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**CITY OF BALTIMORE**

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**TO:** Members of the House Oversight Committee

**FROM:** Dr. Leana Wen, Baltimore City Health Commissioner

**RE:** Testimony for the Record

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

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

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

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

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

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

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

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

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

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

## **A. Baltimore’s Response to Addiction and Overdose**

Our work in Baltimore is built on three pillars:

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

### **1. Preventing deaths from overdose**

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

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

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

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

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

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

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

- b. We use up-to-date epidemiological data to target our training to “hotspots,” taking naloxone directly into the most at-risk communities and putting it in the hands of those most in need. This was put into effect in 2015, when 39 people died from overdose of the opioid Fentanyl between January and March of 2015. In 2016 we lost 419 people to Fentanyl overdoses; the numbers continue to escalate, and there are now 50 times the number of people dying from Fentanyl than there were in 2013. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. These data led us to target our messaging so that we could save the lives of those who were at immediate risk. Through our citywide Fentanyl Taskforce, we coordinate our data with agencies across the city, including the police department, fire department, and hospitals, to ensure our information is complete and our efforts are unified.
- c. In order to train even more people in the use of naloxone, we have launched an online platform that now allows residents to get trained online and immediately receive a prescription for naloxone. This online platform, which is the first-of-its-kind around the country and the world, is the next step to reduce barriers to the use of naloxone.
- d. Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to train police officers, who have saved 182

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

- e. We successfully advocated for Good Samaritan legislation, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone.
- f. Our state Medicaid program has agreed to set the co-pay for naloxone at \$1. While we still struggle with the pricing for naloxone (see below), this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life—which we believe is each and every one of us.

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

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

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

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

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

- a. In Baltimore, we have started a 24/7 “crisis, information, and referral” phone hotline that connects people in need to a variety of services, including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services. This hotline is not just for addiction but for mental health issues; behavioral health issues are closely related, and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line receives approximately 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by schoolteachers and family members seeking resources and by police and providers looking to connect their patients to treatment.
- b. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. SBIRT is now being implemented in nine of our eleven hospitals and in our city clinics to ensure delivery of early intervention and treatment services for those with or at-risk for substance use disorders.
- c. We have piloted a real-time treatment dashboard to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard is being connected to our 24/7 hotline that will immediately connect people to the level of treatment that they require—on-demand, at the time that they need it.
- d. We have secured \$3.6 million in capital funds and \$2 million in operating funds for a “stabilization center”—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 “Urgent Care” for addiction and mental health disorders—a comprehensive, community-based “ER” dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must also be able to seek treatment on-demand. The center will provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings and connect patients to case management and other necessary services such as housing and job training.
- e. We are expanding and promoting medication-assisted treatment, which is the gold standard for helping people recover from opioid addiction. This combines behavioral therapy with FDA-approved medications. Taking medication for opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction. Rather, it manages a patient’s addiction so that they can successfully achieve recovery. Baltimore has been at the cutting edge of

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

- f. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. To build trust, these individuals have been recruited from the same neighborhoods as individuals with addiction, and are trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services. To date, eight of eleven hospitals participate in our Overdose Survivors Outreach Program, in which overdose survivors in the emergency room are linked with peer recovery coaches in the community. These peers work with patients after they are discharged to provide a “warm hand-off” into treatment and other support services.
- g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, more than 75,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an addiction.

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

### **3. Providing education to reduce stigma and prevent addiction**

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

- a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign, “DontDie.org,” to educate citizens about the fact that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches, all coordinated with neighborhood leaders. We work with restaurants and bar owners to post “Don’t Die” posters in their establishments. “DontDie.org” has also become our portal for online trainings and for the dispensing of naloxone through the Standing Order mentioned above. Any resident can watch a short (4 minute) video, take a four-question quiz, and have completed the training.
- b. We have established permanent prescription drug drop boxes at all nine of the city’s police stations and have conducted educational awareness campaigns the address safe storage and disposal. Anyone can drop off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. More than half of 12 to 17 year-olds who misuse prescription opioids say they got them from a friend or family member. Despite this, half of all patients prescribed opioids report receiving no instructions about safe storage and disposal.
- c. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control and Prevention (CDC), there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid bottle for every American adult. Every day, people overdose on or become addicted to their prescription opioids.

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

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

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

- d. We recognize that education must begin as early as possible and that our schools are a critical part of our efforts. We launched a concerted effort to target prevention among our teens and youth through a campaign called “BMore in Control.” We are also incorporating prevention into the public school curriculum. As of 2017, Maryland state law requires schools to teach on addiction. We are working with our school district to implement evidence-based educational curricula.
- e. We have trained all of our nurses in our 180 public schools to save lives with naloxone. We now have addiction and mental health services in 120 of our schools. These efforts are a good start, but are limited for two reasons. First is the issue of billing: certain critical services such as case management and care coordination are not reimbursable, yet these are key to serving children in need. Second is that there must be a focus on a true prevention intervention model. Substance use is often not the problem but a response to trauma, and there must be a more comprehensive approach to social and emotional learning and to addressing intersecting issues such as poverty, violence, racism, and trauma.

## **B. Response to the President’s Commission on Combating Drug Addiction and the Opioid Crisis**

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

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

1. **The Commission failed to advocate for taking all necessary steps to expand health insurance.** This includes protecting Medicaid, which covers 1 in 3 patients who receive treatment for substance use disorder, as well as ensuring that essential health benefits covering addiction and mental health treatment remain part of every insurance plan. There should also be coverage for other wraparound services that are critical for treating addiction, such as connections to treatment, coverage for supportive housing, and reimbursement for peer recovery specialists. The Commission recommended block grants, but grants alone cannot be depended upon for treatment of such a widespread disease as opioid addiction.
2. **The Commission does not adequately address the issue of treatment for the disease of addiction.** The Commission provides recommendations to support medication-assisted treatment, but it needs to go beyond that by requiring the integration of substance use treatment into medical practice. That could include requiring all eligible physicians to obtain the waiver to prescribe buprenorphine and approving state-level pilots for integrating primary care and behavioral health treatment. At the very least, medication-



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

3. **The Commission failed to identify substantial increases in federal funding that may be employed in the fight against the opioid epidemic.** National state of emergency declarations come with commitments for funding. When hurricanes devastate communities, it's understood that billions of dollars are required to rebuild homes and repair infrastructure. The same understanding applies for stopping an epidemic. In Baltimore and across the country, we desperately need these resources. Studies show that only 1 in 10 people with addiction receive the treatment that they need—a statistic we would not find acceptable for any other disease. The President needs to announce a specific dollar amount for new funding, not repurposed dollars that take away from other key health priorities. We know what works to overcome this crisis. We just need the resources and the will to get there.
4. **The Commission does not provide recommendations around evidence-based harm-reduction practices, most notably needle and syringe exchange.** There are dozens of studies showing that needle exchange programs reduce HIV and hepatitis transmission, and do not increase drug use. In Baltimore City, implementation of needle exchange has resulted in the percentage of individuals with HIV from injection drug use decreasing from 63% in 1994 to 7% in 2014. Our needle exchange vans are staffed by individuals in recovery themselves, who are credible messengers and serve as counselors to help connect patients to treatment. Furthermore, these outreach workers teach on naloxone usage to a high-risk population; it is estimated that for every 11 units of naloxone handed out on our vans, one unit is used to save someone's life. Attention should be paid to the omission of this evidence-based practice that has been successful in Baltimore and in many locations across the country and internationally. There is also growing evidence from other countries about other harm-reduction practices such as safe injection facilities. Such evidence should be referenced by the Commission report, if only to call attention to the need for further study.

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

#### Federal Funding and Programs

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

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

2. The Commission believes that ONDCP must establish a coordinated system for tracking all federally-funded initiatives, through support from HHS and DOJ. If we are to invest in combating this epidemic, we must invest in only those programs that achieve quantifiable goals and metrics. We are operating blindly today; ONDCP must establish a system of tracking and accountability.
  - a. **Agree, with reservations.** More opioid work needs to be evidence-based. The tracking system should not, however, impose bureaucratic burdens on local jurisdictions implementing programs that we already know work.
3. To achieve accountability in federal programs, the Commission recommends that ONDCP review is a component of every federal program and that necessary funding is provided for implementation. Cooperation by federal agencies and the states must be mandated.
  - a. **Agree, but this does not far enough.** Maximizing the efficacy of existing resources is a worthy goal, but it will not come close to eliminating the need for new funding. Existing funding is inadequate—and it will remain inadequate no matter how efficiently it is used.
  - b. While cooperation between federal agencies and the states sounds good in theory, federal funding should be allocated directly to local jurisdictions with greatest need without going through the states. State governments do not know the challenges that cities face on the ground. Cities like Baltimore have been dealing with the epidemic for many years; we know what works.

#### *Opioid Addiction Prevention*

4. The Commission recommends that Department of Education (DOE) collaborate with states on student assessment programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a program that uses a screening tool by trained staff to identify at-risk youth who may need treatment. This should be deployed for adolescents in middle school, high school and college levels. This is a significant prevention tool.
  - a. **Agree, but this does not go far enough.** SBIRT is evidence-based—much more so than “just say no”-style abstinence curricula. But its implementation requires funding—as do projects to ensure that treatment is available for those who screen positive for substance use disorder.
5. The Commission recommends the Administration fund and collaborate with private sector and non-profit partners to design and implement a wide-reaching, national multi-platform media campaign addressing the hazards of substance use, the danger of opioids, and stigma. A similar mass media/educational campaign was launched during the AIDs public health crisis.

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

*Prescribing Guidelines, Regulations, Education*

- 6. The Commission recommends HHS, the Department of Labor (DOL), VA/DOD, FDA, and ONDCP work with stakeholders to develop model statutes, regulations, and policies that ensure informed patient consent prior to an opioid prescription for chronic pain. Patients need to understand the risks, benefits and alternatives to taking opioids. This is not the standard today.
  - a. **Agree.** While it’s not clear that these “opioid contracts” have a significant effect on outcomes, it’s certainly worth pursuing—more information about risks and alternatives is helpful.
- 7. The Commission recommends that HHS coordinate the development of a national curriculum and standard of care for opioid prescribers. An updated set of guidelines for prescription pain medications should be established by an expert committee composed of various specialty 13 practices to supplement the CDC guideline that are specifically targeted to primary care physicians.
  - a. **Agree, but this does not go far enough.** It’s important to establish national safety standards for opioid prescribing in all settings. But guidelines are not enough unless they are accompanied by regulatory changes. HHS can go much further to tie reimbursement and licensing to compliance with the guidelines.
- 8. The Commission recommends that federal agencies work to collect participation data. Data on prescribing patterns should be matched with participation in continuing medical education data to determine program effectiveness and such analytics shared with clinicians and stakeholders such as state licensing boards.
  - a. **Agree, with reservations.** This sounds good in theory, but I urge federal officials to seek input from local partners on the ground. In Baltimore City and across the country, we already work closely with law enforcement partners and others to share and collaborate on data. Making federal data available to locals on the ground, and learning from our experiences, will be critical to ensuring the usefulness of such analytics.
- 9. The Commission recommends that the Administration develop a model training program to be disseminated to all levels of medical education (including all prescribers) on screening for substance use and mental health status to identify at risk patients.

- a. **Agree, but this does not go far enough.** Screenings for substance use disorder should be universal—a part of every routine medical encounter.
  - b. Once screenings are done, there must be place for on-demand treatment. There should also be required training for how to treat patients with substance use disorder. Doctors are required to treat patients with all kinds of illnesses, and the disease of addiction should be no exception.
10. The Commission recommends the Administration work with Congress to amend the Controlled Substances Act to allow the DEA to require that all prescribers desiring to be relicensed to prescribe opioids show participation in an approved continuing medical education program on opioid prescribing.
  - a. **Agree.** More should be required of providers before they prescribe opioid analgesics—and less before they prescribe medications to treat the use disorder that those analgesics can cause.
11. The Commission recommends that HHS, DOJ/DEA, ONDCP, and pharmacy associations train pharmacists on best practices to evaluate legitimacy of opioid prescriptions, and not penalize pharmacists for denying inappropriate prescriptions.
  - a. **Agree, but this does not go far enough.** Pharmacists play an important role in preventing overprescription, but we also need their help in distributing naloxone. Many states and local jurisdictions have issued “standing orders” that allow residents to purchase naloxone from a pharmacy without an individualized prescription. The efficacy of these standing orders, however, is contingent on pharmacists: if they are unaware of the standing order, they may inappropriately deny individuals’ requests for naloxone. The federal government should work with pharmacy associations and states/local jurisdictions to educate pharmacists about relevant standing order laws. The federal government should also work with pharmacy associations to ensure that pharmacists are trained to dispense naloxone when filling opioid prescriptions, as appropriate.

#### *PDMP Enhancements*

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

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

- a. **Agree.** PDMP checks should be mandated. If the emendation of EMTALA recommended here consists of defining the “stabilization” of substance use disorder patients to include initiating medication-assisted treatment, per recommendation 45, then we support the change.
14. The Commission recommends that PDMP data integration with electronic health records, overdose episodes, and SUD-related decision support tools for providers is necessary to increase effectiveness.
    - a. **Agree.** Lack of integration with EHRs is a major barrier preventing increased PDMP use.
  15. The Commission recommends ONDCP and DEA increase electronic prescribing to prevent diversion and forgery. The DEA should revise regulations regarding electronic prescribing for controlled substances.
    - a. **Agree, but this does not go far enough.** ONDCP and DEA should require electronic prescribing.
  16. The Commission recommends that the Federal Government work with states to remove legal barriers and ensure PDMPs incorporate available overdose/naloxone deployment data, including the Department of Transportation’s (DOT) Emergency Medical Technician (EMT) overdose database. It is necessary to have overdose data/naloxone deployment data in the PDMP to allow users of the PDMP to assist patients.
    - a. **Agree.** This would help providers identify high-risk patients. Physicians should be provided with the tools they need to appropriately treat these high-risk patients—including education about alternative treatments, tapering, and referrals to a specialty provider. (This is endorsed elsewhere in the report.)

#### *Supply Reduction and Enforcement Strategies*

17. The Commission recommends community-based stakeholders utilize Take Back Day to inform the public about drug screening and treatment services. The Commission encourages more hospitals/clinics and retail pharmacies to become year-round authorized collectors and explore the use of drug deactivation bags.
  - a. **Agree, with reservations.** Take-back days are important, and they do provide opportunities to educate the public about treatment services, but it would be much better if local jurisdictions were provided funding that could be used to refer individuals into treatment services (e.g., through peer recovery specialists) year-round.
  - b. Baltimore City, for example, has 24/7 drop boxes at nine locations around the city. These are available every day of the year, not just on one designated day.
18. The Commission recommends that CMS remove pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids

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

- a. **Agree, but this does not go far enough.** Elimination of the pain survey question would remove a major structural incentive for overprescribing. CMS can consider going further by tying reimbursements to judicious prescribing of opioids and evidence-based treatments of opioid use disorders.
19. The Commission recommends CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.
- a. **Agree, but this does not go far enough.** Rate-setting policies should also be used to incentivize provision of the gold standard of care, which is medication-assisted treatment.
20. The Commission recommends a federal effort to strengthen data collection activities enabling real-time surveillance of the opioid crisis at the national, state, local, and tribal levels.
- a. **Agree, with reservations.** Surveillance data needs to be shared with the local jurisdictions responding to this epidemic on the frontlines.
21. The Commission recommends the Federal Government work with the states to develop and implement standardized rigorous drug testing procedures, forensic methods, and use of appropriate toxicology instrumentation in the investigation of drug-related deaths. We do not have sufficiently accurate and systematic data from medical examiners around the country to determine overdose deaths, both in their cause and the actual number of deaths.
- a. **Agree.**
22. The Commission recommends reinstating the Arrestee Drug Abuse Monitoring (ADAM) program and the Drug Abuse Warning Network (DAWN) to improve data collection and provide resources for other promising surveillance systems.
- a. **Agree.** These are important data collection mechanisms. The report is correct that the NSDUH alone is inadequate.
23. The Commission recommends the enhancement of federal sentencing penalties for the trafficking of Fentanyl and Fentanyl analogues.
- a. **No position.** While efforts to limit supply are important, it's not at all clear—based on the historical record—that increased penalties will limit distribution. And it's very important that we take a public health approach, rather than a criminal justice approach—from people who use drugs to low-level traffickers.
  - b. Law enforcement is important to stem the flow of illicit drugs, including the synthetic opioid Fentanyl. However, we must acknowledge the evidence that

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

- c. Addressing the supply of drugs is critical, but as long as there are millions with addiction who do not have access to treatment, their demand will continue to fuel supply.
24. The Commission recommends that federal law enforcement agencies expressly target Drug Trafficking Organizations and other individuals who produce and sell counterfeit pills, including through the internet.
  - a. **No position.** This should be happening already.
25. The Commission recommends that the Administration work with Congress to amend the law to give the DEA the authority to regulate the use of pill presses/tableting machines with requirements for the maintenance of records, inspections for verifying location and stated use, and security provisions.
  - a. **Agree.**
26. The Commission recommends U.S. Customs and Border Protection (CBP) and the U.S. Postal Inspection Service (USPIS) use additional technologies and drug detection canines to expand efforts to intercept Fentanyl (and other synthetic opioids) in envelopes and packages at international mail processing distribution centers.
  - a. **Agree.**
27. The Commission recommends Congress and the Federal Government use advanced electronic data on international shipments from high-risk areas to identify international suppliers and their U.S.-based distributors.
  - a. **Agree.**
28. The Commission recommends support of the Synthetics Trafficking and Overdose Prevention (STOP) Act and recommends the Federal Government work with the international community to implement the STOP Act in accordance with international laws and treaties.
  - a. **Agree.**
29. The Commission recommends a coordinated federal/DEA effort to prevent, monitor and detect the diversion of prescription opioids, including licit Fentanyl, for illicit distribution or use.
  - a. **Agree, with qualifications.** It is important to prevent diversion of opioid analgesics. For some opioids—and in particular buprenorphine—the risk can be overstated. (Diverted buprenorphine is often used merely to treat withdrawal.)

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

*Opioid Addiction Treatment, Overdose Reversal, and Recovery*

31. The Commission recommends HHS, CMS, Substance Abuse and Mental Health Services Administration, the VA, and other federal agencies incorporate quality measures that address addiction screenings and treatment referrals. There is a great need to ensure that health care providers are screening for SUDs and know how to appropriately counsel, or refer a patient. HHS should review the scientific evidence on the latest OUD and SUD treatment options and collaborate with the U.S. Preventive Services Task Force (USPSTF) on provider recommendations.
  - a. **Agree, but this does not go far enough.** Guidelines are a good way to increase the use of screenings and referrals. But we shouldn't need to review the scientific evidence on OUD treatment options; we know what works. These guidelines should also be tied to regulatory action and/or reimbursement to be maximally effective.
32. The Commission recommends the adoption of process, outcome, and prognostic measures of treatment services as presented by the National Outcome Measurement and the American Society of Addiction Medicine (ASAM). Addiction is a chronic relapsing disease of the brain which affects multiple aspects of a person's life. Providers, practitioners, and funders often face challenges in helping individuals achieve positive long-term outcomes without relapse.
  - a. **Agree.**
33. The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours.
  - a. **Agree, but this does not go far enough.** All insurance plans (public, marketplace, small group, large group) should be required to reimburse for all



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

34. The Commission recommends HHS review and modify rate-setting (including policies that indirectly impact reimbursement) to better cover the true costs of providing SUD treatment, including inpatient psychiatric facility rates and outpatient provider rates.
  - a. **Agree.**
35. Because the Department of Labor (DOL) regulates health care coverage provided by many large employers, the Commission recommends that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations.
  - a. **Agree, but this does not go far enough.** All insurance plans (public, marketplace, small group, large group) should be required to reimburse for all forms of MAT (even if not doing so doesn't constitute a parity violation). Prior authorization requirements and other non-reimbursement barriers should be eliminated.
36. The Commission recommends that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity. NQTLs include stringent prior authorization and medical necessity requirements. HHS, in consultation with DOL and Treasury, should review clinical guidelines and standards to support NQTL parity requirements. Private sector insurers, including employers, should review rate-setting strategies and revise rates when necessary to increase their network of addiction treatment professionals.
  - a. **Agree.**
37. The Commission recommends the National Institute on Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national, state, local, and tribal stakeholders use medication-assisted treatment (MAT) with pre-trial detainees and continuing treatment upon release.
  - a. **Agree, but this does not nearly far enough.** All forms of MAT must be made available in all jails and prisons at all times—not just before trial.
38. The Commission recommends DOJ broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with an SUD who violate probation terms with substance use should be diverted into drug court, rather than prison.

- a. **Agree, but this does not go far enough.** The recommendation needs to explicitly require that all drug courts offer MAT, the gold standard of opioid use disorder treatment; drug courts cannot be used to steer individuals into treatment that does not work. In addition, bolder action is required to ensure that drug courts are established beyond the federal district court system, which accounts for only a small fraction of the nation’s drug cases.
39. The Commission recommends the Federal Government partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas. Insurance companies, federal health systems, and state payers should expand programs for hospital and primary care-based SUD treatment and referral services. Recovery coach programs have been extraordinarily effective in states that have them to help direct patients in crisis to appropriate treatment. Addiction and recovery specialists can also work with patients through technology and telemedicine, to expand their reach to underserved areas.
  - a. **Agree, but this does not go far enough.** Recovery coach programs have indeed been extraordinarily effective—which is why local jurisdictions need additional funding to support them.
40. The Commission recommends the Health Resources and Services Administration (HRSA) prioritize addiction treatment knowledge across all health disciplines. Adequate resources are needed to recruit and increase the number of addiction-trained psychiatrists and other physicians, nurses, psychologists, social workers, physician assistants, and community health workers and facilitate deployment in needed regions and facilities.
  - a. **Agree.**
41. The Commission recommends that federal agencies revise regulations and reimbursement policies to allow for SUD treatment via telemedicine.
  - a. **Agree.**
42. The Commission recommends further use of the National Health Service Corp to supply needed health care workers to states and localities with higher than average opioid use and abuse.
  - a. **Yes, but with amendment.** The issue in many places is not number of healthcare workers—it is number of healthcare workers who can treat SUD. One solution is to have all healthcare workers be trained to treat SUD.
43. The Commission recommends the National Highway Traffic Safety Administration (NHTSA) review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of Fentanyl overdoses.

- a. **Agree, but this does not go far enough.** Local jurisdictions need more funding for naloxone, including for first responders.
44. The Commission recommends HHS implement naloxone co-prescribing pilot programs to confirm initial research and identify best practices. ONDCP should, in coordination with HHS, disseminate a summary of existing research on co-prescribing to stakeholders.
  - a. **Agree, but this does not go far enough.** We cannot delay actions while waiting on the results of further research. We already know that naloxone saves lives.
  - b. Also, it is not enough simply to recommend that naloxone be co-prescribed. It should be required for high-risk patients.
45. The Commission recommends HHS develop new guidance for Emergency Medical Treatment and Labor Act (EMTALA) compliance with regard to treating and stabilizing SUD patients and provide resources to incentivize hospitals to hire appropriate staff for their emergency rooms.
  - a. **Agree.** This would ensure that “stabilizing” OUD patients is understood as initiating MAT, where possible.
46. The Commission recommends that HHS implement guidelines and reimbursement policies for Recovery Support Services, including peer-to-peer programs, jobs and life skills training, supportive housing, and recovery housing.
  - a. **Agree.** Reimbursing for these services is absolutely essential for allowing states and local jurisdictions to make progress toward ending the opioid epidemic.
47. The Commission recommends that HHS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration on Children, Youth and Families (ACYF) should disseminate best practices for states regarding interventions and strategies to keep families together, when it can be done safely (e.g., using a relative for kinship care). These practices should include utilizing comprehensive family centered approaches and should ensure families have access to drug screening, substance use treatment, and parental support. Further, federal agencies should research promising models for pregnant and post-partum women with SUDs and their newborns, including screenings, treatment interventions, supportive housing, non-pharmacologic interventions for children born with neonatal abstinence syndrome, medication-assisted treatment (MAT) and other recovery supports.
  - a. **Agree, but this does not go far enough.** Recommendations and guidelines do not go far enough when there are effective incentive and regulatory mechanisms.
48. The Commission recommends ONDCP, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Department of Education (DOE) identify successful college recovery programs, including "sober housing" on college campuses, and provide support and technical assistance to increase the number and capacity of high-quality programs to help students in recovery.

- a. **Agree, but this does not go far enough.** There should be funding to support evidence-based programs.
49. The Commission recommends that ONDCP, federal partners, including DOL, large employers, employee assistance programs, and recovery support organizations develop best practices on SUDs and the workplace. Employers need information for addressing employee alcohol and drug use, ensure that employees are able to seek help for SUDs through employee assistance programs or other means, supporting health and wellness, including SUD recovery, for employees, and hiring those in recovery.
- a. **Agree, but this does not go far enough.** All employer-sponsored plans should treat SUD, as indicated in above recommendations.
50. The Commission recommends that ONDCP work with the DOJ, DOL, the National Alliance for Model State Drug Laws, the National Conference of State Legislatures, and other stakeholders to develop model state legislation/regulation for states to decouple felony convictions and eligibility for business/occupational licenses, where appropriate.
- a. **Agree, but this does not go far enough.** This should extend to pressuring (or requiring) that employers respond differently to employees who test positive for drugs. The response should be to offer help getting the employee treatment, not termination.
51. The Commission recommends that ONDCP, federal agencies, the National Alliance for Recovery Residents (NARR), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and housing stakeholders should work collaboratively to develop quality standards and best practices for recovery residences, including model state and local policies. These partners should identify barriers (such as zoning restrictions and discrimination against MAT patients) and develop strategies to address these issues.
- a. **Agree.**

#### Research and Development

52. The Commission recommends federal agencies, including HHS (National Institutes of Health, CDC, CMS, FDA, and the Substance Abuse and Mental Health Services Administration), DOJ, the Department of Defense (DOD), the VA, and ONDCP, should engage in a comprehensive review of existing research programs and establish goals for pain management and addiction research (both prevention and treatment).
- a. **Agree, with reservations.** We cannot let further research into treatment modalities delay funding for what we already know works.
53. The Commission recommends Congress and the Federal Government provide additional resources to the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) to fund the research areas cited above. NIDA should continue research in concert with the pharmaceutical industry to develop and test innovative medications for

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

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

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

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

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

- a. **Agree.**

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

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

### **C. Recommendations for Congress and the Federal Government**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **Conclusion**

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

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

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

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

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



EDITORIAL

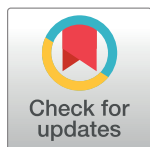
# Evaluating the impact of Affordable Care Act repeal on America's opioid epidemic

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The November 2016 United States elections resulted in a Republican sweep of the presidency and both chambers of Congress. Republicans' first major policy priority has been to "repeal and replace" the Obama administration's effort to reform healthcare, the Patient Protection and Affordable Care Act (ACA), signed into law in 2010. While the repeal process faltered in the Senate, suffering a major legislative defeat in late July 2017, its resurrection remains a possibility. To date, a key component of proposed legislation from both the House and Senate has been severe cuts to Medicaid, which currently provides the lion's share of health insurance for low-income Americans.

These legislative proposals have been introduced at a time when the U.S. is experiencing an epidemic of opioid addiction and overdose. In 2015, there were more than 2.6 million Americans with opioid use disorder (OUD) [1]. During the same year, more than 33,000 Americans died of overdoses involving one or more opioids, corresponding to an age-adjusted opioid-related death rate of 10.4 per 100,000 [2]—more than triple the rate in 2000 [3]. The U.S. now accounts for about a quarter of the world's drug-related deaths [4].

The tragedy of opioid overdose is compounded by the fact that evidence-based treatments have existed for more than 4 decades. The acute phase effects of opioid overdose can be blocked through the administration of naloxone, a U.S. Food and Drug Administration (FDA)-approved medication available at many pharmacies. In the chronic phase, persons with the disease of OUD can be successfully treated and enter long-term recovery through a combination of medication-assisted treatment (MAT) and psychosocial support. The FDA has approved three medications for MAT—methadone, buprenorphine, and naltrexone—all of which are currently available in generic form (with the exception of extended-release naltrexone). Notwithstanding rhetoric about "replacing one drug with another"—or more legitimate concerns about adverse effects like respiratory depression—evidence for the efficacy of MAT prescribed in combination with psychosocial support in the treatment of OUD is robust: it suppresses illicit drug use more effectively than placebo and other treatments that do not use MAT [5–6], and it reduces criminal behavior [7] and both all-cause and overdose mortality [8].

Despite this evidence, only 1 in 10 Americans with substance use disorders receive treatment [1]. Nearly one-third of all those who did not seek treatment cite cost or lack of insurance coverage as a reason [1]. The treatment gap represents a substantial inefficiency for American taxpayers given that treatment can pay for itself by averting the medical morbidity

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**Abbreviations:** ACA, the Patient Protection and Affordable Care Act; FDA, Food and Drug Administration; MAT, medication-assisted treatment; OUD, opioid use disorder.

and mortality—including HIV infection, overdoses, and hepatitis C—services utilization, and criminality associated with substance abuse [9]. According to the National Institutes of Health, every \$1 invested in addiction treatment saves society \$12 [10].

Medicaid cuts like the kind proposed in Congress [11–13] would make it significantly harder for those with OUD to access treatment. Nearly one-third of all those who receive substance use disorder treatment rely on Medicaid [1], and the program’s support for OUD treatment has grown rapidly in recent years, with growth concentrated in states that participated in the ACA’s expansion of Medicaid [14].

The importance of Medicaid in the treatment of OUD cannot be overstated for cities like Baltimore, where it provides coverage to one-third of all residents [15]. In Baltimore, Medicaid enrollees can purchase two doses of naloxone for \$1—a potentially lifesaving discount compared with the \$100–\$4,500 sticker price [16]. A 2015 blanket prescription for naloxone issued by the first author (LSW), empowered by legislation passed by the Maryland legislature, enabled every Baltimore resident to receive training and obtain naloxone at any pharmacy. Between 2015 and 2017, approximately 1,000 lives were saved in Baltimore by lay people administering naloxone [17]. Other major efforts to combat the opioid epidemic in Baltimore would be severely compromised if Medicaid were cut, including programs to expand access to MAT and to construct a behavioral health crisis center to stabilize patients and connect them with care.

Plans to repeal and replace the ACA have threatened access to OUD treatment in another way: they would weaken or even eliminate the requirement that marketplace plans cover “essential health benefits,” which currently require insurance companies to cover OUD treatment. This means that, in addition to the millions of Americans who would lose their health insurance coverage entirely, there would also be many more **insured** Americans whose insurance would no longer cover OUD treatment [18]. The plans would also have allowed states to waive the requirement to cover preexisting conditions, immediately pricing people with OUD out of the individual market.

One version of the Senate bill attempted to ameliorate the effects of the Medicaid cuts by including \$45 billion set aside for OUD treatment. This amount, however, would not adequately compensate for the reduction in future outlays associated with the loss of Medicaid and marketplace coverage: one estimate places the cost of treating OUD and its common comorbidities among Americans at or below 200% of the federal poverty line at \$183 billion over the next 10 years [19].

Based on our reading of the evidence, Medicaid cuts of the kind proposed in House and Senate bills would have devastating consequences for the millions of Americans suffering from OUD. Patients who lose health insurance coverage and the ability to pay for their treatment may go into withdrawal and see no other choice but to turn to illicit opioids—with overdose and death as the possible result.

The consequences of untreated addiction extend beyond individual patients. Pregnant women with OUD are at risk for giving birth to babies with neonatal abstinence syndrome [20–21]. Children who grow up in homes affected by substance abuse are much more likely to suffer from OUD themselves as adults [22]. Parental incarceration for OUD-associated criminal activity also has deleterious intergenerational health and economic consequences [23–24].

No matter what, the American people will bear the cost of this epidemic—either by paying for treatment now or by paying for the medical, economic, and social consequences of denying it later. The choice should be clear.

## Author Contributions

**Conceptualization:** Leana S. Wen, Evan B. Behrle, Alexander C. Tsai.

**Writing – original draft:** Leana S. Wen, Evan B. Behrle.

**Writing – review & editing:** Leana S. Wen, Evan B. Behrle, Alexander C. Tsai.

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**Bio: Leana S. Wen, M.D. M.Sc. FAAEM**

Dr. Leana Wen is the Commissioner of Health for the City of Baltimore. An emergency physician and patient and community advocate, she leads the Baltimore City Health Department (BCHD), the oldest, continuously-operating health department in the United States, formed in 1793. BCHD is an agency with a \$130 million annual budget and 1,000 employees committed to improving well-being and combatting disparities through education, policy/advocacy, and direct service delivery. BCHD's wide-ranging responsibilities include maternal and child health, youth wellness, school health, senior services, animal control, restaurant inspections, emergency preparedness, STI/HIV treatment, and acute and chronic disease prevention.

Facing an unprecedented number of people dying from opioid overdose, Dr. Wen issued a blanket prescription for the opioid antidote, naloxone, to all 620,000 residents of Baltimore. Since 2015, this program has saved nearly 1,500 lives. Under her direction, the Baltimore City Health Department leads the country in health innovations, including: B'More for Healthy Babies, a collective impact strategy resulting in a 38 percent reduction of infant mortality in just seven years; Vision for Baltimore, an initiative to provide glasses to every child who needs them; Safe Streets, a program to engage returning citizens and hospitals in treating gun violence as a contagious disease; and Healthy Baltimore 2020, a blueprint for health and well-being that enlists all sectors to achieve the ambitious goal of cutting disparities in half in ten years.

Before her appointment in January 2015, Dr. Wen was an attending physician and Director of Patient-Centered Care in the Department of Emergency Medicine at George Washington University. A professor of Emergency Medicine at the School of Medicine and of Health Policy at the School of Public Health, she co-directed its Residency Fellowship in Health Policy and co-lead a new national collaboration on health policy and social mission with Kaiser Permanente. The author of the critically-acclaimed book [\*When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests\*](#), Dr. Wen has given six TED and TEDMED talks on patient-centered care, public health leadership, and healthcare reform. Her TED talk on transparency in medicine has been viewed over 1.5 million times.

Dr. Wen received her medical training from Washington University School of Medicine in St. Louis and Brigham & Women's Hospital/Massachusetts General Hospital in Boston, where she was a Clinical Fellow at Harvard Medical School. A Rhodes Scholar, she studied public policy and economic history at the University of Oxford. She has served as a consultant with the World Health Organization, Brookings Institution, and China Medical Board; an advisor to the Patient-Centered Outcomes Research Institute and the Lown Institute; and as national president of the American Medical Student Association and American Academy of Emergency Medicine-Resident & Student Association. In 2005, she was appointed by the U.S. Secretary of Health & Human Services to serve on the Council on Graduate Medical Education, an advisory

commission to Congress. In 2010, she served as Chair of the Young Professionals Council, a global leadership network of medical, nursing, and public health professionals.

In addition to her extensive scholarship in public health and patient safety, Dr. Wen has conducted international health systems research in Rwanda, D.R. Congo, Nigeria, South Africa, China, Singapore, Slovenia, and Denmark. She has been published over 100 articles including in *The Lancet*, *JAMA* and *Health Affairs*. She is regularly featured on National Public Radio, CNN, *The New York Times*, *The Washington Post*, and *USA Today*.

A Fellow of the American Academy of Emergency Medicine and Academy of Medicine, Dr. Wen is an associate faculty member at George Washington University and Johns Hopkins University. In 2016, Dr. Wen was named by *Modern Healthcare* to be one of the country's 50 Most Influential Physician Executives and Leaders. She was also honored to be the recipient of the American Public Health Association's highest award for local public health work, the Milton and Ruth Roemer Award.