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COMBATING THE OPIOID CRISIS: BATTLES IN THE STATES

WEDNESDAY, JULY 12, 2017

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Tim Murphy [chairman of the subcommittee] presiding.

Present: Representatives Murphy, Griffith, Barton, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Ruiz, Peters, and Pallone (ex officio).

Also Present: Representatives Guthrie, Bilirakis, Bucshon, and Kennedy.

Staff Present: Elena Brennan, Legislative Clerk, Energy/Environment; Zachary Dareshori, Staff Assistant; Paul Edattel, Chief Counsel, Health; Ali Fulling, Professional Staff Member; Brittany Havens, Professional Staff Member, Oversight and Investigations; Katie McKeough, Press Assistant; John Ohly, Professional Staff Member, Oversight and Investigations; Chris Santini, Professional Staff Member; David Schaub, Detailee, Oversight and Investigations; Kristen Shatynski, Professional Staff Member, Health; Alan Slobodin, Chief Investigative Counsel, Oversight and Investigations; Evan Viau, Staff Assistant; Hamlin Wade, Special Advisor, External Affairs; Christina Calce, Minority Counsel; Jeff Carroll, Minority Staff Director; David Goldman, Minority Chief Counsel, Communications and Technology; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; Dino Papanastasiou, Minority GAO Detailee; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Murphy. Good morning, everyone. Today, the Subcommittee on Oversight and Investigation holds a hearing entitled Combating the Opioid Crisis: Battles in the States. Make no mistake, the term "combating" and "battle" are entirely appropriate. Our Nation is in the midst of a tremendous fight against death and devastation affecting every corner of our Nation.

In 2015, there were more than 52,000 deaths from drug overdose in the U.S., with more than 33,000 deaths involving an opioid, a 24 percent increase from the prior year. The overdose death rate in 2015 was almost seven times the rate of deaths from the heroin epidemic of the 1970s. For 2016, we have learned from an analysis by The New York Times that we have lost roughly 60,000 people to drug overdoses. That is more in 1 year than all the names on the Vietnam Veterans' Memorial Wall, and likely, that number is underestimated because much of the data will not be in until the end of this year, 2017. It is staggering.

For every fatal overdose, it has been estimated there are 20 nonfatal overdoses. And for 2016, that could be near 1 million. More than 183,000 lives have been lost in the U.S. from opioid overdoses between 1999 and 2015. That is about 50,000 will be lost over the next -- 500,000 will be lost over the next decade. The roots of this crisis began back in 1980 when a letter to the editor by two doctors published in the New England Journal of

Medicine was misinterpreted as evidence. It was unlikely that someone would become addicted. Out of 40,000 cases, they said there was only four addictions.

Twenty years later, the Joint Commission on Accreditation of Healthcare Organizations following the American Medical Association recommendation that pain be assessed as the fifth vital sign, and established standards for pain management interpreted by many doctors as encouraging the prescribing of opioids. Under the Affordable Care Act, prescribing pain killers is incentivized by patient questionnaires where a question specifically asked if their pain was adequately addressed to their satisfaction. Based upon their answer, a hospital may receive more or less money.

As we learned in our oversight hearing held in March, the opioid epidemic is an urgent public health threat fueled by fentanyl, a much more dangerous and potent synthetic opioid and a clear and present danger to America.

Two States represented on today's panel, Rhode Island and Maryland, were the first ones hit by the fentanyl wave, and unfortunately, it seems certain that this wave will sweep the Nation as low-cost, high-profit, hard-to-detect profile of fentanyl is increasingly attracted to traffickers and easy to manufacture, or obtain over the Internet.

This is an in extremis moment requiring all the experience, resources, cooperation of our Federal, State, and local governments, as well as all the different industries, professionals, and experts to curb this terrible outbreak. With this hearing, we will focus on the actions of our State governments to find out what efforts are working, what is not working, how we can work together to save lives. To the panel, I say, we want to know the problems, and please be candid with us, because as you know, there are millions of families being torn apart by this.

As drug industry -- excuse me, as drug policy expert Sally Satel noted, quote, "It is at the State and county levels that the real progress will be made. It makes sense that the efforts to find inspired solutions would be most concentrated there. We should invest in those solutions and learn from them," unquote.

Serving the front lines of the opioid epidemic, State governments have been pursuing their own innovative initiatives, such as more inventive use of incentives, more structured medication-assisted treatment, more comprehensive prescription drug monitoring.

States such as Maryland are making the best use of the Center for Disease Control opioid prescribing guidelines to help push back on the overprescribing. Kentucky's All Schedule Prescription

Electronic Reporting system, more known as KASPER, a web-based monitoring system to help prescription use across the State, is helping State regulators identify questionable prescribing practices by physicians and abuse by patients.

Virginia has greatly expanded access to Naloxone, the drug that can rapidly reverse an opioid overdose, but then again, can have its own risk and its use. Some States are expanding the availability of Naloxone by permitting third-party prescribing by family and friends of individuals who are at high risk of overdose. Rhode Island has developed the AnchorEd Program that matches overdose victims with peer recovery coaches to encourage treatment, who follow up with the patient for the next 10 days after the overdose.

Much of the work of the States should help inform the President's Commission on Combating Drug Addiction and the Opioid Crisis. Two years ago, the subcommittee held a similar hearing on what the State governments were doing to combat the opioid abuse epidemic. Such oversight helped Congress enact provisions in the Comprehensive Addiction Recovery Act, or CARA, and it will help the administration.

We put $1 billion into grants over the next 2 years, but we want to know if this money is being used wisely, and how -- what is working. We are eager to learn about those programs. But the

21st Century Cures State program is just the beginning. Our State government witnesses can help this committee develop a more effective and national strategy to combat the opioid crisis in such areas as substance abuse prevention and education, physician training, treatment of recovery, law enforcement, expanded access to Vivitrol, while testing for drugs in correctional facilities, data collection, examining what reforms can be made to the 42 CFR Part 2, so there is better coordination of care among physicians, and we can help prevent relapses and overdose and improve patient safety.

We are in one of the worst medical tragedies of our time, perhaps the worst. And although this committee has given -- this subcommittee has given its attention to many other problems in the past, we recognize this is paramount among them. This is a national emergency. And we look forward to hearing from the States and what you are doing on the front lines of this.

Now I yield to my colleague for 5 minutes, Ms. DeGette of Colorado.

Ms. DeGette. Thank you so much, Mr. Chairman. And I appreciate this most recent hearing on opioid addiction. As you said so accurately, this crisis is really devastating America, as all of us on the dais have seen it play out in our communities, urban and rural alike. Not a day passes without a report about

children watching their parents overdose, about librarians and school nurses being trained to administer Naloxone to overdose victims, or about local and State governments trying to respond to the myriad of issues surrounding addiction, all, at the same time, trying to stay within their budgets.

There is some good news. Recently, the CDC reported that opioid prescriptions peaked in 2010, and have since fallen by 41 percent. That is the good news. The bad news is, opioid prescribing remains untenably high. And I am hoping our future investigations will concentrate on this.

In addition, as you pointed out, Mr. Chairman, is the emergence of illegal fentanyl, which is an exceptionally potent opioid. In 2017, fentanyl overtook both heroin and prescription opioids as the leading cause of death in many places. Each of the States who are here today, and I want to thank you all for coming, have faced alarming overdose outbreaks due to this drug's pervasive dangerous nation.

This committee has done some good work, in particular, investigating the seemingly voluminous amount of pills distributed in West Virginia. And I know that we are planning to do more. As you know, a number of State Attorneys General are investigating manufacturers, and, in some cases, distributors. The attorney general in my home State of Colorado, for example, has joined a

bipartisan coalition of States nationwide, looking into whether manufacturers engaged in illegal or deceptive practices when marketing opioids.

Coming up with an effective solution to the opioid epidemic will require us to understand the actions of all actors. I hope to hear from some of the States today on what role they believe drug manufacturers and distributors may be adding to the crisis. Also, I look forward to hearing from the panel about the impact of fentanyl on the towns and communities in which they work. States really are on the front lines of fighting this crisis, and I look forward to hearing from all of you.

I know that Rhode Island, for example, has led the way in reconnecting people with -- or in connecting people with substance abuse disorders to highly trained coaches to guide them through recovery. Virginia is working to implement a similar peer recovery program. And Kentucky has established a program to provide medication-assisted treatment to individuals in correctional facilities and to continue supporting them after they are released. Maryland has just committed to establishing a 24-hour crisis center in Baltimore City.

Mr. Chairman, I know these are all great State efforts. We have made some efforts here in Congress, and I appreciate you referring to the 21st Century Cures legislation that Congressman

Upton and I sponsored, and that this whole committee worked together on a bipartisan basis to pass. But as we move forward on this issue, we really need to work together to continue to address this, and that is why I kind of hate to be the fly in the ointment, and talk about what these efforts to repeal the Affordable Care Act will do to the fight against the opioid epidemic. As you know, the ACA has helped nearly 20 million Americans obtain healthcare coverage. In addition, it's enabled governors to expand Medicaid services that are critical tools in the fight.

For example, studies that show that since 2014, 1.6 million uninsured Americans gained access to substance abuse treatment across the 31 States that expanded Medicaid coverage. This is particularly true for hard-hit States like Kentucky, where one study reports that residents saw a 700 percent increase in Medicaid beneficiaries seeking treatment for substance abuse. Many people think that the House-passed bill that undermines the ACA will threaten people's ability to get opioid treatment. In its assessment, the non-partisan CBO said the House bill would cost 23 million, or 22 million, Americans to lose health insurance. A lot of these people, they need opioid treatment.

Now, there have been discussions, both in the House bill and the Senate discussions, about adding some money for opioid

treatment. But, for example, the most recent Senate suggestion of additional $45 billion to help combat opioid addiction, Governor John Kasich said, quote, "It is like spitting in the ocean, it is not enough."

We have got to get real and understand that access to healthcare treatment is what is going to help with the health of all Americans, including treatment of opioid addiction. And we have got to move forward to work on this together. I hope we can do that. And with that, I will yield back, Mr. Chairman.

Mr. Murphy. The gentlewoman yields back. I now recognize the chairman of the full committee, Mr. Walden.

The Chairman. Thank you very much, Mr. Chairman. Addiction is an equal opportunity destroyer. It is a crisis that does not pick people based on their age, race, or socioeconomic status, and it most certainly does not pick them based on political parties. From my roundtables throughout the Second District of Oregon, it didn't matter if I were in a rural community or a more populated city, the tragic stories were very similar. We all know someone who has been impacted by this epidemic.

In my State, more people die from drug-related overdoses than from automobile accidents, and sadly, that is not unique. According to a preliminary data analysis, drug overdose deaths in 2016 likely exceeded 59,000 people. That is the largest annual

jump ever recorded in the United States. And what's worse, some of the preliminary numbers from the States indicate that their numbers within the first 6 months of this year are already surpassing last year's total numbers. And over the past 7 years, opioid addiction diagnoses are up nearly 500 percent, according to a recent report.

Despite a report released by the Centers for Disease Control last week, which indicates the number of opioid prescriptions has decreased over the last 5 years. That's the good news. The rates are still three times as high as they were just back in 1999. And the amount of opioids prescribed in 2015 was enough for every American to be medicated around the clock for 3 weeks. That report also found that counties in Oregon have some of the highest levels of opioid prescriptions in the country. Of the top 10 counties in my State for opioid prescriptions, five of them are in my rural district.

Moreover, Oregonians, aged 65 and over, are being hospitalized for opioid abuse, overdoses, and other complications at a far higher rate than any other State in the Union. Sadly, overdose deaths continue to escalate, and this epidemic is simply getting worse and more severe. So challenges remain and we need to get after it.

First, we need to improve data collection. In a few States,

we are already requiring more specific information related to overdose deaths. Quite simply, we cannot solve what we do not know. We need to be able to have more timely and reliable data so we can better understand and address the full scope of the problem. There also needs to be an increase in overdose prevention efforts, improvement with respect to the utilization and interoperability of prescription drug monitoring programs. And we need to increase access to evidence-based treatment, including medication-assisted treatment.

Combating this epidemic requires an all-hands-on-deck effort from Federal, State and local officials, and all of us spanning from healthcare experts to our local law enforcement communities, that's precisely why we are having this hearing today. Last year, Congress took action to combat this crisis by passing legislation, including the Comprehensive Addiction Recovery Act, and the 21st Century Cures Act, and States have pursued programs to strengthen our fight against this epidemic. But much more needs to be done. We need to work together to ensure that the tools and funding Congress has created are reaching our State and localities, and that they are being used effectively.

We hope to hear from the State officials today to see how they are utilizing these funds, and whether these programs work or not. We greatly appreciate the witnesses who have agreed to

appear before us today. We hope to have a constructive dialogue about what the States are doing, how we can improve data collection, what initiatives are working, what isn't working, and how the Federal Government can be a better partner in this collective fight.

I look forward to your testimony and working with all of you and our community leaders to help get our hands on this horrific crisis. So thank you for being here. With that, I know I have two members that want to introduce witnesses, so I will go first to Mr. Guthrie, and then I'll go to Mr. Griffith.

Mr. Guthrie. Thank you, Mr. Chairman. Thank you, Mr. Chairman, for letting me sit in for purposes of introduction. I want to introduce our Secretary of Justice and Public Safety in Kentucky, Secretary Tilley. We have been friends for a long time. We served in the general assembly together. Secretary Tilley had a strong reputation, strong work as fiduciary chairman in the House, working with the Senate to produce legislation that I think is landmark and was very important. And we have so much to do in Kentucky. We have 1404 people that passed away last year from opioid addiction.

There is so much to be done. So we are sitting here saying thank you for the work that you have done. I know we have enormous work to be done, and I tell my colleagues on the

committee here and my friends, I can think of nobody else in Kentucky I'd rather have in sitting where you are and leading this effort, and I applaud Governor Bevin for making the choice, and asking you to serve in his cabinet, and appreciate your willingness to do so. I think you will make a big impact. And I yield back.

The Chairman. Now I recognize the gentleman from Virginia, Mr. Griffith, for purpose of introduction

Mr. Griffith. Thank you very much. I appreciate that. I would like to introduce Secretary Brian Moran. Brian was a prosecutor first, and then he came to the Virginia House of Delegates, where he and I served together for a number of years. He was a leader on the other side of the aisle, but he was always a pleasure to work with, and appreciate his work very, very much. And then he became the first director of -- or Secretary of Homeland Security in Virginia's history, and has oversight over 11 agencies. But he is generally well-reasoned, every now and then we would disagree on the floor of the House, but not always. But we worked together on a number of things. And I apologize, both Mr. Guthrie and I have to run to another committee where we have two bills that are upstairs, so I won't be able to stay, but I will read with interest your testimony and learn from my colleagues the good words that you have to say. And I welcome you

to our committee, and I apologize that I can't be here because I'm defending a bill upstairs.

The Chairman. With that, I will yield back the balance of my time. Unfortunately, I, too, must go to that subcommittee.

Mr. Murphy. Come on back. This is where it's going to be exciting. I note Secretary Moran is a spitting image of his brother. I now recognize the gentleman from New Jersey, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman. Thanks for holding this hearing on this critical issue. Our committee has held several hearings on the ongoing opioid crisis, including one in March. The opioid epidemic is not letting up, and neither can our efforts to fight it. Since our last hearing many more lives have been destroyed. There is no community that remains completely untouched by the opioids crisis.

Recently, the CDC reported that the opioid prescribing rate has peaked, but remains far too high, with enough opioids to keep every American medicated around the clock for 3 weeks. I'm glad we have the States here today so we can hear about what they're seeing on the front lines, what successful approaches they have found that deserve to be replicated, and what challenges they still face.

I'd also like to hear from our witnesses about how the

Federal Government can help. While it is important the States be empowered to address the particular challenges of their communities, our response to this epidemic cannot be 51 separate efforts. We must harness our national resources data in cooperation to get this crisis under control.

But as we talk about a public health crisis of this magnitude, there is an elephant in the room that needs to be addressed. Coverage for substance abuse treatment is how an individual in society has a fighting chance to kick the opioids epidemic for good. Health coverage is one of our strongest weapons in the battles against opioids, the epidemic, and the devastation it causes to our families.

Yet, Republicans persist in their attempts to gut the Medicaid program by capping it permanently, and ending Medicaid expansion as part of its efforts to repeal the Affordable Care Act. Repealing the Affordable Care Act and replacing it with TrumpCare would be devastating to 74 million Americans who receive critical healthcare services from the program. Today, 1 in 5 Americans receive their health insurance from Medicaid. Half of all the babies born in this country are financed by Medicaid. And to the working poor, many of whom are hit hard by the opioids epidemic, and are eligible for Medicaid for the first time through the ACA's expansion. Medicaid is, quite literally, the only

affordable health insurance available. And make no mistake, State Medicaid programs are at the center of the opioids epidemic.

Yet, in the House-passed TrumpCare, the CBO determined that 23 million Americans would lose coverage, the majority of them covered through Medicaid, with $834 billion in cuts to the program. The Senate's version of TrumpCare is no better, cutting Medicaid by a full 35 percent over the next two decades. These cuts could not come at a worse time from the perspective of the opioids crisis for States and for people who depend on the coverage Medicaid provides. There's no substitute for coverage for our States or for the people that need the care.

As the Senate continues to make cosmetic changes to its bill with only one goal in mind, passing any bill out of the Senate. Let's be very clear, no one-time amount of funds, whatever that amount may be, will ever replace the certainty of comprehensive coverage. No cosmetic changes can effectively offset the damage that could be caused by repealing the ACA and cutting hundreds of billions of dollars from the Medicaid program.

So, Mr. Chairman, we must stay vigilant in this fight and remain open to any solution that shows promise. So I thank you for having this hearing. But I believe that there is no way that this crisis can be solved with one-time infusions of resources, and it will only get worse if Medicaid dollars are removed from

the fight. We must invest in our healthcare system and its critical public programs for the long term, and Medicaid is clearly a critical pillar that should be strengthened, not decimated.

And I fear that if Republicans are successful in passing TrumpCare, we will end up going in the opposite direction when it comes to fighting the drug problem that has so devastated our communities. Thank you, and I yield back. I don't think anybody on my side wants the time, so I yield back, Mr. Chairman.

Mr. Murphy. Thank you for your comments. I ask unanimous consent that the members' written opening statements be introduced into the record, and without objection the documents will be entered into the record. I also note that two former members of this committee, Representative Mary Bono and Dr. Phil Gingrey, are present. Thank you for being here. And I, believe you said Mr. Stupak was around, too. Obviously, this is an important issue to those who are alumni committee as well.

We heard so many introductions. Let me introduce the rest of our panel for today's hearings, the Honorable Boyd Rutherford, Lieutenant Governor of Maryland, welcome to the hearing. As mentioned before, Secretary Moran, Secretary Tilley; and Director -- the Honorable Rebecca Boss, Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

from the State of Rhode Island.

Thank you for being here today and providing testimony. We look forward to our continued discussion on the opioid crisis facing our nation. As I mentioned before, I really want you to be brutality candid with us of what the problems are, what we need to do, and what are the gaps. You are all aware the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath.

Do any of you have any objections to testifying under oath? Seeing no objections, the chair then advises you that under the rules of the House and rules of the committee, you're entitled to be advised by counsel. Do any of you desire to be advised by counsel during testimony today? Seeing none, then, in that case, please rise, raise your right hand and I will swear you in.

[Witnesses sworn.]

Mr. Murphy. Seeing all have answered in the affirmative, you are now under oath and subject to the penalties set forth in Title 18, Section 1001, United States Code. We'll ask you each to give a 5 minute summary of your statement. Please pay attention to the time here. We'll begin with you, Governor Rutherford, you may begin.

**TESTIMONIES OF HON. BOYD K. RUTHERFORD, LIEUTENANT GOVERNOR, STATE OF MARYLAND; HON. BRIAN J. MORAN, SECRETARY OF PUBLIC SAFETY AND HOMELAND SECURITY, STATE OF VIRGINIA; AND HON. JOHN TILLEY, SECRETARY OF THE JUSTICE AND PUBLIC SAFETY CABINET, STATE OF KENTUCKY; HON. REBECCA BOSS, DIRECTOR, DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS, STATE OF RHODE ISLAND**

**TESTIMONY OF HON. BOYD K. RUTHERFORD**

Mr. Rutherford. Thank you, Chairman Murphy, Ranking Member DeGette. Honorable members of the subcommittee, thank you for the opportunity to join you today to discuss the State of Maryland's response to heroin and opioid crisis. Tackling this emergency necessitates a coordinated response from a Federal, State and local government. And Maryland looks forwards to continuing the -- working together with our Federal partners to address this challenge.

Governor Hogan and I first became aware of the level of this challenge while traveling throughout the State during our 2014 gubernatorial campaign. We quickly realized the epidemic had crept into every corner of our State cutting across demographics.

Maryland, like most States, has experienced an increase in the number of deaths related to opioids. In 2016, 2089 Marylanders died from alcohol or drug-related intoxication; 66 percent increase over the deaths and 2015. And 89 percent of those deaths were related to opioids. Maryland has seen an increase in prescription opioid-related deaths, and so we must address this particular element of the crisis. We must focus on reducing the inappropriate use of prescription opioids, while ensuring patients have access to appropriate pain management.

In Maryland, there were over 8.8 million total CDS prescriptions dispensed in 2016. This is 8.8 million in a State with 6 million souls. Further, the challenge we face has evolved. As was mentioned, cheap, powerful, and deadly synthetic opioids have burst onto the market, bringing a much higher overdose rate. Deaths related to fentanyl have increased from 29 in 2012 to over 1100 in 2016 in Maryland.

Accordingly, as one of the Governor's first acts in 2015, was to establish the Heroin and Opioid Emergency Task Force, which he asked me to chair. After nearly a year of stakeholder meetings and expert testimony and research, the task force adopted 33 recommendations. Those recommendations range from prevention, access to treatment, alternatives to incarceration, enhanced law enforcement, and more. And they form the foundation of our

statewide strategy. Building on those recommendations of the task force, the Maryland General Assembly passed several comprehensive pieces of legislation.

In 2016, we reformed our prescription drug monitoring program to require mandatory registration for all CDS providers. We passed the Justice Reinvestment Act to reform our criminal justice system to shift from incarceration to treatment for offenders who are struggling with addiction.

What we set out to do was make a distinction between those who we are upset with, and those who we are afraid of. This past legislative session, Maryland passed the Heroin and Opioid Prevention Effort, or HOPE Act, and the Treatment Act of 2017, which contains provisions to improve patient education, increase treatment services, and provide greater access to Naloxone.

The Governor signed the Start Talking Maryland Act, which will continue to build school and community-based education and awareness efforts to bring attention to this crisis. Educating young people on the dangers of opioids at an earlier age was something that our task force felt was extremely important. As I have said over and over again, virtually every third grader can tell you how bad it is to smoke cigarettes, but they can't tell you how dangerous it is to take someone else's prescription medications.

With the deadly surge of synthetics on the scene, we saw the death toll continue to rise. Accordingly, in January of this year, Governor Hogan established the Opioid Operational Command Center. The Center brings opioid response partners together to identify challenges and establish a systemwide priority and capitalize on opportunities for collaboration. It is a formal and a coordinated approach, utilizing the National Incident Management System to develop both State and local strategic operational and tactical level concepts for addressing the heroin and opioid crisis.

Shortly after its creation, the Governor declared a state of emergency in response to this crisis. By executive order, he dedicated -- delegated emergency powers to State and local emergency management officials to enable them to fast track coordination with State and local agencies. Thanks to your leadership and commitment, funding of the 21st Century Cures Act, has greatly aided in this effort. And these dollars will be used in expanding educational efforts in the schools, building public awareness, improving treatment, expanding our peer recovery specialist program, and increasing the availability of Naloxone.

The one thing that I would add that we would like to see from the Federal Government, is to consider utilizing FEMA as an outline of the -- as outlined in the national emergency framework

to centralize and coordinate the Federal response to this crisis. The national response framework is a guide to how the Nation responds to all types of disasters and emergencies, and it would allow Federal agencies to work more seamlessly with each other and with the agencies at the State level. We can't afford to have delays due to agency silos and bureaucracies. I appreciate this opportunity to talk to you and await any questions you may have.

[The prepared statement of Mr. Rutherford follows:]

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Mr. Murphy. Thank you. Thank you, Governor. Secretary Moran, you're recognized for 5 minutes.

**TESTIMONY OF HON. BRIAN J. MORAN**

Mr. Moran. Mr. Chairman and members of the committee, it is still very much an honor to be with you this morning, and to be able to discuss with you Virginia's response, as well as working with you to request assistance from the Federal Government to combat this epidemic. As has all been agreed and said this morning, America is in the midst of an opioid and heroin addiction epidemic. The epidemic does not discriminate, it is an equal opportunity killer.

In Virginia, in 2016, 1133 individuals died from opioid overdose. The sad truth is that Virginia actually ranks 18th among the 50 States in overdose deaths. Sadder than that, 17 States are doing worse than we are. And in all likelihood, the other 32 States would be facing similar devastation if we don't take effective action now.

As Secretary of Public Safety and Homeland Security, I am very proud of Virginia sworn law enforcement officers who work 24/7, 365, to keep us safe. But what they tell me over and over and over again is, we cannot arrest our way out of the heroin and

opioid addiction crisis. And we can't simply tell those living with addiction to get over it. Why is that? Because addiction is a disease.

Arrest and incarceration of those addicted will no more cure this disease than it would cure cancer or diabetes. There are a number of causes, multiple causes of this dramatic rise in the deadly epidemic of overprescribing, failure to safely dispose, easy access, and affordability. But over the last several years, we have seen a sharp rise in illegally manufactured synthetic opioids such as fentanyl and Carfentanil. Lethal and even tiny amounts, they contribute significantly to the increased numbers of heroin and opioid deaths. From 2015 to 2016, the number of fatal overdoses involving fentanyl increased to 175 percent, and accounted for 618 of the 1133 deaths in the Commonwealth.

Virginia's response. Virginia's response to this epidemic began immediately upon Governor McAuliffe taking office in 2014. He convened a broad coalition of healthcare providers, criminal justice representatives, and community stakeholders to participate in the prescription drug and heroin use task force. Secretary of Health and Human Resources cochaired the committee with myself. The task force developed over 50 recommendation. I am proud to say we have implemented the vast majority of those recommendations, the full list of which can be found in my

submitted written testimony. Of course, the work continues in Virginia.

Our executive leadership team works across State government and with regional and local agencies and individuals to effectively align goals, share best practices, and work to overcome barriers to success. The leadership team organized a statewide approach to opioid crisis and provided leadership from the Virginia State Police, Department of Health, and from our local community service providers. Again, that is a theme that this is not just a law enforcement problem, but, rather, one that requires healthcare providers to be at the table along with their community providers -- community service providers.

They support coordination among local grassroots organizations, task forces, and other collaborations, including those that exist within Virginia's HIDTA designated areas, which cover parts of Northern Virginia, Appalachia, and Hampton Roads. So there is more work to be done. Let me highlight some of our accomplishments. The General Assembly enacted legislation expanding the deployment of Naloxone. Lay people, law enforcement officers, State agencies like our Department of Forensic Science and other working with potentially dangerous drugs, are being trained in using this overdose reversal agent through the Department of Behavioral Health and Developmental Services Revive

program. Our Commissioner of Department of Health issued a standing order for pharmacies to dispense Naloxone. The Department of Criminal Justice Services issued grants to pay for increased Naloxone to be used by law enforcement. In fact, the city of Virginia Beach has used Naloxone now, and they have had over 60 deployments to save lives in that community.

Now, our requests. I came into this job with a mandate from my 11 public safety agencies that we would rely on data-driven decision making. If we are going to effectively wrap our arms around this epidemic and reverse the devastating upward trend in deaths, overdoses, and related crime, we need to know what the problems are, where they are, and what is working. To do that, we need good data. Here are some of the identified needs that Congress and the administration can help us address.

Craft limited exceptions to current regulatory and statutory barriers under HIPAA, in 42 CFR, Part 2, which is the substance abuse privacy protections. For example, our prescription drug monitoring program is prohibited from accessing any data from our methadone clinics. That is, we need to know how they work and who they are providing care for, and how it is working; provide technical assistance or fund staff positions for States and localities in developing metric-sharing data in analyzing results; support development of consistent national metrics; incentivize

private providers or mandate data collection in requisite -- as a requisite for Federal funding; change how the Federal agencies do business; increase support for SAMHSA and HIDTA; break down Federal funding silos, reduce demand; support, train, incentivize law enforcement to focus on mid and high level dealers; and help us divert those who are addicted into treatment programs. Our treatment programs are currently insufficient to address this epidemic.

Those with addictions shouldn't become law enforcement's problem, they belong in the healthcare system. Examples of programs to further -- to explore further, include assist localities to pilot, analyze, and determine the efficacy of Angel programs in police departments, fully fund the dissemination and utilization of Naloxone or other overdose drugs. My time is up. There is a lot of requests, but you invited the requests, Mr. Chairman, but I will stop if --

[The prepared statement of Mr. Moran follows:]

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Mr. Murphy. We will get more into that as we cover questions. Thank you, Mr. Moran. Secretary Tilley, you are recognized for 5 minutes.

**TESTIMONY OF HON. JOHN TILLEY**

Mr. Tilley. Mr. Chairman and members, thank you so much for allowing me the chance to be here. I want to thank Governor Matt Bevin from Kentucky for that chance as well. He sends his regrets. He wanted to be here himself. He's been outspoken on this topic. I will share with you a quick story. When I first met Governor Bevin, he was interviewing for this position, for this job, and he walked into a room with Dreamland under his arm, and he said, have you read this book? And I -- thankfully, I had. So I said, yes, sir, I have read the book. And, actually, I am trying to reread it because it is, again, I think the best -- the best chronicling of this problem and how it began that I know of.

So that, again, illustrates to you our commitment and our shared understanding of this problem. I want to thank Congressman Guthrie for that far-too-kind introduction as well. Dreamland, again, is relevant to us because, as you know, the problem really has its origins in Kentucky and Ohio. We lost 1404 Kentuckians, as the Congressman said. Fentanyl is now the driving force behind

these overdoses. We had 13,000 ER visits, 13,000 ER visits in a State of 4-1/2 million people. We lose, in this country, as you've heard those numbers, nearly a commercial airplane a day. If this were a communicable disease, we would be wearing hazmat suits to combat it.

But, again, I think overdoses and those visits only tell half the story. This devastates communities. As soon as we got our arms around heroin, we began to see fentanyl. Our State Police tells us that in the last 6 years alone, we have seen a 6,000 percent increase in fentanyl in our labs. 6,000 percent increase. I think all of us know the devastation it's had on our criminal justice community. Our jails and prisons are at capacity. We have no more room at the inn.

The Public Health crisis is on full display. In Kentucky, we have a Hep C rate -- Hepatitis C, a form of viral hepatitis that is seven times the national average. Right across the river in Indiana, they had an outbreak of HIV that rivaled that of Sub-Saharan, Africa. So we passed -- one of the first southern States to pass a comprehensive -- maybe the only comprehensive syringe exchange program. Now in Kentucky, we have 30 programs all passed by local option in our State. We know that that increases the treatment capacity by five times. When someone just walks over the doorstep of one of those programs, and it battles

back these diseases like Hep C and HIV.

Sadly, Kentucky, as the CDC reports, has 54 of 220 counties most susceptible to a rapid outbreak of HIV. So what has our response been in Kentucky to battle this? Again, taking a bold step as a southern State on the syringe exchange program; passing comprehensive legislation in consecutive years on prescription pills and pill mills; the second State in the country to battle back synthetics; dealing with heroin directly and fentanyl; being the first State in the country the mandate usage of what we call KASPER, our PDMP, our prescription drug monitoring program.

Now we have become the first State in the country now to require physicians, when prescribing, to limit -- for acute pain -- to limit prescriptions to 3 days. Some have done 7, some have done 10. We limited that to 3 days. And I could promise you, our Governor has spent some capital on that. That's how important it is to him.

We have doubled down on things like rocket dockets and alternate sentencing worker programs, and help for those who are addicted through various forms of treatment. Again, looking at things like neonatal abstinence syndrome. We have 1900 cases in Kentucky. We've increased funding many times to combat that and to help for the suffering of those addicted there. We have put it in our jails and our prisons. Again, I think I mentioned rocket

dockets with prosecutors, again, to try to make these cases, put them on a separate plane, to deal with them in the most appropriate way possible.

We have increased treatment at the Department of Corrections by nearly 1100 percent since 2004. We validate that treatment every year, and our return on investment now is almost $5. Some of the innovative programs you may have heard about, it was just recently chronicled in The New York Times, is the way we use Naltrexone, or Vivitrol, as it's known, in our jails, on the front lines. We give, again, an injection prior to release, and an injection upon release. And then we try to link that offender, that returning individual, to those services in the community to see if they are Medicaid-eligible, to see what kind of resources they had to continue that particular treatment. And I know a question will be, do we link those folks up to counseling? We do our best to do it. It is not mandated. We do our best to do that.

In fact, in Kentucky, I will tell you both, validated and anecdotally, we are seeing tremendous results from using MAT and counseling together, but counseling in the form of cognitive behavioral therapy, like moral reconation therapy. We are seeing that used in both our jails and prisons, and that is yielding some tremendous results. We intend to emulate what's been going on in

Rhode Island with the AnchorED program. We visited there with Director Boss some time ago through an NGA project. And I can promise you, we are doing peer recovery and bridge clinic soon. We'll do some innovative awareness. We'll use a hotline to get folks linked up to treatment. We're even educating our medical and dental schools. And overall, as I close out and conclude at the end of my time, I will tell you that I think we have the most comprehensive effort I've seen in my 25 years in criminal justice with something called KORE, the Kentucky Opioid and Response Effort.

So with that, I will look forward to questioning. Thank you, Chairman.

[The prepared statement of Mr. Tilley follows:]

******** INSERT 1-3 ********

Mr. Murphy. Thank you, Mr. Secretary. Director Boss, you are recognized for 5 minutes.

**TESTIMONY OF HON. REBECCA BOSS**

Ms. Boss. Thank you, Chairman Murphy. Thank you, Chairman Murphy and Ranking Member DeGette. As the director of Rhode Island's Department of Behavioral Healthcare, Developments, Disabilities and Hospitals, I oversee the State's treatment, prevention and recovery system. I am also a longstanding member of the National Association of State Alcohol and Drug Abuse Directors, and currently serve on their board.

Thank you for the invitation to appear before you today to share Rhode Island's work in combating the opioid crisis, an effort that has been proposed as a national model. Our strategies to address this epidemic are clearly outlined on our website, preventoverdoseri.org. And I will be sharing slides from this website during this testimony.

Our goal is to make these efforts open to the public with complete transparency on outcomes and available for replication throughout the country. First and foremost, I would like to thank Congress for the action taken last year passing the 21st Century Cures Act with $1 billion to help support prevention, treatment,

and recovery. In a time of tight budgets, we fully appreciate the significance of this action.

Addiction and overdose are claiming lives, destroying families, and undermining the quality of life across States in the United States, and Rhode Island has been one of the hardest hit. In 2015, newly elected Governor, Gina Raimondo, recognized the need for this State to develop a comprehensive strategy to prevent, address, evaluate, and successfully intervene to reverse the overdose trends. She signed an executive order establishing the Governor's Overdose Prevention and Intervention Task Force, which is comprised of stakeholders and experts from a broad array of sectors. The resulting plan has one overarching goal, reduce overdose deaths by one-third in 3 years. Governor Raimondo's plan focuses on four specific strategies, which I will briefly outline and focus on two specific areas, others are described fully in my written testimony.

The first is prevention. We take aggressive measures to ensure appropriate prescribing of opioids, promote safe disposal of medication, and encourage the use of alternative pain management services.

Next is Naloxone, rescue. Naloxone is a standard of care for first response. Naloxone saves lives by reversing overdose. And our plan supports increasing access to Naloxone across various

sectors of the State.

Third, we believe that every door is the right door for treatment, and our goal is to increase access to evidence-based treatment. To do this, Rhode Island developed centers of excellence, which provide rapid access to treatment, including induction on all FDA-approved medications for opioid use disorder. These specialized programs provide thorough clinical assessments and intensive treatment services with wraparound support. This program is designed to provide opportunities for stabilization with referrals to community physicians for continued treatment, offering continued clinical and recovery support through the Centers of Excellence. This program is supported through private insurance and Medicaid.

In addition, Rhode Island released the Nation's first statewide standards for treating overdose and opioid use in hospitals and emergency settings. And the Rhode Island Department of Corrections is providing medication-assisted treatment to the population most at risk for overdose. We have worked diligently to increase data-waivered physicians in Rhode Island. For example, Brown University Medical School is the first in the Nation to incorporate data-waivered training into its curriculum.

Finally, recovery. We are looking to expand recovery supports. Recovery is possible. To support successful recovery

from more Rhode Islanders -- sorry -- we are expanding peer recovery services, particularly at moments when people are most at risk. The AnchorED program was started in June of 2014, and is now a statewide, 24/7 service. It connects overdose survivors with peer recovery coaches in hospital emergency departments. These coaches share their own stories of hope and inspiration to engage those in crisis, as well as providing continued services, and follow up in connection. To date, over 1600 individuals have met with recovery coaches; and as a result, over 82 percent have accepted a referral to treatment.

The Anchor MORE Program exists as a statewide peer outreach effort to opioid hotspots that are identified through data, not waiting for someone to overdose to be seen. We are now facing a fentanyl crisis. As you can see in this slide, with approximately two-thirds of overdoses, fentanyl-related, we must develop new strategies to address the changing face of this epidemic.

As we speak, the Rhode Island Governor is signing an executive order expanding our efforts to include more focus on primary prevention, engaging families and youths in these efforts, harm reduction strategies, and access to treatment. I cannot state strongly enough that Rhode Island's strategies rely on sustainable funding through Medicaid and health insurance held to standards of parity with SUD treatment as an essential benefit.

Any action taken on a Federal level which would threaten this funding would weaken this plan substantially.

I would also recommend that any Federal initiatives specifically include involvement of State agencies given their expertise in these matters. I would advocate for continued support of the Substance Abuse Prevention Treatment block grant as the foundation of comprehensive State systems. And, finally, I would encourage continued consideration of targeted funds to address these issues.

Thank you for this opportunity to testify. I look forward to answering questions.

[The prepared statement of Ms. Boss follows:]

******** INSERT 1-4 ********

Mr. Murphy. Thank you all. I recognize myself now for 5 minutes. Starting with Governor Rutherford, regarding the 42 CFR, Part 2, a couple of effects. One is, as also as pointed by Secretary Moran and others, if someone is using a PDMP, the data is simply not in there. A physician prescribing will not know if that patient is on methadone, suboxone or some other synthetic opioid.

Secondly, if a person shows up in an emergency room -- our former colleague, Patrick Kennedy, talks about this incident -- shows up there with an injury, and when asked if that person has any allergies or any drugs, and he says, Please don't give me any opioids. They do it anyway, because there's nothing in the record that's prohibitive of being in the record. We can list if a person has an allergy, but I consider this -- an opioid sensitivity should be in there as well. But the law in place since the Nixon administration does not allow that to be in there. So the person then may leave that hospital with a vial of opioids, and then saying, Well, when I used to be addicted, I used to take 20 of these at a time, I'll take 20 now. Overdose and death. Or they may take them and say, you know -- then they relapse, or they may be on other medications, such as benzadine, the PNN, a bad drug interaction.

What do you recommend we do with that 42 CFR Part 2?

Mr. Rutherford. Well, that does have to be addressed. You're exactly right. And Secretary Moran was correct in terms of that particular challenge. A person who goes in who may be receiving methadone treatment, they go in for a knee replacement. There's nothing to tell that doctor that this person is also receiving methadone, when they prescribe oxycodone or OxyContin or something of that nature. It doesn't show up in our prescription drug monitoring system as well.

So it is a particular challenge. It needs to be addressed. There are some areas with regard to HIPAA that also go to other areas of behavioral health, and I know you talked about that. When we talk about mental health and the challenges associated with getting assistance for an adult family member, once that person goes from 17 to 18, you lose a lot of control when you can help this person. So, yes, if you can make some type of exceptions or clarification --

Mr. Murphy. At least in the --

Mr. Rutherford. That is also a misunderstanding among some of the doctors as well.

Mr. Murphy. At least in the medical record to be able to do a 42 CFR --

Mr. Rutherford. Yes, that would be a start.

Mr. Murphy. Let me ask another quick survey. Noting that

most people with an addiction disorder have a co-occurring mental health disorder. I was just wondering if any of you have taken a survey in your States? Do you have a sufficient number of psychiatrists, psychologists? I believe the national numbers say that half the counties in America have no psychiatrists, no psychologists, no clinical social worker, no licensed drug treatment counselor.

If you know? If you don't know, tell me. But if you do know, do you have ever a sufficient number in your State to meet the need?

Mr. Rutherford. I can only speak anecdotally. There are some counties in our State that have a substantial shortage of those types of professionals, including drug counselors. That is the challenge that we have.

Mr. Murphy. Secretary Moran, real quick, yes or no.

Mr. Moran. Yeah. And it varies by geography in southwest Virginia, Congressman Griffith represents a very insufficient shortage of such counseling.

Mr. Murphy. Secretary Tilley.

Mr. Tilley. Urban areas, yes; rural areas, no. We do have a community mental health network we're proud of. But, again, in the rural areas, they are still struggling to find the qualified professionals.

Mr. Murphy. Thank you. Director Boss?

Ms. Boss. Rhode Island shares in the Nation's struggle with the number of psychiatrists needed to meet the demands. So I would say, yes, there is a psychiatrist shortage.

Mr. Murphy. Thank you. The other issue is medication-assisted treatment, Director Boss, with regard to that. In Pennsylvania, we had some data that says that people who are in an MAT and may be getting suboxone or something. The question is, are they getting treatment? And I'm wondering if your State and other States, too, if people have actually reviewed that? I heard in some cases, the treatment is no more than a nurse in the waiting room, saying, So how are you doing today? And they call that group therapy if a doc says, is everything all right?

But in Pennsylvania, 59 percent had no counseling in the year that they received buprenorphine; 40 percent were not drug tested in the year they received it; 33 percent have between two and five different prescribers; and 24 percent of them didn't see a physician in the prior 30 days.

Can you describe if you have the data in Rhode Island and other States? Is that something to really find out if they are getting real counseling?

Ms. Boss. No. In Rhode Island, our opioid treatment programs are required to provide counseling, and they are --

Mr. Murphy. Do you know if they are really doing it?

Ms. Boss. I'm sorry.

Mr. Murphy. But do you know if they are really doing it?

Ms. Boss. Yes. We actually do reviews of our programs. So the State licenses the opioid treatment programs, and goes out to review records and to make sure that they are abiding by the counseling standards as well --

Mr. Murphy. I appreciate reviewing the records, I am going to push on this, because we need to know this. I have heard from people who go to centers, who tell me that they are listed in the records as having counseling, and they have no more than someone saying, How are you doing? I mean, really -- I'm just curious. Not Rhode Island. I have heard other States.

Ms. Boss. Mr. Chairman, without actually being able to sit in on sessions and time the sessions and make sure that they are happening, we have to rely on the validity of the record with which we review. And so, unless people are willing to commit fraud and put their licenses on the line by documenting something that didn't happy, I would have to say that I believe that what I read in the record to be true.

Mr. Murphy. Okay. I think this committee has dealt with so much fraud. We have to move on. Ms. DeGette, you're recognized for 5 minutes.

Ms. DeGette. Mr. Chairman, it's called medically assisted treatment, and you're right, counseling has to be an important part of that. So if they are not giving the counseling, I would think they should. But I don't think we have any evidence that there's fraud being committed in Rhode Island.

Mr. Murphy. No, I'm not picking on Rhode Island. We love Rhode Island.

Ms. DeGette. Yes, we do. My daughter went to Brown University, and we love Rhode Island. So I want to talk to you a little bit, Director Boss, about this issue of States being able to pay for treatment. And this is -- the full range of treatment -- and I think it applies in all the other three States, too. I would assume that paying for treatment on this scale is really an ongoing challenge facing your State. Would that be a fair statement?

Ms. Boss. Congresswoman, that would be a fair statement prior to 2014. But we have seen significant increases in the number of people being able to access treatment, post Medicaid expansion.

Ms. DeGette. And so the Medicaid expansion has helped. And we hope 21st Century Cures helped, too, but we know that there's a lot more work that needs to be done. In fact, in your statement, you said, Medicaid has laid the foundation for treatment coverage.

Is that correct?

Ms. Boss. That is correct.

Ms. DeGette. So I wonder if you can just tell me, quite briefly, how Medicaid funds are helping Rhode Island fight this epidemic?

Ms. Boss. So Medicaid funds in Rhode Island cover medication-assisted treatment, all three forms of FDA approved medications, methadone, buprenorphine, and injectable Naltrexone. They support something known as OTP health homes, and that's a comprehensive program to integrate healthcare with individuals who are receiving methadone treatment, as well as all other forms of treatment. And Rhode Island has a full continuum of treatment from inpatient detoxification to outpatient treatment to residential treatment to the use of medication and assistant treatment as well.

Ms. DeGette. Now, have you looked at these bills that House Republicans have passed, and that the Senate Republicans are looking at, which would severely reduce -- would severely reduce the Medicaid aid to the States?

Ms. Boss. I have.

Ms. DeGette. How would those impact your State of Rhode Island?

Ms. Boss. So any bill that would reduce access to Medicaid

and Medicaid expansion, or reduce access to affordable health insurance would have negative impact on Rhode Island, as 77,000 lives are covered, approximately, by Medicaid.

Ms. DeGette. You have 77,000 people in Rhode Island covered by the Medicaid expansion?

Ms. Boss. Correct.

Ms. DeGette. Now, Secretary Tilley, a recent AP analysis showed that the Medicaid expansion accounted for more than 60 percent of the total Medicaid spending on substance abuse treatment in Kentucky. Between 2012 and 2014, there's been a more than 700 percent increase in substance abuse treatment provided to Kentucky residents due to Medicaid's expansion.

So, I guess I want to ask you, it looks to me like Medicaid has been particularly helpful in Kentucky's fight against the opioid crisis. Would you agree with that?

Mr. Tilley. Let me say this: I will tell you unequivocally of our Governor's commitment, and again, exampled by the 1115 waiver, and our effort at this very moment to expand our treatment options under that --

Ms. DeGette. Let me ask you my question. Would you agree that Medicaid has been particularly helpful in Kentucky's fight against the opioid crisis?

Mr. Tilley. I would agree --

Ms. DeGette. Thank you.

Mr. Tilley. I would agree. Yes. I'm sorry, you didn't let -- I would agree that through a number of sources of funding, we have increased treatment all the way -- dating back to 2014 by 1100 percent dating to today.

Ms. DeGette. Let me ask you this: Let me ask you this. If the Medicaid expansion went away, would that impair your efforts to fund this in Kentucky?

Mr. Tilley. Ma'am, I'm the Secretary of the Justice and Public Safety cabinet, and I do have five major --

Ms. DeGette. You're not going to answer my question, so I am going to ask Secretary Moran a question. Secretary Moran, Governor McAuliffe attempted to expand Medicaid twice in Virginia, but the Republican legislature rejected both of the attempts. So I want to ask you, I know Virginia is making the most out of the tools it has, but if you had had Medicaid expansion, more money in Virginia, would this have helped you be able to reach out to more people on this opioid issue?

Mr. Moran. Simple answer is yes. That's an emphatic yes.

Ms. DeGette. Why is that?

Mr. Moran. More people would have access to treatment. Now, I will give credit to our Department of Health, they are using a very innovative ARTS program, addiction, recovery and treatment

services, to carve out a Medicaid waiver to try to address these individuals' addiction needs. But with Medicaid expansion, you know, 400,000 Virginians would be covered, and Governor McAuliffe has attempted to do that every opportunity.

Ms. DeGette. Thank you very much, Mr. Chairman. I yield back.

RPTR ALLDRIDGE

EDTR HUMKE

[10:58 a.m.]

Mr. Murphy. I recognize Mr. Collins for 5 minutes.

Mr. Collins. Thank you, Mr. Chairman. I think maybe I'll start this question with Secretary Moran.

All of us all agree here that opioid addiction is a disease, it is an addiction, and we all experienced the tragic deaths of many of our young children when it comes to the overdose. And as was just pointed out, we also have the fentanyl issue.

So my question really is surrounding naloxone, or Narcan, as we know it. And could you help the committee understand some of the key issues on availability -- because we do hear there may be some shortages, cost. Who is picking up the tab for this? Is it patients? Is it the State? Is it the Federal Government -- to maybe give us a little bit of an overview on how we are at least attempting to deal with that piece.

And, also if someone is obviously in an OD, are they given Narcan without really -- you don't know. Are they OD on opioids or fentanyl?

Mr. Moran. Thank you very much for the question, Congressman. The -- we are attempting to expand the coverage of

naloxone in every community. With the law enforcement community, there is some resistance, particularly from our rural jurisdictions because -- merely because they are not the first to respond typically in a large jurisdiction. Usually it is the emergency medical services. EMS does carry it. The majority of our jurisdictions in law enforcement communities, and certainly in urban areas, now carry it. And as I mentioned, Virginia Beach has a tremendous success rate. They are saving up towards of a life a week with the use of naloxone.

Now, that's law enforcement. That's EMS. We appreciate the Federal grants through the Department of Criminal Justice Services so that we can provide, without any cost to the local jurisdiction that naloxone. Now, in terms of lay people, our Department of Health commissioner issued an order so that anyone now can go into a pharmacy and receive the prescription for naloxone.

So we are attempting to expand coverage in any way possible. It is obviously a lifesaver, and the more people who will have it, more lives will be saved.

Now, you know, obviously then once you revive that individual, there are consequences after that in terms of needs for treatment. But the Narcan itself is truly a lifesaver, and more people team that carry it -- within our Department of Forensic Science, for instance, one issue with respect to the

carfentanil and fentanyl, because it is so dangerous and lethal, we have given it -- we are provided authority now for all of our lab technicians to carry it, that they may be subject to a lethal dose when they're analyzing evidence in the criminal case. And so, again, as many people can have it, it is a very significant piece in this entire puzzle.

Mr. Collins. Now, we have heard that the FDA is considering making Narcan over-the-counter. Now, you just mentioned anyone could go in and fill a prescription. But that, I guess, would certainly indicate they have to have a prescription to start with issued by a doctor. And I don't know if there is -- people sometimes do have, you know, different kinds of concerns in admitting that they've got an issue. Could you expand on that a little bit on what you may know of the FDA making over-the-counter and, also, how does someone get this prescription, which obviously they've got to -- would then fill.

Mr. Moran. Congressman, that's what the standing order did is that you do not need a prescription now. You can actually go in and obtain the Narcan without a doctor's written prescription. And that was the standing order from our commission of health.

Mr. Collins. So that's Statewide.

Mr. Moran. That is correct.

Mr. Collins. And that's what the FDA is actually looking on

to expand nationwide. And what's your experience with that? Are people -- are you tracking how many people -- are these, perhaps, family members who know that they've got a -- someone that's got this addiction and they're being anticipatory, to use that word, just in case?

Mr. Moran. That is certainly the intent to -- if -- if you have a loved one who is -- who is addicted, you would take the proactive step of obtaining the Narcan in case of an overdose. And we have been trained -- myself, the first lady of Virginia, the Governor the Virginia. We received revived training. It is very simple. It truly is. And we would encourage people to have access to Narcan in case of an overdose.

Mr. Collins. That's a great example, and I'm just thrilled you have shared that with us. Maybe that's a message, if the FDA doesn't move, that other States obviously could take those same steps, because if we can save lives, then you should be able to go home and say job well done.

Thank you for sharing that. And I yield back.

Mr. Murphy. Mr. Tonko, you are recognized for 5 minutes.

Mr.Tonko. Thank you, Mr. Chair, and thank you, chair witnesses, for their public service and for the testimony that they shared today.

Before I get to my questions, I would be remiss if I didn't

echo my colleagues' remarks on the devastating impact that TrumpCare, in its iterations, would have in the fight against the opioid epidemic. This mean, and might I say very mean, bill will rip hope away from people in communities across my district who depend on coverage from the Affordable Care Act and Medicaid expansion to help them recover from the scourge of opioid addiction. Medicaid by far is the single largest payer for behavioral health services in our country. In Rhode Island, Medicaid pays for nearly 50 percent addiction treatment medication. In Kentucky, it's 44 percent; Maryland, 39 percent; Virginia, 13 percent.

The bill being considered in the Senate would cut $772 billion, or 26 percent, from Medicaid over the next decade. There is no way this highly efficient safety net program could sustain this type of funding loss and continue to provide services for all that require it.

Simply put, passing TrumpCare would be the single biggest step backward in providing treatment for substance use and mental health services in our Nation's history. That being said, last year I collaborated with my friend Dr. Bucshon on legislation that expanded buprenorphine prescribing privileges to nurse practitioners and physician assistants. And I would like to thank -- I would like to gather your feedback on how this law is

being implemented in your States?

Director Boss, you mentioned in your testimony that Rhode Island is actively working to provide DATA 2000 training to interested practitioners. Have you seen significant interest from the nurse practitioners or physician assistants communities in becoming waivered practitioners?

Ms. Boss. Congressman Tonko, I'm not sure that I have data on how many nurse practitioners and physicians assistants have applied to take data-waiver training. I know that we are actively working with medical schools to get that interest and to increase the training available, but I'm not sure that I would be able to answer that comprehensively.

Mr. Tonko. But there -- as you are aware, there is interest in it in?

Ms. Boss. Absolutely. There is interest, and there is active work with the Department of Health and within my department to provide those trainings to any and all interested parties. And we've seen increased number of data-waivered physicians. We will be working with the nurse practitioner in PA schools to increase those as well.

Mr. Tonko. Are there any projections you've made in terms of these additional classes of practitioners being able to prescribe MAT's improved addiction treatment access in Rhode Island?

Ms. Boss. We track through our overdose Web site and our regular performance management meetings the number of people receiving buprenorphine treatments. So we're able to look at the increases and, through our prescription drug monitoring program, track the number of waivered physicians that are actively prescribing. And so we are seeing increases in the number of people receiving buprenorphine treatment through these efforts.

Mr. Tonko. But I would assume that the further expansion of the DATA 2000 waiver, either in higher patient caps or additional classes of practitioners prescribing would have a positive impact on access to treatment in Rhode Island?

Ms. Boss. I would absolutely agree with that. I'm not sure that there has been enough time for us to document how much increase that will result in. But, yes, I do agree. And I thank you for your efforts with that legislation.

Mr. Tonko. Our pleasure.

And to all of our panelists, what barriers do you face in trying to recruit practitioners to become waivered DATA 2000 practitioners?

Start with the lieutenant governor, please.

Mr. Rutherford. Well, we talked about, in certain cases, in certain parts of the State, there are limitations in terms of the number of practitioners in some of our more rural areas of the

State. Also, some of the anecdotal feedback, there is still -- in some cases, there is a stigma associated with treating individuals of substance use disorder, and there is some doctors that just don't want those patients. But the lifting of the cap has helped us with regard to being able to provide the services for more individuals, but stigma is still a challenge.

Mr. Tonko. Secretary Moran -- thank you, Lieutenant Governor. Secretary Moran.

Mr. Moran. I would agree, though, most of that information would be within our secretary of health and human resources as opposed to me. But we have heard from the practitioner. I mean, there is a shortage of personnel to address this issue. I mean -- and, you know, in their defense, it's an epidemic that has really exploded over the last several years. Any assistance you can provide for additional funding in flexibility would be much appreciated by the Commonwealth and other States.

Mr. Tonko. Thank you. And Secretary Tilley.

Mr. Tilley. Yeah. I would reiterate my colleagues, what they stated with regard to -- I would also add that we have a phenomenon -- we have a number of physicians, I think nearly 700, who are prescribing. However, many of them have not applied to prescribe over that 100 up to the 285 cap. And in many of them, we don't know, as has been stated earlier, whether they are

requiring counseling. We do know we require counseling in our correction settings and jails and prisons. We encourage it. We do urinalysis. But we don't know -- that's one of the things we have to get our arms around. We are doing that now.

We have to look beyond why some of these physicians are not applying to do more in their communities. And we also -- again, we struggle with the same challenges with rural versus urban in getting those folks out to those areas largely. In Appalachian, this problem hit first there, and it's more acute there in many ways. So that's a challenge for us.

Mr. Tonko. Thank you.

Director Boss, can I just tap for -- we were going across the board. Can we just have a quick response, Director?

Mr. Murphy. Real quick.

Ms. Boss. All right. Thank you.

So I would agree with all of my colleagues. But I would add, in our discussions with physicians, they want to do the right thing, and they want to be able to make sure that people are receiving counseling and toxicology screen but lack the office staff and the management to do that. So they need increased supports in the offices to do the kind of evidence-based practice that's needed to use buprenorphine appropriately.

Mr. Tonko. Thank you.

Thank you, Mr. Chair. I yield back.

Mr. Murphy. The committee likes those words, evidence-based practices. Thank you.

Mr. Walberg, you're recognized for 5 minutes.

Mr. Walberg. Thank you, Mr. Chairman. And thanks to the panel for being here.

Secretary Moran, according to the Centers for Disease Control and Prevention, approximately one in five deaths that are attributable to a drug overdose failed to list specific drug in the death certificate. Could you explain why this data gap is problematic and what efforts the Commonwealth is taking to ensure that it has sufficient data to understand the true scope of the opioid epidemic?

Mr. Moran. Thank you, sir. The theme of my remarks is the need for additional data, the State silos, which are we trying to break down, and then there are, of course, the privacy provisions with respect to some of the Federal laws and HIPAA.

In a criminal investigation, our Department of Forensic Science will do the investigation. We have good data with respect to what drugs were involved, because they are collected. If it is an accidental death, it eventually goes to the OCME, Office of Chief Medical Examiner. But with respect to the data, it is challenging. And, you know, some folks -- some individuals may

not be anxious to reveal the cause of death under some circumstances. Family members may not, you know, choose to reveal that type of source. So it is a challenge. It's one we're trying to get our arms around, because if we have better data, we know how to respond better and what to do and, what if, anything is working with respect to addressing this epidemic.

Mr. Walberg. Is there anything that you're attempting to get your arms around that data that is working for you, at least with some families?

Mr. Moran. Well, the prevalence of fentanyl and carfentanil, particularly fentanyl, would have been able to -- realized that over the last -- I think -- I have enjoyed the presentations, because we're not alone. You've seen a dramatic rise in the use of fentanyl over the last year. That helps inform not only our healthcare providers but our law enforcement.

Where is the fentanyl coming from? And if it is located in a particular community, there can be a rapid response with respect to education and response and to interdict the fentanyl, because it's typically being manufactured overseas and coming into in the commonwealth and the country.

So that type of information I think is critical to the interdiction of these drugs in addition to the healthcare in response to the individual. So I think it's imperative that we

collect more data and have more access to data because we can better respond to the crisis.

Mr. Walberg. Director Boss, your written testimony notes that Rhode Island's multiple disciplinary overdose prevention and intervention task force makes use of a date-driven strategic plan to combat addiction and substance abuse. Could you tell us more about how the State utilizes data to develop its strategy to address this opioid crisis?

Ms. Boss. That is a wonderful question. And thank you for asking it, because --

Mr. Walberg. As specifically as you can.

Ms. Boss. So we have two things that I will point to. We have something called MODE, which is the multidisciplinary overdose drug response team. Basically, we look at a number of specific overdoses to look for trends, and there is a multidisciplinary team that consists of individuals from Brown University, hospitals, Department of Health, my department. And we review cases in depth in terms of looking at where those individuals were, what kind of treatment services they were receiving, if any, and then develop specific interventions as a response that we propose Statewide.

The others are surveillance response intervention team. We receive weekly reports on 48-hour overdose reporting. All of our

hospitals are required to report overdoses or suspected overdoses within 48 hours, and our medical examiner is able to determine whether or not fentanyl is a factor in those overdoses. As a result, we put out alerts to communities when overdoses, whether fatal or not, exceed a specific target in that particular area. And we're able to notify law enforcement, first responders, treatment providers, and other individuals in the community that there is an increased overdose or -- fatal or nonfatal, in their communities.

Mr. Walberg. Okay. You mentioned that your State still lacks comprehensive data relating to fentanyl even with this approach that you're taking. If I understand it correctly, what are the obstacles preventing hospitals from developing comprehensive testing of fentanyl and how could they obtain more robust data?

Ms. Boss. So I think the fentanyl question is regarding the drug supply. Our hospitals are now able to test for fentanyl as are our drug treatment providers. And so we are looking at how much fentanyl is in the drug supply. And as we see increases in hospital testing, in the testing that's done in our drug treatment providers, we're able to know what kind of fentanyl is out there, but not as necessarily as quickly as we could if it were a law enforcement -- if we had more rapid response in law enforcement in

looking at what's in the drug supply.

Mr. Walberg. Thank you.

I yield back.

Mr. Murphy. Thank you. Mrs. Castor, you're recognized for 5 minutes.

Ms. Castor. Well, thank you, Mr. Chairman. I'd like to thank all of the witnesses here for your attention to this very serious issue. And I think at the outset it's important that we can -- America just cannot go backwards on this.

This is a very costly, severe problem for familles and all of us. And to watch what is happening with proposals from the GOP on healthcare really would take us backwards, whether that's ripping coverage away that's been provided under the Affordable Care Act, under healthcare.gov, or the very serious assault on Medicaid. The most serious retrenchment of Medicaid in its 50-year history would be just disastrous for our ability to support families and address this crisis.

In fact, I'd like to ask unanimous consent to submit, for the record, a consensus statement from the National Association of Medicaid Directors on the Senate version of the GOP health bill.

It states, in part, Medicaid is a successful, efficient, and cost-effective Federal-State partnership. It has a record of innovation and improvement of outcomes for the Nation's most

vulnerable citizens including comprehensive and effective treatment for individuals struggling with opioid dependency.

No amount of administrative or regulatory flexibility can compensate for the Federal spending reductions that would occur as a result of the bill. Medicaid or other forms of comprehensive, accessible, and affordable health coverage in coordination with public health and law enforcement entities is the most comprehensive and effective way to address the opioid epidemic in this country.

Earmarking funding for grants for exclusive purpose for treating addiction in the absence of preventative medical and behavioral health coverage is likely to be ineffective in solving the problem.

So I'll ask unanimous consent that that be admitted for the record, Mr. Chairman.

Mr. Murphy. We're reviewing. We'll get back to you before you're done.

Ms. Castor. Okay.

Mr. Murphy. Thank you.

Ms. Castor. Because this is very important. The -- now, this committee, to its credit, spearheaded the 21st century cures initiative that did provide substantial funds to our states. And I've heard from local experts back home in Florida, held a number

of roundtables with law enforcement, treatment professionals, anesthesiologists, ER docs -- the panoply. And they say the key is long-term coverage to treat this as the chronic disease that it is. And that's why, when you rip away coverage and instead say, in its place, we're going to have another fund, an opioid fund, where maybe you provide a few dollars to an ER, that's not going to provide that long-term coverage that we need to treat this chronic disease. So I just had to get that off my chest here right off the bat.

In fact, Director Boss you have a lot of experience with this. Do you think we'll be able to effectively address this crisis if the -- this retrenchment on Medicaid and ripping coverage away for millions of Americans were to succeed?

Ms. Boss. So I believe that Rhode Island's efforts to address this crisis would not be able to be sustained if we were not able to continue to offer insurance through Medicaid expansion to the number of Rhode Islanders that depend on it. And I thank you for your pointing out the fact that providing substance use disorder treatment alone is not enough. If we dedicate dollars towards that, that's wonderful. However, you know, oftentimes there are comorbid conditions that are interrelated with an individual's addiction, that if we don't have access to affordable health care for the rest of the body, then we're not going to be

able to treat the person well enough to sustain any kind of recovery.

Ms. Castor. So how would -- are you able right now to provide the type of long-term treatment that is needed for this -- for an opioid appointed addiction?

Ms. Boss. Yes, we are.

Ms. Castor. In fact, you've instituted a program called AnchorED which connects individuals struggling with addiction to recovery coaches who help them navigate the treatment process. How successful has this program -- has it been to helping an individual recover?

Ms. Boss. So of the individuals that meet with recovery coaches in the emergency department, 82 percent are receiving referrals to treatment and engage in treatment and recovery services, which is pretty phenomenal, actually. And the actual AnchorED program itself is not supported by Medicaid.

But the fact that we are not required to use substance abuse prevention treatment block grant funds to fund treatment itself, now that individuals can access, it frees up that opportunity to use block grant funding to support recovery activities that may not be supported by Medicaid or other insurance, although the program is so successful that many insurances, including third-party commercial insurances, are paying for the recovery

coaching program.

Ms. Castor. Is that a requirement under Rhode Island law, or is that something that they -- you found to be so cost-effective that they are participating?

Ms. Boss. It is not a requirement.

Ms. Castor. Okay. Thank you very much.

Mr. Murphy. Can I just ask a follow-up question, what you're saying? Recovery coaches have what kind of credentials?

Ms. Boss. So we have a certification process for our recovery coaches that are standardized and involves training and a test and voluntary hours for certification in order to respond. They are not degree --

Mr. Murphy. Okay. No degree.

And do you have, in emergency rooms, then, people who are themselves licensed treatment providers? Not recovery coaches, not peers, but people who are actually -- this is their licensing. Do you have them in the ERs as a requirement?

Ms. Boss. We do not.

Mr. Murphy. Let me just ask: Does Kentucky have them? Or Virginia? Maryland?

There was a study done out of Michigan, and I believe also one done at Yale, that when there is a licensed addiction's counselor in the ER providing treatment, not referral, providing

treatment, they increase the chance that person is going to follow up by 50 percent.

So just saying here's some place you can call, 82 percent -- do you know if they actually follow through in the event -- that's my question that I have now. I'd love to hear that from each State, but I next have to go to Ms. Walters.

Ms. DeGette. Before you do, are -- is Ms. Castor's unanimous consent request?

Mr. Murphy. Yes. We're fine with that. Yes. Thank you. Sorry about that.

[The information follows:]

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

Mr. Murphy. But anyways -- but I was saying that information is critically important. Just getting referral -- and I've heard from a lot of places, give them a card, they may not follow through. So 80 percent may not be valuable to us. But to know they're actually getting treatment, just like you wouldn't send someone home and say, "You broke your arm. Could you, please, you know, make sure you see an orthopedic surgeon next week," but to make sure it's being done.

Mrs. Walters, You're recognized for 5 minutes.

Mrs. Walters. Thank you, Mr. Chairman.

We can all acknowledge that, despite increased societal awareness and government resources, that the opioid crisis continues to devastate our communities. In my home of Orange County, California, there were 361 overdose deaths in 2015. That accounts for a 50 percent increase in overdose deaths since 2006. A majority of those deaths are attributed to heroine, prescription opioids, or a combination of the two.

One of the challenges in responding to the crisis is the stigmatizing of the victims which limits their responsiveness to treatment outreach.

There has been discussion today of the importance of drug courts. And these courts can help overcome the stigma and treat the underlying addiction as opposed to focusing on the resulting

criminal behavior I recently became aware of a specialized drug treatment court in Buffalo, New York, that is focused solely on opioid interventions.

My question is for everybody on the panel. Do you have an opinion whether some drug treatment courts need to be specialized to handle opioid addiction?

Mr. Rutherford. We have extensive drug courts in most of our jurisdictions across the State. I mean, they essentially are specific to opioid addiction. And there's been good results from most of those courts.

The one challenge that we have is that, depending on how long -- some of our counties, that -- that period that you're involved with the drug court is maybe 18 months to 2 years. And if you're your someone who commits a crime at a local jail and you're not ready for treatment, that person will say, "I rather do the 6 to 8 months than to have to commit to 2 years. Even though I'm outside the fence, I rather sit in jail."

Mr. Moran. We're big proponents of drug courts. Unfortunately, Virginia is deficient in drug courts. We have about 37 yet we have over 200 courts. They are used for a variety of different specialities. There's mental health courts; there's veterans dockets. The drug courts, however, provide some coercion. I mean, the individual needs to want to address their

addiction, and then the court can provide that coercive element. And we have a tremendous success rate. I mean, we should expand.

The one issue I would ask Congress to help us with, however, is the medically-assisted treatment. Some of our judges in the drugs courts are reluctant, and as of now, it is required. And so we would like -- we would request, on behalf of those judges, some flexibility with respect to mandating MAT.

Mr. Tilley. And, again, I would concur. We have mental health courts, veterans courts, and drug courts I think that do expand. We did lose our juvenile drug courts due to a funding issue. We're trying to rebuild that program now. Some of the same issues exist. Oftentimes that offender chooses a shorter prison sentence and that two-year, again, very strenuous program. But we're addressing that as well.

I would say that oftentimes too we find that there are cherry picking the best instead of focusing on the more high-risk folks. We do have a program called SMART that deals with high-risk probationers keeping them -- again, a modified drug court that does specialize in opioid, at least one part of it does. And that's being done at seven pilot sites. It's modelled after the HOPE program that began with Judge Steven Alm in Hawaii that many of you know about now.

And I would also add that what we're finding as well is,

again, this combination of specializing in medically assisted treatment and the cognitive behavioral therapies that, again, we're trying to integrate that model with some of our existing. And we also have passage -- passage of recent legislation in Kentucky, through the Department of Corrections, a modified drug court through a reentry program that we'll be rolling out soon that will specialize in the opioid addictions.

Ms. Boss. I would agree with my colleagues as well, especially Lieutenant Governor Rutherford in the fact that our drug courts have been addressing opioid use disorder for a very long time. In Rhode Island, the drug court has been accepting of medication assisted treatment as appropriate treatment for individuals long before it was required to do so.

Probably the biggest issue that we have with drug court is that it's not able to reach enough people. And while it's very successful and effective, the difficulty in getting the numbers through that system is challenging, and we really would like to look at a broader perspective of diversion efforts and getting people connected to treatment prior to arrest as our primary focus.

Mrs. Walters. Thank you.

Mr. Tilley. Mrs. Walters, may I add an interesting thought here? We had, again, a conference recently in Kentucky that

offered a legal opinion from one of our law firms that there -- and, again, as Secretary Moran pointed out, if a judge denies someone medically assisted treatment which then affects their -- the liberty interest if they return to prison, that denial might invoke some protection of the Americans with Disabilities Act. And I think that's an interesting thought moving forward. And I think it's a little bit of a chilling effect on our judiciary in Kentucky to be -- again, might be more accepting of medically assisted treatment.

Mrs. Walters. Thank you. Thank you all. I yield back my time.

Mr. Murphy. Mr. Ruiz, you're recognized for 5 minutes.

Mr. Ruiz. Yeah. Thank you, Mr. Chairman. Thank you all for being here. It's such a very important topic. And as an emergency medicine doctor, I cannot emphasize enough the devastating effect it has on individuals, families, communities.

I've treated patients who have been dumped, blue not breathing in front of our doors, and we go into the emergency care mode providing naloxone and the other cocktails for somebody who you don't know anything about, and they're there unconscious right about to die. And thankfully we've saved many of them because we've had the medication.

We know that one of the primary determinants of successful

treatment is that they get medication, follow-up, and counseling. And one of the factors for success is that they have health insurance that has guaranteed coverage for those medications, guaranteed coverage for mental health, and that -- and that's why it's so devastating for me and for my patients that we -- that we're on the verge of repealing the Medicaid expansion, repealing for some States who choose not to have the mental health and prescription drug guaranteed coverage, that those people who need coverage and want coverage won't be able to have it. And it can be a situation of life and death, as we know.

In a report on addiction released last year, the U.S. Surgeon General found that Medicaid expansion meant that millions of Americans with substance-use disorders now have access to health coverage and, subsequently, substance abuse treatment. And additionally, because substance-use treatment is now a covered essential health benefit, which is at risk of going away, individuals, a small group market participants also gain access to those lifesaving services.

But it's not just about coverage. Okay. You can have coverage like --I've seen some parts in my district but if you don't have providers, if you don't have psychiatrists, if you don't have psychologists, if you don't have healthcare centers or counseling centers or programs in those communities that are

underserved or in rural areas, then coverage does you no good.

So you need to also think about making sure that we have more psychiatrists, more psychologists, more mental health providers in those areas, especially for the youth and young adults.

According to data from HHS, the number of children in foster care increased 8 percent between 2012. Experts have suggested that this rise is due in large part to increased opioid abuse. Moreover, the substance abuse and Mental Health Services Administration, SAMHSA, has estimated that over 8 million children of parents who need treatment for substance abuse disorder.

The Wall Street Journal, the Washington Post, and the New York Times have all recently reported on children who have experienced the impact of their parents' opioid abuse and are being raised by grandparents who have been placed into foster care as a result.

Secretary Tilley, can you please describe how children in your State have been impacted by the opioid crisis, and are there unique challenges facing children in these epidemics?

Mr. Tilley. Again, with the focus on -- I think it's an excellent question. With a focus on correction, sadly I can report that, in Kentucky, as it exists now, more children are living with an incarcerated parent than any other State in the country. In fact, have had or have an incarcerated parent. And,

again, our prison population largely being driven by the epidemic, I think that would be the first thing that comes to mind.

I also believe that it puts an incredible strain on our cabinet for health and family services. We have a record number of children in foster care at the moment. So that certainly is an issue.

And beyond that, I think it just puts a tremendous strain on our community mental health centers as well. I think, again, the absence of proper funding for community mental health in this country is a huge issue. It exists all over. It certainly is acute in Kentucky as well. We rely on our 14 community mental health centers that fan out through our State to provide those services to children.

We have seen an increase with the focus in recent years on addiction issues that increase and proper treatment for children, and so I think that's been critical for some of our --

Mr. Ruiz. So Secretary Tilley, let me just warn you that, by turning Medicaid into per-capita grant, the funding for new addicted folks are -- is going to -- is -- I should say the need for funding is going to increase. States are going to have to make decisions: One, change their eligibility criteria; two, their reimbursement rates; and,

three, the benefits that they would cover. And oftentimes,

unfortunately, the mental health and these community center treatments are the first on the chopping block. So it's going to get worse if this bill is going to pass.

Director Boss, SAMHSA stated that families have a central role to pay in the treatment of individuals with substance abuse disorders. Can you discuss what efforts Rhode Island has taken to provide treatment that covers a person's entire family?

Ms. Boss. All of our treatment providers are encouraged to engage families in treatment and -- as part of effective treatment. We know that addiction is a family disease, and engaging family members is critical in order to have success.

One of the things that the State has done is engage family members in the development overdose task force and plan, and we're creating a family and parent task force as well as engaging youth to help us shape our efforts for the overdose crisis in --

Mr. Ruiz. Have you found positive results on those?

Ms. Boss. Those efforts are just starting. So I will be able to report back hopefully.

Mr. Ruiz. Well, I'm very hopeful that we can work together to help this situation get better.

Mr. Murphy. I appreciate that, because there's some things we need to be working on out there. But I want to make sure Secretary Tilley has a chance to respond to what you're saying

about mental health substance abuse, money being first on the chopping block. Is that Kentucky's intent? Do you know anything about that?

Mr. Ruiz. That was not the intent, I don't -- I don't agree --

Mr. Murphy. No. I didn't know -- but you had asked. I want him to respond.

Mr. Ruiz. No. No. I'm just saying that, historically, mental health is one of the most underfunded --

Mr. Murphy. I understand. But you made a claim, and I want Secretary Tilley to have a chance to the respond to that, find out if it's --

Mr. Tilley. I would only say that the absence of proper mental health funding is not a new phenomenon. I happen to --

Mr. Ruiz. I agree with that.

Mr. Tilley. -- in my private life, be associated with a mental health center as a -- as general counsel. And I happen to know that, since the late 1990s, we haven't had an increase in those reimbursement rates. And that -- that is an issue, and that has existed for some time. And so I don't think that's a recent phenomenon. That's all I would add.

Mr. Murphy. No. I -- and that's why I want to amplify what he's saying, that when everybody looks at mental health funding

gets cut or doesn't get increased, if actually increases costs overall for healthcare. So --

Mr. Carter, you're recognized for 5 minutes.

Mr. Carter. Thank you, Mr. Chairman. I want to thank all of you for being here on such an important subject. And I want to express my dismay and my discouragement at some of my colleagues who have used this as a platform, if you will, for political messages about cuts in Medicaid, et cetera. I mean, we all understand. It is established this is an epidemic in this country.

As a practicing pharmacist for over 30 years, I have seen firsthand, perhaps more than everyone in here collectively, has seen the impact that this has had. At no time have I ever asked a patient or thought in any way is this a Republican or a Democrat or Independent. It's someone who's struggling. That's all there is to it. This is a nonpartisan problem, and I just frustrated by that.

Governor Rutherford, you said something earlier that I'm a little bit confused about. You were talking about the prescription drug monitoring program in the State of Maryland. Did you say that methadone is not on it?

Mr. Rutherford. Well, no. What I was saying is that if you're monitoring -- if you go to the prescription drug monitoring

program, or the database, you will not see that a person has been prescribed methadone, that they're in methadone treatment. So --

Mr. Carter. Why is that?

Mr. Rutherford. There are privacy restrictions associated with drug treatment. And so this was in place prior to our developing these prescription drug monitoring programs. There are different barriers to getting information, be it mental health information or drug treatment and, in some cases, healthcare, that there are walls --

Mr. Carter. Is that something we can help you with, legislatively, here?

Mr. Rutherford. I think that's what we talked about, that that would be very helpful, because a practitioner would not know that someone that they're prescribing an opioid is -- already has a problem associated with opioids.

Mr. Carter. Okay. When I was in the State senate in Georgia, I sponsored legislation that created our prescription monitoring program. And I can tell you, it has been improved since I left. In fact, July 4th -- or, excuse me -- July 1st of this year, just last week, we -- or two weeks ago -- we started 24-hour reporting. Before that, we were reporting every week. Now, we're not in realtime yet, but we're getting there. We're making very good progress there.

I want to know, in the prescription drug monitoring programs within your States -- and, Secretary Tilley, I'll tell you. I've worked closely with the Kentucky Board of Pharmacy and with the Kentucky Pharmacists Association -- very strong. Very strong programs there. And I compliment you on that.

But in your experiences with the prescription drug monitoring program, are you sharing information across State lines?

Mr. Tilley. We are. I think we have 7 border States. Very unique in that regard. I think the only State in which we don't at this moment is Missouri. I think that be to the case now.

Mr. Carter. Yeah. Missouri struggled. They were the last one to add it on, the PDMP.

Mr. Tilley. We are working on that. And, again, I'd be happy to supplement the record to confirm that answer for you. But I do believe we are sharing with six of those seven States that board us.

Mr. Carter. Okay. Secretary Moran, what about Virginia? What are you all doing?

Mr. Moran. Thank you. And I think this is an area where Congress could investigate. We have 21 States. And our neighbor to the South, North Carolina, we do not share information. So if there's a -- we would request some help to better share data across state lines.

Mr. Carter. Right.

Mr. Moran. But 21 -- most of our neighbors are not North Carolina. So we would look for some more relief there.

Mr. Carter. Yeah. In the State of Georgia, we're sharing with South Carolina, Alabama, North Dakota, and someone else way out West. I will tell you, in my over 30 years of practicing pharmacy, I never filled a prescription for North Dakota, for a C2 prescription. I know you find that hard to believe, but -- I mean, it's useful, but -- anyway. It would have been more useful if I could have seen it from Florida. Being in that area, in Savannah, where we're only 2 hours away, it would have been extremely useful for the State of Florida, and hopefully we can get to that points.

I want to ask you, Secretary Tilley, about a program that I thought was pretty interesting that was a result of 21st century cures, and that was the peer recovery specialist and emergency departments in Kentucky. Can you elaborate that -- on that just a minute?

Mr. Tilley. The expert is sitting to my left. We actually had a chance.

Mr. Carter. Right.

Mr. Tilley. And again, I, applaud the work in Rhode Island. We actually had sort of a model that didn't really meet the goals

that we wanted. It was not up to par from previous legislation. We looked at what Rhode Island was doing. We had tried the same thing they did. We just didn't do it as well. I think we're on the path to doing it now. And I think we're fairly ambitious with trying to do both at once.

The peer recovery coaches or specialists in our ERs and also doing the bridge clinics as well to try to keep people there in treatment until we can get them to treatment, maybe outpatient or some kind of other bed outside that hospital. And so I think what they're doing in Rhode Island is certainly a model for the country. And that's -- we're emulating them directly.

Mr. Carter. Great. And I know you are doing great work, Director Boss. And I apologize. I didn't get to you. I got 15 seconds. I just want to add one thing from a pharmacist's perspective. One of the things that we didn't cure was to allow states to implement laws on C2 prescriptions on how much can be filled and whether pharmacists can fill partial quantities. That will help.

You know, we can throw money at this all day long. But we need to be smart. If we're smart and we do practical, rational things, like limiting -- I mean, I got so many prescriptions from a dentist for a 30-day supply of OxyContin. I mean, you know, they take one or two, and then the rest of them are in the

medicine cabinet. That is not being smart. If we can have a partial refill, if States can do that as a result of 21st Century -- or -- excuse me -- as a result of CARA, that's something we need to look at implementing as well.

Thank you, all. My time is out, and I yield back.

Mr. Murphy. Mr. Carter, will you yield for a question?

Mr. Carter. Yes.

Mr. Murphy. When you refer to partial refill, you mean allowing the pharmacist to only give a partial fill at the onset, and then the person could come back and get the rest? Is that what you're referring to?

Mr. Carter. That is exactly right.

Mr. Murphy. So not the position for prescribing partially, but you would have that option?

Mr. Carter. That is one of the options that CARA allowed us to do. I would take it even further. And -- and I've been in talks. My office has been in talks with the DEA about allowing maybe a refill on a C2 for a three-day supply. You know, that -- because a lot of physicians are concerned that the patient's going to run out over the weekend, they're going to be bothered, or they're not going to be available and they're going to go without. And that's a real concern. And I understand that.

But at the same time, again, if we'll just be smart,

if -- you know, allowing them to maybe call in one refill over the phone as long as it's limited to a short-day display.

Mr. Murphy. Thank you.

Mr. Carter. Thank you, Mr. Chairman.

Mr. Murphy. Mr. Pallone, you're recognized for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

I just -- Director Boss, I just -- I wanted to ask you the questions. And I want to go back to the issue of Medicaid, because, as you know, the Republicans are still trying to repeal the ACA's Medicaid expansion and making a lot of changes to the program.

So what role has Medicaid played in Rhode Island's effort to provide medication-assisted treatment in your State?

Ms. Boss. Medication-assisted treatment is covered by Medicaid for both the disabled and the expansion populations. All Medicaid-covered individuals are able to receive all three forms of FDA-approved medications for opioid use disorders. The director of Medicaid is a member of our opioid task force and has been active in working with the managed care organizations that manage our Medicaid product to do things like remove prior authorizations for medication-assisted treatment. It is fully funded through our Medicaid program.

Mr. Pallone. All right. Now, my colleagues on the other

side of the aisle often characterize the Medicaid program as inflexible for States. You know, we hear that a lot, that it's inflexible. To the contrary, though, I think Medicaid has provided for a great deal of innovation in how States have responded to the opioid crisis. So could you please tell us about the health home program in your State and how Medicaid granted Rhode Island the flexibility to develop its own person-centered care opioid treatment program?

Ms. Boss. So there are probably two innovations, and the OTP health home would be one of them where we worked with the Medicaid office for a period of 18 months to develop the comprehensive care management function for opioid treatment programs to provide to their clients in addressing physical health issues as well as their addiction issues. And the process with Medicaid was thorough, but it was one that allowed us to use a monthly rate to support the work that was really improving the health care of individuals in opioid use disorder.

And we know that people who have opioid use disorders often have comorbid conditions, don't necessarily have the greatest access to care in the community. And the health homes allow those programs, which have the greatest access to individuals, to provide nursing support. They're overseen by physicians. They have case management that help them get to the needed

appointments, dental appointments. And Medicaid has been supporting those efforts with an understanding that improving those outcomes will improve outcomes overall and reduce cost.

The Centers of Excellence are also a Medicaid innovation where we allow people to be seen very quickly. And it's the issue. You need to have that access to treatment, which was noted. A person seen in the emergency room needs to be able to follow through and get access to treatment in order for anything to be effective.

Centers of Excellence exist as a Medicaid innovation allowing people access to treatment, all FDA-approved medications, again, within 72 hours, and have intensive services provided in the 6 months of treatment supported by a Medicaid rate with as much treatment in case management and recovery supports as the individual needs with the intention to move that individual into the community once stabilized and continue to provide the clinical and recovery supports needed again through a Medicaid-supported invasion.

Mr. Pallone. I mean, obviously, my concern is that, in States most heavily impacted by the opioid epidemic, if you have cuts to Medicaid that that may lead to cuts in addiction treatment and exacerbate the process.

So -- I have a minute left. Let me ask you: Would you agree

that deep cuts to addiction services that might result from the Senate TrumpCare bill, for example, that if -- that -- you know, if States decided because of the cuts in the Senate TrumpCare bill, that those kinds of cuts to addiction treatment would have a drastic impact on our ability to fight this epidemic?

Ms. Boss. Our recovery -- our overdose strategy engages 4 different components, and three of the four would be effected if Medicaid were not available to support. The access to naloxone, again, is supported by Medicaid. Medicaid covers naloxone for individuals. The treatment component is, again, supported by Medicaid, our Centers of Excellence, as well as -- all of the treatment components have that as well.

And the ability for recovery coaches to be funded if not for the treatment being covered by Medicaid, our substance abuse block grant dollars would have to be redirected from those recovery efforts to support individuals in treatment.

Mr. Pallone. All right. Thank you so much.

Thank you, Mr. Chairman.

Mr. Murphy. Mrs. Brooks, you're recognized for 5 minutes.

Mrs. Brooks. Thank you.

Director Boss, I want to clarify something that -- that my colleague, Congressman Walberg, asked you previously. You talked about a data gap with respect to fentanyl in law

enforcement. -- with respect to law enforcement data. In your written testimony, you've talked about hospital systems are testing for fentanyl, but we do not yet know the frequency of testing or how many tests are returning positive for fentanyl.

And so I just want to clarify and make sure. So the gap -- the gap in collection on data for fentanyl exists in law enforcement and hospitals as well. Is that correct?

Ms. Boss. So the testing for fentanyl in the hospitals is fairly new, and so we are not sure how complete the data is. They do have the ability. And whether or not all the hospitals are testing or not, I'm not exactly sure. And I think it's really, for the most part, an issue of timeliness.

To be able to respond effectively, we need to have access to timely data and making sure that, if testing occurs, that we're able to get the results quickly and in enough time to respond to a community that may be seeing an increase in fentanyl.

Mrs. Brooks. And I guess I'd ask the others on the panel whether or not you know if your hospitals are gathering data on fentanyl specifically and the frequency and so forth.

Yes, Lieutenant Governor.

Mr. Rutherford. I can't speak directly for the hospitals. I know that, through our medical examiner's office, through our emergency first responders, that they get information with regard

to fentanyl usage. A little more than 60 percent of our fatalities, overdose fatalities, on opiates, are related to fentanyl. In most cases, it's a mixture with -- with something else, cocaine or heroine. But we're getting most of our information from the law enforcement and emergency responders.

Mrs. Brooks. I want to just talk a little bit more specifically about the criminal justice system and would like to ask you, Secretary Tilley, the CORE program that you mentioned, that is specific to the criminal justice system in Kentucky, isn't it?

Mr. Tilley. Actually, it is -- it brings in all stakeholders, even education.

Mrs. Brooks. Okay.

Mr. Tilley. The Cabinet for Health and Family Services, our CORE system, certainly many -- all elements of the criminal justice system but any element affected by the opioid scourge is present on that particular effort.

Mrs. Brooks. I'd like to find out from you, and briefly, your States' efforts, because, obviously, when a person is incarcerated, which many family members said that saves their lives. It's sad and we want them to be diverted, and we obviously do want to focus on high level. I'm a former U.S. Attorney. So we want to focus on the mid and high level dealers and those who

were exposing people with addictions. However, at times we have a captive audience of participants in treatment.

And can you talk a bit more about medication-assisted treatment in your facilities and then counseling? Is there drug testing that is part of your incarcerated population, juveniles and adults?

Mr. Tilley. I'll start with adults. Again, counseling is required with any medically assisted treatment we do. Again, I described earlier in my testimony I think a pretty innovative program where we assessed, through a risk needs assessment, those who would need an injection of naltrexone, or more commonly called Vivitrol, prior to their release as a stabilization mechanism. They also get a release -- excuse me. Upon release, get another injection, and then they are matched with a counselor and a peer recovery coach to try to find the necessary resources to continue that treatment, whatever it may be and whatever source it may come from.

In our juvenile setting, we do not have medically assisted treatment at this time. However, we in Kentucky thankfully have a record low in terms of our juvenile detention population at the moment. And that doesn't seem to be near the issue in our facilities, although we do offer that treatment in the facilities, just not medically assisted at this time. And the same way you

would see it in the corrections setting.

One thing that's very unique about Kentucky, and one thing that was not maybe reflected in the New York Times article about that treatment is that Kentucky houses roughly half of its State inmate population in county jails. We have 83 full-service county jails that do that. And that presents some challenges. But we expanding and incentivizing that kind of treatment, that kind of medically assisted treatment, like you may have read about in Kenton County, which is part of the Greater Cincinnati, Northern Kentucky area there. And I think -- I would also add that -- the piece about incarceration.

We are trying to use elements like involuntary commitment. -- we call it Casey's law in Kentucky -- to try to maybe bypass the need for incarceration for those individuals, again, who stand out to their family as someone who needs a forceful hand, maybe a judge's contempt power to keep them in treatment.

Mrs. Brooks. I will be submitting questions, for the record, for each of your States, because I'm interested in knowing more, and my time is up, on medically assisted treatment as well as counseling and what you're doing with your inmate population. And I know you're each doing something but would love to learn more about it.

And I want to thank you all for cooperating with each other and learning from each other. Critically important.

I yield back.

Mr. Murphy. The gentlelady yields back. Recognize Mr. Costello for 5 minutes.

Mr. Costello. Thank you, Mr. Chairman.

Some of you may know the chairman and I both hail from Pennsylvania. The chairman from the Western part of the State. Myself from the Eastern part of the State. And sometimes people think they're two different States. But having said that, in Pennsylvania, the epidemic is particularly acute. And just a few brief comments about what we're doing in Pennsylvania. And then Lieutenant Governor Rutherford, I had a couple of questions for you.

With the enactment of the 21st Century Cures Act, Pennsylvania received 26.5 million dollars in Federal funding to address the epidemic, 3.5 million for drug courts, 23 million being funded to expand access to medication assisted treatment, increase training opportunities to better connect individuals with additional treatment when they visit an emergency room as a result of an overdose and also to improve access to opioid use disorder treatment under -- for uninsured individuals.

And Lieutenant Governor Rutherford, you spoke about

establishing a 24-hour stabilization center in Baltimore city. I would to ask you about that. What services will be provided at the facility? Why do you think it is better suited to have such a facility to treat substance abuse issues rather than in emergency departments? And then, maybe depending upon your answer, I'll have some follow-up questions off that.

Mr. Rutherford. Well, the concept of the stabilization center is a place where both first responders supports as well as law enforcement or family members can take a person who is suffering from substance abuse disorder and they may be ready for some type of treatment. And the idea is to bring them into a locale, not necessarily an emergency room because that is a very high cost approach to addressing this challenge where they can be stabilized and get them into longer-term treatment.

So it's an opportunity to get that person, as I mentioned, stabilized. They could reside there for a few days before we -- if there's a bed available to get them into treatment.

Mr. Costello. Any similar facilities that you might be modeling this off of?

Mr. Rutherford. I believe San Antonio has something similar. I'd have to get more information and talk to my staff. I believe it was San Antonio that I believe was doing something very similar to this.

Mr. Costello. Once stabilized, will the patients then be moved into evidence-based treatment and counseling?

Mr. Rutherford. That -- that is the objective. It hasn't been -- we are not -- we haven't stood this up as yet, and we're working with the city of Baltimore in terms of the parameters and how this is going to actually operate and what the State's oversight role will be with this.

Mr. Costello. Is the hope that the treatment and counseling -- and you said that's your hope -- that the funding that you will be utilizing for the facility itself -- will that funding extended to the treatment and counseling, or are you looking at the facility to just be sort of on the front end?

Mr. Rutherford. The facility is on the front end. We will look to the other funding sources, be it through the Cure Act, through State revenue, through insurance, through Medicaid to pick up the treatment aspects of the challenge.

Mr. Costello. Can you describe some of the challenges that your State currently faces to provide beds in a timely manner for individuals seeking treatment for substance abuse?

Mr. Rutherford. Well, the lifting of the restriction with regard to Medicaid reimbursement on the number of beds in a facility has helped that particular challenge, because we did have situations where we had individuals who would receive treatment

through Medicaid, and we have beds available in some of our facilities, but we could not utilize those. That has helped.

We are working to expand the capabilities, particularly for some of the nonprofits that have services and are providing services and seeing what we can do to assist them in expanding their access. We have close to 800 facilities around the state. There is always a discussion about getting additional beds and capacity, and so we're working on those things as well.

Mr. Costello. Thank you.

My general comment on this epidemic is oriented towards the following. I think there are a lot of variables that contribute to this. I think everyone knows that. I get concerned when we point to one particular actor in this Eco system and say that's the problem, because it is manifold. It is complex. And I think what concerns me more than anything is that the life cycle of treatment is much longer than the infrastructure that has been set up to deal with it.

And as a consequence of that, no matter how good we might be in the first six innings of this, if we're not good in innings seven, eight, and nine, it's not going to ultimately matter. And we're really just embedding more cost into the system by front-loading some of the cost without really acknowledging that, on the back end, if we don't finish it off with the right kinds of

treatment and the right kinds of counseling -- right type of counseling and the right kind of follow-up off that, we will not ultimately be able to drive down the epidemic.

I think we have all -- can identify what some of the front-end issues are here, but that would be something I'd just like to submit to the record.

And, Mr. Chairman, I see I'm well over my time.

Mr. Murphy. Thank you.

Mr. Rutherford. Can I respond just --

Mr. Murphy. Yes.

Mr. Rutherford. -- very briefly.

You're absolutely right. And some of the thought process behind the crisis center is it's a front end. You're right. It's a front end of where the person comes in the door, they're in distress at that point, stabilizing them, getting them into treatment. But even after the treatment, one of the things we've heard over and over again from people who have relapsed is they come out of treatment and they go back into the same community, the same stimuli, the same issues that they had before.

And one of the areas that we're focusing on going forward, including utilizing the Cure Act funding and State funding, is transitional housing. For lack of a better word, you can call it a halfway house -- but transitional housing where a person can go

and continue to get treatment in terms of the counseling aspects of it. But during the day, they can go to work, they can do the things that they need to do, but they have to report back to this facility. And people have said that that is something they need before they go back into the unrestricted society, because all the stimuli is still there.

Mr. Costello. Yeah. Thank you much.

Thank you, Mr. Costello.

It's the policy of this committee to let other members of Energy and Commerce who are not on this subcommittee to ask questions. Mr. Bilirakis You're recognized for 5 minutes.

Mr. Bilirakis. Thank you so very much. And thank you for allowing me to sit in on the hearing. I appreciate it, Mr. Chairman.

Well, I have some prepared questions. But does anyone else want to elaborate on that? Any other suggestions as far as a long-term, the back end? Is there anyone on the panel that would like to talk about that? You mentioned -- and you're so correct -- the transitional housing. And, you know, cooperation, obviously, is so very important. The patient needs to cooperate and voluntarily, in most cases. Is there anyone that wants to make another comment before I get started?

Ms. Boss. If I could, I would add --

Mr. Bilirakis. Yeah.

Ms. Boss. The front door is very important, because, you know, access to care -- oftentimes, you'll hear families saying, "I don't know where to turn for help." And we're looking at a crisis center model as well. And I think that's critically important. You don't know which number to call. You've got a family or loved one, and you're not sure how to connect them.

But then the connection to treatment is critically important as well. It's like someone with hypertension going to the emergency room and getting a pill but not getting a prescription. It's not going to help.

And so without the access to care and the kind of supports needed -- so recovery housing is critical as well. And in part of our Cures Act funding, we are looking to establish that kind of transitional housing for individuals who are not able to return to their communities. We really need to look at the long-term and treating addiction as a chronic disease not through acute episodes.

So I think that the approach to long-term and looking at the long-term needed supports are critically important as well.

Mr. Bilirakis. Thank you.

With regard to Florida, in 2010, in response to the opioid crisis in Florida, the pill mill problem -- I think you probably

know about that. Florida's legislature enacted a Statewide tracking of painkiller prescription coupled with law enforcement using drug-trafficking laws to prosecute providers caught overprescribing. Within three years, Florida saw a decrease of more than 20 percent in overdose deaths, and I want to give Pam Bondi, the attorney general, and others credit for this.

But now the rise in the fentanyl and its various derivatives have presented new challenges to the State of Florida and other States as well. However, we remain optimistic with recent legislative initiatives in Florida.

These include requiring doctors to log prescriptions in a Statewide painkiller database by the end of the next day. I think that's important, to curb the so-called doctor shopping and setting aside state-sponsored medication that can help reduce opioid dependency. So we're working on it.

But during the August recess, I want to meet with stakeholders or -- and conduct roundtables with regard to this issue.

Do you have any suggestions for me? What has succeeded? Obviously, sir, you talked about the Baltimore model, and I think that's very important. Are there any other innovative ideas or legislative initiatives that you would recommend for my State of Florida? Anyone on the panel, please.

Mr. Tilley. I just might start by adding that one thing I wanted to convey to the panel, and I know you're very well aware of the STOP Act and this issue of keeping fentanyl and carfentanil out of our country where it's manufactured legally, sometimes illegally, and still shipped in and mailed into our country.

The DEA recently informed us that the profit margin for these cartels that bring fentanyl in, for a $6,000 investment, to make that more of a heroin-type substance, is about a $1.6 million profit. To do it in pill form, just to press it into a pill, is a $6 million profit. And so with that kind of -- again, the cartels -- that kind of profit margin out there for their taking, it's very difficult to combat this if we're flooded with it with impunity. We've got to figure out ways to stop it from coming into our country in the first place.

And I think that would be -- again, that's not necessarily Florida specific, but I think this idea that's contained in the STOP Act -- and I won't comment on the specifics, but I understand that would again curtail some of that.

Mr. Bilirakis. Does anyone else? Please.

Ms. Boss. If I could, fentanyl is changing the face of this epidemic, and we need to respond in our interventions. And one of the things that I would comment on is that this is a marathon, not a sprint. And we really need to take a look at prevention efforts

as critical to changing the face of this epidemic and not cutting -- not cutting our efforts in prevention. Primary prevention, working with transitional-aged youth. If we can stop their use before they use, we're not going to have them dying with fentanyl.

I think we need more research. You know, recently, we haven't had any new medications. We haven't had any new treatment models necessarily proposed for opioid-use disorders. And I'm not sure enough effort has been placed into the research needs of this epidemic. And we need to start looking at this as we would, you know, the focus on cancer.

This is an epidemic. We need research that's going to support the most evidence-based models that are effective in treating this.

RPTR FORADORI

EDTR HUMKE

[12:03 p.m.]

Mr. Bilirakis. Thank you very much, I agree.

I yield back, Mr. Chairman. Thank you for allowing me to ask questions.

Mr. Murphy. Thank you Mr. Bilirakis.

I recognize Ms. DeGette for followup.

Ms. DeGette. I just really want to commend all of your States for leaning in, for moving forward on this, and for trying to find robust solutions. It's really important that we do that. And I know almost all the States are doing this. My State of Colorado has also started really paying attention. It's the kind of thing where it crept up on us collectively as a society, and so people have had to -- people have had to move really fast. And I just want to commend you.

And I also want to reiterate that we're very flattered. I, personally, am very flattered that you're taking this 21st Century Cures money and really making something with it and developing some programs that are uniquely and appropriately tailored to your States. Sometimes when we're in Congress, we wonder if anything we do actually impacts people's lives? And when I hear what

you're doing, it's really gratifying and I think it will save lives.

I do -- I hate to sound like a downer, though, but to say that this 21st Century Cures money, which was $2 billion, it's really well used I think by the States with these grants to develop programs, but $2 billion is nothing. As Governor Kasich said, $45 billion. If you're trying to substitute the Medicaid expansion money and other treatment monies that are coming, you can't use the money for that.

We have to make opioid treatment and prevention part of our overall mental and physical healthcare in this country. And what that does take, and I'm sorry that Mr. Carter left, because we're not trying to politicize this. What we're trying to say is, if you really want to give treatment to people, you have to develop the programs, which is what something like the Cures money is good for. But then you have to be able to implement them.

You have to be able to give the counseling to people. You have to be able to give the MAT treatment to people. You have to be able to build and maintain these housing options that people were just talking about. You don't do that just with fairy dust. You have to do that with resources. And some of the resources can come from the States, but the States are jammed. And so that's why the Medicaid expansion has helped so many millions of

Americans be able to get access to the treatment that they need, and that's why we need to be able to keep that for these populations.

So I want you to know that -- and, you know, it's not that we really disagree on that either. Mr. Murphy and I agree on a lot of these issues, he just can't say it as forcefully as I can sometimes. But we know that we need to make sure that all Americans can get this treatment. And we will commit to you that we are going to continue to work with the States to make that happen.

Thank you.

Mr. Murphy. Thank you.

I have a few questions I want to follow up on. This goes in the category of coverage without access is a problem. As access to -- without -- excuse me. Coverage without access and access without coverage are both problems. To this extent, I want to make a note or put in the record, and ask unanimous consent.

One is an article why taking morphine and OxyContin can sometimes make pain worse from Science Magazine. And another one is an article that 51 percent of opioid prescriptions go to people with depression and other mood disorders, from Stanton News. I'll let you see that if --

Ms. DeGette. I don't have an objection.

Mr. Murphy. There's no objection, it will go in the record.

**This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.**

[The information follows:]

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

Mr. Murphy. But I want to make reference to a couple of those things. There are about 50 million Americans with low back pain, 25 million of those take an opioid. When a person has pain and depression, about 40 percent of them are 300 to 400 times -- percent -- excuse me, 300 to 400 percent, the risk of abuse, misuse or addiction, noting that when we're dealing with people with addiction disorders and 80 percent of them begin with a prescription for pain, but mood disorders are a big, big part of this. Fifty-one percent of people on opioids have a mood disorder, anxiety, depression or something else.

And I don't know if any of your States ask physicians to screen for that when they are prescribing. I would imagine not, because I think in most States they don't. Do any of you know if your State's medical society or hospitals ask to screen? When you're prescribing a medication for pain, do you also screen for depression, anxiety, anything like that? Do any of your States -- if you don't know, just tell me you don't know.

Mr. Rutherford. I don't know, but I believe that it's not available in the prescription drug monitoring program either.

Mr. Murphy. Oh, okay. Secretary Moran, do you know if you do that in Virginia.

Mr. Moran. My counterpart, he's a doctor, and the medical community was using the chart, and say, 0 to 10, smiley face. We

were addressing pain and we overprescribed. I'm not aware, to answer your particular question, I'm not aware of whether or not we --

Mr. Murphy. Yes. Those emojis are not to do with mood, they're to do with pain. I find it amazing that the other vital signs, blood pressure we measure. Temperature, we have an instrument for that. Respiration. All these are measured, but when it comes to pain, 1 to 10 or an emoji is pretty primitive.

Mr. Moran. We are mandating now 2 hours of continuing education in the medical community to address pain. I mean, it starts in the medical community with better education around how we manage pain.

Mr. Murphy. As far as you know, it doesn't also include assessing a mood disorders. I know there's a -- I've seen this take place where they actually assess it, and there's a big difference. Secretary Tilley, do you know, or Director Boss, do you know if in your States there's any requirement to also concurrently assess patients for mood disorders when prescribing these?

Mr. Tilley. Not specifically, but I did mention the limit to the 3-day supply for acute pain, which again, I think presents a bit of a pause for the physician before that prescription. Also, I did not get a chance to mention the University of Kentucky is

piloting a program, our flagship institution piloting a program there, to start with everything but an opioid in the course of treatment and try to taper -- instead of starting with and tapering down, starting without and maybe moving toward it if it's absolutely necessary.

And then, lastly, I would say we are embarking to your question. We actually are embarking on that very thing potentially with a Statewide mental health approach as to a number of best practices across there, and that's one of the things we've discussed.

Mr. Murphy. Thank you. Director Boss do you know if you evaluate --

Ms. Boss. I can't speak as to whether or not it's required. I can say that the State has had major efforts towards behavioral health integration and primary care. And I know that a lot of our collaboratives and a lot of our -- asking primary care settings, and most large primary care settings are screening for mood disorders as well as anxiety.

Mr. Murphy. I would bet during the time when someone is in the emergency room, the chance of someone actually getting a screen for that is probably pretty close to zero. And just as we have the problems of 42 CFR, a doctor doesn't know if the is on methadone with a prescription or monitoring program. They don't

know if they are on these medications. It's usually patch them up, get them out.

I know when I was prescribed a lot of fentanyl and other opiates when I had an injury in Iraq, nobody ever asked me about any other questions, just, take these, take these, take these. And I ended up with my own issues there, which I didn't get an addiction, but my body developed a dependency upon those. And when I finally said enough is enough, and I had the fun on my own, a mild withdrawal reaction. It was not pleasant at all. But going with --

Director Boss, you mentioned 82 percent of people get a referral in the emergency room by talking with, I guess, the peers support or a counselor there. Do you know how many of that 82 percent actually follow up and follow up consistently in an evidence based program?

Ms. Boss. We don't -- we are not able to measure where the 82 percent go. And so 82 percent, not just are referred, but are connected and do follow through with treatment and recovery supports.

Mr. Murphy. We don't know what the follow up is afterwards?

Ms. Boss. Right.

Mr. Murphy. That's important to me. So we've identified a few things here such as we have a crisis shortage of providers.

We all agree with that, across the Nation, especially in rural areas. Quite frankly, in urban areas, too, if you assess providers, and say, how many of you actually have openings in your schedule, you'll see that they don't. I know in my areas, for example, child and adolescent providers are even more rare, and some say, I just don't have any appointments open for months. And when you're dealing with a substance abuse disorder, I need treatment now. Now is the best time for treatment. Giving them a waiting list is not helpful at all.

So even when we do refer people over, I mean, the statistic I see is of the 27 million people in this county with an addiction disorder, 1 percent get evidence based care. So if you look at this, about 90 percent of the people with a substance abuse disorder don't seek attention. So out of every 1000, 900 don't seek attention.

Out of the 100 that do seek attention, 37.5 can't find it, it's not available. Of those who do get it, get attention, 90 percent of those don't get evidence based care. So we have a crisis that's getting worse. And I might add, too, I think, Virginia, you're the only State that doesn't have Medicaid expansion right?

Mr. Moran. We do not.

Mr. Murphy. You do not. But in this time period of which it

was available, I would assume that your addiction rate, your overdose and death rates have climbed, correct?

Mr. Moran. They have.

Mr. Murphy. And in the States that do have Medicaid expansion, Maryland, Kentucky, Rhode Island, has your overdose and death rates also climbed?

Mr. Rutherford. Oh, yes. Yes, sir.

Ms. Boss. Ours have raised but not sa significantly as other States have experienced in these last few years.

Mr. Murphy. Yea, but -- I want to help, but we need honest data here. I mean look, we don't even have information on if those numbers are accurate, because if your medical examiners and coroners are not doing toxicology tests, and if we don't even have data for 2016, and we won't have it until the end of this year. We just don't know.

And what this committee likes to do is identify. We need the absolute, honest, bare bone problems. And if you tell us, look, we don't know, this is probably much worse. We don't have enough providers. We had legislation, some of it was reduced down and I want to see it reenacted, where we could do more to get more psychiatrists, psychologists, clinical social workers, and licensed addiction counselors out there.

We're probably going to have to do things with the States and

Federal Government providing scholarships or pay for their internships or something to get them out there, because who would want to go into a field that pays so little and the frustration is so high. You're 24/7 on call. You're probably going to get called into court and testimony, a lot of different problems. And that itself could be, it only requires the best who have true altruism in their blood to help fight that. But we've got to do it.

I also want to ask a question, too, with regard to getting drugs back to someone who is not using. I know even realtors now say when you're putting a home up for sale the first thing you should do is go to your medicine cabinet and clean it out. I know there are some products, even in rural areas, some places will have drug recovery programs, you take it to the pharmacist or you take it to the police. There are some products -- someone product called Deterra, which actually -- a drug deactivation system where you can use in your home and then throw it away. Who has -- Virginia, you have programs where you do drug recovery at home?

Mr. Moran. We do, sir. And we are using those. And I would congratulate our private sector partners pharmacies have collection boxes now. And I will tell you, DEA does a terrific job. In fact, they were going to suspend their take-back program,

and we included -- when I heard that we included DEA on our task force -- governor's task force -- and now they continue their robust take-back program. Tons of drugs, it's amazing, I've witnessed it myself, how much. And improper disposal in the medicine cabinets.

As the father of 2 children, teenagers, it's imperative that we keep the drugs out of that medicine cabinet because we've heard from anecdotal stories, that's where the addiction begins. Kids using it our of their medicine cabinets.

Mr. Murphy. They go into homes for a party and the next thing you know --

Mr. Moran. Exactly, sir.

Mr. Murphy. I want to thank this panel. We have a long way to go. And, unfortunately, at this point we're seeing the battles in the States to combat, but I think we have to be honest and say we have a long way to go in this war, it's still quite a crisis here.

I'm looking for my -- and this committee will continue to take this up on lots of different ways, because it isn't just a matter of funding. What good is funding if you haven't got a provider? What good is some of the jail treatment program if a person discharged from jail and they're now back on Medicaid, so they go right back to the streets, right back to somewhere where

they had problems before. I here someone will work in certain professions where everybody -- a lot of the people in the back rooms also have addiction problems and get reexposed. We have an awful, awful mess in this country, and the outcome is a death rate that is mortifying.

So I thank the panel here and I thank the members for being in today's hearing. And I remind members, they have 10 business days to submit questions for the record, and ask the witnesses to all agree to respond promptly to the questions.

Thank you for your honest approaches. Keep fighting the good fight. Thank you.

Mr. Moran. Thank you, Chairman.

Ms. Boss. Thank you.

[Whereupon, at 12:16 p.m., the subcommittee was adjourned.]