just beginning to use the illegal drugs. At least 20 percent of this illicit fentanyl is being ordered online and entering our country through the postal system. According to Customs and Border Protection, the greatest increases in the rates of seizures of fentanyl have been in the mail and express consignment packages. We need to make sure that CBP is using the most effective tools to interdict these drugs in inbound mail and consignments.

According to the Commission on Combating Drug Addiction and the Opioid Crisis, headed by Governor Chris Christie, the most urgent recommendation is for President Trump to declare the opioid crisis a national emergency. Despite his pledge to do so in August, the President waited three months before directing the Department of Health and Human Services to declare a public health emergency. This falls well short of the President's promise. Declaring a public health emergency does not release any additional funds to deal with the crisis and the President did not request any additional funds. Instead, the President announced that to address this quickly evolving and devastating epidemic, the federal government will take on a "really tough, really big, really great advertising" campaign aimed at persuading American's to not use opioids in the first place.

In addition to the tepid response to this ongoing crisis, the Administration has also failed to fill critical vacancies at agencies that would lead the efforts to address the opioid epidemic. More than ten months into this Administration, President Trump has not appointed a Drug Czar to lead the Office of National Drug Control Policy, nor has this Administration produced a National Drug Control Strategy. The head of the DEA resigned two months ago, and there are no signs that the Administration plans to name a permanent Administrator.

The prescription opioid and heroin epidemics are driven by biological, psychological, and social problems that require multi-dimensional solutions, not a carbon copy of the "Just Say No" campaign from three decades ago. We must never forget the human cost of these epidemics. This Administration and Congress need to address this problem with a sense of urgency and focus and contribute adequate resources to assist state and local governments as well as hospitals and nonprofits who are the front lines of this epidemic.

Association for Behavioral Health and Wellness

Advancing benefits and services in mental health, substance use and behavior change.

November 21, 2017

The Honorable Trey Gowdy, Chair
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

The Honorable Elijah Cummings, Ranking Member
Committee on Oversight and Government Reform
U.S. House of Representatives
2471 Rayburn House Office Building
Washington, DC 20515

The Association for Behavioral Health and Wellness (ABHW) thanks you for the opportunity to submit comments for your hearing to examine the opioid epidemic and the recommendations of President Trump's Commission on Combating Drug Addiction and the Opioid Crisis (Commission).

ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health and wellness to 175 million people in both the public and private sector. Our members include both specialty behavioral health organizations and health insurance companies.

ABHW and its member companies are committed to helping defeat the opioid epidemic. Our members work to identify and prevent addiction where they can; and where they cannot, they help individuals with an opioid use disorder get the appropriate treatment to recover and lead full, productive lives in their community with their families and loved ones.

The identification of individuals at risk of opioid dependence is a critical step in helping stop overdose and death. To do this, some ABHW members employ drug utilization review (DUR) programs. These programs flag members who are being treated for opioid dependence but are still filling opioid prescriptions. DUR programs notify a pharmacist when individuals are also filling opioid prescriptions at another pharmacy or have prescriptions for other drugs that may have a counter interaction with their opioids. Other companies analyze claims data to detect opioid use patterns that suggest possible misuse by individuals and then they reach out to the person or notify their health care provider about the situation.

We are painfully aware that there are an inadequate number of qualified substance use treatment providers. ABHW members build provider networks in a manner that helps ensure that they have capacity to meet the needs of their consumers. Some companies have also found peer services and community supports to be useful in helping people engage and remain in treatment. At least one member company partners with Project ECHO, a telementoring platform that links specialists with nonspecialists through virtual clinics, the specialists mentor helps educate

providers about the latest advancements in evidence based care and improves access to opioid use disorder treatment.

Every 25 minutes a baby is born suffering from an opioid withdrawal. ABHW member companies follow established standards of care for newborns with neonatal abstinence syndrome. One example is a company that identifies pregnant women with a substance use disorder and engages them in case management. If allowed, the infant is also followed for at least a year.

ABHW submitted several recommendations to the Commission. The first relates to 42 CFR Part 2 (Part 2), an outdated regulation that limits the use and disclosure of patients' substance use records. This regulation severely constrains the health care community's efforts to coordinate care for persons with substance use disorders, and ABHW members say Part 2 is one of the biggest – if not the biggest – barrier to fighting the opioid crisis. We urge the alignment of Part 2 with the treatment, payment, and health care operations language in the Health Insurance Portability and Accountability Act (HIPAA) through a legislative fix (the Overdose Prevention and Patient Safety Act, H.R. 3545, and the Protecting Jessica Grubb's Legacy Act, S. 1850) or pending regulatory guidance.

Additionally, very few states permit Medicaid managed care organizations and private health plans access to prescription drug monitoring program (PDMP) data. If allowed access, these entities could identify patients at risk of overdose or complications and become a strategic partner in preventing and identifying abuse. We believe each state should have a PDMP which health plans can access; to which prescribers are providing information; and which allows information to be exchanged across state lines. The creation of a national PDMP would be beneficial.

ABHW also advised easing the burden on primary care providers willing to prescribe medication assisted treatment (MAT). Development of educational resources and additional training will help make PCPs more comfortable with MAT. Another idea is to provide incentives to encourage PCPs to take care of their own opioid dependent patients.

The standard of care for opioid use disorder is to treat the disease with a combination of medication and evidence based psychosocial interventions. As such, ABHW suggested creating a mechanism to ensure providers are practicing in accordance with national standards, such as the American Society of Addiction Medicine's National Practice Guideline.

Given the rise in the opioid epidemic and the growing shortage of behavioral health providers, the expansion of telehealth is another important option to consider. A significant barrier is the Ryan Haight Act; ABHW recommends making changes to this law to eliminate the requirement of a face-to-face evaluation. Furthermore, removing the restrictions to Medicare reimbursement of telehealth would provide better access to treatment to Medicare beneficiaries diagnosed with an opioid use disorder.

We appreciate this opportunity to share with you our members' work to fight the opioid crisis, as well as our policy recommendations to eliminate the epidemic. We look forward to working with

you on this issue in the months ahead. If you have any questions, please contact Rebecca Murow Klein on my staff at klein@abhw.org or (202) 449-7658.

Sincerely,

Pamela Greenberg

Pamela Greenberg
President and CEO

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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Testimony on the Opioid Epidemic and the Commission on Combating Drug Addiction and the Opioid Crisis

House Committee on Oversight and Government Reform Hearing
Tuesday, November 28, 2017

As health care providers who will treat nearly 1 million patients experiencing homelessness this year, the growing tragedy of the opioid epidemic is nothing new. Addiction itself can cause and prolong homelessness, and the experience of homelessness complicates the ability to engage in recovery and treatment. Lack of housing for those we serve also compromises the effectiveness of the treatment we are able to deliver, and the vulnerabilities created by homelessness greatly increase the chance of a deadly overdose. A recent study in Boston found drug overdoses accounted for 17% of the deaths among people who were homeless, with opioids accounting for the vast majority of those (a rate nine times higher than in the general population).[1] We have seen so many of our patients become homeless, fare poorly, and/or die because of opioid addiction. At the same time, we have seen countless others receive the care and supports they needed to overcome addiction, exit homelessness, and thrive in recovery.

We appreciate the breadth of the recommendations contained in the Commission's recent report[2] and the opportunity to provide comments for this hearing. To augment the information presented, below are those areas we feel reflect the greatest challenges on the front line of this crisis, some priorities for solutions that need to be implemented, and our remaining concerns.

Greatest Challenges:

- **Limited treatment capacity:** There is a dearth of available treatment slots, especially for residential treatment and for programs that focus on harm reduction strategies. Implementing universal screening procedures without creating a referral capacity into treatment does little to combat this crisis.
- **Cumbersome MAT requirements:** the training, documentation and oversight requirements to become a medication-assisted treatment (MAT)-certified provider creates barriers to treatment capacity in the primary care environment.

> "If more people could prescribe, it would be easier to keep working. I'd like to go to meetings after work in the evening but there's no programs like that. But you have to support yourself."
> - MAT Patient

[1] Baggett, T., et al (February 2013). Mortality Among Homeless Adults in Boston, *JAMA Intern Med.* 2013;173 (3): 189-195.
[2] The President's Commission on Combating Drug Addiction and the Opioid Crisis (November 2017). https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

- **Lack of prevention and harm reduction care approaches:** The current treatment system tends not accommodate patients who relapse, nor does it have the resources or supports in place to prevent addiction from becoming worse. Relapse is part of recovery, yet many treatment programs are not designed to be flexible, focus on harm reduction, or align specific treatment programs with individual patient needs. All too often, programs are recovery-oriented, "zero-tolerance" that have multiple requirements for participation and high rates of non-completion. This makes accessing effective treatment especially hard for those with the most significant addictions.
- **Lack of support services:** A broad range of supports are needed to make access to care possible. Transportation, food, housing, and child care are critical components to successful treatment, yet are frequently inaccessible to those we serve. Our patients have a very difficult time coming to us for care if they are living on the street, hungry, if they have no way to get to us, and/or no one they can trust with their children.

> "You gotta be high to deal with being on the street—you can't get clean on the street."
> - MAT patient

Solutions Needed:

- **Increase treatment capacity:** Far greater resources are needed to expand access to treatment capacity, particularly long-term residential programs and programs that include harm reduction strategies in treatment approaches. Without effective and ongoing treatment, recovery is elusive.
- **Invest in a healthcare workforce:** Across the care spectrum, there is a tremendous need for greater numbers of licensed medical and behavioral health providers, peer recovery specialists, case managers, and community health workers. Raising reimbursements for addiction services and investing in loan repayment programs, tuition assistance, and educational programs to increase the number of trained providers and care team members will help increase treatment capacity.
- **Eliminate provider barriers to MAT:** No other medication imposes patient limits, such onerous documentation and reporting requirements, and specific training—particularly one designed for a primary care setting. Given widespread prescribing authority for opioids themselves, we cannot understand why opioid treatment has been made so difficult prescribe. Eliminating separate training requirements, patient limits, and other prescribing limits for buprenorphine will vastly increase the number of providers who are willing to offer opioid treatment.
- **Implement harm reduction programs:** Low-barrier treatment options that do not impose rigid requirements for abstinence or participation are critically needed to address the significant needs of a vulnerable population. Barriers include programs that require copays, adherence to numerous medical and therapy appointments, requirements for sobriety/abstinence, etc. Piloting new programs such as safe injection sites and expanding existing needle exchange programs are also critical steps to promoting public health and preventing overdose death.

> "It's no wonder there's a lack of MAT providers. You have to keep track of every strip and pill, and it puts an exhausting pressure on the patient-provider relationship. The strict rules and large amount of time needed to complete the waiver training make it harder to engage vulnerable people who really need our help. This is frustrating because these rules do not exist for any other medication I prescribe."
> Laura Garcia, FNP, Baltimore Health Care for the Homeless

> Harm reduction strategies are a vital component of treatment options. Decreasing barriers for patient engagement and expanding treatment capacity are both critical pieces to combatting the opioid crisis.
>
> - Nilesh Kalyanaraman, M.D., Baltimore Health Care for the Homeless

- **Reduce stigma around addiction:** Addiction is still viewed as a personal failing and not as a disease, similar to diabetes, hypertension, and obesity. Public campaigns to eliminate the stigma surrounding addiction and mental health disorders can increase the number of people willing to acknowledge a substance use problem and seek treatment. Reducing stigma can also help increase the number of family members, friends and community members willing to help those seeking treatment.

> "The treatment programs don't actually help you get housing or any placement after you finish. I was in two 6-month programs and they say they'll help you with housing but they do nothing. I did great in those programs and didn't pee dirty once. But once I was back on the street, I went back to using."
> - MAT Patient

- **Require integrated, holistic care:** Addiction treatment programs often cannot accommodate patients who also have a mental health condition, which prevents many from being able to participate in treatment. Licensed addiction programs should be competent in treating co-occurring disorders. Programs should also be required to conduct more comprehensive discharge planning to ensure stability after treatment is completed, or to ensure effective care transitions to other care venues/programs.
- **Expand health insurance coverage:** There are still 29 million people in the United States without health insurance. Of these, 2.5 million are living in poverty in the 19 states yet to expand Medicaid.[3] Comprehensive, affordable health insurance is critical to accessing addiction treatment and addressing health needs. **This cannot be emphasized more strongly.**

Remaining Concerns:

- **Undermining the Medicaid program:** Medicaid remains a vital health insurance program for low-income people, as well as the providers who care for them. Ongoing Congressional and Administration efforts to repeal the expansion of Medicaid to single adults specifically works against the very goals of the Opioid Commission, as do efforts to impose work requirements, time limits and other barriers. **Medicaid must be expanded, not curtailed,** in order to effectively address the health care needs of vulnerable people—particularly those with opioid addiction.
- **Lack of additional funding:** Significant resources are needed to expand treatment and improve the health care delivery system to meet the needs of people with opioid and other substance use disorders. Increasing costs of naloxone (Narcan®) to respond to overdoses have also increased significantly, burdening local and state governments and limiting the supply of lifesaving care. To date, we are unaware of new resources to implement the recommendations contained in the Commission's report.

> "We treat a very vulnerable group of people. Many of our clients cannot jump through all the hoops to get into a formal drug treatment program, and they turn up at our clinic instead asking for help. We have to be flexible in our treatment approach and we need more access to drug treatment on demand. Telling a patient that they have a treatment spot in 2 weeks while they are living in an abandoned building is unacceptable."
> - Tyler Gray, M.D., Baltimore Health Care for the Homeless

- **Lack of housing, food, child care, transportation, and other supports:** It is extremely difficult to access and engage in treatment without stable housing, healthy food, reliable transportation, and trustworthy child care. To us it is very clear: **housing is health care**—and patients need a wide range of supports to be successful. In particular, current budget proposals to reduce funding for U.S. Department of Housing and Urban Development (HUD) programs

[3] While Maine recently voted to expand Medicaid, it remains unclear when the benefit will become active.

related to housing assistance will only increase housing instability and homelessness and exacerbate poor health outcomes.

- **Narrow housing recommendation in Opioid Commission report:** While we endorse the inclusion of recovery housing in the Opioid Commission's report, we are very concerned by the narrow recommendation. Supportive housing is an evidence-based intervention and works well for a broad range of people engaging in substance abuse treatment. We strongly recommend Congress and the Administration promote a broader range of housing models, as well as invest more heavily in these programs.

Thank you for the opportunity to comment on this vital issue. Because this hearing is being held in Baltimore, we have included perspectives directly from patients and providers at the Baltimore Health Care for the Homeless program; however, there are nearly 300 HCH programs nationally and we are happy to connect any member of the Committee to the programs in their state/district. Should you wish to discuss further how the opioid crisis impacts people experiencing homelessness and the providers who treat them, please contact Barbara DiPietro, Ph.D., Senior Director of Policy, at 443-703-1346 or at bdipietro@nhchc.org.

RESPONSE TO
QUESTION SUBMITTED FOR THE RECORD TO
RICHARD J. BAUM
ACTING DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY

FOLLOWING NOVEMBER 28, 2017, HEARING ENTITLED,
"COMBATING THE OPIOID CRISIS"
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

Rep. Gary J Palmer

CMS ties Medicare payments to scores hospitals receive on the Hospital Consumers Assessment of Healthcare Providers and Systems Survey (HCAHPS) survey which includes pain management.

1. **Is this an incentive for doctors to be more inclined to over prescribe medications.**

ANSWER:

Under the Medicare Hospital Value-Based Purchasing (HVBP) program, a portion of a hospital's payment is based on their performance on a set of quality and efficiency measures. Under this program, one of the measures previously used had been based on pain management questions that were part of the Hospital Consumer Assessment and Healthcare Providers and Systems (HCAHPS) survey. However, the Centers for Medicare & Medicaid Services (CMS) had received feedback from stakeholders concerned about the pain management dimension questions being used in the HVBP Program, believing that the linkage of these particular questions to the HVBP Program payment incentives could create pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension. As a result, the pain management measure was removed beginning with the FY 2018 HVBP program. This policy was finalized in the FY 2017 Medicare Outpatient Prospective Payment System final rule[1] (see pages 79855-79862).

Separate from the HVBP program, three new survey questions for pain management were developed for the HCAHPS survey. These questions were finalized in the FY 2018 Medicare Inpatient Prospective Payment System final rule.[2] They replace the old pain management questions and focus more on communication with patients about pain management. Surveys administered on or after January 1, 2018 include these new questions. It is too early to determine the effect of the new questions, if any, on prescribing practices.

The President's Commission on Combatting Drug Addiction and the Opioid recommended, "that CMS remove pain questions entirely when assessing consumers so that providers won't ever use opioids inappropriately to raise their survey scores."[3] ONDCP will monitor the effect of the new survey questions on opioid prescribing in light of the Commission's concerns.

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[1] 81 FR 79562-79892 (Nov. 14, 2016). Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf.
[2] 82 FR 38328-38342 (Aug. 14, 2017). Available at: https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.
[3] Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, at 9. Available at: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

CITY OF BALTIMORE
CATHERINE E. PUGH, Mayor

HEALTH DEPARTMENT
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January 11, 2018

TO: Members of the House Oversight Committee

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Answers for the record
Dr. Leana Wen
"Combating the Opioid Crisis"
November 28, 2017

1. <u>CMS ties Medicare payments to scores hospitals receive on the Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) survey which includes pain management. Is this an incentive for doctors to be more inclined to over prescribe medication?</u>

a. The opioid epidemic did not arrive overnight. The culprits are many. As has been extensively documented, pharmaceutical companies knowingly misled doctors and consumers, minimizing the risk of opioids and perpetuating a "pill for every pain" culture. They were instrumental in the normalization of the pain scale, where patients are assessed for pain as a "fifth vital sign", along with temperature, blood pressure, heart rate, and respiratory rate. The implication is that having pain at all is bad, and that opioids should be used to take away pain—no matter the consequence. This was a clear incentive—both conscious and subconscious—to overprescribe opioids.
b. Starting this month, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) amended their survey questions from inquiring about pain management to focusing more on pain communications. Prior to January 1, 2018, HCAHPS questions regarding pain management included, "During this hospital stay, how often was your pain well controlled?" and "During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?" The new questions focus on communications and include, "During this hospital stay, how often did hospital staff talk with you about how much pain you had?" and "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?"[1] This is a step in the right direction, but this change alone is not enough.

[1] Updated Survey Instruments Effective with January 1, 2018 and Forward Discharges. HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems. http://www.hcahpsonline.org/en/survey-instruments/. Accessed 4 January 2018.

c. The Baltimore City Health Department (BCHD) has been targeting our education efforts to physicians and other prescribers of opioid medications. We have sent "best practice" letters to every doctor in the City of Baltimore; these letters address the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as first-line medication for acute pain, and emphasizing the risk of opioid addiction and overdose. These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the City through presenting at Grand Rounds and medical society conferences.
d. BCHD has also launched physician "detailing," where we deploy teams of public health outreach workers and people in recovery to visit doctors to discuss best practices for opioid prescribing. We emphasize adherence to the CDC guidelines for careful, limited, and targeted prescription of opioids. This best practice also requires co-prescribing of naloxone for any individual taking opioids or at-risk for opioid overdose.
e. We urge for additional systemic change, including specific steps such as: further amending the HCAHPS and other incentive mechanisms to address alternatives to opioids and to include referrals to treatment for addiction; requiring prescribers of opioids for pain to also treat patients who have the disease of addiction; removing the unnecessary barriers to buprenorphine prescribing; and expanding access to treatment (as elsewhere stated in my testimony).

Response to Post-Hearing Questions Posed by The Honorable Gary J. Palmer
Submitted for the Record to the
House Committee on Oversight and Government Reform
As Follow-Up to the Hearing "Combating the Opioid Crisis"
Held on November 28, 2017

January 19, 2018

By G. Caleb Alexander, MD, MS
Co-Director, Center for Drug Safety and Effectiveness
The Johns Hopkins Bloomberg School of Public Health

Representative Palmer asked the following question:

> *"CMS ties Medicare payments to scores hospitals receive on the Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) survey which includes pain management. Is this an incentive for doctors to be more inclined to over prescribe medication?"*

You identify a vital issue, and there is general consensus that incentives such as those you identify, as well as other campaigns to improve the identification and treatment of those with pain (e.g., "Pain as the Fifth Vital Sign"), have served as one of several drivers of the opioid epidemic. The precise effect of these campaigns is difficult to disentangle from other factors that have driven opioid overuse, including pharmaceutical marketing and promotion and overly permissive regulatory and payment policies on the part of the U.S. Food and Drug Administration and insurers, respectively. However, there is little question that the push by hospitals, health systems and accreditation organizations (e.g., Veterans Affairs, The Joint Commission) has had unintended consequences by furthering the use of opioids in many settings with an unfavourable risk/benefit balance.

As you may be aware, CMS has reported that it would no longer include pain management questions as a factor in its hospital payment calculations beginning in 2018.[1] In addition, questions examining pain in the HCAHPS survey have been changed from focusing on "pain management" to "communication about pain", reflecting an effort by CMS to avoid "exert[ing] any unintended, negative influence over prescribing practices".[2]

There are several scientific studies that support the reasonableness of this approach. For example, in a study of 4749 patients discharged from two New England hospitals, overall patient satisfaction scores (not specific to pain) were not associated with the use of either opioid or non-opioid analgesics in the Emergency Department.[3] Similarly, in a study of 4349 patients admitted to a surgical unit, patient satisfaction was much more strongly correlated with whether staff did as much as possible to alleviate their pain, rather than whether their pain was fully controlled.[4] Finally, in a study of 31,481 patients in 47 Michigan hospitals, patient-reported pain satisfaction scores on HCAHPs were not associated with rates of opioid prescribing after surgery, suggesting that reductions in post-surgical opioid use can be achieved without diminishing patient satisfaction.[5] As you might imagine, there are enormous opportunities here[6], and revising these types of patient questionnaires, and the incentives that are linked to them, is an important place to start.

Representative Palmer, thank you again for the opportunity to respond to your query, as well as to participate in this important hearing.

The opinions expressed herein are my own and do not necessarily reflect the views of Johns Hopkins University.

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