IDEAS
ACTION
RESULTS

Tracking FY2019 Federal Funding to Combat the Opioid Crisis

September 2020

Bipartisan Policy Center

STAFF

G. William Hoagland
Senior Vice President

Anand Parekh, M.D.
Chief Medical Adviser

Anita Burgos, Ph.D.
Senior Policy Analyst

Thomas Armooh
Project Assistant

Morgan Bailie
Project Coordinator

Edwin Chen
Project Associate

Regina LaBelle, J.D.
Consultant

Tim Swope
Consultant

ACKNOWLEDGMENTS

The Bipartisan Policy Center would like to acknowledge and thank the dedicated leadership and staff from the states studied in this report for their substantial contributions. Officials from Arizona, Louisiana, New Hampshire, Ohio, Tennessee, and Washington were extremely helpful in reporting their state's use of federal funds to combat the opioid epidemic. Additionally, BPC greatly appreciated the thoughtful input from federal agency budget officials with respect to BPC's determination of opioid-related programs. Finally, BPC acknowledges the support of Arnold Ventures. The views expressed are those of the authors and do not necessarily reflect those of the funder.

DISCLAIMER

Table of Contents

Executive Summary

The COVID-19 pandemic has resulted in one of the most significant public health crises of the last century, but there is also increasing concern about the effect of the pandemic on other health issues, including the opioid use disorder epidemic. Reports from states and counties across the country suggest opioid-involved overdose deaths are rising in 2020. This is on top of provisional data suggesting overall drug overdose death rates climbed by 4.9% in 2019, resulting in over 71,000 deaths and erasing the slight decline observed in 2018. Synthetic opioids, such as fentanyl, continue to be the main driver of opioid-involved deaths. The nation is also seeing an increase in methamphetamine and cocaine use. Multiple substances, including methamphetamine and cocaine, are increasingly being found along with opioids in overdose death toxicology reports—commonly referred to as polysubstance-involved deaths.

As drug use patterns shift, so do the demographics of overdose deaths; we continue to see increases in rates of overdose deaths in communities of color. This is especially concerning in Black and Latino communities that have also experienced higher rates of COVID-19 infection and death rates.

While considerable attention has focused on the drivers of the opioid epidemic, less attention has been paid to how the federal government is allocating financial resources to address the issue; the appropriate allocation of responsibility among federal, state, and local entities; where the funding is going; and whether it is being targeted to communities most affected by the epidemic.

In this report, the Bipartisan Policy Center (BPC) tracks spending targeted to address the opioid epidemic across the federal government for fiscal year 2019 and provides insight into how funds are being spent at the state and county-level to address the opioid epidemic. BPC also selected six states—Ohio, Arizona, Tennessee, Louisiana, New Hampshire, Washington—diverse in many aspects and performed case-studies elucidating more detailed state and county-level opioid spending data.

In FY2019, total federal opioid funding was $7.6 billion, up from $7.4 billion in FY2018, an increase of 3.2%. This is a smaller increase than seen in previous years when total federal opioid funding increased 124% between FY2017 and FY2018. Two-thirds ($5.3 billion) of the funding was disbursed by the Department of Health and Human Services, with nearly two-thirds of that funding ($3.7 billion) administered by the Substance Abuse and Mental

Health Services Administration (SAMHSA). Similar to FY2018, three-quarters of FY2019 funding went to treatment, recovery, and prevention efforts; the remaining dollars went to research, interdiction, law enforcement, and other criminal justice activities. Notably, total interdiction dollars rose from 5% to 9%, representing a significant increase in funds dedicated to disrupting the trafficking of illicit opioids, particularly illicitly manufactured fentanyl. In addition, while this analysis focused only on annually appropriated (discretionary) funding, Medicaid coverage of medications for opioid use disorder (buprenorphine, naltrexone) and for the opioid overdose antidote naloxone increased by 15% to nearly $1.6 billion in 2019.

Opioid spending in the six states studied totaled nearly $820 million in 2019, or 11% of all federal spending that year. While all federal spending increased 3.3% between 2018 and 2019, spending in the six states studied increased 12.8%. Nationwide federal opioid funding averaged $25 per capita in 2019; for the six states reviewed, per capita spending was similar at $24.

BASED ON THE STATE ANALYSIS, THERE ARE SEVERAL TAKE-AWAYS:

1. **With a few exceptions, the geographic distribution of federal opioid funding has remained relatively stable and funds are going to counties with the highest number of overdose deaths**. It is difficult to determine within counties whether funds are meeting the needs of those at highest risk of overdose, even though states are required in grants, including in SAMHSA's State Opioid Response grants to identify at-risk populations and target resources accordingly. In most states, populations most at risk of overdose include justice-involved populations, people experiencing homelessness, and pregnant and parenting women. Rates of polysubstance-involved overdose deaths are increasing, along with rates of methamphetamine and cocaine use. In addition, over the last few years there have been increasing rates of overdose deaths in communities of color.

2. **Few individuals who are incarcerated receive the standard of care for opioid use disorder, although overdose death is the leading cause of death upon release from jails and prisons**. States cited concerns about a lack of sustainable funding sources and access to community-based care upon reentry. States also mentioned shortages in funding for supportive housing, especially for people leaving corrections and in the early stages of recovery.

3. **Workforce shortages continue to limit treatment expansion, with state officials specifically mentioning this as a significant barrier to their efforts**. There is a disconnect between where vulnerable populations reside and where physicians have a "data waiver" practice, which stands in the way of providing treatment to at-risk populations. In addition, the majority

of "data waived" prescribers do not prescribe to the maximum allowed number of patients. Given well documented addiction treatment workforce shortages, several states have expanded scope of practice laws for mid-level practitioners, such as physician assistants and nurse practitioners, to allow them to prescribe controlled substances such as buprenorphine. States are also using federal grants to train and fund recovery support services, another key part of the addiction workforce.

4. **Every state funds naloxone training and distribution**. Naloxone is distributed to law enforcement, community-based organizations, and peers. Harm reduction programs such as syringe services programs, typically receive limited federal funding. At the state level, several have passed legislation sanctioning syringe services programs, although BPC found limited coordination between behavioral health and public health agencies in relation to these services. None of the states examined used federal funding for fentanyl test strips.

BPC MAKES THE FOLLOWING RECOMMENDATIONS:

1. To support sustainable funding and build the necessary infrastructure to reach at-risk populations:

    a. **Increase SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) funding for evidence-based programs**. This block grant has been level funded at $1.85 billion since FY2016 and has not kept pace with inflation over the past decade, despite the startling increase in drug overdose deaths over this 10-year period. BPC recommends increasing the block grant annually, at a minimum, to keep up with inflation. Providing additional funds should also increase culturally competent interventions to eliminate treatment gaps for at-risk populations, including Black and Latino populations who are less likely to receive substance use disorder (SUD) treatment.

    b. **Coordinate federal government harm reduction services**: To facilitate enhanced coordination of services at the state and local level and ensure services reach people most at-risk for overdoses, BPC recommends coordination of harm reduction related funding at the federal level. BPC also recommends that Congress remove the restrictions on purchasing syringes currently in federal appropriations language.

    c. **Evaluate programs and provide feedback**: Since FY2017, the federal government has invested billions of dollars to curb the opioid epidemic. However, rates of annual overdose death are the sole public measure for the effectiveness of these expenditures. Given the size of this investment, publicly available evidence-based evaluations of each of the streams of

federal opioid funding must be conducted. These evaluations should include information on whether the grant is meeting the needs of at-risk populations as well as health equity goals. In addition, evaluations should assess whether federal resources are going to implement evidence-based interventions.

2. To address overdose mortality of at-risk populations:

    a. **Remove restrictive funding language**: Every state official mentioned increasing rates of polysubstance use and overdose deaths in their state as an area of concern, as well as increasing rates of methamphetamine and cocaine availability and use. To the extent possible, revise federal grants to allow spending on substance use disorders generally, including emerging drug use trends such as methamphetamine and cocaine.

    b. **Reduce the treatment gap in diverse communities**: Grant programs should focus on cultural competency to improve treatment access and retention. Evaluations of grant funds as described above must address treatment gaps in communities of color.

    c. **Coordinate criminal justice reform efforts**: Reforms that seek to divert people away from arrest and incarceration, as well as efforts to expand access to medications for opioid use disorder in correctional settings and connect people to services upon reentry are critical. BPC recommends greater coordination between the Justice Department's Bureau of Justice Assistance and SAMHSA to improve the efficacy of these programs and increase opportunities for funding coordination. In addition, efforts should be made to include housing first responses and increase HUD's focus on reentry and recovery supportive housing.

3. To remove regulatory and legal barriers to treatment:

    a. **Extend regulatory revisions made during COVID-19**: The federal government should permanently extend the regulatory flexibilities that have expanded access to treatment via telemedicine. In addition, researchers should examine the effects that changes to other regulations (e.g., increased flexibility around take-home doses) have had on treatment retention and access. Upon completion, the federal government should immediately make permanent the most effective revisions and devise a plan for a comprehensive review of all restrictions on treatment access. The review and recommendations for change should include examining regulatory burdens on opioid treatment programs, or OTPs. The evaluation should include whether the regulatory revisions have made treatment more accessible to at-risk individuals and more equitable.

    b. **Remove the special licensing requirement (data waiver) for health care providers to prescribe buprenorphine**: While removing the data waiver requirement requires legislative action, in the interim HHS has

administrative discretion to lift the buprenorphine provider patient limit, thereby increasing access. Increasing patient limits and ultimately removing the data waiver requirement can lead to expanded access to buprenorphine, a medication available in physicians' offices that is too often out of reach for many vulnerable populations, particularly communities of color.

c. **Expand access through Medicaid**: HHS should conduct a thorough review of all Medicaid practices that restrict access to treatment for people with substance use disorder, including people who are incarcerated but have not yet been sentenced. BPC also recommends states increase Medicaid coverage for 12 months post-partum and increase reimbursement rates to encourage additional providers to cover treatment services. In addition, BPC recommends the elimination of prior authorization for MOUDs for opioid use disorder.

Background

In 2018, more than 67,000 people in the United States died from drug overdoses, approximately a 4% decline from 2017. Overall, opioid-involved overdose deaths (46,802) dropped by 2% mostly due to decreases in deaths involving prescription opioids and heroin (13.5% and 4.1%, respectively). Synthetic opioids, including illicitly manufactured fentanyl, continue to be the main driver of opioid-involved deaths and increased 10% from 2017.[1]

Although overdose death rates decreased in 2018, preliminary data suggests that death rates climbed by 4.9% in 2019 with over 71,148 deaths predicted.[2] Moreover, scattered reports from states and counties across the country suggest that numbers continue to rise in 2020 during the COVID-19 pandemic.[3]

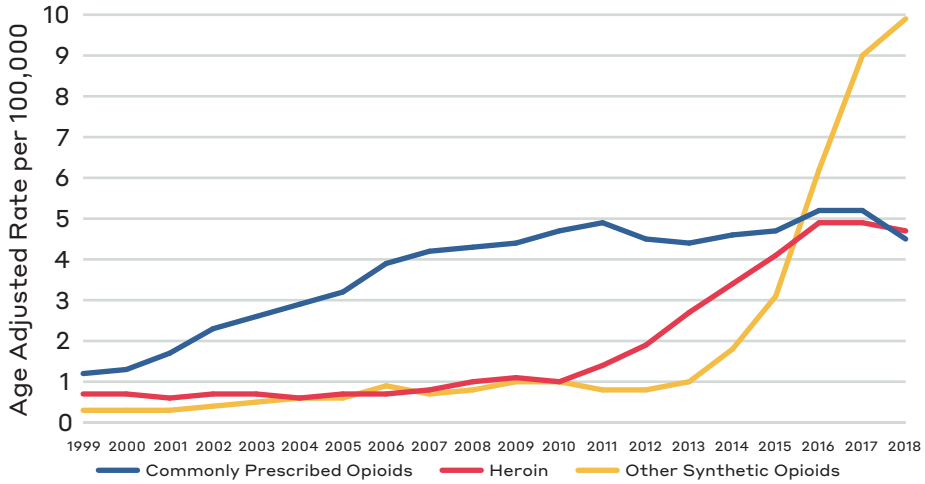
From 2017 to 2018, opioid-related deaths decreased across the country in 11 states and DC, with large decreases in Iowa and Ohio and increased in three states—with the largest increase occurring in Missouri. Rates of opioid-involved overdose deaths decreased in Midwest and South regions of the country but increased in Northeast and West regions.[4] A one-year fluctuation in overdose death rates may not, however, signal a longer-term trend.

Changes in opioid-involved overdose deaths varied across demographics from 2017 to 2018. Decreases were observed among females, individuals ages 15-34, individuals ages 45-54, and non-Hispanic whites. A decrease in death rates for females might be tied to decreased rates in prescription opioid-involved deaths, as women are more likely than men to use and be prescribed prescription opioids.[5] Notably, opioid-involved death rates increased for individuals 65 years or older, and for non-Hispanic Black, and Hispanic Americans.[6]

One of the consequences of the COVID-19 pandemic has been access to critical services and treatment needed to address the opioid epidemic. However, there is limited real-time national data about the impact the pandemic has had on opioid-involved overdose and mortality rates. Some services across the country have either been suspended or otherwise affected by the physical distancing requirements of the pandemic. One such example are syringe services programs, or SSPs, which offer harm reduction services (e.g., sterile syringes, opioid-overdose reversal drug naloxone, testing, health services) and can link people to substance use treatment and other health services.[7] A recent survey found that 43% of SSPs had reduced their services in the months following the declaration of COVID-19 as a public health emergency.[8]

Social distancing measures have challenged substance use disorder treatment service providers. In addition, in-person naloxone distribution has been disrupted, as have drug markets and use patterns, including a possible increase in people using alone. In addition, Black and Latino communities have observed higher rates of COVID-19 infection and death rates, which could compound disparities in opioid-involved overdose death rates for these demographic groups.

Figure 1: 3 Waves of the Rise in Opioid-Involved Death Rates



Source: Centers for Disease Control and Prevention, *CDC WONDER Online Database*, July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

THREE WAVES OF EPIDEMIC

According to the CDC, there have been three waves of the opioid epidemic (Figure 1). Beginning in 1999, the first wave of opioid-involved overdose deaths was driven by high rates of opioid prescribing. In 2010, a second wave occurred involving increasing rates of heroin-involved overdose deaths. This second wave occurred as the price of heroin decreased, stricter prescribing protocols reduced prescription opioid availability, and a tamper resistant version of Oxycontin was introduced.

The third wave and current wave began in 2013. This wave is characterized by a sharp increase in overdose deaths involving synthetic opioids, such as illicit fentanyl. Fentanyl is cheaper, more potent than heroin, and continues to drive opioid-involved overdose death rates. In 2018, deaths involving synthetic opioids increased by 10% compared to the previous year.[9] According to a January 2020 DEA report, illicitly manufactured fentanyl and fentanyl analogs are primarily sourced from Mexico and China; India is emerging as fentanyl source country as well.[10] Table 1 depicts U.S. overdose death totals and death rates for the third wave of the opioid epidemic. Despite a slight decrease in 2018, preliminary 2019 data shows an increase in overdose death rates.[11] There is also evidence to suggest in 2020 opioid-involved overdose death rates

have increased, particularly during the COVID-19 pandemic. One recent study analyzing overdose death data from 1979 to 2016 reported the United States is still amid a long-term increase in overdose deaths that keeps shifting among demographics and substance.[12]

Although more than two-thirds of drug overdose deaths involve opioids, over the course of the third wave, an increasing number of cases are polysubstance-involved deaths (Table 2). From 2015 to 2018, the percent of opioids present in psychostimulant-involved overdose deaths increased by 24% (Table 4), and the percent of cocaine-involved deaths that involve opioids increased by 12% (Table 5). Moreover, in 2018, 63% of illicit fentanyl-involved deaths also showed the presence of benzodiazepines, cocaine, or methamphetamine.[13] Illicit fentanyl is often mixed with other substances, including heroin and cocaine, often without knowledge of individuals using the substance, making it more lethal.[14]

Racial disparities in overdose death rates have been a longer-term trend in the United States, across substance type and racial categories. From 2016-2018, Non-Hispanic white and Non-Hispanic American Indian or Alaska Native populations had the highest rates of overdose deaths overall (Table 3). Non-Hispanic white Americans had the highest rates of opioid-involved overdose deaths, followed by American Indian or Alaska Native groups. However, Non-Hispanic Black Americans (referring to the non-Latino black population) and Hispanics continue to experience the fastest increasing rates of overdose deaths involving synthetic opioids, other than methadone.[15,16] From 2016-2018, American Indian and Alaska Native groups had the highest rates for deaths involving stimulants such as methamphetamine and cocaine (Table 3). Racial disparities in rates of overdose deaths can be indicative of stigma in communities of color, lack of access to culturally-responsive care, and underlying structural issues that can lead to income inequality or intergenerational drug use.[17]

Opioid-involved overdose death rates are not uniform across the United States. In 2018, opioid-involved overdose death rates decreased by 9.9% in the Midwest and 4% in the South but increased by 7% in the Northeast and 3.8% in the West. Figure 2 depicts the trends in opioid-involved overdose death rates across regions of the United States from 1999 to 2018.

Table 1: U.S. Overdose Death Totals, 2012-2018[18]

Year	Opioids		All Drugs	
	Deaths	Age-Adjusted Rate Per 100,000	Deaths	Age-Adjusted Rate Per 100,000
2012	23,166	7.4	41,502	13.1
2013	25,052	7.9	43,982	13.8
2014	28,647	9.0	47,055	14.7
2015	33,091	10.4	52,404	16.3
2016	42,249	13.3	63,632	19.8
2017	47,600	14.9	70,237	21.7
2018	46,802	14.6	67,367	20.7

Table 2: U.S. Overdose Deaths, 2015-2018[19]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	52,404	33,091	63%
2016	63,632	42,249	66%
2017	70,237	47,600	68%
2018	67,367	46,802	69%

Table 3: U.S. Overdose Death Rates by Race, 2016-2018[20]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	26.2	18.5	7.8
Non-Hispanic Black or African American	19.6	12.4	9.1
Hispanic or Latino	10.4	6.9	4.3
Non-Hispanic Asian or Pacific Islander	3.4	1.6	1.5
Non-Hispanic American Indian or Alaska Native	25.6	14.6	11.1

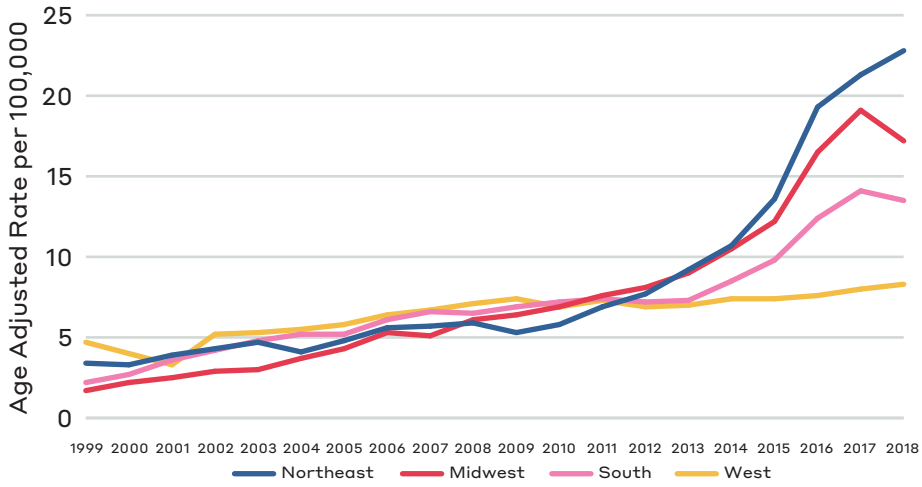
Table 4: U.S. Psychostimulant Overdose Deaths, 2015-2018[21]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	5,716	2,345	41%
2016	7,542	3,416	45%
2017	10,333	5,203	50%
2018	12,676	6,405	51%

Table 5: U.S. Cocaine Overdose Deaths, 2015-2018[22]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	6,784	4,506	66%
2016	10,375	7,263	70%
2017	13,942	10,131	73%
2018	14,666	10,887	74%

Figure 2: Opioid-Involved Death Rates by Census Region



Source: Centers for Disease Control and Prevention, *CDC WONDER Online Database*, July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

POLICY RESPONSE

In 2019, the federal government continued to pursue a comprehensive effort involving a range of government agencies to curb overdose deaths.

The federal government continued to emphasize opioid prescribing as a driver in opioid-involved overdose death rates. However, in response to concerns about unintended consequences of reductions in opioid prescribing and abrupt tapering of patients from opioids, the CDC issued a clarification of its guidelines in April 2019. In a commentary published in the *New England Journal of Medicine*, the authors of the 2016 guideline raised concerns about abrupt tapering and inappropriate application of the guideline. The authors also reminded prescribers of the parameter of the guideline and cautioned against applying it too broadly.[23]

In 2019, the federal government implemented elements of The SUPPORT Act, legislation signed into law in October 2018. The SUPPORT Act included provisions expanding access to treatment under Medicaid, including a provision to allow states to receive Medicaid matching funds to pay for services provided in "institutions for mental disease" until 2023. The SUPPORT Act also permanently authorized nurse practitioners and physician assistants to prescribe

buprenorphine and increased the number of patients certain health care professionals can treat with buprenorphine. The bill also authorized numerous grant programs, some of which received funding in the appropriations process and reauthorized The Office of National Drug Control Policy.[24]

The Trump administration also continued to prioritize implementation of its opioid plan and renewed the public health emergency relating to opioids, first declaring a public health emergency in October 2017.[25,26] In addition, the Trump administration issued its first National Drug Control Strategy outlining the nation's approach to controlling substance use and substance use disorder.[27]

The COVID-19 public health emergency prompted temporary revisions to SAMHSA, Centers for Medicare and Medicaid Services (CMS), and Drug Enforcement Agency regulations intended to minimize disruptions in substance use treatment. These changes included increasing access to telehealth and allowing take-home doses of methadone for people in early stages of treatment. In addition, Congress included funding in the Coronavirus Aid, Relief, and Economic Security (CARES) Act for SAMHSA and Federal Emergency Management Agency (FEMA) among others—to help states, territories and tribes tackle behavioral health conditions during the COVID-19 pandemic. This legislation also included a legislative change to align 42 CFR Part 2 regulations that govern confidentiality and sharing of SUD treatment data[28] with the privacy rules of the Health Insurance and Portability Act (HIPAA) and initial patient consent.

BPC STUDY PURPOSE AND METHODOLOGY

While considerable attention has focused on the drivers of the opioid epidemic, less attention has been paid to how the federal government is allocating financial resources to address the issue; what the appropriate allocation of responsibility is among federal, state, and local entities; where funding is going; and whether it is being targeted to communities most affected by the epidemic. Since BPC's last opioid spending report was released, HHS created a dashboard to track federal opioid spending across its agencies, and Office of National Drug Control Policy (ONDCP) has issued a federal drug control budget that includes annual federal drug control outlays.[29] The current report tracks opioid-involved spending across the federal government and provides insight into how funds are being spent to address the opioid epidemic at state and county levels.

Key information about resource availability and allocation will allow policymakers and the American public to determine if resources are sufficient and allocated appropriately to support an effective national response. This information will also help policymakers identify and advocate for evidence-based activities to curb the opioid epidemic and anticipate emerging

substances of concern. BPC provides an update to our previous study to determine how federal funds are allocated to states and localities and for what purpose in the government's effort to decrease opioid use disorders and overdose deaths. The study takes a closer look at spending by selected states to elucidate how states are receiving and spending federal opioid funds. The information in this report will help inform federal and state policymaking and future appropriations, as well as identify gaps that could be filled by private-sector and philanthropic organizations.

BPC's robust analysis for this study relied on multiple research approaches:

1. Identifying Federally Funded Opioid Programs: BPC reviewed congressional appropriations and documentation to identify opioid-involved federal grant programs. The review included scans of congressional committee and agency documents and a review of Explanatory Statements for each of the federal appropriations bills in 2019.[30] When choosing programs to include in the report, BPC erred on the side of broad inclusion, including programs that are not limited in focus to opioids, to include the Substance Abuse Prevention and Treatment Block Grant, the Drug-Free Communities program, and the High Intensity Drug Trafficking Areas program.[a]

2. Validating a Catalog of Federal Appropriations and Awards: BPC spoke with budget officials from multiple federal agencies to validate the programs included and to verify opioid program levels.

3. Aggregating and Analyzing State Spending Data: After determining programs to include as opioid-related federal spending, BPC obtained state-level award information from agency sources. Agency data were then cross-referenced with spending information catalogued by the Department of Treasury in USAspending.gov for quality control.

4. Preparing Case Studies: BPC selected six states representative of a broad cross-section of issues related to resource allocation and an emphasis on addressing the opioid epidemic. Information gathered for the cases was obtained from leadership in state agencies that received the federal opioid grants to verify state-level information. BPC included the five states from the previous report (Ohio, Arizona, Tennessee, Louisiana, New Hampshire) and Washington as an additional state case study. For case-study states, BPC also obtained state- and county-level opioid spending data for spatial analysis.

A detailed explanation of BPC's methods and considerations is included in Appendix III.

---

a These programs address all forms of substance use and drug trafficking and are not limited to opioids. BPC erred on the side of inclusion since it is impossible to separate out funding specifically targeted to opioids from spending on other substances in programs such as these. However, these programs form the basis for much of the federal government's prevention, treatment, and supply-reduction efforts.

Federal Analysis

Federal expenditures dedicated to the opioid epidemic are distributed across the federal government, from the Department of Health and Human Services to the Department of Justice. The variety of agencies involved in the federal opioid response reflects the complexity of the issue and the need for an "all of the above" approach to reducing opioid use disorders and opioid-involved overdoses. Over the past three fiscal years, HHS has received the vast majority of congressional appropriations for the opioid epidemic, primarily in the form of the State Targeted Response, State Opioid Response, and Substance Abuse Block Grant programs. In FY2019, total federal opioid funding was $7.6 billion, up from $7.4 billion in FY2018, representing an increase of 3.2%. This contrasts with previous years when total federal opioid funding increased 124% from FY2017 to FY2018.

BPC conducted an analysis of all discretionary spending to identify and categorize opioid appropriations in FY2019. Table 6 displays federal appropriations across federal departments.

Table 6: Opioid Appropriations by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$2,765,589,000	$5,521,368,000	$5,326,161,180
Substance Abuse and Mental Health Services Administration	$2,603,679,000	$3,685,479,000	$3,697,479,000
Indian Health Service	$6,000,000	$6,000,000	$16,946,000
Centers for Disease Control and Prevention	$112,000,000	$630,579,000	$480,579,000
Health Resources and Services Administration	*	$480,000,000	$407,265,000
Administration for Children and Families	$43,910,000	$125,310,000	$125,310,000
Administration for Community Living	*	$982,831	$989,411
Agency for Healthcare Research and Quality	$3,570,046	$3,579,337	$592,769
National Institutes of Health	*	$500,000,000	$500,000,000
Food and Drug Administration	*	$94,000,000	$47,000,000
Centers for Medicare and Medicaid Services	*	*	$50,000,000
Office of National Drug Control Policy	$351,000,000	$379,000,000	$380,000,000
Department of Justice	$194,000,000	$515,839,484	$562,339,484
Veterans Affairs	*	$704,552,000	$724,362,000
Homeland Security	*	$261,100,000	$654,397,000
Department of Labor	*	$21,000,000	$0
Total Opioid Spending	**$3,314,159,046**	**$7,402,859,484**	**$7,647,259,664**

*—No opioid-specific appropriations.

As shown in Table 6, in FY2019 Congressional appropriations across federal departments remained relatively stable from FY2018. HHS received roughly $245 million less opioid spending in FY2019, with reduced appropriations for CDC, AHRQ, and FDA. However, IHS received $10 million to initiate the Special Behavioral Health Pilot Program.[31] Other notable changes in FY2019 include significant additional funding to the Department of Homeland Security and elimination of opioid-related funding for the Department of Labor. The DHS appropriation was for U.S. Customs and Border Protection to improve interdiction of illicitly manufactured fentanyl.

Further details follow on agencies responsible for programs that provide treatment and prevention, oversee criminal justice programs related to opioids, and provide surveillance of the opioid epidemic: SAHMSA, DOJ, and CDC respectively.

SAMHSA

The Substance Abuse and Mental Health Services Administration is one of the primary federal agencies charged with providing funding to address the opioid epidemic. In FY2019, SAMHSA continued to administer two main opioid grant programs: The State Targeted Response (STR) and the State Opioid Response (SOR) grants. STR was authorized in the 21st Century Cures Act and is intended to close the gap between individuals seeking treatment and those receiving it. In FY2017, STR was funded at $500 million; in FY2018, $1.5 billion was appropriated to STR and SOR combined.

The SOR grant program continued to be awarded to states in FY2019 for the full continuum of care, prevention, treatment, and recovery. According to the funding announcement, the SOR grant is to be used for expanding access to MOUDs, reducing unmet treatment need, and preventing opioid-involved overdose related deaths. The SOR grant program made $1.5 billion available to states—level with the $1.5 billion in FY2018 from SOR and STR. The SOR program includes a 15% set-aside for states with the highest rates of drug overdose deaths. Additionally, grant recipients were required to fund treatment programs that made FDA approved opioid treatment medications—methadone, naltrexone, and buprenorphine—available. The SOR and STR programs made up 20% of total opioid-related appropriations in FY2018 and FY2019.

For purposes of this report BPC included the Substance Abuse Prevention and Treatment Block Grant (SABG) program in its calculation. The SABG addresses all forms of substance use, not only opioid misuse and is the largest federal discretionary program for treatment and prevention. In FY2019, the SABG made up approximately 23.4% of total opioid funding and 24% in FY2018.

SAMHSA continued to administer 19 additional programs that target opioid use disorder through the Programs of Regional and National Significant, or PRNS, in FY2019. PRNS includes programs such as Medication-Assisted Treatment for Prescription Drug and Opioid Addiction, which awards grants to states to expand MOUDs systems, thereby increasing access to evidence-based treatment.[32] PRNS also includes the Strategic Prevention Framework for Prescription Drugs, or SPF Rx, program. SPF Rx raises awareness within the medical community about the risks of opioid overprescribing, and funds prescription drug misuse prevention activities.[33] The total appropriations for all PRNS programs combined increased slightly in FY2019 but continued to make up 7% of opioid funding in FY2019 as it did in FY2018.

DOJ

The DOJ administers 11 grant programs targeted to the opioid epidemic. In FY2019, DOJ eliminated funding for Enhancing Community Responses to the Opioid Crisis program administered by the Office for Victims of Crime but initiated the Tribal Assistance Anti-methamphetamine and Anti-opioid Activities Grant under the Office of Community-Oriented Policing Services. $27 million were appropriated to improve tribal law enforcement efforts, including hiring, equipment, training, anti-methamphetamine activities, and anti-opioid activities.

The key opioid response programs administered by DOJ are the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP); Helping Children and Youth Impacted by Opioids; and the Paul Coverdell Forensic Science Improvement Grant Program. COSSAP, formerly titled the Comprehensive Opioid Abuse Program, was funded at $163 million in FY2019 and $162 million in FY2018.[34,35] The program supports efforts at the front lines of the opioid epidemic by funding partnerships between first responders and treatment providers responding to an overdose.[36] COSSAP grants support four purpose areas:[37]

1. Promoting public safety and supporting access to recovery services in the criminal justice system.
2. Strengthening the collection and sharing of data across systems to understand and address the impact of illicit substance use and misuse.
3. Align and maximize resources across systems and leverage diverse program funding.
4. Prevent substance use and misuse.

In FY2019, DOJ provided $15.8 million in funding to the Enhancing Community Responses to the Opioid Crisis: Serving Our Youngest Crime Victims program, which expands services to children and youth who have been victimized as a result of the opioid crisis.[38] DOJ also awarded $7.9 million under the Opioid Affected Youth Initiative in FY2019.[39]

In FY2019, DOJ administered $30 million under the Paul Coverdell Forensic Science Improvement Grants Program—an increase from $17 million in FY2018—to continue expanding the capabilities of forensic examiners and coroners processing backlogs of seized drugs and toxicology requests in opioid-related crimes and deaths.

CDC

CDC opioid funding helps build state public health capacity. The CDC administers the Opioid Overdose Prevention and Surveillance (OOPS) program, funded at $476 million in both FY2018 and FY2019. The OOPS program expands case-level surveillance data to identify possible outbreaks.[40]

In addition, the CDC launched Overdose Data to Action in September 2019 to generate more comprehensive data on opioid-involved overdose and deaths.[41] The program will provide $301 million in funding over three years to 47 states to gather and report overdose data, including demographic data and information regarding the circumstances, substances used, and locations.[42] Funds will also be used to support prevention activities such as strengthening prescription drug monitoring programs, establishing linkages to care, and improving the health system response.[43]

In FY2019, in recognition of increasing risks of infectious disease and rates of injection drug use, the CDC also provided $5 million in funding for the Infectious Disease and the Opioid Epidemic program. The program increases hepatitis testing, connects people to care from emergency departments, and syringe services programs. Additional funding for strengthening syringe services programs is also included in CDC's OOPS program, described above.

In FY2018, federal appropriations for the CDC increased significantly, allowing the CDC to make $155 million available to states and four territories using the funding mechanism of the Cooperative Agreement for Emergency Response: Public Health Crisis Response.[44] The one-time funding aimed to expand prevention and response activities; it was not continued in FY2019.[45]

OPIOID APPROPRIATIONS BY CATEGORY

BPC's previous analysis of opioid-specific appropriations noted that in FY2018, funds for research increased to $500 million (Table 7). In FY2019, $500 million in funding for research was appropriated again in FY2019 through the National Institutes for Health specifically for research related to the opioid epidemic. The NIH established the Helping to End Addiction Long-term (HEAL) Initiative, a major trans-agency research effort to improve pain management and reduce reliance on opioids, which distributed $945 million in grants, contracts, and cooperative agreements in FY2019.[46] Although funding for the HEAL Initiative was first appropriated in FY2018, distribution of funding was delayed until FY2019. Furthermore, due to the coronavirus pandemic, NIH has temporarily halted non-COVID-19 research, including studies on delivery of MOUDs to focus efforts on the pandemic, further delaying opioid research programs.[47]

The previous report also noted that $355 million in new funding was appropriated for interdiction efforts in FY2018. In FY2019, $701 million was

appropriated for interdiction efforts, representing a near doubling of funds dedicated toward disrupting the trafficking of illicit opioids.

- **Treatment and Recovery**—Awards to improve treatment capacity and support substance use treatment services. Recovery includes grant funding for programs to sustain recovery, including community supports and recovery housing.
- **Prevention**—Primary prevention and secondary prevention activities, including funding for surveillance, screening, naloxone, and prescription drug monitoring programs.[b]
- **Mixed: Treatment/Recovery and Prevention**—Includes grant programs that are targeted to fund the continuum of care for opioid use disorders, including 80% of the SABG.[c]
- **Research**—Grants to fund research related to opioid use disorder, funded through NIH.
- **Criminal Justice**—Grants directed at enhancing criminal justice responses to the opioid epidemic, including the justice system and correctional institutions.
- **Law Enforcement**—Grants awarded to law enforcement to reduce the supply of illicit opioids and other drugs.
- **Interdiction**—Grants directed at efforts to disrupt trafficking of illicit opioids at ports of entry and through FDA opioid enforcement and surveillance activities.

Table 7: Opioid Appropriations by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	$598,800,000	$2,115,574,000	$2,125,771,000
Prevention	$789,685,800	$1,684,442,800	$1,560,001,800
Mixed: Treatment/ Recovery and Prevention	$1,423,103,200	$1,903,103,200	$1,830,368,200
Research	$3,570,046	$504,562,168	$501,582,180
Criminal Justice	$235,000,000	$532,639,484	$539,139,484
Law Enforcement	$264,000,000	$312,000,000	$339,000,000
Interdiction	*	$355,100,000	$701,397,000

*— No opioid-specific appropriations.

b This category also includes 20% of the STR and SOR grant funding based on BPC's analysis of the STR reports and SOR budgets for the five case-study states that found approximately 20% of these funds were spent on prevention. As explained further below, this category also includes 20% of funds from the SABG.

c The SABG program requires 20% to fund primary prevention; the remaining portion includes sub-awards that fund "Prevention (other than primary prevention) and Treatment Services" that could not be separated out.

Figure 3: FY2017 Opioid Spending by Category

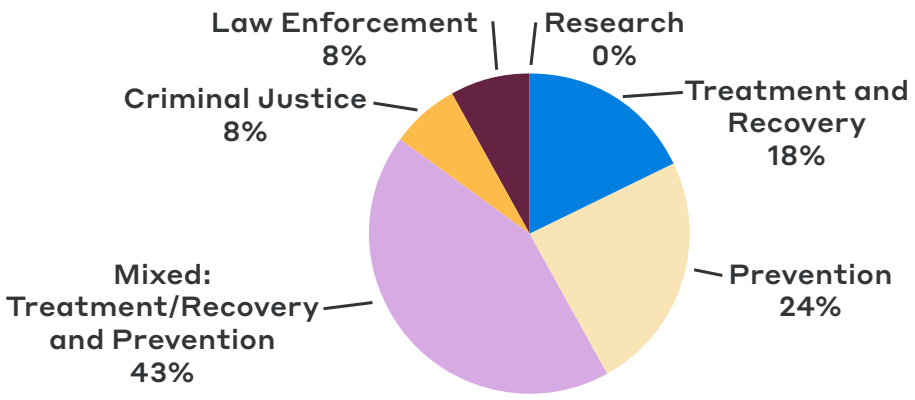


Figure 4: FY2018 Opioid Spending by Category

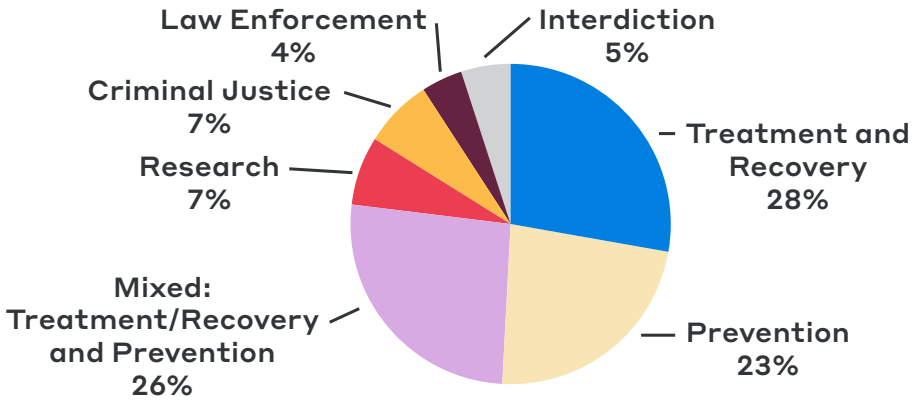
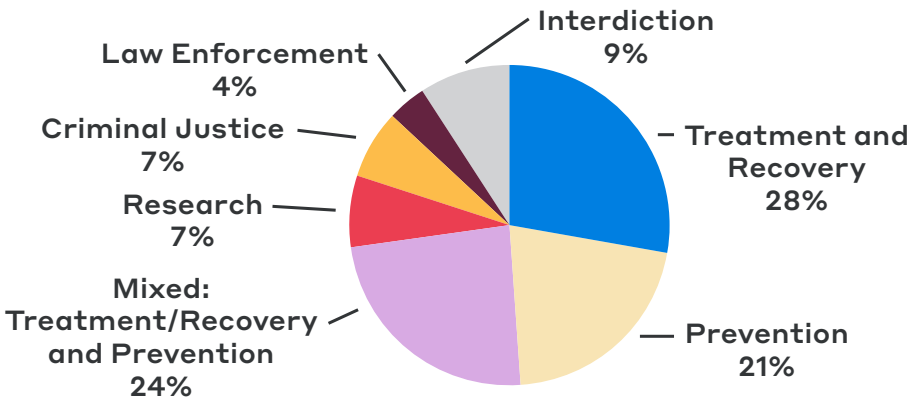


Figure 5: FY2019 Opioid Spending by Category



From FY2017 to FY2018, federal opioid funding across the United States doubled from $10 per capita to $23 per capita. In FY2019, federal funding increased slightly to $25 per capita. To provide additional funding to hard hit states, Congress established a set-aside in both FY2018 and 2019 for states with a disproportionate share of opioid-involved overdose deaths. SAMHSA's SOR grant programming included a 15% set-aside for the 10 states with the highest mortality rates related to drug-poisoning deaths, which was awarded to the District of Columbia, Delaware, Kentucky, Massachusetts, Maryland, New Hampshire, Ohio, Pennsylvania, Rhode Island, and West Virginia. For instance, West Virginia, which had the highest opioid-related mortality rates in both 2017 and 2018, received $47 per capita in FY2019 and $40 in FY2018, compared to only $13 in FY2017. Figure 6, Figure 7, and Figure 8 display per capita funding for every state in FY2017, FY2018, and FY2019, respectively.

Figure 6: Opioid Spending per Capita FY2017

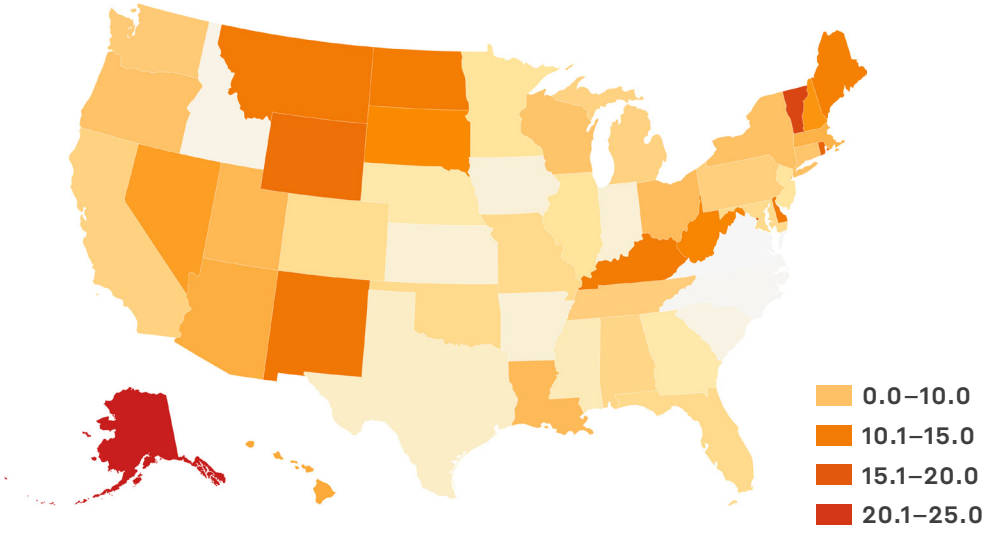


Figure 7: Opioid Spending per Capita FY2018

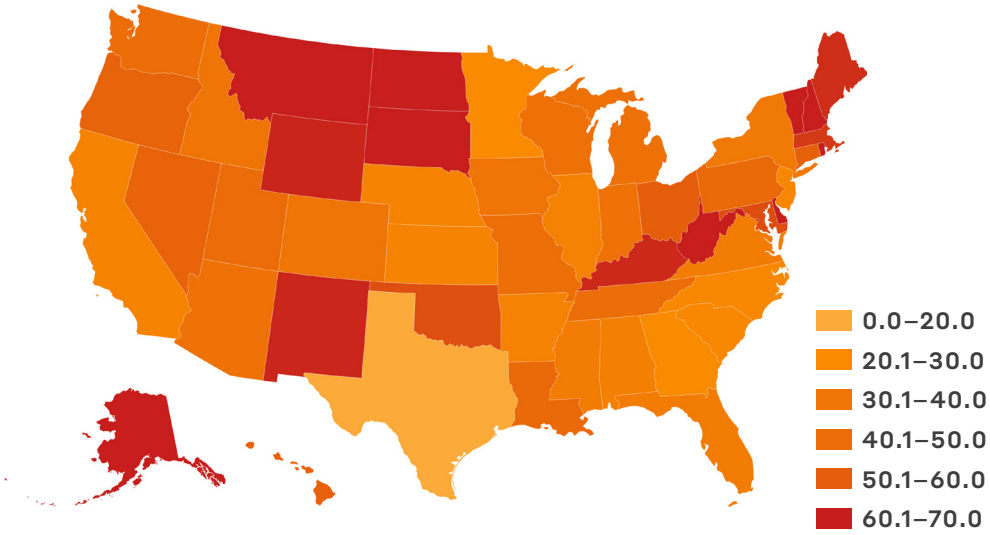
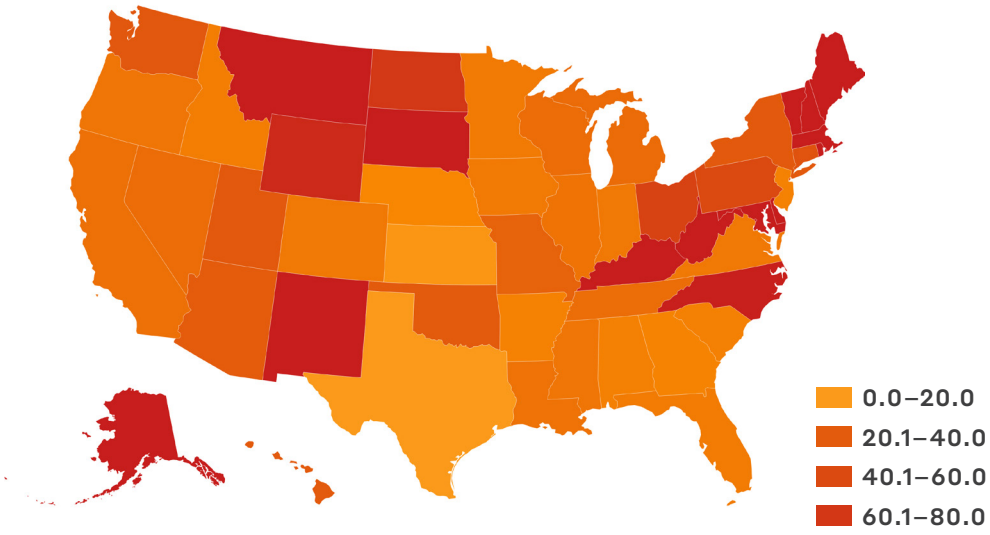
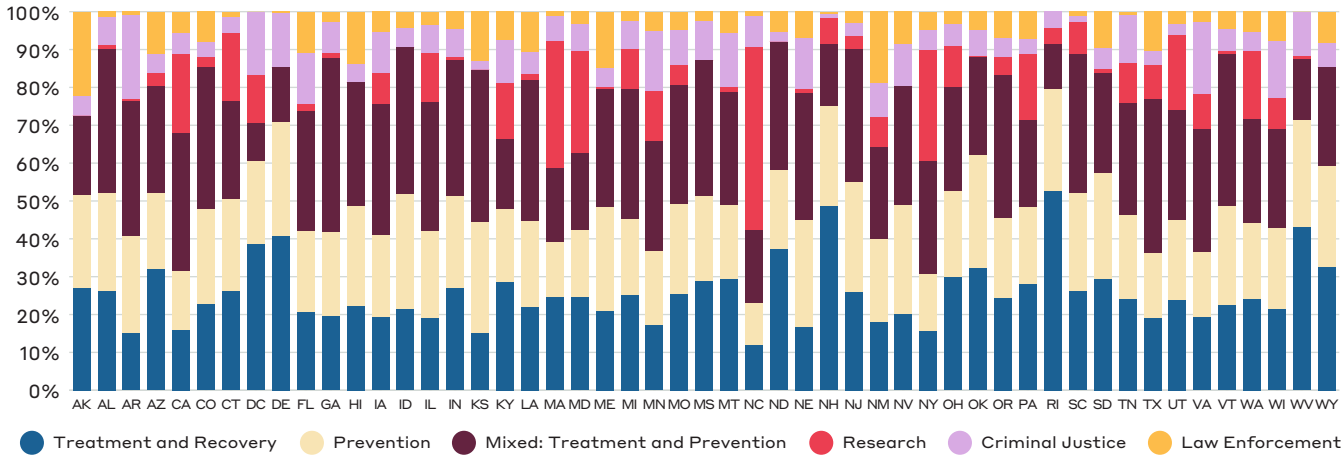


Figure 8: Opioid Spending per Capita FY2019



BPC has also analyzed federal opioid funding in FY2019 by category in each state, displayed in Figure 9. "Treatment and Recovery" (shown in dark blue) is largely from the SOR grant. In the District of Columbia, Delaware, North Dakota, New Hampshire, Rhode Island, and West Virginia, nearly 40% or more opioid funding is spent on treatment and recovery. SABG—categorized as "Mixed: Treatment and Prevention" (shown in maroon)—continues to make up roughly a third of overall spending in each state as with the previous year. Funds categorized as "Prevention" (shown in tan), which include 20% of the STR, SOR, and SABG funds, also continue to make up roughly 25% of spending on average. It is important to note the SABG program is not exclusively for opioid use disorder; however, given the prevalence of opioid use disorder, it is impossible to separate out the amount of the grant spent solely on opioid use disorder versus other substance use disorders.

Figure 9: FY2019 Opioid Spending by State by Category



MEDICAID

Medicaid is a key component of the U.S. response to the opioid epidemic and is the largest payer of substance use disorder services.[48] As of July 2020, 37 states and the District of Columbia have expanded Medicaid, which includes benefits for mental health services and substance use disorder services.[49] According to Kaiser Family Foundation, non-elderly adults with Medicaid were significantly more likely to receive treatment for opioid use disorder than those who have private insurance.[50] Still, only 34% of those with opioid use disorder received treatment across all payers.[51]

Most state Medicaid programs also cover a range of treatment and related services such as inpatient and outpatient detoxification, residential treatment, and intensive outpatient care.[52] The number of opioid-related hospitalizations in the United States increased from 672,900 in 2013 to 974,550 in 2017, yet the rate of uninsured visits decreased from 14% to 6.5%.[53] In 2017, Medicaid was the expected payer for 37% of opioid-related inpatient hospital stays.[54] For

emergency departments, Medicaid was the expected payer in 43% of opioid-related visits in 2017—up from 32% in 2013.[55]

All state Medicaid programs provide coverage of buprenorphine and naltrexone, and 41 state Medicaid programs cover methadone, as well.[56] Medicaid reimbursed $1.53 billion for buprenorphine and naltrexone in 2019—an increase from $1.15 billion in 2017 and $1.34 billion in 2018 (Table 8). However, barriers to further expanding access to MOUDs for Medicaid beneficiaries remain.[57]

Further, there has been a substantial increase in Medicaid spending and funding for the opioid overdose antidote naloxone. In three years, Medicaid funding more than doubled, increasing from $22 million in 2016 to $47 million in 2019. This reflects increased emphasis on naloxone distribution to decrease opioid-involved overdose deaths. Other sources of naloxone funding for states include SOR and SABG, as well as other smaller grants including the Drug Free Communities program. SAMHSA's First Responder Training grant also tripled in size, from $12 million in FY2017 to $36 million in FY2019. Purchasing naloxone, an opioid overdose antidote approved by the FDA, is an allowable use in SAMHSA's First Responder Training grant.

Table 8: Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016–2019[d,58]

	2016	2017	2018	2019
Buprenorphine	$757,111,597	$907,934,790	$1,038,868,488	$1,201,058,620
Naltrexone	$179,597,503	$248,143,006	$302,821,333	$327,632,876
Naloxone	$22,040,501	$18,784,465	$28,677,621	$47,194,386
Total	**$958,749,601**	**$1,174,862,260**	**$1,370,367,442**	**$1,575,885,883**

d BPC was unable to identify Medicaid spending on methadone for opioid use disorder from 2016 to 2019, due to inconsistent data reporting on methadone spending in the State Drug Utilization Data versus spending reported from Opioid Treatment Programs, which is reimbursed under the physician payment code H0020.

Case Studies

ARIZONA

In Arizona, opioid-involved overdose deaths have continued to increase every year from 2015 to 2018. Arizona had the second-highest overdose death rate in the West Census Region in 2018, following New Mexico.[59] Preliminary drug overdose death rates in Arizona demonstrate a 14.5% increase in 2019.[60] Opioid-involved overdose deaths increased 18% per year from 2017 to 2018 (Table 9). The number of deaths involving synthetic opioids, such as fentanyl, surpassed overdose deaths involving prescription opioids and heroin in 2018 and accounted for nearly 50% of opioid-involved overdose deaths in the state (Figure 10; Table 10).[61] As shown in Table 11, the opioid-involved overdose death rate from 2016 to 2018 among non-Hispanic Whites was higher than any other group. Overall drug overdose death rates in Black, Latino, and Asian or Pacific Islander populations were higher in Arizona compared to national death rates; in fact, the Black overdose death rate approached that of non-Hispanic whites (Table 3; Table 11). Blacks have the highest rate of overdose deaths involving stimulants of any racial group in Arizona (Table 11).

Table 9: Arizona Opioid-Involved Death Rates, 2015-2018[62]

Year	Deaths	Arizona Rate*	West Region*
2015	671	10.2	7.4
2016	769	11.4	7.6
2017	928	13.5	8.0
2018	1,106	15.9	8.3
Total	**3,474**	**12.8**	**7.8**

* Age-Adjusted Rate per 100,000

Figure 10: Arizona Opioid-Involved Death Rates[63]

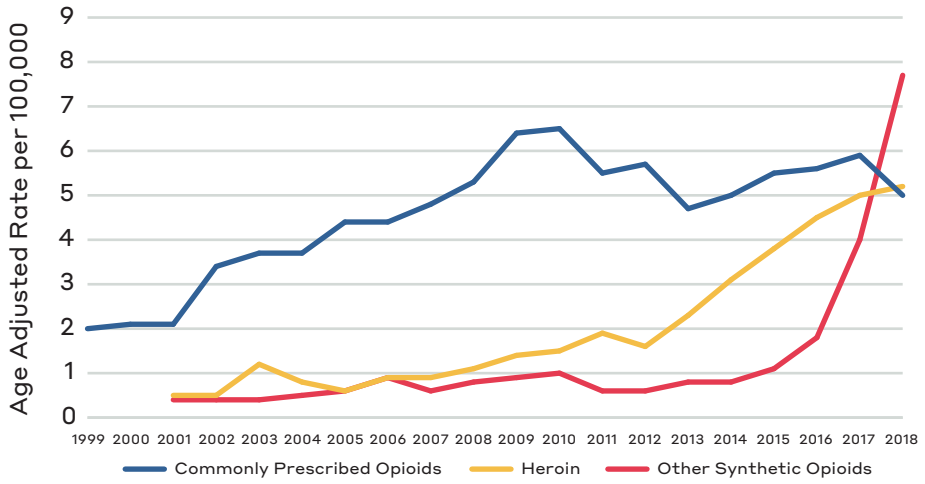


Table 10: Arizona Opioid-Involved Death Rates by Class, 2015-2018[64]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	19.0	10.2	4.5	1.1	3.8	1.1
2016	20.3	11.4	4.8	1.8	4.5	1.1
2017	22.2	13.5	4.9	4.0	5.0	1.2
2018	23.8	15.9	4.3	7.7	5.2	0.9
Total	**21.4**	**12.8**	**4.6**	**3.7**	**4.6**	**1.1**

Table 11: Arizona Drug Overdose Death Rate by Race, 2016-2018[65]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	25.7	16.1	9.9
Non-Hispanic Black or African American	24.0	11.1	15.1
Hispanic or Latino	15.8	10.8	7.1
Non-Hispanic Asian or Pacific Islander	4.9	Unreliable	2.7
Non-Hispanic American Indian or Alaska Native	19.8	10.2	9.9
Total	**22.1**	**13.6**	**9.4**

** Age-Adjusted Rate per 100,000
Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.

Arizona Polysubstance Overdose Death Data

Overdose death data between 2015 and 2018 shows polysubstance use has continually increased in Arizona. In 2018, 66% of overdose deaths involved opioids and 18% involved psychostimulants, including methamphetamine (Figure 11; Table 12). Half of the psychostimulant overdose deaths also involved opioids in 2018 (Table 13). Moreover, the percentage of cocaine deaths involving opioids has steadily increased since 2015, reaching more than 70% of cocaine deaths in 2018 (Table 14).

Figure 11: Arizona Drug Overdose Deaths by Substance, 2018[66]

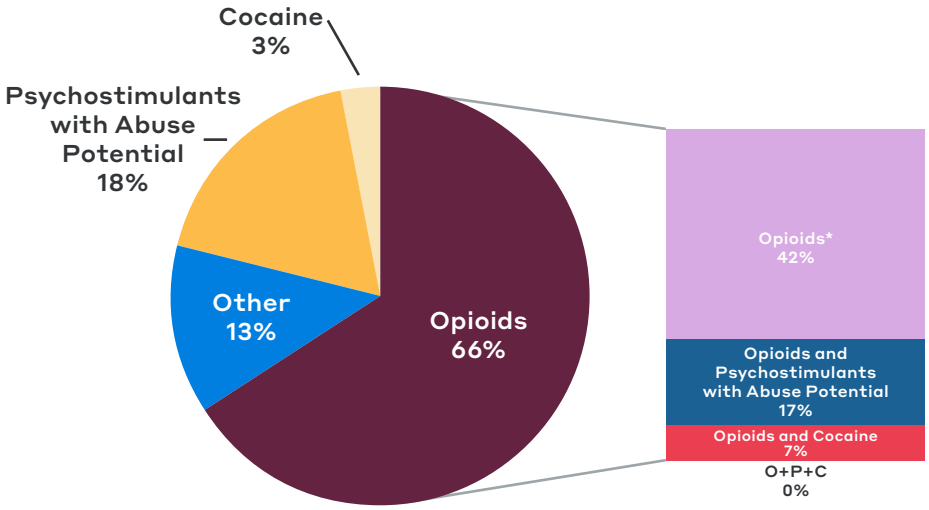


Table 12: Arizona Overdose Deaths, 2015-2018[67]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	1,274	671	53%
2016	1,382	769	56%
2017	1,532	928	61%
2018	1,670	1,106	66%

Table 13: Arizona Psychostimulant Overdose Deaths, 2015-2018[68]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	333	133	40%
2016	454	198	44%
2017	572	247	43%
2018	577	286	50%

Table 14: Arizona Cocaine Overdose Deaths, 2015-2018[69]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	62	31	50%
2016	82	44	54%
2017	136	78	57%
2018	170	120	71%

State Leadership and Federal Appropriations

The Arizona Health Care Cost Containment System, or AHCCCS, administers the SOR and SABG programs. AHCCCS coordinates its efforts with the Arizona Department of Health Services (ADHS) and Governor's Office of Youth, Faith, and Family, which coordinates the state's policy response to the opioid epidemic.

AHCCCS distributes grant funding to three Regional Behavioral Health Authorities, each with a behavioral health coordinator who oversees funding of grants within the region. In addition, Arizona has four Tribal Regional Behavioral Health Authorities. These groups provide treatment for opioid use disorder using all three types of FDA-approved MOUDs and provide outreach and navigation services for treatment.

Arizona's federal funding to combat the opioid epidemic increased by $22.8 million in FY2019, nearly a 20% increase. Funding from SAMHSA increased by 15% in FY2019 and continues to comprise most of the federal spending (Table 15). The SAMHSA increase came from the $17.7 million to the Tribal Opioid Response program, an increase of $15.4 million over FY2018. Funding from DOJ increased by more than $4 million in FY2019, due to new funding for Tribal Assistance Anti-methamphetamine and Anti-opioid Activities Grant with additional funding for Second Chance Act Grants. Arizona's opioid spending by category remained largely the same from FY2018 to FY2019 (Table 16).

Table 15: Arizona Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$59,455,230	$99,380,264	$117,477,783
Substance Abuse and Mental Health Services Administration	$56,746,270	$82,370,933	$94,748,396
Centers for Disease Control and Prevention	$2,170,408	$6,700,713	$8,412,270
Health Resources and Services Administration	$0	$5,488,029	$6,720,572
Administration for Children and Families	$538,552	$2,577,955	$2,440,941
National Institutes of Health	$0	$2,242,634	$5,155,604
Office of National Drug Control Policy	$13,413,416	$13,765,542	$15,003,719
Department of Justice	$3,004,885	$3,913,037	$7,378,338
Department of Labor	$0	$0	$0
Total Opioid Spending	**$75,873,531**	**$117,058,843**	**$139,859,840**

Table 16: Arizona Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	15%	27%	32%
Prevention	22%	25%	20%
Mixed: Treatment/Recovery and Prevention	42%	32%	28%
Research	0%	2%	4%
Criminal Justice	5%	4%	5%
Law Enforcement	15%	10%	11%

Figure 12 shows FY2019 funding per capita by county across the state. Apache County, Greenlee County, and Santa Cruz County have the highest funding per capita due to very small population sizes. Apache County received 12% of Arizona's total federal funding (Table 17). Figure 13 shows the age-adjusted death rate by county from 2016 to 2018. The five counties receiving the largest proportion of federal funding represent 85% of federal funding and 86% of overdose deaths (Table 17). It is important to note funding reflects the location of the recipient of federal funding, which does not necessarily correspond with the service area of the funding (see Appendix V for more details).

Figure 12: Arizona Opioid-Specific Funding per Capita by County, FY2019

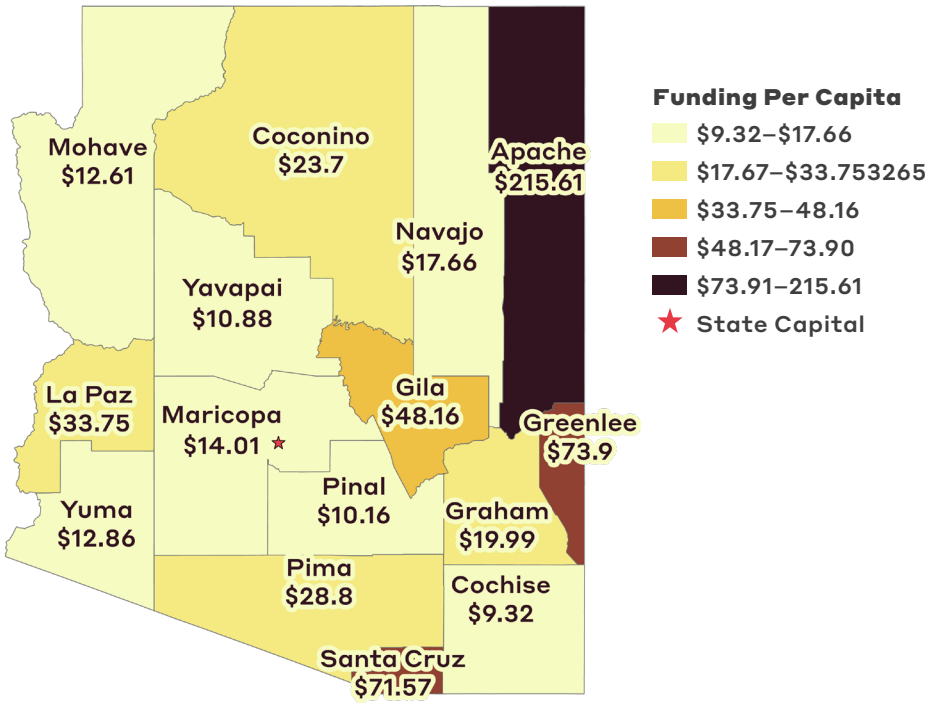
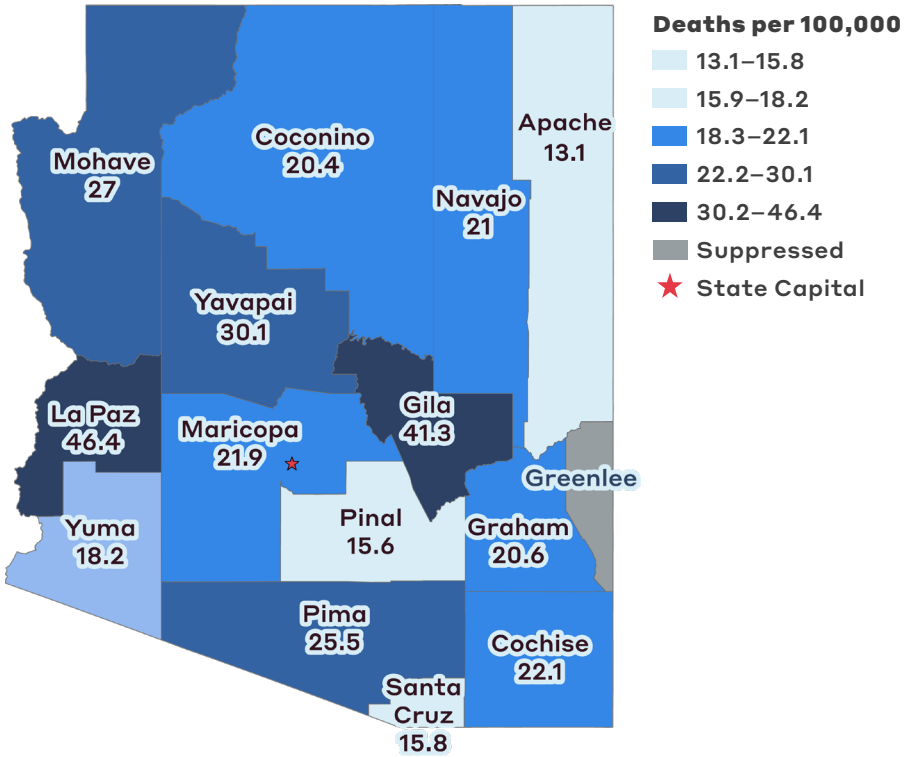


Figure 13: Arizona Age-Adjusted Death Rate by County, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 17: Top 5 Counties Receiving Share of Federal Funding, FY2019

County	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
Maricopa County	$62 (46%)	2,845 (62%)	62%
Pima County	$30 (22%)	749 (16%)	14%
Apache County	$15 (12%)	25 (1%)	1%
Pinal County	$5 (3%)	189 (4%)	6%
Yavapai County	$3 (2%)	180 (4%)	3%

Opioid Use Disorder Treatment and Harm Reduction

In July 2019, Arizona released its Opioid Action Plan 2.0. The plan included recommendations to continue improving access to treatment and prevention services, prescribing practices, and statewide surveillance. Timeline for completion of the recommendations is 2021.[70] Arizona utilized SOR grant funding to build on programs that began with STR funds.[71] A main goal of SOR funding was to expand treatment and recovery services statewide, including comprehensive MOUDs services.[72] All three types of FDA-approved MOUDs are provided in the state.[73] Despite improvements in access, 66% of OTPs are located in Maricopa County—Arizona's most populous county—and access to MOUDs remains low in rural areas.[74] To improve access in rural areas, the state conducted trainings to enlist new buprenorphine-waivered providers.[75]

The Arizona Department of Corrections receives SOR funding to work with community partners providing reentry services for individuals who have been released from prison.[76] The department's reentry services focus on substance use and treatment education, but community partners may provide resource navigation, case management, and MOUDs.[77,78] Within state correctional facilities, however, MOUDs is only offered to pregnant females who are incarcerated.[79] The Arizona Criminal Justice Commission did not receive new funding in FY2019 to implement pre-arrest diversion programs.[80] The commission previously received a planning grant in FY2018 through the DOJ Comprehensive Opioid Abuse Program. In 2019, Arizona was in its third year of funding for SAMHSA's Medication Assisted Treatment-Prescription Drug and Opioid Addiction program—a grant to improve access to MOUDs in drug courts, probation/parole, and within four months of release from correctional facilities in Pima and Maricopa counties.

In addition, the Governor's Office for Youth, Faith, and Family continued the substance use treatment locator, expanded the Positive Parenting Program (Triple P), and launched a statewide stigma reduction media campaign focused on treatment and recovery for opioid use disorder. The substance use treatment locator provides information about available treatment services. Triple P

provides parental support services for parents who are incarcerated, were previously incarcerated, or have received services for intimate partner violence.

The AHCCCS and the ADHS use SOR funding for naloxone distribution activities that were initially established using CDC and STR funding.[81] The ADHS purchases and distributes naloxone to hospitals, law enforcement agencies, community public health agencies, and tribal communities.[82] Between September 30, 2018 and September 29, 2019, 16,924 naloxone kits were distributed, and first responders administered one or more doses of naloxone to 7,772 people who were subsequently discharged alive from a hospital.[83] The AHCCCS has also utilized SABG funding to expand community distribution of naloxone.[84]

Arizona's Opioid Action Plan 2.0 identified providing patients with naloxone at discharge as a strategy to prevent at-risk individuals from future overdoses.[85] In 2019, only 2% of patients were given naloxone upon discharge and 9% were given a prescription upon discharge.[86] The plan aims to increase naloxone distribution for patients at discharge. However, the state has identified lack of funding to purchase naloxone for uninsured or underinsured patients and requiring a physician or pharmacist to provide naloxone as barriers to greater distribution.[87]

Arizona does not use any state or federal funds for syringe services programs.[88]

In addition to federal grants, Table 18 demonstrates that Medicaid spending on buprenorphine and naltrexone for MOUDs and naloxone significantly increased between 2017 and 2018 (52%), complementing the state's efforts to expand treatment and harm reduction activities.

Table 18: Arizona Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2019[89]

	2016	2017	2018	2019
Buprenorphine	$3,495,907	$6,292,062	$11,822,578	$18,841,558
Naltrexone	$362,687	$1,424,315	$2,282,173	$2,667,209
Methadone	$13,354,969	$17,114,076	$22,582,301	$29,925,223
Naloxone[85]	$64,823	$561,027	$1,431,289	$1,630,614
Total	**$17,278,386**	**$25,391,481**	**$38,118,341**	**$53,064,603**

*2018 methadone total projected based on first two quarters of 2018.

Arizona was awarded SAMHSA COVID-19 Emergency Funding. These funds were distributed throughout Arizona via Regional Behavioral Health Authorities and Tribal Behavioral Health Authorities to identify specific behavioral health needs in each region. In response to COVID-19, providers in Arizona have expanded telehealth services and have anecdotally reported increased participation in opioid treatment and decreased no show rates. To reduce risk to patients and providers, opioid treatment programs have allowed

individuals in treatment to take home MOUDs and has begun working on curbside dosing of MOUDs and safe room methadone dosing.

LOUISIANA

Opioid-involved overdose deaths in Louisiana increased between 2017 and 2018, although the rate is still lower than the South region's rate (Table 19). Louisiana ranks 11th out of 17 states in the South region based on age-adjusted mortality rates.[91] Synthetic opioids such as illicitly manufactured fentanyl continues to drive overall overdose death rates, offsetting the reduction in prescription opioid-involved overdose deaths (Figure 14; Table 20). Preliminary 2019 data reveal a 12.1% increase in drug overdose deaths between December 2018 and 2019.[92] Based on available data, non-Hispanic whites have a higher rate of drug overdose deaths compared to Black Americans or Hispanics (Table 21), similar to national trends already presented in the Background (Table 3). With respect to opioids, also noteworthy in Table 21 is that while Black Americans have a higher opioid-involved overdose mortality rate compared to Hispanics nationally (12.4% versus 6.9%), Hispanics have a higher rate compared to Black Americans in Louisiana (6.8% to 5.1%) (Table 3; Table 21).

Table 19: Louisiana Opioid-Involved Death Rates, 2015-2018[93]

Year	Deaths	Louisiana Rate*	South Region Rate*
2015	287	6.3	9.8
2016	346	7.7	12.4
2017	415	9.3	14.1
2018	444	10.0	13.5
Total	**1,492**	**8.3**	**12.5**

*Age-Adjusted Rate per 100,000

Figure 14: Louisiana Opioid-Involved Death Rates[94]

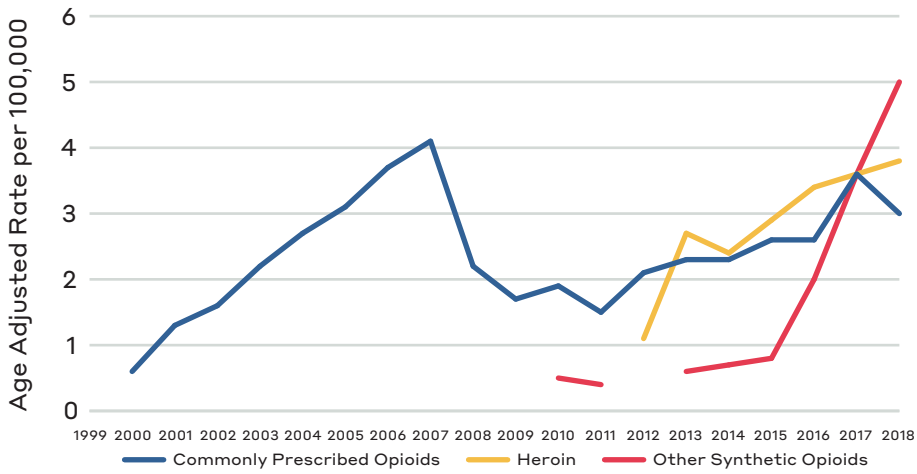


Table 20: Louisiana Opioid-Involved Death Rates by Class, 2015-2018[95]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	19.0	6.3	2.3	0.8	2.9	Unreliable
2016	21.8	7.7	2.3	2.0	3.4	Unreliable
2017	24.5	9.3	3.5	3.6	3.6	Unreliable
2018	25.4	10.0	2.9	5.0	3.8	Unreliable
Total	**22.7**	**8.3**	**2.7**	**2.8**	**3.4**	**0.3**

*Age-Adjusted Rate per 100,000

Table 21: Drug Overdose Deaths by Race, 2016-2018[96]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	29.4	11.6	5.2
Non-Hispanic Black or African American	17.3	5.1	4.7
Hispanic or Latino	11.1	6.8	Unreliable
Non-Hispanic Asian or Pacific Islander	Unreliable	Suppressed	Suppressed
Non-Hispanic American Indian or Alaska Native	Unreliable	Suppressed	Suppressed
Total	**23.9**	**9**	**4.7**

*Age-Adjusted Rate per 100,000
Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.

Louisiana Polysubstance Overdose Death Data

Polysubstance use continues to be a feature of Louisiana's drug overdose death spectrum. The percent of opioids involved in overdose deaths increased slightly in 2018 (Figure 15; Table 22) (Note that this percentage appears significantly lower than the national average, perhaps due to the significant share of "other," or unspecified substances). Further, an increasing share of psychostimulant and cocaine deaths involved opioids (Table 23; Table 24).

Figure 15: Louisiana Drug Overdose Deaths by Substance, 2018[97]

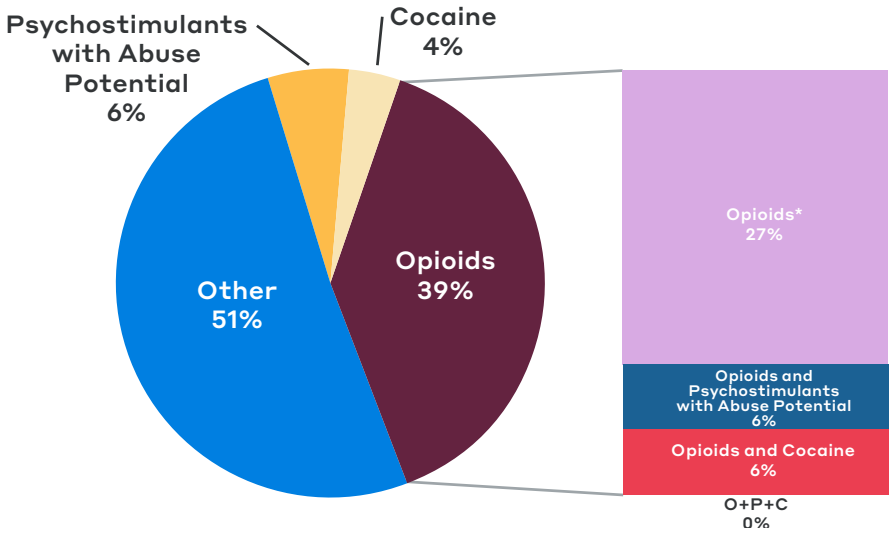


Table 22: Louisiana Overdose Deaths, 2015-2018[98]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	861	287	33%
2016	996	346	35%
2017	1,108	415	37%
2018	1,140	444	39%

Table 23: Louisiana Psychostimulant Overdose Deaths, 2015-2018[99]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	43	13	30%
2016	79	21	27%
2017	100	46	46%
2018	137	64	47%

Table 24: Louisiana Cocaine Overdose Deaths, 2015-2018[100]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	80	35	44%
2016	121	49	40%
2017	136	53	39%
2018	117	72	62%

State Leadership & Federal Appropriations

Since 2017, Louisiana's response to the opioid epidemic has been aided by the Advisory Council on Heroin and Opioid Prevention and Education, or HOPE. The Council is chaired by the Louisiana Department of Health and co-chaired by the Louisiana Department of Children and Family Services. HOPE tracks all state initiatives responding to the opioid crisis and identifies gaps and opportunities to improve agency partnerships. HOPE includes state legislators and senior state agency officials from the departments of the Office of Behavioral Health, Education, Children and Family Services; Public Safety and Corrections; State Police; Veterans Affairs; Office of Workers' Compensation; Insurance; and the Louisiana Supreme Court.[101]

Federal appropriations to address the opioid epidemic are detailed in Tables 25 and 26 below. FY2019 funding by department is roughly similar to FY2018, with the exception of funding from DOJ. Several programs funded by DOJ—such as the Mentally Ill Offender Act (Justice and Mental Health Collaboration), Comprehensive Opioid Abuse Program (COAP), and Second Chance Act Grants—were either eliminated or funding came in the form of one-time grants. However, in FY2019, the Louisiana State Police received funding for the Anti-Heroin Task Force, a program administered by the DOJ's COPS program to support heroin and illegal prescription opioid trafficking investigations.

Table 25: Louisiana Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$39,355,629	$66,603,880	$62,767,644
Substance Abuse and Mental Health Services Administration	$37,972,317	$50,820,229	$47,186,899
Centers for Disease Control and Prevention	$997,702	$4,159,002	$5,434,910
Health Resources and Services Administration	$0	$8,969,833	$7,767,838
Administration for Children and Families	$385,610	$1,661,377	$1,657,820
National Institutes of Health	$0	$993,439	$1,170,177
Office of National Drug Control Policy	$5,480,170	$5,815,883	$6,279,741
Department of Justice	$3,424,118	$9,513,672	$5,677,859
Department of Labor	$0	$0	$0
Total Opioid Spending	**$48,259,917**	**$81,933,435**	**$75,251,417**

Table 26: Louisiana Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	19%	24%	22%
Prevention	21%	21%	23%
Mixed: Treatment/Recovery and Prevention	41%	36%	37%
Research	0%	1%	2%
Criminal Justice	9%	13%	6%
Law Enforcement	9%	6%	11%

Figures 16 and 17 depict FY2019 federal funding to Louisiana and drug overdose death rates in Louisiana between 2016-2018 by parish. The five parishes in the state receiving the greatest share of federal funding represent 75% of total funding and 47% of total overdose deaths (Table 27). It is important to note that funding totals reflect the location of the recipient of federal funding, which does not necessarily correspond with the service area of the funding (see Appendix V for more details).

Figure 16: Louisiana Opioid-Specific Funding per Capita by Parish, FY2019

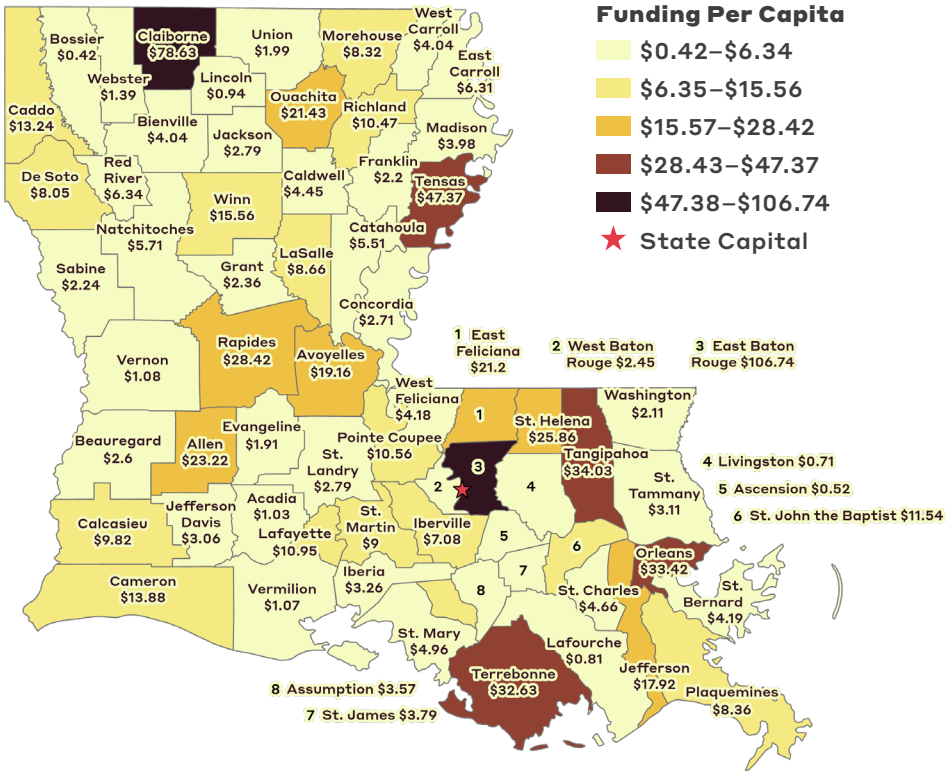
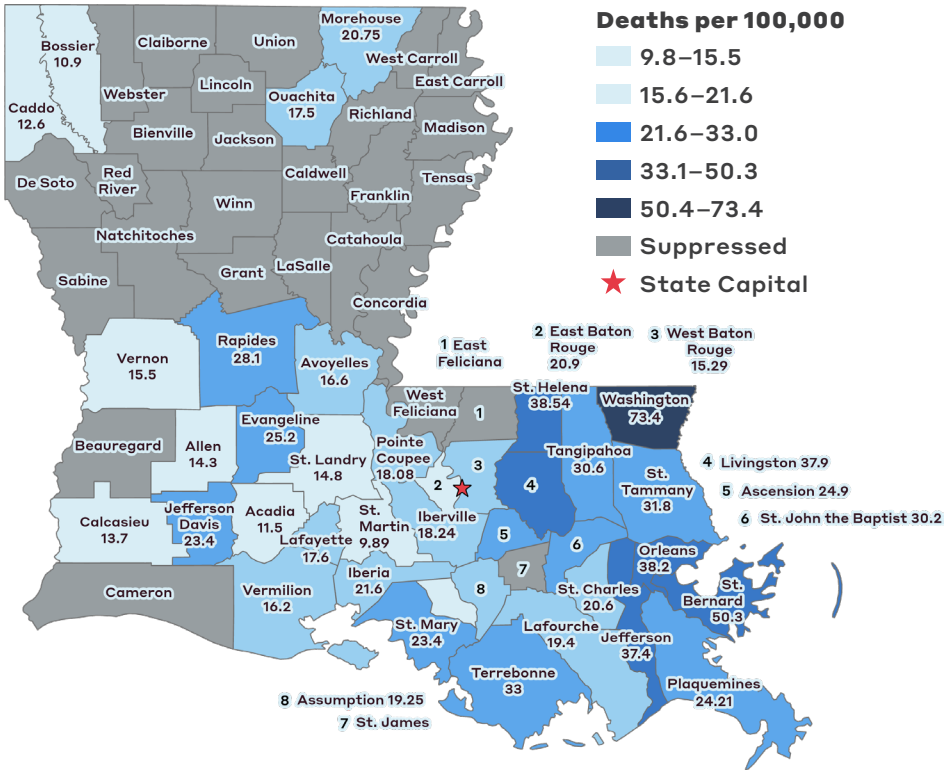


Figure 17: Louisiana Age-Adjusted Death Rate by Parish, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 27: Top 5 Parishes Receiving Share of Federal Funding, FY2019

Parish	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
East Baton Rouge Parish	$47 (46%)	266 (9%)	9%
Orleans Parish	$13 (13%)	463 (15%)	8%
Jefferson Parish	$8 (8%)	480 (16%)	9%
Tangipahoa Parish	$5 (4%)	120 (4%)	3%
Rapides Parish	$4 (4%)	98 (3%)	3%

Opioid Use Disorder Treatment & Harm Reduction

The Louisiana Office of Behavioral Health within the Department of Health administers most of the federal opioid funds the state receives. The Office of Behavioral Health distributes the SOR grant and the SABG to local governing entities and independent opioid treatment programs. Louisiana has 10 local governing entities that encompass all 64 of its parishes. The Louisiana SOR program aims to address the opioid crisis by increasing access to all three FDA-approved medications for opioid use disorder to reduce unmet treatment needs and opioid-involved overdose deaths. The program target populations include the under and uninsured, criminal justice population, state-recognized tribes, pregnant women or women with infants experiencing Neonatal Opioid Withdrawal Symptoms, and prevention in school-age children.[102]

Through the SOR grant, Louisiana has created a hub-and-spoke model to support MOUDs for 2,150 unduplicated individuals (1,300 in year one and 850 in year two), as well as recovery support services for 80 individuals (40 per year for two years), totaling 2,230 individuals served over the two year grant (1,340 in year one and 890 in year two).[103] SOR funding complements state Medicaid spending supporting MOUDs, which continues to increase as shown in Table 28—a 28% increase between 2018 and 2019. Methadone is now covered by Medicaid.[104] However, Louisiana's SOR report points to transportation challenges, a lack of recovery support personnel, and a shortage of opioid treatment programs as barriers to treatment access. In 2019, legislation was passed to increase the number of opioid treatment programs.[105]

Table 28: Louisiana Medicaid Spending on Opioid Treatment Drugs[e] and Naloxone, 2016-2019[106]

	2016	2017	2018	2019
Buprenorphine	$12,102,145	$21,568,180	$26,973,916	$33,875,610
Naltrexone	$308,138	$1,109,879	$1,966,449	$3,304,896
Naloxone	$193,524	$129,498	$317,368	$468,260
Total	**$12,688,603**	**$22,861,767**	**$29,257,734**	**$37,648,765**

The Louisiana SOR grant also provides the opportunity for the local governing entities to coordinate opioid use disorder services with local networks including hospitals and emergency departments. Each entity has been allocated funds for a peer support specialist who connects with first responders to follow up on residents discharged from hospitals or referred by EMS. Entities also have Crisis/Outreach Mobile Teams that include a licensed mental health professional, nurse, and peer support specialist to divert individuals from unnecessary incarcerations and or emergency room visits and serve as a navigator for individuals in need of behavioral health or medical services.[107] In the midst of COVID-19, outreach efforts have occurred via telephone from the local governing entity level, including residents housed at the state-sponsored specific locations set up to house COVID-19 positive individuals in need of quarantine facilities.[108]

There has been a focus around criminal justice efforts in reducing opioid-involved overdose deaths. The state targeted four parishes with the highest rate of opioid use disorder and highest numbers treated for opioid dependence. Certified peer support specialists provide individual and group sessions for participants and provide them with recovery support services. They also provide them with referrals upon discharge to transportation and health care in the community. Specialty court navigators determine if individuals with opioid use disorder are eligible for specialty court referrals or residential treatment. Given the expiration of the COAP grant, the state Department of Corrections is looking at replacement funding. Unfortunately, MOUDs are not being provided for the most part in jails not operated by DOC.[109]

With respect to harm reduction, provider agencies operating syringe services programs are hiring health coordinators to support expansion to Hepatitis C Virus (HCV) and HIV testing and linkage to care. Naloxone has also been dispersed to these identified provider agencies from the SOR grant. The state's goal is to distribute a total of 1,000 Narcan kits statewide (500 in FY2019 and 500 in FY2020); during the first year, the state distributed 566 naloxone kits and educated 1,307 individuals on naloxone statewide.[110]

e Louisiana Medicaid only began methadone coverage for OUD in 2020.

Provider agencies operating syringe services programs are being supported to hire health coordinators to support expansion to HCV and HIV testing and linkage to best practices care. Naloxone has also been dispersed to these identified provider agencies through from the funding from the state SOR grant.

As part of its COVID-19 response, the state was awarded $1.8 million over 16 months by SAMHSA through the Emergency COVID-19 Grant. The grant includes support of a residential substance use disorder provider in New Orleans to increase capacity to service COVID-19 positive patients, hire a case manager, purchase personal protective equipment, and support a Baton Rouge hospital with care coordination services for their new COVID-19 positive unit.[111]

NEW HAMPSHIRE

For the second straight year, New Hampshire experienced a slight reduction in opioid-involved overdose deaths in 2018; however, its opioid-involved overdose death rate was still 50% higher than the Northeast region (Table 29). New Hampshire's age-adjusted mortality rate ranks highest among the nine states in the region.[112] Death rates have stabilized over the last several years due to a plateauing in deaths involving synthetic opioids such as fentanyl, as well as a reduction in deaths involving prescription opioids and heroin (Figure 18; Table 30). Preliminary 2019 data reveal a 11.4% decrease in drug overdose deaths between December 2018 and 2019.[113] Drug overdose death data by race are largely suppressed because of the lack of racial diversity in the state and low overall population. It appears, however, that overall drug overdose mortality rates and specifically opioid-involved overdose mortality rates are markedly higher for both non-Hispanic white and Hispanic populations compared to national rates (Appendix IV).

Table 29: New Hampshire Opioid-Involved Death Rates, 2015-2018[114]

Year	Deaths	New Hampshire Rate*	Northeast Region Rate*
2015	380	31.3	13.6
2016	437	35.8	19.3
2017	424	34.0	21.3
2018	412	33.1	22.8
Total	**1,653**	**33.5**	**19.2**

*Age-Adjusted Rate per 100,000

Figure 18: New Hampshire Opioid-Involved Death Rates[115]

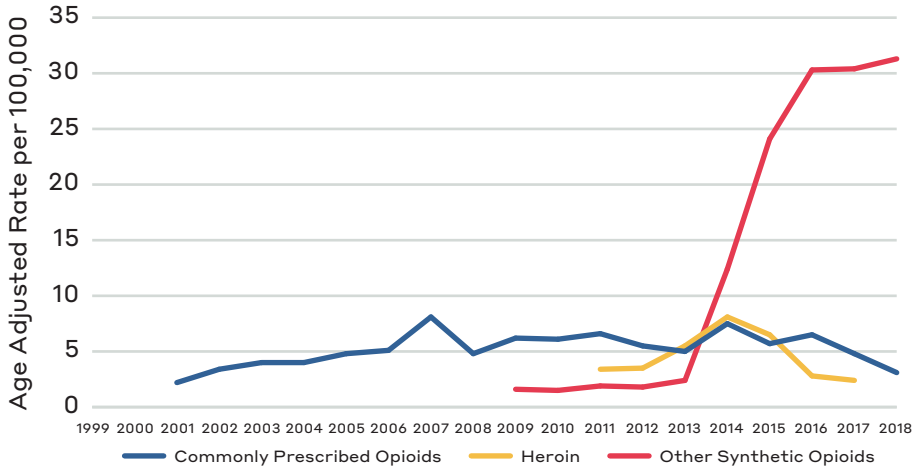


Table 30: New Hampshire Opioid-Involved Death Rates by Class, 2015-2018[116]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	34.3	31.3	4.4	24.1	6.5	1.9
2016	39.0	35.8	5.0	30.3	2.8	2.2
2017	37.0	34	3.9	30.4	2.4	Unreliable
2018	35.8	33.1	2.4	31.3	Unreliable	Suppressed
Total	**36.5**	**33.5**	**3.9**	**29.0**	**3.2**	**1.5**

*Age-Adjusted Rate per 100,000

New Hampshire Polysubstance Overdose Death Data

Opioid-involved overdoses continue to drive overdose death rates in New Hampshire. Over 90% of drug overdose deaths involve opioids, significantly higher than the national average of 69% in 2018 (Figure 19; Table 31).[117] However, New Hampshire has seen an increasing number of overdose deaths involving psychostimulants and cocaine in the last few years (Table 32 and Table 33). SOR grant funding for FY2020 expanded its use of grant funds and allows for use of grant dollars associated with other substances, including cocaine and methamphetamine in its next iteration of the funding to be awarded for use beginning of 2021.

Figure 19: New Hampshire Drug Overdose Deaths by Substance, 2018[118]

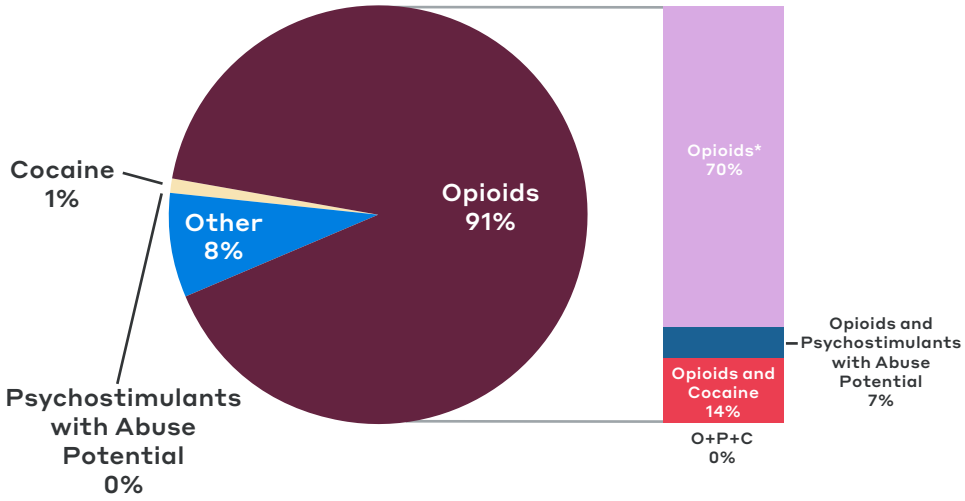


Table 31: New Hampshire Overdose Deaths, 2015-2018[119]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	422	380	90%
2016	481	437	91%
2017	467	424	91%
2018	452	412	91%

Table 32: New Hampshire Psychostimulant Overdose Deaths, 2015-2018[120]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	3	0	0%
2016	13	9	69%
2017	26	23	88%
2018	32	30	94%

Table 33: New Hampshire Cocaine Overdose Deaths, 2015-2018[121]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	47	43	91%
2016	61	55	90%
2017	51	43	84%
2018	68	64	94%

State Leadership & Federal Appropriations

The New Hampshire Governor's Commission on Alcohol and Other Drugs promotes collaboration among state agencies and communities to foster the development of effective community-based substance misuse and addiction programs. The Commission disburses an alcohol fund—roughly $10 million per year; develops a statewide plan to prevent alcohol and drug misuse; promotes the development of addiction treatment, prevention, and recovery services; identifies gaps in the delivery of those services; and makes recommendations to the Governor regarding legislation and funding to address those needs.[122] Last year, the Commission released a 2019-2022 Strategic Plan highlighting key actions to comprehensively address the state's addiction crisis. The plan is a blueprint for the state's shared efforts with a focus on alignment, coordination, innovation, and accountability.[123]

Federal appropriations to New Hampshire to combat the opioid epidemic increased approximately 11% between FY2018 and FY2019 (Table 34). SAMHSA accounted for the largest funding amount by agency, largely due to the SOR grant. Funding from the Administration for Children and Families, or ACF, increased significantly due to the Promoting Safe Families–Regional Partnership Grant. The Regional Partnership Grant supports a program to screen and treat women with opioid use disorder. New Hampshire also received NIH funding for the HEAL Initiative to translate research to practice with the goal of reducing opioid use disorder and overdoses. The Labor Department's National Health Emergency Dislocated Workers Demonstration Grant has expired, but it is still operational through a no-cost extension until 2021. The Dislocated Workers Demonstration Grant provided support and services for workers affected by the opioid overdose epidemic, an important effort in a state with a low unemployment rate.[124] Opioid spending by category was largely level between FY2018 and FY2019, although criminal justice spending decreased noticeably from 5% to 1% due to the relative increases to NIH and SAMHSA (Table 35).

Table 34: New Hampshire Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$13,067,089	$49,708,110	$63,005,599
Substance Abuse and Mental Health Services Administration	$12,581,241	$40,333,301	$46,871,437
Centers for Disease Control and Prevention	$356,373	$4,292,327	$3,672,978
Health Resources and Services Administration	$0	$3,262,257	$4,720,411
Administration for Children and Families	$129,475	$635,313	$3,247,060
National Institutes of Health	$0	$1,184,912	$4,493,713
Office of National Drug Control Policy	$1,500,000	$1,500,000	$996,192
Department of Justice	$1,452,791	$3,297,316	$2,126,491
Department of Labor	$0	$5,000,000	$0
Total Opioid Spending	**$16,019,880**	**$59,505,426**	**$66,128,282**

Table 35: New Hampshire Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	29%	53%	48%
Prevention	28%	24%	26%
Mixed: Treatment/Recovery and Prevention	35%	16%	17%
Research	0%	2%	7%
Criminal Justice	4%	5%	1%
Law Enforcement	4%	0%	1%

Figures 20 and 21 depict FY2019 federal funding to New Hampshire and drug overdose death rates in New Hampshire between 2016-2018 by county. The five counties in the state receiving the greatest share of federal funding represent 91% of total funding, 64% of total overdose deaths, and 61% of the population (Table 36). Funding reflects the location of the recipient of federal funding, which does not necessarily correspond with the service area of the funding (see Appendix V for more details). While this report focuses on federal funds, New Hampshire officials stressed that funding from state and philanthropic sources also addresses substance use across the continuum of care, including significant investments in high need areas of the state.

Figure 20: New Hampshire Opioid-Specific Funding per Capita by County, FY2019

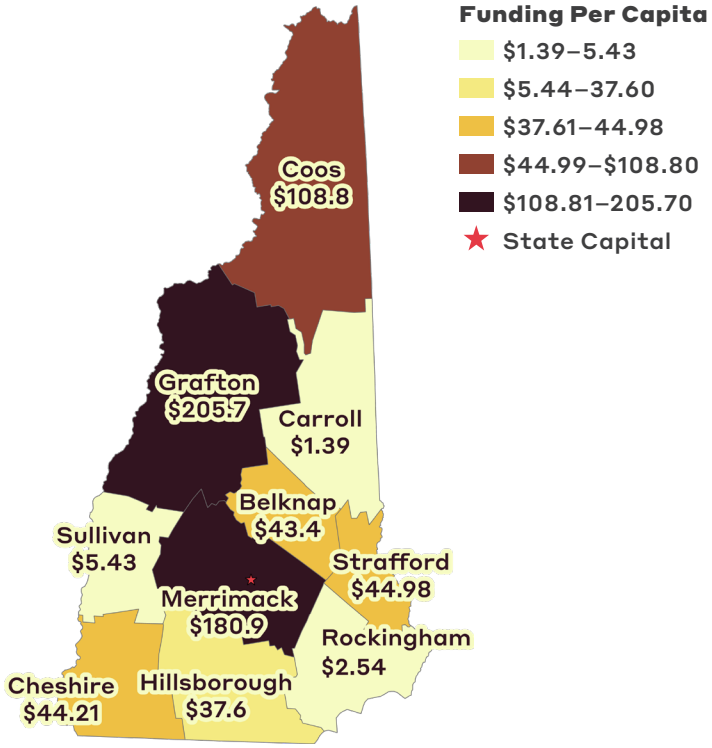
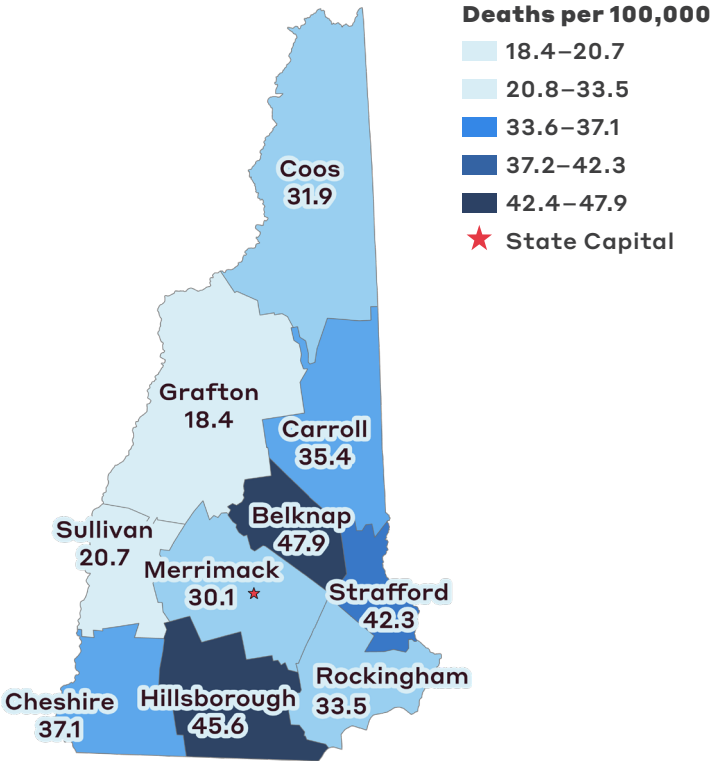


Figure 21: New Hampshire Age-Adjusted Death Rate by County, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 36: Top 5 Counties Receiving Share of Federal Funding, FY2019

County	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
Merrimack County	$27 (35%)	129 (9%)	11%
Grafton County	$18 (24%)	48 (3%)	7%
Hillsborough County	$16 (20%)	540 (39%)	31%
Strafford County	$6 (8%)	153 (11%)	10%
Coos County	$3 (4%)	27 (2%)	2%

Opioid Use Disorder Treatment & Harm Reduction

Almost a quarter of New Hampshire's SOR funds went to restructuring the treatment access system through the implementation of a state specific hub-and-spoke model for access and delivery of OUD services. The hubs, known as Doorways, provide screening; clinical assessments; identify needs services; and referrals to treatment, recovery, and social supports (e.g., housing, childcare) via nine physical locations. The Doorways are located geographically across the state so no one in the state travels more than 60 minutes to enter treatment. The program receives referrals through 2-1-1 and existing referring partners. Additionally, consumers and providers may directly contact the Doorways for services. The Doorways provide screening, evaluation, referrals, and continuous recovery monitoring for each client throughout their experience along the continuum of care, with prioritization given to MOUDs for individuals with OUD when clinically appropriate.[125]

FY 2019 SOR funding to New Hampshire led to 3,698 clients being referred by Doorways for treatment services (1,617 for buprenorphine, 99 for naltrexone, and 79 for methadone treatment). Ultimately, 1,004 clients were seen by MOUDs providers. In addition, SOR funding led to 535 clients being referred to peer recovery support services, with 125 actually being provided services.[126]

New Hampshire's FY2019 SOR grant also focused on provider education. MOUDs Drug Addiction Treatment Act (DATA) waiver courses were provided to over 300 qualified physicians, physician's assistants, and nurse practitioners interested in seeking waivers to prescribe buprenorphine to treat opioid use disorders. Every Department of Corrections provider and clinical staff was trained in MOUDs practices and benefits.[127]

Efforts are being made to expand treatment for incarcerated populations, although state officials report more funding may be needed to track outcomes, as well as ensuring maintenance of treatment upon re-entry.[128] In July, the governor signed into law healthcare omnibus legislation to require MOUDs

in the state's county jails; New Hampshire's next SOR proposal also supports MOUDs for those who are incarcerated.

Given COVID-19, the state has organized a rapid response centered around ten community mental health centers to augment access to treatment services. Individuals can access a comprehensive array of substance use disorder treatment services including evaluations, withdrawal management, outpatient counseling, residential services, MOUDs, and recovery support services.[129] Finally, Medicaid spending on MOUDs has increased over the past few years (Table 37).

Table 37: New Hampshire Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2019[130]

	2016	2017	2018	2019
Buprenorphine	$7,371,792	$9,501,388	$10,794,568	$11,054,534
Naltrexone	$893,541	$1,862,638	$2,348,509	$2,923,708
Methadone[127]	$9,221,699	$9,706,353	$8,976,851	$8,718,518
Naloxone	$69,170	$98,737	$145,161	$190,741
Total	**$17,556,201**	**$21,169,115**	**$22,265,089**	**$22,887,502**

Naloxone continues to be widely distributed in local communities. From the FY2019 SOR grant, 5,221 naloxone kits were distributed, with an estimated 350 overdose reversals. In addition, 402 people released from the Department of Corrections accepted and were trained on the use of Naloxone.[132]

With additional SAMHSA grants, the state implemented NH Project FIRST (First Responders Initiating Recovery, Support, and Treatment), which includes two programs to support first responders in their efforts to reduce opioid-involved deaths and direct interested at-risk individuals toward treatment and recovery. Specifically, in the Naloxone Leave-Behind Initiative, first responders provide naloxone kits, naloxone training, and distribute information on treatment and recovery resources. The Mobile Integrated Healthcare Plan enables first responders to conduct follow-up visits with individuals who have overdosed or with their friends and family. During follow-ups, first responders talk to the at-risk person and their support systems about treatment and harm reduction options and provide opioid overdose naloxone kits and the training to use them—including CPR, rescue breathing, naloxone administration, and information about the Good Samaritan Law. Providers can initiate a referral

for an assessment via The Doorways through 2-1-1. COVID-19 has disrupted program activities for both programs.[133]

Support for syringe services programs continues to receive a mixed response in the state. These programs are largely funded through philanthropic gifts, though one program in Manchester receives federal funding. None of the current syringe services programs receive state funding, although the New Hampshire's Department of Public Health has a current request for proposal posted to fund syringe services programs. During COVID-19, several syringe services programs have shifted to mobile options and have been distributing more sterile syringes, harm-reduction supplies, and naloxone. Those programs that provided linkage-to-care and other harm-reduction services (e.g. HIV/HCV testing, etc.) have gone to a telehealth model, where clients can call those respective programs and 2-1-1 to access one of the Doorways programs to receive assistance.[134]

OHIO

From 2014 through 2017, Ohio had the highest number of opioid-involved overdose deaths per year for any U.S. state, but in 2018 death rates dropped by 24.5%.[135] Although opioid-involved deaths decreased in both Ohio and the Midwest Region, Ohio death rates were still the highest in the region (Table 38)[136]. Decreases in Ohio's opioid-related death rates were observed across opioid categories, including prescription opioids, fentanyl, and heroin (Figure 22; Table 39). Preliminary overdose data from 2019 suggests Ohio is experiencing a 6.9% increase in drug overdose deaths.[137] While the 2019 overdose data are preliminary, Ohio Department of Mental Health and Addiction Services (OhioMHAS) personnel suggested that any increase is related to a continued trend of fentanyl-involved overdoses. The Ohio Department of Health (ODH) reports fentanyl was involved in 73% of overdose deaths in 2018—up from 38% in 2015.[138] Illicitly manufactured fentanyl is often combined with other drugs, including stimulants such as cocaine and methamphetamine.[139]

Between 2016-2018, the overall drug overdose death rate, opioid overdose death rate, and stimulant overdose death rate were higher than national averages for each racial category (Table 3; Table 40). According to the ODH, in 2018 Black, non-Hispanic males had the highest rate of drug overdose deaths compared to other sex, race, and ethnic groups.[140] In 2018, despite a decrease in overdose death of 19.2% among females in Ohio, overdose death rates among Black non-Hispanic females aged 15-44 rose by 6%.[141] Moreover, Blacks in Ohio experienced the highest rate of overdose deaths involving stimulants between 2016-2018 (Table 40).

Table 38: Ohio Opioid-Involved Death Rates, 2015-2018[142]

Year	Deaths	Ohio Rate*	Midwest Region Rate*
2015	2,698	24.7	12.2
2016	3,613	32.9	16.5
2017	4,293	39.2	19.1
2018	3,237	29.6	17.2
Total	**13,841**	**31.6**	**16.3**

*Age-Adjusted Rate per 100,000

Figure 22: Ohio Opioid-Involved Death Rates[143]

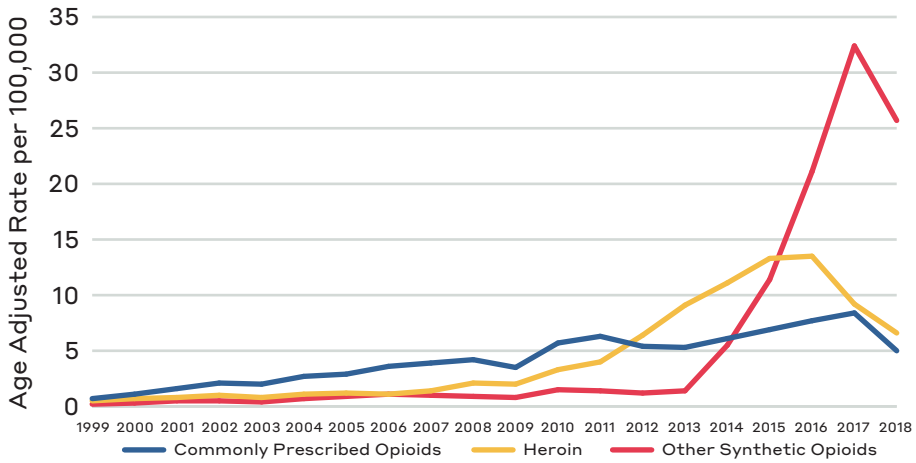


Table 39: Ohio Opioid-Involved Death Rates by Class, 2015-2018[144]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	29.9	24.7	6.1	11.4	13.3	1.0
2016	39.1	32.9	6.9	21.1	13.5	0.8
2017	46.3	39.2	7.6	32.4	9.2	1.0
2018	35.9	29.6	4.4	25.7	6.6	0.6
Total	**37.8**	**31.6**	**6.3**	**22.7**	**10.6**	**0.8**

*Age-Adjusted Rate per 100,000

Table 40: Ohio Overdose Deaths by Race, 2016-18[145]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	44.0	37.3	15.0
Non-Hispanic Black or African American	35.4	27.1	20.0
Hispanic or Latino	22.8	19.9	8.2
Non-Hispanic Asian or Pacific Islander	3.9	2.8	Unreliable
Non-Hispanic American Indian or Alaska Native	28.5	23.9	Suppressed
Total	**40.5**	**33.9**	**14.8**

**Age-Adjusted Rate per 100,000
Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.

Ohio Polysubstance Overdose Death Data

In 2018, opioids were the main driver of overdose deaths in Ohio, and a vast majority of psychostimulant and cocaine deaths also included opioids. In 2018, 81% of overdose deaths involved opioids (Table 41)—higher than the national rates of 69% (Table 2, Background section). In 2018, 74% of psychostimulant-involved deaths, including methamphetamine, and 80% of cocaine-involved deaths also involved opioids (Table 42 and 43). Given the complex nature of substance use issues, the state is now addressing mental health and substance use disorders, more broadly.[146]

Figure 23: Ohio Drug Overdose Deaths by Substance, 2018[147]

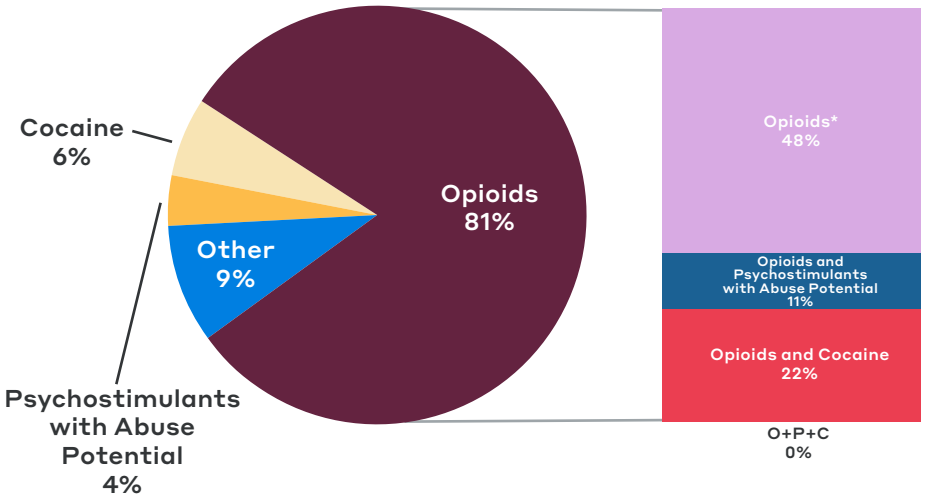


Table 41: Ohio Overdose Deaths, 2015-2018[148]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	3,313	2,698	81%
2016	4,329	3,613	83%
2017	5,111	4,293	84%
2018	3,980	3,237	81%

Table 42: Ohio Psychostimulant Overdose Deaths, 2015-2018[149]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	105	73	70%
2016	243	183	75%
2017	556	439	79%
2018	577	427	74%

Table 43: Ohio Cocaine Overdose Deaths, 2015-2018[150]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	698	563	81%
2016	1,124	901	80%
2017	1,556	1265	81%
2018	1,105	886	80%

State Leadership and Federal Appropriations

To achieve cross-agency coordination, Governor Mike DeWine commissioned RecoveryOhio—a group of representatives from state departments, boards, and commissions. This group works closely with an external Advisory Council, which includes experts from the public and private sector with experience in treatment, prevention, recovery support and criminal justice. The council also includes family members and people with lived experience. In 2019, the Advisory Council was developed recommendations to improve mental health and substance use prevention, treatment and recovery support services in Ohio. RecoveryOhio's goals are to create a system to help make treatment available to Ohioans in need, provide support services for those in recovery and their families, offer direction for the state's prevention and education efforts, and work with local law enforcement to provide resources to fight illicit drugs at the source.Their report is a framework for cross-agency work to tackle the opioid epidemic. To further assist with coordination, the Office of Budget Management has launched the Ohio Grants Management Coalition, which is currently focused on tracking federal funding related to COVID-19 but in the future intends to track all opioid-involved grants.

OhioMHAS administers the majority of federal opioid funds; it distributes the STR grant, SOR grant, and SABG. Ohio is a local rule state that includes 50 ADAMH boards that encompass all 88 Ohio counties. The treatment, prevention, and recovery services provided by ADAMH boards are funded by state, federal, and local tax levy funds.

Federal appropriations to Ohio to address the opioid epidemic increased by approximately 21% in FY2019 from FY2018. SAMHSA programs continued to make up most federal opioid appropriations, or approximately 62% of all opioid funding in FY2019. Ohio received an increase in CDC funding from approximately $8.7 million in FY2018, to $22 million in FY2019 (Table 44). There was also an increase in NIH funding—from approximately $5.9 million to $29.5 million, largely due to the HEAL Initiative. HEAL aims to translate research into improvements in pain management and the prevention and treatment for opioid use disorders. This increase in funding from the NIH is also reflected in the opioid spending by category, which remained largely consistent between FY2018 and FY2019, with one exception—the increase in research spending from 3% to 11% (Table 45).

Table 44: Ohio Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$105,682,024	$197,360,876	$245,246,433
Substance Abuse and Mental Health Services Administration	$101,271,017	$163,668,657	$167,757,488
Centers for Disease Control and Prevention	$3,569,715	$8,667,739	$22,396,877
Health Resources and Services Administration	$0	$15,200,899	$21,504,550
Administration for Children and Families	$841,292	$3,920,859	$4,036,204
National Institutes of Health	$0	$5,902,722	$29,551,314
Office of National Drug Control Policy	$7,348,105	$7,551,607	$9,263,247
Department of Justice	$6,000,736	$20,009,036	$17,042,810
Department of Labor	$0	$0	$0
Total Opioid Spending	**$119,030,865**	**$224,921,519**	**$271,552,490**

Table 45: Ohio Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	21%	33%	30%
Prevention	25%	22%	23%
Mixed: Treatment/Recovery and Prevention	43%	30%	27%
Research	0%	3%	11%
Criminal Justice	7%	9%	6%
Law Enforcement	4%	2%	3%

Figure 24 and 25 depict federal funding per capita across counties and drug overdose rates in Ohio between 2016-2018 per county. According to Figure 24, the highest overdose death rates were clustered in the northeast and southern regions of the state. Although Figure 25 represents total overdose death rates, an overwhelming majority of these deaths involve opioids (Figure 23).

In FY2019, 67% of funding went to counties experiencing 40% of drug overdose deaths in Ohio. These counties are some of the most populous in Ohio and accounted for approximately 37% of the state's population. One caveat is that funding reflects the location of the recipient of federal funding, which does not necessarily correspond with the service area of the funding (see Appendix V for more details).

Figure 24: Ohio Opioid-Specific Funding per Capita by County, FY2019

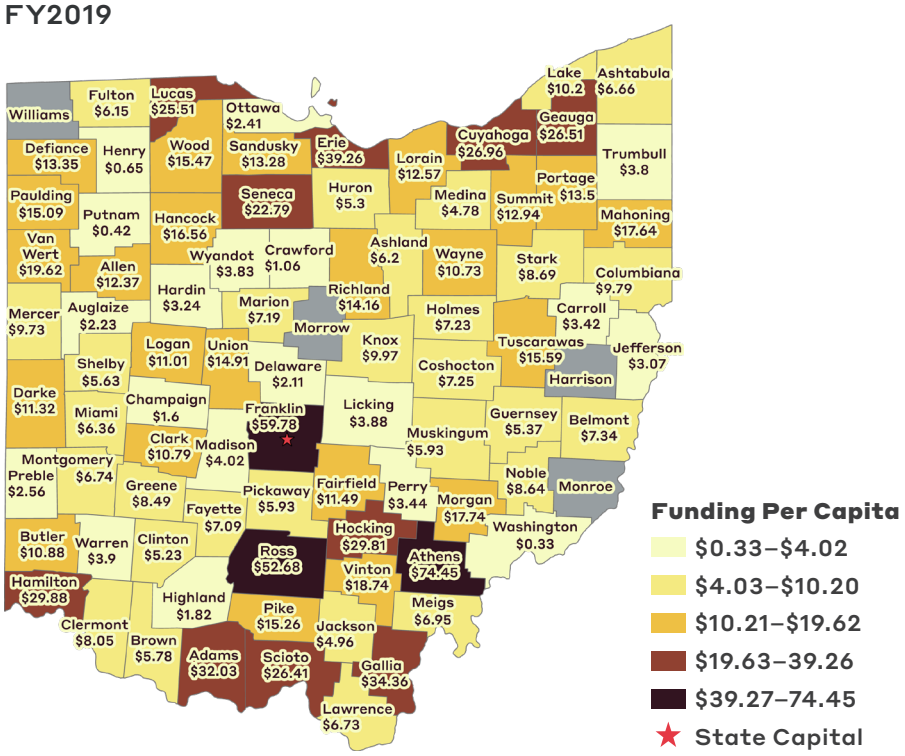
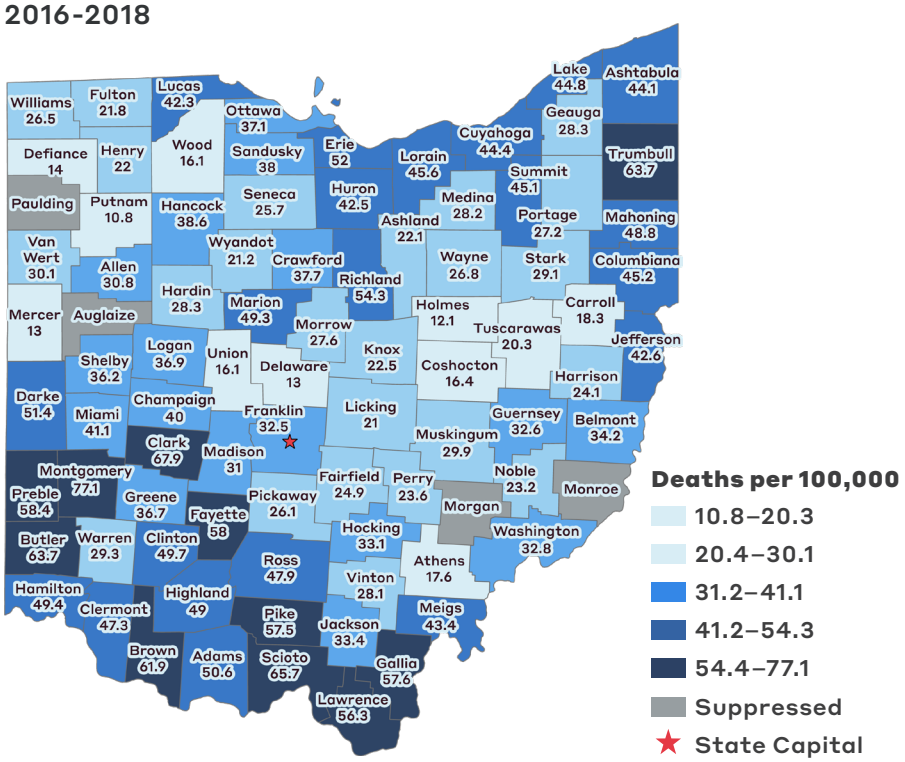


Figure 25: Ohio Age-Adjusted Death Rate by County, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 46: Top 5 Counties Receiving Share of Federal Funding, FY2019

County	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
Franklin County	$78 (34%)	1,288 (10%)	11.2%
Cuyahoga County	$34 (14%)	1,659 (12%)	10.6%
Hamilton County	$24 (11%)	1,172 (9%)	7.0%
Lucas County	$11 (5%)	509 (4%)	3.7%
Summit County	$7 (3%)	700 (5%)	4.6%

Opioid Use Disorder Treatment & Harm Reduction

In FY2019, Ohio received NIH funding to support treatment efforts through the HEALing Communities Study. The goal of this study is to reduce overdose deaths by 40% by testing how tools and strategies can be implemented at the local level to prevent and treat opioid use disorder.[151] Ohio has utilized SOR grant funding to address key barriers to treatment, especially in at-risk populations. For example, the Maternal Opiate Medical Supports, or MOMS, program has served 490 women across twelve sites and resulted in fewer infants with Neonatal Abstinence Syndrome and reduced stays for infants in neonatal intensive care. To increase access to buprenorphine treatment, Ohio has utilized SOR funding to conduct DATA waiver training for prescribers, reaching more than 200 prescribers in the first year of SOR funding. In addition, to target racial disparities in opioid use disorder treatment, Ohio received an SOR supplemental award of $29 million for use in underserved communities that are not able to access other sources of funding. These funds will expand workforce capacity, support culturally competent care training, and increase awareness of OUD among communities of color.[152] Ohio has used a variety of federal funding sources to launch a public information campaign[153] directed to individuals at elevated risk for overdose, including a focus on Black males who are experiencing high overdose death rates.

As for correctional settings, there have been increased efforts to link individuals with MOUDs, as well as case management, behavioral health care, and peer support upon re-entry.[154] One key success is the Community Alternative Sentencing Center that provides group programming, peer support, and MOUDs during incarceration and has reported an 85% success rate, defined by percent of individuals not returning to jail. Additional SOR funding has gone towards linking individuals to employment training and services through local efforts and OhioMeansJobs centers and increasing the number of recovery houses implementing MOUDs.

In Ohio, Medicaid continues to provide critical coverage for inpatient treatment and range of outpatient opioid treatment. In 2019, CMS approved a five-year

demonstration waiver that would allow Ohio to expand residential treatment services for individuals with an opioid or substance use disorder in an effort to shift away from inpatient settings towards treatment in communities and residential settings.[155] In 2019, Medicaid reimbursed over $112 million for buprenorphine and naltrexone (Table 47).

Ohio has focused its harm reduction efforts on increasing access and distribution of naloxone and syringe services programs. Ohio General Revenue and federal funds cover the costs of purchasing naloxone. In FY2019, Ohio distributed 27,750 naloxone kits. Expansion of naloxone distribution through these programs has been delayed as a result of COVID-19[156] Ohio has a number of syringe services programs across six counties that offer a range of services, including hepatitis C screening, wound care, fentanyl test strips, naloxone, and connections to treatment and wrap around services. One of the most successful harm reduction programs in the Summit county region of the state has exchanged over 91,000 syringes.[157] Another SSP in the region is co-located with a Family Recovery Center clinic that offers MOUDs and behavioral health counseling. During the pandemic, OhioMHAS and ODH have increased shipments of naloxone to syringe services programs. Funding for syringe services programs comes from both SOR dollars going towards naloxone distribution, peer support, and linkage to care, as well as funds from CDC's HIV prevention program funding. In order to expand funding for SSPs, ODH filed a Determination of Need with the CDC, which allows federal funds to support staffing and operating costs at SSPs, but does not support purchase of syringes.[158,159]

To further advance harm reduction, SOR funds have supported Project DAWN (Deaths Avoided With Naloxone), a collaboration between the ODH and the Office of Criminal Justice to provide overdose education and increase distribution of naloxone. A recent collaboration with the nonprofit NEXT Naloxone that provides mail order naloxone distribution[160] was able to ramp up its services during COVID-19.[161] Another successful partnership with law enforcement has been the Quick Response Teams, which have been duplicated in additional states, including Kentucky[162] and West Virginia.[163] This team of first responders, law enforcement, certified peer supporters, and health care providers are deployed to provide follow-up and connections to treatment to individuals who have overdosed.[164]

Ohio received SAMHSA COVID-19 Emergency Funding to expand existing crisis services and to prioritize support for behavioral health services for children and adults with serious mental illness, substance use disorders, and co-occurring conditions.[165] Staff outreach with OhioMHAS, revealed that telehealth expansion during COVID-19 may have increased the number of individuals engaging with SUD treatment across Ohio. During the public health emergency, Ohio has allowed OTPs to provide a 14-day supply of methadone, along with naloxone, for individuals in treatment. Other efforts in response to COVID-19 have included early release of prisoners to mitigate the

spread of the virus and easing the 120 day restriction to Community Transition Program that provides links to MOUDs, counseling, and housing resources, among other services, for individuals released from the criminal justice system. Finally, in response to the COVID-19 pandemic, Ohio was able to use HEALing Community research funds to provide naloxone to individuals leaving the criminal justice system who were at high risk of opioid overdose.[166]

Table 47: Ohio Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2019[167]

	2016	2017	2018	2019
Buprenorphine	$81,326,864	$88,381,334	$86,884,759	$72,146,547
Naltrexone	$30,426,294	$46,611,205	$47,255,453	$40,687,852
Naloxone	$1,135,023	$1,132,691	$1,718,756	$3,162,348
Methadone	†	†	†	†
Total	$112,888,181	$136,125,230	$135,858,968	$115,996,747

†Due to the marginal cost, Ohio Medicaid includes the methadone medication cost in the administration payment; therefore the cost of the methadone medication alone cannot be separately calculated at this time.

TENNESSEE

Opioid overdose death rates increased slightly between 2017 and 2018 while rates in the South region decreased slightly (Table 48). Tennessee ranks 6th out of 17 states in the South Region in terms of age-adjusted mortality rates from opioid overdoses.[168] Tennessee's upward trend continues to be driven by heroin and synthetic opioid-involved overdoses such as fentanyl (Figure 26; Table 49). However, as we have seen nationwide, opioid overdose death rates involving prescription opioids have decreased significantly since 2016, which correlates to lower rates of opioid prescribing both in Tennessee and across the country.[169] Preliminary 2019 data reveal a 16.4% increase in drug overdose deaths between December 2018 and 2019.[170] Overall drug overdose death rates and opioid overdose death rates for non-Hispanic whites are roughly twice as high as for Black Americans and four times as high for Hispanics (Table 50). Opioid overdose deaths for Black Americans and Hispanics in Tennessee are roughly the same as rates nationwide (Table 3; Table 50).

Table 48: Opioid-Involved Death Rates, 2015-2018[171]

Year	Deaths	Tennessee Rate*	South Region Rate*
2015	1,038	16.0	9.8
2016	1,186	18.1	12.4
2017	1,269	19.3	14.1
2018	1,307	19.9	13.5
Total	**4,800**	**18.3**	**12.5**

*Age-Adjusted Rate per 100,000

Figure 26: Tennessee Opioid-Involved Death Rates[172]

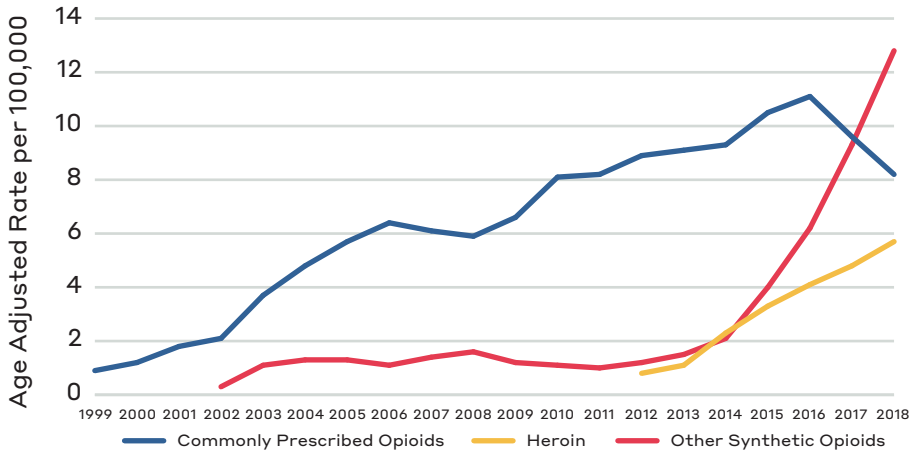


Table 49: Tennessee Opioid-Involved Death Rates by Class, 2015-2018[173]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	22.2	16.0	9.7	4.0	3.3	1.0
2016	24.5	18.1	10.2	6.2	4.1	1.3
2017	26.6	19.3	8.8	9.3	4.8	1.0
2018	27.5	19.9	7.4	12.8	5.7	1.0
Total	**25.2**	**18.3**	**9.0**	**8.1**	**4.5**	**1.1**

*Age-Adjusted Rate per 100,000

Table 50: 2016-2018 Drug Overdose Deaths by Race[174]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	30.3	22.4	9.3
Non-Hispanic Black or African American	16.9	11.0	9.5
Hispanic or Latino	7.8	6.1	Unreliable
Non-Hispanic Asian or Pacific Islander	Unreliable	Unreliable	Suppressed
Non-Hispanic American Indian or Alaska Native	Unreliable	Suppressed	Suppressed
Total	**26.2**	**19.1**	**8.6**

**Age-Adjusted Rate per 100,000
Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.

Tennessee Polysubstance Overdose Death Data

The majority of drug overdose deaths in Tennessee involve opioids and over a third of these opioid deaths also involve other substances (Figure 27; Table 51). More than half of psychostimulant, including methamphetamine, and cocaine deaths continue to involve opioids (Table 52; Table 53). The Tennessee Department of Children's Services reported seeing an increase in methamphetamine use among parents needing treatment for substance use, as well as an increase in neonatal methamphetamine exposure. Trainings for staff now focus on drug-exposed children, rather than a specific substance such as opioid-related neonatal abstinence syndrome.[175]

Figure 27: Tennessee Drug Overdose Deaths by Substance, 2018[176]

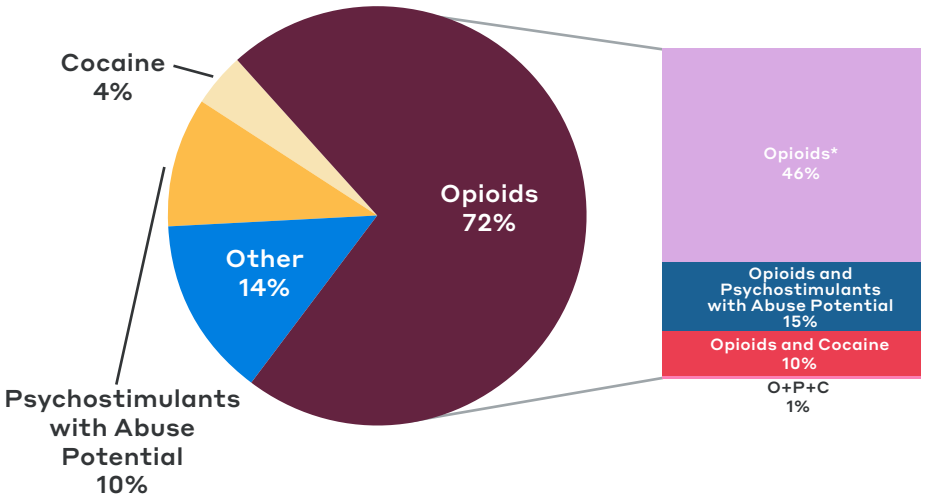


Table 51: Tennessee Overdose Deaths, 2015-2018[177]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	1,457	1,038	71%
2016	1,630	1,186	73%
2017	1,776	1,269	71%
2018	1,823	1,307	72%

Table 52: Tennessee Psychostimulant Overdose Deaths, 2015-2018[178]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	113	66	58%
2016	186	111	60%
2017	320	178	56%
2018	463	281	61%

Table 53: Tennessee Cocaine Overdose Deaths, 2015-2018[179]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	202	124	61%
2016	249	153	61%
2017	306	195	64%
2018	252	175	69%

State Leadership & Federal Appropriations

Tennessee continues to organize its statewide opioid response through its TN Together program that focuses on prevention, treatment, and law enforcement. The Tennessee Department of Mental Health and Substance Abuse Services, or TDMHSAS, administers the majority of the opioid grants the state receives from the federal government. TDMHSAS allocates the SOR grant and the SABG to seven Behavioral Health Planning Regions in all 95 Tennessee counties. Through its grant programs, the Tennessee Department of Health also plays a critical role in supporting prescriber education, conducting surveillance, and coordinating a comprehensive and multifaceted data-driven response to the opioid epidemic.[180]

Federal appropriations to Tennessee to help combat the opioid epidemic were similar between FY2018 and FY2019. The biggest increase involved NIH research spending (Table 54; Table 55) for the HEAL Initiative grants. Specifically, the state received five HEAL Initiative grants targeted at the treatment of opioid addiction and pain management.[181]

Federal Appropriations to Tennessee

Table 54: Tennessee Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$57,895,196	$97,218,827	$101,085,934
Substance Abuse and Mental Health Services Administration	$54,619,043	$76,847,566	$72,007,582
Centers for Disease Control and Prevention	$2,775,304	$7,126,573	$6,696,197
Health Resources and Services Administration	$0	$7,141,106	$7,597,614
Administration for Children and Families	$500,849	$2,700,566	$2,754,876
National Institutes of Health	$0	$3,403,016	$12,029,665
Office of National Drug Control Policy	$2,204,410	$2,232,386	$1,391,220
Department of Justice	$3,258,457	$15,152,890	$12,125,166
Department of Labor	$0	$0	$0
Total Opioid Spending	**$63,358,063**	**$114,604,103**	**$114,602,320**

Table 55: Tennessee Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	29%	29%	24%
Prevention	24%	23%	22%
Mixed: Treatment/Recovery and Prevention	40%	29%	30%
Research	0%	3%	10%
Criminal Justice	7%	15%	13%
Law Enforcement	0%	1%	1%

Figures 28 and 29 represent Federal FY2019 funding to Tennessee and drug overdose death rates for Calendar Years 2016-2018 by county. It is important to note funding totals reflect the primary location of the agency administering the federal funds, which does not necessarily correspond with the service area of funding (see Appendix V for more details). For example, Lewis County is the primary location for one of the largest treatment providers in Tennessee. Lewis County has a population of 12,086 (as of 2018) and receives $261.15 per capita. However, for State FY2019, the agency in Lewis County provided services to individuals in 92 of the 95 counties. The five counties in the state receiving the greatest share of federal funding represent 81% of total funding and 44% of total overdose deaths (Table 56).

Figure 28: Tennessee Opioid-Specific Funding per Capita by County, FY2019

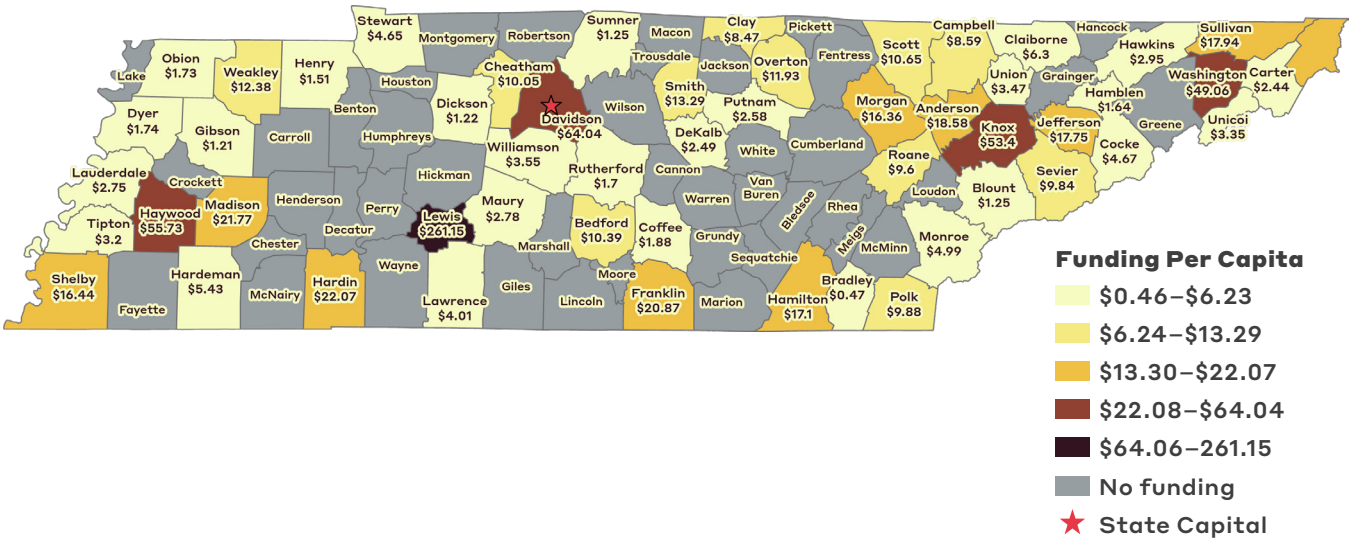
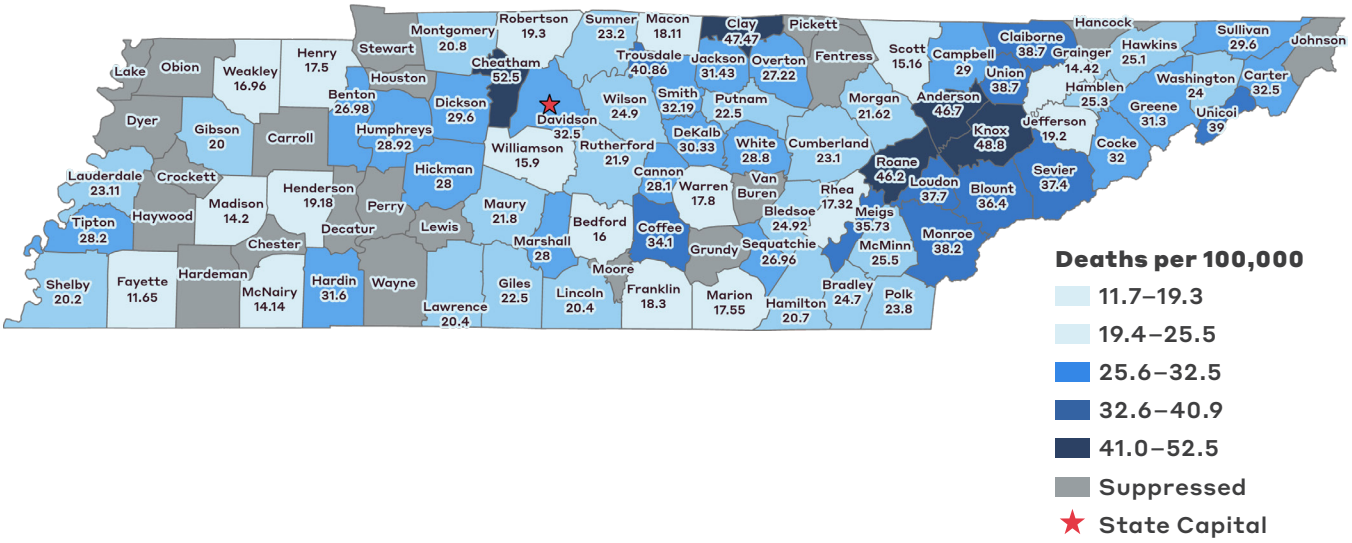


Figure 29: Tennessee Age-Adjusted Death Rate by County, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 56: Top 5 Counties Receiving Share of Federal Funding, FY2019

County	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
Davidson County	$44 (37%)	706 (14%)	10%
Knox County	$25 (21%)	679 (13%)	7%
Shelby County	$15 (13%)	563 (11%)	14%
Washington County	$6 (5%)	92 (2%)	2%
Hamilton County	$6 (5%)	220 (4%)	5%

Opioid Use Disorder Treatment and Harm Reduction

Through its SOR grant, Tennessee has implemented several hub-and-spoke models throughout the state to increase access to treatment, particularly in rural, underserved parts of the state. In addition, the state has deployed Recovery Navigators and Regional Overdose Prevention Specialists, referred to as ROPS, to support individuals at high risk for overdose. Recovery Navigators, who are certified peer recovery specialists, work with 31 hospitals and their emergency departments to follow-up with individuals who experienced a non-fatal overdose. Regional Overdose Prevention Specialists—RNs, emergency medical technicians, or certified peer recovery specialists—provide overdose prevention education and access to naloxone, address stigma, and share information for other harm reduction and treatment resources.

Results from the first year of the SOR grant demonstrate that 999 clients received treatment services: and of those 525 received methadone, 207 received buprenorphine, and 117 received injectable naltrexone. In addition, 613 clients received recovery support services. With respect to naloxone, 23,628 kits were distributed with SOR funds and 7,675 opioid overdose reversals were reported between September 2018 and September 2019. In the same timeframe, 52,810 individuals were trained by the ROPS.[182]

With respect to harm reduction, the efforts of both these professionals have transitioned to virtual trainings and no-contact distribution during COVID-19. For naloxone distribution, agencies have set up a weekly time for individuals to pick up naloxone in the parking lot or leave it on the hood of a car or in a mailbox for pickup. More broadly, Tennessee Department of Mental Health and Substance Abuse Services received a $2 million federal grant from SAMHSA to provide additional services in response to COVID-19. The funding will expand behavioral healthcare treatment to Tennessee residents by increasing services, including telehealth services, statewide. Activities will include, as appropriate: 1) screening and assessment; 2) evidence-based, population-appropriate treatment services; and 3) recovery support services, provided to a focus population of Tennessee residents with severe mental illness (SMI), mental

disorders less severe than SMI, substance use disorders (SUD), and co-occurring SMI and SUD, or COD.

Harm reduction efforts include syringe services programs, which are now sanctioned in the state upon receiving approval from the state health department since 2017. Syringe services programs are approved for operation and monitored and receive some funding through the Tennessee Department of Health. These syringe services programs facilitate HIV and Hepatitis C testing, distribute and collect used syringes and other supplies, and make referrals to treatment and for various social services (e.g., housing).[183] Naloxone is provided to SSP's through a partnership with the TN Department of Mental Health and Substance Abuse Services. State officials estimate that partnerships developed with SSPs to provide monthly naloxone supplies have resulted in an average of 600 lives saved monthly from naloxone distributed to SSPs.[184]

The CDC is also funding the Tennessee Department of Health in employing overdose prevention programs in the most highly impacted areas of the state through the Overdose Data to Action Cooperative Agreement, or OD2A. OD2A requires the state to identify areas of need through data and allocate funding to local jurisdictions for evidence-based public health interventions aimed at reducing fatal and non-fatal overdose. The state's high-impact areas represent the largest population centers and several rural and suburban counties surrounding the population centers. The funding is supporting 20 multi-sector large-scale interventions across the state including: development of substance misuse task forces, development of regional acute overdose response plans, prevention education programs, correctional setting MAT and navigation programs, expansion of syringe-services, rapid team response to overdose from the emergency department and EMS settings, and linkage to care programs from health departments.[185]

The state Medicaid program, TennCare, and its Managed Care Organizations (MCOs) have also increased its focus on treatment by implementing a comprehensive high-quality Medication-Assisted Treatment (MAT) Provider Network. This statewide network launched January 1, 2019. Providers who participate in the specialized MAT Provider Network must comply with the clinical care and quality review requirements, which includes counseling and care coordination. The state has developed the ability to educate, partner with, and financially support high-quality MOUDs providers through the network. Additionally, the MAT Provider Network allows for enhanced data reporting and transparency. The state and MCOs partner with the network to better evaluate provider capacity, track member clinical outcomes, review clinical care requirements, and review quarterly quality metric reports.[186] While overall Medicaid spending on opioid treatment drugs remained fairly constant between 2017 and 2018 (Table 57), as of July 2020, the state program started covering methadone as a form of MOUDs.

Table 57: Tennessee Medicaid Spending on Opioid Treatment Drugs[f] and Naloxone, 2016-2019[187]

	2016	2017	2018	2019
Buprenorphine	$5,706,000	$4,198,833	$4,531,924	$4,635,696
Naltrexone	$12,930,940	$10,686,038	$10,826,717	$8,923,586
Naloxone	$577,666	$106,638	$181,395	$508,188
Total	**$19,214,606**	**$14,991,509**	**$15,540,035**	**$14,067,470**

WASHINGTON

From 2015-2018, Washington's opioid-involved death rate remained consistently around 9%, and above average in the Western region of the United States (Table 58). In 2018, heroin continued to be the main driver of opioid-involved deaths. Decreases in opioid-involved deaths from 2017 to 2018 were not uniform across substances; prescription drug death rates dropped from 3.1% to 2.7%, but rates for heroin-involved and fentanyl-involved deaths increased slightly (Table 59; Figure 30). Preliminary overdose death data from 2019 suggest a 7.5% increase from 2018.[188]

In Washington, the opioid epidemic has disproportionately impacted Black and Native communities. From 2016-2018, drug overdose death rates in Non-Hispanic Black groups and Non-Hispanic American Indian or Alaska Native groups were 20.5 and 51.1, respectively, compared to 16.3 for White Americans (Table 60). While the overdose death rate from 2016-2018 in white American populations was below national rates, this was not the case for Black and American Indian or Alaska Native groups whose rates were two times higher than national overdose death rates (Table 3; Table 60). Moreover, the American Indian/Alaska Native groups experienced stimulant involving death rates four times higher and Blacks experienced rates two times higher than white populations (Table 60). Discrepancies between opioid-involved death rates were less stark between white and Black populations, but both rates were lower than those observed in American Indian or Alaska Native groups (Table 60).

Table 58: Opioid-Involved Death Rates, 2015-2018[189]

Year	Deaths	Washington Rate*	West Region Rate*
2015	692	9.3	7.4
2016	709	9.4	7.6
2017	742	9.6	8.0
2018	737	9.4	8.3
Total	**2,880**	**9.4**	**7.8**

*Age-Adjusted Rate per 100,000

f Tennessee Medicaid does not cover methadone for opioid use disorder.

Figure 30: Washington Opioid-Involved Death Rates[191]

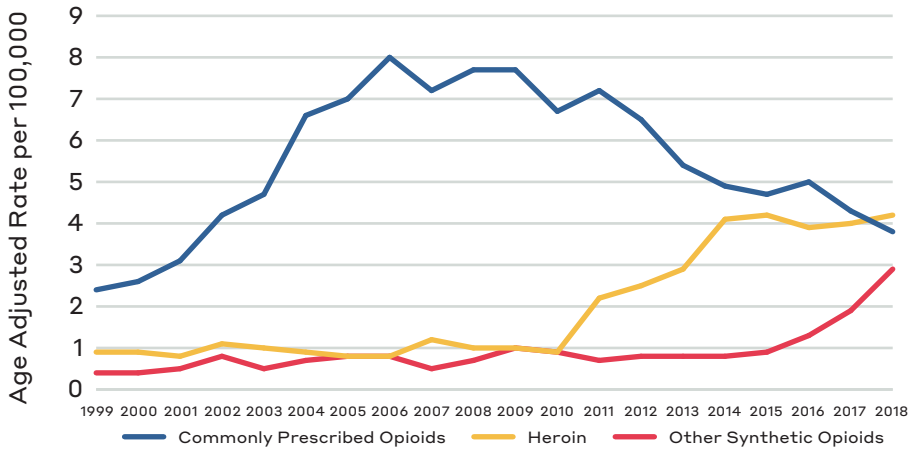


Table 59: Washington Opioid-Involved Death Rates by Class, 2015-2018[190]

Year	All Drugs	Any Opioid	Rx Opioids	Fentanyl	Heroin	Methadone
2015	14.7	9.3	3.5	0.9	4.2	1.4
2016	14.5	9.4	3.7	1.3	3.9	1.6
2017	15.2	9.6	3.1	1.9	4.0	1.5
2018	14.8	9.4	2.7	2.9	4.2	1.1
Total	**14.8**	**9.4**	**3.3**	**1.7**	**4.1**	**1.4**

*Age-Adjusted Rate per 100,000

Table 60: Washington Overdose Deaths by Race, 2016-18[192]

Race	All Drugs	Opioids	Stimulants
Non-Hispanic White	16.3	10.7	6.4
Non-Hispanic Black or African American	20.5	11.0	12.2
Hispanic or Latino	8.0	4.9	4.0
Non-Hispanic Asian or Pacific Islander	4.1	2.3	2.4
Non-Hispanic American Indian or Alaska Native	51.1	31.2	24.9

**Age-Adjusted Rate per 100,000
Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths

Washington Polysubstance Overdose Death Data

Although opioids continue to drive drug overdose deaths in Washington, 26% of opioid-involved deaths also involved more than one substance in 2018 (Figure 31). Psychostimulants, such as methamphetamine, made up 20% of overdose deaths in 2018 and 50% of those deaths involved opioids (Table 62). Cocaine made up a smaller percentage of overdose deaths at 4%, but 63% of

cocaine-related deaths, also involved opioids (Table 63). These numbers have remained relatively steady from 2015-2018, highlighting an ongoing need to address polysubstance use in Washington as part of the overall response to the opioid epidemic.

Figure 31: Washington Drug Overdose Deaths by Substance, 2018[193]

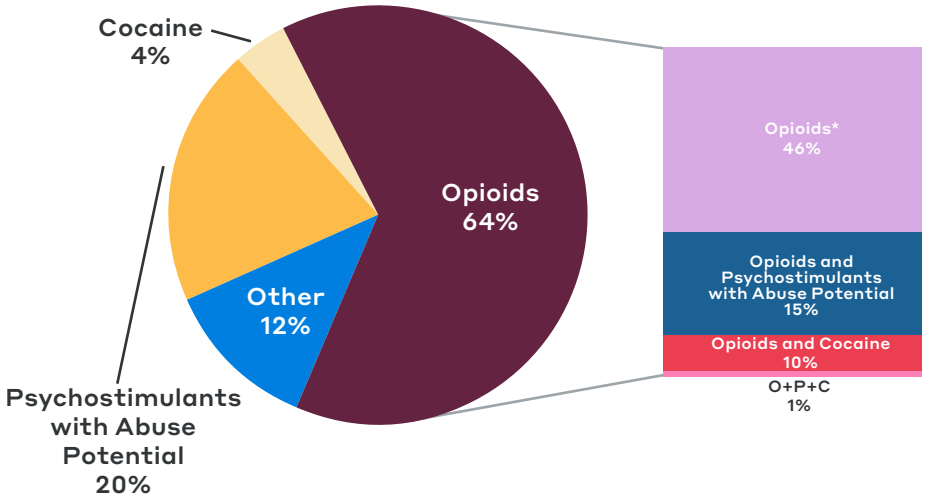


Table 61: Washington Overdose Deaths, 2015-2018[194]

Year	All Drugs	Involving Opioid	% Involving Opioid
2015	1,094	692	63%
2016	1,102	709	64%
2017	1,169	742	63%
2018	1,164	737	63%

Table 62: Washington Psychostimulant Overdose Deaths, 2015-2018[195]

Year	Psychostimulants with Abuse Potential	Involving Opioid	% Involving Opioid
2015	304	127	42%
2016	326	163	50%
2017	392	194	49%
2018	466	233	50%

Table 63: Washington Cocaine Overdose Deaths, 2015-2018[196]

Year	Cocaine	Involving Opioid	% Involving Opioid
2015	85	53	62%
2016	90	52	58%
2017	111	70	63%
2018	128	81	63%

State Leadership and Federal Appropriations

The Washington State Health Care Authority, or HCA, distributes STR and SOR funding and coordinates policy and collects outcome data for tackling the opioid epidemic. The SABG is administered by the Department of Social and Health Services' Division of Behavioral Health and Recovery.[197] Washington coordinates its opioid response through an Opioid Response Workgroup, which includes the representatives from across the government, including the governor's office, HCA, Department of Health and University of Washington, Alcohol and Drug Abuse Institute. In addition, there are specific workgroups that focus on the continuum of opioid use disorder treatment and address the unique challenges of special populations including individuals involved in the criminal justice system, pregnant women, and American Indian and Alaska Native Americans.

Federal appropriations to Washington increased by approximately 18% in FY2019 (Table 64). This increase is largely due to increased funding from the National Institutes of Health from approximately $6 million to $27 million, resulting from the HEAL Initiative. One of the NIH funded initiatives in Washington state seeks to improve adherence to MOUDs through behavioral or social interventions. This increase in NIH funding is reflected in the opioid spending by category, which went from 5% in FY2018 to 18% in FY2019 (Table 65). The Labor Department funding was reduced to zero in FY2019, due to the expiration of the National Health Emergency Dislocated Workers Demonstration Grant, which provided workforce services such as training for individuals impacted by opioid use disorder.[198]

Table 64: Washington Opioid Spending by Department

Department	FY2017	FY2018	FY2019
Health and Human Services	$60,103,257	$107,375,656	$132,630,059
Substance Abuse and Mental Health Services Administration	$56,940,775	$83,570,230	$87,505,274
Centers for Disease Control and Prevention	$2,627,244	$6,424,375	$4,723,037
Health Resources and Services Administration	$0	$8,155,430	$10,408,662
Administration for Children and Families	$535,238	$2,813,899	$2,882,841
National Institutes of Health	$0	$6,411,722	$27,110,245
Centers for Medicare and Medicaid Services	N/A	N/A	$3,872,766
Office of National Drug Control Policy	$7,092,814	$7,270,138	$6,480,355
Department of Justice	$3,793,825	$9,070,705	$13,038,329
Department of Labor	$0	$4,892,659	$0
Total Opioid Spending	**$70,989,896**	**$128,609,158**	**$156,021,509**

Table 65: Washington Opioid Spending by Category

Category	FY2017	FY2018	FY2019
Treatment and Recovery	21%	35%	24%
Prevention	14%	13%	20%
Mixed: Treatment/Recovery and Prevention	53%	37%	28%
Research	0%	5%	18%
Criminal Justice	6%	7%	5%
Law Enforcement	5%	3%	5%

Figure 32 and 33 show the federal funding per capita per county in FY19, and the corresponding overdose death rates from 2016-2018. According to Table 66, the top five counties receiving 65% of funding represent 57% of total overdose deaths from 2016-2018, and approximately 54% of the state's population. An important consideration is that funding reflects the location of the recipient of federal funding, which does not necessarily correspond with the service area of the funding (see Appendix V for more details).

Figure 32: Washington Opioid-Specific Funding per Capita by County, FY2019

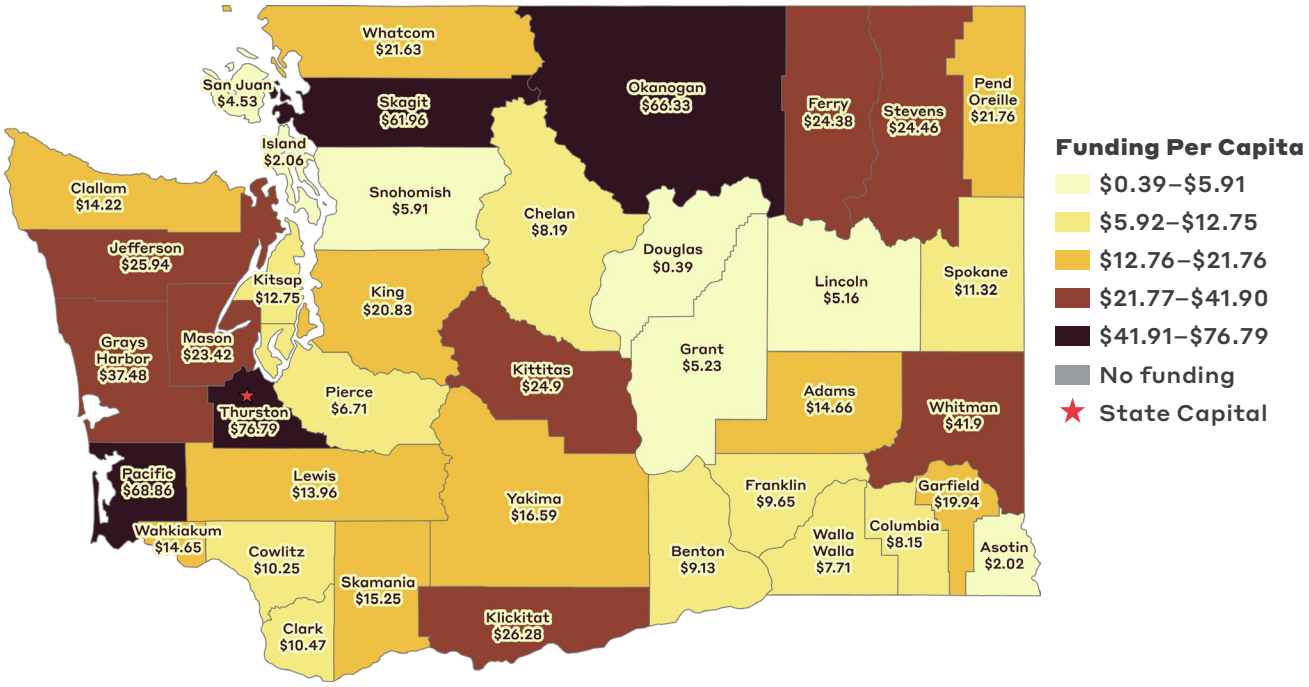
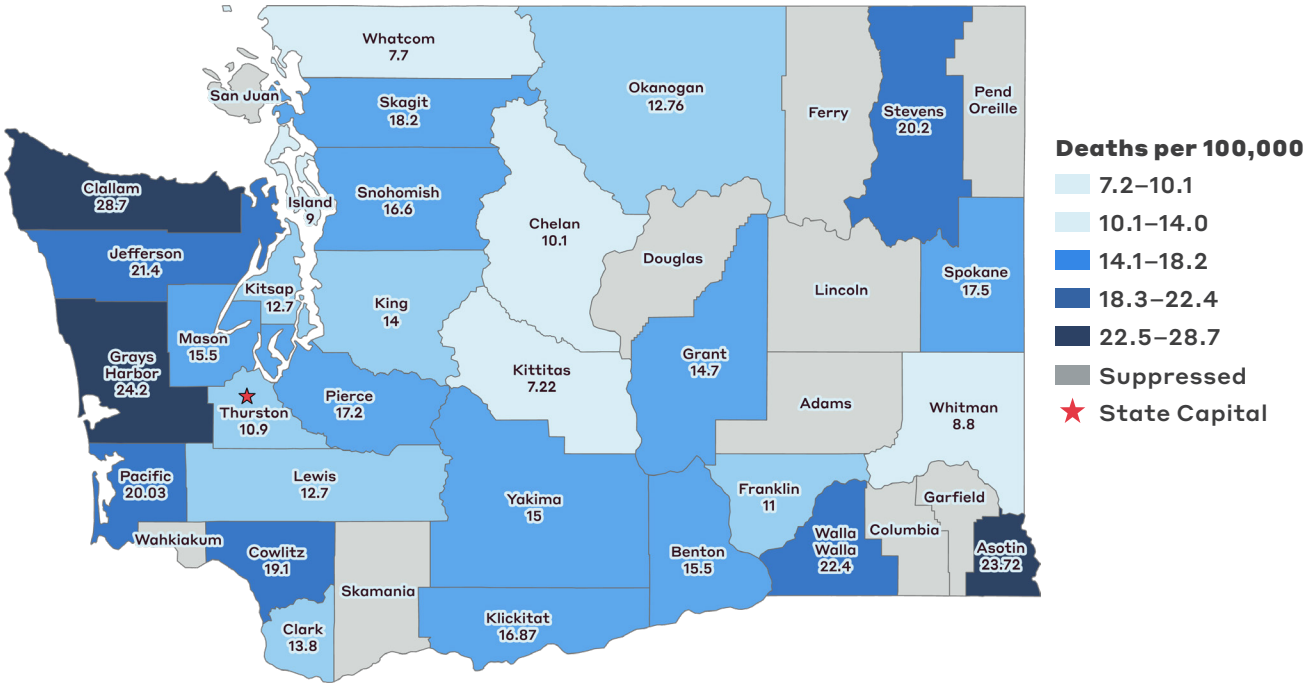


Figure 33: Washington Age-Adjusted Death Rate by County, All Drugs, 2016-2018



Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths.
Source: Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

Table 66: Top 5 Counties Receiving Share of Federal Funding, FY2019

County	2019 Funding (millions) % of State Total	Number of Deaths % of State Total	Population
King County	$47 (35%)	1,011 (30%)	29.6%
Thurston County	$22 (16%)	97 (3%)	3.8%
Skagit County	$8 (6%)	66 (2%)	1.7%
Pierce County	$6 (4%)	466 (14%)	11.8%
Hamilton County	$6 (5%)	220 (4%)	5%

Opioid Use Disorder Treatment and Harm Reduction

Washington's policy response to the opioid epidemic is outlined by the State Opioid Response Plan, which includes four goals: 1) prevention; 2) identifying and treating opioid use disorder; 3) reducing morbidity and mortality associated with opioid use; and 4) using data to detect opioid misuse and abuse, monitor morbidity and mortality, and evaluate interventions. There are associated metrics that assess outcomes across the Plan's four main goals, including measuring opioid-involved overdose death rates, number of infants born with neonatal abstinence syndrome, percent of Medicaid beneficiaries with OUD receiving MOUDs, and number of naloxone kits distributed at syringe services programs.[199]

To increase access to treatment, Washington has utilized SOR funding to support services across the treatment continuum. One successful example is the Opioid Treatment Networks, or OTN, which expand access to MOUDs. Washington has also used federal funds to implement six hub-and-spoke models, where hubs provide at least two of the three FDA approved opioid treatment medications and refer out to spokes, which provide SUD treatment, primary care, and wrap around services. Some hubs are more specialized. For example one is focused on individuals with OUD and Hepatitis C; another hub works with high risk pregnant individuals receiving medications.[200] Washington's recovery efforts have largely focused on connecting individuals to peer support individual and group services.[201]

In FY2019, 1,689 individuals received MOUDs through the hub-and-spoke treatment model, over 2,800 received MOUDs through the Opioid Treatment Networks, and 38 received low-barrier buprenorphine.[202] Nearly 4,000 individuals received buprenorphine through these programs, making it more widely received treatment than methadone and injectable naltrexone. Washington state has made some improvements in access to OUD treatment and the state is also focused on improving treatment retention rates, currently at 24% for six months, per state interviews.

Washington has targeted SOR funding to address some of the unique barriers to opioid use disorder treatment and recovery faced by special populations,

such as communities of color and individuals involved in the criminal justice system. For instance, the Community Prevention and Wellness Initiative (CPWI), supported low-resource, high-need communities through community-based outreach and education for youth and adults, media outreach, and safety initiatives (e.g. take back events, lock boxes).[203] In an effort to expand community reach, events have featured Spanish language materials and translators.[204] One of the key barriers reported for CPWI is lack of sustainability and uncertainty around long-term funding.

Low-barrier buprenorphine treatment access has been deployed to provide opioid use disorder treatment to vulnerable populations in various settings, such as emergency departments and syringe services programs. In FY2019, 37% of individuals served were American Indian or Alaska Native and 55% identified as a member of a minority group; treatment engagement was approximately 60%. The Department of Correction received SOR funds to continue initiatives for incarceration and re-entry services to expand access to opioid use disorder treatment. One program, the Care for Offenders with OUD Releasing from Prison, or COORP, connects individuals to MOUDs and expedites their enrollment into Medicaid to ensure coverage for ongoing treatment post release. In FY2019, COORP screened over 600 individuals and enrolled approximately 400 individuals in services.

Medicaid continues to provide coverage for treatment for individuals who are particularly at risk for opioid overdose deaths. From 2006 to 2012, death rates for Medicaid enrollees were more than four times higher than the overall population in Washington; many of these individuals were experiencing homelessness or involved in the criminal justice system two years prior to their death.[205] Washington was able to use STR funding and align it with the goals from the Medicaid Transformation CMS 1115 waiver focused on integrating behavioral health, primary care, and wrap around services in Medicaid[206] The goal of this alignment is to combine all funding into a single source and monitor outcomes across different domains of health care. In 2019, Medicaid spending increased for MOUDs and naloxone (Table 67).

In September 2019, Washington state was awarded a $3.8 million planning grant through CMS to assess the current state of SUD treatment and recovery services and to develop a policy framework to increase service capacity and alternative payment models among Medicaid beneficiaries.[207,208] Washington state's Health Care Authority will subsequently apply for a three-year demonstration project to implement the policy framework.[209]

There has been considerable focus on increasing access to and distribution of naloxone. The Center for Drug Safety and Services Education, a project of The University of Washington, offers education and technical assistance to individuals, providers, and communities on prevention and harm reduction. The Tacoma Washington Fire Department distributes and trains individuals

in naloxone administration and runs a Safe Station program modeled on a Manchester, New Hampshire Program. Safe Station provides individuals seeking treatment with transportation and referral to a treatment provider 24/7.

STR and SOR funds supported naloxone distribution to high risk populations, including through syringe services programs, and the Department of Corrections. From 2018 to 2019, Washington distributed 3,448 naloxone kits and trained 3,208 individuals.[210]

There are currently 30 SSPs in Washington and in 2019, 46% of participants reported polysubstance use in the past three months.[211] The Department of Health uses CDC funding to support SSPs and has replicated a New York model of using Medicaid to fund some aspects of SSPs. One SSP located in Southwest Washington is co-located with a federally qualified health center, or FQHC.[212] Approximately $100,000 per year in state funding supports the purchase and distribution fentanyl test strips.[213]

Table 67: Washington Medicaid Spending on Opioid Treatment Drugs and Naloxone, 2016-2019[214]

	2016	2017	2018	2019
Buprenorphine	12,562,386	18,681,755	28,257,237	35,557,931
Naltrexone	717,906	4,013,269	6,106,981	7,334,302
Naloxone	149,217	441,152	862,596	1,504,202
Total	**13,429,508**	**23,136,175**	**35,226,815**	**44,396,435**

To treat substance use disorders and improve mental health during COVID-19, Washington state applied for a $2.2 million Crisis Counseling Assistance and Training Program, or CCP, grant through SAMHSA and the Federal Emergency Management Agency, in addition to the $2 million from SAMHSA COVID-19 Emergency Funding.[215,216] While CCP did not have a SUD focus, the COVID-19 emergency finding was used to increase access to treatment to individuals who are uninsured or underinsured.[217] To prevent COVID-19 spread in jails, Governor Jay Inslee ordered the early release of 1,100 individuals, but the fast release timeline made it difficult to track who might require additional opioid treatment services.[218,219]

State Analysis

KEY TAKEAWAYS

In this report, BPC closely examined federal opioid spending in six states. Opioid spending in these states totaled nearly $820 million in 2019, or 11% of all federal spending that year. However, while all federal spending increased 2.5% between 2018 and 2019, spending in these six states increased 12.8%.

We have a few general observations based on this examination. Federal opioid funding remains at record levels; however, to varying degrees, each state continues to face workforce and addiction treatment infrastructure challenges. In addition, increasing rates of polysubstance use and changing demographics among those most at risk for overdose is requiring states to shift strategies to reduce overdose death rates. For example, national data have shown increases in overdose death rates in the Black population as well as in the Latino population.[220] These increases are primarily driven by deaths involving synthetic opioids such as illicitly manufactured fentanyl.[221] Illicitly manufactured fentanyl, along with cocaine and methamphetamine, is increasingly being found in overdose death reports.[222]

Due to COVID-19, state and federal governments temporarily lifted restrictions on MOUDs access. These policy changes include increased access to take-home doses for people receiving methadone treatment, expanding the use of telemedicine and the use of telephonic devices, and allowing for initiation of buprenorphine treatment via telemedicine. The Drug Enforcement Administration and SAMHSA moved swiftly to enact these revisions in the face of stay at home restrictions due to COVID-19.[223] Individuals we interviewed from Washington and Tennessee told us they received anecdotal reports of increased retention in treatment and a decreased number of missed appointments under the revised COVID regulations.

All of the states we looked at have expanded Medicaid from the Affordable Care Act, with the exception of Tennessee. The latest state in our sample to expand Medicaid, Louisiana, did so in July 2016. Medicaid expansion has been associated with increased access to MOUDs.[224,225]

TARGETING OF FEDERAL FUNDS TO AT-RISK REGIONS/INDIVIDUALS

With a few exceptions—New Hampshire and Louisiana—the geographic distribution of federal opioid funding has remained relatively stable and funds are going to counties with the highest number of overdose deaths (Table 68).

Table 68: Opioid Funding in Counties/Parish with Highest Number of Drug Overdose Deaths

	County/ Parish (City)	Number of Overdose Deaths (% of state total)	2017 Funding (millions) (% of state total)	2018 Funding (millions) (% of state total)	2019 Funding (millions) (% of state total)
Arizona	Maricopa (Phoenix)	2,845 (62%)	$44 (58%)	$67 (61%)	$62 (46%)
Louisiana	Jefferson (New Orleans)	480 (16%)	$6 (13%)	$7 (10%)	$8 (8%)
New Hampshire	Hillsborough (Manchester)	540 (39%)	$4 (31%)	$15 (26%)	$16 (20%)
Ohio	Cuyahoga (Cleveland)	1,659 (12%)	$13 (16%)	$17 (12%)	$34 (14%)
Tennessee	Davidson (Nashville)	706 (14%)	$23 (38%)	$43 (47%)	$44 (37%)
Washington	King (Seattle)	1,011 (30%)	*	*	$47 (35%)

*Not included in previous BPC report of FY2017 and FY2018 funding

It is difficult to determine within counties and parishes whether funds are meeting the needs of those at highest risk of overdose, even though states are required by the SOR grant to identify at-risk populations and target resources accordingly. In most states, populations most at risk of overdose include justice-involved individuals, people experiencing homelessness, and pregnant and parenting women. In addition, with the growth in the rate of polysubstance-involved overdose deaths, Blacks and Latinos are increasingly at risk.[226] For example, rates of overdose deaths in Ohio among Black and Latino populations are markedly higher than national rates for these populations (Appendix IV). In Washington, overdose death rates among Native Alaskan/American Indians in 2018 were more than three times the rate of white overdose rates (Appendix IV).

Long-standing policies often stand in the way of meeting the needs of populations most at-risk for overdose. For example, few individuals who are incarcerated receive the standard of care for opioid use disorder—medications for opioid use disorder—although overdose death is the leading cause of death upon release from jails and prisons.[227] State officials we interviewed were either in the planning stage of medications for opioid use disorder programs in corrections facilities or had only recently begun implementing such programs. States cited concerns about a lack of sustainable funding sources and community-based care. Some states use SOR funding to provide medications for opioid use disorder in correctional systems, while other states use DOJ grants to fund planning and pilot programs.

As with access to health care generally, racial and ethnic disparities persist and limit access to medications for opioid use disorder—the standard of care for people with opioid use disorder. Black and Latina pregnant women with opioid use disorder are less likely to receive medications for opioid use disorder.[228] Buprenorphine treatment is divided along racial lines and white Americans are more likely to receive buprenorphine treatment in physicians' offices than methadone, which must be dispensed in an opioid treatment program.[229] Methadone treatment remains highly stigmatized and subject to more restrictions than either buprenorphine or naltrexone.[230]

Washington state funds low-barrier buprenorphine programs with federal grants and provides treatment to individuals experiencing homelessness who are at increased risk for overdose. States also mentioned shortages in funding for supportive housing, especially for people leaving corrections and in the early stages of recovery.

WORKFORCE SHORTAGES

Workforce shortages continue to limit treatment expansion, with state officials specifically mentioning this as a significant barrier to their efforts. In 2019, Arizona reported there were 258 data-waived physicians, who can prescribe buprenorphine—52% of whom are in rural areas of the state. There is a disconnect between where vulnerable populations reside and where data-waived physicians practice, which stands in the way of providing treatment to at-risk populations. In addition, the majority of data-waived prescribers do not prescribe at the maximum allowed number. Federal grant funding is being allocated to provide training and increase the number of data-waived prescribers. Nationally, there are approximately 86,000 data-waived prescribers, 72.8% of whom are limited to 30 patients.[231]

Given well documented addiction treatment workforce shortages, several states have expanded scope of practice laws for mid-level practitioners, including physician assistants and nurse practitioners, to allow them to prescribe controlled substances such as buprenorphine. As of the writing of this report, legislation to allow advanced practice nurses and physicians assistants to prescribe buprenorphine in Tennessee had not yet passed the state legislature.[232] The state of Louisiana expanded scope of practice laws in 2019 to allow advanced practice nurses to prescribe medications to treat opioid use disorder. Removing such barriers will allow federal opioid funding to be spent more effectively and reach individuals at highest risk for overdose.

States are also using federal grants to train and fund recovery support services, another key part of the addiction workforce. Recovery support programs include supports for treatment retention, naloxone and other harm reduction services, and linkages to housing and other needed services. Recovery support services are sometimes, but not always, provided by peers.

HARM REDUCTION

Every state funds naloxone training and distribution. Naloxone is distributed to law enforcement, community-based organizations, and peers. Some states, including New Hampshire, have developed first responder programs to leave behind naloxone to individuals who have overdosed, while others provide naloxone to individuals upon release from incarceration or in the emergency department after an overdose. These techniques provide naloxone to individuals most at-risk for overdose.

Syringe services programs also play a vital role in naloxone distribution to reach at-risk populations. Syringe services programs provide testing, sterile syringes, and referrals to treatment for individuals at high risk for both overdose and infectious disease. At the federal level, these programs typically receive funding from CDC grants and in limited cases from SOR or STR funds. Congress included funding in FY2019 for technical assistance to syringe services programs, as well as in CDC's Infectious Disease and the Opioid Epidemic project.[233]

In recent years, several states have passed legislation to allow sanctioned syringe services programs, including three states we examined: Tennessee, Louisiana, and New Hampshire. In Arizona, syringe services programs remain prohibited under state law. Removing legal prohibitions on syringe services programs is a step forward; however other restrictions may remain in place, including restrictions on state funding that prevent such programs from reaching their full potential. At the state level, we found limited coordination between behavioral health and public health agencies with respect to syringe services programs. Given that they serve individuals at high risk for overdose, enhanced coordination between public health and behavioral health agencies at both the state and federal levels could improve services for this population.

State officials also noted that they do not use SOR funds to purchase fentanyl test strips. Fentanyl test strips are used to detect the presence of fentanyl in heroin and other substances. Only one state interviewed said they used state funding to purchase fentanyl test strips.

Summary & Recommendations

SUSTAINABLE FUNDING

This report focused on FY2019 federal opioid expenditures, the third year of enhanced federal opioid funding. Federal funding remained relatively constant from 2018 to 2019, with most of the opioid-related funding administered by the Department of Health and Human Services. The third year of funding allowed states to continue building capacity to prevent, treat, and support recovery for individuals with substance use disorders. However, the unmet need for treatment continues to outstrip state capacity. According to the National Survey on Drug Use and Health, an annual household survey conducted by SAMHSA, more than 2 million individuals in the United States have an opioid use disorder.[234] Unfortunately, according to that same survey, less than 20% receive treatment. Further, of those receiving treatment for an opioid use disorder, even fewer receive the standard of care—medications for opioid use disorder—for their condition.[235] Treatment gaps are even more pronounced among specific demographic groups, with Black Americans and Latinos less likely than white Americans to receive substance use disorder treatment.[236]

Addressing this unmet treatment need is particularly important considering the long-term trends in overdose rates. As stated earlier, overdose mortality rates decreased in 2018; however, early release data from 2019 shows overdose rates have rebounded and continue to climb in 2020.[237] Recent reports during COVID-19 show even greater spikes in overdoses in parts of the country.[238]

SAMHSA administers STR and SOR grants, totaling more than $3 billion in funding to states from 2017-2019. However, states were delayed in spending the initial round of STR funding. According to a HHS Inspector General Report, the majority of states had unspent funds from the first year of the STR grant program, requiring states to request approval to carry over funds into the following year.[239] The inability of states to spend federal funds in the first two years of the program reflects the state of the nation's addiction treatment system—a system built outside of healthcare, resulting in a siloed, underfunded, and less developed system of care. It also calls for sustained, long-term investment in the nation's addiction response infrastructure and Medicaid expansion in every state. The HHS Inspector General's Report found that states needed additional time to spend the STR and SOR grants due to procurement challenges, including a lack of state workforce capacity.

The long-standing treatment gap and lack of treatment and workforce capacity predate the opioid epidemic. A study of MOUD availability found that out of 3,142 counties in 2017, almost half did not have a publicly available MOUD provider.[240] While billions of dollars in grant funding has gone to states, building treatment capacity in the United States will take sustained, long-term funding to bend the curve of overdose deaths in the country and meet the nation's addiction challenge. The nation's addiction treatment and recovery infrastructure is insufficient to meet today's opioid challenge or increasing rates of polysubstance involved overdoses. Some in Congress have called for a wholesale restructuring of the federal government's approach to funding for substance use disorders. A notable example of this is The Comprehensive CARE Act to Combat the Opioid and Substance Use Epidemic. The legislation, patterned on the Ryan White Act, would authorize $100 billion in funding over a 10-year period for state and local governments to fund the continuum of care for people with substance use disorders.[241] The legislation has not yet garnered bipartisan support. We suggest the following actions to support sustainable funding and build the necessary infrastructure to reach at-risk populations:

1) Increase block grant funding for evidence-based programs. As in BPC's 2019 report, state officials with whom we spoke emphasized the importance of federal funding for their state's opioid response. They expressed concern about the ability to continue programs in the absence of ongoing congressional appropriations. Grant programs that rely on annual appropriations pose a challenge for state and local governments seeking to build systems of care.

SAMHSA's SABG block grant has been level funded at $1.85B since FY2016 and has not kept pace with inflation over the past decade.[242] This level funding has occurred despite the startling increase in drug overdose deaths in the same time period. We call for sustained and increased funding to SAMHSA's SABG block grant annually to keep pace with inflation and require that funds be spent only on evidence-based programs. In addition, we recommend SAMHSA make public a report on compliance with grant language requirements that funding be used only for evidence-based programs.

2) Coordinate Harm Reduction Services: As part of this year's report, BPC examined federal funding sources for harm reduction programs. Included under harm reduction services is funding for naloxone, syringe services programs, and other programs intended to reduce the harms associated with drug use. As was the case in 2018, each state purchases and distributes naloxone to community-based organizations, law enforcement, and family and friends of people with opioid use disorders using federal funds. In the HHS FY2021

Congressional Justification, SAMHSA reports that since the beginning of the 2019 SOR grant, 256,978 naloxone kits were distributed and 13,739 overdoses were reversed using SOR funding.[243]

In the states we examined, the majority of federal funding for syringe services programs came from the CDC via HIV prevention grants and other opioid related funding, not from SOR. These funding sources tend to be blended with other funds however, making it difficult to trace specific funding dedicated to syringe services or other harm reduction programs. It was also difficult to determine how much, if any, SOR funding went to fund syringe services programs.

State officials we interviewed noted a lack of coordination between public health departments and addiction services or behavioral health agencies regarding syringe services programs. To facilitate enhanced coordination of services at the state and local level and ensure that services are reaching people most at risk for overdoses, we recommend coordination of harm reduction-related funding at the federal level. We also recommend that Congress remove the restrictions on purchasing syringes that currently exist in federal appropriations language. A few states, following the federal government's lead, have included similar restrictions on state funds, thereby limiting vital funding for these programs.

3) Evaluate and Provide Feedback: Since FY2017, the federal government has invested billions of dollars to curb the opioid epidemic. Unfortunately, the nation lacks a mechanism to determine the effectiveness of federal opioid grant expenditures. HHS has provided updates on outcome measures.[244] However, it is difficult to determine the efficacy of federal opioid spending without transparent evaluations of all streams of funding. Given the size of this investment, publicly available evaluations of each federal opioid funding stream must be conducted. Each agency should then disclose the results of these evaluations on its website, as well as on ONDCP's website. Such evaluations will help guide congressional appropriators on the type of additional investments to make in the future and allow the executive branch to track progress toward building a comprehensive response to addiction. Specifically, these evaluations should include information on if the grant is meeting the needs of at-risk populations and addressing treatment gaps in communities of color. Reporting should also determine the extent to which all funding streams are supporting evidence-based interventions. Finally, an examination of how these funds are used differently in states that have expanded Medicaid versus those that have not is warranted.

AT-RISK POPULATIONS

Every state official mentioned increasing rates of polysubstance use and overdose deaths in their state as an area of concern, as well as increasing rates of methamphetamine and cocaine availability and use. Methamphetamine use and overdoses predominate in certain parts of the country, particularly in the West and Midwest.[245] Given these changing circumstances, allowable uses in the FY2020 SOR grant were revised to allow spending on substances other than opioids, including stimulants such as methamphetamine and cocaine. As recommended in BPC's 2019 Report, flexibility of this type allows states to adapt to changing conditions. We recommend expanding other grants to remove restrictive funding language.

The treatment gap for people with substance use disorder is stark and lack of access to quality community-based care is even more pronounced for communities of color. Research has shown that Blacks and Latinos are less likely than whites to complete publicly funded substance use disorder treatment, largely due to other socioeconomic factors.[246] Other issues contributing to the treatment gap for people of color include the risk of losing a child to the child welfare system, lack of access to the full range of medications for opioid use disorder, lack of culturally competent treatment, and the imposition of punitive consequences.[247,248,249] The range of demographic groups exposed to illicitly manufactured fentanyl is increasing as polysubstance overdoses increase and include substances such as cocaine, methamphetamine, and counterfeit opioids.[250] Specific efforts to reduce the treatment gap in diverse communities must be expanded and grant programs should focus on cultural competency to improve treatment access and retention.[251] Evaluations of grant funds as described above must address treatment gaps in communities of color.

Criminal legal reforms that seek to divert people away from arrest and incarceration, as well as efforts to expand access to medications for opioid use disorder in correctional settings and connect people to services such as housing and employment upon reentry must be included as part of any effort to address the addiction epidemic. We recommend greater coordination between the Bureau of Justice Assistance COSSAP grants and SAMHSA SOR and SABG funding to improve the efficacy of these programs and increase opportunities for funding coordination. In addition, efforts should be made to include housing first responses and increase HUD's focus on reentry and recovery supportive housing.

REGULATORY AND LEGAL BARRIERS TO TREATMENT

Several federal opioid grant programs are targeted to underserved rural areas of the country. Such regions face issues that must be addressed, including transportation access, workforce limitations, and telehealth issues. Similar

treatment barriers also exist in non-rural areas, including transportation and workforce capacity issues.

Regulatory changes made during COVID-19 to allow for increased access to treatment using telemedicine (e.g., buprenorphine induction) and ease of take-home doses for methadone can help in treatment retention across the board and ease disparities in treatment access in both rural and more urban areas of the country. The benefits of telehealth in addressing barriers to care are considerable. As previously noted, several states shared anecdotal reports that the regulatory changes made during COVID-19, including those expanding access to telemedicine, have increased retention in treatment and decreased number of missed appointments. We recommend the federal government permanently extend the regulatory revisions that have enabled increased access to treatment via telemedicine. We also recommend the federal government extend additional regulatory revisions made during COVID-19, including increased flexibility around take-home doses, to allow researchers time to examine the effects these regulatory changes have had on treatment retention and access. Upon completion, the federal government should immediately make permanent the most effective revisions and devise a plan for a comprehensive review of all restrictions on treatment access. This review and recommendations for change should include regulatory burdens on opioid treatment programs.

We also recommend removing the special licensing requirement—data waiver—for health care providers to prescribe buprenorphine. While this takes legislative action, in the interim, HHS has administrative discretion to lift the buprenorphine provider patient limit, thereby increasing access. Removing the data waiver requirement and increasing patient limits can lead to expanded access to buprenorphine, a medication available in physicians' offices that is too often out of reach for Blacks, Latinos, and other people of color.[252]

With the exception of Tennessee, every state included in this Report has expanded Medicaid, allowing coverage for individuals with incomes below 138% of the federal poverty level. In states without Medicaid expansion, the SAMHSA SABG program pays for substance use disorder treatment for uninsured individuals, thereby decreasing available funds for other programs, including expanding workforce capacity and other long-term capacity building efforts. Given the importance of Medicaid coverage for people with substance use disorders, we recommend HHS conduct a thorough review of all Medicaid practices that restrict access to treatment for people with substance use disorder, including people who are incarcerated but have not yet been sentenced. We also recommend states increase coverage for 12 months post-partum and increase reimbursement rates to encourage additional providers to cover treatment services. A 2019 study found that prior authorizations still existed in 40 state Medicaid programs for buprenorphine-naloxone combination medications, limiting the ability of people with opioid use disorder to access this life-saving treatment.[253] We recommend the elimination of prior authorization for medications for opioid use disorder.

Conclusion

All of the recommendations included in this report are necessary to build the national treatment system that is essential if we are to curb the growing numbers of individuals needlessly dying from overdose deaths. Saving these lives will require building a sustainable funding base for the nation's addiction treatment system, addressing the needs of vulnerable populations and removing regulatory and legal barriers. It is also critical that substance use disorders be prevented from ever occurring by taking an upstream approach to improving health care outcomes.

Appendix I

FULL APPROPRIATION DATA 2017-2019

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

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$400,000,000	$400,000,000	0
P*	LHHS	SAMHSA	STR	$100,000,000	$100,000,000	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$800,000,000	$1,200,000,000
P*	LHHS	SAMHSA	SOR	N/A	$200,000,000	$300,000,000
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	$50,000,000	$50,000,000
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	$3,000,000	$3,000,000
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$1,423,103,200	$1,423,103,200	$1,423,103,200
P*	LHHS	SAMHSA	SABG	$355,775,800	$355,775,800	$355,775,800
T*	LHHS	SAMHSA	Opioid Treatment Programs	$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
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$56,000,000	$84,000,000	$89,000,000
T	LHHS	SAMHSA	Pregnant and Postpartum Women	$19,931,000	$29,931,000	$29,931,000
T	LHHS	SAMHSA	Building Communities of Recovery	$3,000,000	$5,000,000	$6,000,000
T	LHHS	SAMHSA	Recovery Community Services Program	$2,434,000	$2,434,000	$2,434,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T	LHHS	SAMHSA	Children and Families	$29,605,000	$29,605,000	$29,605,000
CJ	LHHS	SAMHSA	Criminal Justice Activities	$78,000,000	$89,000,000	$89,000,000
CJ	LHHS	SAMHSA	Offender Reentry Program	N/A	$6,800,000	$6,800,000
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	$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
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	$12,000,000	$12,000,000	$12,000,000
P*	LHHS	SAMHSA	First Responder Training	$12,000,000	$36,000,000	$36,000,000
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	$1,000,000	$1,000,000	$1,000,000
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	$5,000,000	$5,000,000	$6,000,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	$15,000,000	$15,000,000	$20,000,000
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$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
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	$6,000,000	$6,000,000	$6,946,000
T	Interior	Indian Health Service	Special Behaviora Health Pilot Programl	N/A	N/A	$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
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$155,000,000	N/A
P*	LHHS	CDC	Infectious Diseases and the Opioid Epidemic	N/A	N/A	$5,000,000
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$350,000,000	$200,000,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A	N/A	$87,265,000
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	$30,000,000	$120,000,000
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	$100,000,000	N/A
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$25,310,000	$85,310,000	$85,310,000
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$20,000,000	$20,000,000
P	LHHS	ACF	Promoting Safe and Stable Families— Regional Partnership Grants	$18,600,000	$20,000,000	$20,000,000
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	N/A	$982,831	$989,411
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	$3,570,046	$3,579,337	$592,769
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$250,000,000	$250,000,000
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke	N/A	$250,000,000	$250,000,000
T	LHHS	CMS	Demonstration Project to Increase Substance Use Provider Capacity	N/A	N/A	$50,000,000
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Veterans Health Administration	Medical Care — inpatient/ outpatient, pharmacy	N/A	$329,953,000	$348,000,000
	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	$52,025,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
	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
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
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
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
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
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	$13,000,000	$145,000,000	$157,000,000
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	$10,000,000	$32,000,000	$32,000,000
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A	N/A	$27,000,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$68,000,000	$85,000,000	$87,500,000
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	$22,000,000	$9,000,000
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	$21,000,000	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$29,839,484	$29,839,484
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$13,000,000	$17,000,000	$30,000,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
	Department of Veterans Affairs					
T	Veterans Affairs	Veterans Health Administration	Medical Care — inpatient/ outpatient, pharmacy	N/A	$329,953,000	$348,000,000
T	Veterans Affairs	Veterans Health Administration	Medical Care — CARA opioid safety initiatives	N/A	$55,821,000	$52,025,000
P	Veterans Affairs	Veterans Health Administration	Medical Care — Justice Outreach and Prevention Program	N/A	$48,778,000	$54,337,000
T	Veterans Affairs	Veterans Health Administration	Medical Care — Office of Rural Health's Rural Health Initiative	N/A	$270,000,000	$270,000,000
	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
	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
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
I*	Homeland	Homeland Security Investigations	Opioid/ Fentanyl-related Investigations	N/A	N/A	$31,605,000
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
	Food and Drug Administration					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	$21,000,000	0
			TOTAL	***$3,314,159,046***	***$7,407,421,625***	***$7,647,259,664***

Appendix II: Case Study States Appropriation Data 2017-2019

ARIZONA

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$9,737,214	$9,737,214	0
P*	LHHS	SAMHSA	STR	$2,434,304	$2,434,304	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$16,215,442	$24,679,903
P*	LHHS	SAMHSA	SOR	N/A	$4,053,861	$6,169,976
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	$2,288,944	$17,688,589
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	0	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$32,150,562	$32,515,446	$32,609,347
P*	LHHS	SAMHSA	SABG	$8,037,641	$8,128,861	$8,152,337
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	0
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	0	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	0	0	0
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$950,000	$1,935,296	$1,569,705
T	LHHS	SAMHSA	Pregnant and Postpartum Women	0	0	0
T	LHHS	SAMHSA	Building Communities of Recovery	0	$195,138	$195,217
T	LHHS	SAMHSA	Recovery Community Services Program	0	0	0

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T	LHHS	SAMHSA	Children and Families	$694,899	$517,928	$523,576
CJ	LHHS	SAMHSA	Criminal Justice Activities	$966,091	$2,139,435	$2,057,704
CJ	LHHS	SAMHSA	Offender Reentry Program	0	0	0
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	0	0	0
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	0	0	0
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	0	0	0
P*	LHHS	SAMHSA	First Responder Training	$784,790	$784,791	$500,000
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	0	0	0
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	$50,000	$50,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	$799,783	$1,204,867	$552,042
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$190,986	$169,406	0
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behavioral Health Pilot Program	N/A		0
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Control — Opioid Overdose Prevention and Surveillance	$2,170,408	$2,170,408	$8,412,270
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$4,530,305	0
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$5,488,029	$2,920,572

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		0
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	0	0
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	0	$3,800,000
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$538,552	$1,834,669	$1,756,152
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$743,286	$684,789
P	LHHS	ACF	Promoting Safe and Stable Families — Regional Partnership Grants	N/A	0	0
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$2,242,634	$5,155,604
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	$11,413,416	$11,817,776	$13,753,719
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$2,000,000	$1,947,766	$1,250,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	$346,676	$360,656	$862,503
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Veterans Treatment Courts	0	0	$500,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$354,771	$773,138	$783,216
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	0	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	0	$747,591	$100,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	0	$99,353	0
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	0	0	0
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		$2,050,403
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$2,142,995	$550,000	$1,858,891
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	0	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$466,167	$538,441
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$160,443	$916,132	$684,884

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	0	0
			TOTAL	***75,873,531***	***117,058,843***	***139,859,840***

LOUISIANA

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$6,534,377	$6,534,377	0
P*	LHHS	SAMHSA	STR	$1,633,594	$1,633,594	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$9,391,923	$14,294,507
P*	LHHS	SAMHSA	SOR	N/A	$2,347,981	$3,573,627
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	$167,997	$76,173
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	0	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$20,021,379	$20,235,254	$20,287,280
P*	LHHS	SAMHSA	SABG	$5,005,345	$5,058,813	$5,071,820
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	0
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	0	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	0	0	$375,000
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$1,000,000	$1,025,000	0
T	LHHS	SAMHSA	Pregnant and Postpartum Women	0	0	0
T	LHHS	SAMHSA	Building Communities of Recovery	0	0	0
T	LHHS	SAMHSA	Recovery Community Services Program	0	0	0

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T	LHHS	SAMHSA	Children and Families	$552,928	0	0
CJ	LHHS	SAMHSA	Criminal Justice Activities	$1,213,654	$1,754,096	$1,427,974
CJ	LHHS	SAMHSA	Offender Reentry Program	$400,000	0	0
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	0	0	0
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	$371,616	$371,616	$371,616
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	0	0	0
P*	LHHS	SAMHSA	First Responder Training	0	0	0
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	$1,000,000	0	0
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	0	0
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	0	0	0
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$239,424	$2,299,578	$1,785,075
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behavioral Health Pilot Program	N/A	0	
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Control — Opioid Overdose Prevention and Surveillance	$997,702	$997,702	$4,984,910
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response— Opioid Prevention in States	N/A	$3,161,300	0
P*	LHHS	CDC	Infectious Diseases and the Opioid Epidemic	N/A	N/A	$450,000
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$8,569,833	$5,164,830

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		$280,683
T&P*	LHHS	HRSA	Rural Health—Rural Communities Opioids Response	N/A	$400,000	0
T&P*	LHHS	Office of Rural Health	Rural Health—Rural Communities Opioids Response	N/A	0	$2,322,325
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs—Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$385,610	$1,300,257	$1,296,700
P	LHHS	ACF	Promoting Safe and Stable Families—Kinship Navigator Programs	N/A	$361,120	$361,120
P	LHHS	ACF	Promoting Safe and Stable Families—Regional Partnership Grants	N/A	0	0
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$993,439	$1,170,177
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	$4,355,420	$4,691,133	$5,654,991
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$1,124,750	$1,124,750	$624,750

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	$400,000	$859,926	$997,800
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Veterans Treatment Courts	0	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$302,849	$663,964	$649,435
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	$542,160	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	$224,223	$1,054,411	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	$796,277	$2,999,126	$1,335,270
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	0	0	$2,423,079
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		0
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$1,048,770	$2,736,267	0
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	0	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$749,124	0
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$109,840	$450,855	$272,275
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	0	0
			TOTAL	***$48,259,917***	***$81,933,435***	***$75,251,417***

NEW HAMPSHIRE

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$2,502,693	$2,769,093	0
P*	LHHS	SAMHSA	STR	$625,673	$692,273	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$18,386,086	$27,983,623
P*	LHHS	SAMHSA	SOR	N/A	$4,596,522	$6,995,906
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	0	0
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	0	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$5,574,302	$6,291,709	$6,208,022
P*	LHHS	SAMHSA	SABG	$1,393,576	$1,572,927	$1,552,006
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	$150,000
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	$150,000	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	0	0	$375,000
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$1,000,000	$1,777,726	$1,131,680
T	LHHS	SAMHSA	Pregnant and Postpartum Women	0	0	0
T	LHHS	SAMHSA	Building Communities of Recovery	0	0	0
T	LHHS	SAMHSA	Recovery Community Services Program	0	0	0
T	LHHS	SAMHSA	Children and Families	$760,000	$785,000	$785,000
CJ	LHHS	SAMHSA	Criminal Justice Activities	$324,997	0	0
CJ	LHHS	SAMHSA	Offender Reentry Program	0	0	0
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	0	0	0
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	0	0	0

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	0	0	0
P*	LHHS	SAMHSA	First Responder Training	0	$787,551	0
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	0	0	0
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	$50,000	$50,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	0	0	0
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$400,000	$2,474,414	$1,640,200
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behaviora Health Pilotl	N/A		0
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Control — Opioid Overdose Prevention and Surveillance	$356,373	$356,373	$3,672,978
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$3,935,954	0
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$2,812,257	$1,503,000
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		$368,076
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	$450,000	0
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	0	$2,849,335

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$129,475	$419,082	$383,876
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$216,231	$216,231
P	LHHS	ACF	Promoting Safe and Stable Families — Regional Partnership Grants	N/A	0	$2,646,953
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$1,184,912	$4,493,713
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	0	0	0
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$1,500,000	$1,500,000	$996,192
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	0	0	$493,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Veterans Treatment Courts	0	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$56,168	$142,272	$149,405

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	$399,436	0	$722,137
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	$200,000	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	0	$1,697,079	0
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	$688,856	0	$489,674
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		0
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	0	0	0
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	0	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$1,186,005	0
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$108,332	$271,960	$272,275
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	$5,000,000	0
			TOTAL	***$16,019,880***	***$59,505,426***	***$66,128,282***

OHIO

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$20,848,402	$20,848,402	0
P*	LHHS	SAMHSA	STR	$5,212,100	$5,212,100	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$44,632,478	$68,355,106
P*	LHHS	SAMHSA	SOR	N/A	$11,158,120	$17,088,776
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	0	0
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	$549,625	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$51,629,194	$53,003,741	$53,099,243
P*	LHHS	SAMHSA	SABG	$12,907,298	$13,250,935	$13,274,811
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	$749,380
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	$285,396	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	0	$305,000	0
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$2,000,000	$5,172,787	$6,740,080
T	LHHS	SAMHSA	Pregnant and Postpartum Women	$377,273	0	$549,000
T	LHHS	SAMHSA	Building Communities of Recovery	0	$444,519	$444,519
T	LHHS	SAMHSA	Recovery Community Services Program	0	$25,000	$175,000
T	LHHS	SAMHSA	Children and Families	$800,000	$1,365,463	$1,345,492
CJ	LHHS	SAMHSA	Criminal Justice Activities	$4,534,274	$3,082,541	$2,716,334
CJ	LHHS	SAMHSA	Offender Reentry Program	0	0	0
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	0	0	0
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	$371,616	$396,616	$396,616

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	0	0	0
P*	LHHS	SAMHSA	First Responder Training	$1,493,080	$2,607,673	$416,116
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	0	0	0
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	$50,000	$50,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	0	0	0
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$1,097,780	$1,278,261	$2,357,015
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behavioral Health Pilot Program	N/A	0	
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Control — Opioid Overdose Prevention and Surveillance	$3,569,715	$3,569,715	$22,396,877
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$5,098,024	0
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$12,951,245	$7,181,000
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		$9,323,550
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	$2,249,654	0
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	0	$5,000,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$841,292	$2,847,313	$2,962,598
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$473,607	$473,607
P	LHHS	ACF	Promoting Safe and Stable Families — Regional Partnership Grants	N/A	$599,939	$599,999
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$5,902,722	$29,551,314
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	$4,219,163	$4,343,707	$7,327,729
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$3,128,942	$3,207,900	$1,935,518
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	$1,411,376	$1,400,000	$3,116,201
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Veterans Treatment Courts	$229,526	0	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$423,016	$928,732	$935,667

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	$1,297,965	$647,500	$1,852,497
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	$1,077,636	$680,796	$1,745,318
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	$799,999	$11,019,932	$3,000,000
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	0	$742,182	$1,500,000
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		0
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$253,560	$2,930,042	$3,775,749
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	0	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$750,000	$448,222
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$507,657	$909,851	$669,156
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	0	0
			TOTAL	***$119,030,865***	***$224,921,519***	***$271,552,490***

TENNESSEE

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$11,052,106	$11,052,106	0
P*	LHHS	SAMHSA	STR	$2,763,026	$2,763,026	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$14,834,471	$22,578,065
P*	LHHS	SAMHSA	SOR	N/A	$3,708,618	$5,644,516
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	0	0
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	0	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$25,582,898	$26,342,240	$26,386,944
P*	LHHS	SAMHSA	SABG	$6,395,724	$6,585,560	$6,596,736
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	$150,000
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	0	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	0	$280,000	0
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$6,000,000	$3,662,908	$3,696,595
T	LHHS	SAMHSA	Pregnant and Postpartum Women	$524,000	$2,223,000	$1,125,000
T	LHHS	SAMHSA	Building Communities of Recovery	0	0	0
T	LHHS	SAMHSA	Recovery Community Services Program	0	0	0
T	LHHS	SAMHSA	Children and Families	0	0	0
CJ	LHHS	SAMHSA	Criminal Justice Activities	$1,227,452	$3,312,449	$2,941,948
CJ	LHHS	SAMHSA	Offender Reentry Program	0	$820,675	$791,162
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	0	0	0
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	$371,616	$396,616	$396,616

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	0	0	0
P*	LHHS	SAMHSA	First Responder Training	0	0	$1,600,000
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	0	0	0
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	$100,000	$100,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	0	0	0
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	$702,221	$765,897	0
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behavioral Health Pilot Program	N/A		0
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Control — Opioid Overdose Prevention and Surveillance	$2,775,304	$2,772,696	$6,696,197
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$4,353,877	0
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$6,141,106	$3,484,122
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		$1,313,492
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	$1,000,000	0
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	0	$2,800,000

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$500,849	$1,700,745	$1,755,055
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$399,821	$399,821
P	LHHS	ACF	Promoting Safe and Stable Families — Regional Partnership Grants	N/A	$600,000	$600,000
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$3,403,016	$12,029,665
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	$204,410	$232,386	$266,220
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$2,000,000	$2,000,000	$1,125,000
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	-$44,031	$2,860,000	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs— – Veterans Treatment Courts	$1,500,000	$550,000	0
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$250,423	$549,489	$572,645

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	0	$748,556	$115,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	$41,228	$75,172	$660,356
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	$100,000	$6,249,534	$8,140,371
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	0	$1,253,294	$899,356
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		0
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$1,265,032	$1,491,865	$602,482
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	$1,000,999	0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	0	747,410
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	$145,804	$373,981	$387,546
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	0	0
			TOTAL	***$63,358,063***	***$114,604,103***	***$114,602,320***

WASHINGTON

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
T*	Labor, Health and Human Services (LHHS)	Substance Abuse and Mental Health Services Administration (SAMHSA)	State Targeted Response (STR)	$9,432,205	$9,432,205	0
P*	LHHS	SAMHSA	STR	$2,358,051	$2,358,051	0
T*	LHHS	SAMHSA	State Opioid Response (SOR)	N/A	$17,258,474	$27,147,398
P*	LHHS	SAMHSA	SOR	N/A	$4,314,619	$6,786,850
T*	LHHS	SAMHSA	Tribal Opioid Response	N/A	$1,801,095	$1,534,164
T*	LHHS	SAMHSA	Rural Opioids Technical Assistance	N/A	0	0
T&P	LHHS	SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	$30,228,085	$31,562,798	$31,615,185
P*	LHHS	SAMHSA	SABG	$7,557,021	$7,890,699	$7,903,796
T*	LHHS	SAMHSA	Opioid Treatment Programs	0	0	$148,157
T*	LHHS	SAMHSA	Provider's Clinical Support System — Universities	0	$147,773	0
T*	LHHS	SAMHSA	Target Capacity Expansion-General	$249,916	$274,916	0
T*	LHHS	SAMHSA	Medication-Assisted Treatment for Prescription Drug and Opioid Addiction	$999,997	$3,114,852	$5,614,272
T	LHHS	SAMHSA	Pregnant and Postpartum Women	$524,000	$549,000	$549,000
T	LHHS	SAMHSA	Building Communities of Recovery	0	0	0
T	LHHS	SAMHSA	Recovery Community Services Program	$148,624	$173,624	$173,624
T	LHHS	SAMHSA	Children and Families	$641,593	-$601,821	$601,821
CJ	LHHS	SAMHSA	Criminal Justice Activities	$1,006,508	$1,147,334	$1,447,927
CJ	LHHS	SAMHSA	Offender Reentry Program	0	0	0
T	LHHS	SAMHSA	Addiction Technology Transfer Centers	$771,163	$775,285	$775,202
P*	LHHS	SAMHSA	Strategic Prevention Framework Rx	$371,615	$396,615	$396,615

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P*	LHHS	SAMHSA	Grants to Prevent Prescription Drug/Opioid Overdose	$1,000,000	$1,025,000	$1,025,000
P*	LHHS	SAMHSA	First Responder Training	0	0	249,665
T*	LHHS	SAMHSA	Improving Access to Overdose Treatment	0	$205,187	$203,179
P	LHHS	SAMHSA	Community-Based Coalition Enhancement Grants	0	$50,000	$50,000
P	LHHS	SAMHSA	Tribal Behavioral Health Grants	$1,651,997	$1,694,524	$1,283,419
T	LHHS	SAMHSA	Primary and Behavioral Health Care Integration	0	0	0
T	LHHS	SAMHSA	Primary/ Behavioral Health Integration TA	0	0	0
T	Interior	Indian Health Service	Behavioral Health Integration Initiative	0	0	0
T	Interior	Indian Health Service	Special Behavioral Health Pilot Program	N/A		0
P*	LHHS	Centers for Disease Control and Prevention	Injury Prevention and Contro – I— Opioid Overdose Prevention and Surveillance	$2,627,244	$2,627,244	$4,723,037
P*	LHHS	CDC	Cooperative Agreement for Emergency Response: Public Health Crisis Response — Opioid Prevention in States	N/A	$3,797,131	0
T&P	LHHS	Health Resources and Services Administration (HRSA)	Expanding Access to Quality Substance Use Disorder and Mental Health Services	N/A	$7,511,890	$4,507,740
T&P	LHHS	HRSA	Opioid Workforce Expansion Programs	N/A		$1,576,062
T&P*	LHHS	HRSA	Rural Health — Rural Communities Opioids Response	N/A	$643,540	0
T&P*	LHHS	Office of Rural Health	Rural Health — Rural Communities Opioids Response	N/A	0	$4,324,860

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
P	LHHS	Administration for Children and Families (ACF)	Children and Families Services Programs — Child Abuse Prevention and Treatment Act Infant Plans of Safe Care	$535,238	$1,832,610	$1,901,831
P	LHHS	ACF	Promoting Safe and Stable Families — Kinship Navigator Programs	N/A	$387,289	$387,010
P	LHHS	ACF	Promoting Safe and Stable Families — Regional Partnership Grants	N/A	$594,000	$594,000
R	LHHS	Administration for Community Living	ACL National Institute on Disability, Independent Living, and Rehabilitation Research	0	0	0
R	LHHS	Agency for Healthcare Research and Quality	Research on Healthcare Costs, Quality and Outcomes	0	0	0
R	LHHS	National Institutes of Health	National Institute of Drug Abuse	N/A	$6,411,722	$27,110,245
R	LHHS	NIH	National Institute of Neurological Disorders and Stroke			
T	LHHS	CMS	Demonstration Project to Increase Substance Use Provider Capacity	N/A	N/A	$3,872,766
	Office of National Drug Control Policy					
LE	Financial Services and General Government (FSGG)	Executive Office of the President	Office of National Drug Control Policy — High Intensity Drug Trafficking Areas	$3,842,814	$4,145,138	$4,232,584
P	FSGG	Executive Office of the President	ONDCP — Drug-Free Communities	$3,250,000	$3,125,000	$2,247,771
	Department of Justice					
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — drug courts	$1,485,511	$399,074	$1,142,667
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Veterans Treatment Courts	0	$550,000	0

Cat.	Subcommittee	Agency	Account	FY2017	FY2018	FY2019
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Residential Substance Abuse Treatment	$114,057	$394,647	$1,051,429
P*	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Prescription Drug Monitoring	$838,056	$749,906	$1,996,316
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Addiction and Recovery Programs — Mentally Ill Offender Act (Justice and Mental Health Collaboration)	$75,000	$392,449	$250,000
CJ	Commerce Science Justice	State and Local Law Enforcement	Comprehensive Opioid Abuse Program	$300,000	$3,720,732	$2,100,000
LE*	Commerce Science Justice	Community-Oriented Policing Services	Anti-Heroin Task Forces	$0	$0	$0
LE*	Commerce Science Justice	Community-Oriented Policing Services	Tribal Assistance Anti-metham-phetamine and anti-opioid activities	N/A		$3,819,139
CJ	Commerce Science Justice	State and Local Law Enforcement	Second Chance Act Grants	$998,259	$2,192,882	$1,997,407
CJ*	Commerce Science Justice	State and Local Law Enforcement	Reaching Youth Impacted by Opioids	N/A	$0	$0
CJ*	Commerce Science Justice	Office for Victims of Crime	Enhancing Community Responses to the Opioid Crisis	N/A	$0	$0
P	Commerce Science Justice	State and Local Law Enforcement	Paul Coverdell Forensic Science	-$17,058	$671,015	$681,371
	Department of Labor					
T	Department of Labor	Employment and Training Administration	National Health Emergency Dislocated Worker Demonstration Grants	N/A	$4,892,659	$0
			TOTAL	***$70,989,896***	***$128,609,158***	***$152,148,743***

Appendix III: Detailed Methodology

1) IDENTIFYING FEDERALLY FUNDED OPIOID PROGRAMS

To identify opioid-specific federal appropriations, BPC conducted the following steps. First, BPC conducted a scan of summary documents from the House of Representatives and the Senate detailing the reported totals for opioid funding. BPC identified each opioid-related program through careful consideration and expert judgment of the program description, award announcements, and designation from federal agency sources. When including programs, BPC erred on the side of broad inclusion.

To identify the program funding levels for FY2017, FY2018, and FY2019 BPC examined each of the final explanatory statements from the 2017, 2018, and 2019 Consolidated Appropriations Acts:[254,255,256]

1. Division A – Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act
2. Division B – Commerce, Justice, Science, and Related Agencies Appropriations Act
3. Division C – Department of Defense Appropriations Act
4. Division D – Energy and Water Development and Related Agencies Appropriations Act
5. Division E – Financial Services and General Government Appropriations Act
6. Division F – Department of Homeland Security Appropriations Act
7. Division G – Department of the Interior, Environment, and Related Agencies Appropriations Act
8. Division H – Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act
9. Division I – Legislative Branch Appropriations Act
10. Division J – Military Construction, Veterans Affairs, and Related Agencies Appropriations Act
11. Division K – Department of State, Foreign Operations, and Related Programs Appropriations Act

12. Division L – Transportation, Housing and Urban Development, and Related Agencies Appropriations Act

Within the Divisions of the Explanatory Statement, BPC was able to identify opioid-specific programs and their funding levels for FY2017, FY2018 and FY2019. Below is a list of the specific programs included in each division. Additionally, programs considered but not included in BPC's analysis are listed following the included programs.

Programs Included in Opioid-Related Funding:

Division H, which includes the Department of Health and Human Services, contained most of the opioid-related programs including:

- **Substance Abuse and Mental Health Services Administration**
  - State Targeted Response
  - Opioid State Targeted Response Technical Assistance
  - State Opioid Response
  - Tribal Opioid Response
  - Rural Opioids Technical Assistance
  - Substance Abuse Prevention and Treatment Block Grant
  - Opioid Treatment Programs
  - Provider's Clinical Support System
  - Targeted Capacity Expansion-General
  - Medication-Assisted Treatment for Prescription Drug and Opioid Addiction
  - Pregnant and Postpartum Women
  - Building Communities of Recovery
  - Recovery Community Services Program
  - Children and Families
  - Criminal Justice Activities
  - Offender Reentry Program
  - Addiction Technology Transfer Centers
  - Strategic Prevention Framework Rx
  - Grants to Prevent Prescription Drug/Opioid Overdose
  - First Responder Training
  - Improving Access to Overdose Treatment
  - Community-Based Coalition Enhancement Grants to Address Local Drug Crises

    - Tribal Behavioral Health Grants
    - Primary and Behavioral Health Integration
    - Technical Assistance
- **Centers for Disease Control and Prevention**
    - Injury Prevention and Control – Opioid Overdose Prevention and Surveillance
    - Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States
- **Health Resources and Services Administration**
    - Expanding Access to Quality Substance Use Disorder and Mental Health Services
    - Rural Health – Rural Communities Opioid Response
    - Opioid Workforce Expansion Programs
- **Administration for Children and Families**
    - Children and Families Services Programs – Child Abuse Prevention and Treatment Act-Infant Plans of Safe Care
    - Promoting Safe and Stable Families
    - Kinship Navigator Programs
    - Regional Partnership Grants
- **National Institutes of Health**
    - National Institute of Neurological Disorders and Stroke—Opioids Research
    - National Institute on Drug Abuse – Opioids Research
- **Centers for Medicare and Medicaid Services**
    - Demonstration Project to Increase Substance Use Provider Capacity

Division A: Agriculture, Rural Development, Food and Drug Administration

- **Food and Drug Administration** – Opioid Enforcement and Surveillance

Division B: Commerce, Justice, Science

- **Department of Justice**
    - Comprehensive Addiction and Recovery Programs
    - Drug Courts
    - Veterans Treatment Courts

    - Residential Substance Abuse Treatment
    - Prescription Drug Monitoring
    - Mentally Ill Offender Act (Justice and Mental Health Collaboration)
    - Other Comprehensive Addiction and Recovery Act activities
- Community Oriented Policing Services
- Anti-Heroin Task Forces
    - Tribal Assistance Anti-methamphetamine and anti-opioid activities
    - Second Chance Act Grants
    - Reaching Youth Impacted by Opioids
    - Office for Victims of Crime – Enhancing Community Responses to the Opioid Crisis
    - Paul Coverdell Forensic Science

Division D: Energy and Water Development: This division had no opioid-related programs.

Division E: Financial Services and General Government.

- **Office of National Drug Control Policy (ONDCP)**
    - High Intensity Drug Trafficking Areas
    - Drug-Free Communities

Division F: Homeland Security

- **Department of Homeland Security**
    - U.S. Customs and Border Protection, Operations and Support—Opioid detection equipment and labs
    - U.S. Customs and Border Protection, Procurement, Construction, and Improvements – opioid detection and nonintrusive inspection equipment
    - Science and Technology – Research, Development, and Innovation—Opioids/Fentanyl
    - Homeland Security Investigations
- Opioid/Fentanyl-related Investigations
- International Investigations-Opioid/Fentanyl
- Intelligence-Opioid/Fentanyl

Division G: Department of the Interior, Environment

- **Indian Health Service**
    - Behavioral Health Integration Initiative

- Special Behavioral Health Pilot Program

Division I: Legislative Branch: This division had no opioid-related programs.

Division J: Military Construction, Veterans Affairs

- **Veterans Affairs**
  - Medical Care – inpatient/outpatient, pharmacy
  - Medical Care – CARA opioid safety initiatives
  - Medical Care – Justice Outreach and Prevention Program
  - Medical Care – Office of Rural Health's Rural Health Initiative

Division L: Transportation, Housing and Urban Development: This division had no opioid-related programs.

Programs Considered But Not Included in Opioid Funding:

Division C: Department of Defense. BPC considered including the Drug Interdiction and Counter-Drug Activities program but decided to exclude this program from the total opioid funding as these accounts were not grant programs and were dedicated to international interdiction efforts.

Division E: Financial Services and General Government. BPC only included the specific programs listed above from the ONDCP, not the entire ONDCP budget as its programs to disrupt drug trafficking networks are not opioid-specific.

Division K: Department of State, Foreign Operations. BPC considered but did not include the Department of State international narcotics control and law enforcement program as these funds are dedicated to international interdiction, not granted to the states.

BPC cross-referenced information gathered from legislative documents with information provided in publicly available agency-specific sources, such as congressional justifications.

Medicaid Treatment Medication Spending

BPC found the state and federal Medicaid spending levels for drugs related to opioid use disorder and the overdose reversal medication naloxone for 2016 to 2019 through the Centers for Medicare and Medicaid Services State Drug Utilization Data files. BPC found the national drug codes using the FDA National Drug Code Directory. BPC excluded buprenorphine codes for buprenorphine injection, Buprenex, Butrans, and Belbuca following a previous study's methods that noted these forms are used primarily to treat pain, not for opioid use disorder.[257] BPC found the spending for naltrexone and naloxone through national drug codes.

At the national level, BPC was unable to identify Medicaid spending on methadone for opioid use disorder from 2016 to 2019 due to inconsistent data reporting on methadone used for pain spending in the State Drug Utilization Data versus spending reported from opioid treatment programs, which is reimbursed under the physician payment code H0020. To find the methadone spending in states, BPC worked the state Medicaid programs to identify the spending for H0020, which BPC reported in each of the state Medicaid tables. For Louisiana and Tennessee, these states do not cover methadone for opioid use disorder through Medicaid.

2) VALIDATING CATALOG OF FEDERAL APPROPRIATIONS AND AWARDS

Expert Interviews. To validate information gathered from document reviews, BPC cross-checked agency sources to USAspending.gov data. BPC then verified the opioid funding levels with federal agency budget officials from SAMHSA, CDC, HRSA, DOJ, and ACF to describe the publicly available information, to further BPC's understanding of the flow of federal funds and evaluation plans to assess their effectiveness and solicit additional detailed information and data related to identified expenditures that may be relevant but not otherwise publicly available.

3) AGGREGATING AND ANALYZING STATE SPENDING DATA

Database Queries and Text Analysis. After identifying the programs BPC decided to include as opioid-related appropriations, the next step was finding the awards granted to each state. Through a cross-check of agency websites posted lists of awards and data from USAspending.gov—the official source for spending data for the government mandated by the Federal Funding Accountability and Transparency Act of 2006—BPC was able to match the program levels from federal appropriations to the actual awards in each state.[258]

For each program, BPC identified the Catalog of Federal Domestic Assistance, or CFDA, number and then searched for the awards from this program in USAspending.gov. This entailed manually verifying the grants for each program, as the CFDA number is same for multiple programs. For example, the SAMHSA Programs of Regional and National Significance, CFDA 93.243, includes many of the opioid-related grants but also includes many other programs not specific to opioids. To parse out the opioid awards, BPC used SAMHSA's grant archive lists to identify each of the 528 opioid-related awards from this CFDA in 2017. From FY2018, BPC located 903 opioid-related awards from the 93.243. In total, BPC identified 5,467 awards funded in FY2019; 3,786 awards in FY2018; and 2,585 awards in 2017.

BPC also reviewed agency materials for additional verification of program levels, including the Congressional Justification documents for FY2018 and FY2019 for SAMHSA that specified the prior-year program totals.[259,260] In addition to SAMHSA's awards, DOJ public disclosures on their opioid awards helped to identify all DOJ funding to states.[261]

4) CASE STUDIES

BPC selected six states representative of a broad cross-section of issues related to resource allocation and emphasis on addressing the opioid epidemic.

Liaisons with designated state officials who oversee the receipt and administration of federal funds targeted to opioids. BPC held conference calls and corresponded with state agencies that oversaw the opioid-related grants in the state. BPC also conducted site visits in 2019 for two states—Ohio and New Hampshire—to further learn directly from state agency leadership about the state's use of federal funds as well as the challenges for the state in addressing the opioid crisis. This allowed BPC to gain perspectives from the diverse group of state agencies overseeing federal funds.

Mapping the data. For the awards to states, USAspending.gov provides the location of the recipient, including the county and Congressional District. Using this information, BPC was able to display the state-level funding. To determine the funding per capita in the states and case study counties, the total award data for the state and county was divided by the population, using the CDC's 2018 county population figures.[262] For the case study states, BPC also identified the sub-award-level data for the SABG and STR grants. For Arizona, Louisiana, and Ohio, sub-award recipients included regional behavioral health organizations responsible for service to multiple counties. For the purpose of this report, BPC considered these sub-awards distributed equally between the counties included in the regional organization. For the Congressional District map purposes, the sub-award was designated as the representative for the address of the award. The tables and charts in this report reflect BPC's analysis of this information.

5) OVERDOSE DEATH DATA

BPC included the overdose death rates from the CDC's WONDER database, including outputs from 1999-2018. BPC followed CDC National Center for Health Statistics' methods to identify overdose deaths from all drugs and opioid-involved overdoses. Within CDC WONDER, drug-poisoning, or overdose, deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Among deaths with drug poisoning as the underlying cause, the following multiple cause-of-death codes indicate the drug type or

types involved: any opioid, T40.0–T40.4 and T40.6; heroin, T40.1; commonly prescribed opioids/Rx opioids, T40.2; methadone, T40.3; and other synthetic opioids/fentanyl, T40.4; stimulants, T40.5 and T43.6; cocaine, T40.5; and psychostimulants with abuse potential, T43.6.

Limitations

At the outset of the research planning for this project, BPC recognized one important limitation: the divergence of publicly available spending information at the unit of analysis needed. In practice, publicly available estimates of federal spending may not be the final estimates of funds available to agencies for several reasons, including the execution of budget transfers, reprogramming for activities within budget accounts, and implementation of mandatory sequestration. Because each of these reasons for variations subsequent to an enacted appropriation is subject to further policy choices, for the purposes of this report, federal appropriations or federal spending reflect direct estimates reported in appropriations law. The use of these estimates reflects the most consistent and accurate baseline estimate for identifying availability of federal funds in a given fiscal year.

The state- and county-level grantee information gathered from USASpending.gov reflects information provided by agencies and grantees to the Bureau of the Fiscal Service at the Department of Treasury. Because of variation in federal appropriations subsequent to the enactment of an appropriations law, in addition to the availability of resources that can be made available to grants from prior fiscal years or re-obligations from de-obligated funds, BPC chose to report "Federal Action Obligation" estimates as the most consistent and reliable estimate of "spending" at the transactional level for grantees. Thus, throughout this report, the use of the term "spending" when referring to state- or local-level data means "obligated amounts."

Appendix IV: Drug Overdose Deaths by Race

STATE DATA

2016-2018 Drug Overdose Deaths by Race		All Drugs 2016–2018 Rates	Opioids 2016–2018 Rates	Stimulants 2016–2018 Rates
Country/State	Race			
United States	Non-Hispanic White	26.2	18.5	7.8
United States	Non-Hispanic Black or African American	19.6	12.4	9.1
United States	Hispanic or Latino	10.4	6.9	4.3
United States	Non-Hispanic Asian or Pacific Islander	3.4	1.6	1.5
United States	Non-Hispanic American Indian or Alaska Native	25.6	14.6	11.1
United States	**Total**	**20.7**	**14.2**	**6.9**
Arizona	Non-Hispanic White	25.7	16.1	9.9
Arizona	Non-Hispanic Black or African American	24.0	11.1	15.1
Arizona	Hispanic or Latino	15.8	10.8	7.1
Arizona	Non-Hispanic Asian or Pacific Islander	4.9	Unreliable	2.7
Arizona	Non-Hispanic American Indian or Alaska Native	19.8	10.2	9.9
Arizona	**Total**	**22.1**	**13.6**	**9.4**
Louisiana	Non-Hispanic White	29.4	11.6	5.2
Louisiana	Non-Hispanic Black or African American	17.3	5.1	4.7
Louisiana	Hispanic or Latino	11.1	6.8	Unreliable
Louisiana	Non-Hispanic Asian or Pacific Islander	Unreliable	Suppressed	Suppressed
Louisiana	Non-Hispanic American Indian or Alaska Native	Unreliable	Suppressed	Suppressed
Louisiana	**Total**	**23.9**	**9**	**4.7**
New Hampshire	Non-Hispanic White	39.3	36.3	6.8
New Hampshire	Non-Hispanic Black or African American	Unreliable	Unreliable	Suppressed
New Hampshire	Hispanic or Latino	26.2	23.6	Suppressed
New Hampshire	Non-Hispanic Asian or Pacific Islander	Suppressed	Suppressed	Suppressed

2016-2018 Drug Overdose Deaths by Race		All Drugs 2016–2018 Rates	Opioids 2016–2018 Rates	Stimulants 2016–2018 Rates
Country/State	Race			
New Hampshire	Non-Hispanic American Indian or Alaska Native	Suppressed	Suppressed	Suppressed
New Hampshire	**Total**	**37.2**	**34.3**	**6.4**
Ohio	Non-Hispanic White	44.0	37.3	15.0
Ohio	Non-Hispanic Black or African American	35.4	27.1	20.0
Ohio	Hispanic or Latino	22.8	19.9	8.2
Ohio	Non-Hispanic Asian or Pacific Islander	3.9	2.8	Unreliable
Ohio	Non-Hispanic American Indian or Alaska Native	28.5	23.9	Suppressed
Ohio	**Total**	**40.5**	**33.9**	**14.8**
Tennessee	Non-Hispanic White	30.3	22.4	9.3
Tennessee	Non-Hispanic Black or African American	16.9	11.0	9.5
Tennessee	Hispanic or Latino	7.8	6.1	Unreliable
Tennessee	Non-Hispanic Asian or Pacific Islander	Unreliable	Unreliable	Suppressed
Tennessee	Non-Hispanic American Indian or Alaska Native	Unreliable	Suppressed	Suppressed
Tennessee	**Total**	**26.2**	**19.1**	**8.6**
Washington	Non-Hispanic White	16.3	10.7	6.4
Washington	Non-Hispanic Black or African American	20.5	11.0	12.2
Washington	Hispanic or Latino	8.0	4.9	4.0
Washington	Non-Hispanic Asian or Pacific Islander	4.1	2.3	2.4
Washington	Non-Hispanic American Indian or Alaska Native	51.1	31.2	24.9
Washington	**Total**	**14.8**	**9.5**	**6.3**

Unreliable: Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less.
Suppressed: Data are Suppressed when the data meet the criteria for confidentiality constraints, below 10 deaths

Appendix V: FY19 Funding Per Capita & 2016-2018 Age-Adjusted Death Rates by County

ARIZONA MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Apache	15,484,901	13.1	25	Mohave	2,643,281	27.0	149
Cochise	1,181,172	22.1	78	Navajo	1,950,991	21.0	63
Coconino	3,385,313	20.4	80	Pima	29,927,075	25.5	749
Gila	2,595,314	41.3	59	Pinal	4,542,348	15.6	189
Graham	760,894	20.6	23	Santa Cruz	3,328,761	15.8	21
Greenlee	700,827	Suppressed	Suppressed	Yavapai	2,523,367	30.1	180
La Paz	712,126	46.4	22	Yuma	2,728,744	18.2	100
Maricopa	61,807,571	21.9	2,845				

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[263]

LOUISIANA MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Acadia	63,922	11.5	20	Madison	44,371	Suppressed	Suppressed
Allen	594,546	14.3	11	Morehouse	211,371	20.7	16
Ascension	64,636	24.9	91	Natchitoches	220,748	Suppressed	Suppressed
Assumption	79,636	19.3	13	Orleans	13,066,607	38.2	463
Avoyelles	775,291	16.6	22	Ouachita	3,311,139	17.5	82
Beauregard	96,746	Suppressed	Suppressed	Plaquemines	195,818	24.2	17
Bienville	53,748	Suppressed	Suppressed	Pointe Coupee	231,636	18.1	12
Bossier	53,748	10.9	42	Rapides	3,710,019	28.1	98
Caddo	3,215,336	12.6	89	Red River	53,748	Suppressed	Suppressed
Calcasieu	1,994,782	13.7	81	Richland	211,371	Suppressed	Suppressed
Caldwell	44,371	Suppressed	Suppressed	Sabine	53,748	Suppressed	Suppressed
Cameron	96,746	Suppressed	Suppressed	St. Bernard	195,818	50.3	67

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Catahoula	52,966	Suppressed	Suppressed	St. Charles	246,636	20.6	32
Claiborne	1,253,748	Suppressed	Suppressed	St. Helena	265,417	38.5	12
Concordia	52,966	Suppressed	Suppressed	St. James	79,636	Suppressed	Suppressed
De Soto	220,748	Suppressed	Suppressed	St. John the Baptist	498,279	30.2	36
East Baton Rouge	47,067,786	20.9	266	St. Landry	230,922	14.8	34
East Carroll	44,371	Suppressed	Suppressed	St. Martin	482,565	9.9	16
East Feliciana	409,351	Suppressed	Suppressed	St. Mary	246,636	23.4	33
Evangeline	63,922	25.2	23	St. Tammany	801,933	31.8	242
Franklin	44,371	Suppressed	Suppressed	Tangipahoa	4,552,538	30.6	120
Grant	52,966	Suppressed	Suppressed	Tensas	211,371	Suppressed	Suppressed
Iberia	230,922	21.6	40	Terrebonne	3,622,147	33.0	108
Iberville	231,636	18.2	18	Union	44,371	Suppressed	Suppressed
Jackson	44,371	Suppressed	Suppressed	Vermilion	63,922	16.2	26
Jefferson	7,778,356	37.4	480	Vernon	52,966	15.5	21
Jefferson Davis	96,746	23.4	20	Washington	98,417	73.4	93
Lafayette	2,657,976	17.6	126	Webster	53,748	Suppressed	Suppressed
Lafourche	79,636	19.4	54	West Baton Rouge	64,636	15.3	12
LaSalle	129,139	Suppressed	Suppressed	West Carroll	44,371	Suppressed	Suppressed
Lincoln	44,371	Suppressed	Suppressed	West Feliciana	64,636	Suppressed	Suppressed
Livingston	98,417	37.9	158	Winn	219,966	Suppressed	Suppressed

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[264]

NEW HAMPSHIRE MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Belknap	2,648,117	47.9	75	Hillsborough	15,613,816	45.6	540
Carroll	67,900	35.4	44	Merrimack	27,339,052	30.1	129
Cheshire	3,381,523	37.1	77	Rockingham	786,504	33.5	284
Coos	3,436,892	31.9	27	Strafford	5,851,597	42.3	153
Grafton	18,469,025	18.4	48	Sullivan	234,164	20.7	23
Greenlee	700,827	Suppressed	Suppressed	Yavapai	2,523,367	30.1	180

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[265]

OHIO MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Adams	887,903	50.6	39	Licking	681,652	21.0	107
Allen	1,269,609	30.8	88	Logan	499,307	36.9	45
Ashland	333,044	22.1	30	Lorain	3,891,143	45.6	392
Ashtabula	648,988	44.1	120	Lucas	10,965,454	42.3	509
Athens	4,900,061	17.6	27	Madison	178,453	31.0	43
Auglaize	102,131	Suppressed	Suppressed	Mahoning	4,051,118	48.8	309
Belmont	495,466	34.2	62	Marion	469,055	49.3	89
Brown	252,218	61.9	75	Medina	855,977	28.2	131
Butler	4,158,608	63.7	670	Meigs	160,583	43.4	27
Carroll	92,606	18.3	15	Mercer	398,561	13.0	16
Champaign	62,107	40.0	43	Miami	675,169	41.1	112
Clark	1,451,816	67.9	247	Monroe	0	Suppressed	Suppressed
Clermont	1,654,093	47.3	274	Montgomery	3,586,961	77.1	1,139
Clinton	220,083	49.7	59	Morgan	259,003	Suppressed	Suppressed
Columbiana	1,005,066	45.2	126	Morrow	0	27.6	25
Coshocton	265,556	16.4	18	Muskingum	510,811	29.9	67
Crawford	44,140	37.7	40	Noble	124,036	23.2	10
Cuyahoga	33,529,080	44.4	1,659	Ottawa	98,094	37.1	37
Darke	581,165	51.4	68	Paulding	283,128	Suppressed	Suppressed
Defiance	509,398	14.0	16	Perry	124,036	23.6	24
Delaware	431,171	13.0	77	Pickaway	344,528	26.1	44
Erie	2,929,701	52.0	98	Pike	428,307	57.5	42
Fairfield	1,790,436	24.9	107	Portage	2,200,092	27.2	121
Fayette	203,382	58.0	44	Preble	105,000	58.4	65
Franklin	78,335,558	32.5	1,288	Putnam	14,119	10.8	11
Fulton	260,056	21.8	22	Richland	1,714,572	54.3	176
Gallia	1,030,162	57.6	47	Ross	4,052,490	47.9	110
Geauga	2,493,152	28.3	63	Sandusky	781,069	38.0	61
Greene	1,426,237	36.7	167	Scioto	1,993,830	65.7	138
Guernsey	209,462	32.6	34	Seneca	1,257,964	25.7	37
Hamilton	24,403,706	49.4	1,172	Shelby	273,875	36.2	47
Hancock	1,257,650	38.6	80	Stark	3,229,109	29.1	295
Hardin	102,131	28.3	23	Summit	7,014,984	45.1	700
Harrison	0	24.1	11	Trumbull	754,556	63.7	338

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Henry	17,517	22.0	18	Tuscarawas	1,436,945	20.3	49
Highland	78,382	49.0	55	Union	862,050	16.1	27
Hocking	846,222	33.1	25	Van Wert	554,861	30.1	21
Holmes	317,387	12.1	16	Vinton	246,222	28.1	11
Huron	310,315	42.5	67	Warren	905,859	29.3	190
Jackson	160,583	33.4	29	Washington	19,933	32.8	52
Jefferson	201,999	42.6	70	Wayne	1,244,795	26.8	82
Knox	616,837	22.5	36	Williams	0	26.5	25
Lake	2,351,404	44.8	277	Wood	2,022,201	16.1	57
Lawrence	402,766	56.3	92	Wyandot	84,000	21.2	14

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[266]

TENNESSEE MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Anderson	1,421,360	46.7	107	Lauderdale	70,939	23.1	18
Bedford	509,440	16.0	21	Lawrence	175,278	20.4	28
Benton	0	27.0	13	Lewis	3,156,291	Suppressed	Suppressed
Bledsoe	0	24.9	11	Lincoln	0	20.4	21
Blount	163,630	36.4	134	Loudon	0	37.7	50
Bradley	49,627	24.7	75	McMinn	0	25.5	40
Campbell	340,000	29.0	31	McNairy	0	14.1	11
Cannon	0	28.1	12	Macon	0	18.1	13
Carroll	0	Suppressed	Suppressed	Madison	2,124,609	14.2	38
Carter	137,238	32.5	57	Marion	0	17.6	15
Cheatham	406,379	52.5	63	Marshall	0	28.0	28
Chester	0	Suppressed	Suppressed	Maury	262,486	21.8	59
Claiborne	200,000	38.7	39	Meigs	0	35.7	13
Clay	65,372	47.5	11	Monroe	231,422	38.2	49
Cocke	167,000	32.0	30	Montgomery	0	20.8	123
Coffee	104,972	34.1	52	Moore	0	Suppressed	Suppressed
Crockett	0	Suppressed	Suppressed	Morgan	353,020	21.6	14
Cumberland	0	23.1	32	Obion	52,403	Suppressed	Suppressed
Davidson	44,351,883	32.5	706	Overton	263,219	27.2	18
Decatur	0	Suppressed	Suppressed	Perry	0	Suppressed	Suppressed
DeKalb	50,052	30.3	18	Pickett	0	Suppressed	Suppressed

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Dickson	65,304	29.6	46	Polk	167,000	23.8	12
Dyer	65,042	Suppressed	Suppressed	Putnam	203,598	22.5	46
Fayette	0	11.7	14	Rhea	0	17.3	17
Fentress	0	Suppressed	Suppressed	Roane	510,002	46.2	77
Franklin	874,326	18.3	21	Robertson	0	19.3	40
Gibson	59,104	20.0	30	Rutherford	553,309	21.9	210
Giles	0	22.5	20	Scott	234,636	15.2	10
Grainger	0	14.4	10	Sequatchie	0	27.0	12
Greene	0	31.3	60	Sevier	963,539	37.4	103
Grundy	0	Suppressed	Suppressed	Shelby	15,380,471	20.2	563
Hamblen	106,071	25.3	47	Smith	265,018	32.2	19
Hamilton	6,227,702	20.7	220	Stewart	63,106	Suppressed	Suppressed
Hancock	0	Suppressed	Suppressed	Sullivan	2,828,889	29.6	143
Hardeman	136,993	Suppressed	Suppressed	Sumner	234,158	23.2	122
Hardin	568,980	31.6	21	Tipton	197,214	28.2	49
Hawkins	167,000	25.1	43	Trousdale	0	40.9	12
Haywood	966,113	Suppressed	Suppressed	Unicoi	59,565	39.0	23
Henderson	0	19.2	16	Union	68,287	38.7	23
Henry	48,887	17.5	17	Van Buren	0	Suppressed	Suppressed
Hickman	0	28.0	21	Warren	0	17.8	21
Houston	0	Suppressed	Suppressed	Washington	6,309,687	24.0	92
Humphreys	0	28.9	16	Wayne	0	Suppressed	Suppressed
Jackson	0	31.4	11	Weakley	413,728	17.0	17
Jefferson	958,760	19.2	30	White	0	28.8	22
Johnson	259,531	Suppressed	Suppressed	Williamson	822,427	15.9	96
Knox	24,845,036	48.8	679	Wilson	0	24.9	96
Lake	0	Suppressed	Suppressed				

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[267]

WASHINGTON MAP DETAILS

County	FY2019 $ Amount	Death Rate	Death Count	County	FY2019 $ Amount	Death Rate	Death Count
Adams	289,621	Suppressed	Suppressed	Lewis	1,110,953	12.7	34
Asotin	45,607	23.7	16	Lincoln	55,460	Suppressed	Suppressed
Benton	1,842,711	15.5	90	Mason	1,534,089	15.5	30
Chelan	630,783	10.1	22	Okanogan	2,794,469	12.8	16
Clallam	1,091,043	28.7	56	Pacific	1,517,300	20.0	13
Clark	5,045,568	13.8	199	Pend Oreille	295,945	Suppressed	Suppressed
Columbia	33,071	Suppressed	Suppressed	Pierce	5,979,073	17.2	466
Cowlitz	1,116,811	19.1	61	San Juan	77,625	Suppressed	Suppressed
Douglas	16,667	Suppressed	Suppressed	Skagit	7,943,064	18.2	66
Ferry	186,479	Suppressed	Suppressed	Skamania	181,866	Suppressed	Suppressed
Franklin	910,664	11.0	27	Snohomish	4,815,418	16.6	423
Garfield	44,809	Suppressed	Suppressed	Spokane	5,825,247	17.5	271
Grant	509,052	14.7	38	Stevens	1,107,244	20.2	24
Grays Harbor	2,769,768	24.2	52	Thurston	21,993,853	10.9	97
Island	173,850	9.0	22	Wahkiakum	64,851	Suppressed	Suppressed
Jefferson	823,156	21.4	20	Walla Walla	469,774	22.4	38
King	46,511,771	14.0	1,011	Whatcom	4,882,043	7.7	48
Kitsap	3,438,913	12.7	111	Whitman	2,086,119	8.8	13
Kittitas	1,179,524	7.2	10	Yakima	4,172,149	15.0	105
Klickitat	581,029	16.9	11				

Death rates and counts are age-adjusted mortality rates for all drug overdose deaths, 2016-2018.[268]

Endnotes

1 Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV, Nicole L. Davis, "Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018," *MMWR Morbidity and Mortality Weekly Report*, 69(11): 290-297, March 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm.

2 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

3 Josh Katz, Abby Goodnough, and Margot Sanger-Katz, "In shadow of Pandemic, U.S. Drug Overdose Resurge to Records," *New York Times*, July 15, 2020. Available at: https://www.nytimes.com/interactive/2020/07/15/upshot/drug-overdose-deaths.html?referringSource=articleShare.

4 Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV, Nicole L. Davis, "Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018," *MMWR Morbidity and Mortality Weekly Report*, 69(11): 290-297, March 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm.

5 Mirsada Serdarevic, Catherine Striley, Linda Cottler, "Gender Differences in Prescription Opioid Use," *Current Opinion in Psychiatry*, 30(4): 238-246, July 2017. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5675036/.

6 Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV, Nicole L. Davis, "Drug and Opioid-Involved Overdose Deaths – United States, 2017–2018," *MMWR Morbidity and Mortality Weekly Report*, 69(11): 290-297, March 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm.

7 Centers for Disease Control and Prevention, "Syringe Services Programs (SSPs)," June 2019. Available at: https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html.

8 Sara N. Glick, Stephanie M. Prohaska, Paul A. LaKosky, Alexa M. Juarez, Maria A. Corcorran, and Don C. Des Jarlais, "The Impact of COVID-19 on Syringe Services Programs in the United States," *AIDS and Behavior*, 1-3, April 24, 2020. Available at: https://doi.org/10.1007/s10461-020-02886-2.

9 Liana W. Rosen & Clare Ribando Seelke, *Trends in Mexican Opioid Trafficking and Implications for U.S.- Mexico Security Cooperation*, Congressional Research Service, April 16, 2020. Available at: https://crsreports.congress.gov/product/pdf/IF/IF10400.

10 Drug Enforcement Agency, *Fentanyl Flow to the United States*, January 2020. Available at: https://www.dea.gov/sites/default/files/2020-03/DEA_GOV_DIR-008-20%20Fentanyl%20Flow%20in%20the%20United%20States_0.pdf.

11 Centers for Disease Control and Prevention. "Provisional Drug Overdose Death Counts." July 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

12 Hawre Jalal, Jeanine M. Bucahnich, Mark S. Roberts, Lauren C. Balmert, Kun Zhang, and Donald S. Burke, "Changing Dynamics of the Drug Overdose Epidemic in the United States from 1979 to 2016," Science, 361(6408), September 21, 2018. Available at:

13 Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV, Nicole L. Davis, "Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018," *MMWR Morbidity and Mortality Weekly Report*, 69(11): 290-297, March 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm.

14 Centers for Disease Control and Prevention, "Fentanyl," March 19, 2020. Available at: https://www.cdc.gov/drugoverdose/opioids/fentanyl.html.

15 Agency for Healthcare Research and Quality, *Blacks Experiencing Fast-Rising Rates of Overdose Deaths Involving Opioids other than Methadone*, February 2020. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-opioid.pdf.

16 Nana Wilson, Mbabazi Kariisa, Puja Seth, Herschel Smith IV, Nicole L. Davis, "Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018," *MMWR Morbidity and Mortality Weekly Report*, 69(11): 290-297, March 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm.

17 Substance Abuse and Mental Health Services Administration. "The Opioid Crisis and The Black/African American Population: An Urgent Issue. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

18 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

19 Centers for Disease Control and Prevention, *CDC WONDER Online Database*, July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

20 Ibid.

21 Centers for Disease Control and Prevention, *CDC WONDER Online Database*, July 2020. Multiple Cause of Death Code T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

22 Centers for Disease Control and Prevention, *CDC Wonder Online Database*, July 2020. Multiple Cause of Death Code T40.5. Available at: http://wonder.cdc.gov/mcd-icd10.html.

23 Centers for Disease Control and Prevention. "CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain." June 2019. Available at: https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html.

24 Congress.gov, "H.R.6 – SUPPORT for Patients and Communities Act," October 2018. Available at: https://www.congress.gov/bill/115th-congress/house-bill/6/text?overview=closed.

25 U.S. Department of Health and Human Services, "5-Point Strategy to Combat the Opioid Crisis," August 7, 2018. Available at: https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html.

26 Public Health Emergency, "Public Health Emergency Declarations," July 2020. Available at: https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.

27 White House. "National Drug Control Policy." January 2019. Available at: https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf.

28 Congress.gov. "H.R. – 748 CARES Act." July 2020Available at: https://www.congress.gov/bill/116th-congress/house-bill/748/text.

29 U.S. Department of Health and Human Services. "HHS by the numbers." January 2019. https://www.hhs.gov/opioids/about-the-epidemic/hhs-by-numbers/index.html.

30 115th Congress, *H. Rept. 115-952 – Department of Defense for the Fiscal Yar Ending September 30, 2019, and for Other Purposes*. U.S. Government Publishing Office, September 13, 2018. Available at: https://www.congress.gov/115/crpt/hrpt952/CRPT-115hrpt952.pdf.

31 116th Congress, *H. Rept. 116-9 – Making further Continuing Appropriations for the Department of Homeland Security for Fiscal Year 2019, and for Other Purposes*, U.S. Government Publishing Office, 751, February 13, 2019. Available at: https://congress.gov/congressional-report/116th-congress/house-report/9/1.

32 Substance Abuse and Mental Health Services Administration, "Targeted Capacity Expansion: Medication Assisted Treatment—Prescription Drug and Opioid Addiction," April 29, 2020. Available at: https://www.samhsa.gov/grants/grant-announcements/ti-18-009.

33 Substance Abuse and Mental Health Services Administration, "Strategic Prevention Framework for Prescription Drugs," July 13, 2020. Available at: https://www.samhsa.gov/grants/grant-announcements/sp-16-006.

34 U.S. Department of Justice, "Justice Department is Awarding More than $333 Million to Combat Opioid Crisis," December 13, 2019. Available at: https://www.justice.gov/opa/pr/justice-department-awards-more-333-million-fight-opioid-crisis.

35 U.S. Department of Justice, "Justice Department is Awarding Almost $320 Million to Combat Opioid Crisis," October 1, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

36 U.S. Department of Justice, "Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)." Available at: https://bja.ojp.gov/program/cossap/overview.

37 Ibid.

38 U.S. Department of Justice, "Justice Department is Awarding More than $333 Million to Combat Opioid Crisis," December 13, 2019. Available at: https://www.justice.gov/opa/pr/justice-department-awards-more-333-million-fight-opioid-crisis.

39 Ibid.

40 H.R. 1625 Consolidated Appropriations Act, 2018. "Explanatory Statement-Division H." March 21, 2018. Available at: https://docs.house.gov/billsthisweek/20180319/DIV%20H%20LABORHHS%20SOM%20FY18%20OMNI.OCR.pdf.

41 Centers for Disease Control and Prevention, "CDC Awards New Funds to Stop Drug Overdoses, Deaths," September 4, 2019. Available at: https://www.cdc.gov/media/releases/2019/p0904-stop-drug-overdoses-deaths.html.

42 Ibid.

43 Ibid.

44 Centers for Disease Control and Prevention, "Opioid Funding," May 12, 2020. Available at: https://www.cdc.gov/cpr/readiness/funding-opioid.htm.

45 Ibid.

46 National Institutes of Health, "NIH funds $945 million in research to tackle the national opioid crisis through NIH HEAL Initiative," September 26, 2019. Available at: https://www.nih.gov/news-events/news-releases/nih-funds-945-million-research-tackle-national-opioid-crisis-through-nih-heal-initiative.

47 Brianna Ehley, "Pandemic Unleashes a Spike in Overdose Deaths," Politico, June 29, 2020. Available at: https://www.politico.com/news/2020/06/29/pandemic-unleashes-a-spike-in-overdose-deaths-345183.

48 Kaiser Family Foundation, *Medicaid's Role in Addressing the Opioid Epidemic*, June 3, 2019. Available at: https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.

49 Kendal Orgera, Jennifer Tolbert, "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment," Kaiser Family Foundation, May 24, 2019. Available at: https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/.

50 Ibid.

51 U.S. Government Accountability Office, *Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications*, GAO-20-233, January 24, 2020. Available at: https://www.gao.gov/products/GAO-20-233.

52 Kaiser Family Foundation, *Medicaid's Role in Addressing the Opioid Epidemic*, June 3, 2019. Available at: https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.

53 Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), "HCUP Fast Stats—Opioid-Related Hospital Use," April 29, 2020. Available at: https://www.hcup-us.ahrq.gov/faststats/OpioidUseServlet.

54 Ibid.

55 Ibid.

56 Kaiser Family Foundation, "Medicaid's Role in Addressing the Opioid Epidemic," June 3, 2019. Available at: https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.

57 U.S. Government Accountability Office, "Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications," January 24, 2020. Available at: https://www.gao.gov/products/GAO-20-233.

58 Centers for Medicare and Medicaid Services. *State Drug Utilization Data*. Available at: https://data.medicaid.gov/.

59 National Institute on Drug Abuse, "Opioid Summaries by State," April 16, 2020. Available at: https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state.

60 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

61 National Institute on Drug Abuse, "Arizona: Opioid-Involved Deaths and Related Harms," July 13, 2020. Available at: https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/arizona-opioid-involved-deaths-related-harms.

62 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

63 Ibid.

64 Ibid.

65 Ibid.

66 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

67 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

68 Ibid.

69 Ibid.

70 Arizona Department of Health Services, "Arizona Opioid Action Plan Version 2.0 July 2019-July 2021." Available at: https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php.

71 Correspondence with Hazel Alvarenga, Arizona Health Care Cost Containment System, March 2, 2020.

72 Ibid.

73 National Association of State Alcohol and Drug Abuse Directors, "Arizona STR/SOR Profile," October 1, 2019. Available at: https://nasadad.org/2019/10/arizona-str-sor-profile/.

74 Correspondence with Hazel Alvarenga, Arizona Health Care Cost Containment System, March 2, 2020.

75 National Association of State Alcohol and Drug Abuse Directors, "Arizona STR/SOR Profile," October 1, 2019. Available at: https://nasadad.org/2019/10/arizona-str-sor-profile/.

76 Interview with Karen Hellman, Arizona Department of Corrections, March 27, 2020.

77 Correspondence with Hazel Alvarenga, Arizona Health Care Cost Containment System, March 2, 2020.

78 Interview with Karen Hellman, Arizona Department of Corrections, March 27, 2020.

79 Ibid.

80 Interview with Andrew Lefevre, Arizona Criminal Justice Commission, April 10, 2020.

81 Correspondence with Hazel Alvarenga, Arizona Health Care Cost Containment System, March 2, 2020.

82 Ibid.

83 Ibid.

84 Ibid.

85 Arizona Department of Health Services, "Arizona Opioid Action Plan Version 2.0 July 2019-July 2021." Available at: https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php.

86 Ibid.

87 Ibid.

88 Correspondence with Hazel Alvarenga, Arizona Health Care Cost Containment System, March 2, 2020.

89 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." July 2020. Available at: https://data.medicaid.gov/.

90 Ibid.

91 Centers for Disease Control and Prevention. "CDC WONDER Online Database." July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

92 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

93 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

94 Ibid.

95 Ibid.

96 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

97 Centers for Disease Control and Prevention. "CDC WONDER Online Database." July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

98 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

99 Ibid.

100 Ibid.

101 Bipartisan Policy Center, *Tracking Federal Funding to Combat the Opioid Crisis*, March 2019. Available at: https://bipartisanpolicy.org/report/tracking-federal-funding-to-combat-the-opioid-crisis/.

102 SOR Year 1 Annual Report, October 1, 2018-September 30, 2019, Louisiana Department of Health/Office of Behavioral Health.

103 Ibid.

104 Beth Connolly, "Louisiana Expands Access to Addiction Treatment," The Pew Charitable Trusts, August 27, 2019. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2019/08/27/louisiana-expands-access-to-addiction-treatment.

105 Bill Track 50, "LA HCR71," June 4, 2019. Available at: https://www.billtrack50.com/BillDetail/1122461.

106 Centers for Medicare and Medicaid Services. "State Drug Utilization Data." July 2020. Available at: https://data.medicaid.gov/.

107 SOR Year 1 Annual Report, October 1, 2018-September 30, 2019, Louisiana Department of Health/Office of Behavioral Health.

108 Interview with Lee Mendoza and Nell Wilson, Louisiana Dept of Health, March 5, 2020.

109 Interview with Blake Leblanc and Shelley Edgerton, Louisiana Dept of Corrections, March 3, 2020.

110 SOR Year 1 Annual Report, October 1, 2018-September 30, 2019, Louisiana Department of Health/Office of Behavioral Health.

111 Correspondence with Janice Williams, Louisiana Department of Health, May 19, 2020.

112 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

113 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, July 15, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

114 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

115 Ibid.

116 Ibid.

117 Ibid.

118 Centers for Disease Control and Prevention, "CDC WONDER Online Database." July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

119 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

120 Ibid.

121 Ibid.

122 Bipartisan Policy Center, *Tracking Federal Funding to Combat the Opioid Crisis*, March 2019. Available at: https://bipartisanpolicy.org/report/tracking-federal-funding-to-combat-the-opioid-crisis/.

123 New Hampshire Department of Health and Human Services, "Governor's Commission on Health and Other Drugs," July 2020. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/commission.htm.

124 U.S. Department of Labor, "National Dislocated Worker (DW) Demonstration Grant Summary," Available at: https://www.dol.gov/sites/dolgov/files/ETA/DWGs/pdfs/NH-NHE-Demo-Grant.pdf.

125 New Hampshire Department of Health and Human Services, *State Opioid Response (SOR) (FOA) No. TI-18-015 New Hampshire Non-Competing Progress Report: September 30, 2018 – September 30, 2019*. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/sor-grant-proposal.pdf.

126 Ibid.

127 Ibid.

128 Interview with staff, New Hampshire Department of Corrections, 3/27/2020.

129 Correspondence with staff, New Hampshire Department of Health and Human Services, May 12, 2020. Available at: https://www.dhhs.nh.gov/dcbcs/bbh/documents/rapid-response-narrative.pdf.

130 New Hampshire Department of Health and Human Services, "NH Medicaid FFS and MCO Reimbursement Summary by Paid Calendar Year 1/1/2016 to 12/31/2019," Medicaid Management Information System data extracted from New Hampshire Department of Health and Human Services Enterprise Business Intelligence Data Warehouse, September 10, 2020. Note: Excludes claims paid by Qualified Health Plans for members in NH Medicaid's Premium Assistance Program.

131 New Hampshire Department of Health and Human Services, "NH Medicaid FFS and MCO Reimbursement Summary by Paid Calendar Year 1/1/2016 to 6/30/2018," Medicaid Management Information System, February 20, 2019. Note: Excludes claims paid by Qualified Health Plans for members in NH Medicaid's Premium Assistance Program.

132 New Hampshire Department of Health and Human Services, *State Opioid Response (SOR) (FOA) No. TI-18-015 New Hampshire Non-Competing Progress Report: September 30, 2018 – September 30, 2019*. Available at: https://www.dhhs.nh.gov/dcbcs/bdas/documents/sor-grant-proposal.pdf.

133 Correspondence with staff, New Hampshire Department of Health and Human Services, May 12, 2020.

134 Correspondence with staff, New Hampshire Department of Health and Human Services, June 4, 2020.

135 Centers for Disease Control and Prevention, *CDC WONDER Online Database*, July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

136 Ibid.

137 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

138 Ohio Department of Health, *2018 Ohio Drug Overdose Data: General Findings*, December 4, 2019. Available at: https://odh.ohio.gov/wps/wcm/connect/gov/d9ee6d3b-bf62-4b4f-8978-d7cfcd11348f/2018_OhioDrugOverdoseReport.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-d9ee6d3b-bf62-4b4f-8978-d7cfcd11348f-mXhFqNO.

139 Centers for Disease Control and Prevention, "Fentanyl," March 2020. Available at: https://www.cdc.gov/drugoverdose/opioids/fentanyl.html.

140 Ohio Department of Health, *2018 Ohio Drug Overdose Data: General Findings*, December 4, 2019. Available at: https://odh.ohio.gov/wps/wcm/connect/gov/d9ee6d3b-bf62-4b4f-8978-d7cfcd11348f/2018_OhioDrugOverdoseReport.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-d9ee6d3b-bf62-4b4f-8978-d7cfcd11348f-mXhFqNO.

141 Ibid.

142 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

143 Ibid.

144 Ibid.

145 Ibid.

146 RecoveryOhio, "Priorities," July 2020. Available at: https://recoveryohio.gov/wps/portal/gov/recovery/priorities.

147 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

148 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

149 Ibid.

150 Ibid.

151 National Institute of Health. "HEALing Communities Study," July 2020. Available at: https://heal.nih.gov/research/research-to-practice/healing-communities.

152 "SOR Annual Report," Correspondence with Jamie Carmichael, OhioMHAS, July 24, 2020.

153 Harm Reduction Ohio, "Ohio launches new anti-overdose media campaign," June 2020. Available at: https://www.harmreductionohio.org/state-of-ohio-launches-controversial-new-anti-overdose-media-campaign/.

154 "SOR Annual Report," Correspondence with Jamie Carmichael, OhioMHAS, July 24, 2020.

155 Ohio Governor, "CMS Approves Ohio's Substance Use Disorder Demonstration Waiver to Improve Patient Treatment Options," September 2019. Available at: https://governor.ohio.gov/wps/portal/gov/governor/media/news-and-media/cms-approves-ohios-substance-use-disorder-demonstration-waiver-to-improve-patient-treatment-options?fbclid=IwAR0pS9LVjBAfFo_D3mb1txuq-DTYma1p_kbk8GLx9pLjkVzHGf5MQ6YZFlw.

156 Correspondence with Jamie Carmichael, OhioMHAS, May 26, 2020.

157 "SOR Annual Report," Correspondence with Jamie Carmichael, OhioMHAS, July 24, 2020.

158 The Center for Community Solutions, "Ohio Syringe Services Program Profiles," May 2019. Available at: https://www.communitysolutions.com/research/profiles-ohio-syringe-service-programs-ssps-doubled-since-2016/.

159 Centers for Disease Control and Prevention, "Determination of Need for Syringe Services Programs," February 2020. Available at: https://www.cdc.gov/ssp/determination-of-need-for-ssp.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Frisk%2Fssps-jurisdictions.html.

160 Naloxoneforall, "Find Resources in Ohio," July 2020. Available at: https://www.naloxoneforall.org/ohio.

161 Interview with Aimee Shadwick, RecoveryOhio, May 26, 2020.

162 WCPO Cincinnati, "WCPO rides along with Heroin Quick Response Team in Kenton County," March 2017. Available at: https://www.wcpo.com/news/local-news/kenton-county/wcpo-rides-along-with-heroin-quick-response-team-in-kenton-county.

163 WV News, "New Huntington Team bringing raping response to opioid epidemic," December 2017. Available at: https://www.wvnews.com/news/wvnews/new-huntington-team-bringing-rapid-response-to-opioid-epidemic/article_07e4a543-7c47-5af5-8a8b-7a924cf97d4e.html#.

164 Cover 2 Resources, "Quick Response Team Workshop Videos," July 2020. Available at: https://cover2.org/programs/quick-response-teams/.

165 Substance Abuse and Mental Health Services Administration. "Emergency Grants to Address Mental and Substance Use Disorders During COVID-19." April 2020. Available at: https://www.samhsa.gov/grants/grant-announcements/fg-20-006.

166 Interview with Aimee Shadwick, RecoveryOhio, May 26, 2020.

167 Centers for Medicare and Medicaid Services, "State Drug Utilization Data," July 2020. Available at: https://data.medicaid.gov/.

168 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

169 Centers for Disease Control and Prevention, "U.S. Opioid Prescribing Rate Maps," March 2020. Available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.

170 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

171 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

172 Ibid.

173 Ibid.

174 Ibid.

175 Interview with Amy Koslick, Department of Children Services, March 6, 2020.

176 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

177 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

178 Ibid.

179 Ibid.

180 Bipartisan Policy Center, *Tracking Federal Funding to Combat the Opioid Crisis*, March 2019. Available at: https://bipartisanpolicy.org/report/tracking-federal-funding-to-combat-the-opioid-crisis/.

181 National Institues of Health, "Funded Projects," March 18, 2020. Available at: https://heal.nih.gov/funding/awarded.

182 "SOR Year 1 Performance Progress Report," Correspondence with Taryn Sloss, Tennessee Department of Mental Health and Substance Abuse Services, July 23, 2020.

183 Interview with Meredith Brantley, Tennessee Department of Health, March 6, 2020.

184 SOR Year 1 Performance Progress Report," Correspondence with Taryn Sloss, Tennessee Department of Mental Health and Substance Abuse Services, July 23, 2020.

185 Correspondence with Kristen Zak, Tennessee Department of Health, August 26, 2020.

186 Interview with Dr. Victor Wu, TennCare, March 26, 2020 & State PowerPoint presentation.

187 Centers for Medicare and Medicaid Services, "State Drug Utilization Data," July 2020. Available at: https://data.medicaid.gov/.

188 FB Ahmad, LM Rossen, P Sutton, "Provisional Drug Overdose Death Counts", National Center for Health Statistics, August 20, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

189 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

190 Ibid.

191 Ibid.

192 Ibid.

193 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Opioids include T40.0-T40.4, T40.6; Cocaine T40.5; Psychostimulants with Abuse Potential T43.6. Available at: http://wonder.cdc.gov/mcd-icd10.html.

194 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

195 Ibid.

196 Ibid.

197 Washington State Department of Health, "2018 Washington State Opioid Response Plan," July 2018. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/140-182-StateOpioidResponsePlan.pdf.

198 U.S. Department of Labor, "National Health Emergency," July 2020. Available at: https://www.dol.gov/agencies/eta/dislocated-workers/grants/health-emergency.

199 Washington State Department of Health, "2018 Washington State Opioid Response Plan," July 2018. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/140-182-StateOpioidResponsePlan.pdf.

200 Ibid.

201 Washington State Opioid Response (SOR) and SOR Supplement Grants Performance Progress Report – December 2019, Washington State Health Care Authority.

202 Ibid.

203 Ibid.

204 Ibid.

205 Washington State Department of Social and Health Services, *Overdose Deaths among Medicaid Enrollees in Washington State*, September 2015. Available at: https://www.dshs.wa.gov/sites/default/files/rda/reports/research-4-92.pdf.

206 Interview with Kristopher Shera, Division of Behavioral Health and Recovery, February 7, 2020.

207 Centers for Medicare & Medicaid Services, "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003," June 25, 2019. Available at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorder-prevention-promotes-opioid-recovery-and-treatment-patients-and-communities-support-act-section-1003/index.html.

208 Correspondence with Kristopher Shera, Washington State Health Care Authority, August 17, 2020.

209 Ibid.

210 National Association of State and Alcohol Drug Abusers, "Washington State STR-SOR Profile," Available at: https://nasadad.org/washington-state-str-sor-profile/.

211 University of Washington Alcohol and Drug Abuse Institute. "WA State Syringe Exchange Health Survey, 2019 Results," April 2020. Available at: https://adai.uw.edu/wa-state-syringe-exchange-health-survey-2019-results/.

212 Gray Harbor Public Health and Social Services. "Syringe Services." March 2020. Available at: http://www.healthygh.org/directory/syringe.

213 Washington State Department of Health, "Fentanyl Strip Test Project," July 2020. Available at: https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone/FentanylTestStrip.

214 Centers for Medicare and Medicaid Services, "State Drug Utilization Data," Available at: https://data.medicaid.gov/.

215 Substance Abuse and Mental Health Services Administration, "Crisis Counseling Assistance and Training Program," August 2019. Available at: https://www.samhsa.gov/dtac/ccp.

216 Substance Abuse and Mental Health Services Administration, "Emergency Grants to Address Mental and Substance Use Disorders during COVID-19," April 2020. Available at: https://www.samhsa.gov/grants/grant-announcements/fg-20-006.

217 Substance Abuse and Mental Health Services Administration, "Emergency Grants to Address Mental and Substance Use Disorders during COVID-19," April 2020. Available at: https://www.samhsa.gov/grants/grant-announcements/fg-20-006.

218 Interview with Dawn Williams, Department of Corrections, April 17, 2020.

219 James Drew, "State, Inmates' Attorney Clash Over COVID-19 Early Release Plan," The Olympian, April 32, 2020. Available at: https://www.theolympian.com/news/politics-government/article242221436.html.

220 Kumiko M. Lippold, Christopher M. Jones, Emily O'Malley Olsen, Brett P. Giroir, "Racial/Ethnic and Age Group Differences In Opioid and Synthetic Opioid – Involved Overdose Deaths Among Adults Aged ≥ 18 Years in Metropolitan Areas – United States, 2015-2017," *MMWR Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, November 1, 2019. Available at: http://dx.doi.org/10.15585/mmwr.mm6843a3.

221 Ibid.

222 Ibid.

223 American Society of Addiction Medicine, "COVID-19 Resources," July 2020. Available at: https://www.asam.org/Quality-Science/covid-19-coronavirus.

224 Alana Sharp, Austin Jones, Jennifer Sherwood, Oksana Kutsa, Brian Honermann, Gregorio Millett, "Impact of Medicaid Expansion on Access to Opioid Analgesic Medications and Medication-Assisted Treatment," *American Journal of Public Health*, 108(5):642-648, April 4, 2018. Available at: https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304338.

225 Benjamin A.Y. Cher, Nancy E. Morden, and Ellen Meara, "Medicaid Expansion and Prescription Trends: Opioids, Addiction Therapies, and Other Drugs," *Medical Care*, 57(3), March 2019. Available at: https://pubmed.ncbi.nlm.nih.gov/30629018/.

226 Kumiko M. Lippold, Christopher M. Jones, Emily O'Malley Olsen, Brett P. Giroir, "Racial/Ethnic and Age Group Differences In Opioid and Synthetic Opioid – Involved Overdose Deaths Among Adults Aged ≥ 18 Years in Metropolitan Areas – United States, 2015-2017," *MMWR Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, November 1, 2019*. Available at: http://dx.doi.org/10.15585/mmwr.mm6843a3.

227 Paul J. Joudrey, Maria R. Khan, Emily A. Wang, et. al., "A Conceptual Model for Understanding Post-release Opioid-related Overdose Risk," *Addiction Science & Clinical Practice*, 14(17), April 15, 2019. Available at: https://doi.org/10.1186/s13722-019-0145-5.

228 Davida M. Schiff, Timothy Nielson, Betina B. Hoeppner, et.al., "Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts." *JAMA Network Open*, 3(5):e205634, May 26, 2020. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766203.

229 P.A. Lagisetty, R. Ross, A. Bohnert, M. Clay, D.T. Maust, "Buprenorphine Treatment Divide by Race/Ethnicity and Payment," *JAMA Psychiatry*, May 7, 2019. Available at: https://europepmc.org/article/med/31066881

230 Providers Clinical Support System, "Negative Stigma of Methadone," October 2017. Available at: https://pcssnow.org/resource/negative-stigma-of-methadone/.

231 Substance Abuse and Mental Health Services Administration, "Practitioner and Program Data," April 2020. Available at: https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data.

232 Grace King, "Tennessee Lawmakers Move to Expand Treatment for Those Struggling with Addiction," *WBIR*, June 19, 2020. Available at: https://www.wbir.com/article/news/local/od-epidemic/tennessee-lawmakers-move-to-expand-treatment-for-those-struggling-with-addiction/51-91883dd9-b3aa-4c1c-9c0e-9639355dfab4.

233 Grants.gov, "National Harm Reduction Technical Assistance and Syringe Services Program (SSP) Monitoring and Evaluation Funding Opportunity," May 2019. Available at: https://www.grants.gov/web/grants/view-opportunity.html?oppId=312354.

234 Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, August 2019, Available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

235 Hannah K. Knudsen, Amanda J. Abraham, Paul M. Roman, "Adoption and Implementation of Medications in Addiction Treatment Programs," *Journal of Addiction Medicine*, 5(1);21-27, March 2011. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3045214/.

236 K Wells, R Klap, A Koike, C Sherbourne, "Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care." *American Journal of Psychiatry,* 158(12):2027-2032, December 2001. Available at: https://pubmed.ncbi.nlm.nih.gov/11729020/.

237 Holly Hedegaard, Arialdi M. Miniño, Maragaret Warner, "Drug Overdose Deaths in the United States, 1999-2018." January 2020. Available at: https://www.cdc.gov/nchs/products/databriefs/db356.htm.

238 Aliese Alter & Christopher Yeager, "COVID-19 Impact on US National Overdose Crisis," June 2020. Available at: http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-June-2020.pdf.

239 Office of Inspector General, "States' Use of Grant Funding for a Targeted Response to the Opioid Crisis," Department of Health and Human Services, March 2020. Available at: https://oig.hhs.gov/oei/reports/oei-BL-18-00460.pdf.

240 Rebecca L. Haffajee, Lewei Allison Lin, Amy S.B. Bohnert, et. al., "Characteristics of US Counties with High Opioid Overdose Mortality and Low Capacity to Deliver Medications for Opioid Use Disorder," *JAMA Network Open*, 2(6):196373, June 28, 2019. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2736933.

241 Warren.Senate.Gov, "The Comprehensive Addiction Resources Emergency (CARE) Act: Section-by-Section," September 2020. Available at: https://www.warren.senate.gov/imo/media/doc/Care%20Act%202019%20Section-by-Section%20final.pdf

242 National Association of State Alcohol and Drug Abuse Directors, "SAPT Block Grant Fact Sheet," May 2, 2018. Available at: https://nasadad.org/wp-content/uploads/2018/06/SAPT-Block-Grant-Fact-Sheet-5.2.2018.pdf.

243 Substance Abuse and Mental Health Services Administration, *Fiscal Year 2021: Justification of Estimates for Appropriations Committees*, Department of Health and Human Services, February 2, 2020. Available at: https://www.samhsa.gov/budget/fy-2021-budget.

244 SAMHSA's FY21 Congressional Justification states on page 341 that it will provide SAMHSA's evaluation of the State Opioid Response Grants to Congress in April 2020 and asks SAMHSA to make the report publicly available.

245 Erin Artigiani, Maggie Hsu, David McCandlish, Eric Wish, "Methamphetamine Report September 2018" National Drug Early Warning System, September 2018. Available at: https://ndews.umd.edu/publicationprofile/2077.

246 Brendan Saloner & Benjamin Lê Cook, "Blacks and Hispanics Are Less Likely than Whites to Complete Addiction Treatment, Largely Due to Socioeconomic Factors," *Health Affairs (Project Hope), 32*(1), 135–145. January 2013. Available at: https://doi.org/10.1377/hlthaff.2011.0983.

247 Substance Abuse and Mental Health Services Administration, *TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women*, November 2015. Available from: https://store.samhsa.gov/ product/TIP-51-Substance-Abuse-Treatment-Addressing-theSpecific-Needs-of-Women/SMA15-442.

248 Keturah James & Ayana Jordan, "The Opioid Crisis in Black Communities," The Journal of Law, Medicine, & Ethics. 46(2):404-21. July 17, 2018. Available from: https://doi.org/10.1177/1073110518782949.

249 Substance Abuse and Mental Health Services Administration, *Tip 59: Improving Cultural Competence*. November 2015. Available at: https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849.

250 Kumiko M. Lippold, Christopher M. Jones, Emily O'Malley Olsen, Brett P. Giroir, "Racial/Ethnic and Age Group Differences In Opioid and Synthetic Opioid – Involved Overdose Deaths Among Adults Aged ≥ 18 Years in Metropolitan Areas – United States, 2015-2017," *MMWR Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, November 1, 2019. Available at: http://dx.doi.org/10.15585/mmwr.mm6843a3.

251 Centers for Disease Control and Prevention, "Understanding the Epidemic," March 2020. Available at: https://www.cdc.gov/drugoverdose/epidemic/index.html#three-waves.

252 P.A. Lagisetty, R. Ross, A. Bohnert, M. Clay, D.T. Maust, "Buprenorphine Treatment Divide by Race/Ethnicity and Payment," *JAMA Psychiatry*, May 7, 2019. Available at: https://europepmc.org/article/med/31066881.

253 Ellen Weber & Arka Gupta, "State Med State Medicaid Programs Should Follow Medicare Model," Legal Action Center, July 2019. Available at: https://www.lac.org/resource/state-medicaid-programs-should-follow-the-medicare-model-remove-prior-authorization-requirements-for-buprenorphine-and-other-medications-to-treat--opioid-use-disorders.

254 H.R. 244. Consolidated Appropriations Act, 2017. Available at: https://rules.house.gov/bill/115/hr-244-sa.

255 H.R. 1625. Consolidated Appropriations Act, 2018. Available at: https://rules.house.gov/bill/115/hr-1625-sa.

256 H.R. 6157. Department of Defense for the Fiscal Year Ending September 30, 2019, and for other purposes. Available at: https://www.congress.gov/115/crpt/hrpt952/CRPT-115hrpt952.pdf.

257 Lisa Clemans-Cope, Marni Epstein, and Genevieve M. Kenney. "Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose." Urban Institute. June 2017. Available at: https://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_2.pdf.

258 USAspending.gov., "About USAspending," 2019. Available at: https://www.usaspending.gov/#/about.

259 Substance Abuse and Mental Health Services Administration, "Justification of Estimates for Appropriations Committees Fiscal Year 2018," May 14, 2018. Available at: https://www.samhsa.gov/sites/default/files/samhsa-fy-2018-congressional-justification.pdf.

260 Substance Abuse and Mental Health Services Administration, "Justification of Estimates for Appropriations Committees Fiscal Year 2019," November 27, 2018. Available at: https://www.samhsa.gov/sites/default/files/sites/default/files/samhsa-fy-2019-congressional-justification.pdf.

261 U.S. Department of Justice, "Fact Sheet-Justice Department is Awarding Almost $320 million to Combat Opioid Crisis," October 1, 2018. Available at: https://www.justice.gov/opa/press-release/file/1097546/download.

262 Centers for Disease Control and Prevention, "CDC WONDER Online Database," July 2020. Available at: http://wonder.cdc.gov/mcd-icd10.html.

263 Ibid.

264 Ibid.

265 Ibid.

266 Ibid.

267 Ibid.

268 Ibid.

1225 Eye St NW, Suite 1000
Washington, DC 20005

bipartisanpolicy.org

202 - 204 - 2400

The Bipartisan Policy Center (BPC) is a Washington, D.C.-based think tank that actively fosters bipartisanship by combining the best ideas from both parties to promote health, security, and opportunity for all Americans. Our policy solutions are the product of informed deliberations by former elected and appointed officials, business and labor leaders, and academics and advocates who represent both ends of the political spectrum.

BPC prioritizes one thing above all else: getting things done.

@BPC_Bipartisan
facebook.com/BipartisanPolicyCenter
instagram.com/BPC_Bipartisan

Policy Areas

Campus Free Expression

Economy

Education

Energy

Governance

Health

Immigration

Infrastructure

Bipartisan Policy Center

1225 Eye Street NW, Suite 1000
Washington, D.C. 20005

IDEAS. ACTION. RESULTS.