

# COMBATING THE OPIOID CRISIS: BATTLES IN THE STATES

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## HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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JULY 12, 2017  
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## CONTENTS

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	Page
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement .....	1
Prepared statement .....	3
Hon. Diana DeGette, a Representative in Congress from the State of Colorado, opening statement .....	5
Hon. Greg Walden, a Representative in Congress from the State of Oregon, opening statement .....	6
Prepared statement .....	8
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement .....	9

### WITNESSES

Boyd K. Rutherford, Lieutenant Governor, State of Maryland .....	11
Prepared statement .....	14
Answers to submitted questions .....	
Brian J. Moran, Secretary of Public Safety and Homeland Security, State of Virginia .....	24
Prepared statement .....	26
Answers to submitted questions .....	
John Tilley, Secretary of The Justice and Public Safety Cabinet, State of Kentucky .....	45
Prepared statement .....	47
Answers to submitted questions .....	
Rebecca Boss, Director, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, State of Rhode Island .....	50
Prepared statement .....	52
Answers to submitted questions .....	

### SUBMITTED MATERIAL

Statement of the National Association of Medicaid Directors Board of Directors, submitted by Ms. Castor .....	95
Article entitled, "Why taking morphine, oxycodone can sometimes make pain worse," Science, May 30, 2016, submitted by Mr. Murphy .....	97
Article entitled, "51 percent of opioid prescriptions go to people with depression and other mood disorders," STAT, June 26, 2017, submitted by Mr. Murphy .....	100
Committee memorandum .....	104



## **COMBATING THE OPIOID CRISIS: BATTLES IN THE STATES**

**WEDNESDAY, JULY 12, 2017**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

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

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

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

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

### **OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

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

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

For every fatal overdose, it has been estimated there are 20 nonfatal overdoses. And for 2016, that could be near 1 million. More than 183,000 lives have been lost in the U.S. from opioid overdoses between 1999 and 2015. That is about 500,000 that will be lost over the next decade. The roots of this crisis began back in 1980 when a letter to the editor by two doctors published in the New England Journal of Medicine was misinterpreted as evidence. It was unlikely that someone would become addicted. Out of 40,000 cases, they said there were only four addictions.

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

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

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

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

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

Serving the front lines of the opioid epidemic, state governments have been pursuing their own innovative initiatives, such as more

inventive use of incentives, more structured medication-assisted treatment, more comprehensive prescription drug monitoring.

States such as Maryland are making the best use of the Center for Disease Control opioid prescribing guidelines to help push back on the overprescribing. Kentucky's All Schedule Prescription Electronic Reporting system, more known as KASPER, a web-based monitoring system to help prescription use across the state, is helping state regulators identify questionable prescribing practices by physicians and abuse by patients.

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

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

We put \$1 billion into grants over the next 2 years, but we want to know if this money is being used wisely, and what is working. We are eager to learn about those programs. But the 21st Century Cures state program is just the beginning. Our state government witnesses can help this committee develop a more effective and national strategy to combat the opioid crisis in such areas as substance abuse prevention and education, physician training, treatment of recovery, law enforcement, expanded access to Vivitrol, while testing for drugs in correctional facilities, data collection, examining what reforms can be made to the 42 CFR Part 2, so there is better coordination of care among physicians, and we can help prevent relapses and overdose and improve patient safety.

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

[The prepared statement of Mr. Murphy follows:]

#### PREPARED STATEMENT OF HON. TIM MURPHY

Today, the Subcommittee holds a hearing entitled, "Combating the Opioid Crisis: Battles in the States." Make no mistake. The terms "combating" and "battles" are entirely appropriate; our nation is in the midst of a tremendous fight against death and devastation affecting every corner of our nation.

In 2015, there were more than 52,000 deaths from drug overdoses in the U.S., with more than 33,000 deaths involving an opioid, a 24 percent increase from the prior year. The opioid overdose death rate in 2015 was almost seven times the rate of deaths from the heroin epidemic during the 1970's. For 2016, we have learned from an analysis by the New York Times—not from the Federal government—that we have lost roughly 60,000 people to drug overdoses, more than all the Americans who died in the Vietnam War. The staggering number of deaths is only part of the

picture. For every fatal opioid overdose, it has been estimated that there are approximately 20 non-fatal overdoses. For 2016, the number of overdoses could be nearing one million.

More than 183,000 lives have been lost in the U.S. from opioid overdoses between 1999 and 2015. A recent forecast from STAT News projects that almost 500,000 lives will be lost from opioid overdoses in the U.S. over the next decade.

The roots of this crisis began back in 1980, when a letter to the editor from two doctors published in the *New England Journal of Medicine* was misinterpreted as evidence of the unlikelihood that patients given pain drugs would develop addiction. About twenty years later, the Joint Commission on Accreditation of Healthcare Organizations, following the American Medical Association recommendation that pain be assessed as the fifth vital sign, established standards for pain management interpreted by many doctors as encouraging the prescribing of opioids. Under the Affordable Care Act, prescribing painkillers is incentivized because hospital payments are tied to patient satisfaction surveys that reward hospitals financially when patients give them high ratings.

As we learned in our oversight hearing held in March, the opioid epidemic is an urgent public health threat fueled by fentanyl, a much more dangerous and potent synthetic opioid and a clear and present danger to America. Two states represented on today's panel, Rhode Island and Maryland, were the first ones hit by the fentanyl wave. Unfortunately, it seems certain that this wave will sweep the nation as the low-cost, high-profit, hard-to-detect profile of fentanyl is increasingly attractive to traffickers and is relatively easy to manufacture or obtain on the street or over the internet.

This is an in extremis moment requiring all the experience, resources, and cooperation of our federal, state, and local governments, as well as all the different industries, professionals, and experts to curb this outbreak. With this hearing, we will focus on the actions of our state governments to find out what efforts are working, what is not working, and how we can work together to save lives, restore communities, and repair the millions of families torn apart by the deadliest drug crisis in United States history. As drug policy expert Sally Satel noted "[it] is at the state and county levels that the real progress will be made. It makes sense that the effort to find inspired solutions would be most concentrated there; we should invest in those solutions and learn from them."

Serving on the front lines of the opioid epidemic, state governments have been pursuing their own innovative initiatives, such as more inventive use of incentives, more structured medication assisted treatment and more comprehensive prescription drug monitoring. States such as Maryland are making the best use of the Centers for Disease Control Opioid Prescribing Guidelines to help push back on the overprescribing of opioids. Kentucky's All-Schedule Prescription Electronic Reporting System, or KASPER—a web-based database to monitor opioid prescription and use across the state—is helping state regulators identify questionable prescription practices by physicians and abuse by patients. Virginia has greatly expanded access to Naloxone, the drug that can rapidly reverse an opioid overdose.

Some states are expanding the availability of Naloxone by permitting third party prescribing by family and friends of individuals who are at high-risk of overdose. Rhode Island has developed the AnchorED program that matches overdose victims with peer recovery coaches to encourage treatment, who follow-up with the patient for the next 10 days after the overdose. Much of the work of the states should help inform the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Two years ago, the Subcommittee held a similar hearing on what the state governments were doing to combat the opioid abuse epidemic. Such oversight helped Congress enact provisions in the Comprehensive Addiction Recovery Act and 21st Century Cures Act which authorized the Substance Abuse and Mental Health Services Administration to administer nearly one billion dollars in grants over the next two years to states and territories for substance abuse prevention programs, treatment, and training for health professionals. We are eager to learn about how the states represented here today plan to use these grants, to ensure the grants are reaching local communities in need, and that the help provided is really working.

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

We are honored to have our distinguished witnesses join us this morning. We thank you for appearing today and look forward to hearing your testimony.

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

**OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Ms. DEGETTE. Thank you so much, Mr. Chairman. And I appreciate this most recent hearing on opioid addiction. As you said so accurately, this crisis is really devastating America, as all of us on the dais have seen it play out in our communities, urban and rural alike. Not a day passes without a report about children watching their parents overdose, about librarians and school nurses being trained to administer Naloxone to overdose victims, or about local and state governments trying to respond to the myriad of issues surrounding addiction, all, at the same time, trying to stay within their budgets.

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

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

This committee has done some good work, in particular, investigating the seemingly voluminous amount of pills distributed in West Virginia. And I know that we are planning to do more. As you know, a number of state Attorneys General are investigating manufacturers, and, in some cases, distributors. The attorney general in my home State of Colorado, for example, has joined a bipartisan coalition of states nationwide, looking into whether manufacturers engaged in illegal or deceptive practices when marketing opioids.

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

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

Mr. Chairman, I know these are all great state efforts. We have made some efforts here in Congress, and I appreciate you referring to the 21st Century Cures legislation that Congressman Upton and I sponsored, and that this whole committee worked together on a bipartisan basis to pass. But as we move forward on this issue, we really need to work together to continue to address this, and that is why I kind of hate to be the fly in the ointment, and talk about what these efforts to repeal the Affordable Care Act will do to the fight against the opioid epidemic. As you know, the ACA has helped nearly 20 million Americans obtain healthcare coverage. In addition, it's enabled governors to expand Medicaid services that are critical tools in the fight.

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

Now, there have been discussions, both in the House bill and the Senate discussions, about adding some money for opioid treatment. But, for example, the most recent Senate suggestion of additional \$45 billion to help combat opioid addiction, Governor John Kasich said, "It is like spitting in the ocean, it is not enough."

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

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

**OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON**

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

In my state, more people die from drug-related overdoses than from automobile accidents, and sadly, that is not unique. According to a preliminary data analysis, drug overdose deaths in 2016 likely exceeded 59,000 people. That is the largest annual jump ever recorded in the United states. And what's worse, some of the preliminary numbers from the states indicate that their numbers within the first 6 months of this year are already surpassing last year's

total numbers. And over the past 7 years, opioid addiction diagnoses are up nearly 500 percent, according to a recent report.

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

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

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

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

We hope to hear from the state officials today to see how they are utilizing these funds, and whether these programs work or not. We greatly appreciate the witnesses who have agreed to appear before us today. We hope to have a constructive dialogue about what the states are doing, how we can improve data collection, what initiatives are working, what isn't working, and how the Federal Government can be a better partner in this collective fight.

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

[The prepared statement of Mr. Walden follows:]

## PREPARED STATEMENT OF HON. GREG WALDEN

Addiction is an equal opportunity destroyer. It is a crisis that does not pick people based on their age, race, or socioeconomic status. And it most certainly does not pick based on political parties.

From my roundtables throughout the Second District of Oregon, it didn't matter if I was in a rural community or a more populated city; the tragic stories were similar. We all know someone who has been impacted by this epidemic. In Oregon, more people now die from drug-related overdoses than from automobile accidents—and sadly, that is not unique to my home state.

According to a preliminary data analysis, drug overdose deaths in 2016 most likely exceeded 59,000—the largest annual jump ever recorded in the United States. What's worse? Some of the preliminary numbers from the states indicate that their numbers within the first six months of this year are already surpassing last year's total numbers. And over the past seven years, opioid addiction diagnoses are up nearly 500 percent, according to a recent report.

Despite a report released by the Centers for Disease Control last week which indicates that the number of opioid prescriptions has decreased over the past five years, the rates are still three times as high as they were in 1999, and the amount of opioids prescribed in 2015 was enough for every American to be medicated around the clock for three weeks.

That report also found that counties in Oregon have some of the highest levels of opioid prescriptions in the country. Of the top 10 counties in Oregon for opioid prescriptions, five of them are in my rural district. Moreover, Oregonians age 65 and older are being hospitalized for opioid abuse, overdoses, and other complications at a far higher rate than any other state in our union.

Sadly, overdose deaths continue to escalate. This epidemic is getting more severe. Challenges clearly remain.

First, we need to improve data collection, and a few states are already requiring more specific information related to overdose deaths. Quite simply, we can't solve what we don't know.

We need to be able to have more timely and reliable data so we can better understand and address the full scope of the problem. There also needs to be an increase in overdose prevention efforts, improvement with respect to the utilization and interoperability of Prescription Drug Monitoring Programs, and we need to increase access to evidence-based treatment, including Medication-Assisted Treatment.

Combating this epidemic requires an all-hands-on-deck effort from federal, state, and local officials—spanning from health care experts to our law enforcement community. That is precisely why we are having this hearing today.

Last year Congress took action to combat this crisis by passing legislation, including the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act, and states have pursued programs to strengthen our fight against this epidemic. But much more needs to be done. We need to work together to ensure that the tools and funding Congress has created are reaching our state and localities, and that they are being used effectively. We hope to hear from the State officials before us today to see how they are utilizing these funds and what programs have proven to be successful.

We greatly appreciate the witnesses who have agreed to appear before us today. We hope to have a constructive dialogue about what the states are doing; how we can improve data collection; what initiatives are working, what isn't working; and how the federal government can be a partner in this collective fight. I look forward to your testimony, and working with all of you to help our communities and solve this horrific crisis.

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

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

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

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

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

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

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

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

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

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

I'd also like to hear from our witnesses about how the Federal Government can help. While it is important the states be empowered to address the particular challenges of their communities, our response to this epidemic cannot be 51 separate efforts. We must harness our national resources data in cooperation to get this crisis under control.

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

Yet, Republicans persist in their attempts to gut the Medicaid program by capping it permanently, and ending Medicaid expansion as part of its efforts to repeal the Affordable Care Act. Repealing the Affordable Care Act and replacing it with TrumpCare would be devastating to 74 million Americans who receive critical healthcare services from the program. Today, 1 in 5 Americans receive their health insurance from Medicaid. Half of all the babies born in this country are financed by Medicaid. And to the working poor, many of whom are hit hard by the opioids epidemic, and are eligible for Medicaid for the first time through the ACA's expansion. Medicaid is, quite literally, the only affordable health insurance available. And make no mistake, state Medicaid programs are at the center of the opioids epidemic.

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

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

So, Mr. Chairman, we must stay vigilant in this fight and remain open to any solution that shows promise. So I thank you for having this hearing. But I believe that there is no way that this crisis can be solved with one-time infusions of resources, and it will only get worse if Medicaid dollars are removed from the fight. We must invest in our healthcare system and its critical public programs for the long term, and Medicaid is clearly a critical pillar that should be strengthened, not decimated.

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

Mr. MURPHY. Thank you for your comments. I ask unanimous consent that the members' written opening statements be introduced into the record, and without objection the documents will be entered into the record. I also note that two former members of this committee, Representative Mary Bono and Dr. Phil Gingrey, are present. Thank you for being here. And I, believe you said Mr. Stu-

pak was around, too. Obviously, this is an important issue to those who are alumni committee as well.

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

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

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

[Witnesses sworn.]

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

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

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

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

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

Maryland, like most states, has experienced an increase in the number of deaths related to opioids. In 2016, 2089 Marylanders died from alcohol or drug-related intoxication; 66 percent increase

over the deaths and 2015. And 89 percent of those deaths were related to opioids. Maryland has seen an increase in prescription opioid-related deaths, and so we must address this particular element of the crisis. We must focus on reducing the inappropriate use of prescription opioids, while ensuring patients have access to appropriate pain management.

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

Accordingly, as one of the Governor's first acts in 2015, was to establish the Heroin and Opioid Emergency Task Force, which he asked me to chair. After nearly a year of stakeholder meetings and expert testimony and research, the task force adopted 33 recommendations. Those recommendations range from prevention, access to treatment, alternatives to incarceration, enhanced law enforcement, and more. And they form the foundation of our state-wide strategy. Building on those recommendations of the task force, the Maryland General Assembly passed several comprehensive pieces of legislation.

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

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

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

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

Shortly after its creation, the Governor declared a state of emergency in response to this crisis. By executive order, he dedicated—delegated emergency powers to state and local emergency manage-

ment officials to enable them to fast track coordination with state and local agencies. Thanks to your leadership and commitment, funding of the 21st Century Cures Act, has greatly aided in this effort. And these dollars will be used in expanding educational efforts in the schools, building public awareness, improving treatment, expanding our peer recovery specialist program, and increasing the availability of Naloxone.

The one thing that I would add that we would like to see from the Federal Government is to consider utilizing FEMA as outlined in the national emergency framework to centralize and coordinate the Federal response to this crisis. The national response framework is a guide to how the Nation responds to all types of disasters and emergencies, and it would allow Federal agencies to work more seamlessly with each other and with the agencies at the state level. We can't afford to have delays due to agency silos and bureaucracies. I appreciate this opportunity to talk to you and await any questions you may have.

[The prepared statement of Mr. Rutherford follows:]

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TTY USERS CALL VIA MD RELAY

**Testimony of Lieutenant Governor Boyd K. Rutherford  
Hearing before the Subcommittee on Oversight and Investigations of the House Energy &  
Commerce Committee**

**July 12, 2017**

Chairman Murphy, Ranking Member DeGette, honorable members of the Subcommittee, thank you for the opportunity to join you today to discuss the State of Maryland's response to the heroin and opioid crisis ravaging the nation. Tackling this emergency necessitates a coordinated response from federal, state, and local government and Maryland looks forward to continuing to work together with our federal partners to address this challenge.

As Governor Hogan and I traveled throughout Maryland during our 2014 gubernatorial campaign, we heard devastating stories from families and friends hurt from the destruction of heroin and opioid abuse. We quickly realized this epidemic had crept into every corner of our state and cut across all demographics. At the time, though the problem was well known to health and law enforcement personnel who confronted it every day, it received little media attention, and many families suffered in silence.

Since taking office in 2015, we have worked aggressively to raise awareness of and take action to address the heroin and opioid crisis, combat the stigma associated with the disease of addiction, and increase and improve coordination among state and local agencies. Our approach has been multidisciplinary, and includes prevention, treatment, and enforcement strategies. But as this crisis continues to evolve, so must our response to it. Earlier this year, Maryland became the first state in the nation to declare an official State of Emergency in response to this epidemic, which in part allows for improved coordination among government entities at every level. It is only through a multi-pronged approach and intense collaboration by all stakeholders that we can begin to truly solve this problem. I appreciate the opportunity to share some of our strategies and lessons learned with you here today, and hope that we can work together to save the lives of our friends, families, and neighbors.

**I. The Opioid, Heroin, and Fentanyl Crisis in Maryland**

Maryland, like most of the nation, has experienced an increase in the number of deaths related to opioids. In 2016, 2,089 Marylanders died of alcohol- or drug-related intoxication, a 66% increase

over the number of deaths in 2015.<sup>1</sup> 89% of these deaths were opioid-related and substantial increases in the number of heroin and fentanyl-related deaths were largely responsible for the overall rise in opioid-related deaths.<sup>2</sup>

The state has also seen an increase in prescription opioid-related deaths, and so as we address this crisis, we must focus on reducing the inappropriate use of prescription opioids while ensuring patients have access to appropriate pain management. According to several nationwide studies, nearly 80% of heroin users reported using prescription opioids prior to heroin.<sup>3</sup> In Maryland there were 8,847,085 total CDS prescriptions dispensed in 2016; this equates to more prescriptions dispensed than citizens who reside in the state. A little over 66% of the initial prescriptions last year were written for a supply of more than 7 days.<sup>4</sup> The number of prescription opioid-related deaths in Maryland has been rising since 2012, in large part as a result of the use of these drugs in combination with heroin and/or fentanyl.<sup>5</sup>

Further, the challenge we face has evolved. Cheap, powerful, and deadly synthetic opioids have burst onto the market, bringing with them higher overdose rates and even more devastation. Deaths related to fentanyl, a synthetic opioid 50 to 100 times more powerful than morphine, have increased from 29 in 2012 to 1,119 in 2016.<sup>6</sup> Fifty-eight percent of heroin-related deaths in 2016 occurred in combination with fentanyl.<sup>7</sup> In Maryland, we have also begun to see deaths related to the synthetic opioid carfentanil, the clinical use of which is to sedate large animals.

As the crisis evolves, so too must our response. Accordingly, Maryland has adopted a multipronged approach, which includes addressing the epidemic from every possible angle. Education and prevention go hand-in-hand with treatment and enforcement, and all are essential components of the state's efforts to turn the tide against this crisis.

## II. Maryland's Response

### *Maryland's Heroin and Opioid Emergency Task Force and Inter-Agency Heroin and Opioid Coordinating Council*

<sup>1</sup> Maryland Department of Health and Mental Hygiene. 2017. *Drug- and Alcohol-Related Intoxication Deaths in 2016*. Published June 2017. Accessed July 7, 2017. [https://bha.health.maryland.gov/VERDOSE\\_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf](https://bha.health.maryland.gov/VERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf)

<sup>2</sup> *Ibid.*

<sup>3</sup> National Institute on Drug Abuse. Prescription opioid use is a risk factor for heroin use. <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use> Published December 2015. Accessed July 7, 2017.

<sup>4</sup> Maryland Prescription Drug Monitoring Program; information provided by the Vital Statistics Administration.

<sup>5</sup> Maryland Department of Health and Mental Hygiene. 2017. *Drug- and Alcohol-Related Intoxication Deaths in 2016*. Published June 2017. Accessed July 7, 2017.

[https://bha.health.maryland.gov/VERDOSE\\_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf](https://bha.health.maryland.gov/VERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf)

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

In February 2015, Governor Hogan issued Executive Order 01.01.2015.12, formally establishing the Heroin and Opioid Emergency Task Force and appointing me as chair.<sup>8</sup> The task force—made up of 11 members with expertise in substance abuse, treatment, and law enforcement, including a mother who lost her daughter to a heroin overdose—was established to advise and assist the governor in establishing a coordinated statewide and multi-jurisdictional effort to improve public awareness, access to treatment, quality of care, alternatives to incarceration for nonviolent drug abusers, and law enforcement coordination.

In addition to creating the task force, Governor Hogan also issued an executive order establishing the Inter-Agency Heroin and Opioid Coordinating Council.<sup>9</sup> The council is a sub-cabinet of the governor and consists of the heads of agencies and offices across all disciplines within the administration. The council was tasked with sharing data and information with one another and the Office of the Governor to support public health and public safety responses to the heroin and opioid epidemic. The council continues to meet in order to ensure fidelity to the task force recommendations and to share new information and developments.

The task force held regional summits throughout the state to listen to the input of concerned Marylanders who had been affected first-hand by the disease of addiction and the opioid epidemic. We heard from more than 220 individuals on the frontlines of the crisis and dozens more submitted written testimony, suggestions, and comments to the task force through its web portal.

The task force took swift action and issued an interim report including 10 recommendations, which could be implemented by the relevant state agency within a few weeks: (1) earlier and broader incorporation of heroin and opioid prevention into the health curriculum; (2) infusion of heroin and opioid prevention into additional school disciplines; (3) heroin and opioid addiction integrated into school service learning projects; (4) student-based heroin and opioid prevention campaign; (5) video PSA campaigns; (6) Maryland emergency department opioid prescribing guidelines; (7) Maryland State Police training on the Good Samaritan Law; (8) Maryland State Police help cards and health care follow-up unit; (9) faith-based addiction treatment database; and (10) launching an Overdose Awareness Week.<sup>10</sup>

In addition to the recommendations, the report also included 10 funding announcements: seven Department of Health and Mental Hygiene allocations to improve access to treatment and quality of care, and three Governor's Office of Crime, Control, and Prevention grants to support law enforcement efforts.

In December 2015, the task force issued its final report, containing 33 recommendations ranging from prevention and access to treatment to alternatives to incarceration and enhanced law

<sup>8</sup> Larry Hogan. 2015. Executive Order 01.01.2015.12 Heroin and Opioid Emergency Task Force. Available online at <https://governor.maryland.gov/wp-content/uploads/2015/03/EO0101201512.pdf>

<sup>9</sup> Larry Hogan. 2015. Executive Order 01.01.2015.13 Inter-Agency Heroin and Opioid Coordinating Council. Available online at <https://governor.maryland.gov/wp-content/uploads/2015/03/EO0101201513.pdf>

<sup>10</sup> Maryland Heroin and Opioid Emergency Task Force. 2015. *Interim Report*. August 24. Available online at <https://governor.maryland.gov/fgovernor/wp-content/uploads/sites/2/2015/08/Draft-Heroin-Interim-Report-FINAL.pdf>

enforcement.<sup>11</sup> These recommendations fell into seven categories: expanding access to treatment; enhancing quality of care; boosting overdose prevention efforts; escalating law enforcement options; reentry and alternatives to incarceration; promoting education tools for youth, parents, and school officials; and improving state support services. Each recommendation was fully funded in the administration's proposed budget.

These 33 recommendations, based on research, discussion, and expert and community feedback, built the foundation of our statewide strategy:

#### Expanding Access to Treatment

1. Implementing a Statewide Buprenorphine Access Expansion Plan
2. Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years
3. Expanding Access to Treatment through Payments to Non-Contracting Specialists and to Non-Contracting Nonphysician Specialists
4. Improving Provider Panel Lists
5. Expanding Access to Training for Certified Peer Recovery Specialists
6. Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders
7. Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers
8. Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

#### Enhancing Quality of Care

1. Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program
2. Authorizing the Opioid-Associated Disease Prevention and Outreach Program
3. Requiring and Publishing Performance Measures on Addiction Treatment Providers
4. Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy
5. Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids

#### Boosting Overdose Prevention Efforts

1. Expanding Online Overdose Education and Naloxone Distribution
2. Implementing a Good Samaritan Law Public Awareness Campaign

#### Escalating Law Enforcement Options

1. Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute
2. Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose
3. Creating a Multi-Jurisdictional Maryland State Police Heroin Investigation Unit
4. Designating HIDTA the Central Repository for Maryland Drug Intelligence
5. Enhancing Interdiction of Drug-Laden Parcels

<sup>11</sup>Maryland Heroin and Opioid Emergency Task Force. 2015. *Interim Report*. December 1. Available online at <https://governor.maryland.gov/itgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf>

## 6. Strengthening Counter-Smuggling Efforts in Correctional Facilities

### Reentry and Alternatives to Incarceration

1. Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision
2. Expanding the Segregation Addictions Program in Correctional Facilities
3. Implementing a Swift and Certain Sanctions Grid for Probation and Parole
4. Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative
5. Establishing a Recovery Unit at Correctional Facilities
6. Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-Offenders

### Promoting Education Tools for Youth, Parents, and School Officials

1. Creating a User-Friendly Educational Campaign on School Websites
2. Training for School Faculty and Staff on Signs of Student Addiction
3. Promoting Evidence-Based Prevention Strategies that Develop Refusal Skills
4. Support Student-Based Film Festivals on Heroin and Opioid Abuse

### Improving State Support Services

1. Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources
2. Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

The final report also recognized the need for treatment on demand and discussed the barriers to such a program. The key to improving access to high-quality treatment lies in creating a delivery system that provides a full continuum of substance use services and care. There are health care facilities in Maryland that are well suited to provide the necessary clinical care and support services for individuals on an urgent basis and assist in transitioning patients to the appropriately assessed level of care. Offering crisis services will relieve pressure on hospital acute-care systems. The \$2 million of 21st Century Cures Act funding in support of a 24-hour stabilization center in Baltimore City will be an important step toward a system of treatment on demand.

### *Key Legislative Actions*

Legislation based on several of the task force recommendations was then considered by the Maryland General Assembly, and Governor Hogan signed several key bills that encompass prevention, treatment, and enforcement strategies.

#### A. Prescription Drug Monitoring Program (PDMP) modifications

A direct result of the Heroin and Opioid Emergency Task Force recommendations, House Bill 437 (2016) requires mandatory registration with the PDMP to all providers that have a license to prescribe or dispense controlled dangerous substances before obtaining a new or renewal controlled dangerous substance registration. Beginning July 1, 2018, a prescriber must (1) request at least the prior four months of prescription monitoring data for a patient before initiating a course of treatment that includes prescribing or dispensing an opioid or a

benzodiazepine; (2) request prescription monitoring data for the patient at least every 90 days until the course of treatment has ended; and (3) assess prescription monitoring data before deciding whether to prescribe or dispense – or continue prescribing or dispensing – an opioid or a benzodiazepine.

B. Increased penalty for knowing distribution of fentanyl or its analogs  
Senate Bill 539 (2017), sponsored by the Administration, creates a new felony, punishable by up to 10 consecutive years, for individuals who knowingly distribute fentanyl or a fentanyl analog.<sup>12</sup> The legislation recognizes the deadly impact potent and cheap fentanyl has on our communities by providing law enforcement with more tools to hold drug traffickers accountable.

C. The Prescriber Limits Act of 2017  
House Bill 1432 (2017), sponsored by the Administration, requires a health care provider, based on their clinical judgment, to prescribe the lowest effective dose of an opioid and a quantity no greater than the quantity needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance.<sup>13</sup> Certain exceptions are made for patients with chronic illness, receiving pain treatment associated with cancer or palliative care, or receiving medication assisted treatment for a substance use disorder.

D. The Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017  
Senate Bill 967/House Bill 1329 (2017), a bipartisan omnibus bill, contains provisions to improve patient education, increase treatment services, and includes the administration's Overdose Prevention Act, which enables all citizens to access life-saving naloxone without a prescription.<sup>14</sup> The legislation also requires an assessment of drug courts, the creation of a crisis stabilization center, enhancements to the existing state toll-free crisis hotline, the provision of information on all FDA-approved forms of medication assisted treatment, co-prescribing of naloxone with opioids for patients at an elevated risk of overdose, rate increases for behavioral health providers, and standardized hospital discharging protocols for patients treated for an overdose.

E. Heroin and Opioid Education and Community Action Act of 2017 (Start Talking Maryland Act)  
SB 1060/House Bill 1082 increases school and community-based education and awareness efforts to continue to bring attention to the crisis and to equip our state's youth with knowledge about the deadly consequences of opioids.<sup>15</sup> Among other provisions, the legislation requires programming on heroin and opioid related addiction and prevention (including information on fentanyl) beginning in third grade, a county-level school policy on naloxone, the designation of a

<sup>12</sup> Senate Bill 539. 2017. *Criminal Law - Distribution of Controlled Dangerous Substances - Fentanyl*. Available online at [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_569\\_sb0539t.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_569_sb0539t.pdf)

<sup>13</sup> House Bill 1432. 2017. *Health Care Providers - Prescription Opioids - Limits on Prescribing (The Prescriber Limits Act of 2017)*. Available online at [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_570\\_hb1432t.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_570_hb1432t.pdf)

<sup>14</sup> Senate Bill 967/House Bill 1329. 2017. *Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017*. Available online at [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_572\\_sb0967e.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_572_sb0967e.pdf) and [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_571\\_hb1329e.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_571_hb1329e.pdf)

<sup>15</sup> SB 1060/House Bill 1082. 2017. *Heroin and Opioid Education and Community Action Act of 2017 (Start Talking Maryland Act)*. Available at [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_574\\_sb1060e.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_574_sb1060e.pdf) and [http://mgaleg.maryland.gov/2017RS/Chapters\\_noln/CH\\_573\\_hb1082e.pdf](http://mgaleg.maryland.gov/2017RS/Chapters_noln/CH_573_hb1082e.pdf)

school health services coordinator, and community action officials to coordinate school-based community forums and public awareness efforts.

*State of Emergency and Opioid Operational Command Center*

As the death toll continued to rise, we recognized the need to treat the heroin and opioid crisis as we would treat any other life-threatening emergency. A formal, coordinated, multi-jurisdictional capacity did not exist among state and local health and human services, education, and public safety entities to address and respond to the crisis. The solution was to stand up a formal, coordinated approach utilizing the National Incident Management System to develop both state and local strategic, operational, and tactical-level concepts for addressing the heroin and opioid crisis to protect the residents of Maryland.

In January 2017, Governor Hogan by executive order authorized the Inter-Agency Heroin and Opioid Coordinating Council to establish the Opioid Operational Command Center.<sup>16</sup> The Opioid Operational Command Center (OOCC) brings opioid response partners together to identify challenges, establish system-wide priorities, and capitalize on opportunities for collaboration.

The OOCC is a collaborative effort working across all levels of state and local government. The OOCC is made up of partners representing a broad spectrum of state agencies and coordinating bodies, including:

- Department of Health
- Department of Human Resources
- Department of Juvenile Services
- Department of Public Safety and Correctional Services
- Governor's Office of Crime Control and Prevention
- Maryland Emergency Management Agency
- Maryland Higher Education Commission
- Maryland Institute for Emergency Medical Services Systems
- Maryland Insurance Administration
- Maryland State Police
- Maryland State Department of Education
- Office of the Attorney General
- High Intensity Drug Trafficking Area

The goals of the OOCC include, but are not limited to, the following:

- Facilitate operational collaboration and coordination among state agencies and local partners working on heroin and opioid-related response initiatives
- Strengthen information management and sharing to partners and the public
- Coordinate the development of stakeholder reports to document system-wide progress
- Develop cross-cutting, multi-disciplinary Opioid Intervention Teams based on local needs, to include training and subject matter expertise
- Coordinate training and resources available to state and local agencies

<sup>16</sup> Larry Hogan. 2017. Executive Order 01.01.2017.01 Inter-Agency Heroin and Opioid Coordinating Council. Available online at [https://governor.maryland.gov/wp-content/uploads/2017/01/0199\\_001.pdf](https://governor.maryland.gov/wp-content/uploads/2017/01/0199_001.pdf)

On March 1, 2017, based on initial recommendations of the OOCC, Governor Hogan declared a State of Emergency in response to the heroin, opioid, and fentanyl crisis. This declaration activates the governor's emergency management authority and enables increased and more rapid coordination between the state and local jurisdictions. Maryland needed greater flexibility to activate emergency teams in jurisdictions across the state and engage local communities. The governor's executive order delegates emergency powers to state and local emergency management officials, enabling them to fast-track coordination among state and local agencies and community organizations, including private sector and nonprofit entities to ensure involvement of the entire community.

As a result of the State of Emergency, the OOCC supported emergency managers and health officers in each jurisdiction as they formed Opioid Intervention Teams that serve as the multi-agency coordinating bodies for the opioid response at the local level. Opioid Intervention Teams bring law enforcement, EMS, hospitals, schools, and other partners together with public health to address the opioid crisis. The OOCC provides ongoing support and coordination for the local jurisdiction Opioid Intervention Teams including funding, best practices guidance, legislative and policy support, and data sharing.

Similar in declaring a state of emergency in Maryland, in order to better manage what we believe to be a national crisis, we request your consideration in using the Federal Emergency Management Agency (FEMA) as outlined in the National Emergency Framework to centralize and coordinate the federal response to this crisis in support of state and local efforts. The National Response Framework is a guide to how the Nation responds to all types of disasters and emergencies. It is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System to align key roles and responsibilities across the Nation.

Our federal, state, and local public health service continues to perform admirably. However, as with most crisis situations those sectors of government who are in the lead are often the last to know they need broader assistance in managing a crisis. The National Emergency Response Framework that provides guidance in crisis management and supports the great capability of the Federal Emergency Management System led by FEMA.

In addition, Maryland launched *Before It's Too Late*, a statewide effort to bring awareness to the rapid escalation of the heroin, opioid, and fentanyl crisis in Maryland and to mobilize all available resources for effective prevention, treatment, and recovery. Those looking for help with their own addiction or help for a loved one can access information on treatment and recovery on one web portal, [BeforeItsTooLateMD.org](http://BeforeItsTooLateMD.org).

#### **IV. Funding Allocations**

##### *21st Century Cures Act*

Thanks to your leadership, Maryland has received \$10,036,845 under the 21st Century Cures Act. In addition to state funding commitments, these dollars will allow Maryland to further our prevention and treatment strategies.

Funding from the 21st Century Cures Act will expand our efforts to combat this epidemic. Notably, we will expand education efforts in schools to teach our students about the dangers of opioids, and we will build public awareness efforts to reduce stigma, increase patient-physician communication, and mobilize resources for effective prevention, treatment, and recovery.

Resources will also bolster treatment efforts across the state. 21st Century Cures Act funding will expand treatment beds and adopt a tracking system for bed availability, help fund the establishment of a 24-hour stabilization center in Baltimore City, and expand peer recovery specialists. Additionally, funds will be used to expand access to medication assisted treatment.

21st Century Cures Act funding, along with state funds, will also operationalize a proposal to bring naloxone, the lifesaving drug that can reverse an opioid overdose, to all jurisdictions through coordinated efforts and distribution to local health departments.

#### *State Funding*

In addition to fully funding the recommendations of the Heroin and Opioid Emergency Task Force, Governor Hogan's Fiscal Year 2018 budget included \$159 million of non-Medicaid substance use disorder treatment programs and allocated \$4 million in new funding to bolster the state's effort to help those struggling with opioid addiction. The Administration has also directed discretionary federal funding, such as the Byrne Justice Assistance Grants, to programs that support our strategy to confront the crisis.

When Governor Hogan declared a State of Emergency in March, he concurrently announced an additional \$50 million in new funding over a five year period to support the state's efforts. These state funds will supplement federal funds in expanding access to naloxone, building public awareness, and supporting the data and IT needs critical to this fight. The funds will also improve treatment through increasing medication assisted treatment availability; expand the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in hospitals and parole, probation and correctional facilities, and improving the statewide 24/7 crisis hotline.

The state will provide \$4 million in grants up front to local jurisdictions to be used to address local prevention, treatment, and enforcement priorities. Funding was allocated to jurisdictions with a base amount supplemented by funding based on each jurisdiction's opioid-related deaths, and does not include other grants and additional funding distribution.

In addition, state funds will reinforce Maryland's enforcement efforts to disrupt and dismantle drug trafficking organizations. We will continue that state's heroin coordinator program, which places heroin coordinators in local jurisdictions and promotes an integrated law enforcement and investigative strategy among all Maryland jurisdictions through extensive data-sharing. This, in turn, advances statewide investigations and prosecutions of drug traffickers, as well as referrals for treatment for individuals struggling with addiction.

**V. Conclusion**

Our work with the Heroin and Opioid Emergency Task Force engendered a greater understanding of the gravity of the heroin and opioid epidemic and has informed our response since. What we heard from community members during our task force work varied, but the underlying message was the same: Maryland needs an all-hands-on-deck approach to confront this crisis. Working with our federal, local, and community partners across all disciplines, we will continue to address the heroin and opioid crisis from every angle.

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

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

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

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

As Secretary of Public Safety and Homeland Security, I am very proud of Virginia sworn law enforcement officers who work 24/7, 365, to keep us safe. But what they tell me over and over and over again is, we cannot arrest our way out of the heroin and opioid addiction crisis. And we can't simply tell those living with addiction to get over it. Why is that? Because addiction is a disease.

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

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

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

They support coordination among local grassroots organizations, task forces, and other collaborations, including those that exist within Virginia's HIDTA designated areas, which cover parts of Northern Virginia, Appalachia, and Hampton Roads. So there is more work to be done. Let me highlight some of our accomplishments. The General Assembly enacted legislation expanding the deployment of Naloxone. Lay people, law enforcement officers, state agencies like our Department of Forensic Science and others working with potentially dangerous drugs, are being trained in using this overdose reversal agent through the Department of Behavioral Health and Developmental Services Revive program. Our Commissioner of Department of Health issued a standing order for pharmacies to dispense Naloxone. The Department of Criminal Justice Services issued grants to pay for increased Naloxone to be used by law enforcement. In fact, the city of Virginia Beach has used Naloxone now, and they have had over 60 deployments to save lives in that community.

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

Craft limited exceptions to current regulatory and statutory barriers under HIPAA, in 42 CFR, Part 2, which is the substance abuse privacy protections. For example, our prescription drug monitoring program is prohibited from accessing any data from our methadone clinics. That is, we need to know how they work and who they are providing care for, and how it is working; provide technical assistance or fund staff positions for states and localities in developing metric-sharing data in analyzing results; support development of consistent national metrics; incentivize private providers or mandate data collection as a requisite for Federal funding; change how the Federal agencies do business; increase support for SAMHSA and HIDTA; break down Federal funding silos, reduce demand; support, train, incentivize law enforcement to focus on mid and high level dealers; and help us divert those who are addicted into treatment programs. Our treatment programs are currently insufficient to address this epidemic.

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

[The prepared statement of Mr. Moran follows.]

**Cover Sheet / Written Testimony**

**Hearing Title: "Combatting the Opioid Crisis: Battles in the States"**

**July 12, 2017**

**Attribute statement to: Brian Moran, Secretary of Homeland Security and Public Safety  
for the Commonwealth of Virginia**

**Submitted by:**

Brian Moran, Secretary of Homeland Security and Public Safety for the Commonwealth of  
Virginia

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**Executive Summary**

America is in the midst a national crisis. The opioid and heroin addiction epidemic led to the deaths of nearly 310,000 individuals between 1999 and 2015. The number of deaths annually has quadrupled since 1999. More people in America died of opioid overdose in 2014 and 2015 than were killed in Viet Nam. In addition to the personal devastation this epidemic wreaks upon individuals and families across our great nation, this crisis is overwhelming current health care resources and challenging our criminal justice system to respond in a way that provides for individual and public health needs as well as the safety of our citizens and communities.

Virginia ranks 18<sup>th</sup> among the 50 states in opioid deaths; in 2016, 1,133 people died from opioid overdose in Virginia. We must work collaboratively across Federal, state and local governments, across traditionally silo-ed systems and alongside private providers, faith communities and non-profit organizations to stem the tide of this devastating disease.

The causes of the epidemic are complex – from the prevalence of cash and carry pill mills and overprescribing prescription medications which are then illicitly diverted to the sharp rise in illegally manufactured synthetic opioids such as Fentanyl and Carfentanil – lethal in even infinitesimal amounts. 2016 saw a 175% increase in fentanyl related deaths (616 of 1,133 opioid deaths in Virginia). But it is not only the deaths which must concern us: It is the increasing numbers of non-fatal overdoses, the resource and access challenges to providing evidence based treatment and recovery supports. It is also the nexus between addiction and crime – from the property crimes often committed by those trying to support their illicit habit to the lucrative drug trafficking trade aided by the advent of the “dark web.”

In Virginia our Governor convened a statewide Prescription Drug and Heroin Use Task Force, for which I served as co-chair, along with Secretary of Health and Human Resources, Dr. Bill Hazel. The Task Force membership reflected the necessary breadth of input and developed over 50 recommendations from which have been or are being implemented by the follow up Executive Leadership Team. The goal of these collaborations is to effectively align goals, share best practices, work to overcome barriers to success across Virginia’s localities.

The challenges to effectively combat this epidemic are many. We must remove statutory and resource barriers to data collection, sharing and analytics; increase support for ONDCP, HIDTA and the National Guard’s Counterdrug program; breaking down funding and programmatic silos is imperative; and consistent, flexible and long term funding for evidence based drug treatment programs and interdiction efforts must be undertaken in lieu of sporadic grant based funding.

**Statement**

**Brian Moran, Secretary of Public Safety and Homeland Security for the Commonwealth of Virginia**

**Written Testimony Provided to the Subcommittee on Health of the House Energy and Commerce Committee**

**July 12, 2017**

**Virginia Response to the Heroin, Opioid and Addiction Epidemic**

**Overview**

**I. National Perspective**

a. America is in the midst of an opioid and heroin addiction epidemic that is killing our children and loved ones, devastating families, overwhelming health care resources and challenging our criminal justice system. Between 2006 and 2015 the number of annual deaths from opioid overdoses nearly doubled from 17,545 to 33,091. It quadruples from 1999 to 2015. These numbers are unacceptable. Law enforcement officers, first responders and medical professionals are encountering untold numbers of non-fatal overdose victims on the streets of our towns, cities and counties. This epidemic does not respect social, economic, racial, religious or political divides. It is an equal opportunity killer.

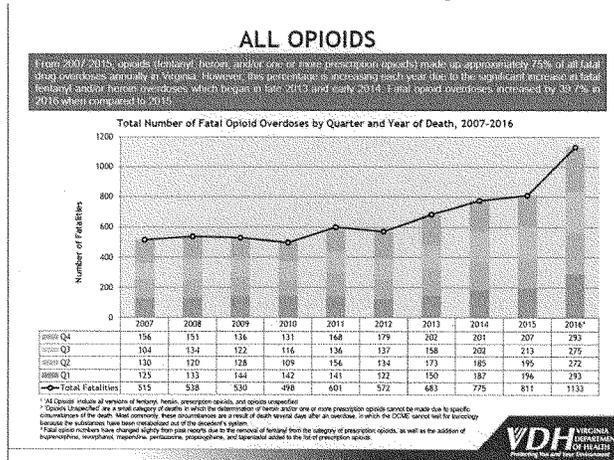
b. Addiction is a devastating disease, and its causes are many. For example, the quantity of opioids prescribed in 2015 would be enough to provide every American with around-the-clock painkillers for three weeks. In the 1960's, nearly 80% of opioid addicts, started out on heroin. By the 2000's those numbers were reversed: according to some sources, nearly 80% of those addicted started out using prescription opioids.

c. However, it isn't just prescribers, the prevalence of prescription drugs or improper storage of legal medications that are to blame. Over the last several years, the rise in illegally manufactured, highly lethal synthetic opioids such as Fentanyl and Carfentanil has contributed significantly to the impact of these drugs, both nationally and in Virginia.

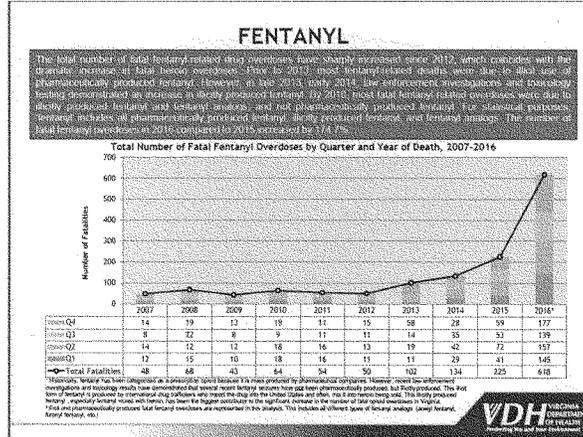
**II. Virginia Perspective**

a. Our own Commonwealth's disheartening statistics bear this out: According to Virginia's Chief Medical Examiner (OCME), since 2014, more people are dying from drug overdose (1028) than from motor vehicle crashes (879) or gunshots (940). In 2016, 1,420 Virginians died from drug overdoses, and

1,133 of those lives (80%) were lost because of opioids.



b. The problem is more acute now than ever. With the rise of illicitly produced fentanyl in Virginia, the total number of fatal fentanyl-related drug overdoses has sharply increased since 2012; which coincides with the dramatic increase in fatal heroin overdoses. Prior to 2013, most fentanyl-related deaths in Virginia were due to illicit use of pharmaceutically produced fentanyl. However, in early 2014, law enforcement investigations and toxicology testing demonstrated an increase in illicitly produced fentanyl. By 2016, most fatal fentanyl-related overdoses were due to illicitly produced fentanyl and fentanyl analogs, and not pharmaceutically produced fentanyl. The number of fatal fentanyl overdoses increased 175% from 2015 to 2016, and now accounts for 618 of 1133 opioid deaths.

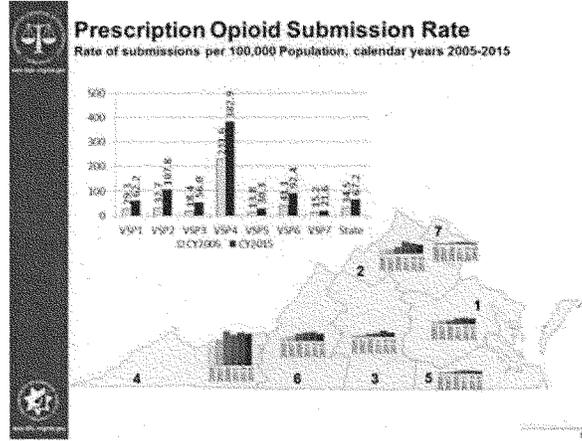


c. III. Regional Differences

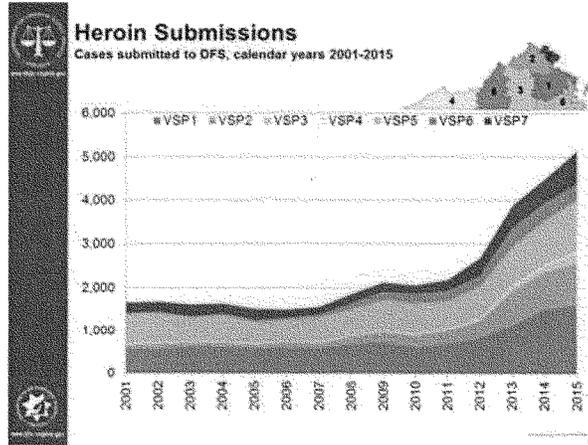
a. Virginia, like the rest of the nation, sees differences based on geography. There is a much higher prevalence of prescription opioids in the Southwest portion of the state (Virginia’s Appalachian and historic coal producing region), and a much greater reliance on heroin in Northern and Eastern areas. We are dedicated to gathering and sharing data across Virginia to analyze relevant drug trends in the Commonwealth. While challenged by limited resources to provide analysis in a more timely way, we are able to coordinate data from a number of sources, including the Virginia Department of Health, the Office of the Chief Medical Examiner, the Department of Forensic Science and the Virginia State Police Fusion Center, among others. We organize and analyze data by Virginia State Police Divisions to determine how the opioid and heroin epidemic is manifested differently across the state, and seek to modify our health and public safety responses to address region-specific problems.

b. While we can create monthly, quarterly and annual reports that aid us in coping with this epidemic, we are severely limited in our capacity to share real time data. Further in this testimony are some suggestions for Federal action which might alleviate some of this backlog.

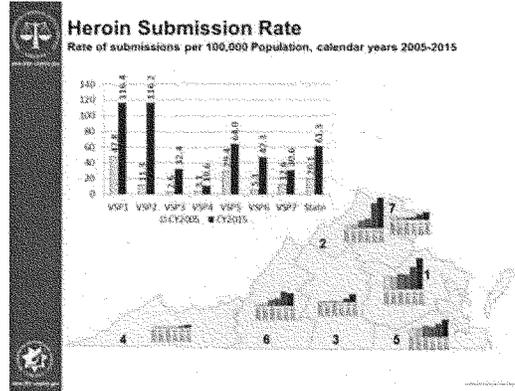




- c.
- f. In Regions II and V, which include Richmond, Northern Virginia, and Hampton Roads, the amount of heroin cases is 2x higher than any other regions.



c.



- h.
- i. A heartbreaking result of this epidemic of addiction is the number of babies who are born addicted. In 2016, 1334 babies were reported to Child Protective Services to have been exposed to substances, a 21% increase from the 1,099 babies in 2015. The prevalence of Neonatal Abstinence Syndrome (NAS) in Virginia has risen steadily over the past 10 years, and in 2015 there were 6.1 NAS discharges for every 1,000 live births. In some localities in Southwest Virginia, up to 58.8 babies for every 1,000 live births are born with NAS.

#### Virginia's Collaborative Approach to Treating the Epidemic

I. We cannot expect law enforcement to arrest our way out of this epidemic; we cannot expect health care providers to treat our way out of it; and we cannot expect people with serious addictions to just "get over it". This is a multifaceted problem that requires a multifaceted solution.

II. Task force

a. Understanding the necessity for cross system collaboration and the importance of a holistic response to this multifaceted crisis, Governor Terry McAuliffe issued an executive order in April, 2014, convening a Task Force on Prescription Drug and Heroin Abuse. The Governor recognized how deeply connected health and public safety are when responding to this issue, so he appointed Secretary Moran of Public Safety and Homeland Security and Secretary Hazel of Health and Human Resources to co-chair the Task Force. This group brought together parents, people in various stages of recovery from drug addiction, legislators, health professionals, educators, corrections and law enforcement to craft policy recommendations addressing the growing opioid and heroin overdose epidemic. The Task Force established five working groups comprised of subject matter experts who developed recommendations in the

following areas: Education, Treatment, Data and Monitoring, Storage and Disposal, and Enforcement.

b. The Task Force issued over 50 policy recommendations in an interim report in April of 2015, and updated that report in October of 2015 (see attached).

c. In December, 2016, the Governor issued Executive Directive No. 9, establishing an Executive Leadership Team (ELT), again led by the Secretaries of Public Safety and Homeland Security and of Health and Human Resources, to oversee continuing implementation of the Task Force recommendations and coordination of ongoing efforts to address the heroin and opioid addiction crisis in the Commonwealth.

i. The Executive Leadership Team is comprised of top management from each of the relevant state agencies with responsibilities for or interaction with individuals affected by the issue. Staffing is provided by the two secretaries' Deputy and Policy Advisor, as well as representatives of key agencies: Virginia State Police, Departments of Criminal Justice Services, Corrections, Health Professions, Health, Behavioral Health and Developmental Services, and Social Services.

ii. The ELT meets twice a year with stakeholders, holds quarterly executive leadership meetings, and the staff group meets monthly.

iii. The staff group oversees coordination of data and resources across state agencies and provides regional leadership to coordinate with regional 'grassroots' coalitions across the Commonwealth. The goal is to make sure that from the grassroots to the tree tops, Virginia's efforts to combat the epidemic are aligned, that communication is open, data and information is easily shared, needs and gaps ascertained and potential resources identified and leveraged to the greatest extent possible.

iv. Through these efforts, we are able to share information on the successes and challenges we are experiencing across the Commonwealth. Our ELT and grassroots coalitions exchange best practices across localities and develop innovative approaches to addressing the heroin and opioid addiction epidemic.

### III. Law Enforcement

a. With the invaluable assistance of the Virginia State Police, Virginia's Public Safety and Homeland Security Secretariat continues to emphasize the importance of viewing addiction as a disease rather than a criminal activity, and promote a culture change in law enforcement and across the criminal justice system. With an understanding that we cannot arrest or prosecute our way

out of this problem, Virginia is emphasizing rehabilitation instead of incarceration for those individuals struggling with opioid addiction. Law enforcement can help addicted individuals access treatment, through “angel programs” and other criminal justice diversion approaches. However, we must also have the resources to limit the supply of illegal opioids into our state, target those pill mills and dealers whose actions are creating the addiction cycle, and interdict the influx of precursors and internet predators from countries such as China.

i. An example of our local law enforcement’s leadership on this issue has been the Chesterfield County Sheriff’s Department. Sheriff Karl Leonard and his staff started the Heroin Addiction Recovery Program (HARP) for incarcerated men in March, 2016, and a corresponding program for incarcerated women in September, 2016. HARP treats addiction as a disease rather than a crime and offers peer-to-peer counseling, group recovery sessions and family participation in the recovery process. Inmates in the HARP program hear interviews from potential participants and have the ability to remove participants who are not fully committed to the program. Additionally, individuals can continue to use HARP as a support network after they are released, and can return to the HARP unit at any time if they are tempted to relapse. This program has a success rate of over 90% for 250 participants since its inception.

ii. In 2014, the city of Winchester and Frederick and Clarke Counties formed the Northern Shenandoah Valley Substance Abuse Coalition. The Coalition brought together over 100 stakeholders, including law enforcement, health personnel, social workers and non-profit organizations, to launch a community model for responding to the opioid epidemic. The three localities initiated education programs, drug take-back and drop-box programs and encouraged participation in the Prescription Monitoring Program to reduce opioid overdoses. These localities show how constant collaboration can lead to community-based solutions.

iii. One way to address the influx of illegal opioids to Virginia is through increased availability and flexibility of funds through Virginia’s two High Intensity Drug Trafficking Area designations and from Department of Justice grant programs funded through the Byrne Justice Assistance Grants and others.

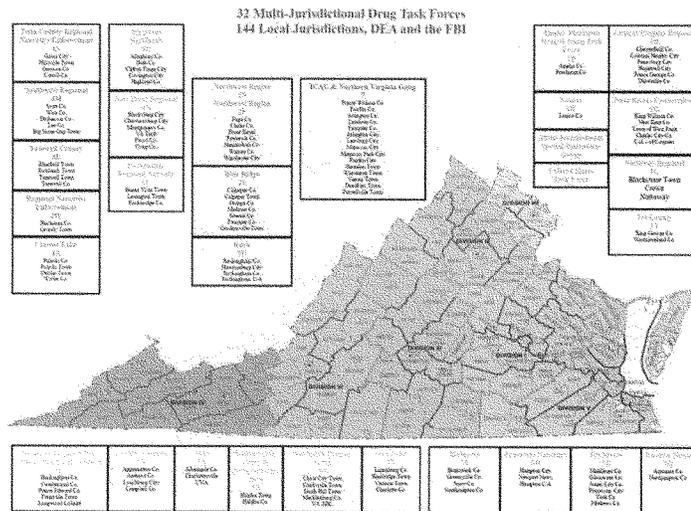
b. High Intensity Drug Trafficking Area (HIDTA)

i. HIDTA provides support for interstate and interagency collaboration, intelligence and information sharing, and specialized training for law enforcement and treatment agencies in areas

characterized by high amounts of drug trafficking. The extra support and resources HIDTA offers increases local law enforcement's capacity to limit the supply of illegal opiates within the region.

ii. Virginia participates in two HIDTA regions, the Washington-Baltimore region and Appalachia region, which includes counties in SW Virginia, Kentucky, West Virginia, and Tennessee. The mission of Appalachia HIDTA is to use a multi-disciplinary approach to deal with ongoing threats to public health and safety, particularly regarding prescription drug diversion and the emerging threat of heroin. The Appalachia region is arguably the epicenter of this crisis, and will require unprecedented multi-disciplined cooperation to effectively address the many health and public safety problems that result from this threat.

iii. Virginia has 22 counties participating in HIDTA efforts (Washington-Baltimore and Appalachia). Our state police are involved in 32 multi-jurisdictional drug task forces, encompassing 144 local jurisdictions, the DEA, and FBI. We appreciate our federal partners at HIDTA for providing resources to Frederick, Pulaski, and Wythe counties; this expansion increases Virginians' ability to share data and collaborate across localities.



c. Interstate collaboration

i. As HIDTA demonstrates, the epidemic of opioid addiction does not recognize borders, so interstate collaboration is a necessary piece in addressing this crisis. In October 2016, Governor McAuliffe, Governor Hogan of Maryland, and Mayor Muriel Bowser of D.C. signed the National Capital Region Compact to Combat Opioid Addiction. On May 9<sup>th</sup>, 2017, Maryland, the District of Columbia, and Virginia came together at the Regional Opioid and Substance Abuse Summit for a day-long conference focused on curtailing this ongoing public health and safety crisis. We hope to continue exchanging best practices and engaging in initiatives with surrounding states, knowing that another state's progress is progress for all of us.

ii. We have also had the opportunity to collaborate with other states through NGA's learning labs on opioids. Virginia has participated in two NGA learning labs regarding the opioid epidemic. From October, 2016 to February, 2017, Virginia was part of a learning lab that addressed the unique problem of fentanyl. In June, 2017, Virginia began another learning lab on expanding opioid treatment options for offenders.

#### **Successful Implementation: Task Force Recommendations**

I. Based on the recommendations of the Task Force, the Governor's office advocated for and passed 14 pieces of bipartisan legislation addressing the opioid epidemic. These bills were passed in the legislative sessions of 2015 through 2017. Some bills adapted existing regulations in response to the opioid crisis and others created new initiatives (see Appendix A for a complete list of bills).

II. Three significant pieces of legislation include:

a. Reducing dispensing reporting time to the Prescription Monitoring Program from 7 days to 24 hours when physicians and healthcare providers prescribe opiates (SB287, 2016).

b. Making Naloxone and Naloxone training available to first responders throughout Virginia (HB1458, 2015).

c. Allowing for the registration of peer recovery specialists to assist addicts in recovering from addiction (SB1020, 2017).

III. The Prescription Monitoring Program (PMP)

a. The Prescription Monitoring Program has been an essential tool in tracking opiate distribution and holding prescribers accountable. Currently, over 64,000 prescribers and 14,500 physicians in Virginia are registered to use the PMP, and the program is interoperable with 21 states. As of January 1, 2016, all newly licensed physicians are automatically registered to participate in this

program. The PMP allows us to see in real time exactly where and how often doctors are prescribing opiates as pain management.

b. At the task force's recommendation, Governor McAuliffe made the PMP a more robust and responsive program. Dispensers formerly were required to submit opioid prescriptions to the PMP within 7 days, but now must do so within 24 hours. Virginia also put procedures in place for reporting egregious prescribing to agency enforcement and for prescribers to request patient information when prescribing a course of opiates longer than 14 days (previously 90 days). These adaptations have already increased awareness of and control over opiate prescriptions.

c. In 2016, Virginia passed a law mandating Continuing Medical Education for medical care providers regarding proper prescription, addiction and treatment. By 2020, all prescriptions containing opiates will be registered electronically. Both of these measures will ensure that our agencies can monitor opioid prescriptions and be poised to respond to future outbreaks.

#### IV. Addiction and Recovery Treatment Services (ARTS) Program

a. The Department of Medical Assistance Services administers Medicaid in Virginia. In 2016, Virginia passed the Addiction and Recovery Treatment Services (ARTS) program. The ARTS program went live in April, 2017, and offers evidence-based addiction treatment to Medicaid users in Virginia. The continuum of treatment includes every level of treatment from inpatient detox to intensive outpatient treatment to office based opioid treatment. Though the ARTS benefit is limited without comprehensive Medicaid expansion, it does expand the menu of options available to those seeking treatment. The ARTS benefit created new treatment types and expanded services in every existing treatment category to provide a more comprehensive response to opioid and heroin addiction. For example, before the ARTS benefit only four providers offered Residential Treatment programs; after the ARTS benefit, 65 did. No providers offered Office-Based (remote) Opioid Treatment before the ARTS benefit; after, 24 did.

#### V. Medically Assisted Treatment (MAT)

a. Additionally, we have expanded Medically Assisted Treatment for those struggling with addiction. MAT is a combined medication and counseling treatment that is successful for 40 to 60% of its users. With MAT, healthcare providers have flexible options to treat the addicted population that uses Medicaid. Providers now can bill all Medicaid plans for substance abuse care and can bill for Certified Peer Recovery specialists under MAT.

b. While MAT is an important component of treating addiction, medication must be combined with peer support services and other wraparound services in order to be effective. Under the MAT model, assessing individuals'

psychosocial needs, linking them to family or peer support networks and referring them to community-based services are as important as providing monitored medication for addicts.

VI. Peer Support Services

a. A critical component of treatment is the Peer Support Services program, effective July 1, 2017. Individuals can be trained and registered as Peer Recovery Specialists to offer support and assistance to those in the recovery process. Peer Recovery Specialists allow individuals to undergo treatment within their communities rather than in a hospital or other intensive care option.

VII. Through the Public Health Emergency declaration in 2014, the Commissioner of the Virginia Department of Health was able to create a standing order that allowed any person to go to a pharmacy and obtain a prescription for Naloxone (commercial name Narcan).

a. In 2015, Virginia expanded Naloxone use and training to first responders in Virginia. EMS and law enforcement personnel are being trained to use Naloxone to respond to overdoses at the scene.

i. In June, 2017, non-profit EMS agencies began applying for Rescue Squad Assistance Fund grants to obtain Naloxone free of charge.

ii. Local law enforcement agencies have been administering Naloxone with great success. In 2016, Fauquier county sheriff's deputies and Warrenton police officers administered Naloxone 22 times. In Virginia Beach, officers began carrying Naloxone in the spring of 2016 and were saving lives at the pace of one per week.

iii. We hope to continue to expand EMS, physician and law enforcement use of Naloxone so that the medication is accessible statewide.

VIII. The passing of HB2317 in the 2017 General Assembly Session initiated Virginia's Comprehensive Harm Reduction with Syringe Services program. In response to this legislation, the Virginia Department of Health drafted standards and protocols which will be used by authorized Comprehensive Harm Reduction (CHR) programs including but not be limited to the Syringe Services Program (SSP). Localities must demonstrate both a need for the CHR and SSP programs, as well as a readiness for implementation, to ensure all stakeholders are invested in the programs' success. Additionally, localities must demonstrate an ability to sustain the program in the long term and a plan for engaging the communities they serve.

**Opportunities for Federal Partnership**

I. Data sharing – Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2

a. HIPAA regulations particularly protect privacy in substance abuse cases pursuant to federal law (42 U.S.C. § 290dd-2) and regulations (42 CFR Part 2). These restrictions limit law enforcement, health professionals and community stakeholders' data sharing ability.

b. Because of the epidemic proportions of the current heroin and opioid addiction crisis, it may be time to reexamine states abilities to access and share information – whether the data is 'de-identified' or individually identifiable – lives can be saved through creation of issue specific strategies for sharing information pertaining to opioid use.

c. Improved data sharing between state and local agencies will better aim the efforts in treatment and prevention that could be measured in several areas, such as the analysis of narcotic related arrests, property crimes and overdoses and types of drugs involved. Treatment and prevention partners can thus better target community needs and adjust law enforcement strategies accordingly.

d. While these regulations protect the privacy of individuals' medical information, they also cause an inability to have real-time data on the number of overdoses, concentration of prescriptions, how drugs are being distributed at the local level, and other key data. Specific relaxation of certain aspects of HIPAA and associated regulations would lead to easier data sharing and better informed efforts in combatting this epidemic.

e. One initiative that could be immediately implemented as a reasonable response to the opioid epidemic is nationwide mandatory reporting of heroin and opioid overdoses. Mandatory reporting would allow hospitals, labs and law enforcement to pinpoint the source of the problem. Additionally, having accurate statistical information on drug overdoses is crucial for federal and state grant applications.

II. II. Medicaid expansion

a. Virginia's Medicaid program spent \$26 million on opioid use and misuse in 2013, with \$10 million of this spending occurring in Southwest Virginia. More broadly, at least 40,000 adults in Virginia's Medicaid program have a substance abuse disorder, and over 50% of Medicaid members with serious mental illness also have a substance use disorder. The Joint Legislative Audit and Review Commission estimates that untreated substance abuse costs Virginia state and local governments \$613 million per year in public safety and health care services alone.

b. In order to address this epidemic, treatment must be available through Medicaid for Virginia's underserved population. Any reduction to

Medicaid funding or services would severely harm our ability to combat this ongoing public health crisis. Expanding opportunities for treatment is one of the most fundamental ways to address this epidemic.

III. The Importance of Drug Courts

a. The success of drug courts is indisputable, but Virginia state legislators have been reluctant to support widespread use of this option.

b. The most rigorous and conservative scientific “meta-analyses” have all concluded that Drug Courts significantly reduce crime as much as 45% more than other sentencing options. Nationwide, 75% of Drug Court graduates remain arrest-free at least two years after leaving the program. For every \$1.00 invested in Drug Court, federal taxpayers save as much as \$3.36 in avoided criminal justice costs alone. Drug Courts produce cost savings ranging from \$3,000 to \$13,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

c. It is essential that public servants in Congress adopt a supportive attitude towards the drug court system and communicate the importance of implementing this system to local legislators.

IV. Supporting local coalitions through grant funding and data expansion

a. In the mid – late 90’s the Department of Justice offered several grants to state/local agencies to slow the distribution and manufacturing of Methamphetamine in this country. These dollars ultimately resulted in the decrease of sales and manufacturing of Methamphetamine. Today, heroin and opioids require a similar response. Using federal Byrne Justice Assistance Grant funds, the Department of Criminal Justice Services (DCJS) in Virginia are providing grants to local law enforcement agencies to purchase naloxone. In Virginia, DCJS developed a program to train law enforcement officers in the delivery of Naloxone as a treatment to overdose cases. Enhanced federal support for the expansion of this program would equip first responders to save lives of more Virginians.

b. Increased federal support for the HIDTA Program would be critical at the state, federal, and local level to allow coordination at all levels designed to stop the flow of drug production and trafficking.

## Appendix A: Opioid Legislation in Virginia, 2015-2017

Opioid Task Force Recommendations: Passed Legislation		
Year	Bill Number	Description
2017	SB1230	Mandates e-prescribing for prescriptions containing opiates beginning July, 2020
	SB848	Allows authorized persons to train emergency services and law enforcement personnel to administer Naloxone in the case of an opioid overdose
	SB1020	Authorizes the registration of peer recovery specialists by the Board of Counseling
	SB1086	Directs department of social services to collect information on in utero exposures to controlled substances
	HB2317	Authorizes pilot programs for the provision of sterile and the disposal of used hypodermic syringes and needles
	HB1885	Extends requirement for PMP prescribers to request patient information when prescribing opiates for longer than 14 consecutive days to 2022 (see SB513)
2016	HB829	Mandates Continuing Medical Education for opiate providers regarding proper prescribing, addiction and treatment
	SB827	Reduces opiate dispenser reporting time from 7 days to 24 hours
	HB657	Authorizes the Director of the Department of Health Professions to send reports on unusual prescribing/dispensing behavior to agency enforcement
	SB513	Requires PMP prescribers to request patient information when prescribing opiates for longer than 14 consecutive days
	HB583	Provides certification for substance abuse peer support
2015	HB1458	Allows trained first responders to administer Naloxone; allows pharmacists to dispense Naloxone under proper protocols
	HB1841	Requires every licensed opiate dispenser to register with the Prescription Monitoring Program
	HB1738	Requires hospices to notify pharmacies of the death of a patient

Source: Virginia's Legislative Information System

**Appendix B: Relevant Links**

Drug Cases Submitted to the Virginia Department of Forensic Science, CY 2015

<http://www.dfs.virginia.gov/wp-content/uploads/2016/09/CY15DfsDataReportSlides.pdf>

\*\*Note: updated report for 2016 to be released soon

Executive Directive 9, Establishing the Governor's Executive Leadership Team on Opioids, 2016:

<http://governor.virginia.gov/media/8166/ed-09-establishing-the-governor-s-executive-leadership-team-on-opioid-abuse-and-addiction.pdf>

Executive Order 29, Establishing the Governor's Task Force on Prescription Drugs and Heroin Abuse, September, 2014:

<https://governor.virginia.gov/media/3342/eo-29-establishing-the-governors-task-force-on-prescription-drug-and-heroin-abuseada.pdf>

OCME Fatal Drug Overdose Report, April, 2017:

<http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Fatal-Drug-Overdose-Quarterly-Report-1.pdf>

Overview of ARTS benefit

[http://www.dmas.virginia.gov/content\\_attachments/bh/Medicaid%20Addiction%20Recovery%20and%20Treatment%20Services%20Update%20-%20April%205%202017....pdf](http://www.dmas.virginia.gov/content_attachments/bh/Medicaid%20Addiction%20Recovery%20and%20Treatment%20Services%20Update%20-%20April%205%202017....pdf)

Prescription Drug Spending Report

[http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD5632016/\\$file/RD563.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD5632016/$file/RD563.pdf)

Task Force Recommendation Report: Implementation Plan (June 2015)

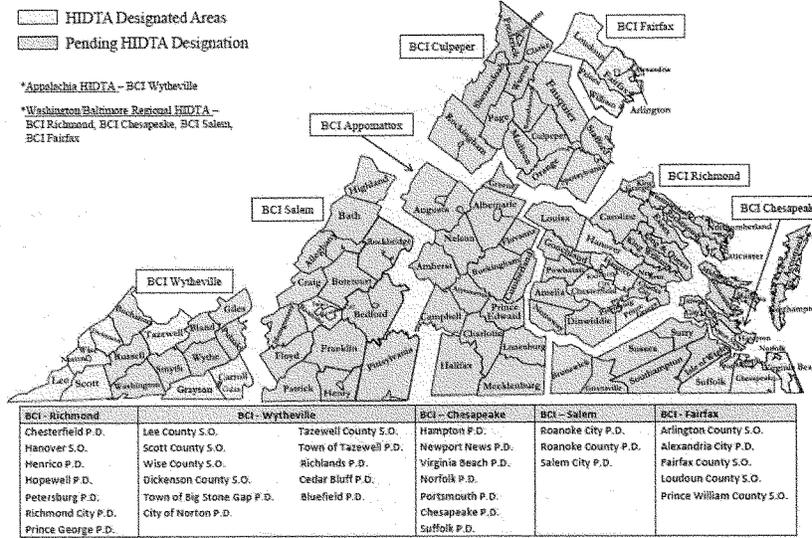
<https://www.dhp.virginia.gov/taskforce/minutes/20150630/TaskForceImplementationPlan.pdf>

Task Force Recommendation Report: Implementation Plan Update (October 2015)

<https://www.dhp.virginia.gov/taskforce/minutes/20150630/TaskForceImplementationPlan.pdf>

Appendix C: HIDTA Map

# HIDTA Task Force Areas



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

**TESTIMONY OF HON. JOHN TILLEY**

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

So that, again, illustrates to you our commitment and our shared understanding of this problem. I want to thank Congressman Guthrie for that far-too-kind introduction as well. *Dreamland*, again, is relevant to us because, as you know, the problem really has its origins in Kentucky and Ohio. We lost 1404 Kentuckians, as the Congressman said. Fentanyl is now the driving force behind these overdoses. We had 13,000 ER visits, 13,000 ER visits in a state of 4 1A½ million people. We lose, in this country, as you've heard those numbers, nearly a commercial airplane a day. If this were a communicable disease, we would be wearing hazmat suits to combat it.

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

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

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

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

We have doubled down on things like rocket dockets and alternate sentencing worker programs, and help for those who are addicted through various forms of treatment. Again, looking at things like neonatal abstinence syndrome. We have 1900 cases in Kentucky. We've increased funding many times to combat that and to help for the suffering of those addicted there. We have put it in our jails and our prisons. Again, I think I mentioned rocket dockets with prosecutors, again, to try to make these cases, put them on a separate plane, to deal with them in the most appropriate way possible.

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

In fact, in Kentucky, I will tell you both, validated and anecdotally, we are seeing tremendous results from using MAT and counseling together, but counseling in the form of cognitive behavioral therapy, like moral reconnection therapy. We are seeing that used in both our jails and prisons, and that is yielding some tremendous results. We intend to emulate what's been going on in Rhode Island with the AnchorED program. We visited there with Director Boss some time ago through an NGA project. And I can promise you, we are doing peer recovery and bridge clinic soon. We'll do some innovative awareness. We'll use a hotline to get folks linked up to treatment. We're even educating our medical and dental schools. And overall, as I close out and conclude at the end of my time, I will tell you that I think we have the most comprehensive effort I've seen in my 25 years in criminal justice with something called KORE, the Kentucky Opioid and Response Effort.

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

[The prepared statement of Mr. Tilley follows:]

John Tilley  
Secretary, Kentucky Justice and Public Safety Cabinet

July 12, 2017

Committee on Energy and Commerce  
Subcommittee on Oversight and Investigations

“Combating the Opioid Crisis: Battles in the States”

### **Kentucky’s Crisis**

2016 proved to be a deadly year for the citizens of the Commonwealth of Kentucky who saw 1,404 of their family members, friends, and neighbors die from drug overdoses. Since 2012, drug overdoses have accounted for more accidental Kentucky deaths than motor vehicle crashes. The leading culprit, Fentanyl, a potent synthetic opioid, was detected in 47% of overdose deaths, up from 34% in 2015. According to the Kentucky State Police, there was a 6,000% increase in laboratory samples submitted to the Central Forensic Laboratory testing positive for fentanyl from 2010 to 2016. Last year, in addition to fentanyl, the Kentucky State Police reported samples from 10 different counties testing positive for carfentanil, a fentanyl derivative which is 100 times more potent than fentanyl itself. Fentanyl continues to engulf Kentucky as the Kentucky State Police report that the number of submissions testing positive for fentanyl in the first two quarters of 2017 has already exceeded the 2016 total. The 2017 samples also included cyclopentylfentanyl, acetylfentanyl, butyrylfentanyl, acrylfentanyl, furanylfentanyl, and carfentanil. According to Appalachia HIDTA’s 2018 Threat Assessment, Kentucky remains particularly vulnerable to drug trafficking organizations because of its central geographical location and many interstate highways.

In addition to increased rates of substance use disorders and overdose deaths, the opioid epidemic has also brought the threat of blood borne pathogens such as viral hepatitis and human immunodeficiency virus (HIV). According to the Centers for Disease Control and Prevention, 54 of the top 220 counties most vulnerable to a rapid outbreak of HIV are located in Kentucky. In response to the devastating HIV outbreak just over the Ohio River in Austin, Indiana in 2014, the 2015 Kentucky General Assembly became the first Southern state to authorize the creation of syringe exchange programs designed to reduce the incidence of needle sharing and prevent the spread viral hepatitis and HIV. Over 30 Kentucky counties have authorized syringe exchange programs since the General Assembly granted county officials the power to do so. Aside from HIV, forms of viral hepatitis such as hepatitis C also pose a large threat to the residents of Kentucky. From 2008 to 2015, Kentucky had the highest rate of acute hepatitis C infections.

**Department of Corrections Response**

The Kentucky Department of Corrections remains the single largest treatment provider in the Commonwealth. In 2004, the Kentucky Department of Corrections had 475 substance abuse treatment slots available. Today, the Kentucky Department of Corrections has 5,901 treatment slots which represents a 1,100% increase in substance abuse treatment slots available to Kentucky inmates since 2004. The Kentucky Department of Correction's substance abuse treatment programs utilize evidence-based cognitive behavioral therapy and therapeutic community models. According to a recent study by University of Kentucky professors, the Kentucky Department of Corrections' Substance Abuse Treatment program resulted in a \$4.29 return on investment in terms of cost avoidance for every \$1.00 spent on the program itself in FY 2015. During the 12 months following release, 70% of participants were not re-incarcerated, 85% maintained housing, and 68% were employed at least part-time. The study participants also reported decreased illicit drug use, decreased feelings of serious depression and anxiety, and decreased instances of suicidal ideation.

In 2015, the Kentucky Department of Corrections began a pilot project aimed at reducing fatal overdoses among inmates released on parole. The Kentucky Department of Corrections uses a validated risk and needs assessment to target those inmates most vulnerable to overdoses and offer them the chance to voluntarily receive injections of naltrexone, a long-acting opioid receptor antagonist, before they leave prison. Within 24 hours of being paroled, participating inmates meet with social service clinicians at their local Probation and Parole offices who assist the inmates in determining healthcare coverage eligibility and setting up an appointment for the inmate's next naltrexone injection. The initial results from the pilot project have been so promising that representatives from five other states, tribal authorities from Montana, and the U.S. Virgin Islands have observed the program.

**21<sup>st</sup> Century Cures Act Programming**

The Kentucky Office of Drug Control Policy worked closely with representatives from the Kentucky Cabinet for Health and Family Services to develop a comprehensive strategy to utilize funds from the 21<sup>st</sup> Century Cures Act to bolster evidence-based treatment interventions aimed at reducing the impact and prevalence of opioid use disorder among non-fatal drug overdose survivors, pregnant and parenting women, and state and county inmates.

Initiatives aimed at survivors of non-fatal overdoses include the creation of specialized medication-assisted treatment bridge clinic programs and the placement of peer recovery specialists in emergency departments. The specialized bridge clinics would initiate a medication-assisted treatment protocol with overdose victims while they are still in hospital in order to stabilize them long enough to obtain treatment in the community. The peer recovery specialist initiative, which was modeled after Rhode Island's Anchor ED program, would incentivize Kentucky hospitals to contract with certified peer recovery specialists who could counsel recent drug

overdose survivors while they are still in the emergency department and help them enroll in a treatment program if the survivor chooses treatment in that instance. Some additional funds will be used to distribute naloxone at community awareness events, emergency departments, and syringe exchange programs

The initiative aimed at pregnant and parenting women would create an integrated continuum of care model, which breaks down silos between obstetrics care, primary care, medication-assisted treatment provider care, and case management. Once the model is perfected, a training program will be developed and offered to healthcare and treatment providers.

Finally, part of the 21<sup>st</sup> Century Cures Act funding will be used to create a targeted employment pilot program for state and county inmates reentering into society with a history of opioid use disorder. The program will hire employment specialists to assist former inmates in finding and maintaining employment in Northern and Eastern Kentucky, which are two regions that have been most affected by the opioid epidemic.

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

**TESTIMONY OF HON. REBECCA BOSS**

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

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

Our goal is to make these efforts open to the public with complete transparency on outcomes and available for replication throughout the country. First and foremost, I would like to thank Congress for the action taken last year passing the 21st Century Cures Act with \$1 billion to help support prevention, treatment, and recovery. In a time of tight budgets, we fully appreciate the significance of this action.

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

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

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

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

and recovery support through the Centers of Excellence. This program is supported through private insurance and Medicaid.

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

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

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

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

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

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

[The prepared statement of Ms. Boss follows:]



**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS**

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Written Testimony of  
Rebecca L. Boss, M.A., Director  
Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals  
Before the  
House Subcommittee on Oversight and Investigations  
The Energy and Commerce Committee  
2123 Rayburn House Office Building  
Wednesday, July 12, 2017 at 10:00 a.m.

Chairman Murphy, Vice Chairman Griffith, Ranking Member DeGette and Distinguished Subcommittee Members, my name is Rebecca Boss. I am the Director of the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) and oversee Rhode Island's substance use disorder division.

It is a privilege to serve my home state of Rhode Island under the leadership of Governor Gina Raimondo and Secretary of Health and Human Services Eric Beane.

With more than 25 year's experience in both state government and the provider community in substance use disorders, and as a long-standing member of the National Association of State Alcohol and Drug Abuse Directors, also known as NASADAD, I feel that I am uniquely positioned to testify on this crucial matter.

Thank you for the invitation to appear before you to allow me to describe how our state is addressing the critical issue of the opioid overdose epidemic. First and foremost, I wish to thank Congress for the federal funding that is essential to state agencies like BHDDH that comes to us through the Substance Abuse and Mental Health Services Administration (SAMHSA), CDC and HRSA.

Furthermore, we are very appreciative of the action Congress took last year through CURES with \$1 billion to help support prevention, treatment and recovery throughout the country. We are grateful for the funds, which enabled us to carry out our much-needed work with Congressional support.

Addiction and overdose are claiming lives, destroying families, and undermining the quality of life across Rhode Island. For over a decade, opioid dependence and accidental drug overdose have been growing problems across the United States, and Rhode Island has been one of the hardest hit. In 2013, Rhode Island had the highest rates of illicit drug use in the nation, as well as the highest rate of drug overdose in New England, and in 2015 had the fifth highest rate of overdose deaths in the nation.

As the numbers indicate, this problem is not going away. Soon after her election in 2015, RI Governor Gina Raimondo recognized the state did not have a comprehensive statewide strategy to evaluate, prevent, and successfully intervene to reverse the overdose trends. She knew that it was not enough to treat a single overdose; recovery support services needed to expand to embrace the full scope and depth of treatment. Clearly a new strategy had to be implemented.

In August 2015, Governor Raimondo signed an Executive Order establishing the Governor's Overdose Prevention and Intervention Task Force naming the Directors of BHDDH and the Department of Health (DOH) as Co-Chairs. The Task Force included stakeholders and experts in fields ranging from public health and law enforcement to healthcare, community-based support services, insurance, academia, business, government and more. Also included were family members of those who lost loved ones, and have added an invaluable perspective that we in government and the private sector sometimes miss.

The Task Force created a Strategic Plan for Addiction and Overdose and recommended numerous strategies within four areas: prevention, rescue, treatment and recovery. The data-driven plan was created and soon after, with the help of Brown University a website was created ([www.preventoverdoseri.org](http://www.preventoverdoseri.org)) where all efforts are tracked in a public and transparent fashion.

The distinguishing factor of the multi-disciplinary Task Force was that the members brought the Plan back to the sectors they represented. For instance, the Medicaid Director worked with her team to cut red tape that was identified and work with the insurers. The community providers, with their boots on the ground, were nimble enough to put plans in action after our meetings.

Each of the four areas has moved forward with numerous initiatives:

## Prevention

**Safer Prescribing:** To achieve safer opioid prescribing, it is important to weigh the benefits of medication access for patients living with acute and chronic pain with those of the risks of diversion, addiction, overdose, and premature death. Unsafe combinations of prescribed medications are linked to addiction and many overdoses are preventable. *To support these efforts, the Rhode Island Legislature passed the following bills: (2016-H8224A, S2823Aaa): Sets out limits for most initial opioid prescriptions. Requires pharmacies to upload dispensing data within 24 hours. (S2822A): Allows patients to synchronize certain drug refills for chronic conditions by requesting a limited supply (less than 30 days), with pro-rata cost sharing applied by the insurer*

The key strategy to reduce dangerous prescribing is to use the Prescription Drug Monitoring Program (PDMP) and system-level efforts to reduce co-prescription of benzodiazepines with opioids (for pain or opioid use disorder). Before DOH launched its Prescription Drug Monitoring Program Enrollment Enforcement Plan in 2016, more than 30 percent of Rhode Island prescribers had failed to enroll in the PDMP, and fewer than 40 percent were using it. As of July 2016, legislation had passed that all such practitioners shall be automatically registered with the Prescription Drug Monitoring Program maintained by the Department of Health. As of today, 100 percent of practitioners are enrolled. *To support these efforts, the Rhode Island Legislature passed the following bills: (2016-H7847, S2897): Allows the Prescription Drug Monitoring Program to be electronically connected to electronic medical records systems. (H7849, S2874): Adds Schedule V prescriptions to the Prescription Drug Monitoring Program. (H8326, S2946A): Requires DOH to look for federal funding opportunities to improve the PDMP, such as by adding additional analytical functions and incorporating data from similar programs in other states.*

Additionally, DOH Director, Dr. Alexander-Scott co-led a successful national petition drive calling on the FDA to require “black box” labels on opioids and benzodiazepines warning that concurrent use of these medications increases the risk of fatal overdose.

**Reducing the Supply of Prescribed Opiates (Rx):** Rhode Island has developed regulations that limit most opioid dosing for acute pain management to a contained period of time (with exceptions for specifically-determined patients) and supports existing hospital policy to restrict opioid prescriptions from emergency rooms to three days or less.

The promotion of non-opioid therapies for chronic pain, such as chiropractic services, massage therapy, physical therapy, and acupuncture as important alternatives to opioid pain relief is another successful effort in Rhode Island. Access to comprehensive health care coverage, including Medicaid, is a crucial component of these non-opioid alternatives.

**Reducing Demand (Illicit):** We cannot arrest our way out of this crisis, but we must build on partnerships with community organizations and law enforcement to reduce demand for heroin and other illicit drugs. Deaths associated with illicit drug use and fentanyl have increased exponentially in recent years. To address the illicit drug crisis, the Rhode Island Department of Health is working with the Rhode Island State Fusion Center and participating in the New England High Intensity Drug Trafficking Area (NEHIDTA) multi-state Heroin Response Strategy. This program, funded through the Office of National Drug Control Policy, currently maintains a 20-state partnership to address heroin and opioid abuse and trafficking. In fact, Rhode Island has designated a Heroin Response Strategy Drug Intelligence Officer and Public Health Analyst who are positioned at the Rhode Island State Fusion Center.

There is no current data on all fentanyl drug seizures from RI law enforcement since many investigations are ongoing. However, the NFLIS data has shown steady fentanyl seizures in powder form with sporadic counterfeit pill seizures (most recently pills containing furanyl fentanyl). Heroin seizures have declined.

The supply chain enters RI via sources in NY and MA as well as from China via US mail and common carrier services (UPS) etc. Cartels are not prominent in RI but their use of secondary drug trafficking organizations to ship the product is the most common source of transport. We remain concerned about the strong potential for the production of counterfeit A-215, M-30 and V-48/12 pills in our area.

**Hospital Testing for Fentanyl:** Some hospital systems are testing for fentanyl, but we do not yet know the frequency of testing or how many tests are returning positive for fentanyl. DOH is hoping to develop a data feed to include fentanyl test results.

With regards to fentanyl testing in the Emergency Departments, there is some preliminary data from one of the largest hospital systems. Between March 1st and May 31st, just under 3,600

toxicology screens were conducted, of which 11.6% were positive for fentanyl. About 40% of discharges coded as overdose (and which a toxicology screen was conducted) were positive for fentanyl.

In February, Rhode Island started testing all inductees in the Opiate Treatment Program (OTP) system (13 locations throughout RI) and have met regularly with the OTP MD's to analyze findings. Initial results indicate that a large percentage of individuals being admitted to treatment are testing positive for either heroin or fentanyl, or fentanyl alone.

**MODE Team:** Rhode Island has implemented a Multidisciplinary Review of Drug Overdose Death Evaluation (MODE) Team which combines strategies of "rapid response" with "community intervention." The Team is modeled after the multidisciplinary review processes for child deaths. The purpose of the MODE Team is to gain insight into emerging overdose trends, identify gaps in or opportunities for policy development and prevention programming and inform the distribution of mini-grants to Rhode Island communities for prevention efforts. The MODE Team is comprised of individuals from varying agencies and organizations, including the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH); Rhode Island Department of Health (RIDOH); Boston Medical Center's Injury Prevention Center; Rhode Island Department of Corrections (RIDOC); and Brown University. Data sources come from RIDOH (Medical Examiner reports, Prescription Drug Monitoring Program (PDMP)), BHDDH (substance abuse and mental health treatment episodes), and RIDOC (incarceration history and medical records from incarceration). The MODE Team has met three times quarterly to review this data on 11 cases. Twenty-five MODE Team recommendations have been developed, with nine community-based drug overdose prevention mini-grants distributed.

**Surveillance, Response, and Interventions (SRI):** This workgroup made up of staff from DOH and BHDDH review overdose information on a weekly basis. When overdoses exceed a certain threshold, alerts are issued to the community, law enforcement, and health providers.

### **Rescue**

**Naloxone as Standard of Care:** Naloxone saves lives by reversing the severe respiratory depression caused by opioids. Its use by laypeople trained to identify and respond to overdose has been linked

to reductions in overdose death rates. People who use opioids are at greatest risk of overdose, and are motivated to protect themselves and others around them to save a life with naloxone. Law enforcement being equipped with naloxone is critical in the fight against opioid overdoses. In fact, in Rhode Island two police departments (East Providence and North Providence) have offered to purchase naloxone for those departments who may not have the funds to purchase it themselves. Further, Rhode Island has promulgated regulations requiring all inpatient substance use disorder providers to offer naloxone to at-risk clients, Emergency Departments are dispensing naloxone to individuals who have overdosed, peers distribute on the street, and inmates with substance use disorders are given naloxone upon release. Fortunately, Medicaid funds pay for Naloxone and allows BHDDH to use other federal funds for additional prevention and intervention activities.

Rhode Island's DOH Director, Dr. Alexander-Scott sent a letter to Rhode Island prescribers encouraging the co-prescription of naloxone and a letter to Rhode Island pharmacists encouraging them to stock naloxone. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7710A, S2460Aaa): Requires all insurers to cover naloxone and related devices, including in cases where the medication is intended for patients other than the insured.*

**Naloxone in the Community:** Rhode Island State Police invested \$40,000 in Google settlement funds in February 2016 to distribute more than 1,000 naloxone kits to law enforcement agencies. BHDDH has secured \$40,000 from the Substance Abuse Prevention and Treatment block grant to purchase 1,000 units of naloxone in 2016. Kits were distributed at the Department of Corrections and through targeted street outreach by peer recovery coaches. This effort will be sustainable for three additional years.

**Good Samaritan Law:** "The Good Samaritan Overdose Prevention Act of 2016" was strongly advocated by the Task Force, after the previous Good Samaritan law had expired. The new law also expanded immunity to people at risk of violating probation or parole and protects from liability those who use life-saving medical treatments such as naloxone that can prevent an overdose. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7003)(S-2002) No liability to any person who administers an opioid antagonist to another person to prevent a drug overdose and provides immunity for violations of probation and/or parole for those persons who in good faith, seek medical assistance for a person experiencing a drug overdose.*

## Treatment

**Medication Assisted Treatment:** Evidence indicates that medication-assisted treatment (methadone, buprenorphine or depotnaltrexone\* injection) has profound effects on people with an opioid use disorder. It reduces their risk of death, relapse, chance of going to prison, and greatly improves their quality of life.

Rhode Island supports a model of shared decision making between the individual and their provider. We support the use of FDA-approved medications for the treatment of opioid use disorder including methadone, buprenorphine products, and injectable naltrexone, always in the context of recovery support services. These supports vary based on patient need, but include drug and alcohol counseling, screening and treatment of co-occurring mental and physical health issues, checking of the state prescription drug monitoring database, toxicology screening, individual and group therapies, peer support services, vocational and educational assistance. These supports must include the development of a treatment agreement with every person receiving care. Governor Raimondo, RIDOH, and BHDDH, along with expert advisors to the Task Force began working with primary care practice leaders across the state to overcome barriers to expanding buprenorphine prescribing among primary care providers.

Rhode Island has developed the Centers of Excellence for the Treatment of Opioid Use Disorder which are being established throughout the state. This model provides a means of rapid access to treatment for opioid use disorder, provides all of the above-mentioned services and works collaboratively with community providers of ongoing treatment for the opioid use disorder once stabilized in the Center of Excellence. This model also provides additional support to community providers—be they physicians or other allied providers, or community treatment programs that may not be equipped to assist a person who experiences relapse to opioid use by re-admitting the person to the Center for any additional stabilization needed. These Centers also serve to assist with the workforce development needs of our state in that these centers provide practical educational experiences in opioid use disorder treatment to community providers and trainees alike. Centers of Excellence are funded through private third party insurers as well as Medicaid. With Medicaid expansion, many more people are able to access Medication Assisted Treatment for opioid addiction.

Rhode Island offers medication-assisted treatment through the Department of Corrections. The

Governor proposed \$2.5 million in the FY17 budget for medication-assisted treatment in the state prisons and the General Assembly approved \$2 million in the final budget. The Governor requested repeat-funding in her FY18 budget. Individuals who are awaiting trial are no longer withdrawn from MAT, and those who are opioid dependent and not in treatment are able to be inducted on medication as appropriate. Incarcerated individuals with histories of opioid use disorder are at a significantly increased risk of overdose upon release, so these individuals are also being offered induction on MAT. The Department of Corrections has worked closely with the Rhode Island Medicaid Office to ensure that these individuals are connected to coverage so that there is not treatment disruption upon release.

**Centers of Excellence:** As described above, the Centers of Excellence for the Treatment of Opioid Use Disorders was created and provides comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as support to providers in the community. It is envisioned that such Centers would refer stabilized patients to other providers and receive back patients if they destabilize and require more intensive services.

Rhode Island's first Center of Excellence opened in November 2016 at CODAC Behavioral Healthcare. CODAC has six sites with a COE at each site; a seventh will open soon in the state hospital known as the Eleanor Slater Hospital System. Additionally, two community providers are opening new COEs this month.

**Waiver Training:** Rhode Island has sought to address the issues of access to care and workforce development by building a program of physician and practitioner Drug Abuse Treatment Act of 2000 (DATA 2000) trainings which are necessary to obtain the waiver to prescribe buprenorphine to individuals with opioid use disorder from office-based practice. These trainings also offer education on the epidemiology of opioid use disorder in the United States, appropriate assessment and treatment of opioid use disorder, an overview of all FDA-approved medication assisted treatment and evidence-based psychosocial interventions, confidentiality issues related to 42 CFR Part 2, and an overview of special populations that may be affected by opioid use disorder. As such, the course is an excellent overview of current approaches to management of substance use disorders. We have trained over 300 practitioners since January of 2016 and we have established a system where institutions can request trainings as needed. This dovetails well with our practical experience available in Centers of Excellence and which we hope will encourage prescribers to engage in office-based treatment of opioid use disorder.

Rhode Island is leading the way with the training of medical students, the first of its kind in the country. The 2018 Class of the Warren Alpert Medical School of Brown University, which will graduate next May, will be the first class to participate in a new program to complete the training necessary to qualify for a Drug Abuse Treatment Act of 2000 (DATA 2000) waiver prior to graduation. The waiver is necessary to prescribe FDA-approved medications for the treatment of opioid use disorders. Once the new graduates receive their full medical license and DEA registration, they can apply for the DATA 2000 waiver.

**Emergency Department Standards:** Leadership from hospitals and emergency departments throughout Rhode Island joined Governor Raimondo's Overdose Prevention and Intervention Task Force. They will release a first-in-the-nation set of statewide guidelines to save lives by ensuring consistent, comprehensive care for opioid-use disorder in emergency and hospital settings. Released in March 2017, it established a common foundation for treating opioid-use disorder and overdose in Rhode Island hospitals and emergency departments, the standards establish a three-level system of categorization that defines each hospital and emergency department's current capacity to treat opioid-use disorder. All emergency departments and hospitals in Rhode Island will be required to meet the criteria for Level 3 facilities. As a facility's capacity to treat opioid-use disorder develops, that facility can apply for a higher designation.

### **Recovery:**

**Expand Recovery Supports:** The growing need and capacity for peer recovery services mirrors the pace of the epidemic. Successful recovery nurtures the individual's health, home, community and purpose. New opportunities are envisioned that support peer recovery services and medication-assisted recovery. Medicaid coverage for treatment of substance use disorders and parity has allowed Rhode Island to maximize block grant fund and state general revenues to fund these important supports as well as prevention activities.

**Recovery Coaches:** It is important to cultivate a recovery coach pipeline, with a plan to double the number of recovery coaches for statewide and extended coverage, supporting in-prison recovery

coaching and certification, and ensuring proper support and supervision of recovery coaches at this scale. Every effort is being made to expand and create consistency in reimbursement for delivery of certified peer recovery coach services. Since RI developed a certification process in 2014, 98 peer recovery coaches have been certified in RI, nearly double in 2016 than in 2015. A related aspect of this strategy is to standardize help-seeking and recovery supports through standardization of employee assistance programs (EAP) for the workforce and by mandating that all drug treatment programs develop recovery planning (including training programs and referrals, establish certification for recovery housing, and support case management to help people access resources) or coordinate such supports with an outside entity.

DOH has a contract with Anchor Recovery through 2019 to provide peer recovery coaches to inmates upon release from the Department of Corrections and through targeted street outreach to state hotspots.

**Recovery Coaches in Emergency Departments (AnchorED):** In May of 2014, Rhode Island started a pilot program using recovery coaches to respond to overdose survivors while they were receiving treatment in hospital Emergency Departments. On-call coaches respond to overdose survivors and offer support, referrals, resources, family support and training on naloxone. This success of this pilot project supported its expansion to be offered statewide twenty-four hours per day, seven days per week. These coaches have had great success at engaging clients with an 85% follow up rate with treatment and/or recovery support services. This service has provided the state with a wealth of information on the experience of individuals with the healthcare system as well as the addiction treatment system. While engaging with recovery coaches at a crucial point in their addiction, many individuals make the decision that they are ready for treatment – seeing the hope of recovery through shared experience and recognizing their desperate state makes people ready for change.

The number of contacts that the Peers have made in the ED has been steadily increasing from around 85 contacts in the first month to 165 contacts in the most recent month. The majority of patients seen in this program (67%) are not currently receiving treatment for substance use disorders (SUD), but more than 85% of them agree to get a referral to SUD treatment.

**Anchor MORE:** The success of AnchorED spurred the development of AnchorMORE, recognizing that successful consumer engagement does not have to wait for an individual to show up at and ED with an overdose. The Anchor MORE is a community outreach program, placing recovery coaches

on the streets to connect with and engage individuals. Anchor MORE currently dispatches these teams of recovery coaches to areas in which individuals are using substances in public places. Anchor MORE teams are also proactively dispatched to certain areas in the state by looking at overdose data and emergency services pick-up data. Both programs connect individuals with recovery coaches - trained peers with lived experience of addiction. Recovery coaches stay actively engaged with individuals after an encounter and connect them to treatment and recovery support services, including integrated health home teams, homeless assistance programs, employment assistance programs, primary care, and case management services, once the individual is comfortable.

**Recovery Houses:** Safe, drug-free living environments are crucial to support recovery. Rhode Island has identified a funding source to begin the certification process for a network of recovery houses across the state. Legislation passed that requires recovery houses to meet a set of standards to receive state certification. The National Alliance for Recovery Residences (NARR) will be tasked with certifying recovery houses and will receive verified training to become a certifying entity. Recovery housing will include on-site staff and resources in addition to housing. Rhode Island Communities for Addiction Recovery Efforts (RICARES) will be tasked with stakeholder oversight. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H8056A, S2579B): Authorizes BHDDH to develop a process to certify recovery housing facilities for residential substance abuse treatment.*

**Discharge and Recovery Plan:** Through the work done by the Task Force, state health agencies developed a model discharge and recovery plan to promote recovery services for patients with substance use disorder. Known as the Perry and Goldner Bill, the legislation is designed to improve emergency room treatment for those with substance use disorders and ensures patients receive a discharge and recovery plan. *To support these efforts, the Rhode Island Legislature passed the following bill: (2016-H7616A, S2356Aaa: The Alexander Perry & Brandon Goldner Act): Requires comprehensive discharge planning for patients with substance use disorders and requires insurers to cover expanded medication-assisted treatment.*

**Rhode Island's Future Plans:** Today, Governor Gina Raimondo is issuing an Executive Order declaring that the alarming rate of deaths caused by opioid overdose constitutes a public health crisis. The Executive Order outlines new initiatives in the four areas recommended in the Task Force's Strategic Plan: Prevention, Rescue, Treatment and Recovery. Included in the Order are

educational components, the promotion of existing systems, and the expansion of partnerships. The Governor also incorporated a coordinated public outreach campaign into the Order to engage parents and youth to prevent opioid abuse through the establishment of a Parental Task Force. This Task Force will collaborate with schools to expand access to prevention programming for high-risk youth and the expansion of family support groups throughout the state. The Executive Order asserts that all state agencies, with coordination and support from the Task Force, shall take all necessary actions to reduce opioid overdose deaths. The Departments of Health and Behavioral Healthcare, Developmental Disabilities, and Hospitals will ensure implementation of the Executive Order initiatives and report back to the Governor on a semi-annual basis. *Executive Order 17-07 issued on July 12, 2017.*

**Recommendations:** I humbly submit a few recommendations –

- Any federal initiatives include the involvement of the state agencies. Between the expertise and authority our staffs have within the substance use disorder system, our agencies can help to chart the right course.
- The importance of the Substance Abuse Prevention and Treatment Block Grant cannot be understated. It is a critical component in our efforts to engage our communities in primary prevention. We hope the strong support you have shown continues. As Medicaid has laid the foundation for treatment coverage, the block grant has been critical in providing coverage for recovery support services and prevention efforts.
- Targeted funds to address the many issues I have discussed today would be helpful. Congress has shown generous support to substance use disorder agencies and we certainly hope there is consideration for continued support.
- Treatment for substance use disorders leads to recovery. Access to the treatment has been advanced by Medicaid expansion. Continuing to support funding for Medicaid expansion to single adults with low incomes is essential to helping more people recover from substance use disorders.
- Many individuals living with substance use disorders do not have access to transportation. Permitting mobile methadone or buprenorphine provisions would eliminate that barrier and make treatment more accessible.
- Workforce development in the field of substance use disorders is crucial with a standardized certification program to license workers across all states. If this were coupled with a loan forgiveness program, the workforce could grow to the numbers needed.

- With elder opioid addiction on the rise, parity for Medicare clients would be welcomed by all.
- Repealing the Institution for Mental Disease (IMD) exclusion would allow for meaningful behavioral health care to those who present with a substance use disorder, truly allowing every door to be the right door.

**Conclusion:** I appreciate the opportunity to present testimony before the Subcommittee. Over the last 5 years we have lost more than 1,200 people to drug overdoses, coming from every community in the state. Our work is focused on saving lives. I encourage the Subcommittee and Congress to work with the NGA, NASADAD and ASTHO as well as other partners to leverage the collective knowledge and expertise of State alcohol and drug agency directors and public health departments across the country to help end this epidemic.

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

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

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

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

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

Mr. MURPHY. At least in the—

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

Mr. MURPHY. At least in the medical record to be able to do a 42 CFR—

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

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

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

Mr. RUTHERFORD. I can only speak anecdotally. There are some counties in our state that have a substantial shortage of those

types of professionals, including drug counselors. That is the challenge that we have.

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

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

Mr. MURPHY. Secretary Tilley.

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

Mr. MURPHY. Thank you. Director Boss?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. BOSS. That is correct.

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

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

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

Ms. BOSS. I have.

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

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

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

Ms. BOSS. Correct.

Ms. DEGETTE. Now, Secretary Tilley, a recent AP analysis showed that the Medicaid expansion accounted for more than 60 percent of the total Medicaid spending on substance abuse treat-

ment in Kentucky. Between 2012 and 2014, there's been a more than 700 percent increase in substance abuse treatment provided to Kentucky residents due to Medicaid's expansion.

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

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

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

Mr. TILLEY. I would agree—

Ms. DEGETTE. Thank you.

Mr. TILLEY. I would agree. Yes. I would agree that through a number of sources of funding, we have increased treatment dating back to 2014 by 1100 percent dating to today.

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

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

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

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

Ms. DEGETTE. Why is that?

Mr. MORAN. More people would have access to treatment. Now, I will give credit to our Department of Health, they are using a very innovative ARTS program, addiction, recovery and treatment services, to carve out a Medicaid waiver to try to address these individuals' addiction needs. But with Medicaid expansion, 400,000 Virginians would be covered, and Governor McAuliffe has attempted to do that at every opportunity.

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

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

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

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

So my question really is surrounding Naloxone, or Narcan, as we know it. And could you help the committee understand some of the key issues on availability—because we do hear there may be some shortages, cost. Who is picking up the tab for this? Is it patients? Is it the state? Is it the Federal Government—to maybe give us a

little bit of an overview on how we are at least attempting to deal with that piece.

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

Mr. MORAN. Thank you very much for the question, Congressman. We are attempting to expand the coverage of Naloxone in every community. With the law enforcement community, there is some resistance, particularly from our rural jurisdictions because—merely because they are not the first to respond typically in a large jurisdiction. Usually it is the emergency medical services. EMS does carry it. The majority of our jurisdictions in law enforcement communities, and certainly in urban areas, now carry it. And as I mentioned, Virginia Beach has a tremendous success rate. They are saving up towards of a life a week with the use of Naloxone.

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

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

Now, obviously then once you revive that individual, there are consequences after that in terms of needs for treatment. But the Narcan itself is truly a lifesaver, and more people that carry it—within our Department of Forensic Science, for instance, one issue with respect to the carfentanil and fentanyl, because it is so dangerous and lethal, we are provided authority now for all of our lab technicians to carry it, that they may be subject to a lethal dose when they're analyzing evidence in the criminal case. And so, again, as many people can have it, it is a very significant piece in this entire puzzle.

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

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

Mr. COLLINS. So that's statewide.

Mr. MORAN. That is correct.

Mr. COLLINS. And that's what the FDA is actually looking to expand nationwide. And what's your experience with that? Are you tracking how many people—are these, perhaps, family members who know that someone that's got this addiction and they're being anticipatory, to use that word, just in case?

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

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

Thank you for sharing that. And I yield back.

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

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

Before I get to my questions, I would be remiss if I didn't echo my colleagues' remarks on the devastating impact that TrumpCare, in its iterations, would have in the fight against the opioid epidemic. This mean, and might I say very mean, bill will rip hope away from people in communities across my district who depend on coverage from the Affordable Care Act and Medicaid expansion to help them recover from the scourge of opioid addiction. Medicaid by far is the single largest payer for behavioral health services in our country. In Rhode Island, Medicaid pays for nearly 50 percent addiction treatment medication. In Kentucky, it's 44 percent; Maryland, 39 percent; Virginia, 13 percent.

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

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

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

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

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

Ms. BOSS. Absolutely. There is interest, and there is active work with the Department of Health and within my department to provide those trainings to any and all interested parties. And we've seen increased number of data-waivered physicians. We will be

working with the nurse practitioners in PA schools to increase those as well.

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

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

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

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

Mr. TONKO. Our pleasure.

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

Start with the lieutenant governor, please.

Mr. RUTHERFORD. Well, we talked about, in certain cases, in certain parts of the state, there are limitations in terms of the number of practitioners in some of our more rural areas of the state. Also, some of the anecdotal feedback, in some cases, there is a stigma associated with treating individuals of substance use disorder, and there are some doctors that just don't want those patients. But the lifting of the cap has helped us with regard to being able to provide the services for more individuals, but stigma is still a challenge.

Mr. TONKO. Thank you, Lieutenant Governor. Secretary Moran.

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

Mr. TONKO. Thank you. And Secretary Tilley.

Mr. TILLEY. Yes. I would reiterate my colleagues, we have a number of physicians, I think nearly 700, who are prescribing. However, many of them have not applied to prescribe over that 100 up to the 285 cap. And in many of them, we don't know, as has been stated earlier, whether they are requiring counseling. We do know we require counseling in our correction settings and jails and prisons. We encourage it. We do urinalysis. But we don't know—that's one of the things we have to get our arms around. We are doing that now.

We have to look beyond why some of these physicians are not applying to do more in their communities. Again, we struggle with

the same challenges with rural versus urban in getting those folks out to those areas largely. In Appalachian, this problem hit first there, and it's more acute there in many ways. So that's a challenge for us.

Mr. TONKO. Thank you.

Director Boss, we were going across the board. Can we just have a quick response, Director?

Mr. MURPHY. Real quick.

Ms. BOSS. All right. Thank you.

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

Mr. TONKO. Thank you.

Thank you, Mr. Chair. I yield back.

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

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

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

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

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

In a criminal investigation, our Department of Forensic Science will do the investigation. We have good data with respect to what drugs were involved, because they are collected. If it is an accidental death, it eventually goes to the OCME, Office of Chief Medical Examiner. But with respect to the data, it is challenging. And some individuals may not be anxious to reveal the cause of death under some circumstances. Family members may not choose to reveal that type of source. So it is a challenge. It's one we're trying to get our arms around, because if we have better data, we know how to respond better and what to do and what, if anything, is working with respect to addressing this epidemic.

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

Mr. MORAN. Well, you've seen a dramatic rise in the use of fentanyl over the last year. That helps inform not only our healthcare providers but our law enforcement.

Where is the fentanyl coming from? And if it is located in a particular community, there can be a rapid response with respect to education and response and to interdict the fentanyl, because it's

typically being manufactured overseas and coming into in the commonwealth and the country.

So that type of information I think is critical to the interdiction of these drugs in addition to the healthcare in response to the individual. So I think it's imperative that we collect more data and have more access to data because we can better respond to the crisis.

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

Ms. BOSS. That is a wonderful question. And thank you for asking it, because—

Mr. WALBERG. As specifically as you can.

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

The others are surveillance response intervention team. We receive weekly reports on 48-hour overdose reporting. All of our hospitals are required to report overdoses or suspected overdoses within 48 hours, and our medical examiner is able to determine whether or not fentanyl is a factor in those overdoses. As a result, we put out alerts to communities when overdoses, whether fatal or not, exceed a specific target in that particular area. And we're able to notify law enforcement, first responders, treatment providers, and other individuals in the community that there is an increased overdose—fatal or nonfatal, in their communities.

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

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

Mr. WALBERG. Thank you.

I yield back.

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

Ms. CASTOR. Well, thank you, Mr. Chairman. I'd like to thank all of the witnesses here for your attention to this very serious issue.

And I think at the outset it's important that America just cannot go backwards on this.

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

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

It states, in part, Medicaid is a successful, efficient, and cost-effective Federal-state partnership. It has a record of innovation and improvement of outcomes for the Nation's most vulnerable citizens including comprehensive and effective treatment for individuals struggling with opioid dependency.

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

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

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

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

Ms. CASTOR. OK.

Mr. MURPHY. Thank you.

Ms. CASTOR. Because this is very important. Now, this committee, to its credit, spearheaded the 21st century cures initiative that did provide substantial funds to our states. And I've heard from local experts back home in Florida, held a number of roundtables with law enforcement, treatment professionals, anesthesiologists, ER docs—the panoply. And they say the key is long-term coverage to treat this as the chronic disease that it is. And that's why, when you rip away coverage and instead say, in its place, we're going to have another fund, an opioid fund, where maybe you provide a few dollars to an ER, that's not going to provide that long-term coverage that we need to treat this chronic disease. So I just had to get that off my chest here right off the bat.

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

Ms. BOSS. So I believe that Rhode Island's efforts to address this crisis would not be able to be sustained if we were not able to continue to offer insurance through Medicaid expansion to the number of Rhode Islanders that depend on it. And I thank you for your pointing out the fact that providing substance use disorder treat-

ment alone is not enough. If we dedicate dollars toward that, that's wonderful. However, oftentimes there are comorbid conditions that are interrelated with an individual's addiction, that if we don't have access to affordable health care for the rest of the body, then we're not going to be able to treat the person well enough to sustain any kind of recovery.

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

Ms. BOSS. Yes, we are.

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

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

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

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

Ms. BOSS. It is not a requirement.

Ms. CASTOR. OK. Thank you very much.

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

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

Mr. MURPHY. OK. No degree.

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

Ms. BOSS. We do not.

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

There was a study done out of Michigan, and I believe also one done at Yale, that when there is a licensed addiction's counselor in the ER providing treatment, not referral, providing treatment, they increase the chance that person is going to follow up by 50 percent.

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

Ms. DEGETTE. Before you do, are—is Ms. Castor’s unanimous consent request?

Mr. MURPHY. Yes. We’re fine with that. Yes. Thank you. Sorry about that.

[The information appears at the conclusion of the hearing.]

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

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

Mrs. WALTERS. Thank you, Mr. Chairman.

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

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

There has been discussion today of the importance of drug courts. And these courts can help overcome the stigma and treat the underlying addiction as opposed to focusing on the resulting criminal behavior I recently became aware of a specialized drug treatment court in Buffalo, New York, that is focused solely on opioid interventions.

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

Mr. RUTHERFORD. We have extensive drug courts in most of our jurisdictions across the state. They essentially are specific to opioid addiction. And there’s been good results from most of those courts.

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

Mr. MORAN. We’re big proponents of drug courts. Unfortunately, Virginia is deficient in drug courts. We have about 37 yet we have over 200 courts. They are used for a variety of different specialities. There’s mental health courts; there’s veterans dockets. The drug courts, however, provide some coercion. I mean, the individual needs to want to address their addiction, and then the court can provide that coercive element. And we have a tremendous success rate. I mean, we should expand.

The one issue I would ask Congress to help us with, however, is the medically-assisted treatment. Some of our judges in the drug courts are reluctant, and as of now, it is required. And so we would

request, on behalf of those judges, some flexibility with respect to mandating MAT.

Mr. TILLEY. And again, I would concur. We have mental health courts, veterans courts, and drug courts I think that do expand. We did lose our juvenile drug courts due to a funding issue. We're trying to rebuild that program now. Some of the same issues exist. Oftentimes that offender chooses a shorter prison sentence and that 2-year, again, very strenuous program. But we're addressing that as well.

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

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

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

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

Mrs. WALTERS. Thank you.

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

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

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

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

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

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

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

But it's not just about coverage. OK. I've seen some parts in my district but if you don't have providers, if you don't have psychiatrists, if you don't have psychologists, if you don't have healthcare centers or counseling centers or programs in those communities that are underserved or in rural areas, then coverage does you no good.

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

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

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

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

Mr. TILLEY. I think it's an excellent question. With a focus on correction, sadly I can report that, in Kentucky, as it exists now, more children are living with an incarcerated parent than any other state in the country. In fact, have had or have an incarcerated parent. And, again, our prison population largely being driven

by the epidemic, I think that would be the first thing that comes to mind.

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

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

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

Mr. RUIZ. So Secretary Tilley, let me just warn you that, by turning Medicaid into per-capita grant, the funding for new addicted folks are—I should say the need for funding is going to increase. States are going to have to make decisions: One, change their eligibility criteria; two, their reimbursement rates; and three, the benefits that they would cover. And oftentimes, unfortunately, the mental health and these community center treatments are the first on the chopping block. So it's going to get worse if this bill is going to pass.

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

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

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

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

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

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

Mr. MURPHY. I appreciate that, because there's some things we need to be working on out there. But I want to make sure Secretary Tilley has a chance to respond to what you're saying about mental health substance abuse, money being first on the chopping block. Is that Kentucky's intent? Do you know anything about that?

Mr. RUIZ. That was not the intent, I don't agree—

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

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

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

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

Mr. RUIZ. I agree with that.

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

Mr. MURPHY. No. And that's why I want to amplify what he's saying, that when everybody looks at mental health funding gets cut or doesn't get increased, if actually increases costs overall for healthcare. So——

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

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

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

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

Mr. RUTHERFORD. Well, no. What I was saying is that if you go to the prescription drug monitoring program, or the database, you will not see that a person has been prescribed methadone, that they're in methadone treatment. So——

Mr. CARTER. Why is that?

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

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

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

Mr. CARTER. OK. When I was in the state senate in Georgia, I sponsored legislation that created our prescription monitoring program. And I can tell you, it has been improved since I left. In fact, July 1st of this year, 2 weeks ago, we started 24-hour reporting. Before that, we were reporting every week. Now, we're not in realtime yet, but we're getting there. We're making very good progress there.

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

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

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

Mr. CARTER. Yes. Missouri struggled. They were the last one to add it on, the PDMP.

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

Mr. CARTER. OK. Secretary Moran, what about Virginia? What are you all doing?

Mr. MORAN. Thank you. And I think this is an area where Congress could investigate. We have 21 states. And our neighbor to the South, North Carolina, we do not share information. We would request some help to better share data across state lines.

Mr. CARTER. Right.

Mr. MORAN. Most of our neighbors are not North Carolina. So we would look for some more relief there.

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

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

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

Mr. CARTER. Right.

Mr. TILLEY. And again, I, applaud the work in Rhode Island. We actually had sort of a model that didn't really meet the goals that we wanted. It was not up to par from previous legislation. We looked at what Rhode Island was doing. We had tried the same thing they did. We just didn't do it as well. I think we're on the path to doing it now. And I think we're fairly ambitious with trying to do both at once.

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

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

We can throw money at this all day long. But we need to be smart. If we're smart and we do practical, rational things, like limiting—I got so many prescriptions from a dentist for a 30-day supply of OxyContin. They take one or two, and then the rest of them are in the medicine cabinet. That is not being smart. If we can have a partial refill, if states can do that as a result of 21st Century, or as a result of CARA, that's something we need to look at implementing as well.

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

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

Mr. CARTER. Yes.

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

Mr. CARTER. That is exactly right.

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

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

But at the same time, again, if we'll just be smart, if allowing them to maybe call in one refill over the phone as long as it's limited to a short-day display.

Mr. MURPHY. Thank you.

Mr. CARTER. Thank you, Mr. Chairman.

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

Mr. PALLONE. Thank you, Mr. Chairman.

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

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

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

Mr. PALLONE. All right. Now, my colleagues on the other side of the aisle often characterize the Medicaid program as inflexible for states. We hear that a lot, that it's inflexible. To the contrary, though, I think Medicaid has provided for a great deal of innovation in how states have responded to the opioid crisis. So could you please tell us about the health home program in your state and how Medicaid granted Rhode Island the flexibility to develop its own person-centered care opioid treatment program?

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

And we know that people who have opioid use disorders often have comorbid conditions, don't necessarily have the greatest access to care in the community. And the health homes allow those programs, which have the greatest access to individuals, to provide nursing support. They're overseen by physicians. They have case management that help them get to the needed appointments, dental appointments. And Medicaid has been supporting those efforts with an understanding that improving those outcomes will improve outcomes overall and reduce cost.

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

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

Mr. PALLONE. Obviously, my concern is that, in states most heavily impacted by the opioid epidemic, if you have cuts to Medicaid that that may lead to cuts in addiction treatment and exacerbate the process.

I have a minute left. Let me ask you: Would you agree that deep cuts to addiction services that might result from the Senate TrumpCare bill, for example, that if states decided because of the cuts in the Senate TrumpCare bill, that those kinds of cuts to addiction treatment would have a drastic impact on our ability to fight this epidemic?

Ms. BOSS. Our overdose strategy engages 4 different components, and three of the four would be effected if Medicaid were not available to support. The access to Naloxone, again, is supported by Medicaid. Medicaid covers Naloxone for individuals. The treatment

component is, again, supported by Medicaid, our Centers of Excellence—all of the treatment components have that as well.

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

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

Thank you, Mr. Chairman.

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

Mrs. BROOKS. Thank you.

Director Boss, I want to clarify something that my colleague, Congressman Walberg, asked you previously. You talked about a data gap with respect to fentanyl in law enforcement data. In your written testimony, you've talked about hospital systems are testing for fentanyl, but we do not yet know the frequency of testing or how many tests are returning positive for fentanyl.

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

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

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

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

Yes, Lieutenant Governor.

Mr. RUTHERFORD. I can't speak directly for the hospitals. I know that, through our medical examiner's office, through our emergency first responders, that they get information with regard to fentanyl usage. A little more than 60 percent of our fatalities, overdose fatalities, on opiates, are related to fentanyl. In most cases, it's a mixture with something else, cocaine or heroine. But we're getting most of our information from the law enforcement and emergency responders.

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

Mr. TILLEY. Actually, it brings in all stakeholders, even education.

Mrs. BROOKS. OK.

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

Mrs. BROOKS. I'd like to find out from you, and briefly, your states' efforts, because, obviously, when a person is incarcerated, which many family members said that saves their lives. It's sad

and we want them to be diverted, and we obviously do want to focus on high level. I'm a former U.S. Attorney. So we want to focus on the mid and high level dealers and those who were exposing people with addictions. However, at times we have a captive audience of participants in treatment.

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

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

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

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

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

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

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

I yield back.

Mr. MURPHY. The gentlelady yields back. I recognize Mr. Costello for 5 minutes.

Mr. COSTELLO. Thank you, Mr. Chairman.

Some of you may know the chairman and I both hail from Pennsylvania. The chairman from the Western part of the state. Myself from the Eastern part of the state. And sometimes people think

they're two different states. But having said that, in Pennsylvania, the epidemic is particularly acute. And just a few brief comments about what we're doing in Pennsylvania. And then Lieutenant Governor Rutherford, I had a couple of questions for you.

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

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

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

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

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

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

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

Mr. RUTHERFORD. That is the objective. We haven't stood this up as yet, and we're working with the city of Baltimore in terms of the parameters and how this is going to actually operate and what the state's oversight role will be with this.

Mr. COSTELLO. Is the hope that the funding that you will be utilizing for the facility itself, will that funding extend to the treatment and counseling, or are you looking at the facility to just be sort of on the front end?

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

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

Mr. RUTHERFORD. Well, the lifting of the restriction with regard to Medicaid reimbursement on the number of beds in a facility has helped that particular challenge, because we did have situations where we had individuals who would receive treatment through Medicaid, and we have beds available in some of our facilities, but we could not utilize those. That has helped.

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

Mr. COSTELLO. Thank you.

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

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

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

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

Mr. MURPHY. Thank you.

Mr. RUTHERFORD. Can I respond just very briefly.

Mr. MURPHY. Yes.

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

And one of the areas that we're focusing on going forward, including utilizing the Cures Act funding and state funding, is transitional housing. For lack of a better word, you can call it a halfway house—but transitional housing where a person can go and continue to get treatment in terms of the counseling aspects of it. But during the day, they can go to work, they can do the things that they need to do, but they have to report back to this facility. And people have said that that is something they need before they go back into the unrestricted society, because all the stimuli is still there.

Mr. COSTELLO. Yes. Thank you much.

Thank you, Mr. Costello.

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

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

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

Ms. BOSS. If I could, I would add—

Mr. BILIRAKIS. Yes.

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

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

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

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

Mr. BILIRAKIS. Thank you.

With regard to Florida, in 2010, in response to the opioid crisis in Florida, the pill mill problem—I think you probably know about that. Florida's legislature enacted a statewide tracking of painkiller prescription coupled with law enforcement using drug-trafficking laws to prosecute providers caught overprescribing. Within 3 years, Florida saw a decrease of more than 20 percent in overdose deaths, and I want to give Pam Bondi, the attorney general, and others credit for this.

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

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

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

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

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

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

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

Mr. BILIRAKIS. Does anyone else? Please.

Ms. BOSS. If I could, fentanyl is changing the face of this epidemic, and we need to respond in our interventions. And one of the things that I would comment on is that this is a marathon, not a sprint. And we really need to take a look at prevention efforts as critical to changing the face of this epidemic and not cutting our efforts in prevention. Primary prevention, working with transitional-aged youth. If we can stop their use before they use, we're not going to have them dying with fentanyl.

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

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

Mr. BILIRAKIS. Thank you very much. I agree.

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

Mr. MURPHY. Thank you Mr. Bilirakis.

I recognize Ms. DeGette for follow-up.

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

And I also want to reiterate that we're very flattered. I, personally, am very flattered that you're taking this 21st Century Cures money and really making something with it and developing some programs that are uniquely and appropriately tailored to your

states. Sometimes when we're in Congress, we wonder if anything we do actually impacts people's lives? And when I hear what you're doing, it's really gratifying and I think it will save lives.

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

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

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

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

Thank you.

Mr. MURPHY. Thank you.

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

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

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

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

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. But I want to make reference to a couple of those things. There are about 50 million Americans with lower back pain, 25 million of those take an opioid. When a person has pain and depression, about 40 percent of them are 300 to 400 percent, the risk of abuse, misuse or addiction, noting that when we're dealing with people with addiction disorders and 80 percent of them begin with a prescription for pain, but mood disorders are a big, big part of

this. Fifty-one percent of people on opioids have a mood disorder, anxiety, depression or something else.

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

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

Mr. MURPHY. Oh, OK. Secretary Moran, do you know if you do that in Virginia?

Mr. MORAN. My counterpart, he's a doctor, and the medical community was using the chart, and say, 0 to 10, smiley face. We were addressing pain and we overprescribed. I'm not aware, to answer your particular question, I'm not aware of whether or not we—

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

Mr. MORAN. We are mandating now 2 hours of continuing education in the medical community to address pain. It starts in the medical community with better education around how we manage pain.

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

Mr. TILLEY. Not specifically, but I did mention the limit to the 3-day supply for acute pain, which again, I think presents a bit of a pause for the physician before that prescription. Also, I did not get a chance to mention the University of Kentucky is piloting a program, our flagship institution piloting a program there, to start with everything but an opioid in the course of treatment and try to taper—instead of starting with and tapering down, starting without and maybe moving toward it if it's absolutely necessary.

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

Mr. MURPHY. Thank you. Director Boss do you know if you evaluate—

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

Mr. MURPHY. I would bet during the time when someone is in the emergency room, the chance of someone actually getting a

screen for that is probably pretty close to zero. And just as we have the problems of 42 CFR, a doctor doesn't know if they are on methadone with a prescription or monitoring program. They don't know if they are on these medications. It's usually patch them up, get them out.

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

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

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

Mr. MURPHY. We don't know what the follow up is afterward?

Ms. BOSS. Right.

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

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

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

Mr. MORAN. We do not.

Mr. MURPHY. You do not. But in this time period of which it was available, I would assume that your addiction rate, your overdose and death rates have climbed, correct?

Mr. MORAN. They have.

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

Mr. RUTHERFORD. Oh, yes. Yes, sir.

Ms. BOSS. Ours have raised but not as significantly as other states have experienced in these last few years.

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

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

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

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

Mr. MORAN. We do, sir. And we are using those. And I would congratulate our private sector partners pharmacies have collection boxes now. And I will tell you, DEA does a terrific job. In fact, they were going to suspend their take-back program, and now they continue their robust take-back program. Tons of drugs, it's amazing, I've witnessed it myself, how much. And improper disposal in the medicine cabinets.

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

Mr. MURPHY. They go into homes for a party and the next thing you know—

Mr. MORAN. Exactly, sir.

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

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

one will work in certain professions where everybody—a lot of the people in the back rooms also have addiction problems and get re-exposed. We have an awful, awful mess in this country, and the outcome is a death rate that is mortifying.

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

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

Mr. MORAN. Thank you, Chairman.

Ms. BOSS. Thank you.

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

[Material submitted for inclusion in the record follows:]

# STATEMENT



FOR IMMEDIATE RELEASE  
June 26, 2017

Contact: [matt.salo@medicaiddirectors.org](mailto:matt.salo@medicaiddirectors.org)

## **Consensus Statement from the National Association of Medicaid Directors (NAMD) Board of Directors on the Better Care Reconciliation Act of 2017**

**This statement represents the overwhelming consensus of the NAMD Board of Directors, but is not intended to communicate the unanimous position of all 56 members.**

**Washington, DC** - Medicaid is a successful, efficient, and cost-effective federal-state partnership. It has a record of innovation and improvement of outcomes for the nation's most vulnerable citizens.

Medicaid plays a prominent role in the provision of long-term services and supports for the nation's elderly and disabled populations, as well as behavioral health services, including comprehensive and effective treatment for individuals struggling with opioid dependency.

Medicaid is complex and therefore demands thoughtful and deliberate discussion about how to improve it.

Medicaid Directors have long advocated for meaningful reform of the program. States continue to innovate with the tools they have, but federal changes are necessary to improve effectiveness and efficiency of the program. However, these changes must be made thoughtfully and deliberately to ensure the continued provision of quality, cost-effective care.

Medicaid Directors have asked for, and are appreciative of, improved working relationships with HHS and are working hard to streamline and improve the administration of the program. The Senate bill does formalize several critical administrative and regulatory improvements, such as giving Medicaid Directors a seat at the table in the development of regulations that impact how the program is run, and the pathway to permanency for certain waiver programs.



However, no amount of administrative or regulatory flexibility can compensate for the federal spending reductions that would occur as a result of this bill.

Changes in the federal responsibility for financing the program must be accompanied by clearly articulated statutory changes to Medicaid to enable states to operate effectively under a cap. The Senate bill does not accomplish that. It would be a transfer of risk, responsibility, and cost to the states of historic proportions.

While NAMD does not have consensus on the mandatory conversion of Medicaid financing to a per capita cap or block grant, the per capita cap growth rates for Medicaid in the Senate bill are insufficient and unworkable.

Medicaid - or other forms of comprehensive, accessible and affordable health coverage - in coordination with public health and law enforcement entities, is the most comprehensive and effective way address the opioid epidemic in this country. Earmarking funding for grants for the exclusive purpose of treating addiction, in the absence of preventative medical and behavioral health coverage, is likely to be ineffective in solving the problem and would divert critical resources away from what we know is working today.

Medicaid Directors recommend prioritizing the stabilization of marketplace coverage. Medicaid reform should be undertaken when it can be accomplished thoughtfully and deliberately.

# # #

*The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. NAMD members drive major innovations in health care while overseeing Medicaid, the nation's most important health care program. NAMD serves as the voice for state Medicaid directors in national policy discussions, supports state-driven policies and practices that strengthen the efficiency and effectiveness of Medicaid and actively monitors emerging issues in Medicaid and health care policy. Learn more at <http://www.medicaidirectors.org> and follow NAMD on Twitter @statemedicaid.*



Long-term use of opioid painkillers such as oxycodone (above) may increase a person's sensitivity to pain.

## Why taking morphine, oxycodone can sometimes make pain worse

By Kelly Servick May. 30, 2016 , 3:00 PM

There's an unfortunate irony for people who rely on morphine, oxycodone, and other opioid painkillers: The drug that's supposed to offer you relief can actually make you more sensitive to pain over time. That effect, known as hyperalgesia, could render these medications gradually less effective for chronic pain, leading people to rely on higher and higher doses. A new study in rats—the first to look at the interaction between opioids and nerve injury for months after the painkilling treatment was stopped—paints an especially grim

<http://www.sciencemag.org/news/2016/05/why-taking-morphine-oxycodone-can-sometimes-make-pain-worse>[7/12/2017 4:39:22 PM]

Why taking morphine, oxycodone can sometimes make pain worse | Science | AAAS

picture. An opioid sets off a chain of immune signals in the spinal cord that amplifies pain rather than dulling it, even after the drug leaves the body, the researchers found. Yet drugs already under development might be able to reverse the effect.

It's no secret that powerful painkillers have a dark side. Overdose deaths from prescription opioids have roughly quadrupled over 2 decades, in near lockstep with increased prescribing. And many researchers see hyperalgesia as a part of that equation—a force that compels people to take more and more medication, while prolonging exposure to sometimes addictive drugs known to dangerously slow breathing at high doses. Separate from their pain-blocking interaction with receptors in the brain, opioids seem to reshape the nervous system to amplify pain signals, even after the original illness or injury subsides. Animals given opioids become more sensitive to pain, and people already taking opioids before a surgery tend to report more pain afterward.

But how opioids actually interact with pre-existing pain has been poorly studied, says Peter Grace, a neuroscientist at the University of Colorado (CU), Boulder. His team has been trying to trace hyperalgesia to the way opioids affect the immune system. In the new study, he and his collaborators used a rat model meant to mimic chronic nerve pain in people—the kind many might feel from traumatic nerve injury, stroke, or nerve damage caused by diabetes. They sliced into the rats' thighs and tied a fine thread around a major nerve. The thread swelled over time, causing the nerve to painfully constrict, and then dissolved after about 6 weeks.

Ten days after that injury, half the rats received a 5-day treatment of morphine. Then over about 3 months, the researchers periodically measured the rodents' threshold of pain by poking their hind paws with stiff nylon hairs of varying thicknesses. (The finer the hair that causes the rat to withdraw its paw, the logic goes, the more sensitive it is to pain.) After 6 weeks, injured rats that had received no morphine withdrew from the same kind of pokes as uninjured control rats. But morphine-treated rats remained sensitive to pokes with much finer hairs. It took them 12 weeks to return to the same pain sensitivity as the control rats, the team reports today in the *Proceedings of the National Academy of Sciences*. Even after the physical injury had presumably healed, they were in pain.

"Just the primary observation itself, I think, is amazing," says Vania Apkarian, a neuroscientist at Northwestern University, Chicago, in Illinois, who was not involved in the study. The result "should have a wake-up impact on the field."

Control rats with no injury also saw their pain tolerance dip if they got morphine, but they returned to their original threshold after about a week. So what made pain sensitivity jump so much more dramatically in the rats with an injury?

The authors propose that the nerve damage and the morphine delivered a kind of one-two punch to cells in the spinal cord called microglia—sentinels of the nervous system that scout for infection. Microglia release inflammatory signaling molecules into the spinal cord, which activate neurons that shoot pain signals up to the brain. Previous studies have shown that opioids make microglia more sensitive to activation. In the new

Why taking morphine, oxycodone can sometimes make pain worse | Science | AAAS

study, the authors found that morphine activates a specific group of signaling proteins in microglia, collectively known as an inflammasome.

That's not likely to be the only mechanism behind hyperalgesia, Apkarian notes. But in the study, inhibiting microglia—by inserting a gene for a receptor that makes them susceptible to a deactivating drug—reversed the pain-prolonging effect in morphine treated-rats, as did blocking certain proteins in the inflammasome.

Researchers are already exploring drugs that interrupt this pathway to treat pain or improve the performance of opioids. A clinical trial recently launched at Yale University, for example, will test whether an antibiotic that inhibits glial cells prevents the inflammatory effects of opioids. And Linda Watkins, a CU Boulder neuroscientist and senior author on the new study, co-founded a company to develop a chronic pain treatment that blocks one of the signaling proteins in the inflammasome, called toll-like receptor 4.

In the meantime, the finding certainly shouldn't be the basis for withholding opioids from people in pain, says Catherine Cahill, a neuroscientist at the University of California, Irvine. These drugs also work to block the emotional component of pain in the brain, she notes—a form of relief this study doesn't account for. And opioids might not prolong pain in humans the way they did in these rats, she says, because the dosing of morphine and its quick cessation likely caused repeated withdrawal that can increase stress and inflammation. Humans usually don't experience the same withdrawal because they take sustained-release formulations and taper off opioids gradually.

Grace says the field badly needs a human study that systematically tests pain thresholds over time in opioid users. His team is working to confirm the animal findings with pain from other kinds of injury, and in female rats, which weren't included in this study. In the meantime, he says, "I hope that it'll get people to really question what the benefit of long-term opioid therapy might be."

Posted in: Brain & Behavior, Health

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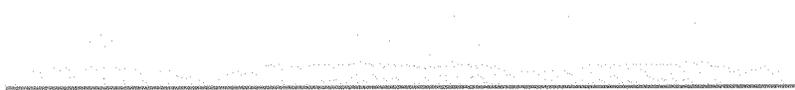
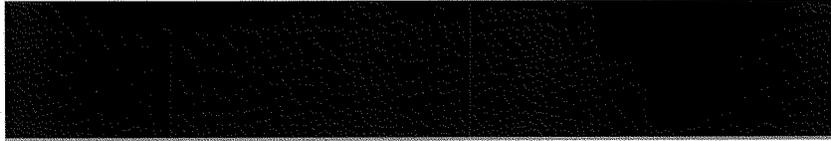
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51 percent of opioid prescriptions go to people with depression and anxiety



HEALTH

## 51 percent of opioid prescriptions go to people with depression and other mood disorders

By CATHERINE CARUSO @cat\_caruso / JUNE 26, 2017

51 percent of opioid prescriptions go to people with depression and anxiety



ROBERT F. BUKATY/AP

**M**ore than half of all opioid prescriptions in the United States are written for people with anxiety, depression, and other mood disorders, according to a new study that questions how pain is treated in this vulnerable population.

People with mood disorders are at increased risk of abusing opioids, and yet they received many more prescriptions than the general population, according to an analysis of data from 2011 and 2013.

<https://www.statnews.com/2017/06/26/opioids-depression-anxiety/>[7/12/2017 4:37:53 PM]

51 percent of opioid prescriptions go to people with depression and anxiety

“We’re handing this stuff out like candy,” said Dr. Brian Sites, of Dartmouth-Hitchcock Medical Center, the senior author of the study. Opioid prescribing in the U.S. quadrupled between 1999 and 2015, and during that time over 183,000 people died from overdoses related to prescription opioids, according to the CDC.

Sites said more research is needed to understand whether opioids are being overprescribed to adults with mood disorders.



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Treating patients with opioid disorders is not just about treating addiction. Here's why

“If you want to come up with social policy to address the need to decrease our out-of-control opioid prescribing, this would be the population you want to study, because they’re getting the bulk of the opioids, and then they are known to be at higher risk for the bad stuff,” he said.

The study, published Monday in the Journal of the American Board of Family Medicine, tapped a U.S. health survey that gathered data from providers and facilities on prescription medications, health status, and basic demographics for about 51,000 adults. It found that 19 percent of the 38.6 million Americans with mood disorders use prescription opioids, compared to 5 percent of the general population — a difference that remained even when the researchers controlled for factors such as physical health, level of pain, age, sex and race.

The analysis showed that adults with mood disorders receive 51 percent of the opioid prescriptions distributed in the U.S., some 60 million prescriptions a year.

It’s unclear why such a discrepancy exists. Sites said it’s possible that patients with mood disorders respond to pain differently, spurring physicians to write more opioid prescriptions; previous research has shown that patients with a history of depression are at increased risk of developing chronic pain. Or physicians might be more sympathetic to patients with preexisting conditions, making them more likely to prescribe opioids. Sites also said that opioids might have a short-term antidepressant effect, which could motivate patients with mood disorders to seek prescriptions.

For Sites, the bottom line is that while opioid prescriptions can be appropriate for individual patients with mood disorders, the study raises concerns about overprescribing on a population scale.

51 percent of opioid prescriptions go to people with depression and anxiety

“We need to understand if this massive prescribing level is appropriate in actually providing benefit commensurate with the risk,” said Sites, who collaborated with researchers at the University of Michigan.



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Your mind can be trained to control chronic pain. But it will cost you

He added that physicians need viable alternatives for treating pain, including cognitive behavioral therapy, acupuncture and acupressure, physical therapy, and massage.

“We don’t have the ability to refer and recommend those things easily,” he said, “So the easiest thing right now is to prescribe a pill.”

Jeffrey Scherrer, a professor and epidemiologist at Saint Louis University not involved in the study, was not particularly surprised by the results. “A lot of pain patients attribute their depression to their pain, but there’s a lot of evidence that depression is playing a role in both the experience of pain and the odds of getting an opioid,” he said.

For Dr. Mark Edlund, a senior public health analyst at RTI International who was also not involved in the study, it adds to a growing and worrisome body of evidence that people with mental health disorders who are at higher risk for abusing opioids are also more likely to receive opioid prescriptions.

“There’s an emphasis now on cutting back opioid prescribing,” he said. “Probably just as important is assuring that we’re prescribing the opioids to the right populations, and that we’re doing our risk-benefit analysis on each patient.”

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U.S. HOUSE OF REPRESENTATIVES  
COMMITTEE ON ENERGY AND COMMERCE

July 10, 2017

TO: Members, Subcommittee on Oversight and Investigations  
FROM: Committee Majority Staff  
RE: Hearing entitled "Combating the Opioid Crisis: Battles in the States"

The Subcommittee on Oversight and Investigations will hold a hearing on Wednesday, July 12, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building, entitled "Combating the Opioid Crisis: Battles in the States." The United States is experiencing an epidemic of opioid abuse and addiction, with drug overdose deaths increasing dramatically over the last two decades and becoming the leading cause of injury death in the U.S. In the early 21st century, overdose deaths primarily involved prescription opioids and then later, around 2005, heroin. Increasingly since 2013, the apparent next wave of the opioid epidemic includes fentanyl, a synthetic opioid 100 times more powerful than morphine.

This hearing will examine how a few states with particular challenges are battling the opioid crisis, what responses show evidence of effectiveness or great promise, where the federal government can assist with such responses, and any state policies that could help improve the federal response to this growing epidemic. This hearing follows up on a series of hearings that the Subcommittee has held over the past two Congresses. In particular, on May 21, 2015, the Subcommittee held a hearing entitled, "What Are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

Pursuant to the 21<sup>st</sup> Century Cures Act enacted in December 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) is administering nearly one billion dollars in grants over the next two years to states and territories for substance abuse prevention programs, treatment, and training for health professionals. This hearing is also an opportunity for the Subcommittee to learn how some of these grants are being spent.

**I. WITNESSES**

- The Honorable Boyd K. Rutherford, Lt. Governor of Maryland;
- The Honorable Brian J. Moran, the Virginia Secretary of Public Safety and Homeland Security;
- The Honorable Rebecca Boss, Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals; and
- The Honorable John Tilley, Kentucky Secretary of the Justice and Public Safety Cabinet.

## II. BACKGROUND

### a. Committee activity on the opioid epidemic

*113th and 114th Congresses.* The Subcommittee held a series of hearings, beginning in April 2014 and continuing into early 2015, that examined the growing problem of prescription drug and heroin abuse nationwide and evaluated solutions to address the crisis. In the course of these hearings, the Subcommittee heard testimony from federal, state, and local levels, and developed a record demonstrating not only the various factors contributing to the opioid abuse epidemic, but also a number of possible solutions. Solutions presented at these Subcommittee hearings helped inform the Committee's legislative efforts ultimately enacted into law as part of the Comprehensive Addiction and Recovery Act (CARA), followed by authorized funding included in the 21st Century Cures Act.

*115th Congress.* Earlier this year the Committee began focusing on the synthetic opioid, fentanyl, which "has spawned a deadly drug crisis in the United States."<sup>1</sup> On February 23, 2017, the bipartisan leaders of the full Committee and the Subcommittee sent a letter to the Acting Director of the Office of National Drug Control Policy (ONDCP) seeking details about the fentanyl problem, actions taken, and any strategic plan to address the fentanyl threat.<sup>2</sup> On March 21, 2017, the Subcommittee held a hearing on "Fentanyl: The Next Wave of the Opioid Crisis." This hearing examined the unique threat that fentanyl has started to pose in communities across the country and what more we need to do at the federal, state, and local level to tackle fentanyl as part of the opioid epidemic.

On May 9, 2017, the Committee launched an investigation into the distribution of prescription opioids in West Virginia. The Committee sent letters to distributors as well as the Drug Enforcement Administration (DEA) inquiring about how so many prescription opioids have been distributed in such high quantities to such small communities, especially in a state that has the highest opioid overdose death rate in the nation.<sup>3</sup> There needs to be a comprehensive approach to combat this growing epidemic that includes all components of the health care and law enforcement community.

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<sup>1</sup> Press Release, U.S. Drug Enforcement Admin., *DEA Warning to Police and Public: Fentanyl Exposure Kills*, June 10, 2016, available at <https://www.dea.gov/divisions/hq/2016/hq061016.shtml>.

<sup>2</sup> Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, Hon. Frank Pallone, Jr., Ranking Member, H. Comm. on Energy & Commerce, Hon. Tim Murphy, Chairman, Subcomm. on Oversight and Investigations, & Hon. Diana DeGette, Ranking Member, Subcomm. on Oversight and Investigations, to Mr. Kemp Chester, Acting Director, ONDCP, February 23, 2017, available at <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/20170223ONDCP.pdf>.

<sup>3</sup> Letters from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, Hon. Frank Pallone, Jr., Ranking Member, H. Comm. on Energy & Commerce, Hon. Tim Murphy, Chairman, Subcomm. on Oversight and Investigations, & Hon. Diana DeGette, Ranking Member, Subcomm. on Oversight and Investigations, to Distributors and DEA, May 8, 2017, available at <https://energycommerce.house.gov/news-center/letters/letters-distributors-and-dea-regarding-alleged-pill-dumping-west-virginia>.

**b. Scope of the opioid crisis**

*Drug overdose trends.* Drug-poisoning (overdose) is now the leading cause of death from injury in the U.S., surpassing motor vehicle accidents, suicide, firearms, and homicide. More than 183,000 people have died from overdoses of prescription narcotics between 1999 and 2015, with more than 15,000 deaths in 2015 alone.<sup>4</sup> Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the U.S., according to preliminary data collected by the *New York Times*.<sup>5</sup> Drug overdoses are now the leading cause of death among Americans under 50.<sup>6</sup>

Opioid-use disorders are surging. An analysis of millions of Americans' medical claims showed diagnoses of opioid-use disorder surged roughly 500 percent over the past seven years, according to a review by the Blue Cross Blue Shield Association.<sup>7</sup> As the opioid crisis accelerates, one forecast projected that almost 500,000 Americans will die from opioids over the next decade.<sup>8</sup>

**c. State policies and issues**

While opioid abuse is a nationwide epidemic,<sup>9</sup> state activities vary depending on circumstances in the particular state. For example, beginning in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states throughout the country, with the increase seen particularly in states on the East Coast.<sup>10</sup> Fentanyl is a narcotic pain reliever used to manage moderate to severe chronic pain.<sup>11</sup> The majority of

<sup>4</sup> Centers for Disease Control and Prevention, Prescription Opioid Overdose Data, updated December 16, 2016, for 2015 alone, the estimate could be as high as 33,000 Americans dying of opioid overdoses, *available at* <https://www.cdc.gov/drugoverdose/data/overdose.html>.

<sup>5</sup> Josh Katz, *Drug Deaths in America Are Rising Faster than Ever*, N.Y. TIMES, June 5, 2017, *available at* <https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>.

<sup>6</sup> *Id.*

<sup>7</sup> Anne Steele, *Opioid Addiction Climbs by 500%*, WALL ST. J., June 30, 2017, *available at* <https://www.wsj.com/articles/opioid-addiction-diagnoses-up-nearly-500-in-past-seven-years-study-shows-1498737603>.

<sup>8</sup> Max Blau, STAT forecast: Opioids could kill nearly 500,000 Americans in the next decade, STAT News, June 27, 2017, *available at* <https://www.statnews.com/2017/06/27/opioid-deaths-forecast/>.

<sup>9</sup> Drug poisoning is the leading cause of death from injury in 30 states, according to CDC in 2011. In addition, opioid analgesics were involved in more than 40 percent of drug poisoning deaths in 2008. According to a 2014 National Association of State Alcohol and Drug Abuse Directors (NASADAD) survey, roughly 40 states consistently say that prescription drug abuse is either "most" or "very" important (slide 17), with 34 states reporting that they have an active prescription drug task force, an increase from 29 reported in 2012. (slide 19). 35 States reported that their strategic plan explicitly addresses prescription drug abuse, and 12 of these states reported that their plan explicitly addresses heroin abuse. 37 states said that heroin abuse is either "most" or "very important" (slide 36), with 15 states reporting that they have an active task force for heroin abuse (slide 40). National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), "State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry," 2014 update, *available at* <http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>.

<sup>10</sup> Maryland Department of Health and Mental Hygiene, "Deaths Related to Fentanyl-Laced Heroin and Other Illicit Drugs," July 2014, *available at* [https://health.maryland.gov/data/Documents/fentanyl%20brief\\_draft.pdf](https://health.maryland.gov/data/Documents/fentanyl%20brief_draft.pdf).

<sup>11</sup> *Id.*

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 4

fentanyl-related deaths do not result from overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances.<sup>12</sup> In response to this problem, for example, the state of Maryland took the following actions to reduce fentanyl-related overdoses throughout the state: sharing data with law enforcement, expanding access to naloxone (a medication designed to rapidly reverse an opioid overdose)<sup>13</sup>, and launching a public awareness campaign.<sup>14</sup>

Despite differences in circumstances, prevention plans, and strategies, the states have identified certain overarching challenges.<sup>15</sup> The challenges have included: a lack of or incomplete data, stigma, the need for increased and interoperable PDMP (Prescription Drug Monitoring Program) utilization, overdose prevention, increasing access to MAT (medication-assisted treatment); and evidence and research on effectiveness of strategies.

*Data Needs.* Concerns have been raised about real-time data/measurement, data quality, and data utilization. As noted by the National Governors Association, to develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of the problem. It can be 6 to 12 months before the medical examiner's information becomes available, long after an OTP [opioid treatment programs] has reported the death to the state.<sup>16</sup> States have reported that CDC data is slow to be released and cannot capture real-time changes in drug use that are occurring.<sup>17</sup> For example, a CDC expert told bipartisan Committee staff that time lags in reporting, for example, would mean that CDC would not have 2016 overdose death data until the end of 2017. Moreover, CDC noted they primarily rely on death certificates which sometimes only note a "drug overdose" and do not always list the specific drug(s).

Serious challenges exist concerning state data on the cause of death regarding drug overdose deaths. State death certificates often do not specify the type of drug related to drug overdose deaths.<sup>18</sup> Lethality issues can be hard to separate when multiple drugs are involved, especially with benzodiazepines.<sup>19</sup> Additionally, defining the cause of death in patients receiving MAT is inherently complex, since, regardless of the cause of death, these patients may have a high level of methadone in their blood. Medical examiners often do not know that the individual is receiving methadone treatment.<sup>20</sup> Further, many states do not conduct the full medical review

<sup>12</sup> *Id.*

<sup>13</sup> National Institute on Drug Abuse, Opioid Overdose Reversal with Naloxone (Narcan, Evzio), September 2016, available at <https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio>.

<sup>14</sup> *Id.*

<sup>15</sup> The Substance Abuse and Mental Health Services Administration, Successful Strategies in Addressing Opioid Overdose Deaths, White Paper developed for the Center for Substance Abuse Treatment, March 2010, available at [https://www.michigan.gov/documents/mdch/SAMHSA\\_Overdose\\_Report\\_345238\\_7.pdf](https://www.michigan.gov/documents/mdch/SAMHSA_Overdose_Report_345238_7.pdf).

<sup>16</sup> *Id.* at 11.

<sup>17</sup> National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), "State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry," slide 14, 2014 update, available at <http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>.

<sup>18</sup> A CDC expert in a briefing with Committee Staff estimated that 25 percent of death certificates listing overdose as a cause did not specify the drug.

<sup>19</sup> Successful strategies, *Supra* note 15 at 10.

<sup>20</sup> *Id.*

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 5

for determining the cause of death.<sup>21</sup> For example, Colorado noted that from 2004 to 2013, 2.4 percent of Colorado death certificates had an unknown cause of death.<sup>22</sup>

CDC believes information collected in Will County, Illinois that tracks “accidental overdoses” by date of death, cause of death, and personal demographics would be extremely helpful if it were collected on all death certificates of drug overdose deaths in the U.S.<sup>23</sup> This information is useful to public health, medical, and legal entities as it helps researchers, investigators, health care providers, and public health practitioners understand and identify drug use risks, appropriate clinical and behavioral care, and possible public health interventions.<sup>24</sup> CDC reported to the Subcommittee that there are multiple national and state efforts underway to address these issues that align with the effort in Will County.<sup>25</sup> Currently, CDC is partnering with the Association of State and Territorial Health Officials (ASTHO) on a project to improve drug specificity on death certificates.<sup>26</sup>

In a response to a Question for the Record that was submitted following the 2015 Subcommittee hearing, one state government witness noted that it had become clear that her state’s ability to address the underlying health issues and social determinants that are driving this epidemic “is dependent on the state’s ability to successfully leverage data and measure results.”<sup>27</sup> This witness wrote that her state had more “than 300 different internal data sources that have been developed by individual programs using a variety of different formats for a variety of different purposes. They are managed by different staff, reside on different servers, and don’t talk to each other.”<sup>28</sup>

*Stigma.* The stigma associated with seeking treatment was reported by states in 2014 as one of the top remaining challenges.<sup>29</sup> In addition to the underlying stigma against addiction, stigma and bias against MAT exists even after research has proved its value for treating opioid dependence. The stigma underlies a score of issues that states confront in developing their strategies. Such issues include: state moratoriums on establishing new opioid treatment programs (OTPs) despite large, unmet treatment needs for the opioid-dependent population, unwillingness of the criminal justice system to set up MAT in correctional facilities, and the requirement of some drug court judges that people must abandon the usage of MAT to participate in the program and of some family court judges who mandate that individuals must

<sup>21</sup> *Id.*

<sup>22</sup> Colorado Department of Public Health & Environment, Special Emphasis report: Drug Overdose Deaths, 1999-2013, October 2014, page 196-197, *available at* [https://www.colorado.gov/pacific/sites/default/files/LPH\\_MCH\\_NA-Report-Appendix-only\\_2016-2020.pdf](https://www.colorado.gov/pacific/sites/default/files/LPH_MCH_NA-Report-Appendix-only_2016-2020.pdf).

<sup>23</sup> Dr. Debra Houry, Director, National Center for Injury Prevention and Control, CDC, Responses to Questions for the Record, Subcomm. hearing on “Fentanyl: The Next Wave of the Opioid Crisis,” March 21, 2017, *available at* <http://docs.house.gov/meetings/IF/IF02/20170321/105739/HHRG-115-IF02-Wstate-HouryD-20170321-SD026.pdf>.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> Commissioner Monica Bharel, MD, MPH, Massachusetts Department of Public Health, Responses to Questions for the Record, “What are the State Governments Doing to Combat the Opioid Epidemic?”, Serial No. 114-46, 102, May 21, 2015, *available at* <http://docs.house.gov/meetings/IF/IF02/20150521/103501/HHRG-114-IF02-Wstate-BharelM-20150521-SD003.pdf>.

<sup>28</sup> *Id.*

<sup>29</sup> NASADAD, 2014 update, *Supra* note 9, at slide 34.

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 6

stop MAT before receiving custody of their children.<sup>30</sup> State initiatives to reduce the stigma of treatment for opioid use disorders are: increasing access to a full range of evidence-based therapies, facilitating access to recovery support services, and expanding access to effective therapies in the criminal justice system.<sup>31</sup>

*Need for PDMP improvement.* PDMPs are state-run electronic databases of prescriptions for controlled substances. PDMPs can provide a prescriber or pharmacist with information regarding a patient's prescription history, allowing prescribers to identify patients who are potentially abusing medications. With Missouri adopting a PDMP in April 2017, all 50 states, the District of Columbia, and Guam have legislation authorizing the creation and operation of a PDMP, and all but the District of Columbia program are operational.<sup>32</sup> While there is evidence indicating the potential of PDMPs to identify high-risk patients and impact prescribing behaviors, the effectiveness of PDMPs is constrained by the lack of consistent utilization, timely data in some states, and limited interoperability with other PDMPs. Witnesses at the March 26, 2015, Subcommittee hearing also testified about their concerns over methadone clinics not being required to report methadone dispensing to PDMPs. One witness said it was "a very serious situation" because if these patients do not disclose their methadone treatment to their primary care providers and the providers do not know about it from accessing the PDMP, other opioids or benzodiazepines could be prescribed leading to an increased risk of an overdose death.<sup>33</sup> Another concern that was expressed at the hearing related to neonatal doctors not knowing about methadone treatment for pregnant women, which poses potential problems for the mother and the life of the fetus if the methadone is being increased while the mother and baby are receiving MAT to treat the addiction.<sup>34</sup>

States have noted that it is critical to an effective statewide strategy for combatting opioid abuse to improve the effectiveness and use of PDMPs. While 50 states and the District of Columbia have legislation authorizing the creation and operation of a PDMP, they vary in their degree of use and overall effectiveness depending on who is registered to use them, whether data is current or real-time, whether there are limitations on authorized users, and whether processes

<sup>30</sup> Successful strategies, *Supra* note 15 at 9.

<sup>31</sup> NASADAD 2014 update, *Supra* note 9, slide 48.

<sup>32</sup> Summer Ballentine, *Missouri House Passes Prescription Drug Tracking Program*, ASSOC. PRESS, April 3, 2017, available at <https://www.usnews.com/news/best-states/missouri/articles/2017-04-03/missouri-house-passes-prescription-drug-tracking-program>. PDMP Training and Technical Assistance center, PDMP Frequently Asked Questions, available at <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>.

<sup>33</sup> *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives Before the H. Comm. on Energy & Commerce Subcomm. on Oversight and Investigations, 114th CONG*, Unofficial hearing transcript, 40, Testimony of Fred Wells Brason II, Executive Director, Project Lazarus, Moravian Falls, North Carolina, March 26, 2015, available at <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HRG-114-IF02-Transcript-20150326.pdf>.

<sup>34</sup> *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives Before the H. Comm. on Energy & Commerce Subcomm. on Oversight and Investigations, 114th CONG*, Unofficial hearing transcript, 90, Testimony of Stefan R. Maxwell, MD, Chair, West Virginia Perinatal Partnership, MEDNAX Medical Group, Director NICU, Charleston Area Medical Center, Charleston, West Virginia, March 26, 2015, available at <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HRG-114-IF02-Transcript-20150326.pdf>.

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 7

for accessing the databases integrate easily into clinical workflows.<sup>35</sup> Another major component of these PDMPs is their interoperability with other states, particularly neighboring states. The level of interoperability with other states varies greatly and currently lacks uniformity. This is a weakness among the programs because the lack of data sharing allows patients to doctor shop across state lines. Thus, a White House report issued in 2011 declared that “[a] major effort must be undertaken to improve the functioning of state PDMPs, especially regarding real-time data access by clinicians, and to increase the inter-state operability and communication.”<sup>36</sup> In addition, in many states, privacy concerns may limit the extent to which PDMP data can be used for law enforcement, public health, and research purposes.

Some states are providing out-of-state access to their PDMPs. For example, prescribers in states bordering Maryland (Delaware, the District of Columbia, West Virginia, northern Virginia, and southern Pennsylvania) can have access to the Maryland PDMP. Maryland currently shares with limited states, but will continue adding new connections.<sup>37</sup> In addition, pharmacists employed outside of Maryland, but who possess a Maryland pharmacist’s license and dispense to Maryland residents are allowed to have access to the PDMP.<sup>38</sup>

States also vary with respect to their continuing medical education (CME) requirements for physicians. Some state licensing boards have established more robust CME requirements to improve prescribing practices among doctors in their state. California is an example of a state that has implemented stricter CME for prescribing doctors while other states may have very little required CME of their doctors. With the release of the CDC guidelines for primary care providers prescribing opioids for chronic non-cancer pain, states are looking to these guidelines as an important tool for curbing overprescribing of opioids.<sup>39</sup>

CDC experts have found that a few states have been able to change prescribing patterns by increasing prescriber use of their PDMPs.<sup>40</sup> New York and Tennessee, for example, mandated prescriber use of the state PDMP in 2012.<sup>41</sup> They subsequently used their PDMPs to document declines of 75 percent and 36 percent, respectively, in their inappropriate use of multiple prescribers by patients.<sup>42</sup> Other actions taken by states affecting prescribers that CDC experts believe are promising interventions are: developing or adopting existing guidelines for prescribing opioid pain relievers that can establish local standards of care that might bring

<sup>35</sup> National Governors Association (NGA), “Six Strategies for Reducing Prescription Drug Abuse,” Issue Brief, September 2012, available at <https://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-hsps-publications/six-strategies-for-reducing-pres.html>.

<sup>36</sup> Executive Office of the President of the United States, “Epidemic: Responding to America’s Prescription Drug Abuse Crisis,” Page 6, 2011, available at [https://www.ncjrs.gov/pdffiles1/ondcp/rx\\_abuse\\_plan.pdf](https://www.ncjrs.gov/pdffiles1/ondcp/rx_abuse_plan.pdf).

<sup>37</sup> Maryland Department of Health and Mental Hygiene, PDMP FAQ, May 22, 2017, available at <https://www.crisphealth.org/wp-content/uploads/2017/05/PDMP-FAQ-v3.pdf>.

<sup>38</sup> *Id.*

<sup>39</sup> National Governors Association, Governors’ Priorities for Addressing the Nation’s Opioid Crisis, February 18, 2016, available at <https://www.nga.org/cms/home/special/col2-content/governors-priorities-opioid.html>.

<sup>40</sup> L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563, July 4, 2014, available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*, citing Prescription Drug Monitoring Program Center of Excellence at Brandeis University. Mandating PDMP participation by medical providers: current status and experience in selected states.

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 8

prescribing rates more in line with current best practices, state Medicaid programs managing pharmacy benefits to promote cautious, consistent use of opioids, and enacting law to address the most egregious prescribing incidents.<sup>43</sup>

The National Institute of Drug Abuse (NIDA) recently reported to the Subcommittee that in states with the most comprehensive initiatives to reduce opioid overprescribing, “the results have been encouraging.”<sup>44</sup> The state of Washington’s implementation of evidence-based dosing and best-practice guidelines, as well as enhanced funding for the state’s PDMP, helped reduce opioid deaths by 27 percent between 2008 and 2012.<sup>45</sup> In Florida, new restrictions were imposed on pain clinics, new policies were implemented requiring more consistent use of the state PDMP, and the DEA worked with state law enforcement to conduct widespread raids on pill mills, which resulted in a dramatic decrease in opioid prescribing and in overdose death between 2010 and 2012.<sup>46</sup> A recent analysis by the CDC found that while the rate of prescribing has decreased since 2010, the prescribing rate in 2015 is still three times as high as it was in 1999 and the amount of opioids prescribed in 2015 was enough for every American to be medicated around the clock for three weeks.<sup>47</sup>

It should be noted that methadone clinics are not covered by PDMPs; thus, physicians treating patients for pain cannot find out if the patient is on methadone, a potentially dangerous situation if an opioid medication is prescribed.

*Overdose prevention.* State efforts to combat heroin abuse have varied from state to state. For example, several states have passed laws that generally provide immunity for victims and witnesses who act in good faith and seek medical assistance for an overdose; these laws are commonly referred to as “Good Samaritan Laws.”<sup>48</sup> States have also taken different approaches to expanding access to naloxone, with some states permitting third party prescribing by family and friends of individuals who are at high-risk of overdose, and others providing a standing order for community organizations who distribute naloxone to those who meet certain criteria.<sup>49</sup> Liability protection for prescribers who administer naloxone, as well as the nature of naloxone distribution programs may differ from one state to the other.<sup>50</sup> In addition, many states have established task forces, or have initiated new law enforcement efforts to combat heroin and prescription opioids.<sup>51</sup>

<sup>43</sup> *Id.* For example, Florida enacted pain clinic legislation in 2010 and prohibited dispensing by prescribers in 2011.

<sup>44</sup> Dr. Wilson Compton, Deputy Director, NIDA, responses to Questions for the Record, “Fentanyl: The Next Wave of the Opioid Crisis,” March 21, 2017, available at <http://docs.house.gov/meetings/IF/IF02/20170321/105739/FHHRG-115-IF02-Wstate-ComptonW-20170321-SD028.pdf>.

<sup>45</sup> *Id.* citing G. Franklin *et al.*, A Comprehensive Approach to Address the Prescription Opioid Epidemic in Washington State: Milestones and Lessons Learned, 105 *American Journal of Public Health* 463 (2015).

<sup>46</sup> *Id.* citing H. Johnson *et al.*, Decline in drug overdose death after state policy changes – Florida, 2010–2012, 63 *MMWR* 569 (2014).

<sup>47</sup> Centers for Disease Control and Prevention, Vital Signs, *Opioid Prescribing*, July 6, 2017, available at <https://www.cdc.gov/vitalsigns/opioids/index.html>.

<sup>48</sup> NGA, *Supra* note 35.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 9

Naloxone is still a prescription in all 50 states and the District of Columbia, although states are taking steps to make naloxone available to their communities. Forty states and the District of Columbia have passed laws that in some way expand the availability of naloxone.<sup>52</sup> This is a dramatic increase compared to the 17 states that had such laws in 2013.<sup>53</sup>

States' efforts in this area have also targeted the proper disposal of prescription drugs. The majority of people who abuse or misuse prescription drugs get them from friends and family; many of those drugs are leftover because a patient did not take the full amount of pills prescribed to them. These efforts have included public education on proper disposal and take-back activities, such as designating times and places where the public can safely dispose of unused prescription medication.<sup>54</sup>

The AnchorED program, developed in Rhode Island, matches overdose victims with peer recovery coaches to encourage treatment.<sup>55</sup> Michelle Harter, Manager of Operations for Anchor Recovery Community Centers, described how the program works:

When a person is brought to a hospital emergency department with an opioid overdose, a member of the hospital staff calls the AnchorED hotline, which is available 24 hours a day, 7 days a week. The hotline connects the caller with a peer recovery coach, who is then dispatched to the hospital. Prior to the patient's release from the hospital, the recovery coach meets with the patient to discuss available recovery supports and resources in the community. Coaches can also provide education on overdose prevention, including information on how to obtain Narcan or Naloxone, a medication used to reverse an opioid overdose, and may provide additional resources and support to family members with the patient's approval. Upon the patient's release from the hospital, AnchorED staff follow-up with the patient for the next 10 days, encouraging him or her to engage in recovery support services.<sup>56</sup>

*Increasing access to MAT.* In 2015, 8.4 million people needed treatment for drug addiction, yet four out of five did not receive it.<sup>57</sup> Forty-nine states and the District of Columbia have opioid treatment programs. All 50 states and the District of Columbia have physicians with waivers to prescribe buprenorphine. All three FDA-approved opioid treatment medications (methadone, buprenorphine, and naltrexone) are covered under the Medicaid Drug Rebate Program. The associated co-pays and authorization requirements vary from state to state. Twenty-six states reported in 2014 that they have expanded or made plans to expand MAT in the

<sup>52</sup> NASADAD, Overview of State Legislation to Increase Access to Treatment for Opioid Overdose, September 8, 2015, available at <http://nasadad.org/2015/09/overview-of-state-legislation-to-increase-access-to-treatment-for-opioid-overdose-3/>.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> Addiction Policy Forum, AnchorED Rhode Island, February 2, 2017, available at <http://www.addictionpolicy.org/single-post/2017/02/02/AnchorED-Rhode-Island>.

<sup>56</sup> *Id.* quoting Michelle Harter, Manager of Operations, Anchor Recovery Community Centers.

<sup>57</sup> Statement of Richard Baum, Acting Director of the Office of National Drug Control Policy (ONDCP) cited in A. Knopf, Report from NASADAD – ONDCP to State Director: Increase Access to Treatment, June 2, 2017, available at <http://atforum.com/2017/06/report-nasadad-ondep-state-directors-increase-access-treatment/>.

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 10

two years prior.<sup>58</sup> Although the opioid addiction field recognizes addiction as a chronic, relapsing disease, some substance abuse counselors and administrators have been reluctant to embrace new technologies for its treatment.<sup>59</sup> At the same time, most physicians and other health care professionals receive little or no training in the treatment of addiction.<sup>60</sup> As a result, adoption of MAT has been slow in some areas.<sup>61</sup>

*Evidence and research on effectiveness of strategies.* Very little evidence-based research exists on the most cost-effective and efficacious strategies for states to use in order to reduce opioid-related overdoses, however states are seeking guidance.<sup>62</sup> Massachusetts, when developing its comprehensive state overdose prevention plan, turned to international sources to identify successful strategies.<sup>63</sup> States have also been frustrated from not knowing the outcomes of their actions.<sup>64</sup> Potential outcomes include: (1) Did physicians change their opioid prescribing practices after receiving webinars and other training; (2) Why do so many physicians train to become registered providers of buprenorphine for addiction, and then not treat any patients; and (3) When informed by letter that a patient has shown up on the PDMP with multiple opioid prescriptions, does the prescribing doctor take action, and, if so, what action?<sup>65</sup> State representatives particularly requested studies that would look at overdose outcomes for opioid-dependent patients who receive drug-free treatment compared to those receiving MAT.<sup>66</sup>

### III. ISSUES

The following issues may be examined at the hearing:

- What are the most critical data gaps facing state governments combating the opioid crisis?
- How can data collection and reporting in the states be improved for responding to the opioid epidemic?
- How could the federal response help bolster state PDMP programs?
- How can states improve surveillance of the fentanyl epidemic?
- What initiatives and programs are the states utilizing that have been successful?
- What barriers exist to enacting successful programs?

<sup>58</sup> NASADAD, 2014 update, *Supra* note 9, slide 45.

<sup>59</sup> Statement of Mark G. Stringer, Director of Division of Behavioral Health, Missouri Department of Mental Health, available at <http://dmh.mo.gov/ada/provider/medicationassistedtreatment.html>.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Successful strategies, *Supra* note 15, at 9.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 10.

Majority Memorandum for July 12, 2017, Subcommittee on Oversight and Investigations Hearing  
Page 11

- What additional burdens is the opioid crisis putting on society, the healthcare system, the criminal justice system, the emergency response system, and state budgets?

**IV. STAFF CONTACTS**

If you have any questions regarding the hearing, please contact Alan Slobodin, Brittany Havens, or David Schaub of the Committee staff at (202) 225-2927.