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COMBATING AN EPIDEMIC: LEGISLATION TO HELP PATIENTS WITH SUBSTANCE USE DISORDERS

TUESDAY, MARCH 3, 2020

House of Representatives

Subcommittee on Health

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. Anna G. Eshoo [chairwoman of the subcommittee] presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Welch, Ruiz, Dingell, Kuster, Kelly, Blunt Rochester, Pallone (ex officio), Burgess, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Gianforte, and

Walden (ex officio).

Also Present: Representatives Tonko, Johnson, and Soto.

Staff present: Joe Banez, Professional Staff Member; Jeff Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Una Lee, Chief Health Counsel; Meghan Mullon, Policy Analyst; Joe Orlando, Staff Assistant; Rebecca Tomilchik, Staff Assistant; Kimberlee Trzeciak, Senior Health Policy Advisor; Rick Van Buren, Health Counsel; Madison Wendell, Intern; C.J. Young, Press Secretary; S.K. Bowen, Minority Press Secretary; William Clutterbuck, Minority Staff Assistant; Caleb Graff, Minority Professional Staff Member, Health; Tyler Greenberg, Minority Staff Assistant; Peter Kielty, Minority General Counsel; James Paluskiewicz, Minority Chief Counsel, Health; Kristin Seum, Minority Counsel, Health; and Kristen Shatynski, Minority Professional Staff Member, Health.

Ms. Eshoo. Good morning, everyone. The Subcommittee on Health will now come to order. The chair now recognizes herself for five minutes for an opening statement.

According to recently reported CDC data in 2018, 67,000 Americans died of a drug overdose. Overdoses in 2018 killed more Americans than those lost in the Vietnam War.

So this is a national crisis. In 2016, Congress passed the 21st Century Cures Act and CARA, and in 2018 the SUPPORT Act was signed into law to stem the tide of addiction and devastation that the opioid crisis has created.

Yet, despite our legislative efforts to give Medicaid more flexibility and increase access to medication-assisted treatment, or MAT, according to a 2019 National Academies of Science report more than 80 percent of the 2 million people with opioid use disorder are not receiving MAT and families and children affected by the opioids crisis also are not receiving the care they need. We will learn more about why during our questions and answered.

I think it is painfully clear that much more work needs to be done. But we also need to know how the administration is carrying out responsibilities that the Congress gave to them in carrying out the laws that we created. We will learn about where and why previous efforts have fallen short. We will grapple with

what is needed to truly end these overdoses. Our next steps will require overcoming stigma and they will require spending money.

From 1999 to 2018, more than 750,000 Americans died from an overdose and we all have to ask ourselves the question are we willing to do what is needed to be done to avoid another near million deaths.

Among the 14 bills we will discuss today, Representative David Trone and Representative Annie Kuster propose providing $1 billion annually to states and $5 billion annually to federal programs already in place that provide treatment and support prevention activities.

Another part of the solution requires investing in a health care workforce to treat under served areas. Representatives Tonko, Ruiz, Schneider, Brooks, Trahan, who -- -Lori Trojan who I understand -- where is Lori? She is in the audience today. There you are. Thank you very much.

And Andy Kim have bills to create a brand-new health care workforce trained to recognize substance use disorder and are able to prescribe the medication-assisted treatment that we know saves lives.

And it will require spending federal dollars to address the stigma against people in jails and prisons who, despite their sentences, deserve health care. People who are released from

prisons and jail are 12 times more likely to die of an overdose than the general public.

Currently, federal law bars Medicaid recipients from accessing their federal health benefits while incarcerated, so state and local governments face challenges to provide needed medication-assisted treatment to people that are incarcerated.

Bills by Representatives Tonko and Kuster address these inequities by expanding Medicaid coverage during and after incarceration.

And lastly, we will be considering bills from Representative Matsui, McKinley, and Griffith to fight back against suspicious drug orders and diversion to stop the illicit flow of opioids into our communities.

So I look forward to discussing the impact of these 14 bills and the effect they can have and hearing from the federal agencies in charge of implementing our past legislation, which are now the laws.

It is a pleasure now for me to yield my remaining time to Representative Annie Kuster, who has just been a superb leader relative to the opioid epidemic.

Ms. Kuster. Thank you so much, Chairwoman Eshoo, and thank you for scheduling these bills for a hearing.

As founder and co-chair of the bipartisan Congressional

Opioid Task Force, now a hundred members of Congress, this issue is one that impacts Republicans and Democratic districts across this country.

Every community no matter race, region, intergenerational -- in short, this crisis knows no bounds. The complexity of the crisis is urgent and it has devastated communities across my district, and one thing we recognize the solution must be comprehensive. There is no silver bullet. It is a silver buckshot approach.

So that is why I am so pleased to see my bill with Representative McKinley, the Humane Correctional Health Care Act, be included. We need to bring treatment to every part of our community and I look forward to working with you all. It saves lives and I would be shocked for anyone to speak out against innovative solutions to address the root cause of this incredibly high recidivism rates in this country.

Thank you, Chairwoman Eshoo, and I yield back.

Ms. Eshoo. And the gentlewoman yields back.

The chair now recognizes Dr. Burgess, the ranking member of our subcommittee, for his five minutes for an opening statement.

Mr. Burgess. And I thank the chair and I appreciate that we are holding this hearing to continue this subcommittee's

important work on addressing the opioid epidemic in our nation.

Last Congress, we conducted a member-driven process that began in October of 2017 with an Energy and Commerce Committee Member Day and concluded with President Trump signing the SUPPORT Act one year later.

Throughout that process we held four subcommittee hearings, a subcommittee markup, two full committee markups. This process allowed members to hear from relevant stakeholders, offer amendments to improve the legislation under consideration and, perhaps most importantly, allow the public a window into the process.

While I am grateful that we are continuing our work on opioids I still believe it is critical that we have a standalone SUPPORT Act implementation hearing. This committee does important work. We have passed many landmark laws over the last five or 10 years.

But one thing I have learned our job does not stop at the signing ceremony. We must monitor the implementation as it goes through the agency process and be sure that the agencies are implementing the law as Congress intended and we can accomplish that through oversight hearings and implementation hearings.

We need to monitor what is or what is not working, what deadlines the agencies might have missed. I appreciate that we have agency witnesses here today and I promise I will take full

advantage of that.

But I hope we will have a separate implementation hearing soon. I also hope that any future legislative hearings will include some of the outstanding issues such as aligning 42 CFR Part 2 with HIPAA, a bipartisan effort that Representatives Mullin and Blumenauer have championed and passed the House by a vote of 357 to 57 in the last Congress.

The 14 bills before us today cover a broad range of ways to address substance use disorder, from solving problems with suspicious orders to requiring increased levels of education and training.

A number of these have the potential to provide quality assistance to individuals with substance use disorders and to prevent future addiction. As we look at these bills we must be mindful of what we did in the SUPPORT Act to ensure that there are not duplicative provisions or policies that will complicate the implementation of the SUPPORT Act.

I especially appreciate the inclusion of Representative Griffith's H.R. 4812, the Ensuring Compliance Against Drug Diversion Act of 2019, and Representative McKinley's H.R. 3878, the Block, Report, and Suspend Suspicious Shipments Act of 2019.

H.R. 4812, Mr. Griffith's bill, requires that the DEA registrants must obtain written consent from the DEA to assign

or transfer a registration. This is a common sense step to prevent fraud and maintain up-to-date DEA records.

Mr. Griffith's bill, H.R. 3878, builds off the Oversight and Investigations' important work last Congress on opiate pill dumping, particularly in the state of West Virginia. The sharing and reporting of suspicious order data is critical in ensuring we can prevent similar situations in the future.

While I appreciate that the attention of H.R. 2483, the Mainstreaming Addiction Treatment Act of 2019, which is to increase the availability of medication-assisted treatment. We still do not have the reports that were mandated in the last legislation that we passed in the SUPPORT Act as to whether expanding prescribing power under the data waivers has made a meaningful difference.

I understand that access to buprenorphine is important, sometimes limited, especially in rural areas. But we need to make certain that the policies for which we are advocating are effective and we should allow our current laws to be enacted and examined.

I do have concerns with H.R. 3414, the Opiate Workforce Act, as it would require the secretary of the Department of Health and Human Services to establish an additional 1,000 residency positions paid for by the Medicare program for the purpose of

combating the opiate epidemic.

Ensuring an adequate workforce can certainly be part of this discussion. But we need to keep in mind the danger of having a centralized government dictate how many health care professionals we need practicing which specialties. We already have health professional shortages and establishing this new requirement could create shortages in other areas.

While I am grateful we are having the conversation today, the crisis continues to ravage communities across our nation. We have all heard from our constituents who have been affected in one way or another.

I hope we will be able to soon have a standalone SUPPORT Act implementation hearing to do our due diligence in ensuring that the law is having a positive impact on our communities.

Thank you, and I will yield back my time.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the chairman of the full committee, Mr. Pallone, for his five minutes for his opening statement.

The Chairman. Thank you, Madam Chair.

Today, the subcommittee will continue its bipartisan work to combat an ongoing and devastating epidemic involving opioids and substance use.

We all know the statistics. In 2018, over 67,000 Americans died from a drug overdose. Well over half of these deaths involved opioids. There are approximately 20 million Americans living with a substance use disorder while only a fraction are receiving treatment.

This committee has taken action to reverse this trend. We advanced major pieces of legislation through the committee in recent years, including the Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, and the SUPPORT for Patients and Communities Act.

These were important legislative achievements that invested in critical treatment and I look forward to hearing from our witnesses about the implementation of these laws, and what gaps remain to be addressed.

Nationwide, opioid prescribing rates and overdose deaths are decreasing but our work in fighting this epidemic is far from over. There are still a lot of people and communities struggling and we must continue to do more.

We must also address the emergence of synthetic opioids like illicit fentanyl and the rise in deaths attributed to stimulants like cocaine and methamphetamine.

Our first panel of witnesses includes officials from both the Department of Health and Human Services and the Drug

Enforcement Administration. I look forward to hearing more about the progress the administration has made in implementing the SUPPORT Act.

Among some of the key provisions of this law, HHS was charged with providing grant support and guidance to states and other stakeholders, while DEA was charged with issuing telemedicine regulations aimed at helping more patients in areas with doctor shortages, and I hope to drill down on these provisions and many others.

I am concerned that the administration may be falling behind on some of the deadlines in the SUPPORT Act and I want to understand why that is happening.

Our second panel includes experts on the ground of this epidemic, all of which are working to turn the tide for Americans across this country.

I look forward to hearing testimony about the impact that recent federal funding and policy changes are having and what more we can do. I thank all of our witnesses for their ongoing dedication.

As I said, when all the prior substance use packages passed out of this committee, we have made progress, but our work is far from complete. So today, we will be considering 14 pieces of legislation aimed at providing more help and more resources

to those still struggling across the country.

Some of these policies were Democratic priorities that were not included in the SUPPORT Act but that we continue to feel are critical to effectively responding to this national epidemic. Others are new ideas to address new and emerging problems that my colleagues on both sides of the aisle have identified.

The unique jurisdiction of this subcommittee spans the work of both HHS and DEA, which allows us to approach this problem from multiple angles. That said, it is critical that we look at substance use disorder as a complex but treatable disease of the brain.

Whether an individual has a substance use disorder in a hospital or within a criminal justice setting, they are a patient and we must address this epidemic as the true public health crisis that it is.

Many of the bipartisan bills we will be discussing today take this public health approach. This includes proposals to address the need for more addiction medicine providers, to dismantle barriers to treatment, and to bolster public health and recovery programs in the states.

And I thank all my colleagues for your continued dedication to combating this devastating epidemic.

And I yield the remaining time to my colleague from New

Mexico, Mr. Lujan.

Mr. Lujan. Thank you, Chairman Pallone, and I am proud to have Lauren Reichelt, the Health and Human Services director for Rio Arriba County in New Mexico here with us in D.C. Rio Arriba County is a state-funded behavioral health investment zone.

In the past five years, they have made incredible progress in reducing overdoses and overdose deaths with intensive case management to connect patients to services. We should learn from their success.

Coordinating only works when there is treatment available. One way we can ensure more patients have access to the treatment they need is by eliminating outdated requirements for providers who are qualified and willing to provide medication-assisted treatment. That is why Congressman Tonko and I introduced the Mainstreaming Addiction Treatment Act. In states where there are high rates of substance use disorder and a shortage of health care providers, removing these hurdles is an easy step that will immediately improve access to treatment.

I would also like to highlight Project ECHO, a telementoring program for health professionals developed at the University of New Mexico by Dr. Sanjeev Arora. ECHO has a curriculum to support rural primary care providers who want to start or expand medication-assisted treatment in their communities.

Nearly 90 programs in 40 states are using ECHO to treat or prevent substance use disorder. I urge my colleagues to yet again come together and work together on this issue as we have in the past.

And I thank the chairman. I yield back.

Ms. Eshoo. The gentleman yields back. Is there anyone on the Republican side that would like to claim the time since Mr. Walden is not here?

If not, we will go directly to our witnesses.

So I would like to introduce our first panel and thank them for being here with us today. Admiral Brett Giroir -- beautiful name. Thank you, and welcome to you. He is the assistant secretary for health and senior advisor to the secretary on opioid policy, U.S. Department of Health and Human Services.

Ms. Kimberly Brandt, principal deputy administrator for policy and operations, Centers for Medicare and Medicaid Services. Welcome to you.

And Mr. Thomas Prevoznik, welcome to you, sir. Deputy assistant administrator, diversion control.

So we look forward to your testimony. I think you are probably familiar with the lights. Green is go, yellow is a warning, and everyone knows what a red light is, right? Stop sign, so and you have a minute remaining when the light turns

yellow.

So Dr. Giroir, you can begin your testimony. You have five minutes. Make sure your microphone is on, and we look forward to hearing you.

STATEMENTS OF ADM BRETT P. GIROIR, M.D., ASSISTANT SECRETARY FOR HEALTH AND SENIOR ADVISOR TO THE SECRETARY ON OPIOID POLICY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; KIMBERLY BRANDT, PRINCIPAL DEPUTY ADMINISTRATOR FOR POLICY & OPERATIONS, CENTERS FOR MEDICARE & MEDICAID SERVICES; THOMAS W. PREVOZNIK, DEPUTY ASSISTANT ADMINISTRATOR, DIVERSION CONTROL DIVISION, DRUG ENFORCEMENT ADMINISTRATION

STATEMENT OF BRETT GIROIR

Dr. Giroir. Thank you, Chair Eshoo, Ranking Member Burgess, and distinguished members of the committee. Thank you for the opportunity to update you on the status of America's overdose epidemic, HHS's implementation of the SUPPORT Act, and how the SUPPORT Act has catalyzed our efforts to address America's evolving substance use crisis.

Because of the SUPPORT Act, we have enhanced the scale and effectiveness of HHS's substance use-related programs within the HHS strategy designed to achieve the following five objectives.

One, improve the access to prevention, treatment, and recovery services.

Two, strengthen public health data reporting and collection to inform real-time public health responses.

Three, advance the practice of pain management.

Four, enhance the availability of overdose reversing medications, namely, naloxone.

And five, support cutting-edge research that improves our understanding of pain and use disorders, leads to new treatments, and identifies effective public health interventions.

In my opening statement, I will provide just a few examples of how the SUPPORT Act has directly benefitted and enabled HHS programs.

First, MAT, or medication-assisted treatment, is a standard of care essential component of evidence-based treatment. Section 3201 of the SUPPORT Act broadened eligibility to allow other qualified practitioners like nurse-midwives and clinical nurse specialists to become trained and prescribe buprenorphine.

Section 3201 has contributed significantly to the now over 110,000 providers currently approved to prescribe buprenorphine and that translates into over 1.3 million Americans now receiving MAT.

Similarly, Section 3202 decreases the burden on physicians who have received appropriate training in medical school to obtain a waiver to prescribe MAT. SAMHSA has already provided 48 grants to universities to train providers to became data waived immediately upon graduation and we will continue this program

in fiscal year 2020.

To further strengthen public health data reporting and collection, Section 7162 authorizes the CDC's support for states to improve their prescription drug monitoring programs, or PDMPs.

To implement this provision, in 2019 CDC awarded $301 million in cooperative agreements through the Overdose Data to Action program, which will enable providers to make better clinical decisions.

And very important to me as a physician, the program funds the effort to assure PDMPs are easy to use and do not interrupt the physician-patient relationship.

Section 7041 of the SUPPORT Act recognizes the critical importance of cutting -- edge research. In fiscal year 2019, NIH awarded $945 million through their HEAL initiative for such topics as basic and applied research on pain, new approaches in medications to treat addiction, treatment of infants with NAS, and perhaps most immediately impactful, the $350 million Healing Communities Study aimed at reducing overdose mortality by 40 percent within three years in communities in Kentucky, Massachusetts, New York, and Ohio.

So where are we now? Since 1999, over 810,000 Americans died of drug overdoses, the majority of which were caused by

opioids, and the latest data from our National Survey on Drug Use and Health showed that approximately 2 million Americans currently have an opioid use disorder.

But we are making progress. Over 1.1 million fewer Americans misused opioids last years compared to the year before. The total amount of opioids prescribed to Americans decreased 32 percent since January 2017 and naloxone prescriptions have increased by 405 percent in addition to the literally millions of doses that have been directly distributed to those at risk, first responders and family members.

As a result of these and other whole of society programs, drug overdose deaths fell by 4.1 percent in 2018 compared to 2017, the first year to year decrease in deaths in almost three decades.

But we have a long way to go and we should not believe for one moment that the crisis is over or even substantially abating. While deaths from prescription opioids continue to decrease, deaths associated with synthetic opioids like fentanyl continue to rise at approximately 10 percent annually.

Even more concerting, data indicate that we have now entered the fourth wave of the crisis, characterized by a shocking increase in deaths from methamphetamine.

From 2012 to 2018, the rate of drug overdose deaths involving methamphetamine increased by nearly 500 percent and our most

recent data demonstrate that that continues to increase 25 to 30 percent annually.

Certainly, as the assistant secretary for health but also as a physician, parent, and grandparent, I want to thank you all, all the members of Congress, for your visionary work on the SUPPORT Act. I am absolutely certain that working together we can provide Americans with not only hope but the lifesaving results they deserve. [The prepared statement of Dr. Giroir follows:]

**********INSERT 1**********

Ms. Eshoo. Thank you very much, Admiral.

I now would like to recognize Ms. Brandt. You have five minutes for your testimony and thank you again for being with us.

STATEMENT OF KIMBERLY BRANDT

Ms. Brandt. Thank you.

Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the subcommittee, thank you for inviting me to discuss the Centers for Medicare and Medicaid Services' work to combat the opioid epidemic.

CMS is committed to a comprehensive strategy to address this public health crisis and we appreciate Congress's leadership in passing the SUPPORT Act, which has given us important new tools to use in this fight.

Over 140 million people receive health coverage through CMS programs and the opioid epidemic affects every one of them as a patient, family member, caregiver, or community member.

The SUPPORT Act was a historic step in helping us address the opioid epidemic. CMS has implemented 18 of its 49 provisions to date and is hard at work to build on that progress.

Just yesterday we completed a provision with the issuance with a state health official letter that provides guidance to states on enhanced behavioral health coverage for separate children health insurance programs as required by Section 5022 of the SUPPORT Act.

This, and all of our opioids work, is focused on three goals:

improving prevention, expanding treatment, and using data.

Key components of any strategy to combat this crisis include insuring that opioid prescriptions are limited to those patients who have a clinical need and prescriptions follow appropriate safeguards.

CMS expects all our Part D sponsors to limit initial opioid prescriptions for acute pain to no more than a seven-day supply, which is consistent with guidelines issued by the Centers for Disease Control and Prevention.

We have seen progress in this area. The number of those receiving opioids for the first time who were prescribed opioids of seven days or less increased from 68 percent in 2017 to 75 percent in 2018.

Also in 2018 the percentage of Part D beneficiaries who were prescribed opioids fell to 29 percent, down from 35 percent in 2013. As a payer for opioid use disorder, or OUD treatment, CMS plays an important role by incentivizing clinicians to provide the right services to the right patients at the right time while at the same time working to expand the services that are available to our beneficiaries.

Beginning this January, for the first time CMS is now covering OUD treatment services furnished by opioid treatment programs in Medicare Part B. As of mid-February, 334 out of about

1,500 opioid treatment programs have already enrolled in Medicare with another 400-plus in the application queue.

As part of our prevention efforts we are also reviewing coverage and payment barriers for non-opioid pain relief. As of January, Medicare now covers acupuncture for Medicare patients with chronic lower back pain. This is a significant expansion of our non-opioid treatment options.

We are building on important lessons learned from the private sector in this critical aspect of patient care. Over reliance on opioids for people with chronic pain is one of the factors that led to this crisis. So it is vital that we offer a range of treatment options for our beneficiaries.

The opioid epidemic has had a significant on some of our most vulnerable beneficiaries and the surge in substance use related illness and death in recent years has particularly affected pregnant women.

In response, CMS had developed the maternal opioid misuse, or MOM, model. The model addresses fragmentation in the care of pregnant and post-partum Medicaid beneficiaries with OUD through state-driven transformation of the delivery system surrounding this vulnerable population.

But supporting the coordination of clinical care and the integration of other services critical for health, well-being

and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants. CMS has ordered 10 states a total of $64.5 million for this five-year model.

We have also worked collaboratively with our state partners to provide the flexibility they need to meet the unique needs of their populations through Medicaid Section 1115 demonstrations targeting substance use disorder treatment.

In November of 2017, we announced a streamline process for states interested in covering the continuum of OUD services including inpatient care, and to date we have approved 27 SUD treatment waivers and we are starting to see results from those.

Virginia has experienced a 4 percent decrease in acute inpatient SUD admissions during the first 10 months of implementation along with a 6 percent decrease in opioid use disorder inpatient admissions.

Finally, responding quickly and effectively to the changing nature of the crisis requires easily accessible data and CMS has leveraged our wealth of data to confront the crisis.

In November of 2019, we released the Substance Use Disorder Data Book, the first nationwide analysis using data from Medicaid's new data system that transformed Medicaid's Statistical Information System, or T-MSIS.

As required by Section 1015 of the SUPPORT Act, the Data

Book details Medicaid beneficiaries' SUD diagnosis, enrollment type and service utilization by state to help CMS, researchers, and policymakers better understand where to focus their efforts.

Along with the SUD Data Book, we released the underlying data that we used to develop the report so that the states and policymakers can understand their challenges in facing the crisis.

With the SUPPORT Act, Congress has equipped CMS with important tools to combat this emergency and we look forward to continue working toward our shared goals.

Thank you for your interest in our efforts and I look forward to answering your questions.

[The prepared statement of Ms. Brandt follows:]

**********INSERT 2**********

Ms. Eshoo. Thank you, Ms. Brandt.

Mr. Prevoznik, you have five minutes for your testimony.

Thank you again for being here with us today.

Put your microphone on, please.

Mr. Prevoznik. I am sorry.

Ms. Eshoo. That is all right. Get it close. Thank you.

STATEMENT OF THOMAS PREVOZNIK

Mr. Prevoznik. Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the committee, on behalf of Acting Administrator Dhillon and the Drug Enforcement Administration, I appreciate the opportunity to update you on the actions of DEA as well as our future intentions to combat the opioid epidemic and protect public health and safety.

My name is Tom Prevoznik. I am the deputy assistant administrator of the Policy Office in the DEA's Diversion Control Division. I am a diversion investigator by training and have been with the DEA since 1991.

As you know, on October 24th, 2018, President Trump signed H.R. 6, the SUPPORT Act, into law. This legislation is a comprehensive government wide approach to reduce the national opioid epidemic.

DEA was one of many entities charged to implement policies and expand existing programs to obtain this goal. Although work remains to be completed for DEA to fully execute the requirements of this law, DEA has successfully implemented key provisions to its enactment.

In October of 2019, DEA made available to all DEA registrants the newly-created centralized database for reporting suspicious

orders. Specifically, this database was created to better track suspicious orders and prevent the diversion of controlled substances.

Also, in October of 2019, the DEA published a notice of proposed rulemaking in the Federal Register to change regulations that improved DEA's ability to oversee the aggregate production quotas for Schedule One and Two controlled substances.

The goal of these changes is to further limit excess quantities of medications that might be diverted. The SUPPORT Act also requires DEA to provide additional information from the existing Automation Reports and Consolidated Order System, or ARCOS, to monitor controlled substances.

In February of 2019, DEA enhanced the ARCOS Buyer Lookup Tool. It now includes the total number of distributors and total quantity and type of ARCOS reportable drugs including opioids sold by each distributor to a pharmacy or practitioner.

The SUPPORT Act also requires DEA to provide state law enforcement and other entities standardized reports containing analytical information on ARCOS distribution patterns.

DEA is currently providing these reports on a biannual basis. DEA was also tasked with promulgating regulations that will expand access to treatment and availability of controlled substances in rural areas.

DEA is resolute in enacting regulatory obligations all in the final step of the review process. An area of great interest for DEA is the data contained in prescription drug monitoring programs, or PDMPs.

PDMPs are state-run data collection programs that, when used properly, could help prescribers, pharmacists, and law enforcement prevent and identify over prescribing and indiscriminate dispensing controlled substance prescriptions.

Currently, there are over 1.7 million practitioners registered with the DEA, 71,000 pharmacies, and 18,000 hospitals. These registrants constitute 99.1 percent of the DEA registrant population. Manufacturers and distributors, the entities that report ARCOS reportable transactions, constitute only .06 percent of registrants.

It is important to note that ARCOS data represents what is received by a pharmacy whereas PDMP data represents what is dispensed by a pharmacy. At present, DEA's access to PDMP data is limited to information relating to the ongoing investigative matter. The means by which DEA obtains this information varies from state to state with approximately half of the states requiring some kind of court or grand jury process.

However, without PDMP data from every state, DEA faces challenging knowledge gaps that hinder its ability to fight

prescription drug diversion, protect public health and safety. Additionally, since the SUPPORT Act requires DEA to estimate diversion and reduce manufacturers' quotas based on those estimates, DEA requires access to state PDMP data to assist in fulfilling its statutory obligation to calculate diversion.

I would like to thank our federal partners here at the table today for our continued work together to address the opioid crisis. The department and DEA thank Admiral Giroir for his support and guidance in the collaborative efforts of the department, DEA, CDC, HHS, OIG, and the Commission Corps to address patient continuity and treatment for patients impacted by enforcement actions taken on health care providers.

This is a collaborative effort in conjunction with state departments of health contacts. The goal is to ensure that persons suffering from addiction to opioids are provided treatment resources.

Finally, I would be remiss if I didn't extend DEA's sincere gratitude to the members of this subcommittee and Congress at large for extending DEA's emergency order controlling fentanyl-related substances.

However, this order will expire in May 2021 so a permanent solution to a controlled fentanyl-related substances remains a necessity for DEA and the department. We look forward to working

with this committee and others in the coming weeks and months to find that permanent solution.

[The prepared statement of Mr. Prevoznik follows:]

**********INSERT 3**********

Ms. Eshoo. Thank you very much. We have now concluded the opening statements of our witnesses. We thank you again. We will now move to members and I will recognize myself for five minutes.

First, I would like to enter into the record Inside Health Policy report dated February 24th, 2020, titled "Administration's Delays in Implementing Major Opioid Law Hinder Efforts to Curb Crisis."

Are there any objections?

Certainly. Okay. I will move to my questions. But I just want to comment. This report found that CMS has not published six guidance documents required under the SUPPORT Act within the statutory time frame.

So I want to begin with Ms. Brandt. I am going to describe each guidance document and ask you to give me the date you expect it to be published. The first document is about reimbursement options for substance use disorder treatments including medication-assisted treatment than can be delivered via telehealth. When do you expect this to be published?

Ms. Brandt. We expect to publish that --

Ms. Eshoo. Turn your microphone on.

Ms. Brandt. Apologies, Chairwoman. We expect to issue that yet this spring. It is currently being in final --

Ms. Eshoo. Let us just keep it short. Spring means what --

Ms. Brandt. Okay. Spring.

Ms. Eshoo. -- April? May?

Ms. Brandt. Hopefully, no later than May.

Ms. Eshoo. All right. The first day of summer is June 21st so --

Ms. Brandt. Duly noted.

Ms. Eshoo. The next document is about opportunities to finance and improve family-focused residential treatment programs. When do you expect that to be published?

Ms. Brandt. That is also one for this spring. May.

Ms. Eshoo. May. The next are recommendations for improving care for infants with neonatal abstinence syndrome and their families. When do you expect that to be published?

Ms. Brandt. We hope to have that one also this spring. Hopefully, no later than May.

Ms. Eshoo. You are also behind on publishing a best practices for ensuring Medicaid coverage of former foster youth. When do you expect that to be published?

Ms. Brandt. That one we are currently working on. We hope to have that by April.

Ms. Eshoo. Got a lot of work to do before spring. You are

also behind on publishing best practices for prescription drug monitoring programs and privacy protections for Medicaid beneficiaries. When do you expect that to be published?

Ms. Brandt. That is one we are working with our federal partners on and we also expect that by the end of the spring.

Ms. Eshoo. By the end of spring. All right. Well, you have a full portfolio there and we will track with you and to make sure that they actually take place.

To the admiral, I would like to ask you what is the status of your efforts in coordinating with NIH and FDA to support research and development for nonopioid pain management?

Dr. Giroir. Thank you for that. There are efforts nearly every day to do that. We are coordinating with all the speciality societies to make sure that nonopioid uses are being done. We have issued guidance on the appropriate tapering of opioids. That was in the fall in substitution of other activities.

The HEAL initiative, as you know, has applied research, meaning not just in the, you know, in a laboratory and a mouse but, really, applied research on pain management. That is, you know, coordinated --

Ms. Eshoo. What is your -- let me ask you this. What is your assessment of a near outcome relative to the R&D?

Dr. Giroir. I am sorry, ma'am. I didn't --

Ms. Eshoo. The outcome of the R&D between NIH and FDA.

Dr. Giroir. Well, the research and development is ongoing. Again, the HEAL initiative just started. There are --

Ms. Eshoo. It just began?

Dr. Giroir. Well, the funding for the HEAL initiative -- there was $945 million last year and there is ongoing research with I think there is going to be very near-term deliverables.

It is really defined -- you know there is some basic research that will take years or a decade to go but there are near-term deliverables with actual clinical trials including neonatal abstinence syndrome, including --

Ms. Eshoo. And when do you expect those clinical trials to begin?

Dr. Giroir. Oh, most of these have already begun. We expect new -- you know, new data, new results, on an ongoing basis.

Ms. Eshoo. But where are they? I mean, the first trial is the easy one. Second phase is longer, more expensive. I still don't have a sense of exactly where we are and when -- I mean, are deliverables three years off? Two years off? Four years off?

Dr. Giroir. So deliverables are being done now. As we said, opioid prescribing is down almost 34 percent even in the

last two years. Substitution of ibuprofen, multi modal management -- that is all going on now with existing technologies that we use.

Ms. Eshoo. Those are the easy things.

Dr. Giroir. But they are also effective. They are also very effective. There are trials --

Ms. Eshoo. Oh, I am not -- I am not diminishing that. I am just saying those are the easy things.

Well, I think that my time has expired and I now recognize the ranking member for his five minutes of questions.

Mr. Burgess. Just before we start my time, my initial perusal of this, since I am quoted accurately I will not object to its inclusion.

Ms. Eshoo. So ordered.

[The information follows:]

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

Ms. Eshoo. I wouldn't think of putting something in the record where you are misquoted, Doctor.

Mr. Burgess. Mr. Prevoznik, let me just ask you a couple questions about the PDMP because, of course, that is something this committee worked on, really, since my first term in this committee so many, many years ago and with the several time reauthorization of NASPER, to the extent that you are able to utilize it in your investigative activity, has that been helpful?

Mr. Prevoznik. Absolutely.

Mr. Burgess. So what extent are you utilizing PDMP data? Is that something that happens frequently or just occasionally?

Mr. Prevoznik. It is typically used in investigative matters so the current investigations that we are doing it we will -- the access is through each state. So it varies state by state how we gain access to that data. But it is case specific.

Mr. Burgess. And just to refresh everyone's memory is there -- may a physician or other practitioner query the PDMP before issuing a prescription to a patient?

Mr. Prevoznik. That, again, varies by state by state, whether the state requires the prescriber or the pharmacist. DEA fully encourages all prescribers, all pharmacists, to look at the PDMP data either prior to or at whatever point that they feel that they need to look at to assess that patient that is

in front of them.

Mr. Burgess. So yes, that is the aspect I was going to get -- if we want it to be effective preventative medicine probably works best. Query before writing the prescription. I think that is something that maybe some of our follow-up can look at as to how that is working, what are the best practices of various states -- other ways we can extend that best practice to other participants.

On the -- Admiral Giroir and Ms. Brandt, on the -- in Section 5052 of the SUPPORT Act there's an option for state Medicaid programs to cover care for 21 to 64-year-olds in certain institutions for mental disease -- the so-called IMD exclusion -- which otherwise would not have been federally reimbursement -- federally -- eligible for federal reimbursement because of the IMD exclusion. So how many states have utilized or expressed interest in utilizing this option?

Ms. Brandt. Sir, we issued guidance to states in November of last year on this and we are working with states and, as of yet, we are still working to assess their interest.

Mr. Burgess. That is really too soon to tell because last November was -- this is -- you know, we all see the problems, the news stories about the numbers of homeless in various cities and I think it was Dr. Drew who correctly identified it is one

thing to put someone in an apartment or a room but you are not going to fix their homelessness.

The cause of their homelessness if you don't address the underlying mental health disorder and so oftentimes that is a substance use disorder. So to the extent -- and I do want to continue to work with you. I know there are other pieces of legislation out there -- the IMD exclusion, I recognize it is expensive when you get the Congressional Budget Office involved.

But it does seem to me that we are being penny wise and pound foolish in not making the investment in the actual fixing the problem for someone rather than just continuing to respond to their symptoms.

Are there any other tools that you think would be helpful for the states or the Center for Medicare and Medicaid Services to increase utilization of this option?

Ms. Brandt. I think continuing to have a dialogue with members such as yourself and continuing to talk to the states about this option and the flexibilities they need is really what we think would be most helpful so that we can understand exactly where the issues are and how we can best used our levers to help with them.

Mr. Burgess. And, Dr. Giroir, do you have anything to add?

Dr. Giroir. I don't have -- I don't have anything to add to that.

Mr. Burgess. Well, I do hope that is one of the things that we, as a committee -- as a subcommittee -- can explore because I think it is terribly important.

One of the things, and Admiral, you mentioned in your five-point strategy the alternative pain treatments for alternative management of pain. So how are we doing? What actions is HHS taking to address the alternative pain treatments?

Dr. Giroir. Thank you for that. There are both informal mechanisms and formal mechanisms. The formal mechanisms often come through CMS issuing a number of guides and guidelines to all practitioners about the use of alternative pain medications including, most recently, acupuncture but also the normal things that we do, and as you understand most of this is driven by our interactions with medical societies.

Mr. Burgess. Yes. I would be interested to know what the discussion was about the coverage determination for acupuncture. Were commercial insurance companies covering that and CMS was late to the table or was CMS on the vanguard here?

Ms. Brandt. There are some private insurers which were covering it. We did, certainly, consult with the private insurers. But this was a groundbreaking and very aggressive move

on our part to cover this particularly in a broad base, not just in a clinical capacity.

Mr. Burgess. Okay. Thank you. I yield back.

Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentlewoman from California, Ms. Matsui, for her five minutes of questions.

Ms. Matsui. Thank you very much, Madam Chair.

Addiction is a devastating disease that knows no bounds and we must provide solutions in a comprehensive manner. This includes extending and expanding community-based behavior health clinics, improving enforcement of mental health parity laws, putting greater transparency on the drug supply chain, and addressing outstanding barriers to using telehealth to expand access to care.

Telemedicine is a critical tool that should be leveraged to expand the ways a patient can receive medication-assisted treatment, especially in rural areas. That is why I reintroduced the Improving Access to Remote Behavioral Health Treatment with several of my colleagues on this committee.

The Ryan Haight Act of 2008 allowed for legitimate entities to register with DEA to use telemedicine to remotely prescribe controlled substances in a regulated way. However, these guidelines were never issued.

As such, Congress included in H.R. 6, the SUPPORT Act, a provision requiring DEA to issue regulations around the special registration process within one year of enactment of the law. SUPPORT passed into law in October 2018. As of today, DEA still has not set the ground rules for providers with a special registration to prescribe controlled substances.

Mr. Prevoznik, can you provide an update on the agency's work on the special registration rule? When can we expect the proposal to be published?

Mr. Prevoznik. Thank you for that question. Telemedicine is being practiced today, being done now. The regs are in the review process. As I said, we are in the final stages of the review process. It is very much an interagency process in that it is not just DEA equities that are involved in this.

This is a lot of different equities that are involved from various agencies and we want to ensure that patients are truly getting legitimate care and that we do not reopen this up to the Wild West, which required the passing of the Ryan Haight Act. So we are working very closely with our interagency partners on this. We are working diligently and very hard to get it done.

Ms. Matsui. Well, thank you. It has been 11 years since the Ryan Haight Act originally called for this process and amid this addiction epidemic we have to expand access to treatment,

particularly through legitimate community addiction and mental health centers that are regulated in a way that does not currently comply with the DEA registration process, and I urge the agency to issue a proposal as soon as possible.

Current regulations require all DEA-registered manufacturers, distributors, and dispensers of controlled substances report suspicious orders to DEA. These suspicious orders may include orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency, which could indicate that controlled substances are being diverted out of legitimate use.

Among other things, the SUPPORT Act tasks DEA with evaluating the utility of real-time reporting of suspicious orders.

Mr. Prevoznik, to what extent has the DEA engaged in capabilities to develop a system to identify real-time report and how does the DEA propose to share this data with suppliers before orders are filled?

Mr. Prevoznik. I appreciate that question as well. As you know, in October, we -- October 23rd we released the newly-created centralized database to report suspicious orders. This requires all registrants that distribute amongst registrants to report suspicious orders.

Currently right now, we are getting data that is inputted.

Prior to that, we did not have that data into that newly-created centralized database system. We want to ensure that the data that is in there is it valid and correct because garbage in is garbage out. So we are working with the industry as well to ensure that the data that is going in there is correct and valid, and then that data will be shared with the state attorney generals. We are working on a portal system now to share that data with the state attorney generals, law enforcement.

Ms. Matsui. Well, thank you. We just want to make sure that we do this in a timely manner because it does hinder the ability of manufacturers and distributors to identify suspicious activity and that is why Representative Johnson and I have introduced the Suspicious Order Identification Act of 2019, legislation that sets up a workable real-time reporting system through DEA to help us prevent diversion and maintain integrity in the supply chain.

We would like this going -- I understand what you mean about -- you know, garbage in -- But, you know, we really need to do this in an expeditious manner and I believe you can handle this. So, please, we have this law -- this bill going through the process right now, bipartisan. We would like to have it done.

Thank you. Yield back.

Ms. Eshoo. The gentlewoman yields back. A pleasure to

recognize Dr. Bucshon for his five minutes of questions.

Mr. Bucshon. Well, thank you very much.

There is one of the bills that we are talking about today that I want to express some concerns about. It is H.R. 2482, Mainstreaming Addiction Treatment Act of 2019. This would -- it eliminates the separate registration requirement for dispensing narcotic drugs in Schedule III, IV, or V such as buprenorphine for maintenance or detoxification treatment and for other purposes.

My concerns are that buprenorphine can be effective if administered by properly educated and trained providers who counsel and educate the patient. However, the vast majority of individuals currently receive -- are receiving no counselling.

Medication-assisted treatment may not be effective unless there is a more comprehensive treatment plan in place, and so my concern of waiving a DEA requirement is significant.

I have been working in this -- in Congress to implement prescribing limits and increase prescriber education for buprenorphine to mitigate the practices that led to the current opioid epidemic.

However, some of my friends in Congress continue to want to expand the scope of practice to allow almost anyone regardless of their qualifications and/or training to prescribe

buprenorphine, and there are other medication-assisted treatments but we seem to be focusing on this one.

In my opinion, that is exactly what H.R. 2482, the Mainstream Addiction Treatment Act does. It removes education requirements and limits making it easier to prescribe a medication known to be highly diverted and misused.

The bill may only expand access to the medication but not real and effective treatment for individuals with substance abuse disorder.

The last thing Congress should be doing, in my view as a physician, is limit and relax requirements for prescribing and dispensing narcotic drugs like buprenorphine, even when there is political pressure and sometimes social pressure to do so.

With that said, I have a few questions. Pain management is real and we must all look to find nonopioid alternatives to use to help individuals that suffer from pain daily.

Admiral, I want to thank you for making improving pain management a key component of the HHS opioid strategic plan and for your leadership of the Pain Best Practices Task Force.

Can you tell us specifically what HHS is doing to promote pain best practices and improve patient and provider education about nonopioid alternatives?

Dr. Giroir. Yes, sir. Thank you for that.

There are both formal and informal mechanisms. Again, we tend to use CMS as a formal mechanism to reach all prescribers with their guidelines and guidances about nonopioid treatment and, again, we are not just talking about acupuncture but we are talking about the things that you and I know to do -- anti-inflammatory agents, multi modal behavioral therapy. All those things are there.

Mr. Bucshon. And there may -- and there is devices, medical devices that can be useful.

Dr. Giroir. And devices. We are in really a transformational period of understanding how medical devices in and of themselves can control or modify pain to a great degree. And, again, this is an interagency process. As you also know, the medical societies have really taken this up on their own with individual guidelines for dental procedures, for outpatient surgery, for knees, hips -- all the issues. So we are working with them actively and on a weekly basis.

Mr. Bucshon. Great. And Ms. Brandt, the HHS pain management report calls for breaking down barriers, improving patient access, and expanding coverage to nonopioid treatment options for pain. Will the task force recommendations be reflected in the forthcoming CMS Opioid Action Plan?

Ms. Brandt. Yes. We plan on using that as well as information we got from a request for information that we issued last fall where we specifically asked for input on things that have enhanced or impeded access to nonopioid treatment so that we can take that into account as well.

Mr. Bucshon. Great. That is important. I just want to say as a physician I do think that the physician community is becoming more and more aware of their prescribing habits. I will speak specifically for Indiana.

That is based on a lot of factors, both state and federal -- the federal government but also on the media and the society at large, and I think our physicians are trying to do their part to help mitigate this opioid crisis.

I do, again, want to reiterate my concerns about lifting regulatory requirements on qualifications required to prescribe these medications for MAT and I think that they are there for a reason. Although I am for expanding treatment but in -- but, again, as a physician I have serious concerns about expanding the treatment in that way.

So with that, and I also want to thank the chairwoman for this hearing, for all of these opioid-related bills as it is a critical problem that our nation needs to continue to address.

I yield back.

Ms. Eshoo. The gentleman yields back and I appreciate the good words. Let us see who is next.

The gentleman from California, Dr. Ruiz, is recognized for five minutes.

Mr. Ruiz. Thank you very much for holding this hearing.

We passed comprehensive legislation that was signed into law last Congress and the Congress before that to address the opioid crisis that has swept our nation. But the crisis is far from over and it is important that we look back at our past work on this issue to assess the results and see what we can further do to make a positive impact on this public health epidemic.

When we passed the SUPPORT Act last Congress, one of my bills was included in that package and that is what I want to focus on today. As we all know, seniors are at heightened risk for opioid use disorder and the severe consequences of the respiratory depression that they may cause.

The purpose of the Advancing High-Quality Treatment for Opioid Use Disorders in Medicare Act is to help ensure our seniors have access to high quality evidence-based opioid misuse disorder treatment.

Specifically, this voluntary demonstration project will create an alternative payment model through Medicare for comprehensive treatment and care programs for opioid misuse

disorder.

Participating providers or institutions will receive a case management fee to enable them to provide wraparound services to Medicare beneficiaries and receive a higher fee if the coordinated care team includes an additional specialist.

For Medicare beneficiaries participating in this program in addition to medication-assisted treatment they will receive psycho social support such as psychotherapy, treatment planning, and appropriate social services to treat substance use disorder.

This coordinated care approach is considered the gold standard of care and if we want to successfully address this crisis we need to ensure that individuals have access to treatments that will result in successful outcomes. I have seen firsthand the importance of this with my patients and beginning medication-assisted treatment is important.

But the success of that treatment is enhanced if the patient is also participating in psychotherapy and receiving the appropriate social services. It is of the utmost importance that all Americans, regardless of their age or how much money they make, have access to high-quality comprehensive treatment.

Our entire health care system is moving towards a more coordinated care and incentive programs for performance outcomes

and our seniors should not be left behind. This demonstration project is slated to begin in January of 2021.

So Ms. Brandt, can you tell me where you are in the development process at this time including which specialists you have consulted with?

Ms. Brandt. Thank you, Dr. Ruiz. We are actually very actively working on this and hope to meet the implementation deadline. Thus far, because this is a very hands-on demonstration, we have been working very closely with stakeholders including clinicians in the primary care community and those in the field of addiction medicine to help us with designing the demonstration.

We did a series of listening sessions in April and May of last year with both stakeholders and beneficiaries to help us better be able to understand the issues and design the demonstration, and we are hopeful that within the next month that we will start to be able to work on the application process and start moving forward.

Mr. Ruiz. So what are steps that still need to be taken to roll out this program?

Ms. Brandt. We need to finish designing the demonstration, finish the cost estimates, and begin with the applications.

Mr. Ruiz. Okay. And are you on schedule for the demo to

be up and running in January as required?

Ms. Brandt. As of right now we are on track and we are pushing hard to remain on track.

Mr. Ruiz. Good. Well, that is important for our seniors. We need to address all the other social determinants of health and that could be as simple as do they have transportation to their treatment and psychotherapy. That can be as simple as looking at some of their addiction behaviors and start creating psychotherapy for them to understand their own physiology. Seniors in particular are more at risk to have pain issues because of the musculoskeletal wear and tear throughout their lifetime.

At the same time, they are more sensitive to opioids. They are more at risk of getting addicted and an opioid of the same dose can cause respiratory depression, severe drowsiness to a point where they can fall, where they can regurgitate from their food, which can cause pneumonias more so than somebody who is, let us say, in their 30s. So that is why we need to pay special attention to our seniors and we need to ensure that this program is ready, up, and running by the due date this January.

Thank you very much. I yield back.

Ms. Eshoo. The gentleman yields back.

A pleasure to recognize Mr. Long, our good friend.

Mr. Long. Thank you, Madam Chairwoman.

And Ms. Brandt, the opioid epidemic continues to devastate families and communities in my district and across the country, as you know, and I myself have some personal experience with opioids over about a four or five day period when I was in the hospital for eight days right before Christmas after I was trying to get a four-pound poodle out of the middle of the street.

That wasn't a very good idea, and I shattered my shoulder. So that led to a long stay and a few days of opioids in there, which -- the hallucinations, the bugs and things crawling on the wall. I saw pain relief I did not get. So I am not sure how people get addicted to these but I know that it is a very, very serious issue.

One thing we can do at the federal level is to ensure Medicare patients have access to safe and effective alternatives to opioids to manage their pain. Unfortunately, Medicare payment policies can keep these alternatives out of the reach of many of our nation's seniors by failing to adequately reimburse hospitals for the cost of the therapy.

I was proud of the work Congress did in the SUPPORT Act to provide CMS with new authorities to adjust payment for evidence-based nonopioid therapies under Section 6082 and I was very disappointed to learn that the agency declined to make payment adjustments for any alternative therapies in its 2020

payment rule.

What more do you need from Congress to make payment adjustments necessary to ensure seniors can access these safe alternatives that reduce opioid use?

Ms. Brandt. Well, first of all, I hope you are recovered from your experience, sir, and I am sorry to hear about that.

But from our perspective at CMS, we are really open to working with you all to get feedback on how we are implementing this section and what else we can do.

I, personally, have met with dozens of stakeholders on this. We have been taking into account additional research and additional information that we have gotten from them about we can better look at how we are adjusting our payment policies to reflect this, and right now we are working with an interagency task force to look into this issue and see how we can continue to evolve on this.

Mr. Long. Okay. How do we ensure that the reimbursement policies don't create a disincentive, I guess you would say, for prescribing opioid alternatives?

Ms. Brandt. Well, one of the things that has been most helpful to us is continuing to have the dialogue not only with you all but with the stakeholder community about the evidence showing the impact of those costs and what we can do to be able

to adjust our payment policies to reflect that.

Mr. Long. Okay. Thank you.

And, Admiral Giroir, you briefly mentioned in your testimony that you are witnessing new and highly dangerous patterns of use including a combination of polysubstance methamphetamines and illicit fentanyl?

And I might add that I toured a drug facility. It wasn't really a drug facility but in the Kansas City area they have a -- if the police pick you up instead of taking you to jail they will take you to this facility for 24 to 48 hours. The first thing they do is drug test you and they got a guy in there and they said, what are you on, and he said, oh man, I am on opioids.

They tested him and they said, sir, you don't have one opioid in your system. They said, you have fentanyl. He said, what is fentanyl. He said, I bought opioids. So I know what an issue is it. Can you explain what is going on here? Can you discuss how the opioid crisis is evolving and how that substances like these can threaten the overall progress being made against opioids and heroin?

Dr. Giroir. Yes. Yes, sir. Thank you.

Overall, the numbers looked good. Prescription opioid deaths are down 10, 12, 14 percent. Heroin deaths are decreasing.

Fentanyl deaths are still going up at 10 percent but they were going up 30 and 40 percent. So we are starting to make headway into this.

You have characterized it. Really, the fourth wave is methamphetamines and methamphetamines combined with drugs like fentanyl that are really a deadly potion. In many parts of the country, particularly in the West, methamphetamines absolutely dominate over opioids now as the cause of death and despair.

A very important thing that Congress did on the State Opioid Response Grants for this year allowed flexibility so states could use the money not just for opioids but predominantly for methamphetamine if that is an issue, and in that regard, the Tribal Opioid Response Grants for this year will be announced today at $50 million to get relief to the tribes on methamphetamines.

So, again, sir, all the investments that you are making -- workforce, training, incentive payments -- these will all go across the board to help methamphetamine but we do need the flexibility and there are some specifics about methamphetamine that are critical.

And, again, there are cartels manufacturing hundreds of thousands of pounds of pure methamphetamine. This is not someone cooking it in the kitchen next door anymore. This is industrial scale methamphetamine that is an all out for DEA, DOJ --

Mr. Long. How about you down the table? I was going to ask Mr. Prevoznik, would you care to comment? What is the DEA seeing in terms of new patterns of use?

Mr. Prevoznik. The biggest thing that we are seeing is the counterfeiting -- the counterfeiting of these very -- fentanyl, methamphetamine, they are being pressed into pills so that the public does not know what they are getting. This is a very scary time.

As the admiral pointed out, that it is highly industrialized. We have the pill press issue of where they are coming from, who is getting them, who is using them. We are attacking it. We have just started Operation Crystal Shield, which we are targeting eight distribution hubs for methamphetamine and we are doing a full court press on that right now.

Mr. Long. Okay. And I yield back. Thank you all.

Ms. Eshoo. The gentleman yields back.

Pleasure to recognize the gentleman from Massachusetts, Mr. Kennedy, for five minutes.

Mr. Kennedy. Thank you, Madam Chair, and I want to thank Ranking Member Burgess for convening this hearing today and for taking proactive steps to combat the Opioid epidemic.

To our witnesses, thank you for being here. Thank you for your service. A few minutes ago, I left a roundtable discussion

with mental health and substance use disorder experts and dozens of health care leaders from providers to insurers to researchers and advocates.

All of them are intimately familiar with our past failure to prevent this crisis from taking root and all of them have seen how our efforts to confront it today far too often fall short.

Because it simply is not enough to try to smooth out the edges of what ends up being a completely hollow system for far too many Americans. As long as there are Americans out there without health care coverage or who are under insured or covered by junk insurance plans or have plans that simply do not provide adequate coverage for mental and behavioral health services because they do not consider them to be a priority, we will not be able to overcome an opioid epidemic.

Even worse, as long as this administration continues to cut holes into the very safety net system and programs that are meant to catch those who fall through the cracks we will fail without a doubt.

Ms. Brandt, do you know what program is the largest payer of substance use disorder treatment in the country?

Ms. Brandt. Medicaid.

Mr. Kennedy. Do you know, roughly, how much Medicaid pays annually for that treatment?

Ms. Brandt. I do not know that exact amount.

Mr. Kennedy. Well, about $7 billion or so.

Admiral Giroir, is that -- did I pronounce your name anywhere close to correct? I am sorry, sir.

Dr. Giroir. Anything close is fine, sir.

Mr. Kennedy. Apologies, sir.

Dr. Giroir. Cajun names are a problem.

[Laughter.]

Mr. Kennedy. Forgive me. Would you agree that Medicaid is the largest payer of mental behavioral services in the country?

Dr. Giroir. Yes, that is correct.

Mr. Kennedy. And so, Ms. Brandt, are you familiar with the statistics showing that the percentage of people hospitalized with a substance use disorder who did not have health insurance dropped from 20 percent to just 5 percent in states that expanded Medicaid coverage in just two years?

Ms. Brandt. I have heard those statistics.

Mr. Kennedy. And, Admiral, does that sound familiar to you as well?

Dr. Giroir. Yes, sir.

Mr. Kennedy. So, Admiral, have you seen studies showing that Medicaid work requirements or Medicaid block grants would increase access to addiction treatment options?

Dr. Giroir. Have I seen studies that block grants will increase the access?

Mr. Kennedy. Yes.

Dr. Giroir. No, sir. I have not seen those.

Mr. Kennedy. How about work requirements? Would they increase access to treatment options?

Dr. Giroir. I have not seen studies either way on that, sir.

Mr. Kennedy. Ms. Brandt?

Dr. Giroir. I have not either.

Mr. Kennedy. So, Ms. Brandt, in your experience, does cutting a program by, roughly, $1 trillion usually make it more or less effective in treating a population that is already horrifically under served and under treated?

Ms. Brandt. Our efforts are to try and keep the program sustainable at all costs for all of our vulnerable beneficiaries.

Mr. Kennedy. And cutting a trillion dollars makes that easier to do or harder to do?

Ms. Brandt. It will make it so that the program hopefully will be able to be sustainable in the long term to be able to cover those people that need those services.

Mr. Kennedy. And so when you cut a trillion dollars out of it, who gets -- who feels the basis of that cut?

Ms. Brandt. The cut is in the growth of spending, not the actual spending itself and it is to help to sustain the program over the long term.

Mr. Kennedy. So your position then is that cutting a trillion dollars out of Medicaid will not actually harm the beneficiaries from being able to access their care?

Ms. Brandt. It is to help be able to make the program more long-term sustainable.

Mr. Kennedy. I understand that is the hope. What do you think the reality is of cutting a trillion dollars out of the health care program?

Ms. Brandt. That is the genesis behind our budget proposal is to go ahead and keep the program sustainable in the long term.

Mr. Kennedy. And, Admiral, are you familiar with the 10 essential health benefits mandated by the Affordable Care Act?

Dr. Giroir. Yes, generally.

Mr. Kennedy. Yes. I won't quiz you on all of them. But one of those essential health benefits, again, mandated by the ACA is mental health and substance use disorder services.

Yet, this administration will be arguing before the Supreme Court in just a few months that the entire Affordable Care Act should be struck down.

Admiral, if the ACA is struck down in its entirety and

substance use disorder services are no longer considered an essential health benefit, would that be good or bad for patients in need of addiction treatment?

Dr. Giroir. So, as you know, the last thing I am would be to pretend to be a lawyer. But, clearly, having access to substance use and mental health services is absolutely key to eliminating the crisis and also preventing the next one.

Mr. Kennedy. Thank you.

And is there a possibility that health insurers will see mental and behavioral health conditions as preexisting conditions if the ACA is struck down?

Dr. Giroir. If you are asking me, I am sorry, I don't really have expertise to comment.

Mr. Kennedy. The idea being that if it was in fact the Affordable Care Act that mandated coverage for substance use disorder and mental behavioral health coverage, that if somehow those protections were taken away that insurance companies would step into that void voluntarily. They never did in the past. Is there any reason to believe they would now?

Dr. Giroir. Again, you know, I am sorry. I can't predict insurance coverers' behavior. But it is absolutely vital that everyone with substance use disorder, the potential for it and mental illness, get the care they need as soon as possible because

the spiral goes very badly over the decades as they -- as they progress.

Mr. Kennedy. Agree, sir. Thank you very much.

Yield back.

Ms. Eshoo. The gentleman yields back.

A pleasure to recognize the ranking member of the full committee, the gentleman from Oregon, Mr. Walden, for five minutes.

Mr. Walden. Good morning, Madam Chair, and I want to thank our panellists. We got another subcommittee going on so some of us are bouncing back and forth between the two.

Admiral, I want to ask you about 42 CFR Part 2. Are you familiar with that regulation and the impact it has on sharing critical medical information back and forth among providers?

Dr. Giroir. Yes, sir. Of course, I am. Dr. McCance-Katz really is the expert in our department on that, but I am certainly familiar with it.

Mr. Walden. In the last Congress, when I had the great honor to chair the committee, we moved legislation as part of our opioids package dealing with -- to provide some reforms to 42 CFR Part 2. We had instances where there had been loss of life because that information had not been shared.

I know the Trump administration has attempted to do what

we failed to do legislatively. Not in the House. We passed it in the House.

Can you speak to the importance of making these changes and what other legislation might be helpful in this area? Or Ms. Brandt, if you are involved in this?

Dr. Giroir. I think we could probably all speak. But it is clear that the administration believes, and I do as well, and certainly all the experts that I know that we need reform in 42 CFR. It is really meant for a time that is 40 or 50 years ago and does not address the crisis as we have today and, thus, we proposed regulations, as you know, to do as much as we can without legislation. That is still limited in what can be done.

But, clearly, to be able to have information for one provider to know that the patient is in an opioid treatment program and has a long-term substance use issue can be lifesaving and I think there are many examples when it is.

Mr. Walden. That is right.

Dr. Giroir. I think there is a balance that we can protect patients' privacy like through HIPAA but still get lifesaving information to providers.

Mr. Walden. Ms. Brandt, do you have any additional comment on this matter?

Ms. Brandt. Well, in our meetings with stakeholders this

is one of the issues that has come up that is very important.

Mr. Walden. You know, I did a lot of roundtables in my district and this almost above any other with the provider community was the top issue, and we protected patients' privacy rights. I think the bill we passed in the House was stronger than existing HIPAA requirements.

We don't want this information used against them in any way -- their, you know, employment or anything else. But failure to share in a modern environment is deadly and so we worked together on that, and I know it was an issue for Mr. Kennedy as well.

Unfortunately, I have to confess, my dear friend, the chairman of the committee now was the lead opposition to this and we had a problem in the Senate. We got it passed through the House but not in the Senate. So, regretfully, I doubt we will see any forward motion on this, going forward, with those that are in charge right now.

Admiral, how is HHS monitoring the use and determining the success of the Opioids Dashboard? That is something else that my colleague, Mr. Latta, was lead on, and the National Help Line and findtreatment.gov. Mr. McKinley was big on this as well. Are you getting that dashboard up and running?

Dr. Giroir. Yes, sir. The dashboard is up and running at

hhs.gov/opioids, and we tried to certainly highlight and prioritize the things that could be lifesaving like findtreatment.gov, which was completely redone to make sure that people who are in need or need a hotline have that right there.

But as you look down it gives the up-to-date statistics. There is a quick link to make sure that everybody who wants a grant -- that is one thing we heard, is there a quick way to just click to it.

Mr. Walden. That is right.

Dr. Giroir. And also, although you can tell it is made by accountants and not by some of the digital folks, but there is a basic easy-to-use map about where the money has gone and who it has gone to --

Mr. Walden. Oh, good.

Dr. Giroir. -- to be transparent. Again, it is not beautiful but it is easily seen --

Mr. Walden. Right.

Dr. Giroir. -- and downloadable so Congress or the private can have some sunlight on that and see how we are doing.

Mr. Walden. Ms. Brandt, do you have a comment on that?

Ms. Brandt. I would just add that in addition to the dashboard that the admiral mentioned, we at CMS have our own opioid

heat map that is available using our CMS data that allows you to see down to the zip code level trends in utilization and prescribing.

Mr. Walden. One of the things that -- great joys of serving in the Congress people from different districts and different issues and I will never forget the moment Bobby Rush from Chicago made it clear to me it is more than just opioids, and we changed the legislative intent to include all substance use disorder.

In my district, meth is still a huge issue, probably bigger than opioids. Can you speak in the last 20 seconds to what we are doing in methamphetamine and what you see?

Dr. Giroir. Dr. McCance-Katz and I formed a task force last March actually when we saw this really rolling across the states. One of the major issues is we provided technical assistance so the State Opioid Response Grants could be used because --

Mr. Walden. Right.

Dr. Giroir. -- California, Oregon, Washington --

Mr. Walden. It is meth.

Dr. Giroir. -- New Mexico, Arizona, it is really meth, meth, meth, and you were -- you were hand tied. SAMHSA has also opened up a completely nationwide technical assistance programs because there is not MAT for methamphetamine.

Mr. Walden. Right.

Dr. Giroir. And just to be sure, the NIH and FDA are working together to try to develop the MAT but also open the doors to industry to let them know that every power of the FDA, priority reviews, all those kinds of things will be used because we really need to focus on that, and methamphetamine, as you know, is devastating. And, again, more deaths from methamphetamine now than prescription opioids or heroin and it will overtake cocaine within the next month or two.

Mr. Walden. Yes. I know Bobby talked about crack cocaine and the impact in his community, and we want to be on all of these. We don't want to just isolate to specific drugs.

So thank you, Madam Chair. You have been most generous with the time.

Ms. Eshoo. For you, Mr. Chairman.

It is now a pleasure to recognize the gentlewoman from Michigan, Mrs. Dingell.

Mrs. Dingell. Thank you, Madam Chair and to Ranking Member Burgess for holding this hearing and -- to evaluate the impact of opioid legislation passed last Congress and to examine bipartisan legislation to continue to address this epidemic, and I do want to associate myself with the comments that were just made that it is not just opioids but it is a number of other drugs,

and I thank all of the witnesses for being here.

As we all keep saying, the Opioid epidemic is one of the defining public health challenges of our time. It was good that we witnessed in 2018 a reduction in drug overdose deaths for the first time in years.

There were still 67,000 people that lost their lives and, you know, I am one of those families that lost a sister and whose father -- he lived with it but it impacted his whole life. So I know firsthand what a challenge we are dealing with.

And there is not a member on this committee or in the Congress that has not heard about it from their constituents, hasn't seen it firsthand. So that is why we have got to redouble our efforts to understand what is working and what else we need to be doing to help you.

So, Admiral, I want to ask you the first question. The SUPPORT Act included the ACE Research Act, which I introduced with my colleague, Fred Upton, to encourage the development of nonaddictive pain medications. We have talked about alternatives but we have really not talked about what the status is in developing new drugs that aren't addictive.

Earlier this year, Dr. Volkow, the director of the National Institute of Drug Abuse, stated that it would likely take years before new pain medicines could replace today's opioids and reach

the market.

Can you discuss some of the challenges that remain with developing these new treatments and what action we can take further to develop these new medicines in a faster way?

Dr. Giroir. So I am going to answer your question but I just want to be clear that we have a number of nonaddictive medications that are highly effective when used in a multi modal service. And, again --

Mrs. Dingell. So what -- so talk about that because the anti-inflammatory drugs or the other ones you talk about can't be taken by many older people. They get bleeding in their stomach. They have side effects that causes increased high blood pressure. For many, especially older people, who have kidney disease, et cetera, opioids are the only thing they can take.

Dr. Giroir. So there are always going to be exceptions to all pain categories and part of the Pain Management Task Force is we have said like anyone knows, you need a patient-centered approach. You can't just make a rule and have it apply to everyone --

Mrs. Dingell. Right.

Dr. Giroir. -- and we actually go through many special populations including women, including patients with sickle cell disease exactly to work on that. But for many patients, in fact,

most patients, it has been -- it has been shown that high dose ibuprofen can be as good as opioids coming out of the emergency room. That multi-modal --

Mrs. Dingell. But not for long term.

Dr. Giroir. Not for long term. Not for long term at all. So there are a variety of devices -- physical therapy, all the kinds of things that you know about and I know you know about that. On the --

Mrs. Dingell. I have spent a lot of time -- I am not a doctor but -- and that is what I am worried about. We really do need nonaddictive --

Dr. Giroir. So we do have a lot that we can do now. But your point is correct. Unfortunately, it takes a long time to develop new drugs. Fortunately, the incentives are there.

Congress has provided the money to support NIH very dramatically and there are very exciting -- I mean, extremely exciting things on the horizon. But it will take years for a nonaddictive opioid-like substance or antibody to come onto the market.

Mrs. Dingell. We are not doing it quick enough. This is the real world for me. I have lived with it on both sides, as you know.

I am going to do, quickly -- additionally, Rep. Walberg and

I worked on legislation, Jesse's Law, which included as a provision -- it was included as well in the SUPPORT Act. It ensures that doctors have access to a consenting patient's prior history of addiction in order to make fully informed care and treatment decisions -- my colleague, Mr. Walden, was talking about this -- because we want to protect people's privacy but we also need to make sure people who are addicted -- Jesse was a young woman in our district that died of a drug overdose because her doctor didn't know.

Ms. Brandt, can you discuss the additional steps that providers are now taking as a result of the SUPPORT Act to ensure that those with a history of addiction are not receiving opioids as pain treatment and the impact that this has had on opioid misuse?

Ms. Brandt. So one of the things that we have done is to have it as part of the visits that Medicare beneficiaries do with their doctors to encourage the doctors to discuss with them issues of opioid addiction and to help them understand --

Mrs. Dingell. Okay. But Medicare is someone that is over 65 or is disabled. Jesse was just out of college.

Ms. Brandt. Right. And, in general, we also have been giving issuance guidance to states to encourage states to work with their providers.

A lot of this is especially for people who are like Jesse -- younger adults -- are not necessarily people that are covered directly by Medicare or Medicaid. They might, you know, be just on their own. So part of this --

Mrs. Dingell. Like a lot of young people in this country.

Ms. Brandt. Correct. And so as a result we have done all we can within our programs to make sure that we are spreading the word to providers.

Mrs. Dingell. So do we need to do more in this area?

Ms. Brandt. I think we can all work together to do more in this area.

Mrs. Dingell. I would like to do that. My time is up so I have to yield back.

Ms. Eshoo. The gentlewoman yields back.

Pleasure to recognize the gentleman from -- oh, from Kentucky, Mr. Guthrie, for five minutes.

Mr. Guthrie. Thank you, Madam Chair. I appreciate the -- I appreciate that, and I am glad we are here to discuss the implementation of the SUPPORT Act in the ongoing opioid epidemic.

My home state is Kentucky and it has been hard hit by the this tragic epidemic, and I believe implementation of the bipartisan SUPPORT Act deserves our full attention in addition

to examining where the gaps remain in policy.

And I also want to mention, and I know Dr. Giroir -- Admiral Giroir -- I went to Army so it is hard to say admiral. I am kidding.

[Laughter.]

Mr. Guthrie. So I really appreciate the Navy, actually. So but I want to -- you mention the NIH Healing Communities grant and it will help -- and what it will do to help communities affected by the opioid epidemic. I was very pleased that the University of Kentucky was awarded one of the community grants and I look forward to seeing them and other awardees reducing opioid-related overdose deaths by 40 percent over the course of three years.

Well, my question is, Ms. Brandt, in your testimony you mentioned Section 1003 of the SUPPORT Act, which authorized CMS to increase the capacity of Medicaid providers to deliver SUD treatment to recovery -- recovery service in a two-phase demonstration. Kentucky was included in the 15 states for phase one. Can you please explain the current progress of the 15 states and what are next steps through translation to phase two?

Ms. Brandt. Sure. Thank you, sir. I am happy to talk about that. We were excited last September to issue $48.5 million to 15 states including Kentucky for an 18-month demonstration project to be able to have them look at, you know, the benefits

of additional types of flexibilities for SUD treatment.

We are currently monitoring the demonstration. We look forward to evaluating the results. The program will end in March of 2021 at the end of the period. At that point we will select no more than five of the 15 states to participate in the final 36 months of the demonstration and there will be an additional $5 million that will go to those states at that point.

Mr. Guthrie. So, next, to Ms. Brandt and to Admiral, how does HHS ensure that opioid federal grant funds are not diverted for unauthorized purposes and do you periodic -- do you do periodic check-ins or are these done annually?

I just want to make sure the money and resources are getting to those who need the resources the most. So how do you do oversight of the funding?

Dr. Giroir. Well, I think we can all take a bit of that. It depends on the -- it really depends specifically on what grant category it is. The State Opioid Response Grants from SAMHSA, as you know, by design provide great flexibility to the states because we want the states to be able to use the funds that are needed for the states but there is, clearly, reporting requirements about what category there are clear stipulations about it has to be evidence-based therapy, right.

So you can't do things that are not supported by science

and medicine, and in other programs they are much more, you know, specifically managed. It just depends on the programs. But, obviously, we are -- we are getting into a phase right now -- not that we haven't been there before but we are really getting to a phase that there is a lot of money on the streets and we have at least four different groups right now doing modelling and simulation to determine where is the best bang for the buck.

In other words, so we can advise you if you put a dollar here it will be better than putting a dollar there right now. It's a very complex system but we are getting to the point of being able to do that.

Mr. Guthrie. Okay. Thank you.

Ms. Brandt?

Ms. Brandt. So for ours because there are demonstrations where we give federal moneys to the states directly or we have models where we give money directly to entities, we track those very closely. That is part of the demonstration agreement is that we look at their spending. We look at how it is being spent.

In particular, with the demonstration you mentioned we have reports to Congress that we are required to give, the first of which I believe we are going to be issuing in October of this

year and that would continue to have it so that we would be able to say how the money is being spent and holding them accountable.

Dr. Giroir. And, for example, some are very easy to monitor like the CDC grants to improve data reporting. So we now know there has been astronomical progress in being able to report data on deaths and on real-time in the emergency rooms.

This was an exercise in history a couple years ago where you were always two years behind. Now for fatalities within six months we have 99.8 percent done down to the level of fentanyl or the analogs. So there are some very specific things that are easy to monitor and we see those results.

Mr. Guthrie. Thank you. My time has expired and I yield back.

Ms. Eshoo. The gentleman yields back.

A pleasure to recognize the gentleman from California, Mr. Cardenas, for five minutes.

Mr. Cardenas. Thank you, Madam Chair, and also the ranking member for having this important committee.

I am happy that this committee is continuing its work on the opioid epidemic and also looking forward to talking about how we can help patients with other substance use disorders. This is a public hearing and I just want to read off some of the legislation that had been introduced by my Republican colleagues

and Democrat colleagues in Congress.

The Medicaid Reentry Act. Another one is Easy Medication Access and Treatment for Opioid Addiction Act. Another one is State Opioid Response Grant Authorization Act. Another one is the Mainstreaming Addiction Treatment Act of 2019.

Another one is Respond to the Needs in Opioid War Act. Another one is Opioid Workforce Act of 2019. Another one is Block, Report, and Suspend Suspicious Shipments Act. And the list goes on.

The reason why I wanted to point that out is because I think the people who have gathered in this room they are all familiar with these bills but the issue that I think that we need to convey to the American people is that we have too many people saying that Congress is doing nothing, and the fact of the matter is we are trying to tackle issues in Congress.

That is why my colleagues on both sides of the aisle, Republican and Democrat, are introducing bills so that we can have legislative hearings like this so that we can actually hear from the experts and try to figure out how do we make life better for the American people on a day-to-day basis, and much of it has to do with making sure that we take the resources that come to the United States Congress, the taxpayer dollars, and make sure that we put it to good, good use.

So I first want to thank my colleagues for the attention that many of my colleagues are putting on this issue but also the experts who are in fact working with the various departments at the federal level, working with our state and local governments to make sure that American lives are in fact being addressed when it comes to issues of opioid addiction and other issues.

I would also like to point out that data from the agencies testifying today tell us that while we are seeing positive signs with the opioid epidemic our work is far from over.

Adding to the need to continue work on substance use disorders in this country is the rise in availability and use of stimulants like methamphetamine and cocaine. The Drug Enforcement Administration's 2019 National Drug Threat Assessment states that methamphetamine remains widely available and the DEA field divisions are reporting an increasing availability of the drug compared to the previous year.

Mr. Prevoznik, is there a difference between the methamphetamine use we saw in the early 2000s compared to what we are seeing now and how is your agency working to reduce its availability?

Mr. Prevoznik. I can address the latter part of your question in that we are currently working Operation Crystal Shield that we just launched that we are targeting the eight districts

-- eight city hubs where we have the transport hubs of methamphetamine, which we have seized. Over 75 percent of the methamphetamine that we have had are in these eight different cities. So we are full court press in those cities. I believe what you -- I am not the expert on -- the whole expert on the methamphetamine of the 2000s compared to that. But if --

Mr. Cardenas. Okay. Please.

Dr. Giroir. So the methamphetamines we are seeing now are essentially -- they are industrial scale. So it is 100 percent pure. It is cheap, very cheap. Much less expensive than it was before and it is being intentionally put in other supplies like fentanyl and heroin to create mixed addictions. So this is a whole different ball game. Not that it wasn't severe before but this is really a true national security issue with hundreds of thousands of pounds of industrialized methamphetamine coming in.

Mr. Cardenas. So the intensity that we are seeing on the streets of America today is higher and then also the activity is more?

Dr. Giroir. Yes, sir. And methamphetamine is, by itself, an extraordinarily addictive drug that you know is toxic to -- it is really toxic to the brain and if you have seen individuals who are on methamphetamines for a period of time you understand the devastation it has to the person and to the community.

Mr. Prevoznik. And if I could add to that. The counterfeiting of the pills themselves is huge because the public just does not know what they are getting. It looks like Adderall but it's not, and we don't know what it is mixed with.

Mr. Cardenas. Okay. Doctor, HHS has a five-point opioid strategy. Is your agency considering a five-point stimulant strategy?

Dr. Giroir. We have a much larger strategy than -- the five points is a good overriding and, in general, access to treatment and prevention that really works, right. There are so many things that work with that.

But, again, we have an intra agency methamphetamine task force of the leaders of every single one of our divisions that have moved forward with a number of actions specific for methamphetamines and also working with DOJ and ONDCP. Director Carroll has been really on top of this coordinating across the agencies as well.

Mr. Cardenas. So you do have a stimulant strategy as well? And many others?

Dr. Giroir. Yes, sir.

Mr. Prevoznik. Yes.

Dr. Giroir. And we briefed -- I think we just briefed your staff on this very recently, maybe a few weeks ago. Is that right?

On our methamphetamines approaches. Yes, sir.

Mr. Cardenas. Thank you so much.

I yield back.

Ms. Eshoo. The gentleman yields back. Excuse me.

Pleasure to recognize the gentleman from Florida, Mr. Bilirakis, for five minutes.

Mr. Bilirakis. Thank you, Madam Chair. I appreciate it so much.

I am going to yield to Representative Brooks my five minutes. If she doesn't take the entire five minutes I will take whatever is left. Appreciate it.

Ms. Eshoo. Well, we can recognize you as well.

Mr. Bilirakis. Okay. That would be great. I was going to --

Ms. Eshoo. I know that Congresswoman Brooks has another --

Mr. Bilirakis. She has another --

Ms. Eshoo. Exactly. So you are recognized for five minutes.

Mrs. Brooks. Thank you so much, Madam Chairwoman. I thank my colleague for yielding to me, and I want to thank each of our witnesses for your incredibly important work.

I must say that given how bipartisan our work has been for

quite some time, I do have one concern about one of the bills that is being put forth, the H.R. 2466, the State Opioid Response Grant Authorization Act.

This committee worked so hard on CARA, 21st Century Cures, and the SUPPORT Act, and we, in 21st Century Cures, passed -- I am sorry, with the SUPPORT Act we actually already have put forth state and local grant programs. And so I am very concerned that H.R. 2466 might undermine the State Opioid Response Grants that the states are already very much working hard on. And so I would be -- I would like to see us remain focussed on the grant programs we have already initiated rather than create a whole new set of grant programs.

With that, I would also like to focus on Section 101 of the CARA Act, which I was involved -- the Pain Management Best Practices Task Force. And we know that that is one of the great challenges in this opioid crisis is trying to figure out ways to treat real chronic and the need for implementation of best practices has never been greater.

In fact, a Harris poll found that 80 percent of primary care physicians believe that the opioid crisis has made it actually more difficult to treat pain patients and they need more information on nonopioid options. Many of the front line providers have actually stopped seeing pain patients because they

are concerned about what they can do for pain patients.

Admiral Giroir, you mentioned already in your testimony the Pain Management Best Practices Task Force and, Madam Chairwoman, this report, which was -- which was the product of really our legislation that we worked on so hard together was issued May 9th. With unanimous consent, I would like for this to be entered into the record.

Ms. Eshoo. So ordered.

[The information follows:]

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

Mrs. Brooks. And I also would ask us to consider potentially even having a future hearing relative to these are incredible recommendations that dozens of providers worked very hard on for an entire year.

But I am very concerned as to what Health and Human Services is doing to ensure that these pain best practices are disseminated. It is a lot for providers. How is this being disseminated to our nation's primary care physicians?

Admiral Giroir, if you know.

Dr. Giroir. Well, it -- first of all, it is being disseminated through the mechanisms that we normally disseminate -- having it posted, speaking about it, having the Surgeon General amplify it.

But we are picking out specific pieces of it and amplifying it on a regular basis. For example, one of the largest issues we are facing is that, as you pointed out, because of all the issues, physicians and other providers are too rapidly tapering people from opioids or taking them off of them acutely. This is really one of the most urgent issues that we face and we have put out sequential guidance for that. The CDC -- I put out guidance from my office in the fall of 2018 with opioid tapering guidelines. So we are doing it generally but our strategy is also to take small buckets of it and to disseminate that as the

priorities exist and that is just -- that is just one example of them. Another one and, again, that I am, as a pediatric ICU doctor, sickle cell patients is one of those categories who have tremendous needs for pain. Not only have we worked with the national program with prescribers through our Office of Minority Health, but even CMS has put out letters that said that you need to exempt these kinds of individuals from their regs.

Mrs. Brooks. So is there a strategic plan, though, to implement these task force reports? As I look at the content -- table of contents -- medications, restorative therapies, interventional procedures -- there are -- I mean, that is just to name the first half of the --

Dr. Giroir. Yes.

Mrs. Brooks. -- special populations there is -- this report is actually I think chock full of incredible information. So is there a strategic plan rather than each of the different agencies taking small buckets at a time?

Dr. Giroir. Yes. So there is an overall -- we -- part of my job is to coordinate across the agencies and you will see in that report almost every section has an individual recommendation associated with that and not every one of those recommendations are being implemented.

But they are sort of being parsed out. For example, some

of the pain research that went directly into the HEAL program. So research on special populations, on women's pain, on pain in special needs population went directly into the HEAL program. So there is no independent strategic plan to implement that. But it is coordinated through our normal activities.

Mrs. Brooks. Well, thank you.

Dr. Giroir. But I hear what you are saying.

Mrs. Brooks. Very proud of this work and all of the work that all the providers and patients put into this, and so would strongly urge that somehow, Madam Chairwoman, we get if not either part of the hearing or that we get more information out about all of this good work that has been done.

With that, I yield back.

Dr. Giroir. And I do think it is one of the best documents and it was incredible. The people who worked on the committee and the thousands of people who provided input makes it a really special contribution and thank you for making that requirement. It was great to do that.

Mrs. Brooks. Thank you, and I yield back.

Ms. Eshoo. The gentlewoman yields back.

Pleasure to recognize the gentlewoman from New Hampshire who once again I want to say has exhibited terrific, very important leadership on the issue of opioids, Ms. Kuster, five minutes of

questions.

Ms. Kuster. Thank you so much, Chairwoman Eshoo, and thank you again for including H.R. 2922, the Respond NOW Act, and H.R. 4141, the Humane Correctional Health Care Act, as part of today's hearing.

I am also grateful to see our discussion include the Opioids Workforce Act, which I introduced with Congressman Schneider. This important bill would increase the number of physicians trained in pain medicine, addiction medicine, and addiction psychiatry.

I have heard from treatment and recovery providers, law enforcement and first responders all across New Hampshire about the need for additional resources to support their efforts on the front line and that is why I introduced the Respond NOW Act, which creates a $25 billion opioid epidemic response fund.

This bill provides those tangible sustained resources of $5 billion a year over five years to our front line. This funding spans across agencies to fund programs like the State Opioid Response Grants and the Child Abuse Prevention and Treatment Act.

This epidemic is complex and what we have learned in New Hampshire is there is no silver bullet approach. I call it a silver buckshot approach with all hands on deck, and because I have heard what many others can attest to, we will not arrest

our way out of this epidemic. So that is why I introduced H.R. 4141, the Humane Correctional Health Care Act, bipartisan legislation to repeal the Medicaid inmate exclusion and allow justice-involved individuals to access quality health care including mental health and substance use treatment.

Across New Hampshire we have seen the difference it can make to have appropriate health care in our criminal justice system. In Sullivan County in my district beginning in 2010 at the beginning of this crisis the jail superintendent had a choice to make to deal with an incredibly high recidivism rate. He could build a new jail for $42 million or bring treatment in-house for $7 million, and thankfully, he chose the latter. As a result, we saw recidivism in that country drop from 54 percent down to just 18 percent, and even those a substantial number were parole violations. It was only 6 percent new crimes.

That is the difference that appropriate health care can make for our most vulnerable population. We can build off of the success that we have seen in New Hampshire by bringing this model to correctional facilities across the country. I am pleased to see that Michigan is implementing a similar program.

So my bill will do just that, improve access to treatment for justice-involved populations by allowing health care to follow the person into incarceration. We have heard in this

committee that Rhode Island has opioid addiction treatment for justice-involved populations that reduced post-incarceration death by 61 percent. These aren't just statistics.

These are real lives of people in our communities. If we are serious out overcoming addiction we must treat this as a disease, not a moral failing, and because let me tell you, if we were to design a system to fail this would be it. A system that strips health care from a person at their most vulnerable point. A system that leaves the crippling disease of addiction untreated and a system that perpetuates recidivism instead of prioritizing rehabilitation.

So it is time to look at the evidence, listen to our communities on the front line, and end this outdated policy. I want to thank Chairwoman Eshoo and Chairman Pallone for including this bill in today's discussion. This bill presents our committee with the opportunity to turn the tide. I have seen how it works in our state.

I would love to hear your comments on how it could work across this country if we eliminated the Medicaid exclusion for justice-involved individuals, if you have any comment.

Ms. Brandt. I will address that, at least from the Medicaid perspective. We are in the process right now of finalizing implementation of support at Section 1001, which requires states

to suspend, not terminate, Medicaid enrollment for juveniles and that is going to be finalized within the next few months.

And then we also have two budget proposals, one which would, again, suspend, not terminate, Medicaid enrollment for not only all incarcerated individuals but for those covered under CHIP, the Children's Health Insurance Program, as well. Both of those would be for six months.

Ms. Kuster. And what I am hoping is that you would consider supporting our bill that would take it a further step. I appreciate the efforts you are doing but your hands are tied. We need to go a further step and actually have the Medicaid coverage follow the individual during their incarceration so that they can get access for their co-occurring mental health and substance use.

And so my time is up, but I do want to submit for the record the wonderful letters of support from all of the great organizations that will be on our next panel that support this approach.

And I thank you and I yield back.

Ms. Eshoo. And so ordered, and we thank the gentlewoman.

[The information follows:]

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

Ms. Eshoo. Those are dramatic figures that you cited. Excellent. The gentlewoman yields back.

Pleasure to recognize Mr. Griffith for five minutes.

Mr. Griffith. Thank you very much, Madam Chair, and I appreciate having this hearing and considering one of my bills.

Before we get to that, I do want to address some of the comments that were just made. And Ms. Brandt, I really appreciate the fact that you are working on the juvenile issue and suspending, because it is one of the concerns that we have had back home.

When a juvenile goes into custody and then has to reapply when they get out, and so suspending instead of terminating will make a huge difference so that when that juvenile gets back out we don't start the process all over again and take 60, 90, or more days to get them back into the system to make sure they have their health care. So I appreciate that, and you mentioned CHIP as well. Is there anything else you wanted to say on that?

Ms. Brandt. No. We do think these are important flexibilities that will, to your point, be able to allow these individuals to have that much needed coverage.

Mr. Griffith. I am concerned about going that extra step and I think it is probably a good bill that Representative Tonko has that says we will start -- for adult prisoners we will start

the process 30 days before they are released so that if they are eligible for Medicaid they can -- they can receive it but not while they are in prison.

How much would the bill that Ms. Kuster was talking about a minute ago, her H.R. 4141, what would that cost if we suddenly took on the responsibility for all the prisoners, whether they be local -- and most of them would be local and the state because we are already responsible, maybe not through Medicaid but through other federal coffers, to pay for medical care for those in federal prisons. But how much would it cost if we suddenly took on all the state and territory, local and state folks who are incarcerated and in jail for some reason?

Ms. Brandt. That would be something, sir, where I would have to get back to you. But we would be happy to work with you all to be able to provide estimates based on our information.

Mr. Griffith. I would assume it would be billions and billions of dollars. Is that a fair assessment?

Ms. Brandt. It would be substantial, yes.

Mr. Griffith. Yes, ma'am. I thought so.

Now, we are also -- you know, we have been talking about a lot of different things and I want to make sure I get in a plug for a bill that I am carrying and that is -- and that we are considering today, the Ensuring Compliance Against Drug Diversion

Act.

H.R. 4812 would terminate controlled substance registration belonging to someone who dies, ceases to legally exist, or discontinues business or professional practice. It would also require registrants to obtain written consent from the DEA to assign or transfer their registration.

Can you tell us a little bit about the process of registering to manufacture, distribute, dispense controlled substances and remind us of why it is important for DEA to be involved in these changes to controlled substance registrations?

Mr. Prevoznik?

Mr. Prevoznik. Yes, sir. Thank you for that question.

The current way that it works is that we work with each registrant to assess are they terminating, how they are terminating, where are they being sold, how are they being sold. So we work with each individual to assess that particular situation.

It would be helpful to engage them more on that because what we do see is we are seeing some transactions in which it is just the actual shares are being sold. So it kind of makes it convoluted on who actually is owning it. So we would certainly work with you on that to discuss that.

Mr. Griffith. Well, whatever you -- if you have got

suggestions now is the time to make them because I think it is something that is a good idea and we are going to go forward. But if there is something we need to tweak, let me know.

Mr. Prevoznik. Absolutely.

Mr. Griffith. Absolutely. We brought up -- one of the members on the other side brought up methamphetamine. It is a serious problem.

Mr. Prevoznik, I will continue with you for just a second. You indicated that there were counterfeits that were looking just like Adderall. Adderall is a prescription drug. Are we seeing any problems in our drug supply chain or is it just on the street -- in the street market for Adderall?

Mr. Prevoznik. On the street market.

Mr. Griffith. On the street market. And are there some people who -- we talked about how cheap it was to get these meth products. Is this a lot cheaper than they can get through their prescription -- regular supply chain -- the Adderall? If you actually had a prescription but is it a lot cheaper on the street?

Mr. Prevoznik. It would depend on the supply.

Mr. Griffith. Depend on the supply.

Mr. Prevoznik. Yes.

Mr. Griffith. And, Admiral, you indicated that we had a big supply of this -- of meth coming in. I remember, you know,

when we had a previous spike we had what was known as shake and bake. People were making it themselves. Is that what we are seeing today with this higher quantity or higher intensity meth?

Dr. Giroir. Because of the law enforcement efforts, there is essentially negligible production in the United States. This is transnational Mexican cartels that are making it on an industrialized basis at the hundreds of thousands of pounds per factory and every cartel has a number of factories and they are pouring into our country.

Mr. Griffith. And what is the main way of bringing that in? Is it over the border or are they flying it in?

Mr. Prevoznik. It comes from all different ways.

Mr. Griffith. But isn't it true that most of it would be coming across the border in the South?

Dr. Giroir. Yes.

Mr. Prevoznik. That is true.

Mr. Griffith. Thank you very much. I yield back.

Ms. Eshoo. The gentleman yields back.

And now I would like to recognize the gentlewoman from -- oh, no, the gentleman from New Mexico, Mr. Lujan, for five minutes.

Mr. Lujan. Thank you, Madam Chair. I want to thank Chairwoman Eshoo, Ranking Member Burgess, Chairman Pallone, and Ranking Member Walden.

I mentioned earlier that I have Lauren Reichelt, the Health and Human Services director for Rio Arriba County, New Mexico, here with us today. Lauren, thank you for your work and thank you for what you do.

Five years ago, Rio Arriba County received funding from the state of New Mexico to establish a behavioral health investment zone. As part of the investment zone, her department leads an Opiate Use Reduction Network, which allows the various health care agencies and providers to work collaboratively to manage individual cases and connect patients to services.

The network had an immediate impact in 2015 when it made overdose reversal drugs available throughout the county. Right away they saw a 30 percent drop in overdose deaths. Over the past few years, overdose deaths in the county have continued to decline.

While ER visits for overdose initially increased because people's lives were saved and they were able to receive treatment, those numbers are now being driven down as well with better prevention in the community.

Rio Arriba County was selected for this project because it was a national leader in overdose deaths. Now they are a leader in showing the rest of the nation how to address substance use disorder head on with a network of community supporters.

So, Lauren, again, I want to recognize your work and that of your team.

Mr. Prevoznik, you mentioned in your testimony that there are just over 75,000 D-A-T-A, DATA-waived practitioners who are authorized to provide medication-assisted treatment with buprenorphine. Is that correct?

Mr. Prevoznik. Correct.

Mr. Lujan. And how does that number compare to the number of practitioners who are registered to prescribe controlled substances?

Mr. Prevoznik. It is a much smaller percentage.

Mr. Lujan. How much smaller? A little bit? A lot?

Mr. Prevoznik. Quite a lot.

Mr. Lujan. According to the Diversion Control Division's website, there are over 1,756,677 practitioner registrants, including over 1.3 million doctors, over 400,000 mid-level practitioners. We have nearly 12 -- and just to compare that number, so 75,000 on the other side, 1.7 million on the other.

In New Mexico, we have nearly 12,000 practitioners who are registered with the DEA to prescribe controlled substances including opioids. Yet, only 1,200 who can prescribe buprenorphine for medication-assisted treatment. Isn't that

something that we should fix?

Mr. Prevoznik. Yes. I mean, it is requirement by SAMHSA that they have certification for the treatment so they have to take the training in order to get -- to be DATA-waived.

Mr. Lujan. So if there is the ability to prescribe the opioid, shouldn't those practitioners or others be able to also help treat people to prevent overdose?

Mr. Prevoznik. Those that -- those that are certified, yes.

Mr. Lujan. Well, how do we close the gap for 1.7 million to 75,000? How do we close that gap?

Mr. Prevoznik. Well, I mean, one of -- one of the things that we did do that was part of the SUPPORT Act is we just passed notice of proposed rulemaking for mobile NTPs so that NTPs -- that brick and mortars can now have mobile units that can go out to the rural areas or those areas of need so that we have proposed that and it is out and looking forward to comments from the industry on that. So that should help out some.

Mr. Lujan. And there is another piece of legislation that Senator Tonko and I have introduced called the Mainstreaming Addiction Treatment Act to eliminate the outdate requirements for providers to go through additional hurdles to provide the treatment that patients need and which are qualified to provide, and I hope that is an area that we can work on together and that

the committee is willing to be supportive of as well.

I urge my colleagues to support this legislation and I am proud to support several of the other proposals that we are considering here today including the State Opioid Response Authorization Act to make sure these crucial grants make it to states and the Opioid Workforce Act to create more residency slots for physicians to enter the field of addiction medicine.

And lastly, just because it was mentioned, the importance of Project ECHO, which has been highlighted by the Office of National Drug Control Policy in their new action guide for drug-free rural communities.

ECHO provides a telemonitoring program to train and support primary care providers who want to start or expand medication-assisted treatment in their communities. It is proven to be a cost saver and a lifesaver. It has been expanded to the VA as well and I am certainly hopeful that we can continue to be supportive of this.

Admiral, I see you nodding in agreement there. So anything you might want to add there on Project ECHO?

Dr. Giroir. I just think Project ECHO and Dr. Sanjeev Arora at University of New Mexico has been transformational and a game changer, whether it is opioids, whether it is sickle cell or now they are doing ECHOs on coronavirus, it really is a gift from

New Mexico and the University of New Mexico to the world. I could not be more impressed with that program.

Mr. Lujan. Glad to hear you say that. Dr. Sanjeev Arora is a real hero of mine and someone that I appreciate very much, sir.

Thank you so much. I yield back.

Ms. Eshoo. The gentleman yields back.

A pleasure to recognize the gentleman from Florida, Mr. Bilirakis, whose father was chair of this Health Subcommittee when he served in the Congress.

Mr. Bilirakis. Thank you.

Ms. Eshoo. Another true gentleman. Five minutes.

Mr. Bilirakis. Yes, he is a good man. Thank you. Thank you very much.

Ms. Eshoo. Sure.

Mr. Bilirakis. I appreciate it, Madam Chair. Thank you so much.

The first question is for Mr. Prevoznik. I hope I got that right.

Mr. Prevoznik. It is okay.

Mr. Bilirakis. I will get it right the next time.

One of the bills we are considering would eliminate the separate DEA registration requirement for providers prescribing

buprenorphine for SUD treatment.

Why does a patient limit exist today for buprenorphine and what is its extent post-SUPPORT Act?

Mr. Prevoznik. So it is buprenorphine and --

Mr. Bilirakis. Yes. Sorry.

Mr. Prevoznik. That is okay. The requirement is actually an HHS SAMHSA requirement.

Dr. Giroir. It is statutory.

Mr. Prevoznik. Statutory as well.

Mr. Bilirakis. Okay. Very good.

Admiral, Congress commissioned an HHS study due later this year in the SUPPORT Act that will include recommendations on where patient limits should be set.

Does the HHS have any concerns with Congress removing this limit without this study idea? The data, in other words. The study data idea.

Dr. Giroir. So two points, sir. The main problem we have are not with people bumping up against their limit but people not even prescribing even close to their limit. So we are trying to work on that set of barriers that are -- that are there that keep people prescribing for five or 10 people instead of 120 or 130 people.

The general concern, and it is not an overwhelming concern,

but the concern is, as all of you have pointed out, people in my generation or even younger do not get appropriate training for addiction medicine in medical schools.

So there needs to be a gradual process as people get trained under a DATA waiver that eventually -- now it is moving very quickly, that people are getting more and more training there is funds to do that.

But right now, we are sort of in that unstable period where we don't want to just give people the ability -- it is not just give a pill. These are people with a chronic brain disease and there needs to be some training.

It is only eight hours training, right? It is only eight hours of training for a physician. So we would, of course, like to do the study and work with you on that.

But again, we have been focused on the main problem of people -- only 110,000 prescribers by our data, or 70,000 have waivers, and they are prescribing only at a small fraction of their prescribing ability.

Mr. Bilirakis. So you are saying it is mandated now in the medical schools that they get the training. How many hours you said?

Dr. Giroir. So the DATA waiver, it is only eight hours or physicians --

Mr. Bilirakis. Eight hours.

Dr. Giroir. -- and, you know, that is not a big burden. Most states you have to do 20 or 30 hours of continuing education a year, and for nonphysician prescribers in general it is 24 hours of training.

Mr. Bilirakis. All right. Thank you very much.

Next question is for Ms. Brandt. What can CMS do to encourage or utilize nonopioid-related quality initiative programs to incentivize providers to use less opioids during pain management to decrease the long-term opioid addiction risk? This is a question -- I mean, this affects all our communities, as you know. So if you could answer that I would appreciate it.

Ms. Brandt. Sure. As I mentioned in my opening statement, one of the things we have recently done is expand coverage to things like acupuncture. So we are really looking to, you know, expand our use of nontraditional opioid alternatives.

We also did the RFI, or request for information, in September of last year where we basically sought feedback on ways that we, as an agency, could help address the crisis and look particularly at, you know, what are the Medicare and Medicaid payment and coverage policies that have enhanced or impeded nonopioid treatments -- where are the barriers that we have that we can potentially change.

We have really been working very closely with the department and taking the recommendations that were discussed earlier from the interagency pain task force to really look at how we can pull our levers to try and expand our coverage as much as possible for these nonopioid alternatives.

Dr. Giroir. And maybe I will just --

Mr. Bilirakis. Yes, sir?

Dr. Giroir. -- mention that we have many ongoing work streams. So under CDC but being done by AHRQ, the Agency for Health Research and Quality, there is a report that is going to be published in April on nonopioid pharmacologic treatments to chronic pain that review the entire world's literature as well as one that talks about noninvasive nonpharmaceutical treatments coming in April.

So there is going to be a whole lot more guidance coming out that we want to be evidence-based, right. We got into this problem because we didn't look at the evidence and opioids got over-prescribed.

So we are trying to be very careful through CDC and AHRQ to make sure the best evidence is considered as we roll this out, again, in the spring. The spring is going to be a busy time.

Ms. Brandt. Busy.

Mr. Bilirakis. Very good. I am on the VA Committee as well

and, you know, we have been exploring these alternative therapies for PTS and TBI but also for opioids, whether they are alternative or complementary, to reduce the dosage of the opioids.

So we all have to work together and think outside the box because this is a true epidemic in this country.

Thank you very much, and I yield back, Madam Chair.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the gentlewoman from Illinois, Ms. Kelly, for five minutes.

Ms. Kelly. Thank you, Madam Chair, and I thank the committee for holding this hearing for all the witnesses for being here today.

We have all heard the statistics about the opioid epidemic and how it is impacting Americans. As chair of the Congressional Black Caucus Health Brain Trust, I have worked with my colleagues to create legislative and policy solutions to reduce health disparities and promote good health outcomes in all communities.

I also think it is important to have a conversation about how we are making sure minority individuals with substance use disorder are receiving equal treatment opportunities.

I understand that there is a number of barriers that exist for patient show seek to receive treatment. However, I was concerned to hear that some of the barrier have also heightened

racial inequities.

An article written last year in JAMA Psychiatry found that although opioid use disorder rates are similar for white patients and black patients, white patients received a prescription for medication-assisted treatment at much higher rates than black patients.

Admiral, were you aware of this study when it was published last May and these statistics?

Dr. Giroir. Yes, ma'am. I don't remember what date it was published by we are acutely aware of that, and it, clearly, is our position and it should be our position that this is a chronic brain disease.

It doesn't matter what color you are. Everybody deserves medication-assisted treatment for opioids as the cornerstone of therapy along with all the psychosocial and other issues.

Stigma is an issue no matter where you go and we are trying to work through those issues specifically not only with racial and ethnic minorities but also for women.

So in my office, the Office of Women's Health and the Office of Minority Health, focus on disparities across the board but specific efforts throughout the regions to make sure that MAT and other evidenced, based treatments are provided.

I will also say that Dr. McCance-Katz, who we are all a fan

of, is absolutely adamant that the State Opioid Response Grants will only support evidence-based treatment. So if you are in a program that doesn't offer MAT or doesn't offer meaningful MAT, you are not going to get funded by that.

So anything we can do, and I would love to work with you to enhance those treatments for everyone.

Ms. Kelly. A morbidity and mortality report issued last year by the Center for Disease Control and Prevention reported that opioid overdose rates for African Americans increased more than any other group from 2016 to 2017.

Admiral, what do you believe are the barriers or challenges facing African Americans with opioid use disorder and accessing treatment?

Dr. Giroir. So it is very complicated and my office tried to do studies as well because it is very interesting. I don't mean interesting in an academic way. It is really challenging because it is not even across the board for African Americans.

It is really segmented into certain age groups that are seeing the higher rates and whether they are urban or rural, and all of those have different -- you know, all of those have different challenges.

On the urban side, particularly recognizing that many

minorities are socioeconomically in a challenged position, we have been working very closely with HRSA and the community health center program, which I love. Now takes care of 30 million Americans and one out of three in poverty, and they have made a full court effort to integrate SUD behavioral health and physical all within the same environment.

In many cases, I think they are a model for how the U.S. health care system should go forward. You know, that is one example on the urban side and we have been -- really been focusing with FQHCs and, you know, rural is a whole another topic but happy to get into that with you as well.

Ms. Kelly. And how do you think Congress can help HHS agencies manage inequities and treatment access? What more can we do?

Dr. Giroir. So, you know, that is a -- that is a big question. Number one, we need to -- we need to take care of treatment across the board, right -- across the board.

We are also -- so number one. Number two, we do need a workforce and that is critically important, and as you know, the workforce tends to be disproportionately not in areas where minorities are in rural.

So, for example, funding the Addiction Medicine Fellowships that are proposed, we think that is very important. And I just

want to make the point is it is not -- it is okay to train addiction psychiatrists. We need that. But we need a lot of primary care practitioners who work in rural, just internists, OB/Gyns, to get that one year of addiction training, because they are really on the front lines and we are trying to incent that with the National Health Service Corps, with HRSA loan repayments, a $5,000 incentive if you get your DATA waiver -- all those kind of things.

So I would say that still workforce is a real issue as well as parity and reimbursement through systems like Ms. Brandt's. I mean, that is very important. If you have the workforce but you don't have the appropriate reimbursement for care, you are not going to have a long-term solution.

Ms. Kelly. And through the Brain Trust we try to make sure that we are pushing for a diverse workforce. And lastly, I just want to say to Ms. Brandt I totally believe in acupuncture. I had a pinched nerve and that is the only thing that worked. So good luck.

Ms. Brandt. Thank you. My mother was also very happy about that.

Dr. Giroir. You can now be covered under Medicare for that once you get to that age. Yes.

Ms. Kelly. I am not far away.

[Laughter.]

Ms. Eshoo. Well, thank God you are feeling terrific. We need you.

The gentlewoman yields back, and now I will recognize the gentleman from North Carolina, Mr. Hudson, for his five minutes.

Mr. Hudson. Thank you, Madam Chair. Thank you for holding this important hearing and thank you to our panel for the great work you do every day. Thank you for your time being here with us.

Congress took strong bipartisan action in 2018 to combat opioids epidemic but I have always believed that that was the first step. In North Carolina, we have four of the top 25 worst cities for abuse in the country, one of which is in my district, the city of Fayetteville.

This issue is personal for me. It is personal for my constituents, just as I know it is personal for everyone in this room. I believe this hearing gives us a good opportunity to examine what we have done and what the next steps are.

Admiral Giroir, I understand that as a senior advisor for opioid policy at HHS you are responsible for coordinating the department's response to the opioid epidemic. I know the primary focus of today's hearing is on treatment and recovery, but I have had many providers in my office tell me that prevention is often

the best treatment.

As we discussed in this committee before and you and I have discussed, most addictions start in the medicine cabinet. Getting unused medications out of the home in a safe and timely manner is critical, particularly if a household has teenagers or other susceptible family members.

Unfortunately, federal disposal recommendations are inconsistent, ineffective, and out of date. Let me just go over a few points that have been a concern to me.

First, we need consistent messaging out of HHS. For example, FDA includes a list of drugs that could be flushed down the toilet, including fentanyl. SAMHSA discourages this practice altogether.

Second, we need someone to review the adequacy of the current federal recommendations. I understand GAO put out a report in September highlighting that very few people actually follow the federal recommendations.

And third, it has been over a decade since these federal recommendations have been updated. And so given all those issues, I do believe it is appropriate to advise people to mix -- I don't believe it is appropriate to advise people to mix their pills with kitty litter, as it says on one of the websites, or coffee grounds, and I know there are better options for in-home

disposal that we could -- that we could talk about instead.

Can you commit to me to look in these issues and get back to me on sort of the next steps on trying to address these disparities?

Dr. Giroir. Yes, sir. I absolutely do. It is an area that we really do need to work on. We focused on take back days and other things that we know have been highly effective.

But it is not just in HHS. There is DEA and many agencies involved with this. And yes, sir, I will do that and I think that is a really good direction for us to move in the next level.

Mr. Hudson. I appreciate that and, sir, from DEA's perspective do you -- interested in commenting?

Mr. Prevoznik. Absolutely. We would certainly work with you, yes.

Mr. Hudson. Okay.

Mr. Prevoznik. And we want to make April 25th as the next Take Back Day. So --

Mr. Hudson. April 25th?

Mr. Prevoznik. -- get it out of the cabinets.

Mr. Hudson. Absolutely. Well, thank you. I appreciate that.

Ms. Eshoo. Mr. Prevoznik, I can't -- I am losing some of your words and I think they are important for everyone to hear.

Can you just answer the gentleman's question again?

Mr. Prevoznik. Yes. The next -- I just want to put a plug in there that the next National Take Back Day is April 25th.

Ms. Eshoo. I see.

Mr. Prevoznik. So please get that medicine out of your cabinets.

Mr. Hudson. That is great. Madam Chair, I think it is important we continue to promote that. But I think it is also important that we look at these federal recommendations and make sure they make sense. Make sure that different agencies don't have, you know, guidance that contradicts other agencies' guidance and that we are giving the best information to folks.

Ms. Eshoo. Well, it is wonderful that you are pointing out. I wasn't even aware of it. So thank you.

Mr. Hudson. With that, I will be happy to yield back.

Ms. Eshoo. You still have some time. Do you want to yield time to someone?

Mr. Hudson. If anyone would be interested in the time I would be happy to yield.

Ms. Eshoo. Can I take 10 seconds?

Mr. Hudson. Please.

Ms. Eshoo. Does anyone on the panel know -- Medicare has been referenced more than once in our hearing this morning. Do

you know what the addicted population of Medicare beneficiaries is in our country?

Ms. Brandt. We can get back to you with an exact number on that, ma'am. But of our Medicare Part D or our drug coverage beneficiaries it is a fairly small but meaningful percentage that we definitely focus on.

Ms. Eshoo. That we what?

Ms. Brandt. It is a -- it is a small percentage of our Part D beneficiaries. But I will get you the exact number. I would be happy to get back to you with that exact --

Ms. Eshoo. Because there was a lot of emphasis about benefits and what they need in the Medicare population, and, I mean, I think Medicaid is the main player in this. But I would appreciate getting that information.

The gentleman yields back. Thank you.

The chair is pleased to recognize the gentleman from Maryland, Mr. Sarbanes, for five minutes.

Mr. Sarbanes. I thank -- thank you, Madame Chair, and thank you too to the panel.

Admiral, you started to speak a moment ago. I want to pick up on this topic of the workforce because I think it is really critical and, you know, we can put resources behind expanding our capacity in terms of the general delivery framework that we

have to address this crisis.

But if we don't have the professionals in place to actually deliver the care then that, obviously, is going to impede progress on our efforts.

Two years ago, and this is -- the workforce issue is something I have brought some special attention to in my time here in Congress, even going back to the passage of the ACA and pushing the idea of developing a national health care workforce commission to kind of look at where the shortages are.

But two years ago, I joined my colleagues, Katherine Clark and Hal Rogers in introducing the Substance Use Disorder Workforce Loan Repayment Act. So that is a bipartisan bill that would help increase a number of health care professionals working in addiction treatment in substance use disorder programs around the country by offering student loan forgiveness when they provide direct patient care at opioid treatment programs, and then that bill was included in the SUPPORT Act, I am glad to say.

I am also a co-sponsor of one of the bills that we are looking at today, which is H.R. 3414, the Opioid Workforce Act. We know many communities across the country are facing shortages of these kinds. Professionals lack access to the services they need as a result.

This is especially true, as you know when it comes to mental

health and substance use disorder providers, and in addition to the affordability the provider capacity is clearly a barrier to treatment.

H.R. 3414 would help expand treatment by growing the provider workforce. It would make a thousand new graduate medical education slots available under Medicare. Those slots would be targeted towards training providers in addiction medicine, addiction psychiatry, pain medicine, or prerequisites of those programs.

So I will just give you the opportunity maybe just to speak broadly about the importance of meeting these workforce needs, where you seen the bottlenecks. Another kind of iteration of this, a kind of second degree issue relates to you can put money in programs in place to train providers but then finding the folks that can deliver the training sometimes also can be a challenge.

So how do we make sure that we fill these gaps in terms of the workforce and to the extent you would kind of prioritize or triage that effort can you speak to that as well?

Dr. Giroir. So thank you, sir, and this is -- this is a critically important long-term issue. This is not a put a Band-Aid on it but this is how we sustainably begin to fix the system.

There are shortages of psychiatrists for mental illness and

shortages of addiction psychiatrists. There are also shortages across the board. Being a physician, I can say don't just focus on physician training.

It is social workers. It is community health workers. It is peer counsellors and peer coaches, all the -- all the different aspects that you need. What we have done is a couple of things, number one, and you will be seeing this coming out this year.

We have asked, and HRSA has been working very much on not just, like, drawing the line. Like, so many psychiatrists die this year and we will draw a line on how many need to come. But what is the impact of the new models of care and what are the impact of things like telemedicine on changing the entire model and how do we move the workforce to that -- just to park that.

Secondly, we have focused on ancillary providers through the National Health Service Corps, you know, nurses, you know, all the health care providers that are non-physician.

But, again, I do want to say that the addiction medicine fellowships, we are very excited about that because it brings people -- like, if you want to decrease neonatal abstinence syndrome, let us train obstetricians to have a year of addiction medicine so they can provide the treatment that is right there.

Pediatrics -- you know, a lot of this starts in -- I am a pediatric ICU doctor in 14, 15, of 16 years of age. So we are very bullish and I think there is broad support in the community to supply these kind of one-year fellowships and you could imagine a family practice group that may have eight physicians and two are trained in addiction medicine. It really changes the way how we deliver care.

So but you can really say all of the above, sir. We really need all of the above types of professionals because they will help not only in opioids but in methamphetamine, in alcohol addiction, in marijuana addiction, all the kinds of things that our society faces. This truly -- if we get the workforce right and we get the model right and we get the incentive payments right, this will work out in the long term.

Mr. Sarbanes. Thanks very much.

Yield back.

Ms. Eshoo. The gentleman yields back.

Please to recognize the gentleman from Georgia, Mr. Carter, for five minutes.

Mr. Carter. Thank you very much. I thank all of you for being here.

Ms. Brandt, I am going to start with you. I need to understand exactly the rule proposals, the rule changes that you

are proposing. If someone is incarcerated their Medicaid would be suspended for 60 days and then reinstated?

Ms. Brandt. Six months, sir.

Mr. Carter. Six months?

Ms. Brandt. It would be for six months.

Mr. Carter. Okay. How do you -- is it six months or less or is it -- I mean, how do you determine how long somebody -- is that he usual sentence or what?

Ms. Brandt. So it's a great question and we came up with six months because there were a number of people whose sentences were less than the six-month period of time. Usually, it's much more serious types of things that would incarcerate them for longer than that.

Mr. Carter. If they are less than six months and they get out after three months, they got to wait three months before it kicks back in?

Ms. Brandt. No, it's up to six months.

Mr. Carter. Up to?

Ms. Brandt. Up to six months.

Mr. Carter. Okay.

Ms. Brandt. So that way we give them that flexibility.

Mr. Carter. Okay. All right. And let me -- let me say that I know what a big problem this is. I have been to the jails

visiting them. I know what a struggle they are having paying for these anti-psychotics, paying -- and I can see the value that this would have.

However, I wanted to ask you specifically about 4141, the Humane Correctional Health Care Act. Do we -- and you have been asked this in this hearing -- do we have any idea how much that would cost?

Ms. Brandt. You know, that particular provision actually would not impact us at CMS but we don't have -- I don't have a good number --

Mr. Carter. It is going to impact somebody in the -- I don't need to hear that it is not going to impact me so I am washing my hands of it.

Ms. Brandt. No, absolutely. No, and we would be happy to work with you to give us any data we have --

Mr. Carter. Well, as I understand it, the bill has got -- part of the bill in there is to do a study to see how much it would cost. But it seems to me like that is after the fact.

I mean, if we were to implement this and then find out how much it costs, this is going to be billions upon billions of dollars that we are looking at here. And what about the impact on the state? The states is going to -- the states are going to have to take up their part of it as well. This could bankrupt

some of these states.

Ms. Brandt. Again, we share your concern. That is why our budget proposals are up to six months and happy to work with you to provide whatever information and data we can.

Mr. Carter. Okay. Good. If I could switch over to Mr. Prevoznik.

Mr. Prevoznik, I was a practicing pharmacist for over 30 years and while I was serving in the Georgia state Senate I sponsored the legislation that led to the establishment of the Prescription Drug Monitoring Act. I have seen what a problem this is.

But I have also been a frustrated pharmacist because over the years I have reported physicians whose practices -- whose prescribing habits in their practices have been questionable. Reported it to the DEA as a number of pharmacists have only to get no response whatsoever.

I just want to ask you has that changed any? Are you helping pharmacists now to identify those physicians that are out of control and to try to get them under control?

Mr. Prevoznik. That is a great question and I appreciate that. As a diversion investigator, when I heard from a health care professional such as a pharmacist, that unequivocally sent all the tentacles up on the back of my neck that this is very

important because this is a pharmacist who knows the community, he knows the practice of medicine. When they say, what are you doing about Dr. Candyman -- the candyman -- what are you going to do about this, you have our undivided attention on that.

As a law enforcement agency we -- well, sometimes we cannot come back to you to talk about the investigation because we are investigating the candyman or whoever you are presenting as a person who is diverting.

I can't overemphasize how important your voice is and that the pharmacists do need to speak up and let us know what is going on because you do have the pulse of that community.

Mr. Carter. And you see what a difficult position -- and I can appreciate the fact that you can't always communicate with us what is going on. You are, obviously, building a case.

But at the same time it puts us in a precarious position as well because we don't know whether to fill the prescriptions or not fill the prescriptions and, you know, I have always said the only thing worse than filling a prescription for someone who doesn't need it is not filling a prescription for someone who does need it.

Now, having said that, I want to ask you this. I am continuing to get calls now at home, I get them in my office, I get them from constituents, I get them from people who know

that I am the only pharmacist currently serving in Congress.

But they want to know, there is a problem here with some of these people who do need this medication getting this medication. I think it was mentioned earlier that we are trying to help soften that blow, if you will.

But we get calls. It was always my fear and I tried to communicate this and articulate it to my colleagues we got to be careful how far we swing that pendulum. Now we have got people out there who truly need these medications who can't get them and that is creating a big problem.

Admiral, are we addressing that?

Dr. Giroir. Yes, sir. It is one of our biggest concerns. We have heard from, you know, hundreds of patients if not thousands about patient abandonment or too abrupt discontinuation of opioids and when you have an opioid use disorder and your opioids get taken away what do you do? You go to the streets because if I can ask you to stop breathing for 10 minutes you can ask them to stop cold turkey.

So we put out -- the CDC and my office put out guidance. We published it in the literature. We are referencing that all the time in order to make sure that, you know, if you do this do this very slow and in a patient-centric noncoercive way, and I just want to echo how important -- we can swing the pendulum

to the other direction and I think we have kind of gone too far, at least for many patients in a significant way.

Mr. Carter. Absolutely. Well, again, I want to thank all three of you for what you are doing. This is extremely important. I witnessed this firsthand when we were at the epitome of this and I have seen improvements and it is encouraging.

So thank you, and I yield back.

Ms. Eshoo. Gentleman yields back.

Pleasure to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for five minutes.

Ms. Blunt Rochester. Thank you, Madam Chairwoman, and thank you so much to the witnesses for this very important hearing today.

Our nation's ongoing overdose crises isn't represented by one community, one region, or one socioeconomic class. We are all being touched.

I am proud to have worked with my colleagues to address the rise of overdose deaths by passing the 21st Century Cures Act and the Support for Patients and Communities Act.

Despite these efforts, Delaware continues to be in the middle of a public health crisis. As our nation's overdose death rate dropped for the first time in two decades, my state remained fifth in the nation due to higher rates in 2018 and 2017.

Looking at the highest age-adjusted drug overdose death

rates in 2018, Delaware is second in the nation. Those aren't just numbers. It means we are losing someone every 22 hours to an overdose.

The rise in synthetic opioids is playing an increasing role in overdose deaths. In 2009, almost all of Delaware's overdose deaths were due to prescription opioids like oxycodone. However, in 2017, synthetic opioids contributed to 72 percent of our 400 overdose deaths.

As our committee continues to combat the opioid epidemic I look forward to working with my colleagues on a comprehensive public health response to the proliferation of synthetic opioids.

My first question is to you, Admiral, and I just want to follow up on Ms. Kelly's line of questioning. You got a chance to talk about the urban area. Delaware is urban, suburban, and rural, and I was hoping that you could speak specifically to the unique challenges and solutions for rural communities.

Dr. Giroir. Yes, ma'am. So rural communities have a whole plethora of issues. Some are the same and some are different. If you look at many of the rural areas they have higher prescribing but many people are also -- have jobs that takes a toll on your bodies, right, so you are in chronic pain.

So it really goes that way. So they have that problem. We find that in rural areas actually the economic issues are more

important than provider issues for neonatal abstinence syndrome.

Urbanly, it is providers. Rurally, it is actually the socioeconomic issues and opportunity. But I think we all know that provider shortages in the rural area is really the 800-pound gorilla in the room and the way to solve that is, of course, increasing providers, National Health Service core issues like that and trying to bring people to under served areas. And I can't -- I can't overestimate -- I can't over emphasize the importance of things like telemedicine.

Telemedicine for MAT is really a game changer because it allows people who may not have a DATA-waived provider to gain access to that provider remotely and I would personally like to see as many efforts as possible to enhance telemedicine -- telemedicine reimbursement across the board.

Ms. Blunt Rochester. Thank you. I appreciate that CMS has also taken steps to increase the capacity of Medicaid providers to deliver substance use disorder treatment through funding grants authorized by the SUPPORT Act.

Delaware was fortunate to be one of the 15 states to receive a planning grant. Sixty percent of Delawareans who died from an overdose in 2017 were Medicaid eligible the previous year.

We know that the Agency for Healthcare Research and Quality

will consult with CMS to report back to Congress on the experiences of states who were awarded planning grants.

Ms. Brandt, I would like to ask if you would just pay particular attention to how states dealt with one of the greatest barriers that has been discussed here today, which is providers' lack of willingness to treat SUD because of stigma and also knowledge gaps. If I could just have you confirm that that will be a focus.

Ms. Brandt. We will certainly take that into account, ma'am.

Ms. Blunt Rochester. And, Ms. Brandt, also additional statutorily-required reports in these will CMS track or measure whether physicians who receive a waiver through the grant are actively prescribing or treating at the patient capacity they are currently allowed?

Ms. Brandt. I will have to get back to you to confirm that. But I will certainly take it back to make sure whether or not that will be our requirement.

Ms. Blunt Rochester. I only have about 10 seconds, and one of the things that I did want to ask about and I will follow up on is the ability for physician assistants and nurse practitioners to prescribe buprenorphine and I want to make sure that states don't have laws that are preventing us from this expanded

opportunity. So we will follow up with you afterwards. But thank you so much and I yield back the balance of my time.

Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Montana, Mr. Gianforte, for five minutes.

Mr. Gianforte. Thank you, Chairwoman Eshoo and Ranking Member Burgess, for holding this hearing today. This is a very important topic, and thank you for the witnesses for being here for this ongoing discussion of the opioid and substance abuse issues that are facing -- crisis that is facing our country.

This committee has a successful history of working together to respond to this issue. In 2016, we passed the CARE Act and the 21st Century Cures Act. In 2018, the committee followed that with the SUPPORT Act.

These laws expanded substance abuse disorder treatment funding for treatment recovery and prevention, the expanded Medicaid and Medicare coverage for medication-assisted treatment, and Congress has continued to fund these treatment and prevention programs with billions of dollars.

The funding was also made available for stimulant treatment programs like those that treat meth addiction. Meth is the largest substance abuse issue in Montana, accounting for a majority of our substance -- our addiction cases.

I am glad that we have this panel here today to discuss the ongoing implementation and outcomes of these efforts. I think we need more of that and I wish we could have a full committee hearing on this effort.

I am somewhat less excited about some of the new legislation that is also the topic of this hearing. H.R. 2292 creates a new $5 billion mandatory grant program. It also permanently extends what was meant to be a temporary waiver of authority to prescribe opioid treatment medication. That may be useful and we should certainly consider it. But the current waiver does not expire until 2023. So we might best focus our efforts elsewhere.

I can appreciate also the desire to ensure that our state and tribal health agencies have the resources they need. I saw this firsthand.

Last month I spoke to a group of students in Montana at a trade school. There were about 50 of them. Many, if not most, had experienced the heartbreak of substance abuse addiction either directly or in a family member.

I heard their stories. They included family separations, incarceration, and the death of loved ones. It was in their eyes. The pain in the room was palpable.

One gal told me that it was easier for her to get meth on the street than it was to get treatment, even when she was looking

for treatment. Another young man recounted being permanently separated from his brother due to addiction of his parents and even as a young man now has not been reunited. Doesn't know the whereabouts of his brother.

Drugs are ripping our communities and families apart and we must make sure we get this right.

Admiral, a question for you. You are currently senior advisor for the opioid policy at HHS and I appreciate that HHS has a website dashboard to track the stats on the funding, treatment providers, overdose deaths and other metrics, tracking results as a basis for evaluating success or failure of these programs. Where do you feel the department has been most successful in working to deal with the opioid crisis?

Dr. Giroir. For the opioid crisis specifically, I do think the overall -- the overall approach to approaching it as a public health issue, that is the underlying philosophy that people need treatment and you are not going to get well unless you get treatment. That is the number-one issue.

Number two, emphasizing medication-assisted treatment as well as other evidence-based forms of treatment. But we still have a long way to go. There is absolutely no question about that.

One point three million on MAT is good but we still have

a long way to go and, as you know, for methamphetamine our treatment is -- can be effective but it is just behavioral. We don't have any medications to support that treatment right now.

So we really are on a full-out dash with FDA and NIH trying to develop adjuncts to therapy that could be as useful as buprenorphine is for opioids.

Mr. Gianforte. Okay. My colleague just asked you about rural substance abuse and that is, certainly, an issue in Montana. I want to ask you to spend a minute just talking about the unique challenges in Native American tribal environments.

We have about 7 percent of our population is Native American and the substance abuse issues there are chronic and I am just interested in what you -- what you have learned and what resources you are applying to that problem.

Dr. Giroir. So today we are releasing $50 million in tribal opioid response grants which are going to be flexible because of the Congress's action to use on methamphetamines. So that is going to give a very good boost to the tribes to be able to use that money flexibly.

I met with the secretary's Tribal Advisory Committee maybe two or three weeks ago and we spoke specifically about some of the issues, and some of the -- you know, we have to meet people

where they are and understand what the best solutions are.

One thing that we are, clearly, doing is trying to -- and there's a program out of my office -- using community health workers in tribal settings, right, because often you need to bring the care to the people instead of the people to the care, and our preliminary evidence is that is really very successful.

But we are trying to work -- you know, a tribe in Alaska is very different than a tribe in Montana, trying to be, you know, very specifically geared to the solutions that they need and we have an ongoing dialogue. I meet with Admiral Weahkee at least every couple of weeks trying to --

Mr. Gianforte. Admiral, I would just ask that if you could follow up with my office on any specific substance abuse programs for rural or tribal. We would like to stay in touch on that.

Dr. Giroir. Absolutely, yes.

Mr. Gianforte. And with that, Madam Chair, I yield back.

Ms. Eshoo. Gentleman yields back.

A pleasure to recognize the gentleman from New York, Mr. Engel, for five minutes.

Mr. Engel. Thank you, Madam Chairwoman, for holding today's hearing on the drug epidemic plaguing our communities. In my home state of New York, opioids alone claimed 3,000 lives in 2017.

Last Congress, this subcommittee led the efforts to deal -- to draft the legislative response to this ongoing public crisis which culminated in the enactment of the Support for Patients and Communities Act.

This package included my bipartisan Results Act, which directs the National Mental Health and Substance Use Policy laboratory to issue new guidance to applicants seeking federal funding to treat and prevent mental health and substance abuse disorders.

Support For Patients and Communities Act was an important step forward. It lacked the federal funding necessary to expand access to treatment. To that end, I am a co-sponsor of the comprehensive Addiction Resources Emergency Act, which would provide $100 billion to combat the drug epidemic. This epidemic also disproportionately affects communities of color, which face additional barriers and challenges in accessing treatment.

I am working on legislation which would direct the Department of Health and Human Services to commission a study that would look at ways to expand access to substance use disorder treatments in minority and under served communities. I look forward to hearing from our witnesses on the federal government's ongoing response to this crisis and ways that we could strengthen it.

My home state of New York is one of the leadings states for

training physicians. Training hospitals in my state constantly tell me we need additional residency training slots in the field of addiction medicine to promote access to substance use disorder treatments.

The Opioid Workforce Act, which I have co-sponsored and is under consideration today would increase the number of federally-supported residency slots in addiction medicine, addiction psychiatry, and pain medicine by a thousand over five years.

Admiral Giroir, I hope I am not ruining your name too much. I apologize.

Dr. Giroir. It is all good. I respond to anything. It is great, sir.

Mr. Engel. I know before you spoke about Cajun accents. So I figured when it gets to be my turn am I going to blow it. Do you agree, sir, that we need additional providers in these specialties?

Dr. Giroir. Absolutely.

Mr. Engel. Thank you. The ongoing drug epidemic has had a tremendous impact on children, whether it is witnessing their parents overdose on opioids or being torn away from their families and put into foster care.

Admiral, let me ask you again and let me also ask Ms. Brandt.

What efforts have your respective agencies take -- are your respective agencies taking to ensure that children who have experienced trauma as a result of this crisis are getting access to the services and supports they need?

Ms. Brandt. So, sir, Admiral Giroir has deferred to me to answer at least a couple of these. So one of the things that we have done is I mentioned in my opening testimony about our MOM, Maternal Opioid Misuse model, where we are looking to allow for more coordinated care and support for mothers, particularly post-partum, when their children have neonatal abstinence and when they themselves have addiction problems.

We also, and accompanying with that, gave grants to a number of states for what we call Integrated Care for Kids, or InCK model, where it actually allows for things like occupational, behavioral, and physical health services to be covered. So the full suite of wraparound services to really be able to treat children with those addiction issues.

Dr. Giroir. I wanted her to highlight that because I am very, very positive about those programs. We are also trying -- and think it is an important point. As a pediatrician, I would be remiss to say that a child with neonatal abstinence syndrome is not well once they become nondependent.

We now have good data that over the long term they will have

continuing issues and it is really the responsibility of our society to nurture them through their childhood, make sure they get the interventions they need. So we have a very specific program trying to create the long-term data that we can have to support these children so they can overcome that neonatal experience that we know stays with them for many years.

Mr. Engel. Well, thank you both for the good work you are doing. And thank you, Madam Chair. Since you have been chair of this subcommittee you have done so many important and wonderful things and, of course, this ranks with them as well. So thank you.

Ms. Eshoo. I thank the comments of the gentleman. We are all here to give and do for our country and this subcommittee has -- is front and center with some of the really challenging public health issues. So we have to keep the pedal to the metal.

And now, not seeing any other members, the gentleman from New York, Mr. Tonko, is here. He is waiving on to our subcommittee and we are very -- I am really pleased that he is here. He has been very important in this -- in this battle to address opioids in our country. So welcome to our committee and you have five minutes to question.

Mr. Tonko. Thank you, Madam Chair, for your focus. Thank you for allowing me to waive on.

Admiral Giroir, I championed a provision in the SUPPORT Act based on my Medicaid Reentry Act which we are considering today that aimed to improve care coordination for Medicaid-eligible individuals who are reentering the community post-incarceration as this group is particularly vulnerable to opioid overdose, dying at a rate of 120 times that of the general population in the first two weeks post-release.

Section 5032 of the SUPPORT Act required HHS to convene a stakeholder group with a deadline of April 2019 to develop best practices on smoothing health care transitions including best practices for ensuring continuity of health insurance coverage or coverage under the state Medicaid plan for individuals reentering the community post-incarceration.

Has HHS convened this stakeholder panel?

Dr. Giroir. The answer is it is in process but we received guidance from our Office of General Counsel that this is a FACA. So we have to go through all the FACA processes to what delayed it. But I want to get back to your point. We actively need to work with this population because we recognize that they are at high risk and there is specific guidance that we have already delivered. But yes, sir, that is not up and running. It is in the FACA process.

Mr. Tonko. Okay. And let me just make the point that it

is pretty concerning that you have missed a deadline by almost a year at this point. Can you commit to when we might see additional action on this? Quickly, so I can move on.

Dr. Giroir. I am going to have -- we will -- we will -- I will get back to you on that.

Mr. Tonko. Thank you. Thank you.

Administrator Brandt, similar to the provision described to Admiral Giroir, Section 5032 of the SUPPORT Act also required CMS to publish by October 2019 guidance to state Medicaid directors on how they can pursue 1115 waivers to provide coverage to Medicaid-eligible individuals 30 days prior to release from a public institution.

My home state of New York is currently applying for a Medicaid waiver in this space and because this guidance hasn't been issued by CMS I am concerned that they don't have a roadmap for how CMS will ultimately evaluate their request.

Despite the missed deadline, do you have a time line for when this guidance is expected to be published?

Ms. Brandt. Thank you, sir, and appreciate your concern. We are working closely with the department because the stakeholder group that the admiral mentioned is critical for the feedback for us to be able to use that to be able to have the data needed to issue the letter.

Mr. Tonko. Well, these are critical deadlines that have been missed, and so I strongly encourage that we meet them quickly. Thank you.

Let us -- moving on to another issue, one of my top priorities in this epidemic has been to move to a system of treatment on demand for the disease of addiction, ensuring that when an individual has that moment of clarity and is ready to seek help that we have a medical system ready to meet the need.

One of the limiting factors holding us back for treatment on demand is that we have institutionalized through law this concept that medications for addiction should somehow be treated differently than those for other chronic diseases, even when there isn't any underlying safety profile to medications like buprenorphine that merits this special treatment.

We can see this legal stigma clearly through a medication like buprenorphine, which provides -- which providers can freely prescribe without jumping through additional hoops for the treatment of pain. But for some reason, when it comes to the treatment of addiction, providers have to seek a special waiver from the DEA and complete onerous training and paperwork requirements.

If there were any other medication for any other disease that reduced mortality by up to 50 percent we would be doing

everything in our power to make certain that it was an easy to access -- was as easy to access as possible.

Admiral Giroir, are you familiar with the report from the National Academies of Science, Engineering, and Medicine from March of 2019 entitled, "Medications for Opioid Use Disorders Save Lives?"

Dr. Giroir. Absolutely.

Mr. Tonko. So, as you know, some the major conclusions of the report were there, and I will repeat, opioid use disorder is a treatable chronic brain disease. FDA-approved medications to treat opioid use disorder are effective and save lives.

A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it and access is inequitable across subgroups of the population, and confronting the major barriers including existing laws and regulations for the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

So, Admiral, do you have any reason to disagree with the principal conclusions of the National Academies study?

Dr. Giroir. Those conclusions I not only generally agree with but use. The only thing I don't agree with is the fact that

we have made so much progress. About 1.3 million people are now on MAT, about 2 million people -- with opioid use disorder.

So some of the statistics are older. But in general, of course, MAT is important and we support it. It needs to be available to everyone who had opioid use disorder.

Mr. Tonko. So you do agree with the principal conclusions?

Dr. Giroir. From what you just said, yes. I am not commenting on the data waiver and whether that should be waived. That is a very complicated and important issue. But those conclusions I do agree with.

Mr. Tonko. Well, thank you very much, and let us move on and fight this illness of addiction.

With that, I yield back.

Ms. Eshoo. I thank the gentleman for the work that he has done. I want to thank the witnesses for not only being here today, answering our questions, your willingness to answer written questions that will be submitted to you by members and answering them in a timely way.

This concludes the first panel and I want to ask the staff to ready the table for the second panel of witnesses, and I am going to step out to a meeting and Congresswoman Annie Kuster -- no, women are in charge, Doctor.

[Laughter.]

Ms. Eshoo. Congresswoman Kuster is going to chair until I return and I want to thank her in advance for her willingness to do that. Thank you again to you.

Ms. Brandt. Thank you.

Ms. Eshoo. Keep the pedal to the metal.

[Whereupon, the above-entitled matter went off the record at 12:52 p.m. and resumed at 12:57 p.m.]

Ms. Kuster. [Presiding.] Good afternoon. We will now hear from our second panel of witnesses on this critically important issue.

I would like to introduce Mr. Michael Botticelli, executive director, Grayken Center for Addiction from Boston Medical Center; Dr. Smita Das, clinical associate -- assistant professor, psychiatry and behavioral sciences, Stanford University School of Medicine; Ms. Patty McCarthy, chief executive officer, Faces and Voices of Recovery; Mr. Robert Morrison, director of legislative affairs, National Association of State Alcohol and Drug Abuse Directors; Ms. Margaret Rizzo, executive director, ISAS Health Care, Inc. -- JS, excuse me. I am so sorry. JSAS Health Care Inc. And Dr. Shawn Ryan, president and chief medical officer of Brightview.

Thank you to our witnesses for joining us today on the second panel and we look forward to our testimony -- to your testimony.

Mr. Botticelli, you are recognized for five minutes.

STATEMENTS OF MICHAEL P. BOTTICELLI, EXECUTIVE DIRECTOR, GRAYKEN CENTER FOR ADDICTION, BOSTON MEDICAL CENTER; SMITA DAS, MD, PHD, MPH, ADDICTION PSYCHIATRIST, DUAL DIAGNOSIS CLINIC, CLINICAL ASSISTANT PROFESSOR, PSYCHIATRY AND BEHAVIORAL SCIENCES, STANFORD UNIVERSITY SCHOOL OF MEDICINE; PATTY MCCARTHY, CHIEF EXECUTIVE OFFICER, FACES & VOICES OF RECOVERY; ROBERT I. L. MORRISON, EXECUTIVE DIRECTOR/DIRECTOR OF LEGISLATIVE AFFAIRS, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS; MARGARET B. RIZZO, EXECUTIVE DIRECTOR, JSAS HEALTHCARE, INC.; SHAWN A. RYAN, MD, MBA, CHAIR, LEGISLATIVE ADVOCACY COMMITTEE, AMERICAN SOCIETY OF ADDICTION MEDICINE

STATEMENT OF MICHAEL BOTTICELLI

Mr. Botticelli. Thank you, Congresswoman Kuster, Ranking Member Burgess, and members of the committee for the opportunity to speak with you today about legislation to help patients with substance use disorders including continued efforts against the national opioid crisis.

My name is Botticelli. I am the executive director of the Grayken Center for Addiction at Boston Medical Center. BMC is the largest safety net provider and busiest trauma and emergency service center in New England.

Our patient population has the highest public payer mix of

any acute care hospital in Massachusetts. For decades, BMC has been a leader in substance use disorder treatment and research.

Many of our programs have been replicated across Massachusetts and nationally. The Grayken Center for Addiction encompasses over 18 clinical programs for substance use disorders and serves as an umbrella for all of BMC's work, including addiction treatment, research, medical education, and training.

I offer my perspective not only as an executive director but insights gained from my over 30-year career in the addiction field, formerly serving as the director of the White House Office of National Drug Control Policy, the director of the Massachusetts Bureau of Addiction Services, and I am also a person in long-term recovery.

In previous sessions of Congress this committee has taken the lead on and leadership on passing landmark legislation to improve addiction treatment and prevention through the 21st Century Cures Act, CARA, and, most recently, the Support for Patients and Communities Act of 2018. These laws have gone a long way to bring much-needed funding and comprehensive reforms to how our system treats and supports people with substance use disorders.

That said, still over 67,000 people have died from a drug overdose in 2018 and the death rate from fentanyl and other analogs has increased by 10 percent.

This epidemic continues to evolve as polysubstance use, namely, mixing opioids or stimulants like cocaine and methamphetamine has increased and disparities have widened within certain segments of the population including racial and ethnic minorities, youth and young adults, members of the LGBTQ community and incarcerated individuals who are disproportionately burdened by addiction and lack sufficient access to culturally competent care.

The epidemics target challenges our treatment system and providers with other notable longstanding challenges. Notably, in the 2019 report on addressing the opioid crisis that was discussed earlier, the National Academies of Sciences, Engineering, and Medicine recognized opioid use disorder as a chronic and treatable brain disease while underscoring, and I quote, inadequate professional education and training as a key barrier to addressing the addiction epidemic. The bills before the committee today for consideration in many ways rise to meet those challenges and I would like to discuss a few of those areas that I think are most pressing for action.

The 100,000 -- I wish it was 100,000 -- the 1,000 additional

addiction residency slots funded through the Opioid Workforce Act of 2019 would significantly accelerate our ability to fight the mounting burden of addiction faced by individuals and communities nationwide.

BMC was among the first institutions in the country to establish a credited fellowship program in addiction psychiatry and addiction medicine. Graduates of an addiction program like ours go on to hold faculty and clinical leadership roles in medical centers and treatment programs across the country.

Under the direction of BMC -- under the Grayken Center BMC has taken initiative to provide comprehensive education and training to staff on safe opioid prescribing and over the last several years we have systemically reduced opioid prescribing across both inpatient and outpatient settings.

Notably, we require all of our physicians across our system to receive waiver training as part of their commitment to dramatically expand our workforce license to prescribe medication for opioid use disorder treatment and we readily offer addiction training to other staff members.

We also know that addiction affects more than individuals. It impacts families as well. Families struggle with knowing how best to be supportive of their loved ones and avoid doing harm. We also know that getting evidence-based guidance into

the hands of family and community support systems can dramatically influence the trajectory of individuals' care and treatment.

We are, therefore, highly supportive of the Family Support Services Act and appreciate the committee's attention to this often overlooked aspect of addiction.

Two years ago in testimony before this committee I shared the disparity insights gleaned from overdose data in Massachusetts that we heard today, that individuals recently released from incarceration overdosed at 120 times the rate of the general population.

Nationally, there remains much to be done to improve treatment for individuals while incarcerated and upon release into the community and I am, therefore, pleased that several of these bills under review by the committee intend to make substantial progress in those areas.

While we are seeing modest progress against this epidemic, I think we all agree that we can and should do more.

This will require continued leadership at the federal, state, and local levels, additional resources, particularly the reauthorization of SOR funding that can continue to make sure that we have constant surveillance as this epidemic evolves.

As I have said many times before and I will say it again, addiction is a disease and recovery should be the expected

outcome. The work lies in getting our systems to a place where patients with addiction are treated in a way that affects this reality.

Thank you for your time and I look forward to your questions.

[The prepared statement of Mr. Botticelli follows:]

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Ms. Kuster. Thank you, Mr. Botticelli. And I do recall my experience working with you when you were in the White House, and thank you for your expertise.

Dr. Das, you are recognized for five minutes.

STATEMENT OF SMITA DAS

Dr. Das. Thank you.

Congresswoman Kuster, Ranking Member Burgess, and distinguished members of the Energy and Commerce Health Subcommittee, thank you for allowing me the opportunity to serve on today's panel.

My name is Smita Das. I am a clinical assistant professor of psychiatry and behavioral sciences at Stanford. In addition to being a medical doctor, I have completed a Master's of public health and a Ph.D. in community health. I am also board certified in psychiatry, addiction psychiatry, and addiction medicine.

My testimony today is on behalf of the American Psychiatric Association, an organization representing over 38,000 psychiatrists, including addiction psychiatrists.

With help from federal grants, the APA provides thousands of psychiatrists ongoing education and training to improve the diagnosis and care of patients with all substance use disorders.

With your help, we have made strides in reversing the upward trend of opioid overdose deaths and reducing stigma surrounding addiction over the past few years and these efforts must continue.

Given this committee's history on focusing on opioids, I am not going to use my time today to recite statistic aloud or

tell you how real the opioid crisis is. Each of you already know this.

We also know that addiction is a chronic brain disease, a chronic medical illness that can be effectively treated. However, we cannot treat addiction without investing in several areas.

We need to increase workforce capacity, increase provider literacy on addiction treatment, and alleviate fragmentation and barriers to care like cost and stigma. On workforce, psychiatrists are uniquely positioned to treat the substance use disorders with the ability to diagnose and treat co-occurring psychiatric disorders and recognize suicide risk.

However, the shortage of psychiatrists and trained in addiction medicine, addiction psychiatry, or pain management has created a longstanding acute treatment gap for those with or at risk of substance use disorders.

Funding new residency positions, expanding loan repayment and forgiveness, and offering incentives to work in under served areas can help mitigate effects of the overall physician shortage.

As we invest in our workforce, we also need to ensure that clinicians have the support, education, and training that is essential to treating patients with substance use disorders and co-occurring illness.

We have been working to improve education while acknowledging that the complexity of substance use disorders requires thoughtful integration of training across the continuum from medical school to residency fellowship and continuing education.

Turning to the issue of fragmentation, people with substance use disorders are more likely to have physical co-morbidities like chronic pain, cancer, heart, and liver disease. We need more integrated care and for all physicians to be aware of the risk and impact of substance use disorders.

Despite the progress we have made, mental health and addiction treatments are still often siloed. Breaks in continuity of care leave patients at higher risk for relapse and overdose.

Though not the focus of today's hearing I would be remiss not to mention how lack of compliance with the 2008 Mental Health Parity and Addiction Equity Act has aggravated the lack of access to substance use treatment.

Stigma in seeking help is already an enormous obstacle for our patients. But forcing both the patients and the providers to engage in bureaucracy to get coverage makes treatment that much more inaccessible.

We need to ensure that the intent of the law is enforced

appropriately and that patients receive seamless and timely care to lifesaving treatment.

We want to thank the committee for working with us on this critically important issue. Also, as fears spread about the impact of coronavirus, we urge the committee to consider how to reduce barriers to telemedicine including telepsychiatry while also eliminating originating site restrictions.

Lastly, ensuring that incarcerated individuals have continuity of care so that they can get treatment for substance use disorders and mental illness to prevent recidivism when they are released from custody is vitally important.

Using evidence-based common sense policy like allowing incarcerated individuals to enroll in Medicaid prior to discharge defragment care and coordinates support to allow patients to successfully reenter their communities.

Though I am encouraged that the committee has chosen to continue its focus on the opioid epidemic, I want to make one last point, that it is not just opioid misuse that is problematic.

We must treat substance use disorders as the chronic diseases they are and pursue solutions that address all substances including opioids, methamphetamine, alcohol, and tobacco.

I encourage the committee to look beyond opioids and ensure

consideration of all substance use disorder as it considers legislation. While we discuss the 67,000 deaths related to drug overdose, let us not forget the impacts of alcohol, responsible for 88,000 deaths, or tobacco, responsible for nearly 500,000 deaths annually in the United States.

Solutions to close the gap must focus on increasing access and literacy, decreasing stigma, coordinating care, and working together to help our patients and communities recover from the impact that this crisis has had on our country.

Thank you again for inviting us here today. The APA and I look forward to working with members of the subcommittee on substance use disorders and health, more broadly.

I am happy to answer any questions. Thank you.

[The prepared statement of Dr. Das follows:]

**********INSERT 5**********

Ms. Kuster. Thank you very much, Dr. Das, for your insights and for your passionate advocacy. We appreciate it.

Ms. McCarthy, you are recognized for five minutes.

STATEMENT OF PATTY MCCARTHY

Ms. McCarthy. Thank you, Congresswoman Kuster and members of the subcommittee for this opportunity to testify today on behalf of Faces and Voices of Recovery. We are a national recovery advocacy organization based in Washington, D.C., with members and affiliates nationwide. Our mission is to organize and mobilize the over 23 million Americans in recovery.

I have had the honor of being the chief executive officer for five years and I have been in recovery from substance use disorder since 1989. Over the past 30 years of my recovery, I have seen firsthand the impact of addiction and have experienced the loss of friends and colleagues to alcohol and other drug-related fatalities.

However, over my 20-year career in the addiction field I have also witnessed the healing power of recovery for tens of thousands of individuals who courageously overcome addiction to go on to rebuild their lives.

So several of the bills being considered here by this committee are of particular importance to the recovery community. The first pertains to the State Opioid Response Grant Authorization Act.

While medications play an important role in addiction

treatment, medication alone is not a complete solution. In fact, the success of medication often depends on additional recovery support services in the community and millions of Americans find recovery from addiction without the use of medication.

The 2018 Surgeon General's report states that individuals who participate in substance use disorder treatment and recovery support services typically have better long-term recovery outcomes than individuals who receive either alone.

The 2017 President's Commission report recommends that the government partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas.

Federal funding for medication-assisted treatment can be measured in the hundreds of millions while federal funding for recovery support services is still only a fraction of all funding for the opioid crisis.

Recovery community organizations, recovery housing, recovery high schools, collegiate recovery communities and harm reduction, all of which are evidence-based models, have no reliable and sustainable funding sources.

There is, clearly, an issue of scale here and substantial investment in recovery support is needed. In my written testimony I have included a more detailed plan to make this

significant investment by reauthorizing the State Opioid Response Grants, moving that funding into the block grant for long term, setting aside 20 percent of the block grant funding for recovery support services, and increasing the funding for the BCOR, Building Communities of Recovery, grant program to $25 million. Treatment is short term. Recovery is long term and investments must reflect that.

The second bill we strongly support is the Family Support Services for Addiction Act. Parents, children, and other family members including those who have lost loved ones need support groups and they need help navigating the complexity of the treatment system.

However, $5 million per year is not nearly enough to establish this ne grant program. Not only do we need funds, we need an entire paradigm shift on how we view the importance of the family's role in recovery.

We must be bold in this pursuit and we must send a signal to families and the recovery community that we are truly vested in their continued well being.

That being said, increasing the authorization to $25 million is warranted.

Third, we strongly support the Medicaid Reentry Act, which would allow medical assistance for incarcerated individuals 30

days prior to release. This new policy will make it easier for states to provide effective treatment and recovery support services, allowing for smoother transitions to care in the community and reducing the risks of preventable overdose deaths.

If we are truly serious not only about treating addiction but also moving individuals out of incarceration and into long-term recovery, we must take this legislation seriously and see to its passage.

I will conclude by thanking you on behalf of the recovery community for all the work that Congress has done to address the addiction crisis in America. There is much more to be done and we want you to know that we are fighting this battle on the ground every day in communities across the nation.

We focus on providing effective recovery support services, eliminating the stigma of addiction, and celebrating the successes of individuals and families who have found their chosen pathway of recovery, and will continue to be vocal, visible, and valuable part of the solution working with Congress to save lives.

And with that, I conclude my remarks. Thank you.

[The prepared statement of Ms. McCarthy follows:]

**********INSERT 6**********

Ms. Kuster. Thank you, Ms. McCarthy, and I can certainly say as a sister of a brother in recovery, I am very grateful for your organization and for bringing Voices of Recovery here to us in Washington. So thank you.

Mr. Morrison, you are recognized for five minutes.

STATEMENT OF ROBERT MORRISON

Mr. Morrison. Thank you, Congresswoman Kuster, Ranking Member Burgess, and members of the subcommittee. I appreciate you providing us the opportunity to testify. It is a privilege.

I am Rob Morrison. I serve as executive director of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD. We are a nonprofit serving state alcohol and drug agencies directors across the country.

Our board is led by our president, Cassandra Price. She is from the state of Georgia, and our members are very grateful for the program funding authorized by this very committee. These programs are housed in HHS agencies such as SAMHSA, CDC, HRSA, and NIH, and I would like to thank you for your work to pass the Comprehensive Addiction Recovery Act, or CARA, the 21st Century Cures Act, and the SUPPORT Act.

We note our particular appreciation for what is now known as the State Opioid Response Grant, or SOR, which is authorized by this very subcommittee and is being managed by SAMHSA.

SAMHSA is directing $1.5 billion in SOR funding to our members' state alcohol and drug agencies. These resources are supporting evidence-based, innovative, and lifesaving programs at the local level. In short, this program has been a game

changer.

In written testimony, we have outlined some SOR-funded activities for a handful of states, those on the subcommittee, our webpage. We have profiles for all states regarding SOR-funded activities for your review.

And it is a privilege to offer some following principles for your consideration as you examine the legislation before you regarding substance use disorders in general and the opioid crisis in particular.

First, ensure provisions work through and coordinate with the State Alcohol and Drug Agency. This approach promotes efficiency, avoids creating parallel systems and duplicative systems of care.

Second, ensure consistent, predicable, and sustained federal resources to avoid creating a fiscal cliff. We recommend extending the duration of federal grants beyond the typical one- or two-year funding cycle and affording states three year, even five years time frame to allocate funding.

Third, continue to address the opioid crisis but also elevate efforts to address all substance use disorders. This can be achieved in part through a gradual transition from directing funds to opioid-specific grants to the substance abuse prevention treatment block grant.

Fourth, maintain investments in SAMHSA as the lead agency within HHS, focus on substance use disorders program and service delivery.

Finally, work to ensure new legislation complements and builds from the current system. In the process, consider provisions affording state and federal agencies adequate resources to effectively administer these programs, both the previous programs and new ones.

Added people power will be required to additionally manage addictional programs. I would like to focus on the benefits of working through the State Alcohol and Drug Agency for a minute.

Our members draft and implement coordinated statewide plans for program and service delivery. These plans are comprehensive, work across state agencies, and span the continuum of prevention treatment recovery.

State Alcohol and Drug Agencies ensure oversight of providers through tools such as performance management and reporting, contract monitoring, corrective action planning, onsite technical reviews, licensure and certification.

Members also work to promote quality through state-established standards of care, evidence-based practices, collecting and analyzing data, and using these tools to drive management decisions.

The foundation of this work is the Substance Abuse Prevention Treatment Block Grant. This program is designed to be flexible to meet the unique needs of states and to address all substances in its back yard.

Twenty percent of the SAPT block grant by statute is dedicated to much needed primary prevention programming. In fact, of the budgets our members manage for primary prevention, on average approximately 70 percent comes from the SAPT block grant.

So we look forward to a continued dialogue regarding the different proposals before this committee. Again, we appreciate the opportunity.

[The prepared statement of Mr. Morrison follows:]

**********INSERT 7**********

Ms. Kuster. Thank you, Mr. Morrison. I appreciate your remarks as well.

Ms. Rizzo, you are recognized for five minutes.

STATEMENT OF MARGARET RIZZO

Ms. Rizzo. Good afternoon. My name is Margaret Rizzo. I am the executive director and CEO of JSAS Health Care. We are currently treating 700 patients with opioid use disorder. Our agency has been treating this population since 1973 and this is my twenty-ninth year in the field.

I am here to testify on the views of the American Association of the Treatment of Opioid Dependence, ATOD, of which are a New Jersey member.

ATOD represents over 1,000 OTPs throughout the United States. All OTPs are under the regulatory oversight of SAMHSA, the DEA, as well as the individual states' opioid treatment authorities.

We also are required to be accredited every three years through a rigorous process from our SAMHSA-approved accreditation bodies. Only OTPs are authorized to use all three federally approved medications to treat OUD.

At the outset, our association members want to express our appreciation to this committee for authorizing the development of the first ever Medicare reimbursement rate for OTPs in the United States. It will make a profound difference in the lives of Medicare-eligible patients entering and remaining in

treatment.

As you discuss the various legislative proposals before you today, we urge you to consider the following. When DATA 2000 was passed, Congress wisely imposed reporting requirements in order to properly evaluate the quality and integrity of this new expanded program and identify any unintended consequences.

However, we have not seen any publications from SAMHSA reporting the quality of care provided, the effectiveness of the services nor the degree of compliance with current federal regulations.

Thus, any changes being considered today would be in the absence of data. Such policymaking is dangerous and we recommend SAMHSA publish and analyze this data before any changes are made to existing caps, training, or oversight.

We are concerned that proposed legislation would increase buprenorphine diversion. The data clearly shows that opioids are most frequently diverted from private physician offices.

In 2011, the radar surveillance system reported 45.5 percent of individuals presented in a treatment facility used buprenorphine intravenously and 16.3 percent of individuals reported misuse of the buprenorphine naloxone combination medication.

Also, the assertion that training is a barrier to providers

using buprenorphine in their practices is not supported by the evidence. In a survey of MAT waiver prescribers who have taken the waiver course, 83 percent indicated they needed to know more about the topic. There are currently more than 113,000 waiver prescribers who under the current system have collective capacity to prescribe buprenorphine to more than 6.3 million patients.

This nearly triple the estimated 2.5 million people in the United States with OUD. Clearly, this suggests adequate capacity in our current system. Instead of eliminating oversight that will result in greater diversion and abuse, we suggest solutions to expand access to areas where there are limited treatment options.

We are still in the midst of a changing opioid use epidemic which has shifted from prescription opioid misuse to heroin use and, more currently, fentanyl combined with methamphetamine use.

This is not a time to be removing clinical training requirements which are, at best, quite simple. For all of these reasons, we oppose the passage of H.R. 2482.

Regarding H.R. 4141 and 1329, there is a greater interest for correctional facilities and other parts of the criminal justice system including drug courts to increase the use of MAT for opioid use disorder.

Model programs in Connecticut, Rhode Island, Philadelphia,

Baltimore prison systems and Rikers Island in New York City are certainly moving the right direction.

Accordingly, there has been a 55 percent decrease in post-release recidivism as reported in Rhode Island in addition to a 60 percent reduction in post-release mortality as inmates are transitioned from correctional facilities into outpatient treatment settings.

Furthermore, ensuring the newly released inmates have Medicaid coverage in place prior to the release as proposed in H.R. 1329, Improve Access to OUD Treatment.

This is all very encouraging news and we encourage the House to support such measures. This is why we are supporting the passage of H.R. 4141 introduced by Congresswoman Kuster, and H.R. 1329 introduced by Congressman Tonko.

Other bills under consideration today have our strong support. H.R. 5631 would provide funding for addiction education in medical and nursing schools. H.R. 2466 extends the SOR grants. H.R. 2922 provides opioid funding of $5 billion.

H.R. 3414 proposes additional residency positions in hospitals and H.R. 4974 proposes training and education requirements which we support. However, such requirements cannot replace the current oversight and patient limits which are critical to preventing medication diversion and abuse.

Thank you for accepting this testimony. I am happy to answer any questions that you may have.

[The prepared statement of Ms. Rizzo follows:]

**********INSERT 8**********

Ms. Kuster. Thank you, Ms. Rizzo. That was very helpful and I appreciate it. I would love to follow up with you after.

Dr. Ryan, you are recognized for five minutes.

STATEMENT OF SHAWN RYAN

Dr. Ryan. Thank you. Congresswoman Kuster, Ranking Member Burgess, and esteemed subcommittee members, thank you for inviting me to participate in this important meeting.

My name is Dr. Shawn Ryan. I am a board certified addiction specialist and an emergency physician. I take care of patients in Ohio. I am also the chair of the Legislative Advocacy Committee of the American Society of Addiction Medicine, known as ASAM, a medical society representing over 6,000 clinicians who specialized in the prevention and treatment of addiction.

I would like to begin by recognizing the phenomenal work Congress has done to advance crucial pieces of legislation and funding to address this crisis. It has made a life or death difference for many.

However, we must do more to create a sustainable and robust treatment infrastructure, one that addresses addiction as the treatable chronic medical disease that it is.

To realize this addition, we must focus on three primary issues: strengthening the addiction treatment workforce, standardizing the delivery of individualized addiction care by rethinking our largest federal grant programs, and reforming payment policies and strongly enforcing mental health and

addiction parity.

Focusing first on our workforce needs, there are only about 3,000 board certified addiction specialist physicians, according to ABMS, and in a recent survey in Massachusetts only one in four health care providers report receiving on addiction during medical education. I know that I did not.

For a country that prides itself on the medical care available to its citizens, this is simply unacceptable. That is why ASAM supports the Opioid Workforce Act legislation that will provide additional GME slots to hospitals with programs in addiction medicine and addiction psychiatry.

To ensure more health care providers receive basic training in addiction, ASAM supports the MATE Act, legislation that would require all DEA-controlled medication prescribers to have at least a baseline knowledge about addiction.

Dr. James Baker, who is with us here today and behind me, has been a determined championed of the MATE Act, in honor of his son, Max, whose life was, unfortunately, cut short in part because the medical community has yet to reckon fully with addiction.

After or concurrent with the passage of the MATE Act, ASAM supports the passage of the MAT Act, legislation that would eliminate what would then be a redundant separate waiver to

prescribe buprenorphine for addiction along with the waiver of patient limits and regulations.

Secondly, this workforce shortage is exacerbated by a long history of treating addiction in silos, as has been stated many times today, and available treatment is, largely, determined by local culture rather than nationally recognized standards of care.

This must change. To that end, ASAM supports the State Opioid Response Grant Authorization Act with certain technical amendments and the addition of a new provision. This would strengthen the program by applying a Medicaid provider requirement included in both the bipartisan Ryan White Care Act and in the late Elijah Cummings CARE Act.

Such a provision would require certain grantees to enroll in Medicaid, ensure that they can meet -- ensuring that they can meet minimum standards and grant funds are used as they are intended to pay for crucial services that cannot be billed to Medicaid.

Investments above this foundation, however, need to be used efficiently and effectively and they should drive sustainable change. For example, Congress should -- could establish a new supplemental grant program with conditions that require state and localities to adopt certain strategic policies.

To qualify for this supplemental funding, states could be required to adopt nationally recognized levels of care standards for the regulation of the addiction treatment programs. This would make oversight and payment more efficient and set baseline expectations for care as we have with the rest of American medicine.

States could be incentivized to require health plans to use medical necessity criteria for addiction treatment as defined by national medical societies and certain grantees could be required to offer all medication for addiction treatment.

Over time, the largest federal grant programs in this space could be combined with a common set of modernized requirement. But let us be clear. We need these sizeable grants because to this day mental health an addiction parity is not a reality.

Payers continue to discriminate and there is wide disparity in network use in provider payment rates. That brings us to the bills being considered that will improve insurance coverage specifically to those in the criminal justice system, the Medicaid Reentry Act, and Humane Correctional Health Care Act.

Continuation of Medicare and Medicaid coverage during detention and incarceration or reinstatement immediately prior to release will facilitate treatment continuity, retention, and save lives. ASAM is proud to support these bills.

In conclusion, ASAM is actively building, implementing, and advocating for the tools and resources to secure a solid and sustainable foundation for addiction treatment in this country.

While change won't be easy, it is both necessary and worth it to end the suffering being experienced across our nation and our communities and by American families.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Ryan follows:]

**********INSERT 9**********

Ms. Kuster. Thank you, Dr. Ryan.

I need to inform all of you that we are about to be called for votes and so we are going to take a recess to go vote but we will come back, and we will proceed with the questions for the second panel.

So thank you so much for all of you being with us, and patience.

[Pause.]

Ms. Kuster. Actually, it turns out that our votes were not quite called. They are about to be called. So we are going to go ahead, Representative Brooks and I, and get started on our round of questions, and use your time wisely and then we have 15 minutes to get to the floor once they are called. There they are.

So I want to just take a minute for my own questions and then I will turn it over to Mrs. Brooks.

It is our job to continue to bring attention to this opioid crisis and, as you have all pointed out, other drugs as well and to find solutions that will save lives, and that is why I founded the bipartisan Opioid Task Force and it is why I waited and worked for six years to get on this committee. So I am delighted to be with you today.

For folks in New Hampshire and families across the United

States, this hearing is one of the most important that we will hold. These issues that we are discussing are critical and we need to end the stigma of addiction.

Many of you mentioned that, in my view, stigma is just another word for bias and discrimination. When it comes to physical health, we as a society are quite understanding and the same should be said for mental health and addiction treatment.

So I would like to focus my remarks on my bill, H.R. 4141, the Humane Correctional Health Care Act. In New Hampshire, we saw again and again incredibly high rates of recidivism directly related to substance use disorder and mental health issues.

As it turns out, there are many jails and prisons that are not providing adequate health care, especially when it comes to these co-occurring illnesses. I have said it before. I will continue to say it. If we wanted to design a system the fail, this would be it.

This bill is a game changer. It ensures that the justice-involved population gets access to the treatment that they need. It is co-sponsored by many of my friends on both sides of the aisle here on the Energy and Commerce Committee and I am proud to have introduced this bipartisan legislation.

I am particularly appreciative of the many organizations, some of whom are with us today, that have supported this bill,

the American Society of Addiction Medication -- Medicine Smart Recovery, the American Corrections Association, the American Psychological Association, the National Council for Behavioral Health, and Faces and Voices of Recovery, among many others.

So let me jump into the questions. Mr. Botticelli, could you please describe the Grayken Center's direct experience in treating individuals upon release and the importance of seamless care in reducing overdose risk and recidivism?

Mr. Botticelli. So Boston Medical Center we have the largest office space addiction treatment program in New England. We have about 800 active clients.

Directly across the street from us is the Suffolk County House of Correction and literally our job is to get them seamlessly from the County House of Correction into our office-based addiction treatment program without any interruption in care and continuity of providers.

You know, so it is very clearly important. Besides all of the incredible salient points that you already raised about, you know, being able to not just move beyond suspending their Medicaid but actually enrolling them in Medicaid while they are behind the walls so that there is absolutely no interruption in care while people are coming out.

I do want to address the issue of payment because I do think

it might not be Medicaid funding but we are paying for those services anyway.

Whether it is State Opioid Response money or state appropriation dollars or moneys that the sheriffs are paying to implement medications behind the wall. So whether it is Medicaid funding or another funding source we are already paying for those services.

Ms. Kuster. I appreciate that, and I hope the CBO is listening when they take that into consideration.

Mr. Ryan, are you aware of any estimates on the percentage of those who suffer from substance use disorder that become involved with the criminal justice system at some point and with either mental health or substance use disorder?

Dr. Ryan. Absolutely. Thank you for the important question.

So statistics show as high as 50 to 70 percent of individuals in the incarcerated population in any way, shape, or form have mental health and addiction, and in many locations where opioid use disorder is the most pervasive, there are places seeing as high as 75 to 80 percent of their justice population involved.

So I have actually worked a fair bit with an institution that does jail health care across the state of Ohio and other areas. Because I recognize that in this country we are not

disconnecting criminal justice involved and substance use disorder probably ever. And so it is really important that we do -- speak these transitions and I can tell you first hand in taking patients on in our treatment centers right out of, you know, criminal justice settings, the transition is quite hard and we do really need to work to improve that.

Ms. Kuster. So are there any estimates suggesting how many more could receive MAT and jails and prisons if such treatment was widely available?

Dr. Ryan. I cannot say that I have seen an estimate in regards to what this particular or these particular bills would -- how much it would increase the access to medication assisted treatment.

I will tell you in those localities where I have been involved and the sheriffs have been very supporting in doing this and we have seen the estimates and you described in Rhode Island, if we put a pervasive and sustained effort to deliver the absolutely necessary and evidence-based treatments such as MAT to these justice-involved individuals, they will do better.

Ms. Kuster. Thank you very much. I appreciate it.

And that has certainly been our experience in Sullivan County and now in Merrimac County in New Hampshire where the recidivism rate dropped from as high as in the high 50 percent, 58 percent,

all the way down to 18 percent.

So I don't care if you are left, right, or center, that is a savings of tax dollars, if we can get people back to the community, going to work taking care of their families and living in recovery.

So thank you, and I guess I say, Madam Chair, I want to recognize my good friend and colleague, Representative Susan Brooks.

Mrs. Brooks. Thank you, Madam Chairwoman, and thank you so much to all of our witnesses and for your important work. I just want to spend a few minutes talking about H.R. 3414, the Opioid Workforce Act.

As I stated earlier, the crisis continues to plague so many of our communities. That is not to say we haven't made progress. In fact, yesterday an Indiana state public health official shared with our office that Indiana has -- my home state -- has seen a 13 percent reduction of opioid overdoses last year.

But we also increased by 75 percent the number of available inpatient treatment beds. Pretty significant increase. But despite these improvements, one thing that continues to be clear is we have to have more care providers in order to staff and in order to take care of the beds.

Doesn't matter how many beds we have in the hospitals if

we don't have the doctors and the professionals to treat those patients, and so that is why I introduced with you, Madam Chairwoman, along with Representative Schneider and Representative Stefanik the Opioid Workforce Act, providing a thousand Medicare-funded residency slots to hospitals.

So I just have a couple of questions, briefly, before we have to probably take a break to vote.

Mr. Botticelli, in your written testimony, you talked about the additional thousand addiction residency slots. How specifically do you believe those additional slots would improve our ability to help these patients?

And if you could -- your mic, please.

Mr. Botticelli. You think I would know after all these years.

One of the things that the opioid epidemic has laid bares the lack of trained professionals that we have to provide treatment. So we can put out all the funding dollars that we want without a prepared workforce in terms of implementing it.

I think this act has the potential to dramatically expand access to treatment by having a trained pool of professionals, of physicians who are able to understand and treat addiction.

I think it is really important for us to ensure that while we are doing other activities such as integrating addiction

treatment into medical residency training that having a trained workforce both of addiction medicine and addiction psychiatrists are really critical. I think this is a critical piece of legislation. We have known this since the beginning of the epidemic that this is one of the prime areas in terms of if we are going to make an impact.

Mrs. Brooks. Thank you, and thank you for your long decades of work.

Dr. Ryan, in your written testimony you too emphasized just how under served individuals struggling with substance disorder are and, in fact, there are only about 3,000 board-certified specialists in the country really highlights for me how short staffed our treatment facilities might be.

How do you think the addiction specialists would best be used if we were to improve and increase fairly dramatically the number of addiction specialists which, as we have said, would also be trained not just on substance -- I mean, whether it is alcohol, whether it is drug, whether it might be other addictions, you know, addiction just generally, can you just share with us how you believe it would make a meaningful impact on this significant challenge?

Dr. Ryan. Absolutely. A couple of points. So I am board certified in addiction medicine as those of us who are. Not in

opioid medicine.

So we are broadly trained in all of the substance use disorders. Understanding that alcohol still had huge impact on our society and we have to understand how to address that and every other substance so that drug use transitions to methamphetamine, et cetera, that the work force is trained to manage any substance use disorder it becomes the topic of most importance at that time. So I just want to make that point.

Also we do have a system of care in this country for specialists and primary care to interact through different mechanisms.

So as I would -- the way that I would probably put it, Representative, is that a specialist like myself should be taking care of the sickest patients. Not all opioid-use disorder patients need the highest level of care or the highest trained specialists but many do.

And so we have these systems of care in place for chronic disease management. We should simply reflect back to those as so for diabetes so that we, again, diabetes best managed the same way in a whole holistic model for patients. We should really parallel those types of systems of care and use those trained addiction specialists in that.

Mrs. Brooks. Besides residencies, do you believe that our

med schools and the education higher ed institutions are doing enough relative to addictions?

Dr. Ryan. Enough is a loaded question, I guess, a little bit. But no, I don't believe so. Actually, in my personal opinion I feel like there is more to be done. I have spent thousands of hours myself educating, you know, medical students, residents, and I am sure that others on the panel have done the same. I do believe we are behind the eight ball on that and I would say with the workforce at hand we are also under educated in relation to the disease of addiction.

Mrs. Brooks. Thank you, and with that I yield back. Thank you for your work.

Ms. Kuster. With that, I recognize Dr. Raul Ruiz from California.

Mr. Ruiz. Thank you all for being here.

Congress has passed multiple pieces of legislation to address the opioid misuse public health crisis and more still needs to be done.

That is why I introduced the H.R. 2281, the Easy Medication Access and Treatment for Opioid Addiction Act, or EASY MAT Act. This bill will remove a rule that restricts doctors from giving a patient more than one day's worth of buprenorphine or other medication assisted treatment at a time.

Under current DEA regulation, physicians are authorized to give a patient one day's worth of MAT for three consecutive days while the patient is security long-term treatment.

However, they can only give the patient the MAT one day at a time. Meaning, the patient has to go back to the doctor, back to the emergency department, every 24 hours for three days which, as you can imagine, is huge barrier to a patient who may not have access to their provider.

Under this bill, physicians will be allowed to provide three days worth of MAT at one time so that patients don't have to come back every 24 hours to be seen by a doctor while they are waiting to get into long-term treatment.

This will increase the chances that a patient will remain on medication-assisted treatment and off of illegal and illicit drugs.

It will save money for the health care system by requiring fewer visits and it will maintain all of the other safeguards currently in place under DEA regulation. Most importantly, it will save lives.

As an emergency department physician, I know that once a patient walks out of the door of the hospital, the fewer barriers there are to get someone in treatment, the higher the chances of success, and I believe that this bill will remove one of those

barriers.

Dr. Ryan, I understand that you too are an emergency physician and you are also an addiction specialist, correct?

Dr. Ryan. Correct.

Mr. Ruiz. When there isn't long-term treatment on demand, how important is it to have this bridge of care in the interim?

Dr. Ryan. It is very important, and thank you for the good question. I would say two things.

One of which we worked very hard in the state of Ohio where I practiced to develop treatment on demand with ready access to medication-assisted treatment, and in some areas of the state we are there. But in most parts of the country we are not.

And so I said, you know, I would say that the second point is given the safety profile of buprenorphine that what you are proposing makes sense to me and I would support it, as was already said.

Mr. Ruiz. Thank you. And as an emergency physician, what is the practical implication of this current restriction?

Dr. Ryan. Well, the practical implication, as you know, emergency departments are very busy across the country. By and large, it is more common than not that they are overwhelmed.

And so when you add this increased burden of a patient having to come back, not only is transportation for that patient an issue

it is almost a big issue for patients with opiate disorder.

But you burden the emergency department with more unnecessary visits for the simple administration of a very safe medication.

Mr. Ruiz. What would you say the return rate would be if you are in rural area and your emergency department is quite far from your area?

Dr. Ryan. I would say it would be very poor. I cannot quote a specific statistic. I am not sure if anyone else on the panel is aware. I have not seen such a study.

But knowing the return rates we have on the second day of admission for outpatient programs it would be --

Mr. Ruiz. So they would be lost to follow up. They might receive the first dose but then take an incomplete three-day course?

Dr. Ryan. It would seem that that would be fairly common, yes.

Mr. Ruiz. Okay. So what are the implications of reversing this restriction for the provider and, in your experience, would this lead to greater rates of success for patients trying to access long-term treatment programs?

Dr. Ryan. We do note, from some studies, that emergency department initiation medication-assisted treatment with the

appropriate transition to care can lead to substantially better retention rates in treatment and recovery and lower rates of relapse.

Mr. Ruiz. So is there is -- this is evidence-based programs that actually work to improve success in compliance as a bridge into long-term treatment with successful treatment for opioid misuse disorders, correct?

Dr. Ryan. Correct.

Mr. Ruiz. Thank you. I yield back my time.

Ms. Kuster. Thank you, Dr. Ruiz. You have convinced me and I will co-sponsor your bill.

Thank you very much. Now I will ask for your patience. The subcommittee will stand in recess for 20 minutes while we go vote and then we will come back to resume questions.

[Whereupon, the above-entitled matter went off the record at 1:46 p.m. and resumed at 2:14 p.m.]

Ms. Eshoo. [Presiding.] The Subcommittee on Health will come back to order. Thank you to our witnesses. I know I had to go out to have a meeting. I want to thank Congresswoman Kuster, who held the fort down. And I understand that you have all testified and that those of us that are still here can ask our questions.

I am going to recognize myself for some questions. Let me

start with the following. A federal court in northern California recently found that United Behavioral Health rejected the insurance claims of tens of thousands of people seeking mental health and substance use disorder treatment based on defective medical review criteria.

I have heard from many constituents about this and how harmful these denials, obviously, are to their recovery. To the practicing clinicians and, Dr. Das, I mean, you are all wonderful and brilliant and we are all so grateful to you but a special welcome to you, my constituent from Stanford. Very proud. Very proud to represent Stanford and who is there and what you do.

So to the practicing clinicians -- Dr. Das, Dr. Ryan, and to Mr. Botticelli -- what a beautiful name. What a beautiful name. Have you encountered burdensome prior authorization processes or denials from private insurance when you try to get your patients the mental health and substance abuse care both medication and services that they need?

Mr. Botticelli. I think it is probably most appropriate. At Boston Medical Center we, largely, serve Medicaid clientele, and actually I think we know that generally Medicaid and access to benefits under Medicaid has been better, quite honestly, than under most commercial plans. That may vary by state. But I think my colleagues on the panel probably have more experience with

commercial insurance.

Ms. Eshoo. That is wonderful what you just shared with us. That is very good to hear. There are so many on the committee that have worked so hard over the years to bolster, make stronger and better Medicaid. So I appreciate what you said.

Dr. Das?

Dr. Das. I will add that before Medi-Cal covered buprenorphine I would sometimes spend more time on the phone trying to get buprenorphine approved than compared to how much time I was able to spend with a patient. It is one of the most frustrating things when we have evidence-based treatments that work and there is hoops that we need to jump through to get our patients connected with that care.

And as recently as last week, I was ordering nicotine replacement therapies for a patient wanting to quit smoking. Really severely needed to quit smoking, and that wasn't covered by the insurance. And I was just blown away and the reasoning was that it is over the counter.

But, again, another barrier for somebody who is already disadvantaged who is already struggling to get the treatments that they need. It is frustrating as a psychiatrist.

Ms. Eshoo. Thank you.

Dr. Ryan?

Dr. Ryan. I thank you for the question. So I was actually the chair of Peer Relations in my past tenure at the American Society of Addiction Medicine. So a lot of insurance interaction.

I would say that there are substantial utilization management techniques such as the one you described of prioritization and other efforts to block access to care. That can be inadequate networks, it could be inadequate payments in many case whether it be commercial or Medicaid.

And so there are many obstacles to accessing appropriate reimbursement for good mental health and addiction care. There is also a lack of following science or national standards.

So they will often have their own criteria. It may or may not be something that is nationally recognized as a standard. And so the -- in finality I would say the need to hold insurers accountable to the science and the evidence is --

Ms. Eshoo. Is Medicare or Medicaid different with regards to a prior authorization for these types of claims?

Dr. Ryan. It is state by state in my experience with Medicaid specifically, obviously. Medicare, you know, coverage, for opioid use disorder is a new thing, as was talked about earlier. And so I readily don't know that we have an answer to that last part yet. But for Medicaid it is state by state

variance.

Ms. Eshoo. Yeah. So for those who are in recovery from substance use disorder or work directly with patients, and we have some of you here with us, have you had trouble getting your care covered by insurance? I mean, you just touched on some of it. Is it -- you all agree that you have trouble? Any smooth sailing anywhere?

Ms. Rizzo. Yes, as Dr. Ryan said, it's state by state. New Jersey did away with prior authorizations for Medicaid. So we don't have that barrier anymore, which was a big help.

Ms. Eshoo. That is a -- that is big.

I don't have any other questions. You were all here listening this morning. Is there something that if you were up here you would have asked that we didn't, of the first panel?

Dr. Ryan. I would say actually how to better enforce parity is probably the number one thing that we deal with because that would actually answer some of the questions you just asked. We were actually performing oversight and regulation and adherence to parity. We wouldn't be having a conversation about a safe and fairly cheap medication and prior authorizations.

Ms. Eshoo. Yes?

Mr. Botticelli. I would add to this, you know, while we simultaneously build up our treatment system we know there are

considerable number of people who are not ready for treatment but who are also getting infected with HIV. They are getting hepatitis C.

So having access to things like sterile syringes, access to naloxone I think become really important priorities. So I think that part of what I didn't hear as part of kind of the larger federal strategy is how do we significantly expand what we kind of commonly term harm reduction services.

I think it is particularly important priority for those folks who are not ready to enter treatment. We know it's a glide path for people to get into treatment. We know it reduces overdose and infectious disease rates.

You know, I think we have seen outbreaks in other parts of the country that were caused by lack of access to things like sterile syringes. So part of what I think we really have to focus on is not just how do we build up our treatment system but also how do we create those glide paths and those harm reduction services for folks who are not ready to enter care.

Ms. Eshoo. Thank you very, very much. My time has expired.

And is there anyone that hasn't been called on that I need to recognize? Dr. Burgess?

Mr. Burgess. Thank you. I thought you would never ask.

Ms. Rizzo, actually my questions are along the same lines

as the discussion that has just been going on on the prior authorization. In fact, I was rather startled in your testimony that hey, the eight-hour educational requirement is not a barrier -- it is prior authorization and utilization review, I guess, by inferences is more of a barrier.

Prior authorization, something that we live with at a lot of different levels. As someone who has sat in the prescriber's chair, I hated prior authorization; how dare you second guess my intuition and medical knowledge. I guess it is something that we just have to live with but at the same time there ought to be a way to streamline so it's not -- it's not the barrier that certainly you have encountered.

I was also intrigued your testimony that we forget buprenorphine is not always a benign drug. There are some times that it can be misused. It can be diverted. In fact, there is actual harm that can occur with buprenorphine.

So that is I think something that is important for us to bear in mind as we do things that, yes, we want to get more treatment in the hands of more people but at the same time there are -- there are controls because there is a reason to have the control and if we just remove all of that, we may inadvertently be causing harm.

I guess, Dr. Ryan and Dr. Das, both of you, been through

training programs, you know what they are like. So the -- I will just -- I am conflicted because we have a bill that says we need a thousand new residency slots. So I presume these are psychiatric residencies that are three years in duration. Is that correct?

Dr. Das. I believe the bill is for residency slots where there could be addiction treatment provided at the end of it so it would be psychiatry which is four years as well as other programs that support addiction medicine and addiction psychiatry training.

Mr. Burgess. So but it would be in conjunction with an established training program training program that may be several years in length. In others words, a significant investment of time that someone is going to undergo, correct?

Dr. Das. It could be a significant investment in time. However, an addiction psychiatry or an addiction medicine fellowship could be just one year of additional training in addition to the residency.

Mr. Burgess. Right. You are starting with somebody who has already been through your rigorous four-year program that is not everyone can do it, right?

How about you, Dr. Ryan? Are you a psychiatrist by background?

Dr. Ryan. No, sir. Emergency medicine originally and then went back through and trained in addiction. So to the doctor's point, I think that fellowships are a good route to educate folks.

I will tell you that we over the past 10 years have definitely increased our availability of those folks. But they are few and far between still. And the recruiting of them is challenging. You know, we live out of Cincinnati, basically.

It is not exactly Denver or Miami or San Diego. It is not a particularly great place to recruit folks. It is a little challenging and in the rural areas in tri-state where I work is even more so. So anything we can do to improve and increase the education of folks and so funding and support for that is greatly appreciated.

Mr. Burgess. So what I am hearing is actually fellowships might be a wiser course of action than actually creating residency programs de novo. Is that a fair assessment?

Dr. Ryan. I would say it is part of the overall plan.

Dr. Das. I would also add that only a handful, 5 to 7 percent of U.S. medical graduates go into psychiatry residency training programs and so --

Mr. Burgess. There is a reason for that.

Dr. Das. Residencies are important. But it is not just

about residency. I think having an additional thousand spots would emphasize the importance of this problem in our country and that we need to make changes, not just at residency but through medical education all the way up to continuing education.

Mr. Burgess. So going back to Ms. Rizzo's point about prior authorization, it was my opinion back in the early '90s, late '80s that managed care wasn't doing a thing for the practice of psychiatry and in fact probably was a barrier for young people considering that as a speciality.

Then on the other hand we have the bill that is -- well, during the SUPPORT Act we said you don't really even need any special training. If you are a nurse practitioner with no additional credentials, if you are a nurse anaesthetist who may not have ever practiced clinical medicine in a clinic, if you are a nurse midwife who may have never practiced outside labor and delivery, you can also prescribe buprenorphine.

So it seemed like on the one hand we are making additional requirements and training. On the other hand, we are loosening the requirements. So how do you resolve that discrepancy or that dilemma?

Is more training good or is more training just superfluous and it doesn't matter -- we need to push more stuff out and get it out there, even though Ms. Rizzo has testified that there is

harm that is potential from some of these medication?

Dr. Ryan. So I would come into the -- I think it was the previous section when you were out, which is basically we have parallel paradigms of this type of training, meaning as an emergency physician I went through a very rigorous, you know, training program in emergency medicine at the University of Cincinnati and had wonderful NPs and PAs who came on board with me that had been trained in family medicine. But because I had the, you know, upper level of training was capable of bringing those folks along and educating them.

So I would draw that parallel and saying that I think we need, you know, education at all levels. In fact, that is why ASAM supports the MATE and the MAT Act together in order to increase the education.

Mr. Burgess. Right. But in some states, as you know, there is not -- in Texas there is. There is supervisory requirement.

Dr. Ryan. Same in Ohio.

Mr. Burgess. I don't know about Ohio. But as some states there is not.

Dr. Ryan. Understood.

Mr. Burgess. And that is what I know Dr. Bucshon when we had those hearings he was concerned about, as a cardiothoracic surgeon. I think it is something that we need to bear in mind

that we are being asked now to extend the program before its expiration. We have a report due. I just think we ought to evaluate the report before we make a new decision.

So thank you and I will yield back.

Dr. Ryan. Thank you.

Ms. Eshoo. The gentleman yields back.

You know, when we hear these numbers, a thousand -- a thousand new physicians -- when you divide that by 50 states it is a handful of people and the needs in our country are great. I think this discussion about residencies and all of that are really important.

I think that what we approve we want to make sure that it truly is the tip of the spear and that we don't miss the mark because the demands of human being across the country. We have to meet these demands.

This is -- I mean, that statistic I gave that more people have lost their lives to this public health challenge than all of the lives that were lost in Vietnam. It's a huge number. It's a huge number.

So, collectively, we have our work cut out for us but this is the first place where the table is set and we thank you for travelling across the country to come here to testify.

Oh, we still have Doris. I am sorry. I thought you had

already been recognized. There you are. I would never leave her out.

The gentlewoman from California, Ms. Matsui, five minutes. I am sorry. I apologize.

Ms. Matsui. Thank you very much, Madam Chair, for acknowledging me. I know you would never forget me.

And I want to thank the witnesses for being here today on this very important topic. And before I get into my questions, I want to take a quick moment to recognize the important role hospitals are playing in the substance abuse fight.

In building upon our work here, I believe we should look for ways to streamline funding for these entities to improve care coordination efforts, reduce emergency room use and scale abuse prevention initiatives.

Now, the availability and use of stimulants like meth and cocaine are definitely on the rise, according to the DEA 2019 National Drug Threat Assessment and it remains widely available and the DEA field divisions are reporting an increasing availability of drug compared to the previous years and I do have to say that I hear it from my health care providers all the time. It is a cheap drug, easy to make, and the people who get it are the ones who are basically on the streets, a lot of them.

Mr. Morrison, your organization convenes stakeholders who

play a key role in ushering federal dollars into communities that need it the most. In your testimony, you mentioned that state directors are observing increases in stimulant use. Is that correct?

Mr. Morrison. Yes, it is. In certain states there are increases in admissions to treatment that they are reporting.

Ms. Matsui. Right. I would like to note that when we passed the fiscal year 2020 funding package we continued our investment in State Opioid Response Grants while also allowing grantees to use this funding to address stimulant use.

Dr. Ryan and Dr. Das, can you describe the differences in how we treat a patient with meth use disorder?

Dr. Das?

Dr. Das. For psychiatrists and addiction psychiatrists generally we would take the same overall approach where we assess for things that may be occurring along with that primary diagnosis.

The difference with stimulant use disorder is that we don't have a medication in place for us to utilize. However, oftentimes with most substance use disorders, they don't occur by themselves. They are going to occur with some co-occurring disorder, either physical co-morbidities or generally more often other mental illnesses.

And so taking a comprehensive approach to treating all of the patients needs gives them the best options and chance for recovery.

Ms. Matsui. Sure. Dr. Ryan, like to make a comment?

Dr. Ryan. I concur with Dr. Das.

Approaching the patient in that holistic biosocial model is exactly how we should address this. It is unfortunate that we do not have medications developed for stimulant use disorder and probably was a failure of, you know, 20 or 30 years ago of the last stimulant crisis that we had.

So it is my hope and I am working with the different folks and I know that the FDA and other entities are working on developing and approving a medication so that we would have the full biopsychosocial model.

Ms. Matsui. Absolutely, because I mean, as sad and as severe as the opioid crisis we do have something there and we have no pharmacological way to help these people.

Currently, no law enforcement agency or private party has the ability to provide real time nationwide oversight of all orders for controlled substances, which is a major contributing factor to disproportionate prescription opioid shipments to certain pharmacies across the country.

Distributors especially lack any visibility into the total

volume of opioids that customers purchase from other suppliers, severely hindering their ability to make fully informed assessments of an order that could potentially be suspicious.

Mr. Botticelli, given your experience would you agree that the identification of patterns and trends in detecting real-time drug diversion would be an important step in addressing this country's opioid epidemic?

Mr. Botticelli. Incredibly helpful. You know, one of the things that I felt hamstrung by during my time in Washington both on the law enforcement side and the public health side is lack of access to real time data, and I always felt it was hard to see where you are going if the only tool you have is a rear view mirror. And I really felt hampered by our ability to understand things like where parts of the country -- hot spots in parts of the country or where we were seeing -- where we needed to plow additional public health resources.

And, unfortunately, it was only until people died that we actually had that information. So I think anything that the committee can do to really strengthen both our law enforcement and public health data in a real timely way.

Ms. Matsui. Right. And I agree with you. I believe creating a DEA program that collects and shares in real time data of every sale, delivery, or disposal of controlled substances

is essential.

So I ask my colleagues to support my bill with Representative Johnson, the Suspicious Order Identification Act of 2019 to achieve this goal. You need as much information as possible and we would like to get there.

So thank you very much. I yield back.

Ms. Eshoo. The gentlewoman yields back.

Anyone -- no, Mr. Tonko is not here. I thought he was coming back to waive on.

Timing is everything. Mr. Welch of the great state of Vermont, you are recognized for five minutes.

Mr. Welch. Thank you very much.

Some of you might have been here for the first panel. Incredible challenge. But the big challenge for a lot of us is the workforce. It is unbelievable, as you know, I mean, especially in a state like Vermont.

But Vermont is not at all atypical. I mean, the number of nurses we had, LPNs, among others, doctors, regular physicians, it is really declining precipitously just in the last 15 years.

And, first of all, I would just ask Mr. Morrison, that dynamic that I am talking about, is it your awareness that that is very typical of a lot of communities across the country?

Mr. Morrison. In terms of struggles with workforce and

workforce development, absolutely. I would say it is consistent across our members across the country.

Mr. Welch. Yes. Dr. Das?

Dr. Das. In California, yes, we are also facing workforce shortages and with the APA we are wanting to increase the number of psychiatrists that there are and the amount of training that psychiatrists would get in substance use disorders.

Mr. Welch. So we are looking for solutions and one of the proposals is to have more GME residency options. Anybody want to comment on whether that would be helpful or not?

Go ahead.

Mr. Botticelli. I will start. I think it is incredibly helpful. You know, we do a significant amount of medical residency training and fellowships for addiction medicine.

But we don't have enough slots to meet demand for it and I think having more trained professionals, quite honestly, you know, we need a trained workforce at all levels of the organization. Not only at the physician and psychiatrist level but at the nurse level, at the licensed counselor level and even with people with experience.

Mr. Welch. Right. And is it the case -- I don't know what the stats are -- that if you get your degree at a local institution the likelihood is that you will -- there is a higher likelihood

you will stay rather than leave?

Mr. Botticelli?

Mr. Botticelli. I think that anything that we can do to kind of recruit and retain a workforce is incredibly important. I will tell you that as states have expanded services, we are poaching from each for a trained workforce, which is not what we want to be doing here.

Mr. Welch. Right. And then a lot of hospitals are having travellers, right. Ms. Rizzo, do you want to comment on that?

You know, it makes me nervous. I had a relative in a hospital and we had great nursing care. But then we had a lot of people who were coming and going.

Ms. Rizzo. Yes, it is difficult. In New Jersey medical directors and physicians are very hard to come by. We are required to have an opioid treatment program. We have to have a medical director and a medical director designee who has the same certifications as the medical director.

But, again, counselling is another area that is greatly lacking. Again, we have to have 50 percent -- 50/50 ratio of licensed counselors to counsel interns, and as programs are opening, broadly, throughout the state we are all scrambling to build up the workforce so it is very difficult.

Mr. Welch. So what are the impediments to having a

workforce?

Ms. Rizzo. Well, I think one of the things, and I think it was in the SUPPORT Act about the loan forgiveness, I think that is really important.

But it is just enticing people to come into the field. So it is just -- it is a battle that we all face.

Mr. Welch. But the pay is reasonably good, right? I mean, it is not like --

Ms. Rizzo. No.

[Laughter.]

Mr. Welch. All right. We want a raise.

Ms. Rizzo. You know, it is getting better. With Medicaid reimbursements and now Medicare we have definitely been able to grow with our census and we have been able to lift the salaries of our staff.

But it is difficult to compete and especially, you know, we are a private nonprofit and we are competing against some of the larger for profit programs and it is difficult.

Mr. Welch. Mm-hmm. Okay. Well, I just want to thank you all, and I will yield back. Thank you very much.

Mr. Burgess. Will the gentleman yield his last 46 seconds?

Ms. Eshoo. Yes.

Mr. Welch. I will. Thank you.

Mr. Burgess. Just before this panel, it is such a smart panel and before you leave and I think, particularly, Dr. Das, I wanted to ask you -- you might have heard me ask our agency group about the IMD exclusion, and I thought we had dealt with that in the SUPPORT Act.

Perhaps we didn't deal with it as effectively as we might have. Do you have any thoughts on the IND exclusion and how it is contributing to the ongoing problems that we are having?

Dr. Das. Continued exclusions further silo the access to care problem that we have and so I would say that while there are many things that were part of the SUPPORT Act enforcement and having those carried out properly still are panning out.

Mr. Burgess. Well, Medicaid has been held up to us as perhaps one of the better providers but with the Institute of Mental Disease exclusion you can only have 16 beds with Medicaid patients who are hospitalized. It just seems to me to be an impediment as to way the world is now. It is different from what it was in 1960.

I think -- maybe we can have a hearing on that at some point. I think that will be a good idea. I will yield back to the gentleman.

Ms. Eshoo. The gentleman from Vermont yields back and I see that Mr. Bilirakis has returned. The gentleman from Florida

-- you are recognized for five minutes.

Mr. Bilirakis. Thank you, Madam Chair. I appreciate it so very much. Thanks for holding this hearing. I thank the ranking member as well and, of course, the presenters.

Dr. Das, is telepsychiatry an effective -- an evidence-based method for improving access to mental health and substance use disorder treatment?

Dr. Das. During my time at the VA as the director of addiction treatment services, I had the honor of using telepsychiatry to reach veterans in remote areas, veterans who not only were in remote areas but also oftentimes as a result of their co-occurring mental illnesses or PTSD, for example, couldn't get to our clinic sometimes 40 miles, 80 miles away.

In using telepsychiatry I was able to assess them oftentimes in person when there was something acute but then continue to treat them through telepsychiatry very effectively with them going to the local community-based outpatient clinic.

These folks felt and told me more than once throughout their treatment that they felt like this was a lifesaver, that had they not learned about this option they wouldn't be around and that having the ability to see me through the video was life changing for them.

Mr. Bilirakis. Okay. So needless to say -- suffice it to

say that you endorse it?

Dr. Das. Yes.

Mr. Bilirakis. Okay. Are there patient populations like patients with autism spectrum diagnosis, severe anxiety disorders, or geriatric patients with physical limitations who may prefer and benefit from telepsychiatry compared to its in-person counterpart?

So, again, elaborate on how effective it is but let me ask one more question here because it is related. How can telepsychiatry lead to improved overall patient outcomes including shorter hospitalizations and improved medication adherence? What barriers still exist to telepsychiatry, in your opinion?

Dr. Das. I think one of the --

Mr. Bilirakis. What barriers still exist?

Dr. Das. So the care is available and we have been able to do it -- for example, at the VA we have been able to use telepsychiatry. Telemedicine is available across the VA across all disciplines and we use it, for example, in wound care so that somebody doesn't -- somebody who may be an older patient who is limited physically may not be able to come in for wound care post surgery and so they able to do wound care even through telemedicine.

And so the same sort of things apply for telepsychiatry, that we would be able to have continuity of care, easier access to care. I think the -- you asked about barriers, I think, and kind of -- I have been speaking about the VA because that is where I have done most of my telepsychiatry work. But the barriers to care in the general public are reimbursement for telepsychiatry.

Mr. Bilirakis. Reimbursements. Okay. Thank you.

And in your opinion across the board in the medical community, particularly in the psychiatric community, professionals endorse this form of therapy, correct? Across the board.

Dr. Das. Well, the APA has --

Mr. Bilirakis. In general.

Dr. Das. -- a telepsychiatry initiative. They have resources available for telepsychiatry and information on the evidence base for telepsychiatry across the board, across all physicians. I wouldn't be able to speak for all physicians but I think there is a movement towards getting people quicker access to care and removing barriers.

Mr. Bilirakis. Absolutely. Access is definitely the key.

Madam Chair, I recently co-sponsored a bipartisan bill with Congressman Soto called the Enhanced Access to Support Essential,

or EASE for short, Act -- Behavioral Health Services Act and it is H.R. 5473. H.R. 5473 builds upon the SUPPORT Act to connect patients without a primary diagnosis of an SUD to the Behavioral providers they need via telehealth.

My bill enables Medicare reimbursements, to your point -- Medicare reimbursements for behavioral health services delivered via telehealth while also supporting school-based behavioral health services delivered via telehealth -- so very important as well.

I ask for unanimous consent to include a letter of support of H.R. 5473, the EASE Behavior Health Services Act, from the American Psychiatric Association, and I have the letter here somewhere, Madam Chair.

Ms. Eshoo. Well, you find it and we will put it in the record.

[The information follows:]

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

Mr. Bilirakis. Thank you. I appreciate that. Thank you. I am going to yield back, Madam Chair. Thank you very much for giving me the time.

Ms. Eshoo. The gentleman yields back.

We have been joined by the gentleman from New York, Mr. Tonko, and we are glad that you are back and waiving on.

Mr. Tonko. Thank you.

Ms. Eshoo. It is really nice to see you here. You have five minutes.

Mr. Tonko. Thank you, Madam Chair. Thank you for allowing me to waive on and welcome to our panellists.

Ms. Rizzo, let us start with you. I would like to begin by asking you some questions that require a simple yes or no. Does a medical provider need to obtain a special waiver from the DEA in order to prescribe fentanyl?

Ms. Rizzo. No.

Mr. Tonko. Does a medical provider need to obtain a special waiver from the DEA in order to prescribe codeine?

Ms. Rizzo. No.

Mr. Tonko. How about morphine?

Ms. Rizzo. No.

Mr. Tonko. How about hydrocodone?

Ms. Rizzo. No.

Mr. Tonko. I think you see what I am getting at here. Now, let us talk about buprenorphine for a moment. Wouldn't you agree that buprenorphine has a much stronger safety profile than the drugs I just mentioned, specifically in that it has a ceiling effect that doesn't increase with dosage and that the risk of respiratory depression leading to overdose is much lower with buprenorphine compared to the other medications that I just mentioned? Yes or no?

Ms. Rizzo. Yes. Can I follow up?

Mr. Tonko. Thank you, Ms. Rizzo. What I am trying to make clear here is that buprenorphine doesn't have a safety profile that distinguishes it from other medications that providers can freely prescribe.

So I am trying to rationalize why we continue to make this medicine, which has been shown to reduce mortality associated with overdose by up to 50 percent, again, reduces mortality by up to 50 percent and has a safety profile that is much more benign than the powerful opioids that got us into this crisis so difficult to obtain. Perhaps it is because there is something unique about the practice of addiction medicine.

So let me ask you, Ms. Rizzo, do you need a special DEA waiver to prescribe naltrexone, one of the three FDA-approved medications to treat opioid use disorder?

Ms. Rizzo. No.

Mr. Tonko. But, Ms. Rizzo, without a special waiver for naltrexone how are we going to ensure the quality of care that patients are receiving? How are we going to impose the reporting requirements that you find so essential for buprenorphine? And that is, largely, a rhetorical question but let me ask you this.

Because you seem to think that addiction medicine uniquely needs these bureaucratic safeguards in place do you believe Congress should require all providers who want to prescribe naltrexone have a special DEA waiver?

Ms. Rizzo. No.

Mr. Tonko. And the answer is no because it would be ridiculous for Congress to impose such barriers to lifesaving medicine in the middle of an epidemic. So just to recap here, we have an overdose crisis that is killing 67,000 to 70,000 individuals a year.

We have a medication that will treat the vast majority of these individuals and reduce their chance of death by up to 50 percent. This medication has a strong safety profile, especially when compared to other controlled substances that don't require jumping through special hoops.

Other addiction medications can be freely prescribed without

a waiver and yet we have set up a system where somewhere less than 10 percent of our medical professionals can offer this lifesaving medication.

Does anyone actually have any rational defense of this ex-waiver system that is causing people to die on our streets other than it is simply the status quo? Would any of you honestly set up a system like this from scratch today? Anyone?

Ms. Rizzo. Can I respond to that?

Mr. Tonko. Would you set up a system like that?

Ms. Rizzo. I wouldn't set up a system like that but our concern is the diversion potential for buprenorphine on the street and --

Mr. Tonko. Diversion on the streets when you have a better established system for treatment -- I don't think it is an appropriate argument that there were be diversion.

You know what I think? I think this is simply stigma written into our laws. It is right there and crystal clear in the fact that you don't need a special waiver to prescribe this exact same medication for pain.

But once you want to help someone struggling with the disease of despair that is substance use disorder, all of a sudden we throw up all kinds of barriers to a literal miracle drug because we simply don't trust the people we are prescribing them to.

Shame on us. We can fix this by passing the Mainstreaming Addiction Treatment Act. We can't afford to wait and I thank those witnesses and organizations who have offered support for this critical legislation.

Now, Dr. Ryan, can you explain briefly how the current waiver system limits access to care, particularly for the one-third of Americans largely in rural counties who don't have access to a single waivered provider?

Dr. Ryan. Thank you, sir. So I would -- I guess I would summarize by saying there are many barriers to access to care for medication-assisted treatment, specifically buprenorphine, and that this is one of them. There are also stigma, reimbursement challenges, et cetera, but in -- kind of in totality it creates quite a barrier for folks to access treatment.

Mr. Tonko. Well, thank you, and let me be clear before I wrap up. I agree with many aspects of your testimony, Ms. Rizzo, including that there are numerous other barriers we need to address like prior authorizations, clinical support for providers and better access for our incarcerated populations.

But the idea that just because other barriers exist that we shouldn't knock down the one that is staring us in the face is tough to swallow.

With that, I thank you and I yield back the balance of my

time, Madam Chair.

Ms. Eshoo. The gentleman yields back. Seeing no one else, I think that our hearing is coming to an end.

Thank you to each one of you again for travelling across the country and, most importantly, for what you do day in and day out. This is a huge challenge for all of us and your knowledge, your considerable knowledge, is not only a source of inspiration to me, I think to all of the members. But it also gives me confidence that what you have testified to and the answers that you have given will help us to shape legislation that is really going to make a difference for people in our country and that is what we are here for. So I consider you all healers.

I would also like to submit the following statements for the record and request unanimous consent to do so.

Testimony from Danielle Tarino, president and CEO of Young People in Recovery; a statement from the National Association of Chain Drug Stores; a statement from Mark Parrino, president of the American Association for Treatment of Opioid Dependence; a graphic on MAT waiver training produced by Providers Clinical Support System; a statement from the National Safety Council; a statement from the Medication-Assisted Treatment Leadership Council. Never ceases to amaze me all of the organizations we have in our country.

A letter from Ochsner Health System -- I think I am pronouncing it correctly; a letter from the Opioid Safety Alliance; a letter from the American Society of Addiction Medicine; a letter from Bill Greer, president of SMART Recovery; a letter from the American Society of Anesthesiologists; a letter from the American Psychiatric Association.

I don't hear any objection so I will say so ordered.

[The information follows:]

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

Ms. Eshoo. And I know that each one of the witnesses will on a timely basis respond to any written questions that are submitted to you and I want to thank you in advance for that.

Bless you in your work, and with that the subcommittee will now adjourn. Thank you, everyone.

[Whereupon, at 2:53 p.m., the committee was adjourned.]