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COMBATING THE OPIOID EPIDEMIC

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C O N T E N T S

COMBATING THE OPIOID EPIDEMIC

Wednesday, February 26, 2025

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 3:30 p.m., Room 106, Dirksen Senate Office Building, Hon. Rick Scott, Chairman of the Committee, presiding.

Present: Senator Scott, McCormick, Justice, Tuberville, Moody, Gillibrand, Warren, Kim, and Alsobrooks.

OPENING STATEMENT OF SENATOR RICK SCOTT, CHAIRMAN

The CHAIRMAN. The U.S. Senate Special Committee in Aging will now come to order. Over the last decade, we have lost hundreds of thousands of Americans lives to drug overdoses. It's happening in every community across every state. None of us have been spared from the carnage left by this crisis, and we've all heard the heartbreaking stories of families who have lost children, parents and siblings to fentanyl and other opioids.

Fighting the opioid crisis has been an incredible challenge. The precursors of these drugs come from Communist China and are bought by the evil drug cartels to make deadly opioids like fentanyl. These cartels then traffic these drugs over the border and into our communities where they poison and kill tens of thousands of Americans every year.

Thanks for the hard work of our Governors, our state attorney generals, law enforcement advocates, our sheriff's departments, police departments, from 2022 to 2023, we saw a drop in overdose deaths from people aged 15 to 54. Now, that's good news, but it shows we have more work to do.

While overdose deaths in the U.S. dropped for people between the ages of 15 and 54, we saw deaths increase from 22 to 23 for Americans who are age 55 and older, after seeing increase in the 65 and older age group in 2022. In 2023, more than 29,000 Americans aged 55 and older died from an opioid overdose. That's 80 seniors dying from opioid overdoses every single day. Think about it this way. In the two-hours we'll spend together in this hearing today, six people aged 55 and older will die. Every overdose is preventable.

Every single one of those nearly 30,000 lives of older Americans lost could have been saved. While we've all heard the heart wrenching stories of the children and young people lost to the opioid crisis, the stories that have been largely untold are those

about the devastating impact that this crisis is having on American seniors. That includes not only the horrible deaths I just talked about, but also the toll of being a caretaker when parents are impacted by these drugs. I know that we'll hear firsthand today about that from Ms. Mateer.

I believe the Aging Committee must take this issue on, and that's why we're having this hearing today. This isn't a partisan issue, it's an American issue, and Congress must act now. Last year, I was proud to have my bipartisan FEND Off Fentanyl Act signed of the law, which fellow agent committee member Mark Kelly co-sponsored.

The END FENTANYL Act was a bipartisan success because it exposed just how behind parts of the Federal Government were when it came to fighting the opioid epidemic and stopping the deadly fentanyl that is killing thousands of fellow Americans. In 2019, a study from the government accounting office found that drug interdiction guidance of the U.S. custom and border patrol protection not been updated in 20 years. That's clearly unacceptable.

Now that the END FENTANYL Act is law, CBP is required to update its policies at least once every three years to ensure operational fuel manuals, including their drug interdiction guidance are up to date. These are the kind of common-sense policies we need to get done here in Washington. Seeing the END FENTANYL Act become law makes me even more optimistic that we can get things done, and I have more ideas with bipartisan support to combat the opioid crisis.

Last week, I reintroduced my OPIOIDS Act with Senator Welch of Vermont. This bipartisan bill is one step we can take to fight this epidemic here and now. It would provide better insight into overdose deaths nationwide. Local law enforcement agencies are on the front lines of this crisis, and this would provide additional grants to support law enforcement and communities with high rates of overdose.

It would make Federal agencies collaborate on this problem, and my OPIOIDS Act would stop the bad practice of stealing money from the National Drug Control Strategy and Budget, and this would provide additional grants to support law enforcement and communities with high rates of overdoses. It would make Federal agencies collaborate on this problem.

Again, I'm also proud to lead a bipartisan awareness resolution each year for the lifesaving drug naloxone. As our witnesses know all too well, naloxone literally stops overdosing its tracks. That's why each June 6th, we do a National naloxone Awareness Day Resolution to raise awareness and educate people on lifesaving drug capabilities is something so simple to carry.

In addition to those, I also have several other pieces of legislation on this issue, including National Fentanyl Awareness Week Resolution, Overdose RADAR Act, for better health data on overdoses, and SOCIAL MEDIA Act to combat illicit online sales of drugs. This is by no means all we can do, but it has to start somewhere. Like I said earlier, I'm optimistic. I know it may seem like there's not a clear path forward, but if we keep fighting each and every single day, I know we can make a change.

I look forward to hearing your testimony and working with my colleagues on the next step to fight this issue. I now want to recognize Ranking Member Kirsten Gillibrand for her opening statement.

OPENING STATEMENT OF SENATOR KIRSTEN E. GILLIBRAND, RANKING MEMBER

Senator GILLIBRAND. Thank you, Chairman Scott, and thank you for calling on today's hearing. There is no community in this country that has escaped the impact of the opioid crisis. Substance use disorders are growing at an alarming rate in the United States. Broadly, 48.5 million people aged 12 or older had substance use disorder in the past year. While older adults tend to use substances at lower rates than other age groups, 4.6 million people aged 65 or older have or had a substance use disorder.

In the past year, fatal drug overdoses decreased nationally, and while the numbers vary significantly between states, we have the tools to continue reducing overdose deaths to reverse the trend in states where this isn't the case. We know that expanding the availability and affordability of treatments and harm reduction policies like universal access to naloxone are strategies that work. We need to make a multifaceted approach that includes a law enforcement and criminal justice element that places a larger emphasis on public health and social policies.

We can't fully address the opioid crisis if we are not also addressing prevention and access to affordable treatment. It's why protecting Medicaid is so critical. Medicaid is the primary care for substance use disorder treatment, and any cuts to the Medicaid program would devastate our ability to solve this crisis.

Another critical piece of the puzzle is the impact of drug use on the whole family. More than 2.5 million children are currently being raised by grandparents, or relatives, or a close family friend. Over time, more grandparents are forced to become family caregivers because of the opioid crisis. I co-lead the bipartisan Supporting Families Through Addiction Act, which would provide support to the families of people receiving treatment for a substance use disorder.

Congress must do a better job of tackling this crisis holistically. I hope to work with my colleagues in the future to develop policies that take every aspect of this crisis into account from providing necessary public safety tools to making sure those with substance use disorders have access to affordable evidence-based treatments.

I look forward to today's hearing, and I look forward to hearing from our witnesses who can speak to the opioid ecosystem and how we can truly combat the opioid crisis. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member Gillibrand. I'd like to welcome our witnesses here today. Before I introduce our first witness, I'd like to ask each of you to be mindful of our limited time together and keep opening statements to five minutes.

First, I would like to welcome Seminole County Sheriff, Dennis Lemma. Sheriff Lemma serves as the delegate chair on Florida's statewide Council on Opioid Abatement created to enhance the development and coordination of state and local efforts to abate the

opioid epidemic, and to support the victims and families of this crisis.

Sheriff has also served as a member of the Victoria's Voice Foundation. Victoria's Voice Foundation does amazing life-saving work to help prevent overdoses by raising awareness of naloxone, a revolutionary drug to stop an opioid overdose in its tracks, as well as educating students, parents, educators, and communities about the dangers of illicit drugs.

I've actually worked with Victoria's Foundation, now for two years, to introduce the National Naloxone Awareness Day Resolution, and was happy to see it pass to raise awareness of this important opioid tool to combat the epidemic.

I've also been honored to work with Victoria's Voice to help get naloxone into more schools and help them partner with school districts so these parents can come in and talk directly to students about the dangers of fentanyl, and the pain and losses the drug causes.

I've also had the pleasure working with the Sheriff for years on these important issues. Thank you for being here, Sheriff Lemma.

STATEMENT OF THE HONORABLE DENNIS LEMMA, SHERIFF, SEMINOLE COUNTY SHERIFF'S OFFICE, SANFORD, FLORIDA

Mr. LEMMA. Well, good afternoon, Chairman Scott, Ranking Member Gillibrand, and distinguished members of this special Committee. Thank you for the opportunity to testify on the devastating crisis of overdoses and fentanyl poisonings in our country. It is an honor to present a proven strategy from the State of Florida, one that can be replicated nationwide.

Chairman Scott, your leadership, starting with your time as Florida's Governor, when you and Attorney General Bondi took action to shut down pill mills served as a model for the country. Senator Gillibrand, your efforts through the legislative effort like FEND Off Fentanyl Act have been crucial in this fight.

I'd also like to recognize Senator Ashley Moody, who as Florida's attorney general, provided invaluable leadership in the fight against this epidemic. Her vision and dedication inspired my own focus on this issue, which requires both law enforcement and clinical understanding.

I serve as the elected Sheriff of Seminole County, Florida, located in the Orlando metropolitan area. Seminole County is the fourth most densely populated county in the state. Despite its affluence, we are not immune to the devastating effects of this crisis. Simply stated, this epidemic does not discriminate. It affects citizens from all backgrounds, and demands comprehensive solutions.

In my nearly 33 years of law enforcement, I've come to believe that the greatest responsibility of any civilized society is to protect and preserve human life. Overdose death has tragically become a leading cause of death for individual aged 18 to 45. In 2022, the average life expectancy of a U.S. citizen decreased partially due to the rise in overdose deaths.

To effectively combat this crisis, we need a holistic approach that includes prevention, treatment, advocacy for lifesaving interventions, and a strong emphasis on law enforcement strategy that ag-

gressively goes after the drug dealers who are dealing deadly doses of narcotics in our communities.

Prevention remains a critical tool in the process. Through focused education and awareness, we can equip individuals with the knowledge to avoid addiction before it ever starts. Prevention also requires ensuring the highest level of access to opioid antagonists like, Narcan, a lifesaving medication that can immediately reverse the effects of an opioid overdose. In Florida, we've made great strides in expanding access to these antagonists, and they have saved countless lives.

Treatment is equally important in breaking the cycle of addiction. Medication-assisted therapy combined with cognitive behavioral therapy has proven to be effective in helping individuals recover from substance use disorder in both clinical and correctional settings.

Data collection also plays a critical role in combating this epidemic. We need to gather and analyze overdose data at all levels. By understanding overdose trends, we can better allocate resources and target enforcement efforts.

However, accountability for drug dealers is absolutely crucial if we're going to put an end to this epidemic. We must ensure that those who distribute fentanyl and other illicit substances like the emerging trend of street-level xylazine are held fully responsible for their actions, whether there's an associated death or not.

Too often overdoses are treated as accidents when in reality they are crimes. In Florida, we've passed legislation with harsher penalties for those drug dealers whose actions result in fatal overdoses, while at the same time we've created criminal laws to hold drug dealers accountable for the individual overdoses that we bring people back to life with an antagonist.

Drug dealers cannot be let off easily, and the law must hold these individuals accountable to the fullest extent. Additionally, we cannot ignore the illicit drug trade, particularly from cartels like the Sinaloa and Jalisco New Generation, which still pose a threat to our country. Securing the border and preventing fentanyl from entering our country is critical to minimizing its availability and reducing deaths. This crisis must unite us all regardless of partisan lines, because it impacts every community across the country.

In conclusion, we must adopt a holistic strategy that includes prevention, treatment, improved data collection, and the strictest accountability for drug dealers. This strategy works, builds safer communities, and ultimately, saves lives. Utilizing this strategy in Seminole County, we've achieved a 29 percent reduction in overdoses and a 42 percent reduction in fatalities in 2024 alone. While we have seen this reduction, we know that the hard work still lies ahead.

Thank you for having me here today and I look forward to addressing your questions.

The CHAIRMAN. Thank you, Sheriff. Now I'd like to recognize Senator Jim Justice to introduce our next witness.

Senator JUSTICE. Well, first of all, let me just say this, Greg Duckworth, you're an incredible man, and you've done incredible work, and it's a real honor for me to be able to introduce you, but I've got to say just this, I said this earlier today, but can you just

imagine West Virginia, how hard West Virginia was hit? It was unbelievable, unimaginable in every way. We had to have people that really stepped up, people that were superstars. This man's a superstar. He's 27 years, I think, a veteran of the state police, and absolutely a superstar in every way.

With all that being said, let me just tell you this story very quickly. You know, baby dog and I go through a lot of drive through windows, and maybe we shouldn't go through that many, but just the other day we're going through the drive through window at Arby's, and I looked up and the car right in front of me had Amber and had a cross, and it had 1993, 2023.

Well, we made it to the window to pay for our food, and the car had left, and they paid for our food. Now, we tried to run them down. We finally, through a lot of different ways through the state police found them. Amber had played basketball for me as a coach, so many situations to where all of a sudden, a drug takes a life. It's happening all over the place.

Greg, I mean this with all in me. It's an honor to introduce you. You've done great work with our foundation in West Virginia. You have absolutely been just what I've just said. You've been a superstar, because you care, and I am really proud to introduce you.

Thank you so much, Mr. Chairman.

STATEMENT OF THE HONORABLE GREGORY DUCKWORTH, COMMISSIONER, RALEIGH COUNTY, BECKLEY, WEST VIRGINIA

Mr. DUCKWORTH. Thank you very much. Chairman Scott, Ranking Member Gillibrand, and my fellow West Virginian, Senator Justice, and other members of the Committee, thanks so much for having me here today. It's truly an honor.

I spent my law enforcement career in the heart of the opioid epidemic in an area once known as the coal fields. Today, I want to share some firsthand experiences on how this crisis has devastated families affected our aging population, and where we must focus our efforts moving forward.

In 2012, 17-year-old Cheyenne Martin reported to the police that her father and two younger siblings were missing. She had already lost her mother, Kerry Hendricks, who under the influence of OxyContin, had wandered onto the highway and was fatally struck by a truck. During the missing person investigation, police found that her father Hendrix, was lured into a trap by an OxyContin dealer named, Belknap, who owed him money.

Hendrix, his girlfriend, and the two youngest children, ages six and four were ambushed and murdered, and their bodies were discarded as if they were worthless. A decade later, Cheyenne herself died of an opioid overdose leaving behind three small children.

Entire families are being erased by addiction. This is not just a crisis of individuals, it's a crisis of generations. Children lose parents, and grandparents are forced back into parenting, and communities crumble.

The second story involves a single mother in her early 30's with four children: a nine-year-old, a seven-year-old, and three-year-old twins. For years, she lived with her mother who helped care for the children. Recently, she had moved into her own place a single-wide trailer within walking distance of her mother's home. At night after

dinner, she would take the three-year-old twins home while leaving the older children with their grandmother who would ensure that they got to school the next morning. The twins were described as full of life, radiating joy, as most three-year-olds do.

One night the mother put the twins to bed, and by the time she checked back on them again, they were deceased. Autopsies revealed multiple drugs in their systems, including lethal amounts and fentanyl. The neglect was so severe that rigor mortis had already set in before she even realized what had happened.

The children's grandmother had already lost her husband to cancer, and she's fighting for custody of the remaining children, but has been unsuccessful. She is, however, allowed to see them with the help of the Child Protective Services. The mother is currently in jail awaiting trial on two counts of child neglect, resulting in death.

The burden on our seniors in West Virginia. one in seven children lose their parents to overdose or incarceration by the age of 18 with the highest rate of neonatal abstinence syndrome, many of these children have medical and developmental challenges. Grandparents who thought they were retiring are now primary caregivers. They face physical strain raising young children at advanced age.

Financial hardship. Many live on fixed incomes and struggle to meet basic needs, emotional toll raising children while still grieving the loss of their own, and many of these are off the record to avoid the foster care system, so they don't receive financial or legal support either.

The West Virginia First Foundation is supporting grand families and the aging population, and I'm proud to serve on the board of the West Virginia First Foundation and to be part of this organization that is making a real difference in our communities. The Foundation is committed to addressing the full impact of the opioid epidemic, including the burdens placed on West Virginia's aging population, recognizing that addiction does not just affect the individual, but entire families.

The Foundation is dedicated to supporting grand families, the grandparents raising grandchildren, by providing resources and assistance to child advocacy and youth prevention programs. We recognize that the crisis did not end with one generation. It continues to ripple outwards, and by investing in solutions that support full family systems the foundation is helping to break the cycle of addiction, and ensuring the grandparents raising grandchildren are not left to struggle alone.

Where we must focus. Having served on the front lines of the epidemic, I believe that our response must be comprehensive, treatment, access prevention and education, recovery support grand families and child advocacy, and of course, economic recovery. We also must fix some of the systemic failures as well. The under-reported overdose deaths, the inconsistent Narcan use documentation and recovery home is misclassifying overdoses.

In closing, I believe we have to restore hope, and substance use disorder is our enemy. It's destroying the very core of the American way; God, family, and self. To win the war, we must ensure the love of the church, reunite families, and emphasize the importance

of family values, and bring back support systems that give people a sense of worth.

The crisis is more than just statistics. These are real people with names, faces, and stories. If there's one thing I wanted you to take away from today, is that behind every number, there's a human being. Thank you.

The CHAIRMAN. Thank you, Commissioner. Thank you, Senator Justice. Next, I'd like to recognize Ranking Member Gillibrand to introduce the next witness.

Senator GILLIBRAND. Thank you, Chairman Scott. I want to introduce our next witness, Ms. Elizabeth Mateer. Ms. Mateer is a grandparent who has been raising her grandson for more than a decade due to his parents' opioid use disorder. Ms. Mateer, thank you so much for sharing your story with us here today. You may begin.

STATEMENT OF ELIZABETH MATEER, GRANDPARENT CAREGIVER, PITTSBURGH, PENNSYLVANIA

Ms. MATEER. Chairman Scott, Ranking Member Gillibrand, and members of the Senate Aging Committee, thank you for holding this important hearing and for inviting me to share my perspective. My name is Elizabeth Mateer, I am a grandmother raising my grandson due to the impact of opioids. I also volunteer as a Generations United GRAND Voices caregiver advocate.

When my grandson was born, I had no idea that my life would change forever. I did not know the baby was suffering with neonatal abstinence syndrome. I also had no knowledge about opioid use disorder. At first, I did not identify and understand the harsh reality that both parents were addicted to painkillers. When we learned of the mom's opioid use, my husband and I intervened, and arranged for her to be admitted to a treatment facility. Suddenly, we had a baby. Although we were very relieved and hopeful for the future, we had no crib, no diapers, no baby clothing, no formula, and no idea where to start.

Ten days later, I would receive a phone call that mom was leaving treatment. We would not hand our infant grandson back to parents who were using. Fear drove us to find an attorney who obtained emergency custody, but a few weeks later, the parents cheated a drug test, and we were ordered to return the baby. Why do judges misunderstand opioid addiction and the risk in placing children with parents who are inactive addiction?

The cycle of staging interventions and arranging for admissions to treatment continued early on. One interventionist told me to be prepared to keep my grandson long-term because this would go on for a long time. Each relapse was a crushing blow, and each time the recommended length of inpatient treatment increased. The staggering cost for some treatment facilities included $30,000 deposits for admission, and $10,000 a month. I constantly battled with the insurance company.

Opioid addiction is like none other. It takes a person's soul and turns them into someone you don't even recognize. We were desperate to save both mom and baby. The stress of living in this opioid-created crisis landed me in the hospital with pneumonia in both lungs. While we were trying to help our grandson's mom get

treatment, we were fighting a custody battle with the father who was still in the throes of opioid addiction.

Our legal fees exceeded $85,000. The court was permitting supervised visits that were actually not being supervised. We worried every time we went to court. The court halted visitation privileges when we learned that the father had been charged with child endangerment of another child under his supervision. Six months later, he died of a heroin overdose. When I told my then four-and-a-half-year-old grandson that his father died, the first question he asked was, ″Will I still be able to live with you?″

I found that working and caring for a child was harder than when I raised my own children. I had to leave my job. My relationship slowly disappeared. Friends stopped inviting me to social events since I didn't have childcare. I felt isolated as my husband traveled for work. The stigma of addiction that the child I raised could not raise their child made me feel ashamed. No one knocks on your door with lasagna in hand to comfort a family in this kind of crisis. My clergy never called. Depression set in, and I wondered, ″How would I go on?″

By the grace of God, our grandson's mother has been clean for a long time. Our relationship is challenging because her son, now 13, wishes to remain in our home. During the years of battling her addiction, he just grew up. This is his community, his home where his pets live, where his school is, where his friends are.

My husband delayed retirement so we could provide for our grandson, and it is nothing like we envisioned driving the middle school carpool and hosting the baseball team picnic. We hope to stay healthy so we can be there for our grandson.

The staggering number of grandparents who care for their grandchildren, often without any support, is one of the least recognized populations impacted in the opioid crisis. Grandparents and other relatives who step forward to keep children out of foster care and safely with family save taxpayers more than four billion a year. The child welfare system would collapse if grandparents did not take in these children.

Any grandparent raising a grandchild could use financial help. I urge you to consider these recommendations. Encourage states to distribute opioid settlement money to help children and caregivers promote peer support. Being part of Generation United's GRAND Voices network has been a godsend to me.

I was once told that opioid addiction in a family is like pouring acid on it. Expand the number of mental health providers with expertise in grandfamilies. When we enrolled in Medicare, our grandson lost his health insurance. Expand healthcare coverage options so grandparent caregivers on Medicare have coverage for the children they are raising. Allow grandchildren who are in the legal guardianship of their grandparent to qualify for Social Security survivor benefits if the grandparent dies.

SNAP can be a lifesaver. I urge you to protect this program. Continuing support for kinship navigator programs that provide information about community-based services. I cannot imagine what my grandson's life would've been like in foster care with strangers. Grandparents are committed to protecting the children under their care, but we need help.

Thank you.

Senator GILLIBRAND. Thank you, Ms. Mateer. Our next witness is Dr. Malik Burnett. Dr. Burnett is an addiction medicine provider and the medical director of several community opioid treatment programs in Baltimore, Maryland. Dr. Burnett also serves as the vice-chair of the Public Policy Committee for the American Society of Addiction Medicine, and oversaw naloxone distribution for the State of Maryland.

Thank you for being here, Dr. Burnett. You may begin your testimony.

STATEMENT OF DR. MALIK BURNETT, MD, MBA, MPH, VICE CHAIR, PUBLIC POLICY COMMITTEE AMERICAN SOCIETY OF ADDICTION MEDICINE, BALTIMORE, MARYLAND

Dr. BURNETT. Chairman Scott, Ranking Member Gillibrand, esteemed members of the Senate Committee on Aging. I thank you for inviting me to participate in this critically important hearing. My name is Dr. Malik Burnett. I'm a board-certified addiction specialist physician who takes care of patients with addiction and co-occurring conditions in Baltimore, Maryland.

Today, I'm testifying in my capacity as vice-chair of the Public Policy Committee for the American Society of Addiction Medicine, known as ASAM. ASAM is a national society representing over 8,000 physicians and other clinicians who specialize in the treatment and prevention of addiction.

I want to begin today by talking about Baltimore and its forgotten generation; older adults born between 1951 and 1970, particularly older Black men. In my city, one in three drug overdoses come from this demographic. Illicitly manufactured synthetic opioids are among the deadliest health threats that they face. Many of these men struggle with addiction or have struggled with addiction for years, but today, there's no margin for error. A single relapse can leave them at the mercy of a lethal dose of fentanyl or other synthetic drugs.

While addiction is a treatable chronic medical disease, it is also one of the most complex in medicine. It involves interactions among brain circuits, genetics, the environment, and an individual's life experiences. As a result, solutions to our Nation's addiction and overdose crisis can be equally complex and interconnected.

Supply side approaches are important to public safety, but yield little net benefit. If demand-side interventions remain inaccessible, underfunded, and undermined, drug cartels can quickly replace confiscated synthetic drugs with little effort and overhead, ensuring unbroken access to dangerous drugs for fueling this overdose crisis.

The good news, evidence-based addiction treatment works and reduces the risk of overdose death by 80 percent. As a physician, I've personally witnessed hundreds of patients' lives transformed by addiction treatment. People in treatment restore their marriages, rejoin the workforce, leave criminal activity, improve their mental and physical well-being, reunite with their children, and yes, escape the grasp of drug cartels.

We are fortunate to live during a time when effective evidence-based treatment exists for opiate use disorder, yet tens of thou-

sands of people in the U.S. continue to just die from illicit opioids annually. How is this possible? Unfortunately, the people who need these treatments the most are not getting the life-saving care that they need when they need it. In fact, it's this treatment gap that's barely budged for the last decade. We will not end the opioid epidemic until evidence-based addiction treatment is easier to get than illicit opioids.

For many Americans, especially in rural areas, evidence-based addiction treatment is impossible to find Ease of treatment access is critically important because people with addiction often experience a brief window of time between desiring treatment and experiencing painful withdrawal symptoms.

Symptoms that cheap Fentanyl, which is easier to get than addiction medications temporarily stop in an instant, but easier access to addiction treatment cannot happen without a substantially larger addiction treatment workforce, including more addiction specialists, physicians increasing Federal funding for addiction medicine and addiction, psychiatry fellowships and financial incentives to encourage more physicians to enter. These training programs are solely needed to ensure every community has high quality addiction treatment.

In addition, federal law must be amended to allow these addiction specialists to prescribe methadone for opiate use disorder that can be dispensed from community pharmacies. Today, only about 2,000 opioid treatment programs dispense methadone for opiate use disorder. They're lacking in about 80 percent of U.S. counties. Methadone for opiate use disorder has been caught in bureaucratic red tape for nearly 50 years. Allowing states to regulate their methadone treatment without undue Federal restriction could lead to the type of innovation needed in opioid treatment in America.

Yet, continuing individuals or connecting individuals to treatment is not enough. They must also be able to afford their care. Medicaid and Medicare are major insurers for people with opioid addiction, making it essential that these fiscal mechanisms facilitate rather than hinder access. Many clinicians in opioid treatment programs do not accept Medicaid, largely reflecting the program's administrative burdens and low reimbursement rates. Congress should remove these burdens, increase Medicaid rates to change this equation.

Medicare and Medicaid must also cover the full continuum of addiction care. Surprisingly, Medicare does not cover non-hospital-based residential addiction treatment. This must change furthermore, assurance of equal reimbursement for mental health and addiction care must be strengthened by levying civil penalties for parity violations and incentivizing state regulators to be more robust in their enforcement.

Stigma toward addiction is arguably the most difficult barrier to address as it's so entrenched in society. Even when people recognize that they have a problem with drugs or alcohol, they're often too embarrassed or too scared to talk to their physician about it. The Federal Government should stop wasting money on incarcerating people for nonviolent drug offenses, and must continue to emphasize that addiction is not a disease, but a moral addiction is a disease and not a moral failing.

People already in the criminal legal system also need better access to addiction treatment. Congress should eliminate Medicaid's inmate exclusion requirements, and federal funding for prisons and jails should be contingent upon providing evidence-based addiction treatment to ensure that taxpayer money is not wasted on a revolving door of incarceration.

In closing, thank you for the opportunity to share my perspective and expertise today. One thing is clear about America's opioid ecosystem: whether it's funding, and training, more addiction specialists, ensuring access to prescription methadone, closing Medicare coverage gaps, avoiding harmful cuts to Medicaid, or enforcing equal access to addiction treatment in all healthcare settings. Congress owns this. Let's work together to save lives.

Thank you, and I look forward to answering your questions.

The CHAIRMAN. Thank you, Dr. Burnett. Ms. Mateer, I've got a 13-year-old grandson. I can't imagine trying to stay up with him as a parent, as my daughter and my son-in-law have to do so, but thank God, he's got you in his life.

I'd like to introduce Dr. Bradley Stein. Dr. Stein is the director of the RAND-USC Schaeffer Opioid Policy Center, and a senior physician policy researcher at the RAND Corporation. Dr. Stein has worked extensively, examining the effect of state policies and community outcomes related to the opioid crisis.

Thank you for being here.

STATEMENT OF BRADLEY D. STEIN, DIRECTOR, OPIOID POLICY, TOOLS, AND INFORMATION CENTER, RAND CORPORATION, PITTSBURGH, PENNSYLVANIA

Dr. STEIN. Thank you. Good afternoon, Chairman Scott, Ranking Member Gillibrand, and distinguished members of the Committee. Thank you for inviting me to share insights on combating the opioid crisis, which is increasingly impacting older Americans. As the chairman said, I'm a senior physician policy researcher at RAND, a direct and NIH-funded research center devoted to better understanding the effectiveness of opioid related policies. I'm also a practicing child psychiatrist in Western Pennsylvania, where I see firsthand how opioid addiction devastates families across generations.

The toll of the crisis extends far beyond fatal overdoses. It affects millions of Americans, not just older adults fighting to maintain their own recovery, but also those spending their life savings to pay for adult children's addiction treatment or raising their children's children. Today, I will focus on three topics, particularly relevant to this Committee. What escalating rates of opioid use disorder among older adults imply for healthcare. How upstream strategies of better chronic pain management can help prevent opioid misuse, and the social toll of grandparents raising grandchildren due to parental addiction.

Opioid use disorder rates have tripled among Medicare beneficiaries over the last decade. The rapid increase poses significant challenges to our healthcare system, which is not adequately prepared to address the unique needs of this population, who often have conditions that can complicate diagnosing and treating opioid use disorders like dementia or chronic pain.

Primary care providers, the clinicians at the heart of treating our older adults often lack training or confidence in managing opioid use disorder. Meanwhile, few addiction specialists are equipped to handle the complex medical needs of older patients with conditions like dementia. This mismatch leaves many older adults with opioid disorders without adequate care, especially in rural areas experiencing acute clinician shortages.

The American population is aging, but currently most clinicians treating chronic disorders in older adults don't have expertise in substance use disorders, and substance abuse experts treating older adults who have addiction usually have little experience in treating chronic disorders in the elderly.

Only with concentrated efforts in federal investments will the clinical workforce caring for the elderly be prepared to efficiently and effectively treat individuals with opioid use disorder, and disorders like dementia, and chronic pain is even more common than dementia, affecting 36 percent of those over age 65. Efforts to reduce opioid prescribing have curbed misuse, but many individuals with chronic pain don't receive non-opioid treatments, leaving many with without adequate pain management options.

Some clinicians now avoid prescribing opioids altogether, even when they're clinically appropriate, leaving patients to suffer, or turn to elicit opioids for relief. In some situations, expanding access to non-opioid pain management is essential to address this gap and can help prevent new opioid use disorder cases.

Acupuncture, rehabilitative exercise, therapeutic massage can all reduce reliance on opioids and improve quality of life for individuals with chronic pain. However, insurance coverage is often inconsistent or limited in scope, and high out-of-pocket costs often make these non-medication therapies less affordable than opioids, and provider shortages can make this care very hard to find.

Congress can help by considering incorporating non-opioid therapies for chronic pain in value-based insurance designs to enhance affordability and ensure that these services are fully covered by Medicare. It can also possibly consider expanding existing loan forgiveness programs such as rural health grants or the National Health Services Corps to include providers trained in these non-medication therapies to ensure we have an adequate workforce in the future.

Finally, as we've heard, the opioid crisis has far reached social consequences for older Americans beyond their own health needs. An estimated 2.6 million grandparents are raising grandchildren, often becoming informal caregivers when parents struggle with addiction or succumb to overdose. Doing so often entails significant emotional and financial burdens as grandparents working to keep their family together delay retirement or take on new expenses like housing or childcare. These older adults deserve better support.

Better support systems; expanded access to respite care, and kinship navigator programs, and information to help them raise children affected by parental substance use and trauma. Yet, informal caregivers commonly outside the child welfare system often don't receive such support despite the vital role these individuals play in providing stability for so many children.

Congress can help support these families by expanding access to respite care and affordable childcare through programs like Head Start or alongside the Child Abuse Prevention and Treatment Act, CAPTA, reauthorization. It can seek to ensure grandparent caregivers have access to benefits such as health insurance for the children and kinship navigator programs, whether they participate in the formal child welfare system or not.

It's important that we support the development of educational resources tailored specifically for grandparents stepping up to raise children affected by parental substance use disorders. Supporting grandparent caregivers not only strengthens families, but also reduces long-term social costs associated with parental addiction.

There's no single solution to the opioid crisis, but healthcare reforms, improving non-opioid, chronic pain management, and better supporting families affected by addiction, like so many of the patients I treat, will help keep families together, and ensure that our healthcare system is better prepared to meet the diverse needs of older Americans.

Thank you again for this opportunity and I look forward to your questions.

The CHAIRMAN. Thank you, Dr. Stein. Thanks for all of you for being here. Now we'll start going to some questions. First, we'll start with Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chairman. Dr. Stein, I spent 40 years coaching, and all those 40 years, I saw the correlation between family and some kind of addiction. There's direct correlation, and if we don't figure out something to do with family in this country and get back to mom and dad, and discipline, and responsibility, we're going to have a tough time and continue to have a tough time.

Also, I saw over the years, I'd bring young men into my football teams, and of course, with their mom and dad, you know, for four years, and we'd bring doctors in, and for first part of my career, you know, we had a few that was on insulin for sugar diabetes or something, but my last 10 years, there was very few that was not on Adderall or Ritalin for attention deficit. Kids are overprescribed by doctors for some reason. Do you see a direct correlation between over-the-counter drugs or prescription drugs that lead to addiction?

Dr. STEIN. Thank you for your question, Senator. You know, this is a question that scientists have been looking at, and so far, the data really suggests that there isn't a direct relationship between children receiving some of these medications and later addiction.

I also think it's important to recognize that we also do recognize that there is a relationship between mental health disorders in children generally, or in adults in substance use disorders, and so, I think it's important that recognizing that there is this relationship, and individuals may have both mental health disorders and substance use disorders.

I do think it's very important to make sure that not only while we're here focused on opioid use disorders and substance use disorders to try to address the opioid crisis or substance use disorder crisis more generally without recognizing how many of those individuals suffer from mental health problems. Really makes us sug-

gest we're trying to fight that battle with one hand tied behind our back.

Senator TUBERVILLE. Do you think we need to roll back the prescription of childhood drugs, of what I was just talking about a few minutes earlier?

Dr. STEIN. Sir, I——

Senator TUBERVILLE. Are we over drugged, is what I'm asking, at a young age?

Dr. STEIN. That's well beyond the sort of research that I'm currently involved in. As a clinician, I can say it's important that we need to make sure that we're using medications and other therapies appropriately, and that means making sure that individuals who are not being treated and may benefit from medications do receive them, and also making sure that we're not providing medications to children or adults who may not benefit from them.

Senator TUBERVILLE. Thank you. Mr. Duckworth, how have states like West Virginia used opioid settlement funds to fight back against epidemics?

Mr. DUCKWORTH. That's a great question. The West Virginia First Foundation's brand new, it's in its infancy, so, May 24th, was when——

Senator TUBERVILLE. How is it funded, by the way?

Mr. DUCKWORTH. It's the opioid settlement money, so, the executive director actually wasn't hired until May 24th, so, between May and September it took a lot to get the homework done, the policies, procedures, the staff hired. We put an initial opportunity grant together that went out for application, receiving applications in September.

By the end of December, we've committed over $20 million, and most of it at this point has went to youth prevention and child advocacy, and I think we'd all agree that the, the hidden epidemic of our seniors isn't really so hidden anymore. I can anticipate in the future having a lot more funding going toward the grandparents raising grants because of the seniors, that's the direction we want to go in West Virginia.

On to answer your question on the short-term child advocacy and prevention education, things like that is where it went recently.

Senator TUBERVILLE. Yes. Do you think there's anything that you use that we could do on a federal level to help more from this program?

Mr. DUCKWORTH. I think Senator Scott's on a data sharing, education. The data sharing, the support for law enforcement I think is so, it's so important, and I love the mission that you're on there, and hope we can see that come together.

Senator TUBERVILLE. Thank you. Sheriff, we've heard a lot about how children are now able to purchase drugs, which are awful, often laced with fentanyl, and there's this godawful stuff that you can go into one of these convenience stores and buy that all of it's made in China, that's for some reason we're allowed to be sold here in this country.

What can we do here in Washington to curb practices and raise awareness to parents about the things that the kids are able to buy?

Mr. LEMMA. Well, thank you for the question, Senator, and you're spot on. I mean, Chinese really created this epidemic, illicit substances. Now we've seen the most recent number is actually 50 percent of the pills that are made in clandestine labs or somebody's dirty bathroom, in many cases, contain a lethal dose of fentanyl. That's down from 70 percent, seven out of ten people that were taking it for the first time were likely to die with a pill that was manufactured illicit listed environment.

We see these things, these trends. It was just yesterday where we were talking about methylenedioxy, methamphetamine, MDMA, flunitrazepam, Rohypnol, where roofies were available, and then things got confusing for Americans with designer drugs where they would walk in and illicit chemists would stay one step ahead of what the DEA would approve as illegal, and we would clean the shelves off.

I think we have that under control now. There's no longer a problem in this country of over-prescribing. Clearly, you have to have your head in the sand to not realize that we have a problem that's down at our southern border with Mexican chemists now picking up precursor chemicals from China and learning how to process this.

Education is so incredibly important. That's why when we talk about greater access to opioid antagonists, the most significant thing that we can do to prevent people from having a drug overdose is never starting. Many of us remember Nancy Reagan saying, ″Just say no.″ Well, just say no - works incredibly well if you've never started, so, when people have started on a regimen, we have to give them access to science-based, medical-based treatment therapy combined with cognitive therapy.

Not just do that for the person on the journey. Make sure that the family members, and the loved ones, and partnership with businesses and corporations, and the private companies have a big role to play in that, because many people who are on this journey are actually going into an environment, whether they're going to a public school system, or that type of environment, or they're going to work, somebody is formally supervising them, and when they first see the first signs of it, it's important to not only say something, but know what resources are available and stay current with the current trends.

Last, we all remember the program, DARE, which was an incredibly successful program across the country, but DARE had nothing to do with what the challenges are of our kids today. Sexting, texting, cyber bullying, vaping. All of these other things have to be incorporated in educational curriculums, K through 12.

The CHAIRMAN. Thanks, Senator Tuberville. Senator Gillibrand.

Senator GILLIBRAND. Senator Kim, would you like to take the time?

Senator KIM. Sure.

Senator GILLIBRAND. Go ahead.

Senator KIM. Thank you. I appreciate it, Ranking Member. Ms. Mateer, I wanted to just start by just saying how grateful I am that you took the time to come up here and share your personal story. It's so important that we talk about the difficulties that are faced, and I'll be honest with you, I've heard a lot of stories about

the opioid crisis but I haven't heard as much about the challenges that it puts upon grandparents, and I thought that was very powerful.

I wanted to ask you, I don't know if you have this off hand, but you were talking about numbers and figures in terms of how much, in some ways, is being saved by grandparents stepping up, but is there an actual figure in terms of the number, the estimated number of grandparents who are in this situation right now, like you?

Ms. MATEER. Thank you for the question, and to my knowledge, according to what Generations United has at their fingertips, the grandparents save taking care of their grandchildren, save $4 billion a year.

Senator KIM. Do we have a sense of how many grandparents are in this situation?

Ms. MATEER. Yes, we do. There are probably—I know there are around 2.6 million children in our country being raised by caregivers other than their parent, and of those, the majority of them are being raised by grandparents. There is a website that has statistics for every state, and I think it's grandfamilies.org.

If you look at that, where I'm from in Pennsylvania, I know there are over 250,000 grandparents or children in Pennsylvania being raised by other caregivers. It does show you the grandparent statistics. The problem is a lot of these situations stay under the radar because they're unreported and they're not part of the system, so, there are probably many more than we know about.

Senator KIM. Yes, and I think that that stands to be something that this Committee can try to look into. Because kind of as Dr. Stein was saying, we want to make sure that that support is available to all that are struggling. We don't want to have bureaucracy getting in the way or regulations in that specific way, getting in the way of getting support out to those that need it, so, thank you for illuminating me on this, and I certainly promise to continue to followup with you and others to figure out how we can move this needle forward, both in terms of the caregivers.

Dr. Burnett, you know, what I've come to understand is just not just the challenges it is to the caregivers, but that we as a nation right now are not resourced in terms of the workforce needed to be able to address it, both from a practitioner standpoint, and more broadly, against other types of addiction-related specialists.

I guess I wanted to ask you, what can we do at the Federal level to try to increase that sense of workforce to make sure we can rise up to the magnitude of this challenge that we face?

Dr. BURNETT. Sure. Thanks for the question. One thing I would say that we can do is reauthorize a couple of different programs. One called the Substance Use Disorder Treatment and Recovery Act Loan Repayment Program, which is the STAR LRP Program, is a great program that provides loan reimbursement for providers and clinicians up to $250,000 to work in mental health professional shortage areas, or in places where the overdose rate is greater than three times the national average.

Also, there's another HRSA program that currently exists that could be reauthorized that provides fellowship support for addiction medicine and addiction psychiatric fellowship programs to be able to increase the number of these types of providers. Because, cur-

rently, we're about at half the capacity that is estimated to be needed to be able to address and treat the current substance use disorder need for the country.

Senator KIM. One thing you raised as well was just the challenge sometimes getting providers to be able to engage with Medicaid, for instance, and you were actually suggesting maybe increasing the rates to be able to try and get more providers on board.

I guess I just want to end here. We're having a debate here in Congress, in the Senate, about Medicaid right now, and I just want to hear from you just what you think would happen if we saw cuts to Medicaid. What would happen to our ability as a nation to respond to the opioid crisis?

Dr. BURNETT. Sure. I think Medicaid is vital to the ability for us to be able to take care of our patients with substance use disorder. I'd say about 80 percent of the patients in my clinic utilize Medicaid as the financing mechanism for their care. If we were to cut Medicaid funding, it would significantly reduce our capacity to be able to fight the addiction crisis, fundamentally.

Senator KIM. Thank you, and with that, I yield back.

The CHAIRMAN. Senator Justice.

Senator JUSTICE. Thank you so much, Mr. Chairman. I'm going to be very official. I'm going to call Greg, Mr. Duckworth, but I have two questions. I really do. You know, the first question is about our aging, but of course you've seen the crisis on both sides. You've seen it from the law enforcement side, and you've seen it from the community advocacy side. How does this particularly affect the aging population in West Virginia?

Mr. DUCKWORTH. Thank you Senator. It starts with the grandparents raising their grandchildren, so, if a grandparent is raising a grandchild, we've lost a generation out of their family tree, so, the senior is mourning the loss of their child and raising their grandchildren.

It's not just grandparents. It's great grandparents, and there's great aunts and great uncles that are also raising, so, it's like the floods and fires; everything that it touches, it destroys, and it starts with the babies being born with addicted to opioids, or in West Virginia, we have a large amount of babies being born addicted to Suboxone, so, we're dealing with the neonatal abstinence issues, and the seniors who are mourning the loss and raising their grandkids. It's a huge impact. 40 to 50 percent of West Virginia grandparents are raising their grandchildren.

Senator JUSTICE. I hope everyone heard that. You know, the magnitude of the percentage in West Virginia of grandparents that are raising the grand babies. It's terrible. It's all there is to it, and I've said this over, and over, and over, but I said this when I was a Governor, I said, if we don't really get a handle on this, it will cannibalize all of us, and we better absolutely get a handle on. You know, there's so much more we can do.

I've got one more question, and this is I'd like you to talk about the ways we can see hope restored. You know, when it really boils down to this level of crisis, what really keeps our West Virginia families even going? You know, Greg, we started with Jim's Dream, and then we went to Jobs and Hope, and we made a dent, but there's got to be a lot more dents that's just all risk to it.

You know, I've said so many times in life that you'll never get out of the hole till, you know, really where you are in the hole, and the hole in this situation is bad. That's all there is to it, so, I just think that we have got to give people all across this land, if not all, across the globe, hope. I mean, optimism, a chance to be better. This situation has got to have every single one of us arm in arm pulling the rope together. We can do it, but that's exactly what we've got to do.

Tell me your thoughts real quickly on how do we address this terrible crisis and give hope to our West Virginia families?

Mr. DUCKWORTH. Yes, thank you. In my mind, the treatment centers, and the detox centers, the doctors, they do a fine job for those 30 days, and then, our addict gets released from either jail or a recovery home, and there's nowhere to go except back where they came from, so, there's a piece of this in the economic development part of creating jobs, so that when these folks get detoxed or they get out, they have hope for a job, something they can support their family in.

That's where we lack sometimes, is a place for them to go, either when they get out of jail—the overdose rates are highest when someone first gets out of jail or out of a treatment program, and they don't have a place to go to a recovery center or somewhere different than where they came from, and they just go back to the community they were in to start with.

Senator JUSTICE. Isn't that exactly what we tried to do with Jobs and Hope? I would tell everyone just this, you know, we have to have treatment. We know we have to have treatment, and we know we have to have sympathy to bring people back, but these people got to have a job. They have to have training. They can't be trained on a pickup truck, how to drive a dump truck. Absolutely. They got to have real life training, and we got to spend dollars to be able to do that.

I thank you all so much for being here, so, thank you, Greg.

The CHAIRMAN. Thank you. Senator Alsobrooks.

Senator ALSOBROOKS. Thank you so much, Mr. Chair, for hosting this important hearing today. Thank you so much as well to each of our witnesses.

Baltimoreans are dying from overdose at a rate never seen before in a major American city, with the number of deaths quadrupling over the last 10 years. The frequency of overdose deaths in senior homes has likewise increased. More than 340 people have died in Baltimore senior housing complexes in recent years. Black men aged 55 to 74 lead drug fatalities over all other demographic groups in the city, a death rate that is 20 times that of the rest of the country.

Yet, this administration is working to slash funding for research treatment, and our public health workforce, nearly one in ten employees at the Substance Abuse and Mental Health Services Administration known as SAMHSA, were just recently summarily fired by this administration as a part of DOGE's governmentwide cuts. Cuts at SAMHSA threaten continued access to essential mental health and substance use services, including crisis support and suicide prevention, and as you know, SAMHSA is yet another Federal agency that is based in Maryland.

I'd like to start with Dr. Burnett. First of all, to thank you so much for the work that you have done every day on the front lines of the opioid crisis in Baltimore, and just want to ask you, how will public health efforts be impacted by this administration's slashing of the Federal workforce at SAMHSA, and will leaving SAMHSA with a skeleton staff worsen the situation on the ground in Baltimore?

Dr. BURNETT. Thank you, Senator Alsobrooks. I can answer definitively, and talk about a little bit about my experience working for the Maryland Department of Health and how SAMHSA funding was integral to not only ensuring that prevention and public health efforts around opioid overdose were implemented.

The SAMHSA funding supported a large percentage of our efforts toward naloxone distribution statewide, and so, any cuts to SAMHSA funding would significantly curtail our ability to be able to provide naloxone across the State of Maryland, and I'm sure that that's true for many other states here, and it's particularly true in states that have not expanded Medicaid.

SAMHSA funding provides integral not only prevention support, but treatment support in places where patients don't have access to Medicaid. You can provide the funding from SAMHSA to be able to get into community health programs so that people can get access to medications, opiate use disorder, so, it's very, very critical funding.

Senator ALSOBROOKS. Thank you. You know, also, it's really shocking, but the New York Times recently reported that dealers are targeting senior apartments in Baltimore, yet health officials have done little targeted outreach to older people. We're seeing that this is an epidemic that is affecting them.

What more can be done on the ground to help address the pattern of deaths among low-income seniors and to stop vulnerable communities from being preyed upon.

Dr. BURNETT. I see that every day in Baltimore where I work. We have a senior living facility just down the street from our opioid treatment program, and we've taken steps toward partnering with the senior community to be able to talk about treatment and recovery.

You know, the population of seniors experienced opioid treatment in the years before major reforms to opioid treatment took place, and so, they have a very negative perception of opioid treatment, very strong stigma toward medications for opioid use disorder, and so, there's got to be a significant amount of education to be able to bring those individuals back into treatment.

It requires partnerships and peer recovery support services going into these senior homes to be able to talk about what recovery looks like and being able to access medications and really reducing the stigma associated with opiate use disorder because it's very pervasive within the community.

Senator ALSOBROOKS. I think there was a question that addressed at least a part of this, but also would you speak to the importance of supports for seniors who are caring for children impacted by the opioid crisis, and how does keeping families together reduce the trauma experienced by these children?

Dr. BURNETT. Just to clarify, was that question from you?

Senator ALSOBROOKS. That's for anyone who might want it, who can answer.

Dr. BURNETT. I'm happy to take the question. In my clinic, one of the things that we really look for in terms of people's capacity to recover is their connection to community and having family support. Sometimes, people come into treatment and they are by themselves, they don't have any social support systems, and so, it's critical toward your recovery process if you actually have people that can help you through the process. It's a long one. It's much more than the 30-day timeframe that most treatment access provides.

It's really critical that you have family members, especially if you're in an older generation and you're caring for younger individuals. That support and that community-based experience is critical to being able to help people get into recovery. Because a lot large percentage of people who suffer from opiate use disorder are wholly disconnected, right? They're suffering from trauma, they don't have any resources or any places to turn to, and so, they use drugs to cope with their isolation.

Being able to bring them back into the community, whether through faith-based organizations, community partnerships and relationships, non-profit organizations, all of that is critical to their recovery.

Senator ALSOBROOKS. Thank you.

The CHAIRMAN. Thank you. Senator McCormick.

Senator MCCORMICK. Mr. Chairman, thanks for hosting this important meeting on such an important topic. Good to see some fellow Pennsylvanians on the panel, so, thank you for being here today to talk about such an important issue for the Commonwealth of Pennsylvania and the country.

4,000 Pennsylvanians died last year from fentanyl, about 100,000 nationally. This is a crisis of sort of historic proportion. You know, I see it all the time in Pennsylvania. I was in Cambria County, a couple years ago, and I talked to a woman, and she was describing a family member who died of fentanyl poisoning and the devastating effect on her family, so, I started to make these campaign visits. I'd ask people, who among you has been affected by fentanyl? Almost half the people in the audience would put their hands up. Either their immediate family or their friend's group affected by fentanyl.

We've got to get our hands around this, and of course, it's a problem that begins at the southern border, primarily with the precursors from China, comes across our border, and then goes out into a network of drug dealers and cartels in the United States.

My first question is for you, Sheriff Lemma, about the coordination among law enforcement, and is there any gaps you see in the way the federal, state, and various law enforcement bodies coordinate, and any insights you can give us on what we might do better?

Mr. LEMMA. Yes. Thank you for the question, Senator, and I think that first there were gaps. I think that we're reigning those gaps in right now. I think that there is potentially some confusion and need for deconfliction in the past between the law enforcement agencies that worked under the Department of a Homeland Security Secretary, and those that worked for Main Justice. I suspect now those problems are going to be cleaned up pretty quickly.

I do think deconfliction is incredibly important, not only between Federal agencies, but local, state, and there's platforms, and relationships, and task forces that are a huge benefit to the country, so, what we can do better, I think more of what we're witnessing right now. We're witnessing a bipartisan effort to focus on things that move beyond politics and find a way to at least tackle what we agree on, and I think that through that process should build chemistry and comradery.

When we look at what works we cannot lose focus treatment, and access to prevention programs, and access to lifesaving opioid antagonists like Narcan Kloxxado, and generic versions. All of those things are incredibly important, but the bad guys have to go to jail. The cartels are a big part of this. They are a threat to this country, particularly the Sinaloa and the Jalisco New Generation Cartels. We have to be incredibly aggressive about that.

Unfortunately, many overdoses or poisonings across the country are still being treated as accidental, tragic events. Every person who's dealt from those dealers is likely to experience similar fate, so, I've recently had some conversations with incoming Attorney General, Pam Bondi, our association, Major County Sheriffs of America, have had the same conversations, and I think that we're going to see a lot of great progress, so, more of this is good.

Senator MCCORMICK. Thank you, and, Ms. Mateer, fellow Pittsburgher, I want to say, I think your grandson is extremely blessed to have your support. It must be emotionally taxing and financially challenging, but it sounds like you're making it work. Unfortunately, as Senator Justice was saying, many grandparents, hundreds of thousands of grandparents across our country suffer through.

Any advice that you would offer to families going through a similar situation, and particularly grandparents faced with a similar set of challenges?

Ms. MATEER. The best advice I can offer is to join some sort of a peer-to-peer support group. That has been my lifesaver. Because of my advocacy with GRAND Voices, I connect with grandparents raising grandchildren across the country, in the tribal nation, and everywhere, and that's where I get my mojo, because we support one another and we understand one another.

Senator MCCORMICK. Good. Thanks Mojo, and Sheriff Lemma, back to you. Just one final question. You talked about collaboration and, of course, common data, referring to your testimony. Common data is an important part of a unified effort. Any commentary on the quality of the data, and anything in particular Congress could do to ensure common data standards and availability to combat this horrible fentanyl crisis.

Mr. LEMMA. Yes. I think that we have a lot of great things that are going on, and Congress has really been, you know, responsible for those things. The elimination of the X-Waiver I really think that really we should take on permanently scheduling xylazine. Many states have already moved down that path. We're seeing the deadly substance xylazine end up in, again, mixed in substances and a growing problem across this country, but yet still is not scheduled at the Federal level.

What's incredibly frightening about xylazine, it's an animal tranquilizer. It really eats the skin away and is non-responsive to opioid antagonists, so, these success numbers that were presented across the country in various areas would absolutely decline, or the drug dealer would kind of move down the path to move into that business if we don't kind of tighten up on that.

One last thing, is kind of looking at that scheduling of that, and then making sure that we have programs that work. Operation Overdrive is a DEA program that has shown great success, great data tracking. Last report, I think it was in 37 cities across the country. Those should spread out, not to new cities necessarily, but into the unincorporated counties that those major municipalities are in, and I think that data collection, OD Maps, is another great effort to expand research data collection and allow us to kind of let science move the path.

Senator MCCORMICK. Thank you.

The CHAIRMAN. Thank you, Senator McCormick. Senator Warren.

Senator WARREN. Thank you, Mr. Chairman, and thank you and Ranking Member Gillibrand for holding this hearing today. It's a really important topic, and I appreciate the care with which you treat this issue.

Since 2017, the opioid epidemic has taken the lives of nearly half a million Americans. Their families, and so many more people around this country need Congress to come up with some real solutions. For example, I know that Chairman Scott and I agree on the need to close a trade loophole that lets China ship fentanyl precursors into the country uninspected, and it's time to put a stop to that.

As we sit here today, President Trump and congressional Republicans are working hard to advance budget legislation that would make the opioid epidemic worse and not better. They have proposals to cut over $800 billion from Medicaid, which is the largest single payer of substance use disorder services in the entire country, and why? That they can fund tax cuts for billionaires.

Let's be clear about this. Slashing Medicaid funding, either through per capita caps or backdoor cuts, like work requirements in an area that already have work requirements, would mean ripping away healthcare from millions of vulnerable Americans, including about a million people right now who are getting treatment for their opioid addiction.

Dr. Burnett, you've worked on the front lines of the opioid crisis. You have helped countless people overcome addiction. I want to thank you for your work and express my admiration for that, but tell me, in this budget space, what percentage of your patients rely on Medicaid for their treatment?

Dr. BURNETT. I would say, currently, about 80 percent of my patients rely on Medicaid for treatment.

Senator WARREN. Wow. In other words, Medicaid, as I understand it, is not just one option for how people get treatment, it is the backbone of the entire system for treating opioid addiction. Is that fair?

Dr. BURNETT. That's a fair comment.

Senator WARREN. All right, and yet, Republicans are talking about gutting that system to the tune of nearly $1 trillion dollars, so, I'd like to look at just a little deeper level about what those cuts would actually mean for our country's battle against the opioid crisis. Two of the policies proposed by House Republicans are capping Medicaid payments to states, and imposing red tape like additional work requirements.

Dr. Burnett, can you just talk for a minute about how those changes would affect access to treatment if they were put into law?

Dr. BURNETT. Absolutely. I think there was a recent Kaiser Family Foundation study that talks about the work requirements issue, and that actually almost 92 percent of people on Medicaid already are either working or involved in some sort of part-time or full-time work, so, the work requirements situation would just really add a lot of administrative burdens, ultimately resulting people getting kicked off of Medicaid.

Senator WARREN. I just want to make sure we say that again. What proportion of people are now already subject to work requirements?

Dr. BURNETT. There are 92 percent.

Senator WARREN. Ninety-two percent. All right, so, adding more work requirements on top of this has what impact?

Dr. BURNETT. It would certainly increase the administrative burdens of keeping people on Medicaid.

Senator WARREN. That's right, and what's the consequence of increasing those administrative burdens?

Dr. BURNETT. They would lose access to their addiction care.

Senator WARREN. That's right. People just can't get the paperwork filled out. More people fall by the wayside. I think that was the Arkansas experiment, as I recall.

Dr. BURNETT. That's correct.

Senator WARREN. Yes, but there's another part to this as well. What about capping the funding?

Dr. BURNETT. Yes. Capping the funding would create two problems. One, it would definitely curtail the amount of choice that patients have relative to the types of addiction treatment that they would have, and then capping the funding would also create a network advocacy problem because more providers would disenroll from accepting patients on Medicaid, so, patients would not have the ability to access treatment close to where they live.

Senator WARREN. Yes. In fact, we don't have to speculate on what the consequences would be. In states expanding Medicaid, treatment for opioid addiction increased over four times faster than in states that refuse the expansion. Meanwhile, Republican states that imposed so-called work requirements did not actually increase employment because that was never the point. Instead, opioid overdoses went up and access to treatment actually went down, so, look, there is no denying the critical role that Medicaid plays in fighting the opioid epidemic. Cutting that program is not just cruel, it's totally backward in what we're trying to accomplish.

Might I ask one more question, Mr. Chairman? Thank you, so, Dr. Burnett, I want to ask about something you've done some scholarly work on and you've published. You've written extensively about the positive effects of investing in treatment, and how that

ultimately lowers costs down the line so that if you cut the investments for treatment, like cutting Medicaid. The question is, is that really going to save any money?

Dr. BURNETT. No. I think it as I said in my testimony people who experience treatment are much faster to return to work, be productive members of society, and ultimately not be a burden on the social safety net, so, it would actually be more detrimental to cut Medicaid funding in terms of the amount of expenditure that states and public dollars would be needing to use to be able to,

Senator WARREN. This treatment gets people back to work, fewer trips to the emergency room——

Dr. BURNETT. Correct.

Senator WARREN. Long-term cost——

Dr. BURNETT. Totally.

Senator WARREN [continuing]. is that we save money by making these investments. One study found that for every patient treated with medication for opioid addiction, the government saves up to $100,000 over the course of that person's lifetime.

Let's be clear, the budget cuts the Republicans are proposing are not about saving money. If Republicans really wanted to save money, they'd be expanding treatment to folks that they claim they want to represent here, rather than ripping it away so that we can bankroll tax cuts for billionaires.

Families and communities across this country are counting on us to deliver real solutions to the opioid epidemic, not play politics, and I won't stop fighting for that. Thank you very much. Thank you all for being here. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Warren. Senator Moody.

Senator MOODY. Thank you, Senator Scott, and I've always been impressed, Senator Scott, and as a former Governor as well, of the great State of Florida, you have always dug into the details and cared about things that were harming Floridians, and this Committee hearing is a perfect example of that.

You saw how it was affecting seniors, and I don't know how that isn't abundantly clear, and I love that you are the one that highlighted this and brought it as the chairman. When we say working and fighting age Americans are dying at a faster rate than anyone else, the largest bulk of the number of people we lose to overdose death, those are often our parents. They are our parents, in this country.

I'm so grateful Ms. Mateer, that you were here and willing to share your story and your experience. I think it certainly informs everyone and raises awareness that those parents when they fall victim to addiction and that affects not only the children, but the generation before them, and I really appreciate you being here.

Much of what we did in Florida addressed really aiding many levels, and some of that went to helping caregivers and family members of those addicted. I think it is a false narrative and very shortsighted to say that we have to stop incarcerating drug traffickers. In fact, Sheriff Lemma is a leader in our State. I have proudly supported him to numerous boards to oversee not only how we are tackling this problem, but how we are expending the resources that our office recovered going after pharmaceutical compa-

nies, distributors, pharmacies for the opioid epidemic itself. He now helps oversee responsible spending.

We broke it down into, No. 1, you have to put the peddlers of this poison, the traffickers of opioid, synthetic opioids like fentanyl behind bars, because they will do violence to our communities by selling them lethal doses of opioids or synthetic opioids, and to call that nonviolent, I think, is shortsighted, and I think if we do not take them out of the communities, they will continue to create daughter after son, after mother after father falling prey to this, and that is step one.

I'm so proud of law enforcement efforts in Florida. We led the Nation at one point in fentanyl seizures. We are focused on that. We have dedicated resources to that funding, pushing into law enforcement, making sure that they were focused on that and had the resources to go after those traffickers.

You can say, honestly, we cannot arrest our way out of this crisis. That is true, but we cannot stop going after the people who pedal poison indiscriminately that our children, and our mothers, and fathers are taking. That has to be our first step, and going after the cartels and everyone that's helping them spread this is No. 1.

After that, we broke it down into how do we; one, make sure that Narcan is available to family members, caregivers? Readily available, and we pushed it to our first responders. Because of that, we are leading the national rate in decreasing the number of deaths that we are seeing every year, and I'm so proud of that statistic. We're going to keep doing better.

Past that, we want to make sure that people can receive treatment, good treatment, treatment that's proven successful with few rebounds, and that's done so with science-based methods. I agree that that is the case. The problem is, I think a lot of money is getting shoved because this is such a problem and we're trying to fix it, and, tragically, we often try to fix things by just shoving money at the problem and not doing a very efficient and intelligent way of distributing that or accounting for that.

What would you say, Sheriff Lemma, is the independent body that rates these substance abuse providers?

Mr. LEMMA. Well, first, Senator, I want to thank you for your leadership. It was your work that inspired many of us to go down the path, in the first place, and I think it's so incredibly important.

I also think that for the first time in recent history, the stars have aligned and funds have been made available because of work of attorney generals in various states, and Big Pharma settlement money, and, federally, candidly, I think that if you cannot explain what you did last week, you probably don't have that important of a job.

I think when we talk about healthcare, it is incredibly important, and these programs are incredibly important. We said medical-based treatment therapy is the gold standard for treatment, greater access to naloxone, but when it comes to the drug enforcement, connecting the dots, making all of these things work together, I think that there has to be a sensible strategy because many of the cartel members that are in here, they're selling drugs. Some of

them are not even legal citizens anyway. It creates an incredibly challenging dilemma.

We have boards, we have committees in the State of Florida. We have an opioid abatement settlement team that you led when you were attorney general, and it has these checks and balances for 20 qualified counties out of the 67 in the State of Florida that have populations of over 300,000 people, and a comprehensive strategy to make sure that all of the checks and balances are in place, followed by organizations like the Department of Children and Families in the various states that work through the managing entities that are, again, adhering to the gold standard, to making sure that there's checks and balances, and people who are, who are responsible for the money at a local level, are held accountable to make sure that they're doing the right thing.

We don't want patrol cars, and fire trucks, and water treatment plants, because as Big Pharma who created this by saying proper use of OxyContin, the patient was less than one percent likely to become addicted, and the world said, no, no, no, that's simply not true. Well, the money should go to enrich programs that help those individuals and those families.

Senator MOODY. Thank you, Chairman Scott, I appreciate it. Dr. Stein, I'll direct my attention to you. One of the things, as Attorney General, and I dug into this, it was heartbreaking to see so many people in Florida and across our Nation dying.

I was very hands-on on this, and I was shocked to know that there wasn't a directory of sorts that people could go to in the moment when they were ready to get help that had reputable, proven, quality-assured treatment with beds available right then. I ultimately ended up speaking with—and, thankfully, Florida was supportive, and we contracted with a group called Shatterproof Treatment, atlas.org.

I think I was one of the first states, certainly Republican states, that was pushing something like Treatment Atlas. Because as you know, as a mother, as a parent, a family member, when somebody's ready for treatment, you want it then, right now, when the bed is available, but you don't want to put it somewhere where they're just going to take your money and turn them out.

This is what I want to get to; is there an independent body that is ranking the success of these treatment services that are grasping all the grants and the funding from federal, or state government, or even recovery settlements?

Dr. STEIN. Senator, thank you for the question. I think it's an incredibly important issue. This is a topic that has come up over a long period of time in terms of helping people find the places they can offer them the best treatment, right?

As you point out, when someone needs treatment, you need to connect them. Now you have a window of opportunity. Unfortunately, I am not aware of any organization that does this routinely and standardly in the type of way that I think many families look for. I think you're supportive of Shatterproof in naming them. There's certainly an organization that has done tremendous work in this area, and I think has been a leader in many people look to and support the work they've done, and that certainly is helpful.

I want to pick up on your comment and sort of point out two things, though. I think one is sort of identifying places that are providing good evidence-based care, medication treatment for opioid use disorder, cognitive behavioral treatment.

Senator MOODY. I don't want you to get it off-track.

Dr. STEIN. Yes.

Senator MOODY. To your knowledge, is there an independent organization that rates the quality of these drug treatment facilities?

Dr. STEIN. To my knowledge, the organization that comes closest right now is Shatterproof, but I am not aware of anything beyond that.

Senator MOODY. There's probably very limited attention or resources being given to something like that before we're handing out billions, and billions, and billions of dollars.

Dr. STEIN. I certainly think that that is one area that absolutely does need attention. Yes, Senator

Senator MOODY. Would necessarily be a helpful filter. Thank you. Thank you, Chairman Scott.

The CHAIRMAN. Thank you, Senator Moody. Thanks for what you did as attorney general. Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman. Dr. Stein, and everyone who is appearing here today, thank you. Thank you for being here. It's a very important topic.

Dr. Stein, we know, well, based on the conversation with Senator Moody, seniors are rather vulnerable, a vulnerable population when it comes to opioid use disorder. The number of adults who need treatment for this have tripled between 2020, I think is what the statistics on this say, and a study from the Moran Company recently found that opioid use disorder costs $4.3 billion each year for newly diagnosed Medicare beneficiaries.

If you think about not just newly diagnosed beneficiaries, but if you think about all Medicare beneficiaries, and you extrapolate that $4.3 billion each year to the size of the Medicare population, it looks like the treatment for this could be in the tens of billions of dollars.

Dr. Stein, I believe, you know, I think we can stop addiction before it starts for many of these individuals that wind up in treatment, and I have a bill that would improve access to non-opioid pain medication for seniors who are on Medicare. Now, my bill would make sure that seniors aren't paying more for a non-opioid pain reliever than they would pay for an opioid.

Dr. Stein, do you think addressing that financial barrier is important to ensuring folks have alternatives and aren't put on the pathway to addiction?

Dr. STEIN. Senator, thank you very much for the question. I think multiple steps such as making sure that there are not financial barriers to allow adults who could benefit from non-opioid management of their pain and decrease use of opioids would help to decrease the risk for opioid use disorder in that population. I absolutely believe the financial benefit is one barrier that's important to address.

I also believe that we need to have a sufficient workforce providing these treatments that are available. We need to, to make sure that Medicare,

Senator KELLY. What would that workforce look like? Because isn't it just a decision for a doctor to say, ″Hey, I've got these two options. I've got this non-opioid pain reliever. It costs X out of your pocket. I got the opioid. I'd prefer you take the non-opioid. I understand you got financial issues, you might be on a fixed income as a senior. This is a choice we're going to have to make here.″ But what is the workforce beyond that?

Dr. STEIN. Absolutely, I think non-opioid medications is one option, but there are also non-medication options that can very much help people: therapeutic massage and acupuncture. Does it work for everyone? No, but it certainly works for a lot of people, and has been shown to reduce the amount of opioids they need.

We need to make sure that we have sufficient individuals, so, that's an option for the doctor you're talking about that it's not just opioid or non-opioid, but I've got three options. What works best for you and your family? Making sure that Medicare reimburses those services.

For example, right now, non-pain management for chiropractors is limited to back pain, but there are other things within their scope of practice that might be useful: an acupuncturist, so, I think the financial barrier is one. It's critically important, but there are others to make sure that our older adults get the care they need for the pain to reduce the risk of opioid use.

Senator KELLY. The financial barrier extends beyond just the cost of the medication, I think is, you know, one of what you're referring to. Do you have a sense for how many folks wind up on opioids because they can't afford a non-opioid pain medication?

Dr. STEIN. I do not.

Senator KELLY. Does anybody know of any studies that's been done. I'm trying to get this sense for my legislation, and if we were to implement this, how big of an impact it would have. Do you think reducing the price of the non-opioid pain reliever would result in less people addicted to opioids?

Dr. STEIN. I think options that allow the elderly non-opioid medication treatment to better control their pain are all things the less elderly exposed to opioids and potentially more opioids than they need, the more likely we're going to be reducing.

Senator KELLY. Dr. Burnett, it seemed like you wanted to comment?

Dr. BURNETT. Yes. I would just say that when we're talking about chronic pain management, a multimodal approach that Dr. Stein is talking about is critical, and this is something that I see regularly in my clinic, and Dr. Stein highlights this point in that you're actually only limited to pharmaceutical options a lot of the time relative to your pain management.

Coverage for the physical and occupational therapy, being able to get into people's homes to be able to improve their living environments, and having people go in and make those evaluations and those changes in addition to aqua therapy, acupuncture, all these alternative and complimentary strategies would be instrumental to improving the overall quality of life for people with pain and making their pain much more manageable so that we don't have to turn to the pharmaceutical options and avoid people getting addicted.

Senator KELLY. All right. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kelly, so, you know, I ran a large hospital company for a long time, and then I was Governor of Florida, and then one of the frustrating things about any issue, this is an example, but I think all of us have stories that we believe that some sort of treatment, some sort of something is going to save money down the road, and if you believe that, man, you jump at it, right? Nobody comes with comes with an analysis and nobody ever wants to take the risk.

I had at times I had hundreds of thousands of employees in some of my companies and people come and say, oh, if you'll do this test, it'll cost you X dollars. You'll save multiples of that in healthcare. I mean, who wouldn't do that? I said, ″I'll tell you what, I'll do it. I'm going to double what I'll pay you, but you take the risk that I'm going to save the money.″ ″No, wait a minute. We're not in that business. We're not going to take the risk.″

That's the issue you have on all these programs. Nobody wants to go through what Ms. Mateer's going through. Everybody wants to do what all of you have talked, you know, almost everybody's talked about is some program. Nobody, nobody, nobody comes with data. Nobody comes with data, and nobody's willing to take the risk, I mean, on any program whether it's a Medicare program, Medicaid program, and so, it makes it so difficult to say, ″Oh man, I am all in for doing that because there's no data, there's nothing.″ Nobody was willing to take the financial risk.

Like, I've never been in the insurance business, but you would think, right, if you were in the insurance business, and somebody came to you and you could really prove that they could save money by providing this service, or this drug, or this blah, blah, whatever it is, they would jump at it, but for whatever reason it doesn't happen.

I always ask, you know, the biggest thing I always ask everybody is, are you willing to take the risk? I mean, it's a great story. Are you willing to take the risk that it's going to save money? If you are, then, man, you people should jump at that, but nobody does.

Sheriff Lemma, can you just talk about your community for a second? You're not in a big downtown area, you're more of a suburban and a little bit rural area. How is an area like that that most people think of this country? Oh, you don't have drugs in that area. I mean, this is sort of the heartland of America and it never happens, so, how does it happen in an area like yours?

Mr. LEMMA. Yes. Thanks so much, Chairman. You know, Seminole County is, again, the fourth most densely populated per square mile, but we're a small county. We have a population of about 500,000 people, and a little more than 300 square miles. Very affluent county has the highest level of education per capita that does not host home to a major university, and great quality of life. One of the top school systems in the entire state.

When we look at the significance of the reduction, we're proud about that. I talked about a 29 percent reduction in overdoses or poisonings, and a 42 percent reduction in fatalities, but when you look at the volume of numbers even of a community like that, the overdoses last year representing the 29 percent decrease is 427, and the fatalities are 66.

If we had a community meeting just there in Seminole County, and laid 66 body bags and the tragic effects that they have on the entire family, it would be devastating, and it would be a topic of conversation that everybody would like lean in and talk about tremendously, and, again, this is one of the most successful counties in the State of Florida based on recent data.

Palm Beach County is another county that had a remarkable reduction. Forty percent or more reduction in fatalities. I think this is a testament to the strategy that absolutely works, and in addition to that, and I hadn't mentioned it yet, but in Seminole County alone, we've charged 39 drug dealers with first degree murder for dealing deadly doses of narcotics, and at the same time, we worked with the Florida legislature to change the burden of proximate cause of death to substantial factor.

Another key success point there is in areas across the country, the most important thing is to protect and preserve human life. Greater access to opioid antagonists and reversing the effects of the overdose, or bringing people back to life literally with medicine on gun belts, and in back of patrol cars, and in private citizens' pockets, but we created a new law in the State of Florida that allows us to charge every drug dealer with second degree felony culpable negligence if we can prove that they dealt a deadly dose of drugs and we've revived them with the use of naloxone.

This is creating momentum. It's something that people are talking about, not only in the State of Florida and in our community, but across the country, and we would be happy to share it, and I think that it really saves lives.

The CHAIRMAN. Thank you. Ranking Member Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman. Thank you to each of you for your testimony. I was very moved by everyone's perspective and the work that you're doing on the ground every day to save lives, and what's happened to your practice, and what's happened to your community, it really does matter.

Ms. Mateer, thank you so much for sharing your story about your grandson. He sounds like he's a wonderful boy, and you gave some very persuasive recommendations at the end of your testimony. I thought they were excellent. Can you give us a little more guidance on what types of services or supports would make a difference?

I have a piece of legislation called Supporting Families Through Addiction Act, which would provide $25 million to community programs so they can provide families with the resources they need to support loved ones battling addiction, so, that grant money is pretty flexible, but I'd love to hear directly from you at different stages in your life raising your grandson, what types of supports could have made a difference for you and your family?

Ms. MATEER. Thank you for the opportunity to speak and for your reinforcement. It means so much. I think from my standpoint, when I first was showing up at the pediatrician's office with an infant child, and I wasn't the parent right then and there, it would've been so helpful for that community to provide me with at least some basic information where to go for things, what to do, a pamphlet on what kind of crib to buy, what kind of car seat to buy. Because a generation later, all of these things change; how to feed a baby, everything's different.

I think wherever we touch, it would be good to have some sort of supportive measure in place that at least would provide information and maybe a list of where to go for resources, what community groups are there, where you could get baby clothing, things like that. I think those things would really be helpful.

Senator GILLIBRAND. Maybe services through pediatrician's offices, at a minimum?

Ms. MATEER. Yes. It just seems to me that they don't see the issue, they don't recognize it. I know there are so many of us out there, but it's just not on the radar. It's just quiet.

Senator GILLIBRAND. Very helpful. Thank you.

Ms. MATEER. Thank You.

Senator GILLIBRAND. Dr. Burnett, thank you for testifying about what you're doing to help older adults access these critical addiction services in your community. In your testimony, you discuss the challenge of accessing evidence-based addiction treatments for those who need it. You also discuss the impact on older adults who are struggling with their addiction.

Can you expand on some of the challenges that older adults face with regard to substance use disorder treatment, and are there policy changes that you would, that you would recommend that could address some of those barriers?

Dr. BURNETT. Yes, sure. You know, I think Dr. Stein also highlighted this very eloquently in so far as older adults have a multitude of chronic disease issues that you have to manage in addition to their substance use disorder care. They've got issues related to transportation, polypharmacy. Being able to connect your substance use disorder care to their general medical care in and of itself is a challenge, and so, it requires a team-based effort between the nurses on the team, the peers on the team, and collaboration with other physicians that might be taking care of this patient population.

There's definitely lots of different strategies and policy solutions that we can come up with largely focusing on Medicare. We could certainly expand the Mental Health Parity and Addiction Equity Act to Medicare so that reimbursement for these services could be paid at an equal rate within the Medicare population, because currently, that's excluded. We could authorize Medicare coverage of non-hospital-based residential treatment. Currently it is difficult for individuals to be able to participate in community-based IOP and PHP programs because they don't have—Medicare doesn't cover that. The Medicare SUD bundled payments provisions could be in increased.

There's lots of different ways that we could ensure that more providers are able to take Medicare and take care of those patients with substance use disorder.

Senator GILLIBRAND. Thank you. Dr. Stein, you also discussed some of the challenges with treating an older population with substance use disorder, and you mentioned one of the challenges is being the acute shortage of the workforce and the lack of preparedness among the workforce to treat older adults with co-occurring substance use disorder and dementia. Can you elaborate on this issue and what we can do to help?

Dr. STEIN. Sure. Senator, thank you very much for the question. It's a challenge, right? Because as we've heard many of the individuals providing treatment under the addiction specialists, and they don't necessarily have this expertise.

I think one solution that has come up, as I've talked to colleagues, is either to enhance training in geriatrics for those individuals, or find ways to support those systems in bringing in physicians' assistants or people who may have more basic medical training in geriatrics to partner within the care system so they don't have to move back and forth.

I think the other one that we really need to focus on, though, is primary care, because that honestly is where the majority of elderly are going to continue to get care, and despite so many of our efforts, many of them still don't provide medication treatment for opioid use disorder with buprenorphine that we know to be effective.

One of our recent studies actually showed that there are probably only about 1,200 clinicians in the country that treat over a third of the older adults receiving buprenorphine. It's highly concentrated, and so, I think one of the things we really need to think about is in that group of primary care clinicians treating the elderly, so much of our focus has been trying to get a new clinician to prescribe buprenorphine.

Maybe we need to start focusing on the types of supports, whether it be additional supports within the office, better connections with non-physician substance abuse treatment services to make those clinicians more likely not to just prescribe one buprenorphine, but one patient, one elderly patient with buprenorphine, but more of those physicians and physician's assistants, nurse practitioners to treat more elderly with buprenorphine. Let's try to build a greater a workforce of somewhat higher volume prescribers toward the elderly that can merge this expertise.

Senator GILLIBRAND. Got it. Thank you so much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Commissioner Duckworth, what's some examples of success that you think we ought to try to do at the federal level?

Mr. DUCKWORTH. Thank you very much for the question. Some of the issues in West Virginia, and to the sheriff's point, his county of 500,000 would represent about one-third of our whole state, so, we're very rural and very family oriented.

Going back to the seniors and what I came prepared with today was the grandparents raising their grandchildren, so, helping those folks and getting programs in place that helps the seniors. That, I think, is key. I think we're missing a whole generation of people. We're missing workforce. Like I said earlier, the whole generation of the family tree is missing.

You know, to Senator's point of non-opioid medications. Like, 50 and every 1,000 of the babies born in West Virginia are addicted to Suboxone. You know, curbing those things, getting into to some of the non-opioid treatments, I think would be a huge success for what West Virginia needs anyway, and where my space is.

The CHAIRMAN. Yes, I think we have over 50 million Americans, working age, I think like 16 or 15, something like that, to 64 that

don't have a job. That didn't help, so, Dr. Stein, your research at RAND has highlighted unintended consequences of past opioid policies. We know that increased access to naloxone, for example, works. What are some of the lessons learned from past missteps that we should keep in mind in designing future policy.

Dr. STEIN. I think the awareness that there are sometimes unintended consequences for well-meaning policies is critically important, and so, one area that we've certainly seen this and learned about it goes back to actually 2010 and the reformulation of OxyContin, which was approved by the FDA and it was well intended. It took OxyContin, at that point, was subject to being abused and misused and reformulated it to make much more that much more difficult, and about three years later, that old formulation was taken off.

What we've learned in terms of unintended consequences there, though, is subsequently that reformulation led to higher rates of heroin use, higher rates of over overdoses from opioids, and the consequences still stay with us. The communities that were subject to more subject to the effects of that reformulation continue to have higher rates of fentanyl overdoses, cocaine problems, and recent research from a colleague actually shows higher rates of child suicide.

I think as we're putting in place these policies, one of the things that becomes critical that we've learned from that is to continue to monitor and evaluate. It's not one and done. We can't do these things and turn away. We have to continue to learn because the crisis is going to continue to evolve, and our ability to understand how to respond to the changing landscape requires us to continue to pay attention.

The CHAIRMAN. Thanks. Sheriff, are there any different law enforcement issues dealing with seniors? Is there anything that makes it more challenging?

Mr. LEMMA. Yes, Chairman. I think when we look at the baby boomers particularly—you know, their name, baby boomers, for a reason, and we saw a significant population growth in that time, and we find many of that generation are evolving into really some dependency.

What I think the unintended consequences of Covid was, a senior population was thrusted into having a greater online presence that they weren't necessarily prepared for. A clue is if you're still paying $25 for an AOL account, you're probably victim, prime target for a victim of some online scamming. We're seeing an increase in white collar crimes and victimization of seniors.

When it comes to substance use and all of that, I think that we've always tried to balance the need for really reliable services and opioids have its place in certain environments and making sure that people who need the medicine are not getting it—not living in pain as a result of it.

I think that back when you were Governor, we saw that occur in the State of Florida with prescribing three and seven days and for acute pain. Then, prolonged issues, whether it's cancer or other type of items, seniors are able to get access to that. Again, the greatest increase that we're seeing is victimization because many

of our senior population were thrusted into this online presence, and because of that, they become more vulnerable.

The CHAIRMAN. Well, I just want to thank each of you for being here. Thank you for caring so much about this issue. It's impacted—I don't know, actually, of a family that's not been impacted either by alcohol abuse or drug abuse. I mean, everybody has. I lost my brother last spring. He started out, used some marijuana, eventually used all the drugs, and he impacted his life, and so, it screwed up. It doesn't just impact him, impacts my whole family. Just I feel sorry for everybody that does that, goes through this.

Thank each of you for being here, and I want to thank the ranking member for her hard work.

Senator GILLIBRAND. Thank you.

The CHAIRMAN. Thanks.

[Whereupon, at 5:20 p.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

PREPARED WITNESS STATEMENTS

Honorable Dennis Lemma

Good afternoon, Chairman Scott, Ranking Member Gillibrand, and distinguished members of the Special Committee. Thank you for the opportunity to testify on the devastating crisis of overdoses and fentanyl poisonings. It is an honor to present a proven strategy from Florida-one that can be replicated in communities nationwide.

Chairman Scott, your leadership, starting with your time as Florida's Governor when you and Attorney General Bondi took action to shut down pill mills, served as a model for the country. Senator Gillibrand, your efforts through legislation like the FEND Off Fentanyl Act have been crucial in this fight. I would also like to recognize Senator Moody, who, as Florida's Attorney General, provided invaluable leadership in the fight against this epidemic. Your vision and dedication inspired my own focus on this issue, which requires both law enforcement and clinical understanding.

I serve as the elected Sheriff of Seminole County, Florida, located in the Orlando Metropolitan area. Seminole County is the fourth most densely populated county in Florida, and despite its affluence, we are not immune to the devastating effects of this crisis. Simply stated, this epidemic does not discriminate-it affects citizens from all backgrounds and demands comprehensive solutions.

In my nearly 33 years of law enforcement, I've come to believe that the greatest responsibility of a civilized society is to protect and preserve human life. Overdose deaths have tragically become the leading cause of death for individuals aged 18 to 45. In 2022, the average life expectancy in the United States decreased, partially due to the rise in overdoses.

To effectively combat this crisis, we need a holistic approach that includes prevention, treatment, advocacy for life-saving interventions, and a strong emphasis on a law enforcement strategy that aggressively goes after drug dealers who are dealing deadly doses of narcotics in our communities.Prevention remains an incredibly powerful tool. Through focused education and awareness, we can equip individuals with the knowledge to avoid addiction before it starts. Prevention also requires ensuring the highest levels of access to opioid antagonists, like Narcan, a life-saving medication that can immediately reverse opioid overdoses. In Florida, we've made great strides in expanding access to these antagonists, and they have saved countless lives.

Treatment is equally important in breaking the cycle of addiction. Medication-assisted therapy, combined with cognitive behavioral therapy, has proven effective in helping individuals recover from substance use disorder in both clinical and correctional settings.

Data collection also plays a critical role in combating this epidemic. We need to gather and analyze overdose data at all levels. By understanding overdose trends, we can better allocate resources and target enforcement efforts.

However, accountability for drug dealers is absolutely crucial if we are going to put an end to this epidemic. We must make sure that those who distribute fentanyl and other illicit substances, like the emerging trend of street-level Xylazine, are held fully responsible for their actions, whether there is an associated death or not. Too often, overdoses are treated as accidents when, in reality, they are crimes. In Florida, we've passed legislation with harsher penalties for drug dealers whose actions result in fatal overdoses, while at the same time, we have created laws that criminally charge dealers if an individual overdoses and is brought back to life with an opioid antagonist. Drug dealers cannot be let off easily, and the law must hold these individuals accountable to the fullest extent.

Additionally, we cannot ignore the illicit drug trade, particularly from cartels like the Sinaloa and Jalisco New Generation, which still pose a threat to our country. Securing the border and preventing fentanyl from entering our country is critical to minimizing its availability and reducing deaths.

This crisis must unite us all, regardless of partisan lines, because it impacts every community across the country.

In conclusion, we must adopt a holistic strategy that integrates prevention, treatment, improved data collection, and the strictest accountability for drug dealers. This strategy works, builds safer communities, and ultimately saves lives. Utilizing

this strategy in Seminole County, we've achieved a 29% reduction in overdoses and a 42% reduction in fatalities in 2024. While we have seen a reduction, we know the hard work still lies ahead.

Thank you for having me here today. I look forward to addressing any questions you may have.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

PREPARED WITNESS STATEMENTS

Honorable Gregory Duckworth

"HOPE"

Introduction

My name is Greg Duckworth. I am a County Commissioner in Southern West Virginia, a board member of the West Virginia First Foundation (WVFF), and a 26-year retired veteran of the West Virginia State Police.

I spent my law enforcement career in the heart of the opioid epidemic, an area once known as "The Coal Fields." Today, I want to share some firsthand experiences on how this crisis has devastated families, affected our aging population, and where we must focus our efforts moving forward.

State Trooper Experience 1: 2012

In 2012, 17-year-old Cheyenne Martin reported to police that her father and two younger siblings were missing. She had already lost her mother, Kerri Hendrix, who-under the influence of OxyContin-wandered into a highway and was fatally struck by a truck.

During the investigation, police found that her father, Hendrix, was lured into a trap by a drug dealer named Belknap, who owed him money. Hendrix, his girlfriend, and his two youngest children were ambushed and murdered. Their bodies were discarded as if they were worthless.

A decade later, Cheyenne herself died of an opioid overdose, leaving behind three small children. Entire families are being erased by addiction.

This is not just a crisis of individuals-it's a crisis of generations. Children lose parents. Grandparents are forced back into parenting. Communities crumble.

State Trooper Experience 2: 2023

The second story involves a single mother in her early 30s with four children: a nine-year-old, a seven-year-old, and three-year-old twins.

For years, she lived with her mother, who helped care for the children. Recently, she had moved into her own place-a single-wide trailer within walking distance of her mother's home.

At night, after dinner, she would take the three-year-old twins home while leaving the older children with their grandmother, who ensured they got to school each morning. The twins were described as full of life, radiating joy, as most three-year-olds do.

One night, the mother put the twins to bed. By the time she checked on them again, they were deceased. Autopsies revealed multiple drugs in their systems, including lethal amounts of fentanyl. The neglect was so severe that rigor mortis had already set in before she realized what had happened.

The children's grandmother had already lost her husband to cancer. She fought for custody of her remaining grandchildren but was unsuccessful. She is, however, allowed to see them with the help of Child Protective Services.

The mother is currently in jail, awaiting trial for two counts of child neglect resulting in death.

The Burden on Our Seniors

In West Virginia, one in seven children loses a parent to overdose or incarceration by age 18. With the highest rate of neonatal abstinence syndrome (NAS), many of these children have medical and developmental challenges.

Grandparents-who thought they were retiring-are now primary caregivers. They face:

- Physical Strain - Raising young children at an advanced age.
- Financial Hardship - Many live on fixed incomes and struggle to meet basic needs.
- Emotional Toll - Raising children while grieving the loss of their own.

Many do this off the record to avoid the foster care system, meaning they receive no financial or legal support.

West Virginia First Foundation: Supporting Grandfamilies and the Aging PopulationI'm proud to serve as a board member for the West Virginia First Foundation (WVFF) and to be part of an organization that is making a real difference in our communities.

WVFF is committed to addressing the full impact of the opioid epidemic, including the burdens placed on West Virginia's aging population. Recognizing that addiction does not just affect the individual but entire families, WVFF is dedicated to supporting grandfamilies-grandparents raising grandchildren-by providing the resources and assistance to child advocacy and youth prevention programs.

We recognize that this crisis does not end with one generation-it continues to ripple outward. By investing in solutions that support the full family system, WVFF is helping to break the cycle of addiction, ensuring that grandparents raising grandchildren are not left to struggle alone.

The Fight Against Addiction: Where We Must Focus

Having served on the front lines of this epidemic, I believe that our response must be comprehensive. This includes:

- •Treatment Access - Making detox and rehab services more available.
- •Prevention & Education - Stopping addiction before it starts.
- •Recovery Support - Ensuring people have pathways to long-term sobriety.
- •Grandfamilies & Child Advocacy - Protecting children and supporting caregivers.
- •Economic Recovery - People in recovery need jobs, stability, and hope.

We must also fix systemic failures, such as:

- •Underreported overdose deaths.
- •Inconsistent Narcan use documentation.
- •Recovery homes misclassifying overdoses.

Closing Statement: Restoring Hope

I believe that hope can be restored.

Substance use disorder is our enemy. It is destroying the very core of the American way-God, family, and self.

To win this war, we must:

- •Ensure the love and support of the church.
- •Reunite families and emphasize the importance of family values.
- •Bring back support systems that give people a sense of self-worth.

This crisis is more than just statistics. These are real people with names, faces, and stories. If there is one thing I want you to take away from today, it is this: behind every number, there is a human being.

We must act. We must restore hope.

Thank you.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

PREPARED WITNESS STATEMENTS

Elizabeth Mateer

Chairman Scott, Ranking Member Gillibrand, and members of the Senate Aging Committee, thank you for holding this important hearing, and for inviting me to share my perspective. My name is Elizabeth Mateer. I am a grandmother raising my grandson due to the impact of opioids on our family. I also volunteer as a Generations United GRAND Voice caregiver advocate.

When my grandson was born, I had no idea that my life as I knew it would soon be forever changed. I did not know that the baby was suffering from Neonatal Abstinence Syndrome (NAS). I also had no knowledge about Opioid Use Disorder and this made it difficult to identify and understand the harsh reality that both parents were addicted to painkillers.

A few months later my husband and I intervened. We arranged for the mom to be admitted to a treatment facility and suddenly we had a baby! Although we were very relieved and hopeful for the future, we had no crib, no diapers, no baby clothing, no formula and no idea where to start.

Ten days later I received a phone call that the mom was leaving treatment. What were we to do? How could we hand our infant grandson back to parents who were using? Fear drove us to contact an attorney who obtained emergency custody and we were relieved to have the baby safe in our care. However, a few weeks later the parents cheated a drug test and we were ordered to return the baby. Why do judges appear to misunderstand opioid addiction and the risk in placing children with parents who are struggling with it?

For years we lived an endless cycle of staging interventions and arranging for admissions to treatment. Early on, one interventionist told me to be prepared to keep my grandchild long term because this would go on for a long time. Each relapse was a crushing blow and each time the recommended length of inpatient treatment increased.

The cost for all these treatment facilities was staggering. We paid $30,000.00 deposits for admission and $10,000.00/month. I constantly battled with the insurance company. If you have ever known a person to be caught up in opioid addiction, it is like none other. It takes a person's soul and turns them into someone you don't even recognize. We were desperate to save both mom and baby. The stress of living this opioid-created crisis landed me in the hospital with pneumonia in both lungs.

Usually, when your loved one heads to treatment you are relieved that they are safe, and you have a break from the crisis mode. Unfortunately, we did not have that break and were instead slapped with a custody case from our grandson's father and had to obtain legal counsel. Our legal fees mounted over more than two years of custody proceedings and exceeded $85,000.00. The court permitted "supervised" visits that were not actually being supervised. We were treated like bad people who had stolen a baby. Every time we went to court, we worried. We requested that the court stop the father's visitation privileges when we learned that the father was charged with child endangerment when another child of his was under his supervision. Six months later, he died of a heroin overdose. When I told my then four-and-a half-year-old grandson that his father died the First question he asked was "Will I still be able to live with you?".

I found that working and caring for a child was harder than when I raised my own children. I tried to stay in the workforce but managing the daycare requirements of drop off, packing lunches, pickup on time and all the preparation that goes along with it while getting to the office on time was overwhelming. I resigned from my position.

My relationships slowly disappeared. There were no more co-workers. Friends stopped inviting me to social events since I did not have childcare, and social outings at my age are not typically conducive to bringing children along. I felt isolated at home while my husband traveled for work. The stigma of addiction, that the child I raised could not raise their child, made me feel ashamed. No one knocked on my door with a lasagna in hand to comfort our family in crisis. The clergy where I was ordained an elder and served twenty-four years never called. Depression set in and I wondered, how could I go on?

By the grace of God our grandson's mother has been clean for a long time. Our relationship is challenging because her son, now age 13, wishes to remain in our home. During the years of battling her addiction he just grew up. This is his community, his home where his pets live, where his school is, where his friends are. If this is where he wants to be we will support his choice.

Though the years were difficult in many ways, there is great joy knowing that our grandchild is thriving and happy. We are now both retired, my husband delayed retirement so we could provide for our grandson. Our retirement is nothing like we thought it would be, driving the middle school carpool and hosting the baseball team picnic. We hope to stay healthy so that we can be there for our grandson.

The staggering number of grandparents who care for their grandchildren, often without any support from the child welfare system, appears to be one of the least recognized populations impacted by the opioid crisis. According to Generations United, grandparents and other relatives who step forward to keep children out of foster care and safely with family, save taxpayers more than $4 billion each year. The child welfare system would collapse if grandparents did not take in all these children. Any grandparent raising a grandchild could use financial help.

I urge you to consider the following recommendations:

•Encourage states to support grandfamilies with opioid settlement funds. Why is there hardly any consideration to distribute opioid settlement money to help the children and caregivers in grandfamilies that have formed out of the opioid crisis? Anything would help. Seniors on fixed incomes struggle to pay for school supplies, activities, clothing, camps, and orthodontic treatment among many other things for a child they did not plan to raise.

•Peer Support for grandparents raising grandchildren. Peer support from Generation United's GRAND Voices Network has been an important way for me to engage with others in my situation and share ideas. It has eliminated my feelings of isolation. There is a great need for grandparents to connect and support one another.

•Increase availability of knowledgeable mental health providers who work with the whole family. There are few mental health providers who are qualified to provide care to grandfamilies. How can the number of these providers be expanded? The dynamics in the family are difficult to navigate when the parent loses custody. I was once told that opioid addiction in a family is like pouring acid on it. None of the treatment facilities provided any support to our family, the only focus was on the inpatient and yet our whole family was suffering.

•Ensure access to health care and social security for grandfamilies. When we enrolled in Medicare, our grandson lost his health insurance. The Affordable Care Act ensures coverage of children up to age 26, but we had to purchase private health insurance for our grandchild in addition to paying for Medicare and a supplemental policy for us. Why are grandchildren not included in the Affordable Care Act? Allow grandchildren who are in the legal guardianship of their grandparent to qualify for survivor benefits if their grandparent dies. Social Security requires a grandchild to be legally adopted if they are to receive any benefit should the grandparent die. Legal fees for adoption can be $30,000.00 on top of initial custody proceedings.

•Protect SNAP. SNAP can be a lifesaver when a grandparent suddenly takes in a child. I urge you to protect this critical program from cuts.

•Continue federal support for kinship navigator programs. When grandparents step in suddenly to raise children they often do not know where to turn for help. Kinship Navigator Programs offer important information, referral and support to help families connect to community-based services and supports.

Children in the care of grandparents are loved and thrive. I cannot imagine what my grandson's life would have been in foster care with strangers. Grandparents feel a connection and commitment to protecting the children in their care, but we need help. Any grandparent raising a grandchild could use support regardless of their station in life. Please, do what you can to help us.

U.S. SENATE SPECIAL COMMITTEE ON AGING

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PREPARED WITNESS STATEMENTS

Dr. Malik Burnett

Chairman Scott, Ranking Member Gillibrand, and esteemed Members of the Special Committee on Aging, thank you for inviting me to participate in today's critically important hearing.

My name is Dr. Malik Burnett. I am a board-certified addiction specialist physician who takes care of patients with addiction and co-occurring conditions in Baltimore, Maryland. I serve as the medical director of several community opioid treatment programs, an Adjunct Assistant Professor at the University of Maryland, and a consultant for the Maryland Addiction Consultation Service.

Today, I am testifying in my capacity as Vice Chair of the Public Policy Committee of the American Society of Addiction Medicine, known as ASAM. ASAM is a national medical society representing over 8,000 physicians and other clinicians who specialize in the prevention and treatment of addiction.

I want to begin by talking about Baltimore and its forgotten generation - older adults born between 1951 and 1970, particularly older Black men.[1] In my city, almost one in three drug overdose deaths come from this demographic.[1] Indeed, illicitly manufactured synthetic opioids are among the deadliest health threats they face. Many of these men have struggled with addiction for years, but today, there is no margin for error. A single relapse can leave them at the mercy of a lethal dose of fentanyl and other synthetic drugs.

While addiction is a treatable, chronic medical disease, it is also one of the most complex in medicine. It involves interactions among brain circuits, genetics, the environment, and an individual's life experiences. As a result, solutions to our nation's addiction and overdose crisis can be equally complex and interconnected.

Supply-side approaches - like the DEA's record seizure of fentanyl pills in 2023[2] - are important to public safety, but yield little net benefit if demand-side interventions remain inaccessible, underfunded, or undermined. Drug cartels can quickly replace confiscated synthetic drugs - no crops, farmland, or irrigation required - just some precursor chemicals, a few chemists, and hundreds of traffickers, all making more money than most of us will see in a lifetime.

The good news? Evidence-based addiction treatment works, and it as effective as treatments for other chronic diseases.[3]

As a physician, I have personally witnessed hundreds of patients' lives transformed by addiction treatment. Practicing addiction medicine is an immensely satisfying profession, because I get to see people get really well - they restore their marriages, rejoin the workforce, leave criminal activity, improve their mental and physical wellbeing, reunite with their children, and yes - escape the grasp of drugs cartels. Addiction treatment not only improves their lives, but the lives of those around them.

We are fortunate to live during a time when effective, evidence-based treatments exist for opioid use disorder. These treatments cut the risk of death, decrease or eliminate drug use, and facilitate transitions into healthy, productive roles in society.[4,5] Yet, tens of thousands of people in the US continue to die from illicit opioids annually.

How is this possible?

Unfortunately, the people who need these treatments the most - people with opioid use disorder - are not getting the lifesaving care they need, when they need it. In fact, this treatment gap has barely budged over the last decade.[6] We will not end this opioid epidemic until evidence-based addiction treatment is easier to get than illicit opioids.

For many Americans, especially in rural areas, evidence-based addiction treatment can be impossible to find.[7,8] Ease of treatment access is critically important, because people with addiction often experience a brief window of time between desiring treatment and experiencing painful withdrawal symptoms - symptoms that cheap fentanyl, which can be easier to get than addiction medications, can temporarily stop in an instant.

Easier access to addiction treatment cannot happen without a substantially larger addiction treatment workforce,[9] including more addiction specialist physicians. Specialist physicians like me are critical for helping patients with complex, inter-

connected health conditions, for leading interdisciplinary care teams, and for serving as mentors to primary care clinicians who would like to integrate addiction treatment into their practices but need greater guidance to do so. Increased federal funding for addiction medicine and addiction psychiatry fellowships and financial incentives to encourage more physicians to enter these training programs are sorely needed to ensure every community has access to high-quality addiction treatment.

In addition, federal law must be amended to allow these addiction specialist physicians to prescribe methadone for opioid use disorder that can be dispensed from community pharmacies. Today, only about 2,000 clinics dispense methadone for opioid use disorder, and they are lacking in 80% of US counties.[10] Methadone for opioid use disorder (but not for pain) has more federal restrictions than just about any other FDA-approved medication. It has been caught in bureaucratic red tape for nearly fifty years - despite an opioid epidemic that has continued to worsen. Allowing states to regulate their methadone treatment, without undue federal restrictions, could lead to the type of innovation needed in opioid addiction treatment in America.

Yet, connecting individuals to treatment is not enough - they must also be able to afford their care. Medicaid and Medicare are major insurers for many people with opioid addiction, making it essential that their policies facilitate, rather than hinder, access. For example, if states are expected to implement Medicaid work requirements, then they also should have the ability to exempt beneficiaries with substance use disorders that make it difficult for them to meet those requirements. While completing addiction treatment can increase the likelihood of employment,[11] beneficiaries struggling with severe, unmanaged substance use disorders and associated criminal records may not be able to obtain or maintain employment. Without such an exemption, our nation could face an unnecessary increase in expensive emergency room visits, as well as in overdose deaths.[12]

Many mental health therapists,[13] opioid treatment programs,[14] and buprenorphine prescribers[15] do not accept Medicaid, largely reflecting the program's administrative burdens and low reimbursement rates.[13] Congress should remove these burdens and increase Medicaid rates to change this equation. In the meantime, addiction treatment providers who do not accept Medicaid are essentially unavailable to the approximately 40% of nonelderly adults with opioid use disorder who rely on Medicaid.[16]

Medicare and Medicaid must also cover the full continuum of addiction care. (See the enclosed handout on The ASAM Criteria). Surprisingly, Medicare does not cover non-hospital-based residential addiction treatment,[17] even though the rate of drug overdose death rates quadrupled among older Americans between 2002 and 2021.[18] This must change. Further, enforcement of mental health and addiction parity must be strengthened by requiring robust data collection and evaluation, levying civil penalties for parity violations, and incentivizing state regulators to be more robust in their enforcement.[19] Consumers should not have the burden of initiating investigations into insurance practices that may violate parity, especially as many addiction treatment patients lack financial resources or legal knowledge.

Additionally, countless studies indicate that the stigma of addiction prevents treatment access. Even when people recognize they have a problem with drugs or alcohol, they are too embarrassed or scared to talk to their physician about it.[20] Stigma is arguably the most difficult barrier to address, as it is so entrenched in society.[21] The federal government should stop wasting money on incarcerating people for non-violent drug offenses and must continue to emphasize that addiction is a disease, not a moral failing. When government resources are spent on incarcerating people with addiction for non-violent drug offenses, this message gets muddled, and society continues to view addiction as a moral failing, disincentivizing people from seeking help.[21] Incarcerating people for low-level drug crimes is also incredibly fiscally irresponsible. Every dollar spent on addiction treatment saves $7 of justice system resources.[22] Research continues to show that treatment can reduce illicit drug use and associated criminal activity.[23]

People already in the criminal legal system also need better addiction treatment. Congress should eliminate Medicaid's inmate exclusion, and federal funding for prisons and jails should be contingent on providing evidence-based addiction treatment - to ensure that taxpayer money is not wasted on a revolving door of incarceration.[24] The Department of Justice should continue investigating criminal legal institutions that refuse to offer or permit use of methadone and buprenorphine.[25] There is a high risk of overdose death for people leaving jail or prison,[26] as they lose opioids tolerance but may return to drug use without a connection to community-based treatment. Prisons and jails should be incentivized to hire professionals, like social workers, to connect people who are reentering the community to continued addiction

treatment, housing, and employment services - critical services that reduce the chances of returning to environments that involved drug use.[27]

In closing, thank you for the opportunity to share my perspective and expertise today. Prior to this hearing, I had the privilege of reading RAND's report on America's Opioid Ecosystem and related policy ideas.[28] Throughout it, there is one fundamental question: Who owns this?

Whether it is funding the training of more addiction specialists; ensuring that they can legally prescribe methadone; closing the dangerous Medicare coverage gap for residential addiction treatment; equipping the criminal legal system to provide evidence-based addiction care; enforcing mental health and addiction parity, or avoiding harmful cuts to Medicaid, the answer is the same: Congress owns this.

Let us work together to save lives.

Thank you, and I look forward to answering your questions.

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"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

PREPARED WITNESS STATEMENTS

Bradley D. Stein

Addressing the Opioid Crisis Among Older Americans

Strategies for Prevention, Treatment, and Supporting Families Affected by Addiction

Testimony of Bradley D. Stein[1]
RAND[2]

Before the Special Committee on Aging
United States Senate

February 26, 2025

Thank you Chairman Scott, Ranking Member Gillibrand, and distinguished members of the committee for allowing me to testify on opportunities to enhance the government's efforts to combat the opioid crisis. I am a senior physician policy researcher at RAND, where I serve as director of the National Institutes of Health–funded RAND-USC Schaeffer Opioid Policy Tools and Information Center. The views I share today are based on work done as part of that center, as well as the RAND report *America's Opioid Ecosystem*, in which colleagues and I examined how leveraging system interactions can reduce addiction, overdose, suffering, and other opioid-related harms.[3]

In addition to my research, I am a practicing child and adolescent psychiatrist in Western Pennsylvania, one of the regions that has been dramatically affected by the opioid crisis. Much of our nation's response to the crisis has focused on fatal overdoses; however, as a clinician and researcher, I can confirm that the toll of the opioid crisis extends far beyond those who have lost

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research.

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[3] B. D. Stein, B. Kilmer, J. Taylor, and M. E. Vaiana, eds., *America's Opioid Ecosystem: How Leveraging System Interactions Can Help Curb Addiction, Overdose, and Other Harms*, RAND Corporation, RR-A604-1, 2023, https://www.rand.org/pubs/research_reports/RRA604-1.html.

their lives to an overdose: Approximately 40 million American adults have had their lives disrupted by a fatal drug overdose.[4] Of particular relevance to this committee are the harms of the opioid crisis affecting older Americans. Many of the challenges are ones with which we are all familiar. For example, one of my patients, along with her brother and sister, is cared for by their grandmother because their mother continues to struggle with her opioid addiction. The grandmother often has difficulty bringing my patient to our appointments because of her own chronic health issues, including significant arthritis, yet she is spending a good deal of time and resources trying to help her daughter get the treatment she needs for her addiction.

Other issues have not been as widely recognized but represent growing challenges in the years to come, such as the extent to which our health care system is prepared to address the needs of older adults experiencing opioid-related problems.

In my remarks today, I would like to address three important issues that I hope will provide a more nuanced understanding of how the opioid crisis has affected the nation:

- the growing opioid use disorder (OUD) crisis among older adults and their treatment needs
- upstream strategies for preventing opioid misuse and illegally produced opioids by addressing chronic pain
- the social impact of OUD among older adults—how the drug crisis affects the living arrangements of children.

The Growing Crisis of Opioid Use Disorder Among Older Adults and Its Effect on Health and Health Care

The prevalence of OUD has been increasing rapidly.[5] Among Medicare beneficiaries 65 and older, the percentage of individuals with OUD has increased threefold,[6] and increasing rates of OUD in this population are expected to continue.[7] Historically, rates of OUD among older adults have been lower than among younger age groups. Thus, the rapid escalation of OUD among older adults poses serious challenges for our health care system in effectively addressing physical health, cognitive impairment, and functional impairment in this vulnerable population—all issues that are worsened by OUD.

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[4] A. Athey, B. Kilmer, and J. Cerel, "An Overlooked Emergency: More Than One in Eight US Adults Have Had Their Lives Disrupted by Drug Overdose Deaths," *American Journal of Public Health*, Vol. 114, No. 3, March 2024.

[5] D. Dowell, S. Brown, S. Gyawali, J. Hoenig, J. Ko, C. Mikosz, E. Ussery, G. Baldwin, C. M. Jones, Y. Olsen, et al., "Treatment for Opioid Use Disorder: Population Estimates—United States, 2022," *Morbidity and Mortality Weekly Report*, Vol. 73, No. 25, June 27, 2024; N. D. Volkow and C. Blanco, "The Changing Opioid Crisis: Development, Challenges and Opportunities," *Molecular Psychiatry*, Vol. 26, No. 1, January 2021.

[6] C. Shoff, T. C. Yang, and B. A. Shaw, "Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013–2018," *American Journal of Preventive Medicine*, Vol. 60, No. 6, June 2021.

[7] C. B. Mistler, R. Shrestha, J. Gunstad, V. Sanborn, and M. M. Copenhaver, "Adapting Behavioural Interventions to Compensate for Cognitive Dysfunction in Persons with Opioid Use Disorder," *General Psychiatry*, Vol. 34, No. 4, 2021.

The gold standards for OUD treatment are medications such as buprenorphine and methadone, which are associated with reduced fatal overdose risk, less need for urgent health care, and improved quality of life.[8] But despite widespread federal efforts to increase access to such treatment, few older adults with OUD receive medication treatment: Only 15 percent of Medicare beneficiaries with OUD received medication treatment in 2022,[9] lower rates than among younger cohorts.[10] And treatment with buprenorphine, which (unlike methadone) can be provided by primary care clinicians, is highly concentrated in the elderly: Approximately 1,200 clinicians across the country are responsible for the treatment of more than one-third of the 68,000 older adults receiving buprenorphine.[11] Federal policy changes in 2020 and 2021 increased access to medication treatment for Medicare beneficiaries with OUD;[12] however, continued efforts are needed to ensure access to this life-saving treatment for this vulnerable population.

But there are challenges to treating OUD in the elderly that extend beyond the challenges experienced by younger cohorts; in many cases, these challenges are related to the complex interplay between OUD and other health conditions commonly experienced by the elderly.[13] For example, as members of this committee know, because many adults are living longer, rates of dementia are continuing to increase.[14] Medicare beneficiaries living with dementia are more

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[8] M. R. Larochelle, D. Bernson, T. Land, T. J. Stopka, N. Wang, Z. Xuan, S. M. Bagley, J. M. Liebschutz, and A. Y. Walley, "Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study," *Annals of Internal Medicine*, Vol. 169, No. 3, August 7, 2018; O. K. Golan, R. Totaram, E. Perry, E. Perry, K. Fortson, R. Rivera-Atilano, R. Entress, M. Golan, B Andraka-Christou, D. Whitaker, and T. Pigott, "Systematic Review and Meta-Analysis of Changes in Quality of Life Following Initiation of Buprenorphine for Opioid Use Disorder," *Drug and Alcohol Dependence*, Vol. 235, June 1, 2022.

[9] Y. F. Kuo, J. Westra, E. P. Harvey, and M. A. Raji, "Use of Medications for Opioid Use Disorder in Older Adults," *American Journal of Preventive Medicine*, January 30, 2025; Office of the Inspector General, "Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder," U.S. Department of Health and Human Services, December 2021.

[10] C. M. Jones, B. Han, G. T. Baldwin, E. B. Einstein, and W. M. Compton, "Use of Medication for Opioid Use Disorder Among Adults with Past-Year Opioid Use Disorder in the US, 2021," *JAMA Network Open*, Vol. 6, No. 8, August 1, 2023; P. M. Mauro, S. Gutkind, E. M. Annunziato, and H. Samples, "Use of Medication for Opioid Use Disorder Among US Adolescents and Adults with Need for Opioid Treatment, 2019," *JAMA Network Open*, Vol. 5, No. 3, March 1, 2022.

[11] N. C. Ernecoff, F. Sheng, J. Cantor, and B. D. Stein, "Buprenorphine Prescribing Practices for Older Adults in 2019 and 2020," *Journal of the American Geriatrics Society*, December 4, 2024.

[12] Public Law 115-271, Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, October 24, 2018; Public Law 117-2, American Rescue Plan Act of 2021, March 11, 2021; C. Felix, J. M. Sharfstein, and Y. Olsen, "Help Is on the Way: Medicare Coverage of Opioid Treatment Programs," *Journal of the American Geriatrics Society*, Vol. 68, No. 3, March 2020.

[13] L. B. Gerlach, M. Olfson, H. C. Kales, and D. T. Maust, "Opioids and Other Central Nervous System-Active Polypharmacy in Older Adults in the United States," *Journal of the American Geriatrics Society*, Vol. 65, No. 9, September 2017; M. A. Davis, L. A. Lin, H. Liu, and B. D. Sites, "Prescription Opioid Use Among Adults with Mental Health Disorders in the United States," *Journal of the American Board of Family Medicine*, Vol. 30, No. 4, July–August 2017.

[14] "2024 Alzheimer's Disease Facts and Figures," *Alzheimer's and Dementia*, Vol. 20, No. 5, May 2024; M. M. Corrada, R. Brookmeyer, A. Paganini-Hill, D. Berlau, and C. H. Kawas, "Dementia Incidence Continues to Increase

likely to be prescribed potentially inappropriate opioids than those without dementia in the year after a chronic pain diagnosis,[15] potentially leading to an increased rate of OUD.[16] The converse also appears to be true: Individuals with OUD have an 88 percent higher risk of developing dementia compared with those without OUD.[17]

The substance use disorder treatment system must be ready to address the needs of people living with co-occurring dementia and OUD.[18] But there is an acute shortage of the expertise needed to treat these co-occurring conditions. Primary care providers—the clinicians who most commonly care for people living with dementia—express discomfort with and a lack of resources and skills in treating OUD, including prescribing medications effective in treating OUD,[19] and may be less experienced in safely tapering individuals with OUD who have been

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with Age in the Oldest Old: The 90+ Study," *Annals of Neurology*, Vol. 67, No. 1, January 2010; M. Fang, J. Hu, J. Weiss, D. S. Knopman, M. Albert, B. G. Windham, K. A. Walker, A. R. Sharrett, R. F. Gottesman, P. L. Lutsey, et al., "Lifetime Risk and Projected Burden of Dementia," *Nature Medicine*, January 13, 2025.

[15] H. Mörttinen-Vallius, S. Hartikainen, L. Seinelä, and E. Jämsen, "The Prevalence of and Exact Indications for Daily Opioid Use Among Aged Home Care Clients With and Without Dementia," *Aging Clinical and Experimental Research*, Vol. 33, No. 5, May 2021; Y. J. Wei, S. Schmidt, C. Chen, R. B. Fillingim, M. C. Reid, S. DeKosky, L. Solberg, M. Pahor, B. Brumback, and A. G. Winterstein, "Quality of Opioid Prescribing in Older Adults With or Without Alzheimer Disease and Related Dementia," *Alzheimer's Research and Therapy*, Vol. 13, No. 1, April 12, 2021.

[16] F. Qeadan, A. McCunn, B. Tingey, R. Price, K. L. Bobay, K. English, and E. F. Madden, "Exploring the Association Between Opioid Use Disorder and Alzheimer's Disease and Dementia Among a National Sample of the U.S. Population," *Journal of Alzheimer's Disease*, Vol. 96, No. 1, 2023.

[17] F. Qeadan, A. McCunn, B. Tingey, R. Price, K. L. Bobay, K. English, and E. F. Madden, "Exploring the Association Between Opioid Use Disorder and Alzheimer's Disease and Dementia Among a National Sample of the U.S. Population," *Journal of Alzheimer's Disease*, Vol. 96, No. 1, 2023.

[18] C. B. Mistler, R. Shrestha, J. Gunstad, V. Sanborn, and M. M. Copenhaver, "Adapting Behavioural Interventions to Compensate for Cognitive Dysfunction in Persons with Opioid Use Disorder," *General Psychiatry*, Vol. 34, No. 4, 2021; C. Bruijnen, B. A. G. Dijkstra, S. J. W. Walvoort, W. Markus, J. E. L. VanDerNagel, R. P. C. Kessels, and C. A. J. De Jong, "Prevalence of Cognitive Impairment in Patients with Substance Use Disorder," *Drug and Alcohol Review*, Vol. 38, No. 4, May 2019; P. J. Na, R. Rosenheck, and T. G. Rhee, "Increased Admissions of Older Adults to Substance Use Treatment Facilities and Associated Changes in Admission Characteristics, 2000–2017," *Journal of Clinical Psychiatry*, Vol. 83, No. 3, March 28, 2022; V. Sanborn, J. Gunstad, R. Shrestha, C. B. Mistler, and M. M. Copenhaver, "Cognitive Profiles in Persons with Opioid Use Disorder Enrolled in Methadone Treatment," *Applied Neuropsychology: Adult*, Vol. 29, No. 4, July–August 2022.

[19] R. P. Winograd, B. Coffey, C. Woolfolk, C. A. Wood, V. Ilavarasan, D. Liss, S. Jain, and E. Stringfellow, "To Prescribe or Not to Prescribe?: Barriers and Motivators for Progressing Along Each Stage of the Buprenorphine Training and Prescribing Path," *Journal of Behavioral Health Services and Research*, Vol. 50, No. 2, April 2023; K. Foti, J. Heyward, M. Tajanlangit, K. Meek, C. Jones, A. Kolodny, and G. C. Alexander, "Primary Care Physicians' Preparedness to Treat Opioid Use Disorder in the United States: A Cross-Sectional Survey," *Drug and Alcohol Dependence*, Vol. 225, August 1, 2021; K. Mackey, S. Veazie, J. Anderson, D. Bourne, and K. Peterson, "Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: A Rapid Review," *Journal of General Internal Medicine*, Vol. 35, Supp. 3, 2020; C. M. Jones and E. F. McCance-Katz, "Characteristics and Prescribing Practices of Clinicians Recently Waivered to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder," *Addiction*, Vol. 114, No. 3, March 2019; C. H. A. Andrilla, C. Coulthard, and E. H. Larson, "Barriers Rural Physicians Face Prescribing Buprenorphine for Opioid Use Disorder," *Annals of Family Medicine*, Vol. 15, No. 4, July/August 2017.

prescribed benzodiazepines or opioid analgesics.[20] Clinicians who specialize in treating OUD often lack expertise in managing other chronic diseases, including dementia.[21]

Unfortunately, without concerted efforts to address this challenge, most older adults with OUD will not be treated by clinicians with expertise in dementia, and most older adults with dementia will not be treated by clinicians with expertise in substance use disorders. The greatest challenges will be in rural counties,[22] such as Mercer County in West Virginia and Warren County in Georgia, where older adults disproportionately reside and there often are critical shortages of health care clinicians.[23] The interaction of dementia and OUD will make unprecedented and extremely costly health care demands that the U.S. health care system—particularly primary care, geriatrics, and specialty substance use care—is ill prepared to meet.

I have focused thus far on older adults with dementia. However, we face similar challenges in treating older adults with OUD and chronic pain.

The Role of Upstream Strategies and Better Treatment for Chronic Pain

Chronic noncancer pain is one of the most prevalent health conditions in the United States; it is also among the most poorly managed.[24] More-aggressive efforts to treat chronic pain contributed to the dramatic increase in opioid analgesic prescriptions that drove the first wave of the opioid crisis.[25] A variety of federal and state policies, coupled with greater awareness of

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[20] American Society of Addiction Medicine, *ASAM Clinical Practice Guideline on Benzodiazepine Tapering*, draft, 2024, https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/bzd-cpg-narrative-draft-for-public-comment.pdf?sfvrsn=6d96408_2.

[21] J. Dill, C. Henning-Smith, R. Zhu, and E. Vomacka, "Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas," *Journal of Applied Gerontology*, Vol. 42, No. 8, August 2023; J. J. Fenton, A. L. Agnoli, G. Xing, L. Hang, A. E. Altan, D. J. Tancredi, A. Jerant, and E. Magnan, "Trends and Rapidity of Dose Tapering Among Patients Prescribed Long-Term Opioid Therapy, 2008–2017," *JAMA Network Open*, Vol. 2, No. 11, November 2019.

[22] C. H. A. Andrilla, T. E. Moore, D. G. Patterson, and E. H. Larson, "Geographic Distribution of Providers with a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update," *Journal of Rural Health*, Vol. 35, No. 1, Winter 2019; T. Beetham, B. Saloner, S. E. Wakeman, M. Gaye, and M. L. Barnett, "Access to Office-Based Buprenorphine Treatment in Areas with High Rates of Opioid-Related Mortality: An Audit Study," *Annals of Internal Medicine*, Vol. 171, No 1, July 2, 2019; C. H. A. Andrilla, C. Coulthard, and D. G. Patterson, "Prescribing Practices of Rural Physicians Waivered to Prescribe Buprenorphine," *American Journal of Preventive Medicine*, Vol. 54, No. 6, Supp. 3, June 2018.

[23] C. H. A. Andrilla, S. C. Woolcock, K. Meyers, and D. G. Patterson, "Expanding the Opioid Use Disorder Medication Treatment Workforce in Rural Communities Through the RCORP Initiative," *Journal of Rural Health*, Vol. 41, No. 1, Winter 2025; J. Dill, C. Henning-Smith, R. Zhu, and E. Vomacka, "Who Will Care for Rural Older Adults? Measuring the Direct Care Workforce in Rural Areas," *Journal of Applied Gerontology*, Vol. 42, No. 8, August 2023.

[24] R. J. Yong, P. M. Mullins, and N. Bhattacharyya, "Prevalence of Chronic Pain Among Adults in the United States," *Pain*, Vol. 163, No. 2, February 2022.

[25] A. Van Zee, "The Promotion and Marketing of Oxycontin: Commercial Triumph, Public Health Tragedy," *American Journal Public Health*, Vol. 99, No. 2, February 2009.

clinically unnecessary prescribing, substantially reduced opioid prescribing.[26] However, there has not been a corresponding decrease in chronic pain experienced by older adults: 36 percent of Americans over the age of 65 experience chronic pain most days or every day, and 13 percent report that pain limited their life activities every day or most days.[27]

Given concerns about inappropriate prescribing, many clinicians are now reluctant to prescribe opioids to individuals experiencing chronic pain or may refuse to prescribe them at all,[28] despite the fact that thoughtfully prescribed opioids are effective and safe in managing pain in some individuals. Often, prescribing clinicians do not offer non-opioid alternative treatments, leaving elderly patients who are seeking adequate pain relief without options. Those who have trouble accessing appropriate pain management often suffer significant social and economic consequences, including reduced quality of life, impaired physical function, lost productivity, and increased risk of long-term pain.[29] Tragically, an unintended consequence of tighter restrictions on opioid prescribing has been an increase in illicit drug use, most notably heroin,[30] among pain patients who chose to self-medicate as access to prescription opioids became more difficult.[31]

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[26] Congressional Budget Office, *The Opioid Crisis and Recent Federal Policy Responses*, September 2022, https://www.cbo.gov/system/files/2022-09/58221-opioid-crisis.pdf.

[27] J. Lucas and I. Sohi, "Chronic Pain and High-Impact Chronic Pain in U.S. Adults, 2023," Centers for Disease Control and Prevention, November 2024, https://www.cdc.gov/nchs/data/databriefs/db518.pdf.

[28] P. A. Lagisetty, N. Healy, C. Garpestad, M. Jannausch, R. Tipirneni, and A. S. B. Bohnert, "Access to Primary Care Clinics for Patients with Chronic Pain Receiving Opioids," *JAMA Network Open*, Vol. 2, No. 7, July 3, 2019; U.S. Food and Drug Administration, "FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines and Requires Label Changes to Guide Prescribers on Gradual, Individualized Tapering," April 9, 2019, https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes; J. J. Fenton, A. L. Agnoli, G. Xing, L. Hang, A. E. Altan, D. J. Tancredi, A. Jerant, and E. Magnan, "Trends and Rapidity of Dose Tapering Among Patients Prescribed Long-Term Opioid Therapy, 2008–2017," *JAMA Network Open*, Vol. 2, No. 11, November 2019; T. L. Mark and W. Parish, "Opioid Medication Discontinuation and Risk of Adverse Opioid-Related Health Care Events," *Journal of Substance Abuse Treatment*, Vol. 103, August 2019; H. T. Neprash, M. Gaye, and M. L. Barnett, "Abrupt Discontinuation of Long-Term Opioid Therapy Among Medicare Beneficiaries, 2012–2017," *Journal of General Internal Medicine*, Vol. 36, January 29, 2021; Y. Bao, K. Wen, P. Johnson, L. R. Witkin, and M. C. Reid, "Abrupt Discontinuation of Long-Term Opioid Therapies Among Privately Insured or Medicare Advantage Adults, 2011–2017," *Pain Medicine*, Vol. 22, No. 7, November 6, 2020.

[29] M. Jukic and L. Puljak, "Legal and Ethical Aspects of Pain Management," *Acta Medica Academica*, Vol. 47, No. 1. 2018; R. Sinatra, "Causes and Consequences of Inadequate Management of Acute Pain," *Pain Medicine*, Vol. 11, No. 12, December 2010.

[30] T. J. Speed, V. Parekh, W. Coe, and D. Antoine, "Comorbid Chronic Pain and Opioid Use Disorder: Literature Review and Potential Treatment Innovations," *International Review of Psychiatry*, Vol. 30, No. 5, October 2018.

[31] A. Alpert, D. Powell, and R. L. Pacula, "Supply-Side Drug Policy in the Presence of Substitutes: Evidence from the Introduction of Abuse-Deterrent Opioids," *American Economic Journal: Economic Policy*, Vol. 10, No. 4, November 2018; D. Powell and R. L. Pacula, "The Evolving Consequences of Oxycontin Reformulation on Drug Overdoses," *American Journal of Health Economics*, Vol. 7, No. 1, Winter 2021; W. M. Compton, C. M. Jones, and G. T. Baldwin, "Relationship Between Nonmedical Prescription-Opioid Use and Heroin Use," *New England Journal of Medicine*, Vol. 374, No. 2, January 2016.

Nonmedication interventions, either alone or in conjunction with other approaches, can play an important role in addressing the needs of individuals experiencing pain.[32] Such interventions can reduce the need for medication for pain management,[33] particularly for widespread chronic conditions, such as back pain.[34] But nonmedication modalities, including such approaches as acupuncture, rehabilitative exercise, meditation, and therapeutic massage, are commonly underutilized.[35] Even if such interventions are covered by insurance, the burden associated with prior authorization, the number of sessions, and the size of copayments can make it simpler and easier for clinicians and patients to turn to a pill instead.

In addition, there need to be enough providers accessible and available in the insurer's network for patients to get a timely appointment for nonmedication treatment. Ensuring network adequacy and leveraging the existing complementary and integrative health care workforce in the short term is essential, but we also need to ensure an adequate pipeline of clinicians trained to provide nonmedication interventions.

Attention should also be given to enhance the delivery of nonmedication pain interventions in the existing system. Decision support tools can help to reduce the amount of opioids prescribed;[36] including nonmedication treatment in these tools could enhance coordinated efforts to better manage pain. Additionally, in recognition of the possibility that socioeconomically disadvantaged individuals might face additional barriers in accessing these interventions,[37]

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[32] Joint Commission, "Non-Pharmacologic and Non-Opioid Solutions for Pain Management," *Quick Safety*, No. 44, August 2018, https://www.jointcommission.org/-/media/tjc/newsletters/qs-nonopioid-pain-mgmt-8-15-18-final4.pdf.

[33] D. I. Rhon, T. A. Greenlee, and J. M. Fritz, "The Influence of a Guideline-Concordant Stepped Care Approach on Downstream Health Care Utilization in Patients with Spine and Shoulder Pain," *Pain Medicine*, Vol. 20, No. 3, March 2019; J. M. Whedon, A. W. J. Toler, J. M. Goehl, and L. A. Kazal, "Association Between Utilization of Chiropractic Services for Treatment of Low-Back Pain and Use of Prescription Opioids," *Journal of Alternative and Complementary Medicine*, Vol. 24, No. 6, June 2018; L. E. Kazis, O. Ameli, J. Rothendler, B. Garrity, H. Cabral, C. McDonough, K. Carey, M. Stein, D. Sanghavi, D. Elton, et al., "Observational Retrospective Study of the Association of Initial Healthcare Provider for New-Onset Low Back Pain with Early and Long-Term Opioid Use," *BMJ Open*, Vol. 9, No. 9, September 2019.

[34] Diagnosis and Treatment of Low Back Pain Work Group, *VA/DoD Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain*, version 3.0, Department of Veterans Affairs and Department of Defense, 2022; A. C. Skelly, R. Chou, J. R. Dettori, J. A. Turner, J. L. Friedly, S. D. Rundell, R. Fu, E. D. Brodt, N. Wasson, C. Winter, and A. J. R. Ferguson, *Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review*, Agency for Healthcare Research and Quality, Comparative Effectiveness Review No. 209, June 2018; A. Qaseem, T. J. Wilt, R. M. McLean, and M. A. Forciea, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians," *Annals of Internal Medicine*, Vol. 166, No. 7, April 4, 2017.

[35] L. S. Penney, C. Ritenbaugh, L. L. DeBar, C. Elder, and R. A. Deyo, "Provider and Patient Perspectives on Opioids and Alternative Treatments for Managing Chronic Pain: A Qualitative Study," *BMC Family Practice*, Vol. 17, 2016; D. Dowell, K. R. Ragan, C. M. Jones, G. T. Baldwin, and R. Chou, "CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022," *MMWR Recommendations and Reports*, Vol. 71, No. 3, November 4, 2022.

[36] Centers for Disease Control and Prevention, "Electronic Clinical Decision Support Tools: Opioid Prescribing," May 8, 2024, https://www.cdc.gov/overdose-prevention/hcp/ehr/index.html.

[37] D. Elton, T. M. Kosloff, M. Zhang, P. Advani, Y. Guo, S. T. Shimotsu, S. Sy, and A. Feuer, "Low Back Pain Care Pathways and Costs: Association with the Type of Initial Contact Health Care Provider; A Retrospective

efforts should be made to increase their delivery in Federally Qualified Health Centers and rural health clinics, both by ensuring an adequate workforce to deliver these interventions and by making sure that reimbursement is sufficient to allow the communities served by these providers to benefit.

Many efforts to address the drug crisis focus primarily on those who are already misusing opioids. But such downstream efforts overlook strategies to prevent individuals from needing or using opioids to begin with. It is essential to invest in upstream strategies that reduce or eliminate common causes of opioid analgesic use and adequately manage pain, decreasing the likelihood that the many Americans with chronic pain will not turn to the illicit market for relief. Adequately treating pain with non-opioid alternatives implements an upstream preventive strategy for reducing opioid use.

Congress has the following levers for promoting nonmedication approaches to pain management:

- Work to ensure that public insurance fully covers nonmedication therapies—e.g., by expanding coverage for licensed acupuncture for more than chronic low back pain, modernizing chiropractic service coverage to include a broader range of Medicare-covered benefits within a chiropractor's scope of practice.
- Reduce copayments for nonmedication therapies, which now may cost patients more out of pocket than medications do and which sometimes exceed the cost of the nonmedication care itself.
- Ensure that all communities have access to providers delivering nonmedication therapies for managing pain.
- Generate a larger workforce and more robust provider network by including providers of nonmedication therapies in existing loan forgiveness programs, such as rural health grants or the National Health Service Corps, and by providing funding for integrative training opportunities to complementary and integrative health providers, similar to those available through Centers for Medicare & Medicaid Services–funded graduate medical education residency programs.

These strategies are complementary. Ideally, if implemented together, they have the potential to significantly reduce the flow of new OUD cases and associated costs to the health care system, which are estimated to exceed $89.1 billion annually.[38]

Cohort Study," *medRxiv*, November 8, 2022; P. J. Johnson, J. Jou, T. H. Rockwood, and D. M. Upchurch, "Perceived Benefits of Using Complementary and Alternative Medicine by Race/Ethnicity Among Midlife and Older Adults in the United States," *Journal of Aging and Health*, Vol. 31, No. 8, September 2019; D. S. Overstreet, B. D. Pester, J. M. Wilson, K. M. Flowers, N. K. Kline, and S. M. Meints, "The Experience of BIPOC Living with Chronic Pain in the USA: Biopsychosocial Factors That Underlie Racial Disparities in Pain Outcomes, Comorbidities, Inequities, and Barriers to Treatment," *Current Pain and Headache Reports*, Vol. 27, No. 1, January 2023.

[38] S. M. Murphy "The Cost of Opioid Use Disorder and the Value of Aversion," *Drug and Alcohol Dependence*, Vol. 217, December 1, 2020.

Social Impact of Nonfatal Opioid Use Disorder Harms Among Older Adults

But the societal impact of the opioid crisis on older Americans extends well beyond their health needs and the health care system. Many of these issues are well recognized: Far too many older Americans are grieving adult children lost to fatal overdoses, and many are spending their life savings trying to help their children get the treatment they need to break the cycle of addiction. However, older Americans are also shouldering larger burdens generated by the drug crisis that are less recognized. An estimated 320,000 children lost a parent to overdose in the past decade.[39] As a consequence, grandparents are increasingly assuming parenting responsibilities.

The strain of grandparenting is greatest in states that have been hardest hit by the opioid crisis, such as Alabama, where the percentage of individuals over 30 raising grandchildren is 50 percent higher than the national average.[40] Between 1980 and 2018, the percentage of children living in a household headed by a grandparent more than doubled, from 3.7 percent to 8.3 percent. An estimated 2.6 million grandparents are helping to raise the children of parents who are unable to care for them because of substance use,[41] and more than 400,000 children are living in households headed by a grandparent.[42] Opioid misuse has been the primary driver of the increase in grandparenting in recent years, but misuse of other drugs has also contributed. The burden of grandparenting falls most heavily on individuals ages 46 to 65,[43] potentially affecting their ability to fully participate in the workforce.

Grandparenting can dramatically alter an individual's lifestyle: Grandparents taking care of grandchildren because of parents' OUD defer their downsizing plans; take on new mortgages; and incur new costs by trying to move to more child-friendly, and often pricier, communities with good schools.[44] In fact, almost one-third of grandparents caring for their grandchildren either delayed retirement or were forced to go back to work.[45]

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[39] C. M. Jones, K. Zhang, B. Han, G. P. Guy, J. Losby, E. B. Einstein, M. Delphin-Rittmon, N. D. Volkow, and W. M. Compton, "Estimated Number of Children Who Lost a Parent to Drug Overdose in the US from 2011 to 2021," *JAMA Psychiatry*, Vol. 81, No. 8, August 1, 2024.

[40] L. Anderson, "States with High Opioid Prescribing Rates Have Higher Rates of Grandparents Responsible for Grandchildren," U.S. Census Bureau, April 22, 2019, https://www.census.gov/library/stories/2019/04/opioid-crisis-grandparents-raising-grandchildren.html.

[41] Generations United, *Raising the Children of the Opioid Epidemic: Solutions and Support for Grandfamilies*, 2018, https://www.gu.org/app/uploads/2018/09/Grandfamilies-Report-SOGF-Updated.pdf.

[42] K. Buckles, W. N. Evans, and E. M. J. Lieber, "The Drug Crisis and the Living Arrangements of Children," *Journal of Health Economics*, Vol. 87, January 2023.

[43] A. Laurito, "Spillovers of the Heroin Epidemic on Grandparent Caregiving," *Population Research and Policy Review*, Vol. 43, No. 2, 2024.

[44] M. T. Davis, M. E. Warfield, J. Boguslaw, D. Roundtree-Swain, and G. Kellogg, "Parenting a 6-Year Old Is Not What I Planned in Retirement: Trauma and Stress Among Grandparents Due to the Opioid Crisis," *Journal of Gerontological Social Work*, Vol. 63, No. 4, May–June 2020.

[45] C. Stanik, *Collateral Damage of the Opioid Crisis: Grandparents Raising Grandchildren—What They Need and How to Help*, Altarum, 2018.

Children in foster care with relatives (such as grandparents) fare better than those with nonrelative foster families,[46] but relative caregivers require adequate financial, emotional, and social support to effectively meet the needs of these children.[47] Unfortunately, in many communities, collaborative efforts between child welfare agencies and other core systems supporting parents with substance use disorders are limited to the parents, nonrelative foster parents, and children.[48] Given the vital role that grandparents are increasingly playing in the lives of these children, it is essential to expand such collaborative efforts to improve the level of support provided to relative caregivers.

Congress has the following levers it can pull to help support older Americans who are grandparenting children due to the opioid crisis:

- Facilitate grandparents' access to reliable respite care and affordable child care through targeted funding in Head Start and Early Head Start or alongside Child Abuse Prevention and Treatment Act (CAPTA) reauthorization.
- Support efforts to keep families together by ensuring that grandparenting adults and the children they are caring for have access to such supports as kinship navigators and such benefits as health insurance, including both those grandparents participating in the formal child welfare system and those grandparents who choose to care for kin outside the formal child welfare system.
- Support the development of educational materials and tools for grandparents about (1) the effects of prenatal substance exposure on children and (2) how to talk with and support their grandchildren in understanding and dealing with their parent's addiction.

Unfortunately, there is no silver bullet for addressing the country's opioid crisis. However, implementing some of the measures I have mentioned can better prepare us for the challenges ahead. It would help the grandmother of my patient, and many like her around the country, to better care for her grandchildren, increasing the likelihood that the family can stay together. It would also help the U.S. health care system prepare to care effectively and efficiently for the growing elderly population with complex health care needs.

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[46] M. A. Winokur, A. Holtan, and K. E. Batchelder, "Systematic Review of Kinship Care Effects on Safety, Permanency, and Well-Being Outcomes," *Research on Social Work Practice*, Vol. 28, No. 1, January 2018.

[47] M. L. Dolbin-MacNab and L. M. O'Connell, "Grandfamilies and the Opioid Epidemic: A Systemic Perspective and Future Priorities," *Clinical Child and Family Psychology Review*, Vol. 24, No. 2, June 2021.

[48] M. T. Davis, M. E. Warfield, J. Boguslaw, D. Roundtree-Swain, and G. Kellogg, "Parenting a 6-Year Old Is Not What I Planned in Retirement: Trauma and Stress Among Grandparents Due to the Opioid Crisis," *Journal of Gerontological Social Work*, Vol. 63, No. 4, May–June 2020; L. Templeton, "Dilemmas Facing Grandparents with Grandchildren Affected by Parental Substance Misuse," *Drugs: Education, Prevention and Policy*, Vol. 19, No. 1, 2012.

Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

QUESTIONS FOR THE RECORD

Dr. Malik Burnett

Senator Raphael Warnock

Question:

Medicaid is the largest payer of behavioral health care services in the United States, providing access to mental health and substance use disorders.[1] Additionally, Medicaid expansion plays a significant role in access to treatment for opioid use disorder (OUD) across the U.S. For example, research shows that Medicaid expansion leads to an increase in access to treatment for individuals with OUD.[2]

Can you describe the barriers in access to treatment for OUD for people in non-expansion states like Georgia?

Response:

Senator Warnock, states that have not expanded access to Medicaid have populations that face significant barriers to affording SUD treatment. Lack of access to programs like Medicaid means that individuals with an SUD would be required to pay with cash for treatment. Furthermore in non-expansion states individuals would be required to travel farther to access treatment given these states have smaller provider networks due to the limitations on reimbursement for services. Ultimately, these individuals either delay or forgo treatment entirely, and if they do end up in the hospital for medical complications associated with the SUD, these complications are much worse than the otherwise would have been if they were able to be treated sooner. This reality is particularly concerning given that in non-expansion states 60 percent of people in the coverage gap are people of color, closing the gap would also advance more equitable access to behavioral health care and reduce overdose rates in these communities which are some of the highest in the country. The research demonstrated that Medicaid expansion increases coverage for patients, expanded behavioral health care provider capacity, increases the likelihood that substance use disorders are identified and treated. This reduces the likelihood of hospitalization and ensures individual are more likely to participate in the labor force and be value added to the community.

Question:

How would proposed cuts to Medicaid exacerbate these existing barriers to treatment?

Response:

Senator Warnock as of October 2024, there were over 70M people Medicaid enrollees, with approximately 14 million enrollees having a mental health or substance use disorder (SUD). ASAM is extremely concerned about the potential harmful cuts to the Medicaid program which are being discussed by some lawmakers, as the program provides lifesaving care to Americans living with SUD. Proposals that would impose burdensome work requirements on people with SUD are just unnecessary administrative burdens considering 92% of adults on Medicaid in 2023 were reported to be working full or part time, or unable to work due to illness, caregiving obligations, or schooling. America is in the middle of an addiction and overdose crisis. We have evidence-based treatments for addiction, but if patients can't afford or access them, their lives are at risk.

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[1] Behavioral Health Services, Centers for Medicare and Medicaid Services, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[2] Richard G. Frank, The Role of Medicaid in Addressing the Opioid Epidemic, Brookings Institution (Feb. 25, 2025), https://www.brookings.edu/articles/the-role-of-medicaid-in-addressing-the-opioid-epidemic/ .

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

QUESTIONS FOR THE RECORD

Bradley D. Stein[1]

RAND[2]

Senator Raphael Warnock

Question:

According to the Centers for Disease Control and Prevention, non-opioid treatments are effective in managing chronic pain.[3] However, barriers like step therapy requirements and prior authorization create unnecessary burdens on a patient's access to non-opioid pain management treatment.

How can increasing access to non-opioid pain medications, like through the Alternatives to Prevent Addiction in the Nation Act, help address the opioid epidemic in the United States?[4]

Response:

Thank you for the question, Senator. With approximately one in four Americans experiencing chronic pain,[5] there is an urgent need to develop comprehensive solutions that will effectively meet the diverse needs and preferences of chronic pain patients across the nation.

Recent clinical practice guidelines from leading health organizations-including the Centers for Disease Control and Prevention, Department of Veterans Affairs, and World Health Organization-have aligned in recommending non-opioid treatments for the majority of chronic pain conditions.[6]

These guidelines include both non-opioid pain medications and non-pharmacological therapies. Despite this robust evidence foundation, a variety of policies continue to impede implementation in routine clinical practice.

When evaluated solely on direct costs to patients and insurers, generic opioids appear relatively inexpensive.[7] In contrast, non-opioid analgesics face barriers, including tiered formulary placement, elevated cost-sharing, prior authorization, and step

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[1] The opinions and conclusions expressed in this addendum are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research.

[2] +AND is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's mission is enabled through its core values of quality and objectivity and its commitment to integrity and ethical behavior. RAND subjects its research publications to a robust and exacting quality-assurance process; avoids financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursues transparency through the open publication of research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. This testimony is not a research publication, but witnesses affiliated with RAND routinely draw on relevant research conducted in the organization.

[3] Centers for Disease Control and Prevention, "Nonopioid Therapies for Pain Management," webpage, January 31, 2025, https://www.cdc.gov/overdose-prevention/hcp/clinical-care/nonopioid-therapies-for-pain-management.html.

[4] The question is presented verbatim as it was submitted to RAND.

[5] J. Lucas and I. Sohi, "Chronic Pain and High-Impact Chronic Pain in U.S. Adults, 2023," Centers for Disease Control and Prevention, November 2024, https://www.cdc.gov/nchs/data/databriefs/db518.pdf.

[6] World Health Organization, WHO Guideline for Non-Surgical Management of Chronic Primary Low Back Pain in Adults in Primary and Community Care Settings, December 7, 2023; Use of Opioids in the Management of Chronic Pain Work Group, VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, U.S. Department of Veterans Affairs and U.S. Department of Defense, May 2022, https://www.healthquality.va.gov/guidelines/pain/cot/; Centers for Disease Control and Prevention, "2022 CDC Clinical Practice Guideline at a Glance," webpage, May 7, 2024, https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/index.html.

[7] Hilary Aroke, Ashley Buchanan, Xuerong Wen, Peter Ragosta, Jennifer Koziol, and Stephen Kogut, "Estimating the Direct Costs of Outpatient Opioid Prescriptions: A Retrospective Analysis of Data from the Rhode Island Prescription Drug Monitoring Program," Journal of Managed Care & Specialty Pharmacy, Vol. 24, No. 3, 2018.

therapy protocols that mandate treatment failure with cheaper alternatives (often opioids) before covering preferred non-opioid options. These obstacles rarely apply to generic opioid medications, creating a situation in which the clinically preferred options face a broader range of cost and non-cost barriers compared with the less clinically preferred and higher-risk opioid analgesic alternative.

Administrative and reimbursement policies also restrict access to evidence-based non-pharmacological interventions for pain. For example, although the Centers for Medicare & Medicaid Services began covering acupuncture for chronic low back pain in 2020,[8] reimbursement is limited to select providers. This restriction disproportionately affects patients in medically underserved areas and excludes those with other chronic pain conditions. Similarly, Medicare's coverage of chiropractic care is restricted to spinal manipulation,[9] requiring beneficiaries to pay out of pocket for essential services, such as physical examinations or rehabilitative exercises.

Approaches to addressing these barriers and expanding access to non-opioid pain medications that Congress could consider include

•limiting patient cost-sharing for non-opioid pain management medications

•limiting prior-authorization requirements and step therapy protocols for non-opioid pain management medications

•enhancing shared-decisionmaking approaches with patients regarding pain management preferences.

These possible policy changes would enable meaningful shared decisionmaking regarding non-opioid versus opioid medications, which can decrease opioid misuse.[10] It is likely that these changes would reduce opioid prescriptions as patients gain access to alternatives. Additional policy reforms that Congress could consider to reduce barriers to non-pharmacological interventions include the following:

•Cover nonpharmacological therapies-for example, expand coverage for licensed acupuncture for more than chronic low back pain and to any trained provider and add coverage of chiropractic services within Medicare to align with scope of practice.

•Generate a larger workforce and a more robust provider network by including providers of non-pharmacological therapies in existing loan forgiveness programs, such as rural health grants or the National Health Service Corps.

•Provide funding for integrative training opportunities to complementary and integrative health providers, similar to those available through Centers for Medicare & Medicaid Services-funded graduate medical education residency programs.

In conclusion, the policy options presented above could help align payment and administrative policies with evidence-based guidelines for non-opioid pain medications while helping to address additional barriers that exist in accessing non-pharmacological therapies.

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[8] Medicare.gov, ″Acupuncture,″ webpage, undated, https://www.medicare.gov/coverage/acupuncture.

[9] Medicare.gov, ″Chiropractic Services,″ webpage, undated, https://www.medicare.gov/coverage/chiropractic-services.

[10] Vanessa C. Somohano, Crystal L. Smith, Somnath Saha, Sterling McPherson, Benjamin J. Morasco, Sarah S. Ono, Belle Zaccari, Jennette Lovejoy, and Travis Lovejoy, ″Patient-Provider Shared Decision-Making, Trust, and Opioid Misuse Among US Veterans Prescribed Long-Term Opioid Therapy for Chronic Pain,″ Journal of General Internal Medicine, Vol. 38, September 2023.

Statements for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

STATEMENTS FOR THE RECORD

Dr. Stacey McKenna Testimony

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February 25, 2025

The Honorable Rick Scott
Chair
Special Committee on Aging
United States Senate
Washington, D.C. 20510

The Honorable Kirsten Gillibrand
Ranking Member
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Chairman Scott, Ranking Member Gillibrand, and members of the Committee:

Thank you for your decision to hold the February 26, 2025 hearing on "Combating the Opioid Epidemic." My name is Stacey McKenna, and I am a Resident Senior Fellow at the R Street Institute, a public policy research organization focused on promoting free markets and limited, effective government in a variety of areas, including integrated harm reduction. Harm reduction is a pragmatic approach that helps reduce the potential negative consequences of a range of behaviors, including substance use.[1] At the R Street Institute, we recognize that even the best prevention and cessation efforts leave too many people behind.[2] Therefore, we support harm reduction as a key component of comprehensive policy solutions to the ongoing overdose crisis.

For the past decade, the United States has witnessed an unprecedented drug overdose crisis, largely driven by the proliferation of illicitly manufactured fentanyl (IMF) and other potent synthetic opioids.[3] At its peak in 2023, the epidemic took the lives of more than 111,000 people across the country.[4] And although we have recently seen a much-needed decline in overdose fatalities—thanks in large part to the expansion of harm reduction programs—too many people

[1] Substance Abuse and Mental Health Services Administration, *Harm Reduction Framework,* Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf.
[2] Ibid.
[3] Daniel Ciccarone, "The Rise of Illicit Fentanyls, Stimulants and the Fourth Wave of the Opioid Overdose Crisis," *Current Opinions in Psychiatry,* 34: 4 (July 1, 2021), pp. 344-350. https://pmc.ncbi.nlm.nih.gov/articles/PMC8154745.
[4] Centers for Disease Control and Prevention, "Provisional Drug Overdose Death Counts," National Center for Health Statistics, Centers for Disease Control and Prevention, Feb. 12, 2025. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

still die of drug overdoses each year.[5] Consequently, we are grateful to this committee for continuing to seek real policy solutions.

Aging, Opioid Use, and Overdose Risk

People of all ages consume substances for a variety of reasons, including treatment (prescribed or self-medicated) for physical pain, substance use disorder, social coping, experimentation, and more.[6] In the United States, adults 65 and older are more likely than their younger counterparts to be prescribed opioids and to take them for extended periods of time.[7] They are also more likely to be isolated from the community, social, and medical resources that can help prevent chaotic substance use and overdose.[8]

Although opioids can be beneficial when taken as prescribed, they are not risk-free. Long-term use increases the likelihood people will develop tolerance—leading to a need for higher doses of the medication—as well as physical dependence and in rare cases, opioid use disorder.[9] Too-high doses of any substance, whether intentional or unintentional, prescribed or illicit, can result in an overdose, characterized by a range of unpleasant and sometimes deadly effects.[10] An overdose involving IMF or other opioids is life threatening due to changes in blood pressure and heart beat and severe respiratory depression.[11] Individuals who are unable to afford their prescribed opioids or whose prescription is abruptly cut-off may turn to the illicit market, where the supply is much more dangerous and overdose risk skyrockets.[12]

In the United States, although media reporting and policy attention have focused on the overdose crisis' impact on youth, opioid-related risks have been on the rise for older adults in recent years.[13]

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[5] Ibid.

[6] Chelsea Boyd and Stacey McKenna, "Beyond Addiction: The Myriad Reasons People Use Drugs," R Street Institute Explainer, June 23, 2023. https://www.rstreet.org/research/beyond-addiction-the-myriad-reasons-people-use-drugs.

[7] National Institute on Drug Abuse, 2020. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts; Ramin Mojtabai, "National trends in long-term use of prescription opioids," *Pharmacoepidemiology and Drug Safety*, 27: 5, Sept. 6, 2017, pp. 526-534. https://onlinelibrary-wiley-com.ez.lib.jjay.cuny.edu/doi/full/10.1002/pds.4278.

[8] Cassie Sun, "The unseen epidemic: opioid overdoses among older adults," Institute for Public Health and Medicine, Northwestern University Feinberg School of Medicine, August 20, 2024. https://www.feinberg.northwestern.edu/sites/ipham/news/The-unseen-epidemic-opioid-overdoses-among-older-adults.html.

[9] Stacey McKenna, "Drug Use 101: Physical Dependence and Withdrawal," R Street Institute Explainer, Nov. 6, 2024. https://www.rstreet.org/research/drug-use-101-physical-dependence-and-withdrawal.

[10] Chelsea Boyd, "Drug Use 101: What is Overdose?" R Street Institute Explainer, Nov. 21, 2024. https://www.rstreet.org/research/drug-use-101-what-is-overdose.

[11] Ibid.

[12] Julia Dickson-Gomez et al., "The effects of opioid policy changes on transitions from prescription opioids to heroin, fentanyl and injection drug use: a qualitative analysis," *Substance Abuse Treatment, Prevention, and Policy*, 17: 55 (Jul. 21, 2022). https://pmc.ncbi.nlm.nih.gov/articles/PMC9306091.

[13] Sun. https://www.feinberg.northwestern.edu/sites/ipham/news/The-unseen-epidemic-opioid-overdoses-among-older-adults.html.

In fact, from 2002 to 2014, "problematic opioid use" nearly doubled (from 1.1 percent to 2.0 percent) among adults 50 and older, and the estimated prevalence of opioid use disorder among individuals 65 and over tripled between 2013 and 2018.[14] The proportion of older adults reporting heroin use also climbed from 2013 to 2015, and while prescription opioid use fell between 2013 and 2019, heavy and chronic use of medical opioids remains relatively high in this group.[15] Furthermore, although overdose death rates are lowest among adults aged 65 and older, from 2021 to 2022, this group saw a 10 percent increase in overdose death rates, larger than among any other age group.[16]

In short, older Americans are not immune from this crisis, and they deserve access to life saving resources.

Smart Policy Can Improve Well-Being and Save Lives

Unfortunately, there are no silver bullets when it comes to mitigating the risks associated with opioid use. However, the right policies can help people stay safer, healthier, and improve their lives. Harm reduction and medications for opioid use disorder are among the most proven ways to mitigate the risks that opioids pose to individuals and communities.[17] Their efficacy has been demonstrated over decades and across the United States' varied geographic and socioeconomic landscapes.[18] Therefore, policy should facilitate and expand access to these approaches, allowing communities to tailor them to specific needs without being overly prescriptive.

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[14] Carla Shoff et al., "Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013-2018," *American Journal of Preventive Medicine*, 60: 6 (June 2021), pp. 850-855. https://www.ajpmonline.org/article/S0749-3797(21)00092-1/abstract; Substance Abuse and Mental Health Services Administration, "Opioid Misuse Increases Among Older Adults," *The CBHSQ Report,* SAMHSA, July 25, 2017. https://www.samhsa.gov/data/sites/default/files/report_3186/Spotlight-3186.pdf.

[15] Andrew S. Huhn et al., "A hidden aspect of the U.S. opioid crisis: Rise in first-time treatment admissions for older adults with opioid use disorder," *Drug and Alcohol Dependence,* 193 (Dec. 1, 2018), pp. 142-147. https://pubmed.ncbi.nlm.nih.gov/30384321; Morgan I. Bromley et al., "Burden of Chronic and Heavy Opioid Use Among Elderly Community Dwellers in the U.S.," *American Journal of Preventive Medicine,* 3: 2 (April 2024).

[16] Merianne R. Spencer et al., "Drug Overdose Deaths in the United States, 2002-2022," *NCHS Data Brief No. 491,* National Center for Health Statistics, Centers for Disease Control and Prevention, March 2024. https://www.cdc.gov/nchs/products/databriefs/db491.htm#:~:text=mortality%20data%20file.-,The%20rate%20of%20drug%20overdose%20deaths%20increased%20among%20middle%2Daged,and%20older%20(Figure%202).

[17] Don C. Des Jarlais, "Harm reduction in the USA: the research perspective and an archive to David Purchase," *Harm Reduction Journal*, 14: 51 (July 26, 2017). https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6; National Institute on Drug Abuse, "How effective are medications to treat opioid use disorder?" *Medications to Treat Opioid Use Disorder Research Report*, National Institute on Drug Abuse, 2018. https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder.

[18] Ibid; Cameron Bushling et al., "Syringe services programs in the Bluegrass: Evidence of population health benefits using Kentucky Medicaid data," *The Journal of Rural Health*, 38: 3 (Sept. 19, 2021), pp. 620-629. https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12623.

Medications for Opioid Use Disorder

One tried and true way to support the roughly one million adults aged 65 and older who have a substance use disorder is by expanding access to evidence-based treatments.[19] Two FDA-approved medications for opioid use disorder—buprenorphine and methadone—reduce cravings and withdrawal symptoms, improve treatment retention, reduce illicit and chaotic drug use, and slash overdose risk compared to both no treatment and non-medication treatment.[20] Not only do they improve outcomes for patients, they reduce criminal recidivism and yield lifetime savings ranging from $25,000 to $105,000 per person.[21]

Unfortunately, neither of these medications is sufficiently accessible. Methadone is considered the gold standard medication for OUD, especially in an era dominated by IMF.[22] However, it is among the most heavily regulated medications in the United States.[23] People with OUD can only access methadone through opioid treatment programs (OTPs), specialized clinics that are controlled by both state and federal governments and sparsely distributed throughout the country.[24] Despite some recent updates intended to improve methadone access, OTPs still frequently require patients to visit in-person up to 6 days per week to take their medication, submit to regular urine screenings, and more.[25] These barriers disproportionately hurt patients living in low-income and rural areas.[26] Methadone access would be dramatically improved by removing the monopoly that OTPs currently have on its distribution.[27] For example the Modernizing Opioid

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[19] National Institute on Drug Abuse, "Substance Use in Older Adults Drug Facts," U.S. Department of Health and Human Services, July 2020. https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts

[20] Jessica Shortall, "What the...? Safer From Harm on Methadone," Safer From Harm, March 7, 2024. https://www.saferfromharm.org/blog/what-the-safer-from-harm-on-methadone; Sarah E. Wakeman et al., "Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder," *JAMA Network Open*, 3: 2 (Feb. 5, 2020). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032.

[21] Michael Fairley et al., "Cost-effectiveness of Treatments for Opioid Use Disorder," *JAMA Psychiatry* 78: 7 (March 31, 2021), pp. 767-777. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2778020.

[22] Nora Volkow, "To address the fentanyl crisis, greater access to methadone is needed," *Nora's Blog*, National Institute on Drug Abuse, July 29, 2024. https://nida.nih.gov/about-nida/noras-blog/2024/07/to-address-the-fentanyl-crisis-greater-access-to-methadone-is-needed.

[23] "How Can Patients Access Methadone in Other Countries?" Pew Trusts, accessed Feb. 22, 2025. https://www.pewtrusts.org/en/research-and-analysis/articles/2023/05/17/how-can-patients-access-methadone-in-other-countries#:~:text=Methadone%20is%20one%20of%20three,be%20available%20outside%20of%20OTPs; Volkow, https://nida.nih.gov/about-nida/noras-blog/2024/07/to-address-the-fentanyl-crisis-greater-access-to-methadone-is-needed.

[24] Ibid.

[25] Lev Facher, "Methadone treatment gets first major update in over 20 years," *STAT News*, Feb. 1, 2024. https://www.statnews.com/2024/02/01/opioid-addiction-methadone-clinic-regulations.

[26] Ibid.

[27] Stacey McKenna, "Unshackled from OTPs, Methadone Can Still Be Safe and Effective," R Street Institute Explainer, April 11, 2024. https://www.rstreet.org/research/unshackled-from-otps-methadone-can-still-be-safe-and-effective.

Treatment Access Act would do just that by allowing addiction specialist physicians to prescribe and pharmacists to dispense it.[28]

Buprenorphine is another very safe and effective medication for OUD. And while we applaud recent work to reduce its overregulation by removing the so-called X-waiver, access barriers persist, largely due to prescriber and pharmacist hesitancy.[29] Two ways to further reduce persistent barriers to buprenorphine would be to ensure that pharmacies are not subject to excessive law enforcement scrutiny for stocking and dispensing it and by making telehealth buprenorphine treatment guidelines permanent.[30]

Harm Reduction

Unfortunately, improving treatment options alone is not enough to fight the ongoing opioid overdose epidemic. Recovery from a substance use disorder is not linear, and people do relapse. Relapse can lead to overdose, especially for individuals who lost tolerance due to being engaged in abstinence-based treatment.[31] In addition, not all people who use opioids have an opioid use disorder; yet, even individuals who consume substances recreationally, medically, or experimentally are at risk of overdosing if they accidentally take too much.[32] For example, individuals taking high-dose opioid medications may forget they have taken their medication and take a second dose, or take other medications that also slow breathing and heartrate.[33]

Harm reduction interventions can help reduce overdose risk for any person who uses substances, even if that use is casual, medical, or a relapse. Such interventions are therefore an important part of efforts to combat the opioid overdose crisis among older adults.[34] Indeed, several essential harm

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[28] Ibid; American Society of Addiction Medicine, "The Modernizing Opioid Treatment Access Act," ASAM Explainer, accessed Feb. 24, 2025. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/letters-and-comments/methadone-resources/30.06.23_motaa-explainer.pdf?sfvrsn=e08d098e_1.

[29] Stacey McKenna, "How Red Tape Limits Access to Medications for Opioid Use Disorder," R Street Institute Explainer, Nov. 7, 2023. https://www.rstreet.org/research/how-red-tape-limits-access-to-medications-for-opioid-use-disorder; [29] Hannah L.F. Cooper et al., "Buprenorphine dispensing in an epicenter of the U.S. opioid epidemic: A case study of the rural risk environment in Appalachian Kentucky," *International Journal of Drug Policy*, 85 (November 2020). https://pubmed.ncbi.nlm.nih.gov/32223985.

[30] Cooper et al. https://pubmed.ncbi.nlm.nih.gov/32223985; "DEA and HHS delay implementation of buprenorphine final rule," *American Hospital Association*, Feb. 14, 2025. https://www.aha.org/news/headline/2025-02-14-dea-and-hhs-delay-implementation-buprenorphine-final-rule.

[31] Mallory Locklear, "Treating opioid disorder without meds more harmful than no treatment at all," *YaleNews*, Dec. 19, 2023. https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all; John Strang et al., "Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study," *British Medical Journal*, 326: 7396 (May 3, 2003), pp. 959-960. https://pmc.ncbi.nlm.nih.gov/articles/PMC153851.

[32] Chelsea Boyd, "Drug Use 101: Substance Use Disorders," R Street Institute Explainer, Oct. 24, 2024. https://www.rstreet.org/research/drug-use-101-substance-use-disorders.

[33] Sun. https://www.feinberg.northwestern.edu/sites/ipham/news/The-unseen-epidemic-opioid-overdoses-among-older-adults.html.

[34] Stacey McKenna, "Drug Use 101: Physical Dependence and Withdrawal," R Street Institute Explainer, Nov. 6, 2024. https://www.rstreet.org/research/drug-use-101-physical-dependence-and-withdrawal; Stacy Mosel, "Harm

reduction interventions have expanded in recent years in the United States, and can be credited for at least part of the recent decline in overdose deaths.[35]

For example, improving access to the overdose reversal drug, naloxone, has enabled some communities to get the life-saving medication to their most vulnerable populations.[36] One potentially beneficial move on the part of the federal government was when the Food and Drug Administration authorized the intranasal formulation of standard dose naloxone for over-the-counter use.[37] However, cost and stocking continue to present a barrier, especially for older adults.[38] Because Medicare does not cover over-the-counter medications, the price of naloxone may continue to present a barrier for some.[39] The federal government could help ease this burden by allowing Medicare to cover some over-the-counter medications, and by incentivizing the approval of generics to ensure market competition to drive prices lower.[40]

Another important harm reduction intervention that helps reduce overdose is the presence of harm reduction organizations such as syringe services programs in communities. While these programs—sometimes referred to as needle exchanges—originated as a way to reduce infectious disease transmission among people who inject drugs, they provide a comprehensive array of services that may be relevant to older adults who use opioids.[41] First of all, harm reduction organizations are primary distributors of naloxone and drug checking equipment such as fentanyl test strips to people who might not be able to afford them otherwise.[42] Secondly, they serve as key

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Reduction Guide," American Addiction Centers, Jan. 17, 2025. https://americanaddictioncenters.org/harm-reduction.

[35] Nabarun Dasgupta et al., "Are overdoses down and why?" *Opioid Data Lab,* University of North Carolina Chapel Hill, Sept. 18, 2024. https://opioiddatalab.ghost.io/are-overdoses-down-and-why; Moiz Bhai et al., "Impact of Fentanyl Test Strips as Harm Reduction for Drug-Related Mortality," *Medical Care Research and Review,* (Feb. 12, 2025). https://pubmed.ncbi.nlm.nih.gov/39936554.

[36] Olivia K. Sugarman et al., "Achieving the Potential of Naloxone Saturation by Measuring Distribution," *JAMA Health Forum*, 4: 10 (Oct. 27, 2023). https://jamanetwork.com/journals/jama-health-forum/fullarticle/2811061; Stacey McKenna, "Rural Harm Reduction: Spotlight on Cochise County, Arizona," R Street Institute Explainer, Jan. 28, 2025. https://www.rstreet.org/research/rural-harm-reduction-spotlight-on-cochise-county-arizona.

[37] Dasgupta et al. https://opioiddatalab.ghost.io/are-overdoses-down-and-why; Stacey McKenna, "Assessing the State of Over-the-Counter Naloxone Access," R Street Institute Analysis, July 22, 2024. https://www.rstreet.org/commentary/assessing-the-state-of-over-the-counter-naloxone-access.

[38] McKenna, "Assessing the State of Over-the-Counter Naloxone Access"; Stacey McKenna, "Part 1: Exploring Cost and Emerging Landscape of Naloxone Competition," R Street Institute Analysis, July 22, 2024. https://www.rstreet.org/commentary/part-1-exploring-cost-and-the-emerging-landscape-of-naloxone-competition; Stacey McKenna, "Part 2: Assessing the Retail Availability of OTC Naloxone," R Street Institute Analysis, Aug. 22, 2024. https://www.rstreet.org/commentary/part-2-assessing-the-retail-availability-of-otc-naloxone.

[39] Centers for Medicare and Medicaid Services, "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings," Jun. 2020. https://www.medicare.gov/Pubs/pdf/11333-Outpatient-Self-Administered-Drugs.pdf.

[40] McKenna, "Assessing the State of Over-the-Counter Naloxone Access." https://www.rstreet.org/commentary/assessing-the-state-of-over-the-counter-naloxone-access.

[41] "Syringe Services Programs," Centers for Disease Control and Prevention, accessed Feb. 22, 2025. https://www.cdc.gov/syringe-services-programs/php/index.html.

[42] "Syringe Services Programs: A NACo Opioid Solutions Strategy Brief," National Association of Counties, Jan. 23, 2023. https://www.naco.org/resource/syringe-services-programs-naco-opioid-solutions-strategy-brief#

points of connection for people, providing case management and referrals to substance use disorder treatment.[43] In fact, participants in syringe services programs are up to five times more likely than their counterparts who don't use the programs to enter drug treatment, and three times as likely to stop using altogether.[44] Because older people who use drugs may struggle more than their younger counterparts to establish and maintain connection, these types of services are especially important for older adults.[45]

Combatting the Opioid Overdose Crisis Among Older Adults

In sum, older Americans are not immune from the opioid overdose crisis that continues to take tens of thousands of lives annually in the United States. Evidence-based treatment and harm reduction are two effective and cost-effective tools to help these individuals stay safer and healthier, regardless of how or why they use opioids.

The examples provided above represent only a small sampling of the potential interventions available to communities and organizations seeking to reduce the risks associated with opioid use among older adults. Because many harm reduction policies and health regulations are enacted at the state level, perhaps the most important thing the federal government can do is to avoid interfering with successful efforts. Harm reduction is at its most effective when local communities can tailor programs to meet local needs.

Chairman Scott, Ranking Member Gillibrand, and members of the Committee, thank you again for holding this important hearing and for your consideration of my views. Should you have any questions or wish to have further discussion, please do not hesitate to contact me.

Sincerely,

Stacey McKenna, PhD
/s/
Resident Senior Fellow, Integrated Harm Reduction
R Street Institute

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[43] "Syringe Services Programs," Centers for Disease Control and Prevention, accessed Feb. 22, 2025. https://www.cdc.gov/syringe-services-programs/php/index.html.
[44] Ibid.
[45] Sun. https://www.feinberg.northwestern.edu/sites/ipham/news/The-unseen-epidemic-opioid-overdoses-among-older-adults.html.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

STATEMENTS FOR THE RECORD

James Balda Testimony

On behalf of Argentum, the leading national association representing assisted living and memory care communities and the older adults and families they serve, I want to commend you for holding today's hearing: "Combating the Opioid Epidemic." We appreciate the opportunity to share insights on the importance of supervised medication management, especially for seniors who struggle with physical limitations and/or various forms and levels of dementia. Medication management is often confusing and daunting to seniors and can lead to misuse, abuse and addiction, especially with opiates. Our communities offer residents medication management to both control chronic conditions as well as effectively mitigate pain.

The members of Argentum operate senior living communities offering independent living, assisted living, memory care, and continuing care. The members of Argentum and our state partners represent approximately 75 percent of the professionally managed communities in the senior living industry-an industry with an annual national economic impact of nearly a quarter of a trillion dollars and responsible for providing more than 1.6 million jobs. These communities are home to nearly two million seniors, offering choice, dignity, security, and an enhanced quality of life.

The American population is aging rapidly. According to data just released by the U.S. Census Bureau, the median population age reached 39.2 years in 2022-the highest on record. Every day, 10,000 Americans turn age 65, and the U.S. population age 65 and older grew from 2010 to 2020 at the fastest rate since the 1800's and reached 55.8 million-a 38.6 percent increase in just 10 years. The data also showed that for the first time in a century the number of adults over 60 in the U.S. is greater than the number of children under 10 years of age.

Senior living providers start their support of residents and families with an evaluation or assessment of a resident's condition, which helps identify and establish the level and types of care needed. This assessment is conducted by a trained and qualified professional, such as the resident's primary care physician, and takes place at or around the time of move-in for new residents, periodically (e.g., annually), and upon changes in a resident's condition. Senior living community staff participate in this assessment to ensure the community is capable of providing the level of support the resident needs.

Individuals who require assistance with activities of daily living - the type of care provided by family members in the home, such as bathing, walking, dressing, and dining - are recommended for assisted living. Residents living with low to moderate cognitive disability may receive care in an assisted living community, whereas more pronounced levels of cognitive disability typically require higher levels of care offered by memory care or continuing care communities.

A resident's current medications are typically reviewed as part of the resident assessment, with medication optimization being a primary goal. Medications are reviewed for whether or not they're (still) needed, effectiveness, and potential harmful interaction with other medications taken by the resident. Residents are also assessed to determine whether they're able to self-administer their medications, or if this is a service that should be provided by trained staff. Best practice is for a consultant pharmacist to be part of the medication review process.

Senior living residents typically also suffer from multiple chronic conditions. As reported in NCHS Data Brief No. 506, the 10 most frequently observed chronic conditions among senior living residents include high blood pressure (58%), Alzheimer's disease or other dementias (44%), heart disease (33%), depression (26%), arthritis (18%), chronic obstructive pulmonary disease (16%), diabetes (16%, osteoporosis (12%), stroke (7%), and cancer (6%). Further, the Data Brief states that 55% of residents were diagnosed with two to three chronic conditions and 18% of residents with between four and 10 chronic conditions. As reported in Senior Housing News, a September 2020 study conducted by NORC at the University of Chicago showed that assisted living residents specifically manage 14 chronic conditions, on average. Memory care residents are comparable, at just under 13 chronic conditions.

These chronic conditions are often accompanied by chronic pain. Assisted living providers collaborate with each residents' physician and with a consultant pharmacist to explore options for deprescribing, replacement with non-opioid medica-

tions, and implementing non-medicinal interventions such as physical therapy, strength conditioning, walking clubs, and heat and ice treatments, to name a few. All of these options are preferable due to the side effects of opioids in the elderly, such as increased falls, changes in cognition, constipation, and other well-known issues.

Although pharmaceutical developments have increased the availability of nonopioid options in recent decades, many geriatric patients have comorbidities that preclude the use of many other classes of medications. Millions of Americans are treated with opioids each year, and many of these patients are elderly. According to the CDC, 17.4% of the U.S. population, or 56,935,332 persons, filled at least one opioid prescription in 2017, and opioid prescribing was highest at 26.8% in adults aged 65 and up. (See Mayo Clinic Proceedings, Volume 95, Issue 4, April 2020, Opioids in Older Adults: Indications, Prescribing, Complications, and Alternative Therapies for Primary Care.) Due to the multitude of chronic conditions they face, some residents need and benefit from opioid therapy.

According to the Kaiser Family Foundation, more than half of adults 65 and older report taking four or more prescription drugs compared to one third of adults 50-64 years old (32%) and about one in 10 adults 30-49 years old. Medication management is an important support provided in assisted living communities, with up to 85% of residents wanting or needing assistance with taking medications.

This dispensing of medication by trained community staff generally makes it safer for residents, providing a structured system for managing medications, including reminders to take medications as prescribed and reducing the risk of missed doses. Community personnel maintain detailed records of each medication administration, allowing for tracking and communication with healthcare providers. Staff also help monitor for potential interactions or side effects. All of these factors help to significantly reduce the risk of medication errors compared to self-administration by individuals with memory issues or declining cognitive abilities. Medication administration is governed by state regulation.

It is important to note that senior living residents typically retain their own primary care physician - the people who know residents well - when moving into a senior living community.

Senior living community personnel spend a lot of time supporting and getting to know residents and as a result, are in a unique position to advocate for residents. The following statement was provided by Kim Butrum, RN, MS, GNP-BC, Senior Vice President, Clinical for Silverado - a senior living provider operating 27 standalone memory care communities.

The average length of stay in assisted living communities is two to three years. Susan Mitchell's seminal work on those with advanced dementia, found that people living with dementia have a similar degree of pain and suffering in the last 18 months of life as those living with terminal cancer; yet unfortunately many times a behavioral expression in dementia is seen as a psychiatric symptom rather than that the resident with difficulties with language and perception is demonstrating that they are having discomfort.

Despite more than 20 years of regulatory guidance and research showing that pain and behavioral expressions in dementia are correlated, it can be very difficult to get adequate analgesic treatment for residents with moderate to advanced dementia. Pain medications are limited... non-steroidals usually can't be used due to renal impairment, which is common in the elderly, and many prescribers, unfortunately are fearful of prescribing adequate analgesia. Opiates, while dangerous when used inappropriately, are also very effective analgesics when used appropriately. Even the 2022 CDC guidance on chronic opiate use stated that those on palliative care, at end of life, and those with cognitive impairment are at high risk of inadequate treatment for pain.

I hope if further regulations are added that there will be a carve-out around opiate use for those on palliative care, those living with dementia, and on hospice.

Please do not hesitate to contact my office with any questions or requests for additional information.

Sincerely,

James Balda
President & CEO
Argentum

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

STATEMENTS FOR THE RECORD

The ASAM Criteria (Fourth Edition) Handout

THE ASAM CRITERIA

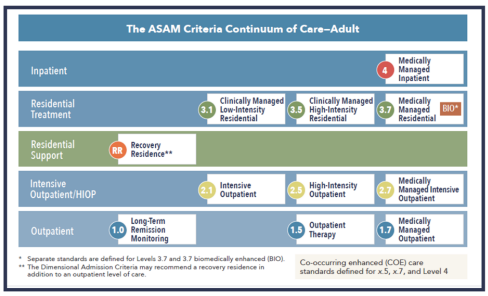
THE FOURTH EDITION

ASAM American Society of Addiction Medicine

The ASAM Criteria helps guide clinicians and care managers in making objective decisions about patient admission, continuing care, and movement along the continuum of care.

Four levels of care mark the treatment continuum

- **LEVEL 1:** OUTPATIENT TREATMENT
- **LEVEL 2:** INTENSIVE OUTPATIENT/HIGH-INTENSITY OUTPATIENT TREATMENT
- **LEVEL 3:** RESIDENTIAL TREATMENT
- **LEVEL 4:** MEDICALLY MANAGED INPATIENT TREATMENT



Decimal numbers mark intensity and type within levels of care

- **Levels "x.1"** and **"x.5"** are **clinically managed**: clinical staff plan treatment.
- **Levels "x.1"** are least intensive: clinical services, mainly counseling & psychoeducation, are provided for 9-19 hours/week.
- **Levels "x.5"** have greater focus on psychotherapy. Levels 2.5 and 3.5 provide at least 20 hours/week of clinical services. Level 1.5 provides less than 9 hours/week of clinical services.
- **Levels "x.7"** are **medically managed**: medical staff plan treatment. **Levels "x.7"** programs have greater focus on withdrawal management and biomedical services, but also integrate psychosocial services to treat SUD.

* Standards for services are included for each level of care, including setting, staff, support systems, assessment and treatment planning, services, and documentation.

U.S. Senate Special Committee on Aging

"Combatting the Opioid Epidemic"

February 26, 2025

Statements for the Record

Moyo Dow and Francesca Beaudoin Testimony

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Addressing Opioid Use Disorder in Older Adults

Gaps, Challenges, and Solutions

Patience Moyo Dow & Francesca Beaudoin

Testimony of Patience Moyo Dow and Francesca Beaudoin submitted to the United States Senate Special Committee on Aging on opioid use disorder in older adults on March 5, 2025

The opinions expressed herein are their own and do not necessarily reflect the views or positions of Brown University or their funders.

Addressing Opioid Use Disorder in Older Adults: Gaps, Challenges, and Solutions

Testimony of Patience Moyo Dow and Francesca Beaduoin
Center for Advancing Health Policy through Research (CAHPR)
Brown University School of Public Health

Submitted to the Special Committee on Aging
United States Senate
March 5, 2025

When it comes to addiction related to opioids, American seniors are facing a one-two punch – an increasing burden of this chronic disease and multiple barriers to obtaining optimal treatment. Recent years have seen a multi-pronged effort to address the overdose crisis and surge of fentanyl at both the state and federal level, but these strategies have not focused on a particularly vulnerable part of our population. Opioid use disorder (OUD) affects approximately 1 million of U.S. adults ages 65 and older, hereafter referred to as older adults.[1] Although rates of OUD are generally lower among older adults than among younger people, the past decade has seen a steady rise in the number of older adults affected. The rate of OUD among older adults tripled from 4.6 to 15.7 cases per 1,000 Medicare fee-for-service beneficiaries between 2013 and 2018,[2] whereas drug overdose mortality rates quadrupled from 3.0 to 12.0 per 100,000 population from 2002 to 2021 among all U.S. older adults.[3] Several factors have contributed to increases in OUD rates among older adults. These

[1] Konakanchi, J. S., & Sethi, R. (2023). The Growing Epidemic of Opioid Use Disorder in the Elderly and Its Treatment: A Review of the Literature. *The Primary Care Companion for CNS Disorders*, *25*(1), 44998. https://doi.org/10.4088/PCC.21r03223

[2] Shoff, C., Yang, T. C., & Shaw, B. A. (2021). Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013-2018. *American Journal of Preventive Medicine*, *60*(6), 850–855. https://doi.org/10.1016/j.amepre.2021.01.010

[3] Humphreys, K., & Shover, C. L. (2023). Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US. *JAMA Psychiatry*, *80*(5), 518–520. https://doi.org/10.1001/jamapsychiatry.2022.5159

include the aging of the "baby boomer generation" - born between 1946 and 1964 - which has historically high rates of substance use than previous generations of older adults,[4,5] high burden of chronic pain and increased likelihood of being prescribed opioids,[6,7] and greater attention to screening and diagnosing OUD in older adults which was previously overlooked.[8,9] Limited access to Food and Drug Administration (FDA)-approved medications to treat OUD (MOUD) in Medicare is another potential contributor to rising OUD-related morbidity and mortality among older adults.[10] To help inform the committee about challenges and potential solutions for addressing OUD in older adults, we are offering insights from relevant research and clinical experience.

Our comments reflect our collective expertise in addiction health services and policy research, epidemiology, and clinical practice. We share clinical vignettes to highlight particular problems and we draw on research studies that employed various methods including (1) evidence synthesis of the literature on preventing, diagnosing, and managing OUD in older adults, (2) claims-based analyses of Medicare data to quantify OUD-related acute and post-acute care use,[11,12] and (3) qualitative inquiry to understand barriers and facilitators to admission and access to MOUD in skilled nursing facilities (SNFs).[13,14] We make three main points:

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[4] Gfroerer, J., Penne, M., Pemberton, M., & Folsom, R. (2003). Substance abuse treatment need among older adults in 2020: the impact of the aging baby-boom cohort. *Drug and Alcohol Dependence*, *69*(2), 127–135. https://doi.org/10.1016/s0376-8716(02)00307-1

[5] Lehmann, S. W., & Fingerhood, M. (2018). Substance-Use Disorders in Later Life. *New England Journal of Medicine*, *379*(24), 2351–2360. https://doi.org/10.1056/nejmra1805981

[6] Nawai A. (2019). Chronic Pain Management Among Older Adults: A Scoping Review. *SAGE Open Nursing*, *5*, 2377960819874259. https://doi.org/10.1177/2377960819874259

[7] Potru, S., & Tang, Y. L. (2021). Chronic Pain, Opioid Use Disorder, and Clinical Management Among Older Adults. *Focus (American Psychiatric Publishing)*, *19*(3), 294–302. https://doi.org/10.1176/appi.focus.20210002

[8] Zullo AR, Danko KJ, Moyo P, Adam GP, Riester M, Kimmel HJ, Panagiotou OA, Beaudoin FL, Carr D, Balk EM. (2020). Prevention, Diagnosis, and Management of Opioids, Opioid Misuse, and Opioid Use Disorder in Older Adults. Technical Brief No. 37. (Prepared by the Brown Evidence-based Practice Center under Contract No. 290-2015-00002-I.) AHRQ Publication No. 21-EHC005. Rockville, MD: Agency for Healthcare Research and Quality. Posted final reports are located on the Effective Health Care Program search page. DOI: 10.23970/AHRQEPCTB37

[9] Duggirala, R., Khushalani, S., Palmer, T., Brandt, N., & Desai, A. (2022). Screening for and Management of Opioid Use Disorder in Older Adults in Primary Care. *Clinics in Geriatric Medicine*, *38*(1), 23–38. https://doi.org/10.1016/j.cger.2021.07.001

[10] Kuo, Y.-F., Westra, J., Harvey, E. P., & Raji, M. A. (2025). Use of Medications for Opioid Use Disorder in Older Adults. *American Journal of Preventive Medicine*. https://doi.org/10.1016/j.amepre.2025.01.019

[11] Moyo, P., Choudry, E., George, M., Zullo, A. R., Ritter, A. Z., & Rahman, M. (2024). Disparities in Access to Highly Rated Skilled Nursing Facilities among Medicare Beneficiaries with Opioid Use Disorder. *Journal of the American Medical Directors Association*, *25*(10), 105190. https://doi.org/10.1016/j.jamda.2024.105190

[12] Moyo, P., Eliot, M., Shah, A., Goodyear, K., Jutkowitz, E., Thomas, K., & Zullo, A. R. (2022). Discharge locations after hospitalizations involving opioid use disorder among medicare beneficiaries. *Addiction Science & Clinical Practice*, *17*(1), 57. https://doi.org/10.1186/s13722-022-00338-x

[13] Moyo, P., Nishar, S., Merrick, C., Streltzov, N., Asiedu, E., Roma, C., Vanjani, R., & Soske, J. (2024). Perspectives on Admissions and Care for Residents With Opioid Use Disorder in Skilled Nursing Facilities. *JAMA Network Open*, *7*(2), e2354746. https://doi.org/10.1001/jamanetworkopen.2023.54746

[14] Nishar, S., Soske, J., Vanjani, R., Kimmel, S. D., Roma, C., & Dow, P. M. (2024). Access and care for people with opioid use disorder in U.S. skilled nursing facilities: A policy commentary. *The International Journal on Drug Policy*, *133*, 104607. https://doi.org/10.1016/j.drugpo.2024.104607

1. Opioid use disorder, opioid-related acute care use, and drug overdose deaths are increasing among U.S. adults ages 65 and over.
2. There is a critical need to address gaps in access to medications for opioid use disorder for older adults including in post-acute and long-term care facilities.
3. There are several opportunities for Congress and the federal government to consider to improve the care and health of older adults with opioid use disorder.

Opioid use disorder, opioid-related acute care use, and drug overdose deaths are increasing among U.S. adults ages 65 and over.

As a practicing emergency physician who now also works in outpatient addiction medicine, I have seen the full impacts of the opioid and overdose epidemic in older adults – from taking care of overdoses in the emergency department (ED) to now helping people access life-saving medical treatment at opioid treatment programs ('methadone clinic'). Older adults with OUD end up coming to the ED for help, not just because they are in crisis, but because they are slipping through the cracks. I remember taking care of a man in his mid-70s in the ED after the family had called 911 after finding him on the floor of his home. The family and EMS had thought they had a stroke, but it turned out that it was actually an opioid overdose and the person regained consciousness and returned to normal after receiving naloxone (the antidote). Not all stories end with a full recovery and when we think of it as a 'young person' problem, we may miss diagnosing and treating a significant number of people. Even when the diagnosis of OUD is made in older adults, there are numerous and unique barriers to accessing care (e.g., location, mobility, whether the methadone clinic accepts Medicare). There is nothing more disheartening than having a patient who is motivated to seek help for their addiction only to have them not be able to get into treatment. (Francesca L. Beaudoin, MD, PhD)

A growing share of older Americans have substance use disorders (SUD) and specifically an OUD and the vast majority of those diagnosed with SUD/OUD are enrolled in Medicare.[2,15] Opioid-related hospitalizations and ED visits and drug overdose mortality are also rising among older adults.[16,17] In our state of Rhode Island, in 2014, 17% of opioid overdose fatalities occurred in people over the age of 55 – by 2024, 36% of all overdose deaths occurred in those over 55.[18]

[15] Yarnell, S., Li, L., MacGrory, B., Trevisan, L., & Kirwin, P. (2020). Substance Use Disorders in Later Life: A Review and Synthesis of the Literature of an Emerging Public Health Concern. *The American Journal of Geriatric Psychiatry : Official Journal of the American Association for Geriatric Psychiatry*, *28*(2), 226–236. https://doi.org/10.1016/j.jagp.2019.06.005

[16] Acevedo, A., Rodriguez Borja, I., Alarcon Falconi, T. M., Carzo, N., & Naumova, E. (2022). Hospitalizations for Alcohol and Opioid Use Disorders in Older Adults: Trends, Comorbidities, and Differences by Gender, Race, and Ethnicity. *Substance Abuse : Research and Treatment*, *16*, 11782218221116733. https://doi.org/10.1177/11782218221116733

[17] Carter, M. W., Yang, B. K., Davenport, M., & Kabel, A. (2019). Increasing Rates of Opioid Misuse Among Older Adults Visiting Emergency Departments. *Innovation in Aging*, *3*(1), igz002. https://doi.org/10.1093/geroni/igz002

[18] Rhode Island Department of Health. (2021). *Statewide Count and Percentage: All Drug Involved Fatal Overdose by Age Category and Year*. ArcGIS Hub; Rhode Island Department of Health.

National trends mirror this alarming statistic, drug overdose mortality rates among older adults quadrupled over the past two decades with Non-Hispanic Black men being disproportionately impacted.[3,19] Older adults also have higher rates of chronic pain and other comorbidities (such as COPD) which make living with an OUD, as well as treating an OUD, much more complicated. There is an urgent and unmet need to identify and treat older adults with OUD through new clinical practice and policy interventions, including strategies in SNFs and expanded access to MOUD.

There is a critical need to address gaps in access to medications for opioid use disorder for older adults including in post-acute and long-term care facilities.

SNFs which provide post-acute medical services following hospitalization report receiving more referrals of patients with OUD than any time in the past.[20] Yet, there remain substantial barriers to SNF placement and access to evidence-based OUD treatment in SNFs.[11,13,14] The confluence of the rising demand for post-acute and long-term care services with older age and increasing rates of OUD in older adults underscores the importance of an age-friendly healthcare system that integrates evidence-based geriatric models of care with OUD treatment and recovery support across diverse settings.[21]

Age-friendly health systems are characterized by providing older adults with safe, effective, reliable, and patient-centered care across the care continuum. Such systems are designed to help overcome the unique challenges experienced by older adults in their ability to access and engage with health services. The existing addiction treatment system, influenced by structural ageism and often fragmented from primary care, impedes the ability of older adults to access MOUD.[22] For instance, lack of transportation and mobility limitations related to multiple and complex health conditions could be barriers to seeking and receiving OUD treatment, particularly from opioid treatment programs (OTPs) which often require daily in-person medication dosing. Social isolation which is a risk factor for substance use and related harms

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https://ridoh-drug-overdose-surveillance-fatalities-rihealth.hub.arcgis.com/datasets/rihealth::statewide-count-and-percentage-all-drug-involved-fatal-overdose-by-age-category-and-year/explore

[19] Kramarow, E. A., & Tejada-Vera, B. (2022). Drug Overdose Deaths in Adults Aged 65 and Over: United States, 2000-2020. *NCHS data brief*, (455), 1–8.

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among older adults could also impede treatment engagement.[23,24,25] The lack of data specific to MOUD use and safety in older adults also may contribute to low clinician self-efficacy to initiate and manage MOUD in this population, which could result in older adults having difficulty accessing MOUD prescribers.[26] It is evident that the aging of adults with OUD poses new challenges in medicine and public health and calls for evidence-informed policymaking and practice to address OUD in older adults.

Methadone, buprenorphine, and naltrexone are FDA-approved to treat OUD. While MOUD is effective in treating OUD,[27] historically fewer than 1 in 5 Medicare enrollees with OUD received these medications[28] lagging the rates of MOUD use observed in both private insurance and Medicaid.[29] Methadone and buprenorphine are effective in reducing opioid withdrawal, all-cause mortality, and overdose death,[30,31] and taking these medications at sufficient doses can support treatment retention.[32] However, MOUD receipt is low with one study estimating that 15% of Medicare beneficiaries with OUD received these medications in 2022.[10,19] Treatment retention is often poor after MOUD initiation with 26% of methadone recipients and 54% of buprenorphine recipients discontinuing treatment within 6 months.[33] However, this research was conducted in younger adults and there could be missed opportunities to optimize

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MOUD initiation and retention in ways that take into account the unique medical, functional, and social factors affecting older adults.[8]

Beyond individual-level factors, older adults also face structural barriers to MOUD access. Importantly, Medicare coverage for methadone MOUD only began in 2020 and there is variable uptake as some OTPs do not accept Medicare insurance as payment.[34] In 2022, of the 1854 OTPs in the U.S., 1115 (60%) billed Medicare, with substantial state-to-state variability of 13% to 100%.[35] Concerningly, Wyoming has no OTPs and South Dakota and Tennessee lack OTPs that bill fee-for-service Medicare. Therefore, older adults with OUD face significant geographic and Medicare insurance related challenges that impede methadone access given that to date, methadone can only be dispensed in certified OTPs - or within hospitals per recent changes to 42 CFR Part 8 that designate hospitals exempt from certification as an OTP to dispense methadone. Furthermore, despite the elimination of the previously DEA-required buprenorphine X-waiver in December 2022,[36] barriers to buprenorphine access persist with the volume of clinicians prescribing buprenorphine remaining low and growing problems around filling buprenorphine prescriptions at pharmacies.[37] In one study, among 5283 pharmacies contacted, 3058 (58%) reported buprenorphine-naloxone stock in 2022.[38]

In our work we have also found that logistical barriers posed by stringent federal regulations that specifically apply to methadone are often cited as reasons for denying SNF admission for individuals, including older adults, with OUD.[13] Currently, SNFs require special procedures to make methadone available to their residents as they are disallowed from directly dispensing methadone.[39] Therefore, SNFs need to coordinate with an OTP to provide methadone either by transporting a resident to the OTP or transporting methadone to the SNF under take home flexibilities or medical exceptions granted by OTPs.[14] However, SNF administrators have reported that persist staff shortages at SNFs often hamper the capacity to navigate the logistics of coordinating methadone access and disincentivize admissions of individuals with OUD. Although people with OUD are referred to SNFs for skilled care needs rather than OUD treatment, SNFs must be equipped to continue existing OUD care and provide MOUD as part of their overall care offerings. Developing the capacity for SNFs and facilities providing long-term

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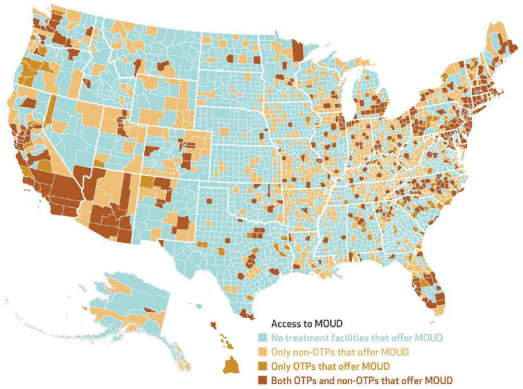
care to serve as touchpoints for OUD treatment is a critical step toward addressing OUD in older adults.

There are several opportunities for Congress and the federal government to consider to improve the care and health of older adults with opioid use disorder.

In the fall of 2021, I began working at an OTP. After 15 years working in the ED and more than a decade of substance use research, I wanted to better understand the people and the problems that I had spent a majority of my career trying to help. The most staggering thing about the OTP system that most people do not realize is just how tightly regulated it is. If we were to ask anyone with any other chronic health condition to come to the same place every day, usually in the early morning, to receive their life saving medications – it would seem a herculean lift. Then we ask our most fragile, our most vulnerable to do this. Now, add in chronic pain, mobility problems (not to mention the problems with Medicare coverage) – we are basically building a brick wall in front of medication treatment for older adults with OUD. The first time I learned that not all OTPs accepted Medicare I was shocked and the patient I tried to help navigate treatment was overwhelmed and eventually lost to care. I still do not know what happened to her. (Francesca L. Beaudoin, MD, PhD)

In 2018, almost 2% of older adult Medicare fee-for-service beneficiaries were diagnosed with an OUD,[2] – this underscores the need to maximize access treatment, particularly to MOUD, via Medicare coverage policies. There have been recent major regulatory (e.g., removal of the buprenorphine X-waiver requirement, expanded methadone take-home flexibilities) and Medicare coverage policy changes that promise to improve access to OUD treatment and health outcomes in older adults. However, continued efforts are still needed to help turn the tide of rising OUD and related consequences among older adults. Patients need to be able to have access to both types of MOUD (buprenorphine and methadone) given that some medications work better for some people, no different than high blood pressure or diabetes medicines. Methadone in particular is highly regulated and many OTPs still do not accept Medicare,[34] despite the fact that Medicare began reimbursing for OTP services in 2020. Rural older adult Medicare beneficiaries have the least access (see figure below, light blue areas), with greatest access in the Northeast and Southwest.



County-level access to medications for opioid use disorder (MOUD) for Medicare beneficiaries in opioid treatment programs (OTPs) and non-OTP specialty substance use treatment facilities in the US, 2021 (Health Aff (Millwood). 2023 Jul;42(7):991–996. doi: 10.1377/hlthaff.2023.00148)

Expanding methadone access should directly result in improved access to treatment for older and younger adults alike. The following are steps that could be taken to optimize the care and health of older adults with OUD:

Allow methadone to be prescribed by addiction specialist physicians and dispensed outside OTPs in community pharmacies.

Allowing methadone to be prescribed by addiction specialist physicians and dispensed outside OTPs in community pharmacies could address structural barriers that currently impede access to methadone. The existing impediments are even more pronounced for older adults who experience functional limitations and complex medical conditions that are compounded by social isolation. Therefore, older adults stand to uniquely benefit from permanent reforms that eliminate regulatory barriers to methadone access both in community and institutional settings. While critics argue that extending the dispensing of methadone outside OTPs poses greater risk of methadone-related adverse events, evidence from other countries (e.g., Canada, England, Australia, France) supports that pharmacy-based methadone for OUD can be provided safely and

effectively [40,41] with adequate safeguards such as training and certification of pharmacists. For example, pharmacy-based dispensing of methadone in Canada has enabled harder-to-reach populations to engage in treatment resulting in rates of methadone receipt that are 3-4 times higher than in the U.S.[42] Leveraging community pharmacists, who are one of the most accessible healthcare professionals in the U.S., has the potential to extend the infrastructure for methadone treatment to better serve older adults with OUD.[43]

Consider further amending 42 CFR Part 8 regulations to clarify and extend the waiver for OTP certification to post-acute and long-term care facilities.

Considering that transitions to post-acute and long-term care become more common as people age, an important aspect of addressing OUD in older age is to ensure the consistent availability of MOUD across the care continuum. Although the final rule for changes to 42 CFR Part 8 ("Medications for the Treatment of Opioid Use Disorder") which became effective in April 2024 waived requirements for hospitals to be certified as OTPs to administer and dispense methadone, long-term care facilities were effectively not granted the same exemption as hospitals. The final rule states that certification as an OTP is not required for the initiation or continuation of MOUD for a patient who is admitted to a hospital, long-term care facility, or correctional facility that is registered with the Drug Enforcement Agency (DEA) as a hospital/clinic.[44] However, most long-term care facilities are not eligible for DEA licenses because they obtain medications from contracted outpatient pharmacies. Therefore, the full benefits of the recent revisions to 42 CFR Part 8 may not be realized without clear guidance that long-term care facilities could provide methadone directly for their residents as acute care hospitals currently do.

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[44] Medications for the Treatment of Opioid Use Disorder, 42 CFR Part 8 (2024). https://www.federalregister.gov/d/2024-01693

Require behavioral health parity in Medicare.

Federal parity rules, per the Mental Health Parity and Addiction Equity Act of 2008, apply to most public and private health insurance but not Medicare, either fee-for-service or Medicare Advantage.[45] Closing this treatment gap for mental health conditions and substance use disorders is an important step toward improving the management of OUD and the mental health conditions that are often occurring and whose prevalence increases with age. Parity in Medicare also has the potential to incentivize a broader cadre of behavioral health providers to accept Medicare insurance thus improving the continuum of services available to promote the health and well being of older adults with OUD.[46]

Invest in research and demonstration projects to generate novel, clinically-important, and policy-relevant evidence to address OUD in older adults.

The intersections of OUD, its treatment, and aging are understudied. Rigorous research is needed to inform tailored care and enable the selection of multi-level interventions to advance age-friendly care including treatment and recovery services for older adults with OUD. Such research may encompass assembling national longitudinal cohorts to study trajectories of aging among adults with OUD with the goal of understanding the evolution of care and outcomes during and after transitions to older adulthood. Implementation science research is also needed to identify, test, and scale interventions tailored to older adults with OUD. Medicare demonstrations to test new ways to deliver, cover, and pay for services to address OUD in older adults also deserve attention.

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

STATEMENTS FOR THE RECORD

Tim Clover Testimony

Thank you, Chairman Scott, Ranking Member Gillibrand, and distinguished members of the Senate Special Committee on Aging, for holding this critically important hearing, "Combating the Opioid Epidemic," to examine addiction and abuse in older Americans. As President and CEO, Rayner Global, I appreciate the opportunity to highlight new laws that have taken effect this year to help combat the opioid crisis, and the shared commitment we have in fighting addiction and curbing the opioid crisis. Rayner is a global ophthalmic company that operates across the United States and is one of the few companies who has developed a non-opioid alternative for use during cataract surgery, the most commonly performed surgery in the USA with nearly five million surgeries per year.[1] Our non-opioid pharmaceutical product, OMIDRIA (phenylephrine and ketorolac intraocular solution) 1%/ 0.3% is the only FDA-approved intracameral Non-Steroidal Anti-Inflammatory Drug (NSAID). OMIDRIAr is indicated for maintaining pupil size by preventing intraoperative miosis and reducing post-operative pain after cataract surgery.

Substance abuse and overdose deaths are rapidly growing in Americans who are 65 years and older. The most common substances abused are alcohol, prescription drugs such as opiates and benzodiazepines (BZD), and over-the-counter (OTC) medications. Due to the highly addictive nature of opioids, many ophthalmologists want to avoid opioid use in cataract surgery, and therefore, having alternative pain management strategies is critical. Sadly, drug-related deaths have skyrocketed since the COVID-19 pandemic and are increasing in seniors. In 2020 alone, over 5000 American seniors died by overdose.[2] For any individual, and especially one who has struggled with addiction or is predisposed to addiction, being prescribed opioids during or after surgery is highly problematic.

There is not one magic bullet solution to the opioid epidemic, it will take a multipronged approach. To that end, at Rayner, we are focused on legislation intended to incentivize development of non-opioid pain treatments, such as the Non-Opioids Prevent Addiction in the Nation (NO PAIN) Act, which passed as part of the Consolidated Appropriations Act (CAA) in December 2022. NO PAIN was created to reduce financial barriers in prescribing innovative non-opioid therapies to Medicare patients for improved management of postsurgical pain. The law was a bipartisan effort led by Senator Shelley Moore-Capito (R-WV) and co-sponsored by several members of this committee, including Chairman Scott (R-FL), Senator Mark Kelly (D-AZ), and Senator Raphael Warnock (D-GA). The law directs the Centers for Medicare and Medicaid Services (CMS) to make a separate payment for certain non-opioid pain relief treatments in the hospital outpatient department (OPD) setting between January 2025 and December 2027. These products may not be bundled into the underlying procedure payment, and CMS may not reduce the payment level of the underlying procedure to offset the separate payment.

For any senior, and especially one who has struggled with addiction or is predisposed to addiction, being prescribed opioids during or after surgery is highly problematic. With the passage of the NO PAIN Act, doctors and surgeons can now provide innovative, non-opioid alternatives -like OMIDRIA-to Medicare patients without facing financial barriers. Policies that promote new, innovative non-opioid treatments and options are a critical component to combating this terrible epidemic with a straightforward solution - prevent addiction before it starts. We want to work with the Committee to ensure that this law and others remain in place to curb the epidemic.

I applaud all the work that the Committee is doing to highlight the issues around opioid abuse in older Americans and look forward to working with you on this law and our shared goal of preventing abuse.

Tim Clover
President and CEO of Rayner Global

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[1] Market Scope, Forecast for the Global IOL Market, 2024, p. 199
[2] https://www.cdc.gov/nchs/data/databriefs/db455.pdf

U.S. SENATE SPECIAL COMMITTEE ON AGING

"COMBATTING THE OPIOID EPIDEMIC"

FEBRUARY 26, 2025

STATEMENTS FOR THE RECORD

Dr. Jeffrey B. Reich Testimony

Overview

Sparian Biosciences is grateful for the opportunity to submit a statement for the record for the Special Committee on Aging hearing on February 26, 2025, entitled, "Combatting the Opioid Epidemic." This timely hearing brought a much-needed spotlight to the challenges and issues engendered by the ongoing opioid and drug use epidemic, which collectively claimed an estimated 105,000 American lives in 2023, according to the Centers for Disease Control and Prevention (CDC).[1]

About Sparian Biosciences

Sparian Biosciences is a clinical stage biopharmaceutical company headquartered in Ranking Member Gillibrand's home state of New York. Sparian Biosciences is developing innovative medications to combat substance use disorders (SUDs), a public health crisis that the congressional Joint Economic Committee estimates costs the United States nearly $1.5 trillion annually.[2] Despite recent advances in addiction medicine, there are still significant unmet medical needs as noted by the CDC and other federal health agencies.[3] To address this gap, Sparian is developing four novel medications. Sparian's AEAr agonists (SBS-1000 and SBS-147) are first-in-class novel analgesics that hold the promise of offering a non-opioid treatment for patients requiring both acute and chronic pain management. In November 2024, Sparian completed a Phase 1 trial that SBS-1000 was safe and well tolerated in healthy volunteers.[4] The company's second program (SBS-226) is a pre-clinical drug candidate that has potential to treat opioid use disorders, which if successful, would provide clinicians with a new pharmacological treatment and an incremental advance over current therapies such as buprenorphine and methadone. Sparian is also developing a third drug candidate (SBS-371) that could vastly improve how first responders reverse drug overdoses from fentanyl and other powerful synthetic opioids. Lastly, Sparian is developing a new therapeutic (SBS-518) for stimulant use disorders. Currently, there are no FDA approved treatments for methamphetamine and cocaine. Sparian is proud that it has built this impressive and innovative pipeline with nearly $60 million in NIH/NIDA grant funding. Sparian Biosciences is a prime example of a successful public-private partnership.

Introduction

The SUD epidemic in all of its manifestations, including opioid use disorders, has affected all corners of the United States or as Ranking Member Gillibrand noted in her opening statement, "There is no community in this country that has escaped the impact of the opioid crisis."[5] Sparian Biosciences strongly supports Ranking Member Gillibrand's call for a "multi-faceted approach"[6] to end this public health crisis. In that spirit, Sparian Biosciences recommends building a coalition of multi-disciplinary stakeholders ranging from law enforcement to healthcare professionals.

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[1] Garnett, M. F., & Minino, A. M. (2024). Drug overdose deaths in the United States, 2003-2023. (NCHS Data Brief No. 522). National Center for Health Statistics. www.cdc.gov/nchs/products/databriefs/db522

[2] The Economic Toll of the Opioid Crisis Reached Nearly $1.5 Trillion in 2020 - The Economic Toll of the Opioid Crisis Reached Nearly $1.5 Trillion in 2020 - United States Joint Economic Committee (senate.gov)

[3] Dasgupta, S., Tie, Y., Beer, L., Broz, D., & Vu, Q. (2021). Unmet needs and barriers to services among people who inject drugs with HIV in the United States. Journal of HIV/AIDS & social services, 20(4), 271-284.

[4] Sparian Biosciences. (2024, November 12). Sparian Biosciences announces results from the Phase 1 clinical trial of first in class novel arylepoxamide receptor (AEAr) agonist analgesic SBS-1000. https://www.sparianbiosciences.com/news/sparian-biosciences-announces-results-from-the-phase-1-clinical-trial-of-first-in-class-novel-arylepoxamide-receptor-aear-agonist-analgesic-sbs-1000

[5] U.S. Senate Special Committee on Aging. (2025, February 26). Combating the opioid epidemic [Video]. U.S. Senate. https://www.aging.senate.gov/hearings/combatting-the-opioid-epidemic

[6] U.S. Senate Special Committee on Aging. (2025, February 26). Combating the opioid epidemic [Video]. U.S. Senate. https://www.aging.senate.gov/hearings/combatting-the-opioid-epidemic

Sparian Biosciences appreciates Chairman Scott's efforts to recognize that ″local law enforcement agencies are on the frontlines of this crisis″[7] and their need for additional resources.

Legislative Accomplishments

Sparian Biosciences commends Chairman Scott and Ranking Member Gillibrand for their leadership to address all facets of the SUD epidemic and its disproportionate impact on seniors. Chairman Scott's leadership was instrumental in the enactment of the End Fentanyl Act (S.206) last Congress; this bipartisan law modernizes Customs and Border Protection's procedures and tools to interdict as well as seize illicit opioids. Sparian Biosciences is also grateful for Senator Gillibrand's authorship of the bipartisan Supporting Families Through Addiction Act (S.1810) that provides resources to help individuals and their loved ones through the experience of recovery. Sparian Biosciences urges the committee to continue its tradition of bipartisan leadership to finally end the SUD crisis.

Recommendations

As the Special Committee on Aging considers its next iteration of bipartisan efforts, Sparian Biosciences respectfully submits the following proposals for the committee's review:

1. Empower the National Institutes of Health (NIH) to catalyze the biomedical innovation ecosystem: The committee has a bipartisan record of supporting policy mechanisms to drive research and innovation to better care for aging Americans. On February 12, 2025, the committee brought this to the forefront by holding a hearing on strengthening research around longevity and aging.[8] To continue this legacy, the committee should push for additional resources for NIH's Helping to End Addiction Long-term (HEAL) Initiative. This initiative represents NIH's largest commitment to combatting SUDs and currently supports more than 1,800 projects in all 50 states. Some of these projects are aimed at addressing the nexus of SUDs and aging. For example, the HEAL Initiative funded a study in 2023 to explore non-opioid based treatment options for older Americans suffering from chronic pain.[9] Another funded study in 2022 assessed how regulatory changes around opioids might affect care in older lung cancer patients.[10] The HEAL Initiative has a demonstrated track record of success and should receive additional resources to combat the SUD epidemic.

2. Support a whole-of-government initiative to combat SUDs: Republican and Democratic presidential administrations have both recognized SUDs are a pressing public health and national security challenge that require a coordinated and disciplined response. To that end, presidents from both parties have consistently declared SUDs a public health emergency.[11] While these declarations have helped marshal additional resources, they have failed to materialize in a whole-of-government effort analogous to Operation Warp Speed, a public-private partnership that delivered lifesaving COVID-19 vaccines in record time. Given the rising toll of SUDs, Sparian would urge the committee to take a leadership role in developing and implementing a whole-of-government SUD initiative. Sparian Biosciences would also encourage committee Members to convey to their congressional colleagues, FDA, the White House, and other relevant stakeholders on the pressing need for such a program.

3. Strengthen the SUD workforce to improve access to care: Multiple hearing witnesses spoke about the need to improve access to SUD care and treatment. Dr. Bradley Stein, who testified on behalf of the RAND Corporation, contextualized this in the case of older Americans, ″Despite widespread federal efforts to increase access to such treatment, few older adults with OUD receive medication treatment. Only 15 percent of Medicare beneficiaries with OUD received medication treatment in

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[7] Scott, R. (2025, February 26). Combating the opioid epidemic: Opening statement. U.S. Senate Special Committee on Aging. https://www.aging.senate.gov/imo/media/doc/31cc37f1-dfa0-063e-8205-0b4c3645bfd5/Opening20Statement—Scott2002.26.25.pdf

[8] U.S. Senate Special Committee on Aging. (2025, February 12). Optimizing longevity: From research to action [Hearing]. U.S. Senate. https://www.aging.senate.gov/hearings/optimizing-longevity-from-research-to-action

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2022, lower rates than among younger cohorts."[12] Patients with SUDs also face numerous hurdles in accessing care, one of which is a shortage of qualified physicians certified in addiction medicine, a trend that Dr. Malik Burnett, who testified on behalf of the American Society of Addiction Medicine (ASAM), reiterated, "Easier access to addiction treatment cannot happen without a substantially larger addiction treatment workforce, including more addiction specialist physicians."[13] ASAM reports the U.S. needs an additional 1,600 physicians to adequately meets its current demand for SUD care. To address this workforce shortfall, Sparian Biosciences urges committee members to consider proposals such as the Substance Use Disorder Workforce Act (H.R. 7050), which would add 1,000 residency slots for pain and addiction medicine over five years.[14]

Thank you for the opportunity to share Sparian's perspective. Sparian Biosciences shares the committee's mission of improving care for aging Americans. If Sparian can serve as a resource on these matters, please do not hesitate to reach out to Sahil Chaudhary at sahil@sparianbiosciences.com.

Thank you,

/s/
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