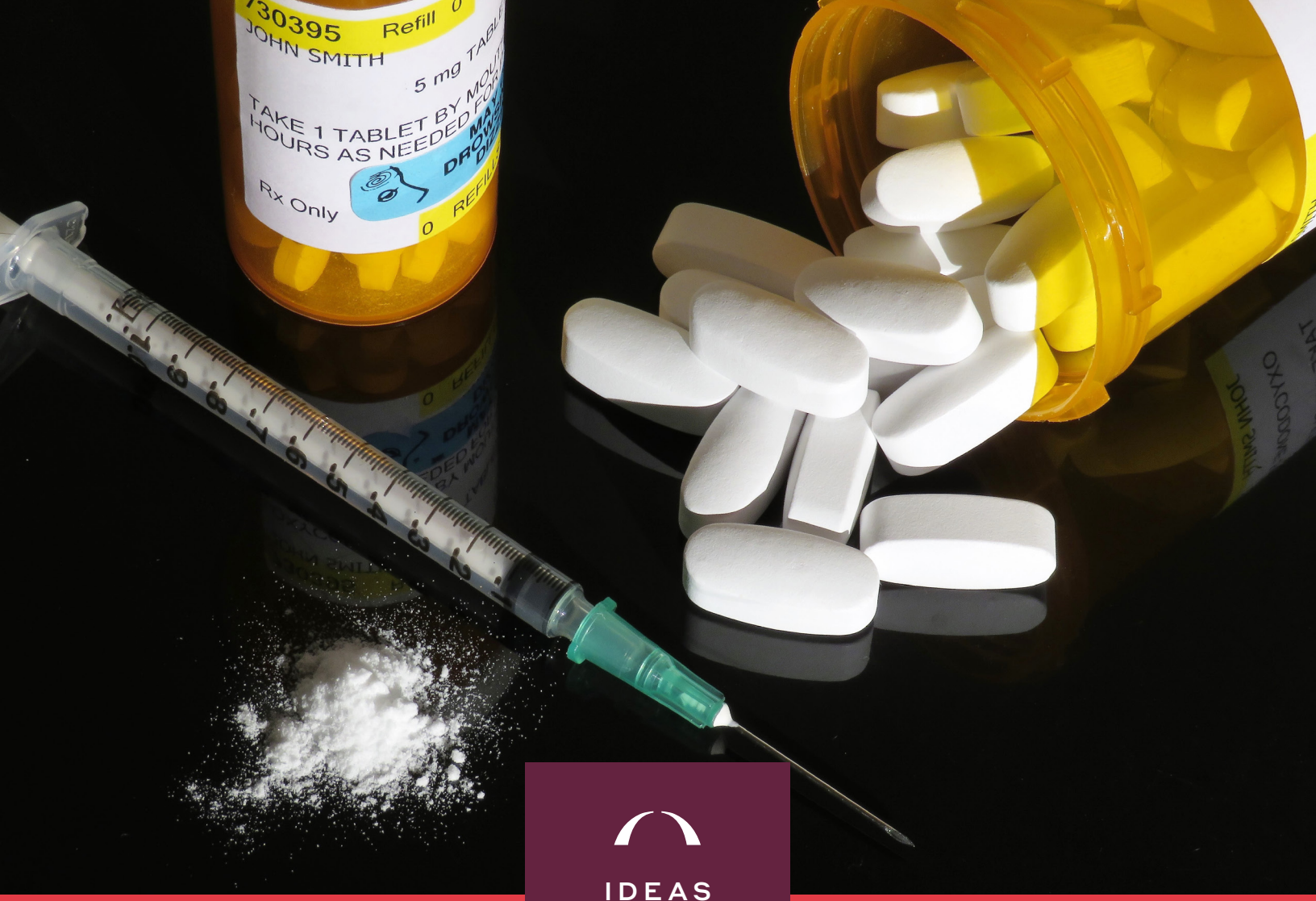

IDEAS
ACTION
RESULTS

Combating the Opioid Crisis

'SMARTER SPENDING' TO ENHANCE THE FEDERAL RESPONSE

April 2022

Bipartisan Policy Center

OPIOID CRISIS TASK FORCE

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ACKNOWLEDGMENTS

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Letter From the Opioid Crisis Task Force

The U.S. Commission on Combating Synthetic Opioid Trafficking recently found that the opioid overdose crisis resulted in more than 550,000 American deaths over the last 20 years, with an annual estimated cost of $1 trillion. The COVID-19 pandemic continues to have an undeniable impact, evident in the United States hitting the grim milestone of over 100,000 drug overdose deaths in a 12-month period.

As former members of Congress, governors, cabinet secretaries, and policy experts from across the political spectrum, we stand together in agreement that the status quo is unacceptable.

The federal government must do better in partnering with all those impacted—states, localities, businesses, nongovernmental organizations, patients, and families—to support a system promoting prevention, treatment, harm reduction, and recovery from opioid use disorder.

A necessary first step in combating the crisis is ensuring that federal funding is allocated and spent wisely to ensure equity, support a holistic approach to patient care, and fund evidence-based programs to maximize reductions in overdose deaths and addiction. To do this, there needs to be robust evaluation data and common metrics to gauge the success or unmet need of current programs. Real-time surveillance and health service delivery data must also be included to better ascertain whether progress is made in combating the opioid crisis.

Leveraging public insurance programs, like Medicaid, with federal grant programs would ensure a greater local impact, and in turn, better support beneficiaries with opioid use disorder and the health care professionals who treat them.

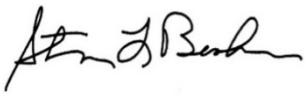
It is a pivotal time in the opioid crisis. Synthetic opioids now drive the crisis; polysubstance use, which increasingly includes methamphetamine, is the norm. The highest increases in mortality rates are now in minority populations. This shift makes it imperative to disaggregate key data by race, ethnicity, and other demographic variables to best ensure an equitable response.

During his State of the Union address, President Biden listed tackling the addiction and overdose crisis as a priority item in his “unity agenda.” We agree that now is the time to redouble bipartisan efforts to support vulnerable Americans at risk from preventable suffering and death.

The recommendations discussed in this report provide near-term actions that Congress and the executive branch could take to enhance the federal response to the opioid crisis. We look forward to collaborating with policymakers to address this urgent public health challenge.

Signed,

Jerome Adams, MD
20th U.S. Surgeon General;
Presidential Fellow, Executive Director of Purdue University's Equity Initiatives, and Distinguished Professor of Practice



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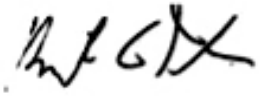

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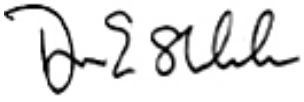

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Glossary of Acronyms

ACA	Patient Protection and Affordable Care Act
ACF	Association for Children and Families
ACL	Administration for Community Living
ADA	Americans with Disabilities Act
ADAM	Arrested Drug Abuse Monitoring Program
AHRQ	Agency for Health Research and Quality
APM	Alternative Payment Model
ARP	American Rescue Plan Act
ASAM	American Society of Addiction Medicine
ASPE	U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation
ATTCs	Addiction Technology Transfer Centers
C/MEs	Coroners or medical examiners
CARA	Comprehensive Addiction and Recovery Act
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CSAT	Center for Substance Abuse Treatment
DATA	Drug Addiction Treatment Act
DEA	Drug Enforcement Administration
DFC	Drug-Free Community
DHS	U.S. Department of Homeland Security
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOSE	Drug Overdose Surveillance and Epidemiology System
DOT	U.S. Department of Transportation
DUA	Data Use Agreement
ED	Emergency Department
EEO	Equal Employment Opportunity
EHB	Essential Health Benefits
EMS	Emergency Medical Services
ERISA	Employee Retirement Income Security Act
FDA	U.S. Food and Drug Administration
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FTE	Full-time employee
GPRA	Government Performance and Results Act
HCBS	Home and community-based services
HCUP	Healthcare Cost and Utilization Project
HIDTA	High Intensity Drug Trafficking Areas
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IC&RC	International Certification & Reciprocity Consortium
IHS	Indian Health Service
IMD	Institutions for Mental Disease
IRS	Internal Revenue Service

MAT-PDOA	Medication-Assisted Treatment – Prescription Drug and Opioid Addiction Grant
MCO	Managed care organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MOU	Memorandum of understanding
MOUD	Medications for Opioid Use Disorder
MTF	Monitoring the Future Survey
NAADAC	Association for Addiction Professionals
NASW	National Association of Social Workers
NCHS	National Center for Health Statistics
NEMSIS	National Emergency Medical Services Information System
NEPQR	Nurse Education, Practice, Quality and Retention program
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NQTL	Nonquantitative treatment limitation
NSDUH	National Survey on Drug Use and Health
OATT	Opioid addiction treatment team
OCR	U.S. Department of Health and Human Services' Office for Civil Rights
OMB	U.S. Office of Management and Budget
ONDCP	Office of National Drug Control Policy
OSTP	Office of Science and Technology Policy
OTP	Opioid treatment programs
OUD	Opioid use disorder
P-COAT	Patient-Centered Opioid Addiction Treatment
PCP	Primary care provider
PHE	Public health emergency
QTL	Quantitative treatment limitation
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOR	State Opioid Response
SSA	Single State Agency
STAR LRP	Substance Use Disorder Treatment and Recovery Loan Program
SUD	Substance use disorder
SUDORS	CDC's State Unintentional Drug Overdose Reporting System
SUPPORT	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
T-MSIS	Transformed Medicaid Statistical Information System
TA	Technical assistance
TEDS	Treatment Episode Data Set
VA	U.S. Department of Veterans Affairs
VTrckS	Vaccine Tracking System
WONDER	Wide-ranging Online Data for Epidemiologic Research
YRBSS	Youth Risk Behavior Surveillance System

Executive Summary

In November 2021, provisional data from the Centers for Disease Control and Prevention (CDC) showed that the U.S. surpassed 100,000 drug overdose deaths from April 2020 to April 2021. This record-setting number follows the previously reported figure of 93,145 overdose deaths in 2020 (roughly 30% higher than in 2019). The recent rise in overdose mortality rates has been exacerbated by increases in fentanyl and polysubstance use, and complicated by an accompanying long-standing stigma regarding addiction. Furthermore, the COVID-19 pandemic has intensified the conditions leading to overdose; people with substance use disorders (SUD) were greatly affected by the pandemic's disruption of daily life and reduced access to treatment services.

Drug overdose mortality rates in minority populations have disproportionately increased recently, with Black and Native American mortality rates increasing by 81%, and Hispanic mortality rates increasing by 65% between 2019 and 2021; by comparison, for whites, mortality rates increased by 40%. Since the start of the COVID-19 pandemic, the South and West regions have seen 57% and 67% increases in drug overdose mortality, respectively, versus an 18% increase in the Northeast and a 37% increase in the Midwest.

In response to this crisis, Congress has maintained opioid-related discretionary spending at over $6 billion per year from fiscal year 2018 through fiscal year 2020. The COVID-19 relief funds have added an additional $2.5 billion in funds targeting SUD. It is important to note that these discretionary dollars are dwarfed by mandatory spending; Medicaid alone spent approximately $23 billion in 2019 on treatment for opioid use disorder.[1, 2]

While considerable attention has focused on the drivers of the opioid crisis, policymakers in Congress remain unsure whether federal investments in opioid-related programs over the past several years have yielded improved patient outcomes, as treatment remains out of reach for the vast majority of Americans with SUD, and overdoses remain high.

Building on its previous 2019 and 2020 reports, BPC launched the Opioid Crisis Task Force to develop recommendations for Congress and the Biden administration to optimize mandatory and discretionary spending and improve opioid-related population health outcomes. The recommendations fall into four policy areas: mandatory spending that could be more fully leveraged; discretionary spending with a focus on "smarter" spending that is evidence-based and coordinated; data reporting and metrics that could be more uniform, frequently reported, and actionable; and governance and leadership to best ensure executive branch-wide coordination and accountability.

The recommendations are as follows:

Mandatory Spending

Recommendation #1: Ensure Parity and Expand Coverage for SUD Services

- *The HHS Secretary and CMS, Alongside DOL and the IRS, Should Coordinate With State Insurance Commissioners and State Medicaid Agencies to Exercise Their Authority to Enforce Parity Rules for SUD Treatment.*
- *The HHS Secretary Should Direct CMS to Work with Section 1115 Waiver Recipients to Ensure That Funds Are Used Primarily to Finance Evidence-based OUD Interventions.*
- *The HHS Secretary Should Direct CMS to Promote Medicaid Section 1115 Waivers for Evidence-based Nonmedical Recovery Services.*
- *CMS Should Promote Medicaid Section 1115 Waivers for Incarcerated Individuals.*

Recommendation #2: Increase Medicaid and Medicare Reimbursements for OUD/SUD Treatment

- *The HHS Secretary and CMS Should Educate Providers on Recently Added SUD-specific Billing Codes.*
- *The HHS Secretary and CMS Should Adopt Alternative Payment Models Incentivizing Patient-centered OUD Care.*

Recommendation #3: Ensure Qualified Health Providers Can Bill for OUD/SUD Treatment *(In-person and via telehealth as appropriate)*

- *Congress and CMS Should Consider Expanding Provider-type Eligibility for OUD Treatment (e.g., SUD counselors, peer support specialists).*
- *Maintain Flexibilities for Eligible Behavioral Health Providers to Provide Care Across States (In-person and via telehealth).*
- *Congress and the DOJ Should Ease Prescribing Restrictions for In-person and Telehealth OUD/SUD Services.*

Discretionary Spending

Recommendation #1: Optimize the SOR and SABG grant programs

- *Congress Should Reexamine the Formula for the SOR Program.*
- *Congress Should Enact Multiyear Authorizations for the Formula Grant Programs.*
- *Congress and the HHS Secretary Should Direct SAMHSA to Work With SOR and SABG Grantees to Ensure That Funds Are Used to Finance Evidence-based OUD Interventions and Promising Innovations.*
- *The HHS Secretary Should Direct SAMHSA to Promote Funding of Evidence-based Recovery Services.*

Recommendation #2: "Braid," or Coordinate, Federal Funding Streams Thematically

- *States Should Be Encouraged to "Braid" Discretionary and Mandatory Funding Streams.*
- *Congress and the White House, Working With Executive Branch Departments, Should "Braid" Discretionary Funding Streams by Directing Similar Opioid-related Programs to Formally Collaborate.*

Data Reporting and Metrics

Recommendation #1: Establish a Set of Evidence-based "Core Metrics" Tied to Surveillance and Health Services Delivery

- *ONDCP Should Guide Executive Branch Departments in Establishing "Core Metrics."*
- *ONDCP Should Work with the HHS Secretary Who Would Direct SAMHSA to Replace Its GPRA Measures With "Core Metrics" Using an Existing OMB Waiver.*

Recommendation #2: Collect "Core Metrics" for OUD/SUD Surveillance and Health Service Delivery More Frequently and Undergo Relevant System Updates

Recommendation #3: Create an OUD/SUD Data Dashboard to Improve Data Sharing and Policymaking While Maintaining Privacy

- *HHS Should Create a New Data System Modeled After HHS Protect for OUD/SUD Data.*

- *HHS Should Establish Anti-discrimination and Privacy Protection Policies for SUD Patient Data Sharing.*

Governance

Recommendation #1: Reorient ONDCP's Role to Focus More on Policy Leadership and Federal Coordination

- *Congress Should Restore Cabinet-level Rank of the ONDCP Director and Consider the Appropriate Placement of the HIDTA and DFC Programs.*
- *The HHS Secretary and ONDCP Should Improve Intradepartmental and Interdepartmental Collaboration.*
- *ONDCP Should Operate as a "Center of Excellence" for Drug Control Policy and Federal Coordination.*

Recommendation #2: Provide Expert Technical Assistance to States

- *Congress Should Fill Existing Vacancies at SAMHSA to Enhance State-level Training and Technical Assistance Efforts.*
- *The Federal Government Should Provide States with Technical Assistance to Direct Opioid Settlement Funding.*

Recommendation #3: Leverage ONDCP's National Drug Control Strategy for Congressional Oversight

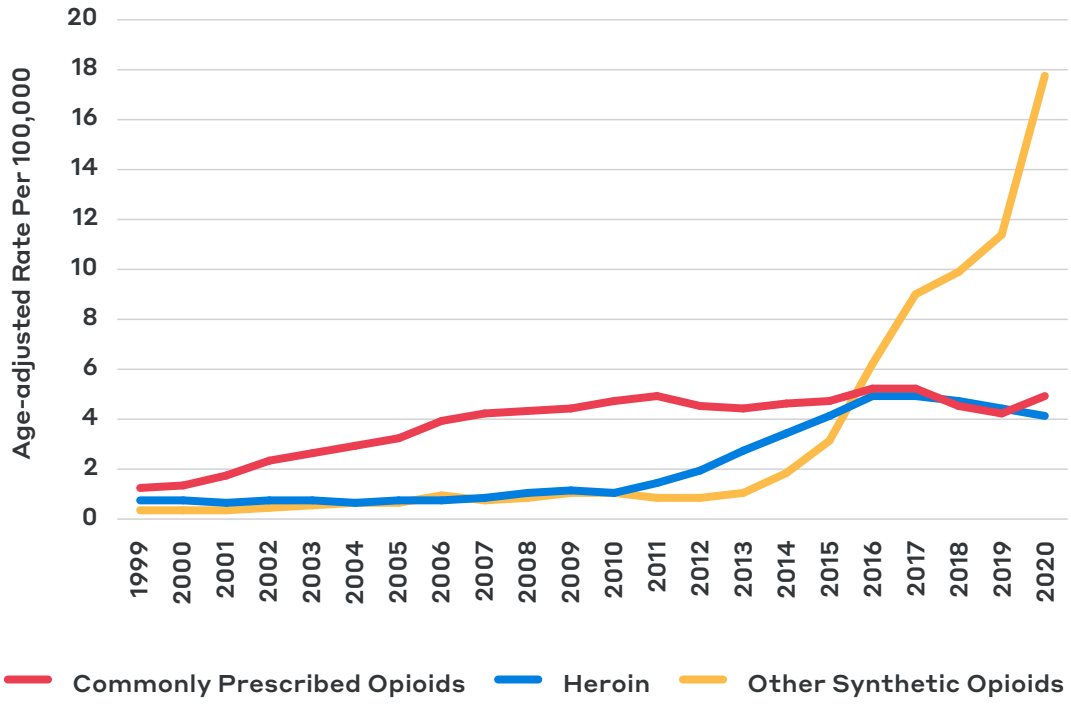
All the recommendations included in this report can assist in optimizing federal spending and the federal response to address the opioid crisis. Stronger federal leadership and actionable metrics will more strategically direct money from discretionary and mandatory funding streams, which can then be used to save lives through evidence-based prevention, treatment, harm reduction, and recovery interventions. With so many preventable lives lost to the opioid crisis to date, it is of high national interest to target funding in a sustainable manner and overcome regulatory and legislative barriers to address the needs of vulnerable populations affected by opioid use disorder.

Introduction

THE STATE OF THE OPIOID CRISIS

The United States is in the midst of an epidemic within a pandemic: drug addiction and overdose deaths increased during the COVID-19 pandemic. The opioid crisis began in the late 1990s, with hundreds of thousands of lives lost since to overdoses and countless more suffering from the impacts of addiction. After decades of rising overdose deaths from prescription opioids, heroin, and synthetic opioids, overdose death rates are at an all-time high (see Figure 1). In November 2021, the CDC announced that the United States surpassed 100,000 overdose deaths from April 2020 to April 2021. This record-setting number follows the previously reported figure[3] of 93,145 overdose deaths in 2020 (roughly 30% higher than in 2019), which indicates that mortality continued to rise well into 2021.

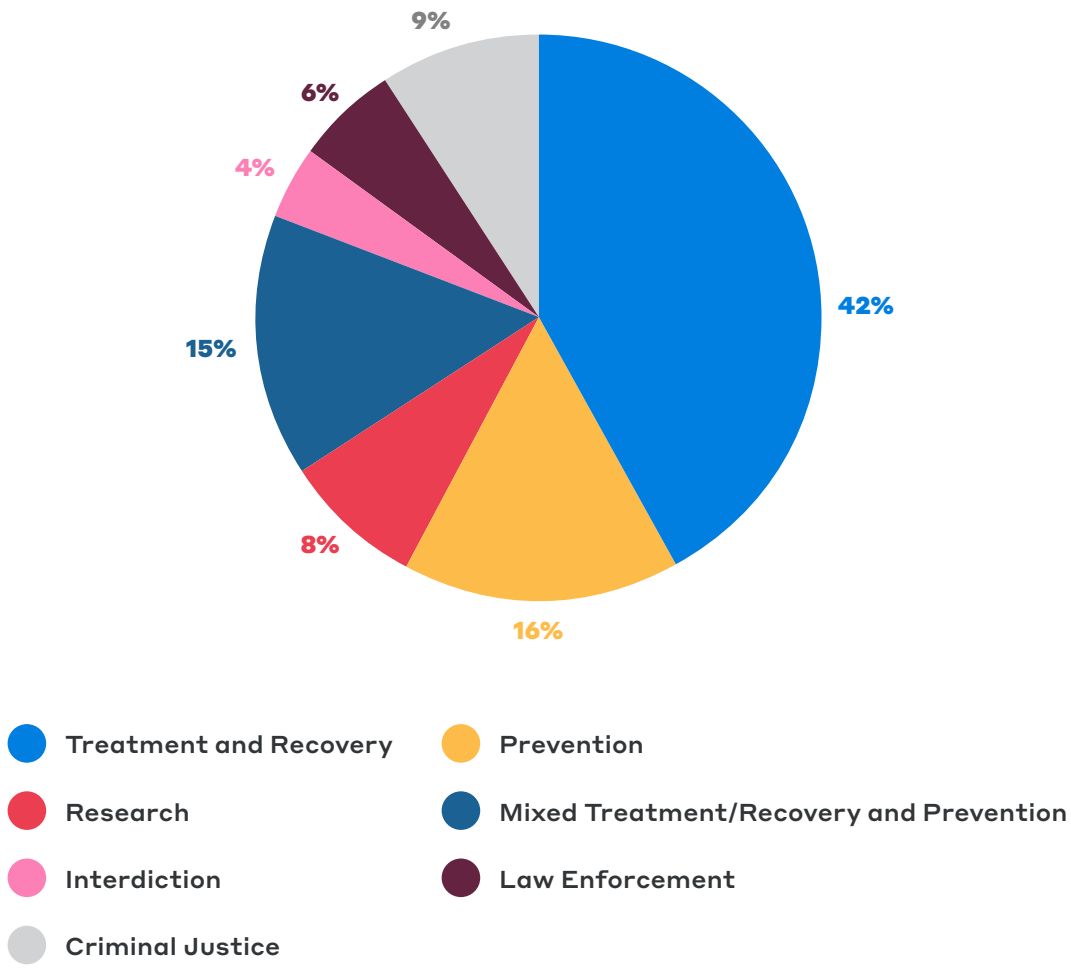
Figure 1: Three Waves of the Rise in Opioid Overdose Deaths



Source: Centers for Disease Control and Prevention, *CDC WONDER Online Database*, February 2022. Available at: http://wonder.cdc.gov/mcd-icd10.html.

The recent rise in overdose mortality rates has been exacerbated by increases in fentanyl and polysubstance use, and complicated by an accompanying long-standing stigma regarding addiction. Furthermore, the COVID-19 pandemic has intensified the conditions leading to overdose; people with substance use disorders (SUD) were affected by the pandemic's disruption of daily life and limited access to treatment services.[4] Congress has responded to this ongoing need with sustained funding of over $6 billion in discretionary dollars (see Figure 2) in addition to COVID-19 relief funds. Together, these resources fund treatment and recovery, prevention, research, interdiction, law enforcement, and criminal justice programs that address the opioid crisis.

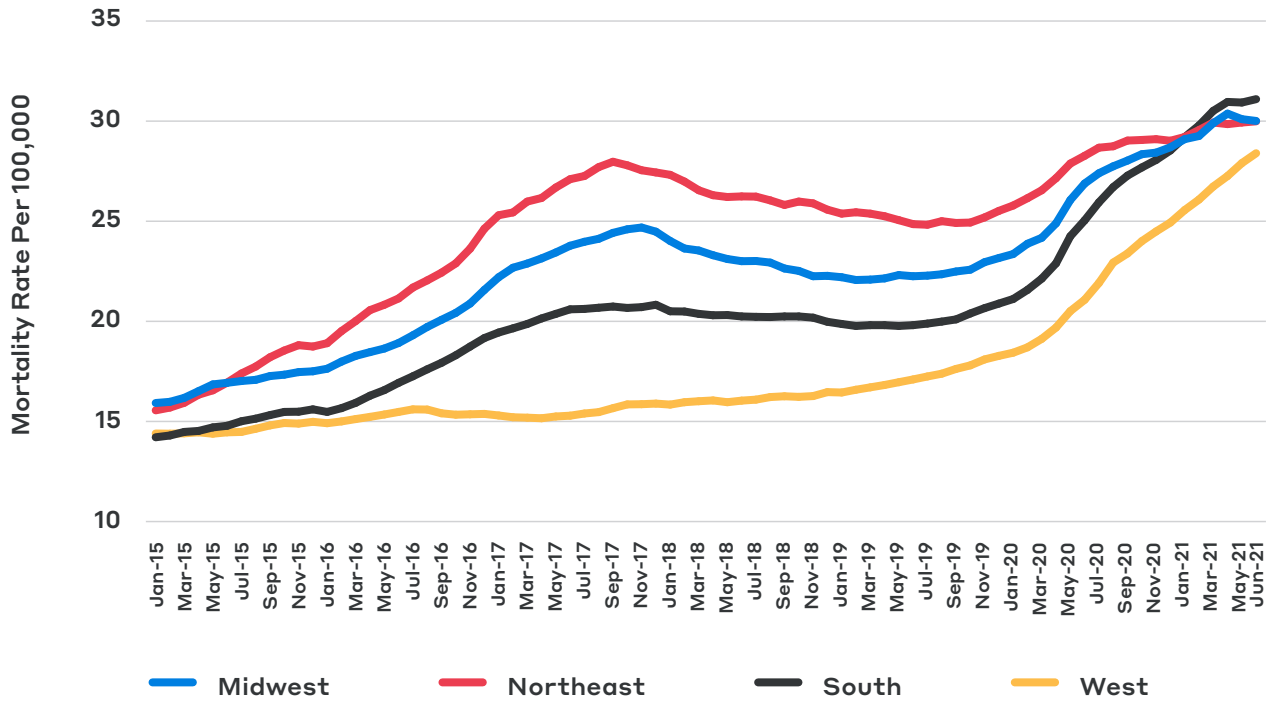
Figure 2: Opioid-related Discretionary Spending by Category (FY2020)



As noted in Figure 3, overdose mortality rates have been increasing across all regions of the country. Between April 2020 and April 2021, rates continued to increase in both the Northeast (10% over 12 months and 18% since January 2019) and the Midwest (22% over 12 months and 37% since January 2019). Even more noteworthy is the stark percentage increase in overdose mortality rates in the West (39% over 12 months and 67% since January 2019) and the

South (36% over 12 months and 57% since January 2019) compared with a year earlier. The faster percentage increases in drug overdose mortality rates in the West and South are supported by data that also indicates an increase in the use of fentanyl in these regions. The South has surpassed the Northeast as the region with the highest drug overdose mortality rate. In fact, when comparing increases in overdose deaths from 2019 to 2020, the majority of states with the highest percentage increases were located in the South. With respect to the West, it is noteworthy that California had an alarming increase of 3,000 deaths between 2019 and 2020 (45.9% increase). Even the highest regional mortality rate in 2020—27.2 per 100,000 in the Northeast—is lower than the lowest regional mortality rate just a year later—27.3 per 100,000 in the West.

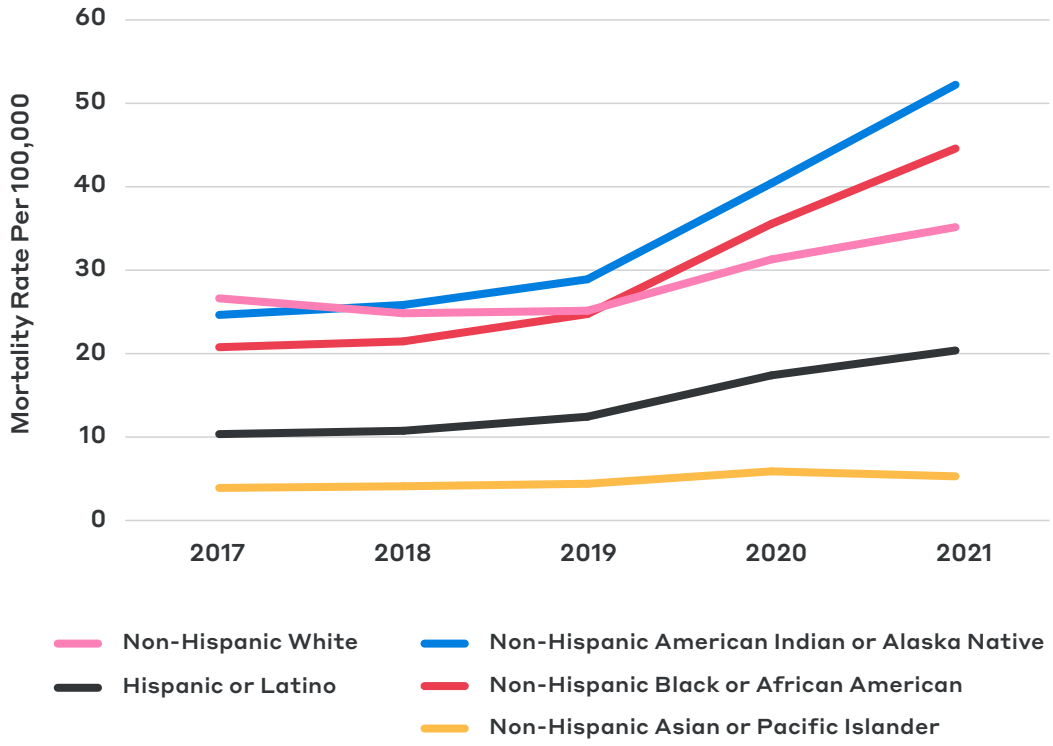
Figure 3: Drug Overdose Death Rates by Region



Source: Centers for Disease Control and Prevention, *CDC WONDER Online Database*, February 2022. Available at: http://wonder.cdc.gov/mcd-icd10.html.

As noted in Figure 4, the increase in drug overdose mortality has not been uniform across racial and ethnic groups. In 2020, Black and Hispanic mortality rates increased by over 40% compared with a 24% increase for whites; and between 2019 and 2021, Black and Native American mortality rates increased by 81% and Hispanic mortality rates increased by 65% compared with a 40% increase for whites. Differences in mortality by sex were roughly the same by quarter between 2019 and 2020[5]—30% of overdose deaths were female, and 67% to 70% of overdose deaths were male.[6]

Figure 4: U.S. Drug Overdose Deaths Per 100,000 by Race, 2017–2021



Note: 2021 data is a projection based on provisional data through June 2021.
Source: Centers for Disease Control and Prevention, *CDC WONDER Online Database*, February 2022. Available at: http://wonder.cdc.gov/mcd-icd10.html.

FEDERAL RESPONSE

By the time the public health emergency (PHE) for the opioid crisis[7] was declared in 2017, there had already been over four decades of discussion about how to structure the federal response to drug control policy.[8] Most notable was the addition of the Special Action Office for Drug Abuse Prevention to the White House in 1971 under President Nixon, the same year the "War on Drugs" was declared.[9] The current Office of National Drug Control Policy (ONDCP) was authorized in 1988, and its responsibility is to "[lead] and [coordinate] the nation's drug policy so that it improves the health and lives of the American people."

The initial declaration of the "War on Drugs" cultivated a criminal justice approach to drug use and addiction rather than a public health approach. The SUD treatment system in general developed separately from the health care system at large, leaving the resources needed for addiction treatment to the criminal justice system, social welfare agencies, and state and local government.[10] Equally important is the issue of stigma and discrimination. Stigma against patients, families, and providers has been real and damaging.

Addiction has also often been "criminalized" in the past, thus thwarting a truly significant emergency-level response by all levels of government and society.

The federal drug addiction policy environment has seen a shift in this paradigm over the last decade. State Medicaid programs that provide health care for millions of low-income people have been on the frontlines of the opioid crisis, and thus the Affordable Care Act's (ACA) Medicaid expansion has been a critical tool for getting care to SUD patients and reducing hospitalizations.[11,12] The ACA also introduced the Essential Health Benefits, which includes SUD services under both the Medicaid expansion programs and qualified health plans offered on the Marketplace.

In recent years, Congress has passed three major bills as part of its response to the opioid crisis: the Comprehensive Addiction and Recovery Act (CARA) of 2016, the 21st Century Cures Act of 2016, and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018. CARA expanded access to opioid rescue medications and MOUD, and extended prescribing and dispensing authority to nurse practitioners and physician assistants; promising prescribing trends in its aftermath indicate that Medicaid beneficiaries exhibited notable increases in life-saving OUD treatment.[13] The Cures Act authorized the State Targeted Opioid Response (STR) Program, which was eventually renamed the State Opioid Response (SOR) Program. The SUPPORT Act increased access to services through various mechanisms, primarily by relaxing eligibility and enrollment for vulnerable populations (e.g., youth in the criminal justice and foster care systems), expanding authorization for new Medicaid demonstration programs to increase provider capacity, and enhancing prescription drug oversight.[14]

Congressional leaders have also noted the growing harm posed by illicit fentanyl-related substances and have recently charted a strategic approach to combating its flow into the United States.[15] Additionally, the Bipartisan Addiction and Mental Health Task Force in the House of Representatives, formed early in the 117th Congress, is supporting numerous pieces of bipartisan legislation as part of its legislative agenda.[16] These bills support those struggling with mental health and substance use, build the public health infrastructure needed to address the addiction crisis, and create safeguards against trafficking.

The Biden administration has continued to prioritize federal action. Early in the administration, ONDCP released its first National Drug Control Strategy, containing seven drug policy priorities, including support of various evidence-based interventions and advancing racial equity.[17] More recently, ONDCP, in conjunction with HHS, released a four-part government-wide strategy for fighting addiction.[18] This approach, comprised of primary prevention, harm reduction, evidence-based treatment, and recovery support, is underpinned by the principles of equity, data and evidence, coordination, collaboration, and integration, as well as reducing stigma. Finally, in his first State of the Union

address, President Biden recognized the need for increased funding across the continuum of care and the need to reform regulatory barriers.[19]

FEDERAL FUNDING

Federally financed SUD care is disproportionately funded through Medicare, Medicaid, and Marketplace resources.[20] Of these, Medicaid is the largest source of opioid-related funding, paying for 47% of opioid-related ED visits and 38% of inpatient visits (see Figure 6).[21, 22, 23] Approximately $1.5 billion was spent on medications for OUD (MOUD) in Medicaid alone in 2019.[24] Prior to the implementation of the ACA, Medicaid spent $9.4 billion in federal and state dollars on comprehensive health care services for 636,000 individuals with OUD.[25] Extrapolating those numbers to the 1.6 million people treated for OUD through Medicaid in 2019, expenditures would be over $23 billion.[26] These resources far outweigh discretionary dollars appropriated for similar purposes. Previous BPC reports found that opioid-specific discretionary funding tripled from FY2017 (approximately $2 billion per year) to FY2018 (over $6 billion per year) when the opioid PHE was initially declared. However, since that time, the amounts for these funding streams have leveled off ($6.4 billion in FY2019, $6.1 billion in FY2020, approximately $6.2 billion in FY2021 without the COVID-19 relief packages, $2.5 billion in additional funds from the COVID-19 relief packages, and $6.7 billion in FY2022).[27, 28]

Of the approximately 70 discretionary funding streams that BPC has been tracking, approximately two-thirds are appropriated to HHS; and of that funding, roughly half comes from the SOR and opioid-specific components of SABG programs of SAMHSA. BPC's prior analyses revealed that federal funding has been reaching areas with the highest number of overdose deaths but that, per capita, rural and metropolitan areas examined were receiving relatively low levels of direct funding compared with more populated cities.

In addition to BPC's previous findings, which suggested that smaller states with high rates of drug overdose mortality received greater proportions of federal spending, it is important to note that current funding levels do not adequately consider annual changes in statewide mortality, especially in larger states with rapid rises in overdose deaths such as California. After incorporating funding levels from FY2020, BPC has observed that the states with the highest mortality rates—particularly those located in the northeastern United States—receive the highest funding because of the way the formula for the SOR grants is calculated. However, this may be leading to inequitable distribution of funds given challenges such as underreporting, as well as the proportional increases in overdose deaths in the western and southern United States.

PURPOSE AND METHODOLOGY

While considerable attention has focused on the drivers of the opioid crisis, policymakers in Congress remain unsure whether federal investments in opioid-related federal programs over the past several years have yielded improved patient outcomes, as treatment remains out of reach for the vast majority of Americans with SUD. Building on its previous work, BPC launched the Opioid Crisis Task Force to develop recommendations for Congress and the Biden administration to optimize mandatory and discretionary spending and improve opioid-related population health outcomes. As noted above, this is particularly important given how the COVID-19 pandemic has exacerbated the opioid crisis.

The task force relied on multiple approaches that included:

- **Analyzing yearly funding trends for select federally funded opioid programs:** BPC analyzed discretionary spending trends over time for FY2017 to FY2020 and COVID-19 relief packages by consolidating awarded funding levels for each of those fiscal years. Note that FY2021 has been omitted for now, as not all these funds have been awarded at the time of this report's publication.
- **Reviewing available evaluations for select federally funded opioid programs:** BPC reviewed and assessed each of the nearly 70 distinct opioid-related discretionary funding streams. In this review, BPC compiled and extracted information from publicly available program evaluations from the following sources when available: independent evaluations, evaluations from agency program managers, and Congressional Justification documents from agencies to the House and Senate Appropriations Committees to the extent possible for each program.
- **Identifying discretionary programs with areas of overlap:** BPC reviewed the descriptions for each of the discretionary funding streams across all the agencies and determined which programs had areas of overlap through a thematic analysis. Programs were then categorized into the following areas: prevention; health services; tribal communities; children, families, and youth; criminal justice; and detection and surveillance. The amount of funding associated with each area was also aggregated.
- **Analyzing available health care expenditure data:** BPC analyzed data on mandatory spending and compared the treated prevalence in Medicaid claims data (the number of beneficiaries treated for opioid use disorder and any SUD) in expansion and nonexpansion states. Furthermore, BPC reviewed health care utilization data to quantify the percentage of opioid-related hospitalizations paid for by either Medicare or Medicaid.
- **Reviewing literature:** BPC reviewed peer-reviewed articles, reports, issue briefs, and other grey literature to identify current best practices, processes, and priorities.

- **Engaging state, federal, and expert stakeholders:** BPC hosted two virtual stakeholder roundtable events whereby subject matter experts within the addiction policy field provided input on program effectiveness, metrics, and various regulations and policies related to opioid-related mandatory and discretionary funding streams.
- **Reviewing federal opioid-related legislation:** BPC monitored policy activity related to the opioid crisis through a legislative tracker.

The recommendations in this report focus on understanding the extent to which federal funding can be used effectively and what an ideal federal response to the opioid crisis should focus on. Recommendations fall in four policy areas: mandatory spending that could be more fully leveraged; discretionary spending with a focus on "smarter" spending that is evidence-based and coordinated; data reporting and metrics that could be more uniform, frequently reported, and actionable; and governance and leadership to best ensure executive branch-wide coordination and accountability. For each of these four policy areas, BPC has noted the overarching challenges to be addressed followed by the corresponding recommendations.

Mandatory Spending

Mandatory spending through CMS accounts for a significant proportion of opioid-related spending; as indicated earlier, at least $23 billion annually can be attributed just to the Medicaid program. Together, Medicare and Medicaid paid 65% of opioid-related ED visits, and 75% of inpatient opioid visits in 2018 according to available health care utilization data.[29] Unlike with discretionary funding streams, mandatory funding streams come in the form of reimbursements for the delivery of health care services rather than through grants, and have implications for access to care based on coverage and provider capacity.[30, 31]

BPC has found in its preliminary analyses of Medicaid claims data from CMS' Transformed Medicaid Statistical Information System (T-MSIS) that states that expanded their Medicaid programs under the ACA had higher treatment rates for both SUD broadly and OUD treatment specifically (see Figure 5). These data reflect historical regional discrepancies in OUD treatment, with the Northeast having higher levels of treatment versus the South and West.[32]

Figure 5: OUD/SUD Medicaid Treatment Rates in Expansion vs. Nonexpansion States

Treatment Type by Year	Expansion States	Nonexpansion States
SUD Treatment in 2017	1,716.4 per 100k	850.8 per 100k
OUD Treatment in 2017	576.4 per 100k	198.9 per 100k
SUD Treatment in 2018	1,992.0 per 100k	824.8 per 100k
OUD Treatment in 2018	688.6 per 100k	203.9 per 100k

Source: Centers for Medicare and Medicaid Services, *Transformed Medicaid Statistical Information System* (*T-MSIS*). Available at: https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

Similarly, BPC analyzed data from the Healthcare Cost and Utilization Project (HCUP), which focuses on health service utilization—such as ED visits and inpatient stays—by payer (see Figure 6). It is important to note that the combination of both Medicare and Medicaid payers account for the majority of both inpatient and ED-admitted opioid patients. Treatment rates in ED and inpatient settings have increased between 2014 and 2018; preliminary analyses of this data set found that opioid-related ED treat-and-release visits increased by 217,000 (or 40%), and inpatient stays similarly increased by 218,000 (or 32%) over this four-year period.

Figure 6: Opioid-related Health Care Utilization in Number of Patients by Payer

Payer	2014	2015	2016	2017	2018
ED Treat-and-release – **Medicare**	87,700 (16%)	107,200 (17%)	132,000 (17%)	133,200 (17%)	134,500 (18%)
ED Treat-and-release – **Medicaid**	227,750 (42%)	284,550 (44%)	335,900 (44%)	350,500 (45%)	358,350 (47%)
ED Treat-and-release – **Private Insurance**	102,900 (19%)	133,450 (21%)	144,300 (19%)	140,500 (18%)	110,750 (15%)
ED Treat-and-release – **Self-pay/No Charge**	119,750 (22%)	116,900 (18%)	144,550 (19%)	156,450 (20%)	151,900 (20%)
Total ED Treat-and-release	538,100	642,100	756,750	780,650	755,500
Inpatient – **Medicare**	220,350 (32%)	257,250 (33%)	332,650 (36%)	344,200 (36%)	334,900 (37%)
Inpatient – **Medicaid**	265,900 (39%)	306,850 (39%)	347,200 (37%)	362,600 (38%)	346,950 (38%)
Inpatient – **Private Insurance**	139,800 (20%)	159,900 (20%)	183,500 (20%)	176,100 (19%)	161,400 (18%)
Inpatient – **Self-pay/No Charge**	63,450 (9%)	56,450 (7%)	62,850 (7%)	63,150 (7%)	64,250 (7%)
Total Inpatient	689,500	780,450	926,200	946,050	907,500

Note: As a result of rounding, some of the percentages in this chart may not add up to exactly 100%.
Source: Agency for Healthcare Research and Quality, *Healthcare Cost and Utilization Project* (*HCUP*), February 2022. Available at: https://www.hcup-us.ahrq.gov/faststats/opioid/HCUP_OpioidRelatedHospitalUse_DataExport.xls.

Though these analyses reveal insights into the relative differences in service utilization, BPC noted several key limitations to the spending and outcome data on OUD. First, the prevalence of OUD/SUD relies on two-year-old voluntary survey data; and more accurate downstream data on mortality from OUD and other drug overdose deaths are not finalized until a year after the fact. While two-year-old mandatory spending data is available to quantify the percentage of opioid-related hospitalizations paid for by either Medicare or Medicaid, there is no total spending figure available to determine how much hospitalizations cost to public payers. Second, the accuracy of upstream data—specifically for hospitalizations and prevalence for SUDs—is highly variable across the country. Had this data been more current and available, BPC would have been able to identify any relationships between federal funding levels and OUD/SUD prevalence, much like what officials are able to examine with COVID-19 spending.[33] The two challenges, along with lack of a common evaluation framework, make it very difficult to understand the impact that federal spending has on opioid use and outcomes. Through the recommendations later in this report, BPC is seeking to address these data limitations and move toward a long-term systemic approach that provides purposeful data exchange.

KEY CHALLENGES

Insufficient and Inconsistent SUD Coverage (Medicare, Medicaid, Marketplaces)

Despite an expansion in insurance coverage for SUD services in recent years, there are still coverage gaps for SUD services within Medicaid, Medicare, and Marketplace plans.[34] This patchwork can have profound effects on the delivery of treatment and recovery across payers, especially for MOUD. In particular, Medicare coverage for select SUD services is limited (see Figure 7); the bulk of Medicare coverage for SUD services is for outpatient services, including screening and early intervention, yet there are gaps in coverage for recovery services. Marketplace plans, which are privately operated, are required to cover behavioral health treatment (e.g., psychotherapy and counseling), mental and behavioral health inpatient services, and SUD treatment, including preexisting conditions and at parity with physical health services, under the ACA.[35, 36, 37] Coverage for these plans may vary by state.[38]

Figure 7: Medicare Coverage for SUD Services and Settings

American Society of Addiction Medicine (ASAM) Level	Medicare Coverage	Medicare Gaps
Level 0.5 – Early Intervention	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) • Alcohol Misuse and Counseling – once per year with up to four counseling visits • Screening for SUD in initial preventative physical examination and annual wellness visits	
Level 1 – Outpatient Services	• Office-based counseling and care management • Hospital outpatient-based counseling • Opioid Treatment Programs • Telehealth for SUD counseling and certain OTP services, which beneficiaries can access from their homes	• Freestanding SUD treatment facilities are not covered • Licensed counselors and certified addiction counselors and peer counselors are not covered, unless providing "incident to" services under the supervision of a physician
Level 2 – Intensive Outpatient/Partial Hospitalization Services	• Partial hospitalization services in hospital outpatient settings and Community Mental Health Centers	• Freestanding SUD treatment facilities are not covered • Intensive outpatient services are not covered • Partial hospitalization services are not available for patients with a SUD primary diagnosis
Level 3 – Residential/ Inpatient Services		• Freestanding SUD treatment facilities are not covered • Residential services are not covered

American Society of Addiction Medicine (ASAM) Level	Medicare Coverage	Medicare Gaps
Level 4 – Medically Managed Intensive Inpatient Services	• Hospital-based intensive inpatient SUD treatment	• 190-day lifetime limit for inpatient psychiatric care
Withdrawal Management	• Office-based withdrawal management • Hospital-based withdrawal management	• Freestanding SUD treatment facilities are not covered • Licensed counselors, certified addiction counselors and peer counselors are not covered, unless providing "incident to" services under the supervision of a physician

Adapted from: Legal Action Center, *Medicare Coverage of Substance Use Disorder Care: A Landscape Review of Benefit Coverage, Service Gaps and a Path to Reform*, February 2021. Available at: https://www.lac.org/resource/medicare-coverage-of-substance-use-disorder-care-a-landscape-review-of-benefit-coverage-service-gaps-and-a-path-to-reform.

Medicare coverage gaps may have large but predictable nationwide impacts, while Medicaid coverage varies by state. Figure 8 summarizes the number of state Medicaid programs that cover select SUD services, particularly medications.[39,40] Several of these services often require prior authorization. Further, though telehealth utilization has climbed during the COVID-19 pandemic, fewer than half of states still explicitly allow MOUD to be administered via telehealth as of November 2021. SUD services are included as a Medicaid Essential Health Benefit under the ACA, though the types of SUD services for which this definition extends is not specified.

In addition, vulnerable populations such as incarcerated individuals, of whom roughly 85% of the population has an active SUD or has been incarcerated for a crime involving drugs or drug use, are unable to receive Medicaid coverage for OUD treatment and/or have limited access to treatment in general, leaving many with short sentences (<30 days) uninsured once they are released.[41, 42]

Figure 8: State Medicaid Coverage for OUD Services

OUD/SUD Service – Medicaid	Number of States (and DC) Covering Service Under Medicaid (2018)
Inpatient Detoxification	43
Residential Rehabilitation	33
Buprenorphine for Medications for OUD (MOUD)	51
Injectable Naltrexone for MOUD	51
Methadone for MOUD	41
Suboxone Treatment	44
Intensive Outpatient Treatment for SUD	38

OUD/SUD Service – Medicaid	Number of States (and DC) Covering Service Under Medicaid (2018)
Naloxone Available in at least One Formulation Without Prior Authorization	46
Naloxone Nasal Spray Covered Without Prior Authorization	43
Naloxone Nasal Spray Atomizer Covered Without Prior Authorization	25
Naloxone Auto-injectors Covered Without Prior Authorization	10
Naloxone Coverage Provided for Family Members or Friends Obtaining a Naloxone Prescription on Enrollee's Behalf	19
Telehealth for MOUD (November 2021)*[43]	Yes (explicitly allows MOUD via telehealth): 21 No (ended provisions): 3 N/A (no further guidance): 27

Source: Kaiser Family Foundation, *Medicaid & CHIP Database*, 2018. Available at: https://www.kff.org/state-category/medicaid-chip/medicaid-behavioral-health-services/substance-use-disorder-sud-services/.

SUD coverage for Medicare and Medicaid also does not extend to include social services critical to prevention and recovery. Evidence suggests that there is a relationship between various social risk factors—namely, housing insecurity, low socioeconomic status, educational attainment, food insecurity, neighborhood violence (especially during childhood), and poor access to transportation—and increased risk of substance use disorders.[44, 45, 46, 47, 48] However, prevention and recovery services that aim to address these factors are typically not included as a benefit under Medicare and Medicaid.[49, 50] The COVID-19 pandemic has certainly exacerbated many risks of OUD/SUD and prompted the need for assistance programs (e.g., rental assistance, stimulus checks) using both discretionary and mandatory dollars.[51, 52] Experts are grappling with the prospect of confronting future challenges as these assistance programs are phased out, presenting an opportunity to examine the extent to which mandatory programs can support SUD prevention and recovery efforts.

With all of the limitations, there is an urgent need to ensure equitable access to care in line with the provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Congress passed the MHPAEA and the ACA to require most health plans to cover treatment for mental health and SUDs no more restrictively than treatment for physical health conditions.[53] Parity rules apply to a variety of health plans, including Medicaid managed care organizations (MCOs) (which cover approximately 70% of Medicaid beneficiaries), CHIP plans, some state and local health plans, group health plans, and Marketplace plans. They do not apply to Medicare[54] (except for Medicare's cost-sharing for outpatient mental health services) and Medicaid fee-for-service plans, though BPC previously recommended that parity rules apply to these plans.[55] It is worth noting that parity rules only guarantee equal coverage, and thus are only as good as the health insurance plan to which it applies; if the plan is limited, even in a state with a strong parity law or in

a plan that is subject to federal parity, then mental health coverage will be similarly limited.[56]

Over the years, it has been difficult to enforce compliance with these rules. With behavioral health concerns on the rise during the COVID-19 pandemic, the Biden administration has made parity enforcement a top priority. Congress has recently proposed bipartisan legislation to further ensure parity laws, including a bill that would provide grant funding to states for the implementation of MHPAEA requirements, especially nonquantitative treatment limitations (NQTLs); and a bill that would provide authority to the Department of Labor (DOL) to enforce parity requirements for group health plans.[57, 58, 59] Biannual reports to Congress over the past decade outline strategies that the DOL, which is authorized to investigate and take enforcement action under MHPAEA, plan to take for addressing noncompliance; these strategies can apply to financial requirements (e.g., copays and deductibles), quantitative treatment limitations (QTLs), and NQTLs. The importance that the Biden administration places on enforcement is reflected in the President's FY2023 budget request and the Consolidated Appropriations Act of 2021, through which Congress amended MHPAEA requiring health insurance plans to perform NQTLs—comparative analyses used to assess plan compliance—on behavioral health benefits.[60] NQTLs include strategies like formulary design for prescription drugs, prior authorization requirements, and concurrent review of in- and out-of-network services; and they may reveal plans that fail to meet network adequacy, reimbursement, and utilization management of benefits.[61] However, though NQTLs include prior authorizations, rate setting methodologies, and other aspects of managing benefits, they do not have the direct authority over plans that are sold to multiple employers, and the NQTLs lack authority to assess civil monetary penalties.[62, 63] Thus, there is an opportunity to reexamine how enforcement of these rules is authorized and implemented.

Low Reimbursement for SUD Services

While they vary by state, reimbursement for SUD treatment is lower than for comparable behavioral health services (e.g., mental health treatment, family and marriage therapy), and Medicaid reimbursement for MOUD varies by state, limiting the solvency of SUD clinical settings and impacting the ability to provide high quality patient care.[64, 65, 66] Some payers restrict billing codes to "behavioral health" providers without recognizing addiction specialist physicians for specialties other than psychiatry.

The reimbursement process itself relies on claims, which use billing codes to capture the services rendered. However, billing codes are known to vary across states and payers, and some of the reimbursement rates have not been revised for a decade.

- **Medicaid:** For Medicaid, states can exercise their discretion when setting payment rates.[67, 68] Unfortunately, Medicaid behavioral health payment rates

are often too low to ensure enough qualified providers accept Medicaid.[69, 70] Some states also may limit diagnosis codes for which primary care providers may receive reimbursement.[71] States are recognizing the extensive reach of Medicaid managed care, which now covers almost 70% of all Medicaid beneficiaries, and are becoming more proactive in their approaches to partnering with MCOs to drive the transition to alternative payment models (APMs) (e.g., Medicaid Alternative Benefit Plans) that can better address SUD.[72, 73, 74] Medicaid also excludes Institutions for Mental Diseases (IMD)[75] from using Medicaid financing, which may lead to barriers to care; however, states can use Section 1115 waivers to circumvent this.

- **Medicare:** Since the COVID-19 PHE, Medicare expanded bundled rates for Opioid Treatment Programs (OTPs) and office-based OUD services, allowing reimbursement for care coordination, individual and group psychotherapy, and counseling activities provided over a one-month period.[76] Still, as a result of a decades-old law enacted by Congress, these programs face additional requirements compared with many other health services programs and private individual providers.[77] Medicare does not authorize or reimburse some facilities that provide SUD care, specifically free-standing SUD treatment facilities that offer community-based care. This limits service availability delivery in community-based settings. Moreover, attrition among SUD providers suggests that Medicare or Medicare Advantage plans may use different standards to set reimbursement rates, or different incentives to ensure provider participation.[78]
- **Private:** Reimbursements by private plans are also low, leading many SUD providers to opt out of accepting insurance, further limiting access to SUD services, and contributing to negative health outcomes.[79, 80, 81, 82]

The ability to reimburse at a higher rate is impeded by the historically widespread use of generic or inaccurate coding that does not provide an accurate assessment of SUD service utilization.[83] Billing codes used for services rendered are often inconsistent and sometimes coded as SUD treatment, but more often coded under generic codes.[84] Updates to the Medicare Physician Fee Schedule for SUD services in recent years allow for more precise billing codes that more accurately assess and account for OUD patient risk and are pay-for-performance; this would give CMS the ability to better track utilization and expenditures for SUD by levels of care, identify opportunities for expanding reimbursement rates, and could help assess access disparities. Still, adoption of these codes has been slow.

Limited Provider Capacity

SUD treatment services are provided by a broad range of practitioners, including physicians, nurses, social workers, psychologists, and many others. Several groups of practitioners are currently not eligible for reimbursement under Medicare, though they must meet significant training requirements.[85, 86] For example, SUD counselors work directly with patients over the course of

their treatment and recovery, help alleviate stigma, and serve in vital case management functions. While counseling is no longer required as part of select quality measures (e.g., Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment) that assess patient care, there is some evidence to support adding behavioral interventions to MOUD, and thus an argument for making SUD counselors eligible for reimbursement.[87, 88, 89] In contrast to other behavioral health professionals, states' approaches to licensing, credentialing, and training of SUD counselors varies widely (Figure 9).[90] Given that insurance reimbursement is correlated with licensure, it is not surprising that eligibility for SUD counselors to participate in Medicaid varies state by state.[91]

A 2018 HRSA study projected that by 2030, the shortage in the national addiction counselor workforce could reach up to 35,000 full-time employees, with 45 states suffering from shortages.[92] Recommendations identified to address this shortage include the adopting of common standards of addiction education, increased availability of degree programs, and financial incentives including increased reimbursement, scholarship and student loan repayment programs that incentivize students to pursue advanced degrees in SUD treatment.[93]

Figure 9: Credentialing Requirements for SUD Counselors

Requirement	Number of States
Overall Requirements	• 31 states offer licensure (legal authority to practice) and certification (demonstrate professional competency) • 20 states offer certification only
Education Requirements	• 37 states require a master's degree to attain the highest SUD counseling credential in the state • 6 states (including the District of Columbia) require a bachelor's degree • 4 states require an associate degree • 3 states only require a high school diploma • 1 state (Alaska) has no minimum degree requirement, but this is complemented with steep practice requirements for those with no baseline level of education
Practice Hours	• 1 state requires <1 year • 38 states require 1-2 years • 10 states require 3-4 years • 1 state requires at least 5 years

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies and Practices Across the Nation*, November 2019. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf.

In addition to SUD counselors, peer support specialists are also important members of the SUD workforce. Peer support specialists are effective in SUD recovery, as they build trust given that they themselves have lived experience.[94] Despite their effectiveness, Medicare currently does not cover peer support specialists except as part of "non-opioid pain management" under Medicare Advantage.[95] Medicaid has more flexibility to cover peer support specialists; however, according to a 2020 GAO report, only 36 states and the District of

Columbia cover peer support specialists through their Medicaid programs.[96, 97] The credentialing process for peer support specialists is often less rigorous than it is for SUD counselors, yet they are still required to complete an additional in-person training program and also pass a state exam in many places.[98]

With respect to MOUD, the specific restrictions and credentialing requirements for providers to prescribe buprenorphine or buprenorphine/naloxone products further limit capacity. Physicians and advanced practice providers, such as physician assistants and nurse practitioners, have had to complete an additional eight-hour training, known as the Drug Addiction Treatment Act (DATA 2000) or X Waiver, on top of their other credentialing requirements, making it difficult to meet patient demand.[99] There are several distinct issues with the X Waiver: it limits the number of providers who are able to prescribe buprenorphine; X Waiver training does not ensure mastery of addiction medicine or ongoing quality of care; and there is evidence to suggest that the few who do are treating fewer patients than they can per the waiver limit.[100, 101, 102, 103, 104] Given these challenges, the Biden administration updated guidelines in 2021 creating an exemption of training requirements for physicians and other prescribers who intend to treat 30 patients or fewer for relevant medications, though they still must obtain the X Waiver.[105,106] While a range of providers can obtain this waiver, certified nurse specialists, certified nurse anesthetists, and certified nurse midwives will only be able to prescribe until October 2023.[107] Overall, these changes should make it easier for providers to obtain the X Waiver; increasing the number of providers with the X Waiver should increase patient reach and further reduce stigma. Removing the waiver entirely would require legislative action.

Finally, since the start of the COVID-19 pandemic, increased flexibilities for telehealth utilization have introduced new modalities for administering treatment, including prescribing controlled substances via telehealth as specified in the Ryan Haight Act. It is worth noting that, according to CMS' interim final rule,[108] the PHE flexibilities allow telehealth for SUD counseling and certain OTP services (primarily for methadone) to be expanded.[109] If finalized, this may provide some additional flexibility for SUD providers, especially across state lines.

RECOMMENDATION #1: ENSURE PARITY AND EXPAND COVERAGE FOR SUD SERVICES

The HHS Secretary and CMS, Alongside DOL and the IRS, Should Coordinate With State Insurance Commissioners and State Medicaid Agencies to Exercise Their Authority to Enforce Parity Rules for SUD Treatment.

BPC previously recommended that the federal government enforce parity rules. The lack of enforcement continues to marginalize mental health and substance use services, add burden on providers, and limit patient access.[110, 111] Enforcing parity rules would expand OUD/SUD coverage for beneficiaries covered by Medicaid MCOs—the majority of Medicaid beneficiaries—and the Marketplace, as well as the other payers specified earlier. There are several mechanisms that the federal government should use to further ensure that parity rules are enforced and that there is compliance:

- CMS and the DOL should increase their funding for parity enforcement of Employee Retirement Income Security Act (ERISA) plans by the DOL.
- CMS and the DOL should also ensure that state and federal regulators strengthen enforcement and compliance activities by empowering regulatory agencies to enforce parity laws and require monitoring agencies to regularly report on steps taken to enforce compliance. In addition, states should mandate that all health benefit plans submit regular (e.g., annual) analyses demonstrating compliance with the relevant laws.[112]
- CMS and the DOL should monitor and enforce standards to phase out NQTLs, processes, or criteria that limit the scope of benefits provided under an insurance plan.[113, 114]
- Congress should grant the DOL the power to issue civil monetary penalties, which is a key recommendation of former President Obama's Parity Task Force.[115]

The HHS Secretary Should Instruct CMS to Work with Section 1115 Waiver Recipients to Ensure That Funds Are Used Primarily to Finance Evidence-based OUD Interventions.

States should use their Section 1115 waivers so that they are consistent with evidence-based treatment, like MOUD. Thus, the HHS secretary should instruct CMS to use various means, including audits and improved reporting, to ensure that states and the waiver recipients are using these funds for interventions most likely to be effective, and that those terms are reviewed and enforced to address rising mortality rates.[116] To determine whether the applications for the Section 1115 waivers are aligned with those of Medicaid, CMS performs a case-by-case review of each proposal; and conducts federal reviews to monitor implementation, especially the impacts of the demonstrations on beneficiaries,

providers, health plans, states, access to care, quality of care, and costs.[117] The requirements for SUD Section 1115 waiver monitoring and evaluation are based on guidance from 2017 (e.g., increased provider capacity and standardized provider requirements, standard patient assessments, opioid prescribing guidelines, care coordination strategies, evaluation, and reporting, etc.). CMS has provided tools that would support these enforcement activities, and thus they should make the data for these efforts publicly available to promote the evaluation of the evidence-based OUD programs funded through Section 1115 waivers.[118, 119]

The HHS Secretary Should Direct CMS to Promote Medicaid Section 1115 Waivers for Nonmedical Evidence-based Recovery Services.

The HHS secretary should direct CMS to promote the use of Section 1115 waivers for nonmedical services that align with social risk factors of addiction.[120, 121, 122, 123, 124] Further, the HHS secretary should instruct CMS to use various means, including audits and improved reporting, to ensure that states and the waiver recipients are using these funds for interventions most likely to be effective, and that those terms are reviewed and enforced. CMS guidance on Section 1115 waivers for OUD has evolved so that states have more flexibility and can obtain them more easily. Since the opioid PHE was declared in 2017, states have obtained Section 1115 waivers more easily to circumvent the IMD exclusion.[125] However, there is not widespread use of these waivers for nonmedical recovery services.

Among these nonmedical services are:

- Housing security
- Transportation
- Employability
- Food security
- Education and school-based health
- Anti-violence

Treatment alone is not always sufficient to effectively address SUD, so promoting the use of Section 1115 waivers in this way will encourage states to offer a wider selection of services beyond those listed in Figure 8. One state, California, uses its Section 1115 waivers to coordinate care for high-risk and high-utilizing Medicaid ("MediCal") enrollees, and notes that SUD patients are one of the target populations, though it does not explicitly target nonmedical services.[126] Other states (e.g., North Carolina) already use their Section 1115 waivers to pay for services that correspond with social risk factors, creating an array of available wraparound services for Medicaid beneficiaries in general.[127]

CMS Should Promote Medicaid Section 1115 Waivers for Incarcerated Individuals.

To address the issues with incarcerated individuals noted above, states should also use their Section 1115 waivers to relax Medicaid coverage restrictions for this community.[128] Congress has appropriately introduced bipartisan legislation to do this (e.g., Medicaid Reentry Act, which enables Medicaid-eligible incarcerated individuals to restart benefits 30 days prerelease),[129] and most recently this has been proposed as part of a larger social spending package. Thus, given the gap in Medicaid coverage at the federal level, there are opportunities for states to use their Section 1115 waivers to pilot Medicaid-funded services for this population while they are still incarcerated.

RECOMMENDATION #2: INCREASE MEDICAID AND MEDICARE REIMBURSEMENTS FOR OUD/SUD TREATMENT

The HHS Secretary and CMS Should Educate Providers on Recently Added SUD-specific Billing Codes.

In response to recent billing code changes, CMS should provide communications and instructions (e.g., a toolkit)[130] to educate health care providers and administrators of Medicare Advantage and Medicaid MCO plans about the use of SUD-related service billing codes.[131, 132, 133] This will ensure that there is a shared understanding of which codes are available and incentivized based on higher payments.[134] Currently, with the ways in which generic billing codes are used, it is difficult to determine the expenditures associated with various clinical practices. Moreover, there are minimal efforts to develop pay-for-performance billing codes for SUD services, limiting the ability to link payment with clinical quality.[135]

With rising drug overdose mortality rates, it is important for CMS to leverage the information gleaned from the new billing codes to ensure that the payment reflects the cost of providing SUD services and accurately assess levels of risk. Widespread adoption of these billing codes would also be a critical element in understanding SUD service costs and utilization.[136] CMS could use the codes to assess service delivery patterns, track utilization and expenditures, and increase incentives. OUD/SUD services are not reimbursed as highly as they are for other services under the current Physician Fee Schedule.[137] The HHS Secretary should review and make adjustments to newer billing codes to ensure that risk adjustments are capturing costs.

The HHS Secretary and CMS Should Adopt Alternative Payment Models Incentivizing Patient-centered OUD Care.

The HHS Secretary should direct CMS to adopt and scale opioid-specific APMs to identify opportunities for expanding reimbursement.[138] APMs offer

the opportunity to provide holistic SUD care with quality metrics driving payments. There are several SUD-specific APMs for CMS to consider, including some that are risk-adjusted.[139, 140] Two examples include:

- The Patient-Centered Opioid Addiction Treatment (P-COAT) model,[141] which is an APM geared toward office-based outpatient OUD treatment, especially MOUD. The model is designed to increase the utilization of office-based treatment of opioid use disorder by providing adequate financial support to successfully treat patients and broaden the coordinated delivery of medical, psychological, and social support services. Providers are incentivized with both initial and monthly payments; thus, the more OUD patients who are seen and treated, the greater the monetary amount to the physician practice.
- The SUD Collaborative Care Model, which would allow states to uniformly reimburse for the care coordination and integrated behavioral health services needed to support recovery. With only 20% of behavioral health patients receiving care in a specialty setting, integrated care models recognize the importance of primary care, especially in treating the underlying factors and comorbidities contributing to an individual's substance use condition.[142] Ensuring that this model meets startup and additional staffing costs at the current reimbursement rates would optimize implementation.[143]

New APMs should be introduced using Section 1115 waivers to redesign service delivery and reimbursement systems. Ultimately, any APM adopted by CMS should be oriented around SUD patient risk, so reimbursements from these models should consider the cost of conducting accurate risk assessments. The APMs must be accompanied by performance-based incentives tied to meaningful process and outcome measures that support a patient-centered system of care. Providers should be incentivized to improve the quality and outcomes of care delivered to their patients, recognizing that SUD is a disease that requires ongoing care management and is underpinned by social risk factors.[144]

RECOMMENDATION #3: ENSURE QUALIFIED HEALTH PROVIDERS CAN BILL FOR OUD/SUD TREATMENT

(In-person and via telehealth as appropriate)

Congress and CMS Should Consider Expanding Provider-type Eligibility for OUD Treatment (e.g., SUD counselors, peer support specialists).

As mentioned previously, eligible Medicare providers of SUD treatment may not include all the providers who can effectively deliver aspects of SUD treatment. Congress and CMS should review these data and consider expanding eligibility for SUD counselors and peer support specialists, which may already be covered under Medicaid. BPC previously recommended passing legislation to increase the behavioral health provider types covered under Medicare for behavioral

health integration, which included peer support specialists.[145] For OUD treatment, exploring additional provider types would allow CMS to potentially broaden workforce capacity and expand access to care for Medicare beneficiaries.

Maintain Flexibilities for Eligible Behavioral Health Providers to Provide Care Across States (In-person and via telehealth).

Congress should consider additional federal incentives as states' temporary COVID-19 PHE flexibilities for out-of-state licensure begin expiring.[146] Early in the COVID-19 PHE, nearly all states and the federal government approved unprecedented flexibilities in licensing rules to allow more interstate mobility for health care professionals, which has been shown to address unmet behavioral health needs complicated by physical comorbidities and inequities.[147, 148, 149, 150, 151, 152] However, the same emergency response does not match the level of urgency for the opioid crisis. Congress should create these incentives within 151 days of the COVID-19 PHE's expiration (as stipulated by the FY2022 omnibus agreement),[153] and promote increased adoption of telehealth-specific licenses (similar in concept to a driver's license) or telehealth-specific exceptions to licensure for behavioral health services, for states that continue to opt out of licensure compacts.[154] While the long-standing function of state licensing boards serves to protect patients from unqualified or unprofessional behavior, the lifting of these restrictions on out-of-state practitioners significantly aided the response to the opioid PHE and care for OUD patients in underserved areas.

Congress and the DOJ Should Ease MOUD Prescribing Restrictions for In-person and Telehealth OUD/SUD Services.

BPC previously recommended[155] removing the special licensing requirement—the X Waiver—for health care providers to prescribe buprenorphine. While the Biden administration introduced a set of practice guidelines for the administration of buprenorphine, as noted above, this does not replace or eliminate the X Waiver; this requires legislative action and therefore, Congress should act.[156]

The DOJ has another waiver for providers prescribing controlled substances via telehealth. They should maintain these waivers and create a special registration for telehealth providers. To do this, the DOJ could use its existing legal authority under the Ryan Haight Act to create this registration program for telehealth providers as part of the SUPPORT Act.[157] Even before the pandemic, the DEA loosened these remote prescribing restrictions for controlled substances for the duration of the PHE for the opioid crisis.[158] Given that high tele-mental health utilization and SUD counseling and certain OTP services (primarily for methadone) are covered via telehealth under Medicare and Medicaid, a special registration program for telehealth providers is most suitable, especially because it would expand patient access while upholding an enforcement mechanism to limit overprescribing.[159, 160]

Discretionary Spending

Discretionary spending for opioid-related programs accounted for over $6 billion in FY2020 as shown in Figure 10. These funds provide grants through many federal agencies—including SAMHSA, CDC, DOJ, DHS, and others—to support surveillance, prevention, treatment, harm reduction, and recovery efforts. They also fill gaps in the provision of services not funded by mandatory programs. BPC has been tracking funding levels from FY2017 to FY2020 for approximately 70 opioid-related discretionary funding streams, including state-by-state distribution of funds, and the relationship between funding levels and overdose mortality rates. Of the 70 discretionary programs (see the Appendix), the largest and most impactful are the formula grant programs at SAMHSA: the SABG and the State Opioid Response (SOR) programs; roughly two-thirds of total opioid-related discretionary spending comes from HHS and roughly half of the total HHS spending comes from the SOR and SABG programs combined.

Figure 10: Opioid-related Discretionary Program Funding by Agency (FY2017–FY2020)

Agency	FY2017	FY2018	FY2019	FY2020
Department of Health and Human Services	$1,523,943,746 (74%)	$4,280,714,868 (69%)	$4,080,945,880 (64%)	$4,146,461,700 (68%)
Substance Abuse and Mental Health Services Administration (SAMHSA)	$1,358,463,700 (66%)	$2,440,263,700 (40%)	$2,452,263,700 (38%)	$2,462,263,700 (40%)
SAMHSA State Opioid Response (SOR)	$500,000,000 (33% of HHS spending)	$1,500,000,000 (35% of HHS spending)	$1,500,000,000 (37% of HHS spending)	$1,500,000,000 (36% of HHS spending)
SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG)	$533,663,700 (35% of HHS spending)	$533,663,700 (12% of HHS spending)	$533,663,700 (13% of HHS spending)	$533,663,700 (13% of HHS spending)
Indian Health Service (IHS)	$6,000,000 (<1%)	$6,000,000 (<1%)	$16,946,000 (<1%)	$16,946,000 (<1%)
Centers for Disease Control and Prevention (CDC)	$112,000,000 (5%)	$630,579,000 (10%)	$480,579,000 (8%)	$564,579,000 (9%)
Health Resources and Services Administration (HRSA)	*	$480,000,000 (8%)	$407,265,000 (6%)	$397,265,000 (7%)
Administration for Children and Families (ACF)	$43,910,000 (2%)	$125,310,000 (2%)	$125,310,000 (2%)	$90,000,000 (1%)
Administration for Community Living (ACL)	*	$982,831 (<1%)	$989,411 (<1%)	$0
Agency for Healthcare Research and Quality (AHRQ)	$3,570,046 (<1%)	$3,579,337 (<1%)	$592,769 (<1%)	$0

Agency	FY2017	FY2018	FY2019	FY2020
National Institutes of Health (NIH)	*	$500,000,000 (8%)	$500,000,000 (8%)	$500,000,000 (8%)
Food and Drug Administration (FDA)	*	$94,000,000 (2%)	$47,000,000 (1%)	$65,408,000 (1%)
Centers for Medicare and Medicaid Services (CMS)	*	*	$50,000,000 (1%)	$50,000,000 (1%)
Office of National Drug Control Policy (ONDCP)	$351,000,000 (17%)	$379,000,000 (6%)	$380,000,000 (6%)	$400,500,000 (7%)
Department of Justice (DOJ)	$194,000,000 (9%)	$515,839,484 (8%)	$562,339,484 (9%)	$572,000,000 (9%)
Veterans Affairs (VA)	*	$704,552,000 (11%)	$724,362,000 (11%)	$771,107,000 (13%)
Homeland Security (DHS)	*	$261,100,000 (4%)	$654,397,000 (10%)	$174,759,000 (3%)
Department of Labor (DOL)	*	$21,000,000 (<1%)	$0	$0
Total Opioid Spending	**$2,068,943,746**	**$6,162,206,352**	**$6,402,044,364**	**$6,089,827,700**

Note: With the exception of the SOR and SABG lines, which denote the percentage of HHS spending, the percentages in parentheses denote the percentage of total federal opioid spending. The portions of the table with an asterisk (*) indicate programs that were not included in that year's appropriations bill.

The SABG program provides funds to single state agencies (SSAs) in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity to help plan, implement, and evaluate activities that prevent and treat substance abuse. According to SAMHSA's official description,[161] each SABG grantee must have a designated unit responsible for administering the SABG, apply for funds annually, distribute funds to local government entities (e.g., municipal, county, or intermediaries, including administrative service organizations), and have subrecipients (e.g., community- and faith-based organizations, or nongovernmental organizations). SABG grantees must deliver substance abuse prevention activities to individuals and communities impacted by substance abuse; and provide treatment and recovery support services to individuals and families impacted by SUDs.

The SOR program also provides funding to SSAs and aims to address the opioid crisis by increasing access to MOUD, reducing unmet treatment need, and reducing opioid overdose deaths through prevention, treatment, and recovery activities for OUD and stimulant misuse and use disorders, including for cocaine and methamphetamine.

In addition to the funding analyzed from FY2017 through FY2020, BPC also tracked the subset of funds authorized through the COVID-19 relief packages of 2020 and 2021 that impacted FY2021 funding; and the most recent appropriations bill for FY2022. Specifically, the CARES Act provided $350 million to SAMHSA for certified behavioral health clinics and emergency

grants for mental health and substance use disorder. The ARP Act provided more substantial increases, funding $2.1 billion related to substance use disorder:

- $1,500,000,000 for SABG
- $420,000,000 Certified Community Behavioral Health Clinic (CCBHC) Expansion
- $100,000,000 Behavioral Health Workforce Education and Training
- $80,000,000 HRSA–Mental Health and Substance Use Disorder Training for Health Care Professionals
- $30,000,000 SAMHSA–Community-Based Funding for Local Substance Use Disorder Services

Combined, the COVID-19 relief packages totaled $2.5 billion in additional funds targeted to substance use disorder. This represents a 41% increase in funding versus FY2020 funding. The FY2022 appropriations bill included $6.7 billion—a 9% increase over FY2020—for opioid-related programs.[162]

KEY CHALLENGES

Insufficient Information About Investment in Recovery Services

The SABG and SOR programs both specify that state recipients of these funds can use them for recovery services but offer vague guidance for which services to fund. While recovery specialists devote time and resources ensuring that recovery efforts match medical as well as social needs, federal funding does not match the immense patient needs still required to provide the necessary wraparound services.[163, 164, 165, 166, 167] Vulnerable populations isolated during the COVID-19 pandemic experienced barriers to accessing critical nonmedical services, especially support services and safe/stable housing.[168, 169, 170, 171, 172, 173, 174, 175, 176] As the pandemic subsides, it will be important that states continue to be given an option to use their SOR and SABG funding to finance nonmedical services for recovery. The president's FY2022 budget included a 10% set-aside in the SABG for recovery support services; however, this was not included in the FY2022 omnibus appropriation.

Current SOR Formula Complicates the Distribution of Funds

Similarly, there is a well-documented misalignment between states that receive a high amount of funding and states with the greatest need based on the SOR formula. An analysis of grant dollars from 2017 and 2018 found that one-sixth of the funds—$1.5 billion—was misallocated.[177] While the SOR formula takes into account the statewide mortality rates, it does not take into account the percentage increase in mortality rates or timely and accurate prevalence data; this is complicated by the fact that the formula includes treatment metrics that come from the National Survey on Drug Use and Health (NSDUH). The NSDUH figures are problematic for estimating prevalence because they rely on

voluntary self-reporting survey data that can be subject to sampling errors.[178] While this program brings large amounts of funding to states, equitable distribution may be compromised because of how the formula for this program is calculated; it includes a 15% set-aside for the 10 states with the highest mortality rates related to drug poisoning deaths.

Year-long SOR and SABG Grant Cycles Are Too Quick for States to Use Effectively

While the annual appropriations bill is one of only a few must-pass bills specified in the U.S. Constitution, Congress renews the funding for the SOR and SABG programs during the annual cycles without full awareness of states' needs to budget in multiyear increments. States that rely on discretionary funds primarily for their opioid-related programs have expressed concerns regarding their ability to access federal funds consistently over multiple years due to these uncertainties in the appropriations process and possible budget cuts. Furthermore, under-resourced grantees are burdened with the task of reapplying for these awards every year.

Many Disparate Programs Within SAMHSA with Low Budgets

In addition to the larger SABG and SOR grants, SAMHSA has appropriated funds for numerous pilot and demonstration programs that have relatively lower funding for individual nonprofits and nongovernmental organization grantees; many of these programs were authorized through the SUPPORT Act of 2018.[179, 180] Based on BPC's analysis, 12 of these programs have an average funding of roughly $25 million each; stakeholders from nonprofits and community-based organizations have expressed that they must apply for multiple grants to cover their operating costs, which may support the need to better align reporting requirements and funding streams.[181, 182, 183]

Overlap of and Gaps in Programs Across Agencies

Opioid-related discretionary funding streams across the entire federal government include programs with overlapping target populations and program objectives. These programs often exist independently of one another, leaving grantees to quilt together a patchwork of federal funding.[184, 185, 186] Neither Congress nor other federal leaders have conducted a meaningful gap analysis to identify government-wide areas of duplication and programmatic gaps. Thus, it is difficult to compare program effectiveness and the geographic equity of these investments as there is no mechanism in place to ensure that resources needed to address substance use issues in different areas are adequately and fairly dispersed.[187]

RECOMMENDATION #1: OPTIMIZE THE SOR AND SABG GRANT PROGRAMS

Congress Should Reexamine the Formula for the SOR Program.

The SOR formula uses the NSDUH dataset to approximate prevalence, which introduces some limitations given the frequency with which it is updated and the data collection methods. This program uses a formula that is designed to assist Congress in disseminating federal funds to states based on greatest need. However, the SOR formula currently equally weights two factors: the NSDUH per capita "dependence or abuse of heroin or pain relievers not receiving treatment" and "drug overdose deaths per capita."

In its authorizing language, the SOR program should be amended so that the formula used to distribute funding appropriately responds to evolving patterns in the states. This would take into account mortality, including percentage increase in drug overdose deaths per capita, especially for vulnerable communities heavily impacted by the opioid crisis; and establish new portions to incorporate prevalence data such as ED overdoses (fatal and nonfatal) from datasets other than the NSDUH. By changing the SOR formula to increase funding for states with rapid rises in mortality, states with larger populations of racial and ethnic minorities in the South and West regions would likely see proportional increases in funding. The set-aside would remain for the 10 states with the highest drug overdose deaths per capita to receive 15% from the overall funding to SOR.

Recognizing that Native Americans have had the highest drug overdose mortality rates in recent years, the SOR should also allocate 5% of the total amount to Native American tribes, tribal nations, or tribal organizations, which is an increase from $50 million to $75 million. The authorizing language would continue to recognize the flexibility of the SOR funds to address stimulant misuse and use disorders, including for cocaine and methamphetamine as well as polysubstance use.

Congress Should Enact Multiyear Authorizations for the Formula Grant Programs.

In order to allow states the ability to budget more effectively, Congress should authorize and appropriate the funding for the SOR and SABG programs in the first session of each Congress such that the funds are awarded every two years instead of every year. These longer cycles would help with budgeting and could mitigate the potential for there to be unspent funds at the end of their annual grant awards.[188] States have expressed that a longer time frame (e.g., five years) would be even more helpful; the Drug-Free Communities (DFC) Program has this five-year window, which gives recipients enough time to track real community-level change, especially if there are two consecutive awards over a 10-year period. A two-year time frame is nimble enough to adapt to changing

conditions so that funding priorities do not become irrelevant and outdated, and it also accounts for shifts in congressional makeup with each session.

Congress and the HHS Secretary Should Direct SAMHSA to Work With SOR and SABG Grantees to Ensure That Funds Are Used to Finance Evidence-based OUD Interventions and Promising Innovations.

Prevention, treatment, and recovery activities are core elements of the SABG and SOR programs, with various requirements for grantees and the ability to select the services funded. Congress should reiterate that funds go only to evidence-based interventions. The SOR grant explicitly notes its support of "evidence-based" interventions; however, it is unclear how much oversight of grantees currently exists. The HHS secretary should instruct SAMHSA to use various means, including audits and improved grantee reporting, to ensure funding goes to interventions most likely to be effective; and pilot promising innovations that have had and plan to include rigorous program evaluations. This is important not only to address OUD but, more broadly, interventions that address polysubstance use.

HHS Secretary Should Direct SAMHSA to Promote Funding of Evidence-based Recovery Services.

SAMHSA should promote investments in recovery services through the SOR and SABG grants. In particular, evidence-based interventions in the following areas should be identified given their linkage to OUD prevention and recovery:

- Housing security
- Transportation
- Employability
- Food security
- Education and school-based health
- Anti-violence

In its current state, the SABG program "support[s] the development of local recovery community support institutions," while the SOR program's recovery funds "include methamphetamine and other stimulants to give states and [tribal nations] flexibility to address their unique community needs."[189] Given the breadth of this language, additional SAMHSA guidance in the promotion of specific recovery services could contribute to better outcomes.

RECOMMENDATION #2: "BRAID," OR COORDINATE, FEDERAL FUNDING STREAMS THEMATICALLY

State Should Be Encouraged to "Braid" Discretionary and Mandatory Funding Streams.

The HHS secretary should direct SAMHSA and CMS to issue joint guidance and leverage a "braiding" framework, which describes when two or more funding sources are coordinated to support similar objectives.[190, 191] To do this, CMS would issue guidance to state Medicaid agencies, which should coordinate with Single State Agencies (SSAs) for substance abuse services to identify coverage gaps for Medicaid beneficiaries with OUD; and SAMHSA would issue guidance to SSAs to direct SABG and SOR funds to fill Medicaid medical and nonmedical coverage gaps as applicable for each state. SAMHSA would incentivize the SSAs by establishing conditional requirements for dispensing their SOR and SABG funding. In order for SSAs to receive these funds, they would first need to establish a memorandum of understanding (MOU) with their state Medicaid program to undergo the following process:

1. SSAs (along with state Medicaid agencies) would identify state-level population/patient needs by analyzing both epidemiological and claims data.
2. SSAs would use results to identify unmet population and patient service needs, including gaps in Medicaid coverage.
3. SSAs would fill the service gaps by funding evidence-based interventions with their SOR and SABG dollars.
4. Report the same health service delivery metrics to enhance both patient navigation and program evaluation.

"Braiding" can allow states and localities to integrate mandatory and discretionary funding streams while accounting for the funds separately in financial systems to improve the coordination and delivery of SUD services.[192] Funds should be used in a very targeted manner so that gaps in Medicaid coverage within a given state can be complemented by discretionary funds from the SOR and SABG programs. Ideally, CMS would standardize minimum coverage requirements for all Medicaid programs, but in the absence of that, this type of coordination could be beneficial.[193]

Congress and the White House, Working With Executive Branch Departments, Should "Braid" Discretionary Funding Streams by Directing Similar Opioid-related Programs to Formally Collaborate.

The task force considered "blending" select discretionary programs or eliminating them and reallocating the funds to the SABG and SOR programs, but ultimately decided to focus on "braiding." Though "braiding" is typically done at the state level (as described above), Congress should apply the same framework at the federal level to require close collaboration between

agencies.[194] To achieve this, Congress and the executive branch would designate opioid-related programs whose impact could be strengthened if federal agencies work together to implement their programs more effectively.

The White House ONDCP and the Office of Management and Budget (OMB), working with executive branch departments, should identify opioid-related programs with similar objectives, and Congress, through appropriations report language, should require federal agencies to ensure collaboration and coordination of those specific programs.[195] These programs would formally work together to share expertise, personnel, resources, and data to be able to maximize impact at the grantee level. Moreover, the programs would synchronize the timing of their funding opportunity announcements (FOA) and their grant period of performance to further enhance collaboration efforts. Executive branch departments that administer similar programs would submit an annual joint memo to the White House so that coordination efforts can be tracked and lessons learned can inform policy guidance (e.g., in the National Drug Control Strategy)[196] and budget priorities (e.g., in the president's budget).

Congress should also include appropriations report language to initiate the process through a formal report. An example of such language could be the following:

> *The Committee believes that federal agencies could improve the effectiveness and efficiency of substance use programs through cross-program coordination and use of targeted evidence-based practices at the state and local levels. ONDCP and OMB should submit a report to the Committee within 180 days that describes actions that the secretaries of HHS, DOJ, DHS, and other departments plan to take to braid funding from multiple programs in order to improve their effectiveness in preventing and treating substance use disorder. The report should include: (1) steps ONDCP and OMB will take to provide clarification and technical assistance to the secretaries on how to braid funding while satisfying accountability and financial management requirements; (2) a list of programs that ONDCP, in conjunction with executive branch departments, believes are strong candidates for cross-agency collaboration; and (3) incentives that ONDCP and OMB will use to encourage agencies and their grantees to adopt coordinated, cross-program strategies, using braided funding.*

For illustrative purposes, ONDCP could catalog opioid-related discretionary funding streams into the following areas (see Figure 11): Prevention; Health Services; Tribal Communities; Capacity Building/Workforce Development; Children, Families, and Youth; Criminal Justice; Detection and Surveillance.

Figure 11: "Braiding" Discretionary Programs

Strand	Programs	Amount ($) in Combined Existing Resources
Prevention	• ONDCP – Drug-Free Communities* • HUD Community Development Fund	$125,500,000
Health Services	• SAMHSA Building Communities of Recovery* • SAMHSA Recovery Community Services Program • SAMHSA Children and Families • SAMHSA Community-Based Coalition Enhancement Grants (Sober Truth on Preventing Underage Drinking) • SAMHSA Primary and Behavioral Health Care Integration • SAMHSA Primary/Behavioral Health Care Integration TA • SAMHSA Target Capacity Expansion – General • SAMHSA Medication-Assisted Treatment for Prescription Drug and Opioid Addiction • SAMHSA Pregnant and Postpartum Women* • SAMHSA Grants to Prevent Prescription Drug/Opioid Overdose • SAMHSA First Responder Training* • HRSA Expanding Access to Quality Substance Use Disorder and Mental Health Services • HRSA Rural Health – Rural Communities Opioids Response • VA Medical Care – inpatient/outpatient, pharmacy • VA Medical Care – CARA opioid safety initiatives • VA Medical Care – Office of Rural Health's Rural Health Initiative	$1,296,030,000 **Can braid with mandatory (CMS) funding and the SABG program*
Tribal Communities	• SAMHSA Tribal Behavioral Health Grants • Blend IHS Behavioral Health Integration Initiative with IHS Special Behavioral Health Pilot Program • DOJ Tribal Assistance Anti-methamphetamine and anti-opioid activities	$49,946,000
Capacity Building/ Workforce Development	• SAMHSA Provider's Clinical Support System – Universities • SAMHSA Improving Access to Overdose Treatment • HRSA Opioid Workforce Expansion Programs • CMS Demonstration Project to Increase Substance Use Provider Capacity Under the Medicaid Program • SAMHSA Addiction Technology Transfer Centers	$147,311,000
Children, Families, and Youth	• ACF Children and Families Services Programs – Child Abuse Prevention and Treatment Act Infant Plans of Safe Care • CDC Prenatal and Postnatal Health • ACF Promoting Safe and Stable Families – Kinship Navigator Programs • ACF Promoting Safe and Stable Families – Regional Partnership Grants • DOJ Reaching Youth Impacted by Opioids • DOJ Enhancing Community Responses to the Opioid Crisis	$118,250,000

Strand	Programs	Amount ($) in Combined Existing Resources
Criminal Justice	• SAMHSA Criminal Justice Activities • SAMHSA Offender Reentry Program • SAMHSA Strategic Prevention Framework Rx • DOJ Comprehensive Addiction and Recovery Programs – Prescription Drug Monitoring • DOJ Comprehensive Addiction and Recovery Programs – drug courts* • DOJ Comprehensive Addiction and Recovery Programs – Veterans Treatment Courts • DOJ Comprehensive Addiction and Recovery Programs – Residential Substance Abuse Treatment • DOJ Comprehensive Addiction and Recovery Programs – Mentally Ill Offender Act (Justice and Mental Health Collaboration) • DOJ Comprehensive Opioid Abuse Program* • DOJ Second Chance Act Grants • DOJ Enhancing Community Responses to the Opioid Crisis • VA Medical Care – Justice Outreach and Prevention Program	$677,907,000
Detection and Surveillance	• CDC Infectious Diseases and the Opioid Epidemic* • ONDCP – High Intensity Drug Trafficking Areas • DOJ Paul Coverdell Forensic Science • DHS Opioid/Fentanyl-related Investigations • FDA Opioid Enforcement and Surveillance ○ Already braided with DHS program • CDC Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids • DHS Operations and Support – opioid detection equipment and labs • DHS Research, Development, and Innovation – Opioids/Fentanyl • DOJ Anti-Heroin Task Forces • DHS Procurement, Construction, and Improvements – opioid detection and nonintrusive inspection equipment* • DHS International Investigations – Opioid/Fentanyl • DHS Intelligence – Opioid/Fentanyl	$656,917,000

Data Reporting and Metrics

The metrics used to understand the scope of the opioid crisis are inadequate given its status as a PHE.[197] It is useful to think about an effective emergency response to the opioid crisis based on the federal government's response to the COVID-19 pandemic. While there have been data challenges with respect to the pandemic as well, access to daily case counts, hospitalizations, deaths, and test results have been helpful to guide the pandemic response, foster interagency collaboration, and enhance federal-to-state coordination. If federal leaders had more frequent and upstream data on the opioid crisis, the federal response, including funding, could be timelier and more impactful.

While the opioid crisis has also been designated a PHE, the level of urgency associated with it is not nearly the same as with the COVID-19 pandemic. The datasets for OUD are still decentralized, which limits informed decision-making among policymakers, program managers, grantees, and everyday Americans. This gap in data impedes the process of translating research into practice. Moreover, for the datasets that are widely used, there are significant time lags, and they are housed in disparate systems that each use different metrics that are not reconcilable. Stigma associated with SUDs overall have heightened considerations around privacy and data-sharing, and reinforced perceptions about possible discrimination, particularly among patients and health care providers.[198, 199, 200, 201] Finally, improved data disaggregated by race and ethnicity is vital to identify disparities in OUD mortality, prevalence, and care.

KEY CHALLENGES

Infrequent and Inadequate Surveillance Metrics

To better understand the scope and details of the opioid crisis, improved surveillance metrics are necessary. The CDC announced in November 2021 that the U.S. surpassed 100,000 overdose deaths—the highest ever recorded in a year, during a 12-month period. This record-setting number follows the previously reported[202] figure of 93,145 overdose deaths in 2020, indicating that mortality continued to rise well into 2021. While tracking mortality is a very visible and tangible outcome measure in prompting action among leaders within the federal government and could be a helpful surveillance metric, the time lag of six to 18 months for such a downstream measure is not conducive to meaningful prevention, treatment, and recovery efforts. Thus, there is a need for additional surveillance and service delivery metrics to better gauge the state of the crisis in real time.

It is currently difficult to assess a metric as basic as prevalence of substance use. The NSDUH and the Monitoring the Future (MTF) surveys both include

prevalence measures (alcohol, tobacco, and illicit substances use), but are not updated often enough to conduct surveillance. Moreover, the CDC's Youth Risk Behavior Surveillance System (YRBSS) dataset, which reports on adolescent and youth risk factors—including prevalence of 30-day and one-year drug use—is neither updated frequently enough nor conducted in every state. In addition, none of the three includes data on social risk factors such as housing instability or provide granular data on socially disadvantaged groups (e.g., homeless populations) that have higher prevalence of OUD/SUDs. These systems are in use because they are the best tools currently available; but robust, real-time instruments are necessary for conducting proper surveillance.

Inconsistent Health Service Delivery Metrics for Discretionary Programs

BPC reviewed publicly available information regarding evaluations of and metrics for the 70 opioid-related discretionary programs. BPC's analysis revealed the following observations:

1. Evaluations of discretionary programs are inconsistent and range from formal evaluations by third parties to reports to Congress to limited information posted on websites. Not all programs have identifiable evaluations.
2. Metrics consist of data collected by grantees and Government Performance and Results Act (GPRA) measures developed by agencies. They range from process measures (e.g., naloxone distributed, trainings/events held, providers trained, patients provided MOUD, referrals made, number of peer recovery support specialists, number of syringe service programs, illicit drugs seized, number of special agents/task force officers, number of drug courts), and outcome measures (e.g., overdose reversals, six-month reduction in use, six-month reduction in ED visits, six-month recovery metrics related to housing, employment, education, and incarceration). Not all programs have identifiable metrics.
3. The SOR and SABG have the most robust evaluations and suite of process and outcome measures. However, the datasets used for the SOR and SABG programs use performance measures that are completely unique from the measures that are included in the CMS datasets, making it difficult to compare the programs' effectiveness. Several of SAMHSA's Programs of Regional and National Significance such as MAT-PDOA and Pregnant and Postpartum Women also have similar process and outcome measures to SOR and SABG.
4. The rest of the agencies use various measures to assess their respective discretionary programs, and these are not always consistent, transparent, or outcome-oriented.

SAMHSA has been using a set of GPRA measures for decades. These GPRA assessments are collected from agencies and data are then combined to evaluate performance and help ensure the continuation of federally funded

programs. The measures themselves may be useful, but reports over the years, including a 2010 Senate report, have uncovered that "agencies are collecting a significant amount of information, but are not necessarily using that information to improve their management and results."[203] Programs have come to treat these measures as a check-the-box exercise that does not lead to meaningful changes and imposes significant administrative burden on recipients of federal funding.

Federal Data Systems Require Updates

To establish better surveillance and health service delivery metrics, the data collection instruments themselves must be updated. National datasets typically have significant limitations (including higher proportions of missing data, infrequent refreshes, shorter-term outcomes, lower quality metrics), and for opioid-related health outcomes, there is a pattern of inconsistencies and underreporting that make it difficult to compare outcomes. The data systems for federal grant programs are outdated, siloed, and agency-specific systems—such as SAMHSA's NSDUH, which surveys a sample of the general population, the CDC's Wide-ranging Online Data for Epidemiologic Research (WONDER), which compiles mortality data, and CMS' T-MSIS, which compiles Medicaid claims data from all 50 states—are largely insufficient for capturing the scope of the opioid crisis, as the metrics used are too downstream and have significant data lags. As a result, the systems that collect program data are fragmented and contain metrics that are not comparable.

While NSDUH and the T-MSIS are perhaps the most critical datasets, it is important to note their shortcomings. The NSDUH, which is managed by SAMHSA, intends to provide up-to-date information on tobacco, alcohol, drug use, mental health, and other health-related issues, yet this dataset is reliant on self-reported survey data, which is very limited in its accuracy, particularly for opioid use disorder.[204] The T-MSIS dataset, which contains Medicaid claims data, has a significant lag between when it is collected and when it is updated, and the frequency with which it is updated is slow; there is also not enough consistency in the metrics submitted by states; and there are large amounts of missing data. CMS reported that while there were "data quality issues related to enrollment, claims volume, and diagnosis codes [that] could affect the validity of the results, analyses of these issues indicate that they are not severe enough to require excluding any states from the analyses presented in this SUD Data Book."[205]

Even the data systems that states must use (e.g., CDC's State Unintentional Drug Overdose Reporting System [SUDORS]) often require significant administrative overhead given substantive differences in metrics and reporting schedules. Furthermore, state-level health systems have high variability, making it difficult for federal systems to aggregate necessary data.

Data are Not in One Centralized, Public Dashboard

For COVID-19, HHS established a new data platform called HHS Protect, which functions as a secure data platform for authentication, aggregation, and sharing of health care information across more than 200 disparate datasets. Health care data are often decentralized and inaccessible; such a tool provides the federal government with a holistic view of the pandemic's impact on the U.S. health care system in order to enable policymakers to make data-driven decisions. No comparable platform currently exists to assess the opioid crisis.

RECOMMENDATION #1: ESTABLISH A SET OF EVIDENCE-BASED "CORE METRICS" TIED TO SURVEILLANCE AND HEALTH SERVICES DELIVERY

ONDCP Should Guide Executive Branch Departments in Establishing "Core Metrics."

There is a clear need for better surveillance metrics and more frequent reporting to inform policymakers and guide funding priorities. In addition to the CDC's mortality data, federal agencies and decision-makers currently use the NSDUH population estimate for the number of heroin users, which is likely a drastic undercount, as the NSDUH estimate for the total number of users was one-third of the number of people treated for heroin use in 2013 (111,000 versus 317,000).[206] Both mortality and information about population-wide utilization are useful, but these alone do not enable timely surveillance; thus, the federal response should rely on other datasets besides the NSDUH for this function. ONDCP should support federal departments and key agencies, such as CDC and SAMHSA, to ensure that opioid-related programs are collecting "core surveillance" metrics that pull from existing national datasets.

The task force identified potential examples of core metrics below. These surveillance metrics would help assess the public health need and provide a foundation upon which funding for formula grant programs could be allocated and disseminated. Evidence suggests that the following four measures would enhance surveillance[207] and enable the federal government to get a better sense of the scope of the opioid crisis. The core metrics include both prevalence measures (ED overdoses, ambulance calls to 9-1-1, and positive urine tests after intake) as well as a rapid sampling for the current mortality metric reported by the National Center for Health Statistics (NCHS). The measures share common properties of being reliable and accurate, and are not dependent on voluntary self-reporting.

- **ED overdoses** from a combined metric that includes:

    1) The Drug Overdose Surveillance and Epidemiology (DOSE) system,[208] a dataset managed by the NCHS at the CDC. DOSE collects data from 42 states on syndromic data (contained within are total ED visits and ED

visits for suspected opioid-, heroin-, and stimulant-involved overdoses per 10,000 within 48 hours).

2) The HCUP at the Agency for Healthcare Research and Quality (AHRQ) collects ED overdose visits (titled "ED treat-and-release") by payer—Medicare, Medicaid, private insurer, uninsured—and opioid-related inpatient stays by payer.

ED overdoses from both the DOSE and the HCUP could be cross-referenced to determine a more accurate number of overdoses—especially nonfatal overdoses—and obtain a more accurate understanding of the scope of opioid-related outcomes.

- **Ambulance calls to 9-1-1** and transitions of care from the National EMS Database[209] known as the National Emergency Medical Services Information System (NEMSIS), a dataset managed by the National Highway Traffic Safety Administration at the Department of Transportation (DOT). The NEMSIS collects information from incidents resulting from EMS activations for emergency care and transport in response to a 9-1-1 call for assistance. Though specific to the immediate response, the dataset includes the following:[210]

  - "Dispatch Reason" with an option to code for "overdose/poisoning/ingestion"
  - "Cardiac Arrest Etiology" with an option to code for "drug overdose"
  - "Protocols Used" (agency and state) with options to code for "general overdose/poisoning/ingestion," "opioid poisoning/overdose," and "stimulant poisoning/overdose"

  The NEMSIS is a valuable surveillance tool, as it can be updated nationally every two weeks, and in as little as seven minutes. Thus, the DOT could track these specific metrics from NEMSIS down to the state and "crew" levels for each EMS team.

- **Positive urine tests after intake** from the Arrested Drug Abuse Monitoring (ADAM) Program,[211] a survey discontinued in 2014 due to budget cuts, could be reintroduced to gather and report data—including urine samples—from arrestees, who are approximately 50 times more likely to test positive for opioids than the proportion of NSDUH respondents. The data collected via ADAM has been used in the past to identify prevalence of drug use through isolating a high-risk sample and without relying on self-reporting. The ADAM program would first be reestablished in the former 10 sites: Atlanta, Charlotte, Chicago, Denver, Indianapolis, Minneapolis, New York, Portland, Sacramento, and Washington, DC. These selected sites would provide "geographic spread," with the ability to track regional trends, and maintain consistent, biannual data collection points to note changes over time. This program would need to be funded at least at the

2012 baseline of $10 million per year, with additional resources needed to expand the program to all 50 states.

- **Rapid sampling methodology for mortality** from the CDC's NCHS National Vital Statistics System through its Provisional Drug Overdose Death Counts.[212] While being collected and reported currently, this rapid sampling would identify a representative subset of coroners or medical examiners (C/MEs) across all 50 states and the District of Columbia. Currently, the provisional counts are presented for reporting jurisdictions based on measures of data quality: 1) the percentage of records where the manner of death is listed as "pending investigation"; 2) the overall completeness of the data; and 3) the percentage of drug overdose death records with specific drugs or drug classes recorded.[213] The NCHS uses data from the counties[214] with higher levels of completeness (at least 90%), while counties with historically low levels of completeness (<90%) contain a footnote. Nevertheless, these metrics include all overdose deaths and do not report drug specificity at the county level.

  Given these considerations, the NCHS could identify a selective sample of C/MEs nationwide with 75 counties: two total (one from an urban jurisdiction and one from a rural jurisdiction) from the 24 states where the population is at least 5 million people; and one from each of the 26 states where the population is fewer than 5 million people, and the District of Columbia.[215] The C/MEs in the selected counties would submit deaths along with toxicology reports immediately to the NCHS, and the NCHS would establish a projection model for deaths along with the Provisional Drug Overdose Death Counts that are already being reported.

There is similarly a need for better health service delivery metrics in order to assess improvements in patient outcomes across discretionary and mandatory funding streams. Ideally, these metrics would align across programs and enable comparability.[216] There should be timely reporting from both mandatory and discretionary programs with metrics that correspond with progressive stages specific to those already identified as having OUD or post-overdose, including, as an example, the following in order:[217]

- **Engagement in care**, or the percentage of individuals with OUD receiving specialty services
- **MOUD initiation**, which examines the percentage of individuals engaged in care (as noted above) who have received MOUD at least once
- **Retention**, which notes the percentage of individuals who continue to receive MOUD (as noted above) for at least 180 days
- **Remission**, which notes the percentage of individuals who have continued MOUD (as noted above) and who no longer meet the criteria for OUD

These critical numbers are not available through current reporting. Most importantly, it is difficult to compare behavioral health outcomes in CMS

datasets with those collected in the SABG program data, making it difficult for states to truly understand the impact of each funding source.[218] ONDCP should work with the HHS secretary to identify core service delivery metrics via the T-MSIS, HCUP, and the relevant discretionary datasets (e.g., the SABG dataset). CMS has recently added its Core Set of Adult Health Care Quality Measures for Medicaid, which provides an alternative set of health service delivery metrics.[219] The Adult Core Set includes 12 behavioral health measures, including three opioid-specific measures: "Use of Opioids at High Dosage in Persons Without Cancer," "Concurrent Use of Opioids and Benzodiazepines," and "Use of Pharmacotherapy for Opioid Use Disorder."

To start, these datasets could collect the four measures above, as these are tangible clinical outcomes that can be captured both through SABG program data and claims data. However, over time, the T-MSIS dataset could collect metrics from the Treatment Episode Data Set (TEDS), which compiles drug history information for patients admitted and discharged multiple times throughout SUD treatment. Currently, the T-MSIS and SABG dataset both collect information about home- and community-based services (HCBS) that are administered after discharge (within 30 days in the T-MSIS; and across a variety of services in the SABG dataset). The SABG program data (see Figure 12) includes metrics originally found in the TEDS, making it a valuable instrument. Still, relying on the SABG data may pose challenges, so a longer-term solution would be to integrate the TEDS metrics into claims data.[220]

Figure 12: Metrics Collected in SABG Program Data

State Level Retention	1. Length of Stay (in Days) of Clients Completing Treatment 2. OUD Medication-Assisted Detoxification 3. OUD Medication-Assisted Treatment
State Level with Admission/Discharge Numbers	1. Employed/In School Full or Part Time 2. In Stable Housing/Living Situation 3. Without Arrests in Prior 30 Days 4. Drug Use Abstinence 5. Attending Social Support of Recovery Programs

By comparison, the T-MSIS only collects and reports progression of care for Medicaid beneficiaries treated for a SUD who received services in an inpatient or a residential setting within 30 days of discharge. As such, the T-MSIS could update the metrics that it collects to match those collected via the SABG program.

ONDCP Should Work with the HHS Secretary Who Would Direct SAMHSA to Replace Its GPRA Measures With "Core Metrics" Using an Existing OMB Waiver.

As noted previously, many recipients of SAMHSA funding have expressed frustration about collecting and reporting GPRA measures. The need to collect these measures distracts from grantees' abilities to use their limited

resources to collect data that would better demonstrate patient outcomes.[221] To circumnavigate this requirement, agencies—particularly SAMHSA—could submit an OMB waiver in accordance with 2 CFR § 200.102(d), which reads:

> *"Federal awarding agencies may request exceptions in support of innovative program designs that apply a risk-based, data-driven framework to alleviate select compliance requirements and hold recipients accountable for good performance."*

This waiver would allow SAMHSA and other relevant agencies to replace the GPRA measures with appropriate "core metrics" as an alternative reporting system.[222, 223] Principles that could guide replacing GPRA measures include selecting metrics that have valid and reliable data collection tools, a demonstrated ability to evaluate programs, and capture patient outcomes.

RECOMMENDATION #2: COLLECT "CORE METRICS" FOR OUD/SUD SURVEILLANCE AND HEALTH SERVICE DELIVERY MORE FREQUENTLY AND UNDERGO RELEVANT SYSTEM UPDATES

Surveillance

Congress should direct the HHS secretary to require the collection and reporting of the core surveillance metrics detailed above. Currently, federal programs leverage mortality data for disseminating funds and other program activities. However, C/MEs should be required to report mortality more frequently. To implement its rapid sampling technique for mortality, the NCHS would require C/MEs from the 75 selected jurisdictions to report their overdose deaths and toxicology in real time to the CDC Provisional Death Data.[224] Rather than wait seven months or more for this provisional data and one year for the final mortality data, the updated reporting could migrate to the CDC WONDER dataset where mortality data is compiled and published, which could then be made available to the general public more frequently. This updated reporting structure would enable the federal government to have a more accurate understanding of deaths from opioid overdoses as they do for COVID-19 and enhance their ability for mortality to be used for surveillance purposes and to inform policy.

The timeliness of these data would be critical to both the evaluation of federal opioid spending as well as a main component of the formula for the SOR grant. CDC has existing authority through the NCHS to release public-use data files "as soon as they have been prepared and the necessary reviews have been obtained, including review by the NCHS Disclosure Review Board." NCHS also has existing authority to work with other federal agencies, states, and private

nonprofit entities to carry out its work, which allows this expedient release of mortality data.

The core surveillance metrics also specify using ED visits through the DOSE and HCUP systems. As it stands, the DOSE system receives data as frequently as every two weeks, but not all states are funded to provide data, and some states have delays in data reporting. For example, the DOSE estimates for nonfatal overdoses during the beginning of the COVID-19 pandemic came from 42 states and did demonstrate a substantial rise in ED visits for suspected overdoses at the same time as a dramatic decline in total ED visits. Ultimately, the function of the NSDUH to gauge population-wide drug use should be replaced by the four core surveillance metrics.

In the same way that the NSDUH is used to direct federal and state program funding,[225] the core surveillance metrics could be used to do the same. Not every program will collect and use the core surveillance metrics, as these are selected from federal datasets with a particular methodology and inclusion criteria. However, opioid-related programs could collect any of the four metrics to evaluate overall outcomes, especially for federally funded programs with state-level grantees. The federal government should promote the disaggregation of racial and ethnic data in order to identify disparities while noting population trends. The core surveillance metrics could replace the NSDUH to satisfy the purpose of directing funding and assessing population needs.

Health Care Service Delivery

Congress should direct the HHS secretary to collect a cascade of data from patients served by opioid-related discretionary programs and mandatory programs, beginning with engagement into care and initiation of MOUD in the short term, followed by retention and remission outcomes. SSAs, the primary recipients of the SOR and SABG programs and health care systems, should collect the core health service delivery metrics on a quarterly basis so that they are available in the SABG dataset, T-MSIS, and HCUP. After integrating these common measures, T-MSIS could then be expanded further to collect the additional five TEDS recovery-focused performance measures: employed/in school full or part time; in stable housing/living situation; without arrests in prior 30 days; drug use abstinence; and attending social support of recovery programs. Finally, this common set of reporting requirements—with mandatory reporting through T-MSIS and HCUP, and discretionary through SABG—would allow continuous, timely evaluation of the progress of programs and policies addressing the opioid crisis.

RECOMMENDATION #3: CREATE AN OUD/SUD DATA DASHBOARD TO IMPROVE DATA SHARING AND POLICYMAKING WHILE MAINTAINING PRIVACY

HHS Should Create a New Data System Modeled After HHS Protect for OUD/SUD Data.

While the HHS Protect system[226] was originally created for the COVID-19 pandemic, HHS should create a new system modeled after HHS Protect for the opioid crisis using the "core metrics" previously mentioned. To support the HHS Protect system being used for COVID-19, agencies have procedures in place to track critical metrics that can then be visible to the general public. For example, CMS has a rule for hospitals to report COVID-19 data on a daily basis, and the CDC is required to submit data on COVID-19 testing and therapeutics given that it is a reportable condition. The CDC also submits COVID-19 vaccination data using the VTrckS dataset, providing insights around vaccination rates nationwide.

Once this new HHS Protect-like system is established, HHS should create a publicly available dashboard specifically for the opioid crisis so that policymakers, clinicians, and the public would be able to assess the state of the crisis in the same way they can for COVID-19. To achieve this, CMS should introduce another daily reporting rule that is in place for COVID-19 to include the core service delivery metrics for OUD/SUD and submit these metrics on a quarterly basis alongside the remaining core metrics. Because these are all within federal government's domain, these datasets should be de-identified, but they do not require data use agreements (DUAs) to be incorporated.

Even with regular reporting and a standardized set of metrics, there are several considerations for HHS to keep in mind and ways to use the core metrics to further understanding of population risk. First, it could establish a method for identifying high-risk individuals in health care systems that experience multiple nonfatal overdoses in a HIPAA-compliant manner. Second, there could be a way to match 9-1-1 call data with ambulance data to account for individuals who experience an overdose but either refuse transport or are stabilized at the scene.

HHS Should Establish Anti-discrimination and Privacy Protection Policies for SUD Patient Data Sharing.

While data-sharing, as allowed through 42 CRF part 2, has its obvious benefits, patient protections that accompany an open system are critical. HHS should introduce and enact anti-discrimination laws alongside a new HHS Protect-like system to guard OUD/SUD patients. For this, HHS can draw from the lessons learned from the HIV/AIDS crisis. HIV/AIDS patients are protected from discrimination under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. Under these laws, discrimination means that those with HIV/AIDS are not allowed to participate

in a service offered to others, or to be denied a benefit, because of HIV status. This rule could be expanded to encompass OUD/SUD so that these patients enjoy the same protections. The DOL could also expand its Equal Employment Opportunity (EEO) rules to protect individuals with OUD/SUD in the workplace. The challenge for the federal government in protecting those with OUD/SUD is the fact that criminal codes for drug-related offenses vary by local jurisdiction. Thus, the federal government would need to consider the ways in which hospitals report overdoses to law enforcement and district attorneys in areas where opioid use is criminalized, especially when considering the differences between use and possession.

Governance

While there are designated federal leaders to guide aspects of the opioid crisis response, executive branch-wide governance and leadership to foster coordination could be improved. Congress, ONDCP, and executive branch departments such as HHS, have important roles to play in fostering interdepartmental and intradepartmental collaboration.

KEY CHALLENGES

Failure to Leverage ONDCP's Unique Role

Congress created ONDCP as a policy coordination office within the White House structure, with an executive branch-wide scope. Since its creation, two changes have occurred that challenge the office's ability to effectively exert executive leadership:

- The director, who once held cabinet rank, no longer does.
- The office's responsibilities have grown to include discretionary programs, which potentially dilutes its ability to focus on strong policy vision and coordination.

No other policy office in the White House manages federal programs at the same scale. In the case of drug control programs—specifically the High Intensity Drug Trafficking Areas (HIDTA) and DFC programs—the administrative program management is conducted within agencies. Nevertheless, ONDCP exerts significant direction and energy to direct these programs.

Discussions with dozens of experts across the addiction policy field have indicated that stronger guidance to foster collaborations between federal agencies and states is needed to establish a foundation for more intentionally integrating real-world evidence into federal programs.[227] This is a capability ONDCP should develop, and it may require augmenting their current staffing to bolster its ability to provide policy guidance to federal agencies.

The need for a "center of excellence" role is especially true when considering the sparse use of MOUD (methadone, buprenorphine, and naltrexone).[228] Though often praised for being the gold standard for OUD treatment, the majority of addiction treatment programs do not provide these vital medications as part of their approach; and of the patients who have access to them, only a small proportion of OUD patients receive these medications as part of their treatment regimen.[229, 230, 231]

Experts also agree that tracking opioid-related federal funding in a way that mimics BPC's previous two reports[232, 233] would be a worthwhile government function. Currently, ONDCP develops an annual "drug budget" for use in the president's budget. Unfortunately, once Congress finalizes its annual appropriations, there appears to be little focus on the actual spending plan beyond the actual dollars distributed to the departments. A robust tracking system would go beyond this to include the annual awarded amounts to grantees and contractors, program evaluations, and key metrics. Such a system could support Congress and the executive branch in implementing opioid-focused programs in a more effective and targeted manner.

Insufficient Formal Collaboration and Information Sharing Between Federal Agencies and Departments

Agencies across the federal government administering opioid-related programs could benefit tremendously from sharing responsibilities, knowledge/capabilities, and expertise, therefore maximizing the impact of their funding.[234] The HHS secretary has an important role in coordinating the efforts of the various HHS agencies; to this end, HHS has reestablished its Behavioral Health Coordinating Committee. Similarly, ONDCP regularly convenes executive branch departments in an effort to share information and develop program and policy priorities. However, experts have indicated that this process does not necessarily include the appropriate staff with decision-making authority, resulting in duplication and inefficiencies.[235]

No Standard Congressional or Executive Branch Process for Determining Opioid-related Program Effectiveness

Congress has the authority and responsibility to conduct meaningful oversight of federal programs, but currently there is no standard process for determining program effectiveness. Given the increase in opioid-related funding, congressional oversight is critical for understanding the extent to which these funds are being optimized. In general, across congressionally authorized program and policy areas, committees of jurisdiction may or may not make a serious oversight effort. Moreover, even in cases when congressional committees do have access to information that can be used to determine program effectiveness (e.g., independent program evaluation), there are no processes in place for revising, replacing, and/or eliminating programs that are not demonstrating positive impacts on health outcomes. Though not an issue specific to OUD or broader drug policy, it impedes Congress' ability to make determinations about continued and new funding. Given the acute nature of the opioid crisis and the significant increase in funds appropriated to address it, action is essential to better target funds to the most effective programs.

These points also hold true for executive branch departments and their component agencies. While they must implement congressionally authorized and funded programs, departments would benefit from a regular, standardized process to help them determine overall program effectiveness. This would

help the executive branch to both know how well programs function from an outcomes perspective and also assist Congress in its own similar oversight responsibilities.

RECOMMENDATION #1: REORIENT ONDCP'S ROLE TO FOCUS MORE ON POLICY LEADERSHIP AND FEDERAL COORDINATION

Congress Should Restore Cabinet-level Rank of the ONDCP Director and Consider the Appropriate Placement of the HIDTA and DFC Programs.

First, the White House should restore ONDCP's director to cabinet rank. Over the years, ONDCP's role has arguably become increasingly diminished, both within the executive branch and in the approach to national drug control policy. Despite this, ONDCP has the potential to serve as the leader of the federal opioid response. Elevating the agency in this way would allow the director to participate in cabinet discussions and signal the importance of drug control and prevention to the rest of the cabinet. Furthermore, this would ensure that drug policies are prioritized as the president consults the cabinet on a range of policy issues. By restoring cabinet rank, the White House could also address the calls for creating yet another coordinator, rightfully the ONDCP director's job.

Second, in addition to restoring the ONDCP director to cabinet rank, Congress should also assist ONDCP by either removing or amending the currently required congressional notification requirement so that ONDCP can make modest changes to agency program operations without having to obtain congressional approval.

Third, Congress should consider whether the HIDTA and DFC programs should remain at ONDCP or be formally transferred to DOJ and HHS, respectively. One option would be to continue to fund the HIDTA and DFC programs through ONDCP's budget and assure that DOJ and HHS conduct all of the related program management. There would be no changes to program funding levels, and these agencies would each assign an official liaison officer to work directly with ONDCP so the office receives the information it needs to set overall federal policy and can easily and directly convey information to the operational agency. Alternatively moving these programs to free up ONDCP to focus on policy leadership and coordination would require legislative change, which could be amended through statute when it comes time to reauthorize ONDCP (and might be achieved through the process of reauthorizing SAMHSA, set to occur at some point this year).

The HHS Secretary and ONDCP Should Improve Intradepartmental and Interdepartmental Collaboration.

In their effort to reduce governmentwide fragmentation, the HHS secretary and ONDCP director should foster greater intradepartmental and interdepartmental collaboration, respectively, on opioid prevention, harm reduction, treatment, and recovery activities. This collaboration should go beyond simply partnering to "braid" similar funding streams to also coordinating opioid-related activities (see Figure 13). The extent to which this is presently occurring is unclear.[236] The recent HHS strategy for overdose prevention notes a lack of coordination within HHS.[237]

Below is a list of potential partnerships, the majority of which could be furthered through HHS leadership, and others that are interdepartmental and would benefit from ONDCP's leadership:

Figure 13: Federal Partnerships

HHS Interagency Partnership

Federal Partnership	Synergies
SAMHSA and CDC	SAMHSA should collaborate with the CDC to design and implement behavioral health surveillance programs; and coordinate harm reduction services (e.g., syringe service programs).
SAMHSA and CMS	SAMHSA should partner with CMS to identify additional services that could be covered by insurance and tracked, especially those that focus on harm reduction (naloxone, syringe services, fentanyl test strips, etc.); and determine clinical effectiveness for various SUD treatments.
SAMHSA and HRSA	SAMHSA should partner with HRSA to expand and improve the behavioral health workforce; coordinate behavioral health services in outpatient settings such as Federally Qualified Health Centers (FQHCs); and bolster the community networks necessary for SAMHSA's Certified Community Behavioral Health Clinics (CCBHCs).
CDC and CMS	CMS should partner with the CDC (and state health departments) to further identify state-level trends in patient outcomes and evaluate SUD clinical activities (including health care costs); and build more cohesive working relationships to fill coverage gaps.
SAMHSA and IHS	IHS and SAMHSA should work together to ensure that culturally appropriate behavioral health services (e.g., expanding CCBHCs to tribal jurisdictions) are accessible to tribal populations, a traditionally hard-to-reach and underserved population.
SAMHSA and NIH	SAMHSA should collaborate with the NIH (primarily but not exclusively NIDA, NIAAA, and NIMH) to both integrate emerging research findings into OUD/SUD programs and offer access to real-world settings in order to study the scalability of promising and finalized evidence-based interventions.
FDA and CMS	CMS should work with the FDA to monitor prescribing activity through claims data. This process should be viewed through the lens of newly released CDC opioids prescribing guidelines.
CMS and HRSA	HRSA should partner with CMS to ensure that there is a sustainable pipeline of health care professionals and to expand Medicaid coverage in FQHCs by aligning FQHC incentives with SBIRT billing codes.
IHS and HRSA	The IHS and HRSA should partner to expand access to outpatient settings such as FQHCs; bolster the health care workforce within IHS facilities; including through tailored recruitment, retention, and training programs; and reach Native Americans living with jurisdictional barriers unique to tribal nations.

Interdepartmental Partnership	Federal Partnership	Synergies
	IHS and DOJ	IHS and DOJ should work together to ensure that culturally appropriate behavioral health services are accessible to Native populations under justice supervision. This work should be informed by and possibly integrated with collaborative work undertaken within HHS, between IHS and SAMHSA.
	CMS and DOJ	DOJ should work with CMS to further streamline existing prescribing requirements (e.g., X Waiver); ensure that incarcerated individuals receive high quality SUD treatment services while institutionalized; and expand Medicaid coverage to potential beneficiaries once released.
	DHS and CDC	DHS and the CDC should partner to design and conduct fentanyl surveillance to monitor international trafficking and epidemiological trends. DHS should be able to alert the CDC of supply shifts geographically tied to morbidity and mortality, while the CDC should be able to identify additional risk factors and opportunities for intervention. It is important to note that **there is not a causal link between supply and health outcomes**, but this partnership would promote more comprehensive surveillance.
	HRSA and VA	The VA and HRSA should partner to expand patient access to outpatient SUD services, through providers such as FQHCs. This is especially important in areas located far from VA clinics and could yield significant increases in overall patient access to quality services.
	DOJ and ACF	The DOJ and ACF should partner to assess potential overlaps in the populations their programs are designed to reach. This review can identify and address risks in these populations and enhance prevention efforts that support at-risk youth.

ONDCP Should Operate as a "Center of Excellence" for Drug Control Policy and Federal Coordination.

ONDCP is well-positioned to provide policy guidance to Congress, the executive branch, and federal departments and agencies. To fulfill its leadership role, ONDCP should collect information from various sources to catalog evidence-based opioid-related programs that merit continued federal support.[238, 239] ONDCP should model its process of providing evidence-based recommendations to OMB on that used by the Office of Science and Technology Policy (OSTP), which advises the White House on the scientific and technological aspects of numerous policy areas. ONDCP should help synthesize information about program effectiveness and assist agencies in providing guidance to states as they use this information to identify and fill service/coverage gaps. Furthermore, based on this process and their understanding of both federally funded opioid-related programs and emerging evidence, ONDCP and HHS should incorporate relevant, proven evidence-based program approaches into a new data set/registry to serve as a "menu" for evidence-based practices that could eventually be implemented by federal grantees.[240]

RECOMMENDATION #2: PROVIDE EXPERT TECHNICAL ASSISTANCE TO STATES

Congress Should Fill Existing Vacancies at SAMHSA to Enhance State-level Training and Technical Assistance Efforts.

In order to appropriately design and administer technical assistance, SAMHSA should strengthen the Division of Services Improvement and the Division

of State and Community Assistance within its Center for Substance Abuse Treatment (CSAT). This would enhance CSAT's ability to assist the field in administering a broad array of technical assistance efforts, as it has aimed to achieve through programs such as the Addiction Technology Transfer Centers. Experts at SAMHSA could better serve state departments of health by reintroducing these processes and structures.

Congress should also direct SAMHSA to fill its current staff vacancies and add funding to SAMHSA's staffing budget if necessary. Approximately 30% of SAMHSA's full-time employee (FTE) positions are currently vacant, meaning that there are opportunities for them to hire and fill these roles to build their training and TA capacity. Moreover, Congress should add funding to SAMHSA's staffing budgets with the explicit purpose of rebuilding their training and technical assistance capacity so that agency staff can provide training to individual states as needed. Properly staffed and focused program offices are a key "good government" approach, and represent a tangible and focused way that Congress can both help and ensure the agency carry out its responsibilities in the best way possible.

With a greater capacity for individualized attention, states should have an opportunity to provide continuous feedback on the training and technical assistance that they receive from SAMHSA for their SOR and SABG programs. The expanded training, technical assistance, and program management capacity would further enable SAMHSA to better oversee the SOR and SABG programs in coordination with the states; and states would thus be able to provide input on programmatic direction and receive customized guidance from agency leaders. States would also be able to share their best practices and lessons learned through these interactions with their federal program managers (Massachusetts' state-level dashboard is an example of such a best practice).[241] Adding a mechanism for bidirectional knowledge sharing could introduce new innovations and best practices to federal leaders.[242, 243, 244, 245, 246, 247]

The Federal Government Should Provide States with Technical Assistance to Direct Opioid Settlement Funding.

To avoid the risk that funds will be used for other state priorities—which could result in opioid remediation and health outcomes remaining stagnant or worsening—the federal government should provide states with regular guidance on directing nonfederal funds from the opioid settlements to enhance programs such as SABG and SOR. Recently, states have been promised billions of dollars in additional funding through the various opioid settlements from drug manufacturers. These settlements are reminiscent of the settlement with tobacco companies in 1998.[248] A 2018 retrospective assessment revealed that, even though tobacco settlement funds were to be used to restrict cigarette sales and marketing by forbidding manufacturers from targeting youth and banning specific types of media (e.g., cartoons), less than 3% of the settlement funds were used for programs to prevent kids from smoking and to help smokers quit.

Even more glaring is that no state was funding tobacco prevention at the CDC's recommended levels at the time the assessment was published.[249]

Much like the 1998 settlement with Big Tobacco, the opioid settlements pose similar funding allocation risks. For one case decided in July 2021, the settlement agreement's primary requirement is that states use at least 85% of the settlement funds on "opioid remediation."[250] While this is accompanied by a list of evidence-based interventions, there is extensive flexibility for states to redefine and selectively enforce their spending parameters. The federal government is well-positioned to determine where funds are already being used and how they could be used to supplement federal funding. Thus, technical assistance to appropriately direct these funds would enhance states' abilities to effectively leverage these funds. In 2021, ONDCP did release a model law for state legislatures to help ensure opioid litigation settlement funds address addiction and overdose.[251]

RECOMMENDATION #3: LEVERAGE ONDCP'S NATIONAL DRUG CONTROL STRATEGY FOR CONGRESSIONAL OVERSIGHT

Congress should use the National Drug Control Strategy that ONDCP develops as a stencil for establishing funding priorities. The Constitution grants congressional committees the authority to conduct oversight, meaning that Congress has the responsibility to monitor and change actions of the executive branch and federal agencies in order to prevent fraud, waste, and abuse; maintain a degree of accountability; and protect the rights and civil liberties of the American people. The National Drug Control Strategy uses evidence from the research field in the final product, which gives Congress opportunities to weigh evidence-based and stakeholder-driven priorities in their funding decision-making.

Conclusion

All of the recommendations included in this report can help optimize federal spending and the federal response to the opioid crisis. Stronger federal leadership and actionable data will more strategically direct money from discretionary and mandatory funding streams, which can then be used to save lives through evidence-based prevention, treatment, harm reduction, and recovery interventions. With so many preventable lives lost to the opioid crisis to date, it is of high national interest to target funding in a sustainable manner and overcome regulatory and legislative barriers to address the needs of vulnerable populations affected by opioid use disorder.

Appendix

Full Appropriation Data 2017–2020							
Cat	**Subcommittee**	**Agency**	**Account**	**FY2017**	**FY2018**	**FY2019**	**FY2020**
T	**Labor-Health and Human Services**	Substance Abuse and Mental Health Services Administration	State Targeted Response (STR)	$500,000,000	$500,000,000		
T	**LHHS**	SAMHSA	State Opioid Response (SOR)	N/A	$1,000,000,000	$1,500,000,000	$1,500,000,000
T	**LHHS**	SAMHSA	*Tribal Opioid Response*	*N/A*	*$50,000,000*	*$50,000,000*	*$50,000,000*
T	**LHHS**	SAMHSA	*Rural Opioids Technical Assistance*	*N/A*	*$3,000,000*	*$3,000,000*	*$3,000,000*
T&P	**LHHS**	SAMHSA	Substance Abuse Prevention and Treatment Block Grant	$533,663,700	$533,663,700	$533,663,700	$533,663,700
T	**LHHS**	SAMHSA	Opioid Treatment Programs	$8,724,000	$8,724,000	$8,724,000	$8,724,000
T	**LHHS**	SAMHSA	*Provider's Clinical Support System – Universities*	$1,999,930	$2,393,000	$2,393,000	
T	**LHHS**	SAMHSA	Target Capacity Expansion – General	$67,192,000	$95,192,000	$100,192,000	$100,192,000
T	**LHHS**	SAMHSA	*Medication-Assisted Treatment for Prescription Drug and Opioid Addiction*	$56,000,000	$84,000,000	$89,000,000	$89,000,000
T	**LHHS**	SAMHSA	Pregnant and Postpartum Women	$19,931,000	$29,931,000	$29,931,000	$31,931,000
T	**LHHS**	SAMHSA	Building Communities of Recovery	$3,000,000	$5,000,000	$6,000,000	$8,000,000
T	**LHHS**	SAMHSA	Recovery Community Services Program	$2,434,000	$2,434,000	$2,434,000	$2,434,000
T	**LHHS**	SAMHSA	Children and Families	$29,605,000	$29,605,000	$29,605,000	$29,605,000
CJ	**LHHS**	SAMHSA	Criminal Justice Activities	$78,000,000	$89,000,000	$89,000,000	$89,000,000
CJ	**LHHS**	SAMHSA	Offender Reentry Program		$6,800,000	$6,800,000	$6,800,000
T	**LHHS**	SAMHSA	Addiction Technology Transfer Centers	$9,046,000	$9,046,000	$9,046,000	$9,046,000
P	**LHHS**	SAMHSA	Strategic Prevention Framework Rx	$10,000,000	$10,000,000	$10,000,000	$10,000,000
P	**LHHS**	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	$12,000,000	$12,000,000	$12,000,000	$12,000,000
P	**LHHS**	SAMHSA	First Responder Training	$12,000,000	$36,000,000	$36,000,000	$41,000,000

Category (Cat.): Treatment and Recovery (T); Prevention (P); Research (R); Mixed (T&P); Interdiction (I); Criminal Justice (CJ); Law Enforcement (LE); *Opioid-Only N/A: program did not exist or no opioid-specific appropriation

Full Appropriation Data 2017–2020							
Cat	**Subcommittee**	**Agency**	**Account**	**FY2017**	**FY2018**	**FY2019**	**FY2020**
T	**LHHS**	SAMHSA	Improving Access to Overdose Treatment	$1,000,000	$1,000,000	$1,000,000	$1,000,000
P	**LHHS**	SAMHSA	Community-based Coalition Enhancement Grants to Address Local Drug Crises	$5,000,000	$5,000,000	$6,000,000	$7,000,000
P	**LHHS**	SAMHSA	Tribal Behavioral Health Grants	$15,000,000	$15,000,000	$20,000,000	$20,000,000
T	**LHHS**	SAMHSA	Primary and Behavioral Health Care Integration	$49,877,000	$49,877,000	$49,877,000	$49,877,000
T	**LHHS**	SAMHSA	Primary/Behavioral Health Integration TA	$1,991,000	$1,991,000	$1,991,000	$1,991,000
T	**Interior**	Indian Health Service	Behavioral Health Integration Initiative	$6,000,000	$6,000,000	$6,946,000	$6,946,000
T	**Interior**	Indian Health Service	Special Behavioral Health Pilot Program	N/A	N/A	$10,000,000	$10,000,000
P	**LHHS**	Centers for Disease Control and Prevention	Injury Prevention and Control – Opioid Overdose Prevention and Surveillance	$112,000,000	$475,579,000	$475,579,000	$475,579,000
P	**LHHS**	CDC	Infectious Diseases and the Opioid Epidemic	N/A	$155,000,000	$5,000,000	$20,000,000
P	**LHHS**	CDC	Prenatal and Postnatal Health	N/A	N/A	N/A	$2,250,000
P	**LHHS**	CDC	Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids	N/A	N/A	N/A	$66,750,000
T&P	**LHHS**	HRSA	Integrated Behavioral Health Services	N/A	$350,000,000	$200,000,000	$200,000,000
T&P	**LHHS**	HRSA	Opioid Workforce Expansion Programs	N/A	N/A	$87,265,000	$87,265,000
T&P	**LHHS**	HRSA	Rural Health – Rural Communities Opioids Response	$25,310,000	$130,000,000	$120,000,000	$110,000,000
P	**LHHS**	Administration for Children and Families	Children and Families Services Programs – Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	N/A	$85,310,000	$85,310,000	$60,000,000
P	**LHHS**	ACF	Promoting Safe and Stable Families – Kinship Navigator Programs	$18,600,000	$20,000,000	$20,000,000	$20,000,000
P	**LHHS**	ACF	Promoting Safe and Stable Families – Regional Partnership Grants	N/A	$20,000,000	$20,000,000	$10,000,000
R	**LHHS**	ACL	Administration for Community Living	N/A	$982,831	$989,411	$0
R	**LHHS**	AHRQ	Agency for Healthcare Research and Quality	$3,570,046	$3,579,337	$592,769	$0

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Full Appropriation Data 2017–2020							
Cat	**Subcommittee**	**Agency**	**Account**	**FY2017**	**FY2018**	**FY2019**	**FY2020**
R	**LHHS**	National Institutes of Health	National Institute of Drug Abuse	N/A	$250,000,000	$250,000,000	$250,000,000
R	**LHHS**	National Institutes of Health	National Institute of Neurological Disorders and Stroke	N/A	$250,000,000	$250,000,000	$250,000,000
T	**LHHS**	CMS	Demonstration Project to Increase Substance Use Provider Capacity	N/A	N/A	$50,000,000	$50,000,000
	LHHS	**Subtotal LHHS Report**		**$1,523,943,746**	**$4,280,714,868**	**$4,080,945,880**	**$4,146,461,700**
Office of National Drug Control Policy							
LE	**FSGG**	Executive Office of the President	Office of National Drug Control Policy – High Intensity Drug Trafficking Areas	$254,000,000	$280,000,000	$280,000,000	$300,000,000
P	**FSGG**	Executive Office of the President	Office of National Drug Control Policy – Drug-Free Communities	$97,000,000	$99,000,000	$100,000,000	$100,500,000
Department of Justice							
CJ	**Commerce Science Justice**	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs – drug courts	$43,000,000	$75,000,000	$77,000,000	$80,000,000
CJ	**Commerce Science Justice**	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs – Veterans Treatment Courts	$7,000,000	$20,000,000	$22,000,000	$23,000,000
CJ	**Commerce Science Justice**	State and Local Law Enforcement	*Comprehensive Addiction and Recovery Programs – Residential Substance Abuse Treatment*	$14,000,000	$30,000,000	$30,000,000	$31,000,000
P	**Commerce Science Justice**	State and Local Law Enforcement	*Comprehensive Addiction and Recovery Programs – Prescription Drug Monitoring*	$14,000,000	$30,000,000	$30,000,000	$31,000,000
CJ	**Commerce Science Justice**	State and Local Law Enforcement	*Comprehensive Addiction and Recovery Programs – Mentally Ill Offender Act (Justice and Mental Health Collaboration)*	$12,000,000	$30,000,000	$31,000,000	$33,000,000
CJ	**Commerce Science Justice**	State and Local Law Enforcement	Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program (COSSAP)	$13,000,000	$145,000,000	$157,000,000	$180,000,000
LE	**Commerce Science Justice**	Community Oriented Policing Services	Anti-Heroin Task Forces	$10,000,000	$32,000,000	$32,000,000	$35,000,000
LE	**Commerce Science Justice**	Community Oriented Policing Services	Anti-methamphetamine and anti-opioid activities	N/A	N/A	$27,000,000	$13,000,000

Category (Cat.): Treatment and Recovery (T); Prevention (P); Research (R); Mixed (T&P); Interdiction (I); Criminal Justice (CJ); Law Enforcement (LE); *Opioid-Only N/A: program did not exist or no opioid-specific appropriation

Full Appropriation Data 2017–2020							
Cat	**Subcommittee**	**Agency**	**Account**	**FY2017**	**FY2018**	**FY2019**	**FY2020**
CJ	**Commerce Science Justice**	State and Local Law Enforcement	Second Chance Act Grants	$68,000,000	$85,000,000	$87,500,000	$90,000,000
CJ	**Commerce Science Justice**	Juvenile Justice	Opioid Affected Youth Initiative	N/A	$22,000,000	$9,000,000	$10,000,000
CJ	**Commerce Science Justice**	Juvenile Justice	Mentoring for Youth Affected by the Opioid Crisis	N/A	$29,839,484	$29,839,484	$16,000,000
P	**Commerce Science Justice**	State and Local Law Enforcement	Paul Coverdell Forensic Science	$13,000,000	$17,000,000	$30,000,000	$30,000,000
Department of Veterans Affairs							
T	**Veterans Affairs**	Veterans Health Administration	Medical Care – inpatient/ outpatient, pharmacy	N/A	$329,953,000	$348,000,000	$345,946,000
T	**Veterans Affairs**	Veterans Health Administration	Medical Care – CARA opioid safety initiatives	N/A	$55,821,000	$52,025,000	$56,054,000
P	**Veterans Affairs**	Veterans Health Administration	Medical Care – Justice Outreach and Prevention Program	N/A	$48,778,000	$54,337,000	$69,107,000
T	**Veterans Affairs**	Veterans Health Administration	Medical Care – Office of Rural Health's Rural Health Initiative	N/A	$270,000,000	$270,000,000	$300,000,000
Food and Drug Administration							
I	**Agriculture, Food and Drug Administration**	Food and Drug Administration	Opioid Enforcement and Surveillance	N/A	$94,000,000	$47,000,000	$65,408,000
Homeland Security							
I	**Homeland**	U.S. Customs and Border Protection	Operations and Support – opioid detection equipment and labs	N/A	$30,500,000	$31,897,000	$6,000,000
I	**Homeland**	U.S. Customs and Border Protection	Procurement, Construction, and Improvements – opioid detection and nonintrusive inspection equipment	N/A	$224,600,000	$570,000,000	$127,300,000
I	**Homeland**	Homeland Security Investigations	Opioid/Fentanyl-related Investigations	N/A	N/A	$31,605,000	$32,959,000
I	**Homeland**	Homeland Security Investigations	International Investigations-Opioid/Fentanyl	N/A	N/A	$4,780,000	
I	**Homeland**	Homeland Security Investigations	Intelligence- Opioid/Fentanyl	N/A	N/A	$7,615,000	
I	**Homeland**	Science and Technology	Research, Development, and Innovation – Opioids/Fentanyl	N/A	$6,000,000	$8,500,000	$8,500,000

Category (Cat.): Treatment and Recovery (T); Prevention (P); Research (R); Mixed (T&P); Interdiction (I); Criminal Justice (CJ); Law Enforcement (LE); *Opioid-Only N/A: program did not exist or no opioid-specific appropriation

Full Appropriation Data 2017–2020							
Cat	**Subcommittee**	**Agency**	**Account**	**FY2017**	**FY2018**	**FY2019**	**FY2020**
Department of Labor							
T	**Department of Labor**	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	$21,000,000	$0	$0
Department of Housing and Urban Development							
T	**Housing and Urban Development**		Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed				$25,000,000
			Total	**$2,068,943,746**	**$6,162,206,352**	**$6,402,044,364**	**$6,089,827,700**

Category (Cat.): Treatment and Recovery (T); Prevention (P); Research (R); Mixed (T&P); Interdiction (I); Criminal Justice (CJ); Law Enforcement (LE); *Opioid-Only N/A: program did not exist or no opioid-specific appropriation

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