Bipartisan Policy Center

Provisions Relevant to Reauthorization of the SUPPORT Act

October 2023

The SUPPORT Act of 2018 changed the federal approach to treating addiction. This bipartisan law represents a comprehensive response to the opioid crisis public health emergency (PHE) by directing federal resources toward prevention, education, coverage, treatment, and law enforcement programs.

The Bipartisan Policy Center is focusing on four major policy areas for Congress's consideration in the reauthorized SUPPORT Act, formally known as the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act: enhancing community-based programs; maintaining Medicaid coverage for high needs patients; updating behavioral health metrics; and improving workforce capacity.

ENHANCE COMMUNITY-BASED PROGRAMS AND SERVICES

In 2022, drug overdose deaths and deaths by suicide reached a record high, making access to behavioral health care extremely important. The increased supply of illicit fentanyl means that the risk of overdose death is no longer high only among patients with diagnosable substance use disorders (SUDs)—it is also rising among first-time triers/buyers and casual users. Though the overdose crisis is national, its effects are not distributed evenly. The CDC reported that, in 2020, Black communities saw overdose deaths increase 44%, and American Indian and Alaska Native (AI/AN) communities experienced increases of 39%, compared to 22% for whites.

With the growing disparities, community-based services play a critical role in addressing the rising need for behavioral health care. BPC's policy options focus on optimizing federal financing for community-based substance use disorder services across the continuum of care: strengthening behavioral health care in primary care settings, expanding treatment availability, and improving coverage through mental health parity.

Integrate Demonstration Grants to Strengthen Community-Based Addiction Services at No Additional Cost

One overarching goal of Congress should be to better direct existing federal funding toward filling gaps in services for addiction prevention, treatment, harm reduction, and recovery.

- Congress could consider integrating similar grant programs to maximize their impact; it should also evaluate the extent to which these programs

address overdose risks and deaths. The federal government has an opportunity to strengthen the various demonstration programs authorized under the SUPPORT Act. Congress can use preliminary evaluation results to determine future funding levels for demonstrations in agencies such as the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

BPC's Opioid Crisis Task Force report in 2022 recommended that Congress direct the White House's Office of National Drug Control Policy (ONDCP) to spearhead interdepartmental coordination to implement the integrated grants. In addition to reauthorizing the SUPPORT Act, Congress is currently reauthorizing ONDCP. Because the office has the authority to coordinate grants across the executive branch, it is well positioned to reduce government-wide fragmentation by guiding agencies according to service needs. Congress could direct ONDCP to track spending across opioid-related programs—a role BPC has assumed for years—and lead efforts to integrate the demonstration grants described above.

- As Congress revisits the role of demonstration programs in addiction services, it could consider directing ONDCP to categorize and evaluate these grants thematically as it tracks federal spending. There is a need for efficient, targeted federal spending that fills critical gaps in addiction services; by categorizing these programs, ONDCP has an opportunity to direct agencies to maximize their resources to fill these gaps and better coordinate health care services for addiction patients.

BPC has identified key themes that Congress could use to catalog the grants authorized in the SUPPORT Act (additional program information is available in the Appendices):

- prevention programs;
- health services;
- capacity building/workforce development;
- children, families, and youth;
- criminal justice; and
- detection and surveillance.

Increase the Availability of Medications for Opioid Use Disorder (MOUD)

The availability of evidence-based treatments for opioid use disorder (OUD), coupled with recent policy changes—such as removal of the X waiver and flexibilities around teleprescribing of MOUD to facilitate treatment access—means stakeholders have an opportunity to increase treatment rates, which remain too low. Before the COVID-19 pandemic, over 85% of patients with a SUD were not receiving care; by 2021, only approximately 1 in 5 adults with past-year opioid disorders received MOUD. Policymakers can take additional steps to ensure better access:

- CMS could consider clarifying that opioid treatment programs (OTPs) can bill Medicare for primary care services. Medicare does not authorize payment or reimburse some facilities providing SUD care, specifically freestanding SUD treatment facilities that offer community-based care. This limitation hinders service delivery. By clarifying that treatment programs can bill Medicare for primary care services, Medicare would encourage OTPs to undergo the necessary prerequisites to offer primary care services to marginalized addiction patients and to enhance integration of primary care services in behavioral health specialty settings.
- CMS could consider encouraging states to take advantage of existing incentives, such as enhanced federal match, to integrate primary care into behavioral health specialty clinics.
- The Drug Enforcement Administration (DEA), Department of Health and Human Services (HHS), and the Department of Veterans Affairs (VA) could consider extending and evaluating the impact of teleprescribing of buprenorphine on public health and safety.
- To avoid additional administrative burdens for clinicians, the DEA, HHS, and the VA could consider implementing the special registration authorized in the 2018 SUPPORT Act for teleprescribed controlled substances using data from Prescription Drug Monitoring Programs (PDMPs) and data collected through prescription labeling requirements outlined in a recent DEA proposed rule.

- The Food and Drug Administration (FDA) could consider clarifying that buprenorphine is on its list of "essential medicines" to ensure that pharmacies are able to keep up with patient demand and population needs.
- To increase the number of primary care providers able to administer opioid disorder medications, SAMHSA, HHS' Health Resources and Services Administration (HRSA), and the VA could consider incentivizing medical schools to offer training on prescribing buprenorphine to patients with OUD. With the removal of the X waiver, clinical providers, especially primary care providers, have an opportunity to administer MOUD. Medical schools can adjust their curricula to ensure that new clinical providers receive appropriate training on how to prescribe MOUD.
- SAMHSA, HRSA, and the VA could consider issuing guidance for practicing primary care providers on how to receive training for prescribing buprenorphine to patients with OUD. Currently, primary care providers can earn credits for continuing medical education (CME) and continuing education units (CEU).

Address Housing Insecurity

BPC supports bolstering access to nonmedical services, especially housing programs, to ensure safe and sustainable addiction recovery. We support the inclusion of programs, such as SAMHSA's Building Communities of Recovery program and SAMHSA's Comprehensive Opioid Recovery Centers, as part of the reauthorization of the SUPPORT Act. In addition to leveraging existing funds from demonstration grants, Congress could consider promoting recovery housing programs:

- CMS could consider encouraging states to use their Medicaid Section 1115 waivers for nonmedical services, including recovery housing.
- SAMHSA could consider encouraging states to use their Substance Use Block Grant (SUBG) and State Opioid Response (SOR) funding for nonmedical recovery services.
- HHS could consider providing technical assistance to help states take full advantage of existing federal Medicaid matching support for recovery housing programs, and identify opportunities for using settlement funds where appropriate. Agencies, such as CMS, can provide examples of reimbursement for recovery housing services (either on the state or county level, or for specific demonstration grant recipients), both for direct payment and administrative matching opportunities. Agency staff can also offer more regular touchpoints (e.g., CMS working with states to directly review and approve coverage options; SAMHSA working with states to provide input on programmatic direction and receive customized guidance) for grant recipients.
- Congress could consider setting up a new tax credit modeled on the Low-Income Housing Tax Credit (LIHTC)—which is available to private investors to support the development of affordable, multifamily housing—to support recovery housing for patients with addiction. The LIHTC has provided social, economic, and educational benefits for communities and families, and has had especially positive outcomes for those with significant health needs, including those with SUDs. An LIHTC-type credit for recovery housing could expand the availability of and access to these programs to further prevent overdose deaths.
- HHS and the Department of Housing and Urban Development (HUD) could consider identifying public housing complexes with high overdose rates, and then ensure an expanded supply of naloxone is available to local law enforcement, public housing professionals, and health care practitioners.
- HHS and HUD could consider coordinating to create a model set of core criteria for "recovery housing" using input from experts.
- HUD could consider issuing guidance for state and local housing authorities on establishing tenant-selection preferences for nonelderly people with severe mental illness, consistent with federal fair housing requirements.
- HUD could consider targeting resources, such as housing choice vouchers, for individuals with severe mental illness or addiction who are experiencing chronic homelessness or transitioning from correctional facilities, nursing homes, board and care homes, or other such institutional settings.

Improve Parity for Mental Health and Addiction Services

Congress and the Biden administration are both committed to expanding the enforcement of parity rules. In July 2023, the administration introduced a proposed rule to enhance requirements from the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Similarly, the Senate Committee on Health, Education, Labor and Pensions (HELP) is considering a proposal to require the Department of Labor's Office of the Investigator General (OIG) to issue a report on the efficacy of implementing parity requirements across the Departments of Labor, HHS, and Treasury. By strengthening parity rules, Congress and the administration are emphasizing the importance of accessing mental health and substance use services and alleviating provider shortages; however, there is more the legislative branch could do.

In addition to the OIG report, to enhance parity rules, Congress could consider:

- expanding the Mental Health Parity and Addiction Equity Act to cover Medicare and Medicare Advantage beneficiaries.
- allocating funding for parity enforcement of Employee Retirement Income Security Act (ERISA) plans.

MAINTAIN MEDICAID COVERAGE FOR HIGH-NEEDS PATIENTS

In certain circumstances, Medicaid coverage is suspended, including for those admitted to institutions for mental diseases (IMD) or for justice-involved communities, such as incarcerated individuals and pretrial detainees.

Scale Back the IMD Exclusion

Since 1965, Medicaid has excluded institutions for mental diseases from obtaining reimbursement for patients under age 65. Although the statutory definition of IMDs is limited to "mental diseases," CMS applies this exclusion to residential addiction services. States can use either of two tools—a state plan amendment (SPA) or a Section 1115 waiver—to work around this exclusion, but the SPA option has lapsed in September 2023. One proposal would permanently extend the SUPPORT Act's SPA option for states to lift Medicaid's IMD exclusion for SUD.

As Congress debates changes to the IMD exclusion, BPC supports a compromise to address the capacity shortage and incorporate safeguards to prevent excessive institutionalization, particularly among vulnerable communities such as youths and people of color:

- CMS could consider increasing the maximum number of inpatient beds that Medicaid can cover from 16 to 39. This adjustment has the potential to more than double the current capacity of inpatients served. According to a Congressional Budget Office report, this option would cost $155 million from 2024 to 2033, but its adoption would be more cost-effective than completely eliminating the IMD exclusion.
- CMS could consider expanding reporting requirements for hospitals and other facilities (e.g., crisis stabilization units) on emergency psychiatric patients. This change would help policymakers understand how increases in hospital capacity affect patient care. Metrics could include length of stay for individuals in crisis, the ratio of providers to patients, overall costs, and patient outcomes.
- Congress could consider directing CMS and SAMHSA to introduce a set of admission criteria (e.g., medical necessity) to encourage "thoughtful admission," and expand reporting to assess their effects. We have identified two established sets of admission criteria: the LOCUS and the CALOCUS, neither of which has been adopted by the federal government.
- Congress could consider enhancing preventive and community-based services, with a particular focus on optimizing demonstration grants, as outlined above. Hospitals might not fit each patient's needs, so strengthening community-based crisis services and grant programs is a critical element for addressing patient needs.

Scale Back the Medicaid Inmate Exclusion Policy (MIEP) for Incarcerated Individuals Prior to Release

BPC supports requiring CMS to convene a stakeholder work group to develop best practices for ensuring continuity of state Medicaid coverage for transitioning inmates. Although CMS issued guidance to encourage states to adopt this policy using its Section 1115 waivers, it would require an act of Congress to set an important minimum federal standard that enables every state to provide prerelease care to Medicaid-eligible individuals for up to 30 days. Wait times for reinstating Medicaid coverage can last months, leaving formerly incarcerated individuals at risk of dying of drug overdose and by suicide.

BPC proposes removing this exclusion for inmates to the greatest extent possible in the reauthorized SUPPORT Act. One proposal would require states to suspend, rather than terminate, Medicaid coverage for individuals while they are incarcerated, and allow them to resume coverage upon release. Numerous experts note the benefits and savings associated with continuous coverage. In fact, one study found that Medicaid beneficiaries with disrupted coverage incurred higher acute care costs compared with those with continuous coverage ($945 versus $295 per Medicaid-enrolled person-month). There is, however, a potential for inappropriate Medicaid billing when benefits are suspended, so state Medicaid agencies will need to introduce safeguards against fraud.

Scale Back the MIEP for Pretrial Detainees

BPC supports restoring access to SUD treatment while redirecting savings to federal funding. Due to the suspension of federal funding for inmates in correctional facilities, the burden of care costs, an estimated $3.34 billion annually, falls to local jails and taxpayers.

Eliminating the MIEP fully presents several challenges, most notably the substantial associated cost. Given these concerns, Congress is debating limiting coverage eligibility for specific populations (e.g., pregnant individuals) or imposing time limits (e.g., a 30-day period). We propose the following as potential paths toward removing the MIEP:

- Congress could consider permitting states to designate behavioral health benefits (e.g., universal MOUD) that Medicaid beneficiaries could retain through their pretrial period and upon release. Alternatively, CMS could consider encouraging states to use their Medicaid Section 1115 waivers to cover behavioral health benefits universally during these periods. Even with the MIEP, Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours. Some states extend limited Medicaid coverage to inmates, resulting in reported annual savings ranging from $5 million in Colorado to $19 million in Michigan. Covering a subset of selected benefits would support continuity of care, potentially reducing the likelihood of severe health complications and preventing fatalities.
- Congress could consider permitting states to maintain Medicaid coverage for beneficiaries under age 65. Alternatively, CMS could consider encouraging states to use their Medicaid Section 1115 waivers to cover beneficiaries under age 65 universally during these periods. Beneficiaries who are dually eligible for both Medicare and Medicaid can use their Medicare coverage to continue their care.
- The VA could consider partnering with local justice systems to enhance veterans' access to and continuity of care. The VA can leverage programs like the Veterans Justice Outreach (VJO) program to help connect justice-involved veterans with their VA benefits. Despite data collection issues for the general population, programs like the VJO help identify veterans when they are processed in local jails, enabling jail health administrators to better address behavioral health issues that are highly prevalent among veterans. Moreover, the VJO program officers can help identify veterans before their reentry, facilitating a smoother transition out of the justice system.

Keeping in mind that better data collecting on justice-involved populations is also needed, BPC proposes:

- The Department of Justice (DOJ) could consider providing national guidance and set best practices for data collection in the local criminal justice system. The absence of comprehensive data regarding health care needs and expenses within jails has hindered calculation of total jail health care expenditures and has contributed to the shortage of financial and other resources. Without existing data infrastructure, imposing criteria such as time limits might add to the administrative burdens on local jails and prisons. The DOJ can begin to alleviate this burden by building an appropriate data management and reporting infrastructure in local justice systems.
- HHS and DOJ could consider setting practices and incentivizing record-sharing between health care systems and county jail health systems. Currently, while coordination between state Medicaid agencies and correctional facilities is possible, it is highly burdensome. To improve coordination, HHS and the DOJ can harness existing technologies such as teleprescribing and telehealth, or invest in data systems that are compatible in both settings. Furthermore, SAMHSA updated 42 CFR part 2 in November 2022, protecting the confidentiality of patients' SUD treatment records; data-sharing and coordination among providers for SUD treatment, as a result, could be stronger.
- To identify justice-involved veterans, the VA and the DOJ could consider establishing best practices for sharing records between the veterans health system and county jail health systems. Data-based tools do exist, but only a handful of law enforcement agencies and jails use them. As a result, most veterans are left to self-identify, and many opt not to do so out of concerns about stigma and the potential loss of benefits. Scaling the existing tools and improving interdepartmental coordination can strengthen long-term efforts to improve veterans' access to behavioral health care.

UPDATE BEHAVIORAL HEALTH METRICS

BPC supports improving reporting requirements for behavioral health services. We also support a proposal to expand the data collected through Medicaid's Transformed Medicaid Statistical Information System (T-MSIS) data set. BPC's Opioid Crisis Task Force report recommended the following regarding expanded data collection and reporting:

- Congress could consider updating the T-MSIS with recovery-focused metrics. For example, BPC outlined five metrics from SAMHSA's Treatment Episode Data Set (TEDS) that could be useful in such an update: 1) employed/in school full time or part time; 2) in stable housing/living situation; 3) no arrests in prior 30 days; 4) abstention from drug use; and 5) attending social support recovery programs. Congress could further update the T-MSIS with recovery-focused metrics for mental health conditions.

IMPROVE WORKFORCE CAPACITY

The COVID-19 pandemic continues to strain the behavioral health workforce. As of March 2021, over one-third of Americans lived in areas with mental health service shortages. During the pandemic, rates of mental illness spiked 41%, while overdose deaths increased 30%. Sadly, fewer than half of adults with mental health conditions receive services, and more than 85% of people with a substance use disorder have not received treatment.

Congress must advance solutions to close the treatment gap for Americans needing behavioral health services. BPC proposes increasing the capacity of primary care providers to deliver behavioral health services, promoting new types of behavioral health professionals, and building a comprehensive crisis response system.

Workforce Capacity Demonstration Project

BPC supports creating a demonstration program, which would allow states to receive additional federal Medicaid funding to expand or improve the capacity of mental health and substance use disorder providers in their state:

- Congress could consider expanding financial support for continuing education programs that prepare providers to work in integrated settings, meet the needs of diverse and underserved populations, and improve health disparities.
- Congress could consider providing funding for the Primary Care Extension Program with an enhanced focus on behavioral health integration. This would provide technical assistance to providers who are integrating behavioral health and primary care services.

Strengthen Behavioral Health Support Specialists

To help reduce the treatment gap, federal policymakers should take steps to foster a behavioral health workforce that extends beyond licensed professionals. This strategy includes encouraging a greater role for peer specialists, community health workers, and paraprofessionals in delivering nonclinical behavioral health services.

- Congress could consider including a proposal in the SUPPORT Act that would do three things:
    1. codify SAMHSA's Office of Recovery, which created a set of National Model Standards for Peer Support Certification in April 2023; the Office of Recovery would support professional development programs, certification, and career pathways for peer specialists.
    2. direct HHS and DOJ to study the impact of certification barriers for prospective peer specialists who have had past interactions with law enforcement.
    3. direct the Office of Management and Budget (OMB) to revise the Standard Occupational Classification (SOC) system to recognize peer specialists as a profession.
- Congress could consider directing SAMHSA and HRSA to create a model set of core competencies for behavioral health support specialists with career lattices and buy-in from states.
- Congress could consider directing SAMHSA and HRSA to establish reporting processes on performance and impact of behavioral health support specialists.
- Congress could consider directing CMS to issue joint guidance and encourage states to adopt core competencies as part of certification requirements for behavioral health support specialists.
- Congress could consider authorizing a pipeline program for individual behavioral health support specialists to become licensed behavioral health providers.
- CMS could consider providing technical assistance to state Medicaid agencies to ensure they are taking full advantage of federal Medicaid matching support for unlicensed behavioral health workers.
- Congress could consider establishing a minimum federal exemption to becoming a behavioral health support specialist for those convicted of nonviolent crimes.

NEXT STEPS

BPC continues to gather evidence and update policy options on the health care workforce. For more information or to discuss the options above, please contact Andrew Hu (ahu@bpcaction.org) or Michele Gilbert (mgilbert@bipartisanpolicy.org).

APPENDIX 1:
DISCRETIONARY DEMONSTRATION GRANTS BY CATEGORY

Congress could catalog the grants authorized in the SUPPORT Act as follows:

Grant Program	Appropriated Amount	Authorizing Law
Prevention		
Sec. 8203*: ONDCP/CDC Reauthorization of Drug-Free Communities (DFC) Program	$102 million appropriated in FY2021 and $101.3 million in FY2020 BPC noted $100.5 million awarded to this program in FY2020	Originally authorized in National Narcotics Leadership Act of 1988 Sec. 1024
Sec. 8071*: HUD Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed	$25 million appropriated in both FY2021 and FY2020 BPC noted $25 million awarded to this program in FY2020	Authorized in SUPPORT Act
Sec. 8204: ONDCP/CDC Reauthorization of the National Community Anti-Drug Coalition Institute	$2.5 million appropriated in FY2021	Originally authorized in National Narcotics Leadership Act of 1988 Title I Subtitle A Chapter 2
Health Services *Note: States can use these programs to fill gaps in Medicaid coverage*		
Sec. 7151*: SAMHSA Building Communities of Recovery	$10 million appropriated in FY2021 and $8 million in FY2020 BPC noted $8 million awarded in FY2020	Originally authorized PHSA Sec. 547(f)
Sec. 7121: Comprehensive Opioid Recovery Centers	$4 million appropriated in FY2021	Originally authorized in PHSA Sec. 552
Sec. 7161: CDC Preventing Overdoses of Controlled Substances	$475.6 million appropriated in FY2021	Originally authorized in PHSA Sec. 392(d) and 399O; CARA Sec. 102
Sec. 7002*: SAMHSA First Responder Training	$42 million appropriated in FY2021 and $41 million appropriated in FY2020. BPC noted $41 million awarded to this program in FY2020	Originally authorized in PHSA Sec. 546(h)
Sec. 7062(b): SAMHSA Residential Treatment Programs for Pregnant and Postpartum Women	$32.9 million appropriated in FY2021	Originally authorized in PHSA Sec. 508
Sec. 7091: SAMHSA Emergency Department Alternatives to Opioids Demonstration Program	$6 million appropriated in FY2021	Authorized in SUPPORT Act
Sec. 7141: CDC Reauthorization and Expansion of Program of Surveillance and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors (F.K.A. Infectious Diseases and the Opioid Epidemic)	$13 million appropriated in FY2021	Originally authorized in PHSA Sec. 317N(d)

Note: The asterisk marks programs that BPC has designated as "opioid-related" in previous spending analyses.

Grant Program	Appropriated Amount	Authorizing Law
Sec. 7183: SAMHSA Comprehensive Addiction Recovery through Effective Employment and Reentry (CAREER) Act	$6 million appropriated in FY2021	Authorized in SUPPORT Act
Capacity Building/ Workforce		
Sec. 7071: HRSA Loan Repayment Program for Substance Use Disorder Workforce	$16 million appropriated in FY2021	Originally authorized in PHSA Sec. 781(j)
Sec. 7073(b): HRSA Mental and Behavioral Health Education Training Program	$36.9 million appropriated in FY2021	Originally authorized in PHSA Sec. 756(f)
Sec. 7152: SAMHSA Peer Support Technical Assistance Center	$1 million appropriated in FY2021	Originally authorized PHSA Sec. 547(e)
Children, Families, and Youth		
Sec. 7064*: CDC Prenatal and Postnatal Health	Funded through multiple accounts, including: • $2.25 million explicitly for Neonatal Abstinence Syndrome • a portion of funding from CDC's Child Health and Development Program (appropriated $65.8 million) • a portion of funding from CDC's Safe Motherhood/Infant Health Program (appropriated $63 million) BPC noted $2.3 million awarded to this program in FY2020	Originally authorized in PHSA Sec. 317L(d)
Sec. 7131: CDC Surveillance and Data Collection for Child, Youth, and Adult Trauma	$5 million appropriated in FY2021	Authorized in SUPPORT Act
Sec. 7133: SAMHSA National Child Traumatic Stress Initiative	$71.9 million appropriated in FY2021	Originally authorized in PHSA Sec. 582(j)
Criminal Justice		
Sec. 8206*: DOJ/OJP Reauthorization of Drug Court Program	$83 million appropriated in FY2021 and $80 million in FY2020 BPC noted $80 million awarded to this program in FY2020	Originally authorized in Omnibus Crime Control and Safe Streets Act of 1968 Sec. 1001(a)(25)(A)
Sec. 8092*: DOJ/OJP Reauthorization of the Comprehensive Opioid Abuse Grant Program Since renamed Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)	$185 million appropriated in FY2021 and $180 million in FY2020 BPC noted $180 million awarded to this program in FY2020	Originally authorized in Omnibus Crime Control and Safe Streets Act of 1968 Sec. 1001(a)(27)
Sec. 8207: ONDCP Drug Court Training and Technical Assistance	$3 million appropriated in FY2021	Originally authorized in ONDCP Reauthorization Act of 1998 Sec. 705(e)(2)

Note: The asterisk marks programs that BPC has designated as "opioid-related" in previous spending analyses.

Grant Program	Appropriated Amount	Authorizing Law
Detection and Surveillance		
Sec. 7011*: CDC Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids	Funded using a portion of funding from CDC's Environmental Health Laboratory (appropriated $66.8 million in FY2020, $67.8 million in FY2021) BPC noted $66.8 million awarded to this program in FY2020 (no awards prior)	Authorized in SUPPORT Act
Sec. 8205*: ONDCP Reauthorization of the High-intensity Drug Trafficking Area (HIDTA) Program	$290 million appropriated in FY2021 and $285 million in FY2020 BPC noted $300 million awarded to this program in FY2020	Originally authorized in ONDCP Reauthorization Act of 1998 Sec. 707

Note: The asterisk marks programs that BPC has designated as "opioid-related" in previous spending analyses.

APPENDIX 2: MEDICAID DEMONSTRATION PROGRAMS

Below are key mandatory programs authorized in the SUPPORT Act.

Program	Appropriated Amount	Terms	Authorizing Law
Sec. 1003: Demonstration Project to Increase Substance Use Provider Capacity Under the Medicaid Program	$50 million for grants and $5 million for report for FY2019	One-time FY2019 appropriation made in the SUPPORT Act.	SSA Sec. 1903(aa)
Sec. 5061: Medicaid Improvement Fund	$31 million total in FY2021	Appropriation made in the SUPPORT Act was subsequently amended. The FY2021 appropriation is $0.	SSA Sec. 1941
Sec. 6083(a): Expanding Access Under the Medicare Program to Addiction Treatment in Federally Qualified Health Centers	$6 million total for FY2019	Appropriation made in the SUPPORT Act.	SSA Sec. 1834(o)
Sec. 6083(b): Expanding Access Under Medicare Program to Addiction Treatment in Rural Health Clinics	$2 million total for FY2019	Appropriation made in the SUPPORT Act.	SSA Sec. 1833(bb)
Sec. 8082: ACF Improving Recovery and Reunifying Families	$15 million for FY2019	A one-time appropriation of FY2019 funds was made in the SUPPORT Act. This funding remains available for use through FY2026. No additional funding is authorized.	SSA Sec. 435(e)(5)
Sec. 8083: Building Capacity for Family-focused Residential Treatment	$20 million for FY2019	A one-year discretionary funding authorization was provided for FY2019 (with any funds appropriated to remain available for use through FY2023). No funds were appropriated under this expired authority.	SUPPORT Act