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Opioid Crisis -- State and Federal Response

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Introduction

Opioids are a class of natural or synthetic substances with similar effects on nerve cell receptors in the brain. Naturally occurring opioids, derived from the opium poppy, are called opiates, and include morphine, codeine, heroin, and opium. Other opioids, such as hydrocodone, oxycodone, fentanyl, and methadone, are synthesized from organic chemical substrates.

Some opioids are commonly prescribed to provide short-term pain relief following surgery, injury, and trauma, and to relieve ongoing pain caused by cancer and severe, chronic, and disabling diseases. Prescription opioids include OxyContin (oxycodone), Vicodin (hydrocodone with acetaminophen), Dilaudid (hydromorphone), and morphine. Other opioids, such as heroin, have no accepted medical purpose and are produced and sold illicitly.

Opioids are addictive because they artificially trigger the release of endorphins, neurotransmitters that dampen perceptions of pain and boost feelings of pleasure**.** Repeated use of opioids reduces a body's natural production of endorphins. Over time, an individual who abuses opioids must continue to increase the amount of opioids they use to maintain the same level of feelings of pleasure (tolerance).

Opioid use disorder (OUD) is a substance use disorder that leads to significant impairment or distress. Individuals with OUD typically use opioids in larger amounts or for longer periods than prescribed, spend much time obtaining, using, and recovering from opioid use, and experience persistent or recurrent social or interpersonal problems caused by, or exacerbated by, the effects of opioids. Individuals who try to reduce or terminate regular use of opioids usually suffer symptoms of withdrawal, characterized by anxiety, restlessness, diarrhea, abdominal cramping, nausea, and vomiting. Based on national survey data, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that, in 2020, approximately 2.7 million people ages 12 and over in the United States had an OUD in the past 12 months.

The National Institutes of Health describes the origin and progression of the national opioid epidemic as follows:

In the late 1990s, pharmaceutical companies that manufactured opioids assured health care providers that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive. Opioid overdose rates began to increase. In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid. That same year, an estimated 1.7 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 652,000 suffered from a heroin disorder (not mutually exclusive).

The Centers for Disease Control and Prevention, National Center for Health Statistics, estimates that there were 108,775 drug overdose deaths in the United States in calendar year 2021, an increase of nearly 14% from the estimated number of drug overdose deaths in 2020 (95,452). Approximately 75% of these deaths were the result of opioid overdoses.

Experts describe the national opioid epidemic as occurring in three waves, or phases. The first began in 1999, when deaths involving opioids began to rise following a significant increase in opioid prescribing. The second followed about ten years later, when deaths involving heroin began to increase, as the price of heroin decreased and heroin became more accessible. This occurred as a result of increased production and importation of heroin, primarily from Mexico and Columbia. Individuals who had become dependent on prescription opioids during the first wave were particularly susceptible to heroin addiction. (The National Institute on Drug Abuse indicates that nationally, 80% of heroin users reported using prescription opioids prior to heroin.) The third phase began around 2014, when synthetic drugs (notably fentanyl) became more readily available. Fentanyl, which may be 50 to 100 times more potent than morphine, can be mixed with heroin, cocaine, methamphetamines, and other drugs to produce a cheaper, but more potent, alternative to other opioids.

Opioid use by a pregnant woman can result in adverse outcomes both for the women and her baby. Maternal OUD is associated with severe maternal complications and mortality, and neonatal abstinence syndrome (NAS) in newborns, characterized by tremors, irritability, seizures, and poor sleeping and feeding. Withdrawal caused by in utero exposure to opioids during the first 28 days after delivery is referred to as neonatal opioid withdrawal syndrome.

In a 2021 article that appeared in the Journal of the American Medical Association, researchers estimated that between 2010 and 2017, the rate of NAS per 1,000 hospital births in Wisconsin increased by 110%, from 4.1 per 1,000 births in 2010 to 8.5 per 1,000 births in 2017. The cost of providing birth-related health services to these children is significantly greater than the cost of providing services to children without NAS, and are disproportionately borne by state Medicaid programs.

This paper provides a summary of recent state and federal legislation enacted to reduce opioid use and improve access to services to individuals who abuse opioids. It describes services that are available to treat individuals with OUD, and recent state and federal funding initiatives intended to reduce opioid abuse and opioid-related deaths. Finally, it provides information on recent trends in opioid use and abuse in Wisconsin.

Federal Legislation

During the past several years, Congress enacted three major bills to address the national rise in drug misuse and addiction -- the Comprehensive Addiction and Recovery Act (P.L. 114-198), the 21st Century Cures Act (P.L. 114-255), and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients (SUPPORT) Act (P.L.115-271). A brief summary of the most significant features of these acts, as they relate to addressing the opioid epidemic, is provided below.

CARA. The Comprehensive Addiction and Recovery Act (CARA), enacted in July of 2016, created several programs, and expanded others, as part of a broad strategy to increase prevention and education, and promote treatment and recovery. Among its many provisions, the act: (a) created several federally-funded grant programs to reduce overdose deaths, and to support overdose reversal medication programs, recovery services, and training for first responders and emergency services personnel in treating persons who overdose; (b) increased federal support for, and promoted interoperability between state prescription drug monitoring programs; (c) created a grant program to implement or expand treatment alternatives to incarceration; (d) directed the Attorney General, in coordination with other agencies, to expand drug "take back" programs; (e) expanded access to medication-assisted treatment; (f) expanded

recovery support for students in high school or enrolled in institutions of higher learning; and (g) expanded prevention and educational efforts, including those aimed at teenagers, parents and other caretakers, and aging populations.

CARA created the comprehensive opioid, stimulant, and substance abuse program (COSSAP), under which the U.S. Department of Justice (DOJ) provides financial and technical assistance to states, local governments and tribes to develop, implement and expand comprehensive efforts to identify, respond to, treat, and support individuals affected by illicit opioids, stimulants, and other drugs subject to abuse. The DOJ Bureau of Justice Assistance (BJA) provides these grants under a competitive bidding procurement process.

Appendix 1 lists Wisconsin's state and local agencies and tribes that received federal fiscal year (FFY) 2019-20, 2020-21, and 2021-22 grants, the amount of the grants, and a brief description of the projects funded with these federal funds.

CARA also reauthorized a grant program for residential opioid addiction treatment of pregnant and postpartum women and their children and created a pilot program for state substance abuse agencies to address identified gaps in the continuum of care, including non-residential treatment services. Finally, the act addressed opioid therapy, pain management, and health services available to veterans.

Although CARA authorized federal agencies to implement new programs and expand previously authorized programs, the act did not directly fund these programs. Instead, funding for these programs was provided through Congress' annual appropriation process.

The 21st Century Cures Act -- State Opioid Response Grants. The 21st Century Cures Act, enacted in December of 2016, included provisions that made significant changes to several aspects of the U.S. health system, including medical research and the development of new drugs and medical devices, mental health research and care, and electronic health records.

In addition, the act authorized one-time funding of $500 million in FFYs 2015-16 and 2016-17 to support grants for state targeted responses to the opioid crisis (state opioid response, or SOR grants). Subsequent federal legislation established the program as an ongoing federal grant program, and significantly increased program funding. Beginning in FFY 2019-20, the SOR program was expanded to support evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including cocaine and methamphetamine. In FFY 2021-22, $1.5 billion is budgeted for the program.

SAMHSA administers the SOR program. In distributing FFY 2021-22 grants, SAMHSA allocated funding to states and territories under a statutory formula that weights two formulas equally-the state's proportion of people who met criteria for dependence or abuse of heroin or pain relievers who have not received any treatment and the state's proportion of drug poisoning deaths. However, each state received a minimum of $4.0 million, and 10 states with the highest mortality rates related to drug poisoning deaths are allocated additional funding, equal to 15% of the total funding available nationwide. (Wisconsin is not among these ten states.)

Table 1 identifies Wisconsin's SOR grant allocations for FFYs 2016-17 through 2021-22.

Table 1: State Opioid Response Grant Funding -- Wisconsin Awards

Fiscal Year	Amount
2016-17	$7,636,900
2017-18	19,616,300
2018-19	11,979,300
2019-20	16,728,100
2020-21	16,728,100
2021-22	16,917,100

The Federal SUPPORT for Patients and Communities Act. The federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-227), enacted in October, 2018, addressed substance abuse exclusively. The act established new federal grant programs, reauthorized and modified existing programs, and included provisions relating to Medicare and Medicaid services and state PDMPs.

The act created 21 new grant programs administered by several federal agencies, including the Department of Health and Human Services, and the Departments of Housing and Urban Development, Justice, and Labor. Most of the programs were created as competitive grant programs, although two new programs authorized formula grants to states -- one to ensure the safety, permanency and well-being of infants affected by substance use, funded as part of the child abuse prevention and treatment grant program, and one to fund stable housing for individuals in recovery from substance abuse disorders.

In addition, the act made several changes to Medicaid to improve access, treatment, and recovery services. For example, the act authorizes individuals with substance use disorders in institutions for mental disease to receive more Medicaid-covered services, and requires states to provide Medicaid coverage for all drugs approved by the federal Food and Drug Administration for medication-assisted treatment.

As a result of the enactment of these three federal acts and subsequent federal budget enactments, the amount of federal funding provided to address the opioid crisis has increased significantly during the past several years. Federal Funds Information for States, a nonprofit research agency that provides information to states on the federal budget, reports that federal funding for programs created specifically to address the opioid crisis increased from approximately $155.5 million in FFY 2014-15 to $3.2 billion in FFY 2018-19, the most recent year for which information is available.

Wisconsin received a three-year grant of $15,585,000 from the Centers for Disease Control and Prevention as part of the Overdose Data to Action program. This funding is available to support state, territorial, county, and city health departments in obtaining higher quality, more comprehensive, and timelier data on overdose morbidity and mortality and using these data to improve prevention and response efforts. The grant period ran from September 1, 2019 through August 31, 2022.

State Legislation

In 2013, the Legislature began enacting a series of bills, collectively referred to as the HOPE (Heroin and Opioid Prevention and Education) Agenda, to address the opioid epidemic. The acts have focused on improving responses to overdose incidents, the dispensing and disposal of opioid medications, and expanding treatment and recovery services. In addition, funding for program services has been provided through biennial budget acts. Brief summaries of the provisions of these acts are presented below.

2013 Session

Act 20 (the 2013-15 biennial budget act). Provided $64,600 GPR in 2013-14 and $1,282,700 GPR in 2014-15 for DHS to distribute grants to regional peer-run respite centers for people with mental health or substance abuse concerns, with the goal of improving crisis treatment and reducing inpatient hospitalizations. Provided funding to support: (a) three regional peer-run centers, beginning in 2014-15, each with an annual allocation of $400,000 ($1,200,000 total); and (b) one position to administer the program ($64,600 in 2013-14 and $82,700 in 2014-15.) (Although not considered a part of the HOPE agenda, a subsequent act

passed during the 2013 session provided an additional $125,000 for peer-run centers.)

Increased funding for the treatment alternatives and diversion (TAD) program administered by the Department of Justice (DOJ), by $1,000,000 GPR annually, beginning in 2013-14. In 2012-13, base funding for the program was $1,085,900, which was supported from program revenues from the justice information surcharge ($1,078,400) and the drug abuse program improvement surcharge and drug offender diversion surcharge ($7,500).

Provided an additional $500,000 GPR annually for DOJ to provide grant funding to counties to establish and operate drug courts. Defined a "drug court" as a court that diverts a substance-abusing person from prison or jail into treatment by increasing direct supervision of the person, coordinating public resources, providing intensive community-based treatment, and expediting case processing.

Act 194. Provided immunity from criminal prosecution for a person who possesses a controlled substance or drug paraphernalia if the person provides aid to a person who is, or is believed to be, experiencing an overdose by taking them to an emergency room or calling emergency services to assist.

Act 195. Directed DHS to create two or three regional comprehensive opioid treatment programs to provide treatment for opiate addiction in rural and underserved, high-need areas. Specified various program components, and directed DHS to submit annual reports on the programs' outcomes. In the 2013-15 biennium, it required DHS to seek funding for the programs by making one or more funding requests to the Joint Committee on Finance. The Committee approved $1,056,000 for this grant program 2014-15 and established the base funding at $2,016,000 for 2015-16.

Act 196. Directed the Department of Corrections (DOC) to develop a system of short-term sanctions for individuals who are on extended supervision, parole or probation, or subject to a deferred prosecution agreement who possess, or attempt to possess a narcotic drug, in order to provide clear and immediate consequences for violations. Specified that the system must include several features, such as taking into account the public's safety, correcting the individual's behavior, holding the person accountable, and rewarding offenders for compliance.

Act 197. Increased funding for the treatment and diversion (TAD) grant program administered by DOJ, by $1,500,000 GPR annually, beginning in 2013-14. Required counties that receive grant funding to submit monthly data to DOJ, and required DOJ to produce a progress report that evaluates the effectiveness of the grant program. It also required DOJ to produce, every five years, a comprehensive report that analyzes program data, and a cost benefit analysis of the grant program.

Act 198. Authorized the operation of drug disposal programs approved by DOJ, and established requirements for persons, cities, villages, towns, and counties that operate such programs. Created definitions of "household pharmaceutical items" for these purpose, and specified that all of the act's provisions would take effect July 1, 2015.

Act 199. Required individuals to provide an identification (ID) card at the time a controlled substance is dispensed or delivered, and required the dispenser to record the name of each ID card, and maintain the record for a period determined by the Controlled Substances Board. Provided immunity to pharmacists for any act taken by the pharmacist, in reliance on an ID card that the pharmacist reasonably believed was authentic and displayed the name of the person to whom the drug was being delivered, if the sale was made in good faith.

Act 200. Provided for the administration of naloxone (Narcan), an opioid antagonist used in emergency situations to counter the effects of an

opioid overdose. Authorized certified first responders, emergency medical technicians (EMTs), law enforcement officers, and firefighters to administer naloxone or another opioid antagonist to individuals who are undergoing, or believed to be undergoing, an opioid-related drug overdose. Required DHS to permit all EMTs to administer naloxone, and directed DHS to require EMTs to undergo any training necessary to safely and properly administer naloxone or another opioid antagonist. Required ambulance service providers to have a supply of naloxone or other opioid antagonist available for administration by EMTs, to the extent that the opioid antagonist is available to the ambulance service provider.

Authorized a licensed physician, physician assistant and advanced practical nurse (APRN) who is certified to issue prescription orders to prescribe an opioid antagonist to a person who is in a position to assist another person who is at risk of experiencing an opioid-related drug overdose, either directly or by using a standing order, if: (a) the person to whom the drug is delivered or dispensed has the knowledge and training necessary to safely administer it to an individual who is experiencing an opioid-related overdose; and (b) the person to whom the drug will be delivered or dispensed will ensure that any individual to whom the person further delivers or dispenses the drug has or receives that knowledge and training necessary to safely administer it to an individual experiencing an opioid-related overdose. (A standing order allows a pharmacy to dispense the opioid antagonist without a patient-specific prescription.)

Provided that a licensed physician, licensed physician assistant, or APRN, who, while acting in good faith, prescribes, delivers or dispenses an opioid antagonist in accordance with procedures created in the act may not be subject to professional discipline for any outcomes resulting from prescribing, delivering or dispensing that drug, and is immune from criminal or civil liability. Created the same immunity from professional discipline and criminal or civil liability for pharmacists, who, in good faith, deliver opioid antagonists.

Provided that any person who, acting in good faith, delivers or dispenses an opioid antagonist to another person is immune from civil or criminal liability for any outcomes resulting from delivering or dispensing the opioid antagonist.

2015 Session

Act 115. Clarified provisions created in 2013 Act 200 relating to the use of standing orders that authorize prescribing and dispensing of opioid antagonists by APRNs, physicians, and pharmacists by adding references to these orders in Chapter 441 (Regulation of Nursing), 448 (Medical Practices) and 450 (Pharmacy Examining Board).

Act 264. Prohibited an individual from using or possessing, with the primary purpose to use, a masking agent, which is defined as any substance or device that is intended for use to defraud, circumvent, interfere with, or provide a substitute for a bodily fluid in conjunction with a lawfully administered drug test. Prohibited advertising to promote the sale of a masking agent. Established penalties for violations of these prohibitions.

Act 265. Provided for the regulation and certification of pain clinics by DHS. Defined a "pain clinic" as either of the following: (a) a privately owned facility where a majority of the health care providers, practicing within the scope of their licenses, devotes a majority of their practices to the treatment of pain syndromes through the practice of pain medicine or interventional pain medicine; or (b) a privately owned facility that advertises or otherwise holds itself out as providing pain medicine services and that has one or more employees or contractors who prescribe opioids or opiates, benzodiazepines, barbiturates, or carisoprodol (muscle relaxers) as chronic therapy for pain syndromes.

Required pain clinics to be certified by DHS in

order to operate, and to meet certification requirements established by DHS. Provided that operating certificates issued by DHS are valid for three years, and may be renewed. Exempted certain types of health care providers, including hospitals, medical schools, hospices, and nursing homes, from the certification requirements. Authorized DHS, after consulting with the Medical Examining Board, to promulgate rules governing the operation of pain clinics.

Act 266. Required pharmacy or practitioners to submit a record to the PDMP documenting each dispensing of a monitored prescription drug by 11:59 p.m. of the next business day after the drug is dispensed. (Previously, there was no time frame required for the submission of a record.) Required a practitioner to review a patient's PDMP records before issuing a prescription order for the patient for a monitored drug, with specified exceptions.

Required the Controlled Substance Board to permit disclosure of PDMP information to: (a) relevant prosecutorial units; (b) individuals authorized to treat alcohol or substance dependency or abuse; (c) a practitioner, pharmacist, registered nurse, or substance abuse counselor who is treating or rendering assistance to the patient; (d) certain individuals for the purposes of evaluating the job performance of a practitioner or performing certain quality assessment and improvement activities, if the information disclosed does not contain personally identifiable information; and (e) a state board or agency, law enforcement agency, or prosecutorial unit if a written request is made, the requester is engaged in an active investigation or prosecution of a drug violation, and the record is reasonably related to that investigation or prosecution.

Applied PDMP requirements relating to the dispensing of monitored drugs by pharmacists to also apply to monitored drugs dispensed pursuant to a prescription order issued by a veterinarian for an animal patient. However, veterinarians are not required to submit information to the PDMP.

Act 267. Created review and reporting requirements relating to the PDMP, effective through October 30, 2020 (and subsequently extended). Required the Controlled Substances Board ("the Board") to conduct a quarterly review of the PDMP to evaluate program outcomes, including: (a) the satisfaction with the program of pharmacists, pharmacies, practitioners and users; (b) the program's impact on referrals of pharmacists, pharmacies, and practitioners to licensing or regulatory boards for discipline and to law enforcement agencies for investigation and possible prosecution.

Required the Board to provide quarterly reports to DSPS that includes all of the following: (a) the results of the Board's reviews, as described above; (b) an assessment of the trends and changes in the use of monitored prescription drugs in the state; (c) the number of practitioners, by profession, and pharmacies submitting records to the Board in the previous quarter; (d) a description of the number, frequency, and nature of submissions by law enforcement agencies; (e) a description of the number, frequency, and nature of requests made in the previous quarter for disclosure of records generated under the program; (f) the number of individuals receiving prescription orders from five or more practitioners or having monitored prescription drugs dispensed by five or more pharmacies within the same 90-day period at any time over the course of the program; (g) the number of individuals receiving daily morphine milligram equivalents of one to 19 milligrams, 20 to 49 milligrams, 50 to 99 milligrams and 100 or more milligrams in the previous quarter; and (h) the number of individuals to whom both opioids and benzodiazepines were dispensed within the same 90-day period at any time over the course of the program.

Authorized the Board to contract with an analytics firm to augment the PDMP with an analytics platform that provides data integration, advanced analytics, and alert management capabilities to detect problematic behaviors of practitioners, pharmacies, pharmacists and patients. Created

statutory goals for such augmentation.

Act 268. Required law enforcement officers to report to the PDMP the inappropriate or illegal use of monitored prescription drugs, opioid-related drug overdoses, and reports of stolen prescription drugs. Specified that the report must include names and birthdates of individuals involved in these cases, which must be available to relevant practitioners, pharmacists and others.

Act 388. Provided $2,000,000 PR in 2016-17 of unallocated program revenue DHS collects for the operation of DHS care and treatment facilities to the Department of Justice to provide as grants to counties under the treatment and diversion grant program.

Modified the TAD program to specify that counties receiving funding must allow a participant to use a medication that is approved by the U.S. Food and Drug Administration if all of the following are true: (a) a licensed health care provider, acting in the scope of his or her practice, has examined the person and determined that the person's use of the medication is an appropriate treatment for the person's substance use disorder; (b) the medication was appropriately prescribed by a person authorized to prescribe medication in Wisconsin; and (c) the person is using the medication as prescribed as part of a treatment for a diagnosed substance use disorder.

2017 Session

Act 25. Prohibited certain narcotic drugs that contain nonnarcotic, medicinal active ingredients, such as codeine cough syrup, from being dispensed without a prescription.

Act 26. Provided $63,000 GPR annually, beginning in 2017-18, to support fellowships in addiction medicine or addiction psychiatry in graduate medical training programs. Authorized DHS to award these funds to hospitals to increase the number of physicians trained in an addiction specialty.

Act 27. Provided $1,000,000 GPR annually, beginning in 2017-18, to create two or three additional regional comprehensive opioid and methamphetamine treatment programs, and expanded the treatment program created in 2013 Act 195 to include methamphetamine treatment programs.

Act 28. Provided $500,000 GPR annually, beginning in 2017-18, to create an addiction medicine consultation program that assists participating clinicians in providing enhanced care to patients with substance use addiction, and offers provider referral support for patients with substance use disorder. Specified conditions a qualified organization must meet in order to contract with DHS to provide these services, and that these consultations could be provided by teleconference, voice over Internet protocol, electronic mail, pager, or in-person conference.

Act 29. Provided civil immunity for school employees who administer an opioid antagonist to students who experience an overdose if, as soon as practicable, the employee reports the drug overdose by dialing 911 or the telephone number for an emergency medical service provider.

Authorized a residence hall director employed by the University of Wisconsin (UW) System, a technical college district, or the governing body of a private college to administer an opioid antagonist to a student or any other person who appears to be undergoing an opioid-related drug overdose if the residence hall director received training approved by his or her employer, and he or she reports the drug overdose by dialing 911 or the telephone number for an emergency medical service provider. Provided civil immunity for the residence hall director, or the employer who approved training for the residence hall director, for acts or omissions in administering the opioid antagonist, unless the act or omission constitutes a high degree of negligence. Specified that this civil immunity does not apply to health care professionals.

Act 30. Provided one-time funding of $50,000

GPR in 2017-18 to fund start-up costs for the Office of Educational Opportunity (OEO) in the University of Wisconsin System to contract for the establishment of a charter school for high school students in recovery, but required OEO to secure matching funds to access the state funds. In addition, funding to operate the charter school was provided from federal funds and a sum sufficient appropriation from the state to provide per pupil payments.

Specified that the OEO Director may contract to establish, as a pilot project, one recovery charter school that operates only high school grades, for four consecutive school years, and required that the charter school operator: (a) provides academic curriculum that satisfies state high school graduation requirements; (b) provides therapeutic programming and support for pupils recovering from substance use disorder or dependency; (c) establishes suspension and expulsion policies, modeled after state expulsion law; and (d) permits a pupil to withdraw from the school upon completion of any required treatment program. Limited enrollment at the charter school to no more than 15 pupils at a time.

Specified that, as a condition of enrollment, a pupil must: (a) begin treatment in a substance use disorder or dependency program; (b) maintain sobriety for at least 30 days prior to attending the school; and (c) submit to a drug screening assessment, and, if indicated, a drug test. To maintain enrollment, students must receive counseling from substance use disorder or dependency counselors employed by the school, and, if the pupil has coverage for mental health service under a health plan, submit claims for coverage of therapy and counseling provided by the school to that plan.

Required health policies, plans and contracts to cover mental health or behavioral health treatments or services provided in a recovery charter school if they would cover the same treatments or services provided by another health care provider. Required the OEO Director to report to DHS on the operation and effectiveness of the charter school following the third year the charter school operates. (To date, OEO has not implement this provision.)

Act 31. Provided $200,000 GPR annually, beginning in 2017-18, for the Department of Public Instruction (DPI) to establish a mental health training support program, under which DPI provides training on the 'screening, brief intervention, and referral to treatment' program, an evidence-based strategy related to addressing mental health issues in schools, to school district staff and instructional staff of charter schools.

Act 32. Provided additional funding for diversion programs as follows: (a) increased funding for grants under the DOJ treatment and diversion grant program by $2,000,000 GPR annually, beginning in 2017-18 to replace one-time PR funding provided under 2015 Act 388; (b) increased funding for the DOJ treatment and diversion grant program by $150,000 GPR annually, beginning in 2017-18, to expand the grant program to additional counties; and (c) provided $261,000 GPR annually, beginning in 2017-18, in the Joint Committee on Finance program supplements appropriation, to fund a new diversion pilot program for nonviolent offenders to be diverted to a treatment option. Required DOJ to submit a request of the release of this funding to support the pilot program, under a 14-day passive review process. Repealed a new appropriation to fund the pilot program on July 1, 2019.

Act 33. Expanded the provisions created in 2013 Act 200 (the "Good Samaritan Law') by extending immunity to a person experiencing an overdose from revocation of parole, probation, or extended supervision if that person completes a treatment program or, if the program was not available or financially prohibitive, agrees to spend 15 days in a county jail. Includes several clarifying provisions to Act 200.

Act 34. Modified provisions authorizing

emergency civil commitments for intoxicated persons and involuntary civil commitments of alcoholics to include persons who have drug dependence, who are incapacitated by the use of drugs, and who habitually lack self-control as to the use of drugs. Provided for the voluntary treatment of drug-dependent persons at approved public treatment facilities.

For these purposes, defined "drug dependence" as a disease that is characterized by a person's use of one or more drugs that is beyond the person's ability to control to the extent that the person's physical health is substantially affected.

Act 35. Provided $420,000 GPR annually, beginning in 2017-18, to fund an additional 4.0 GPR criminal investigation agents in DOJ that are focused on drug interdiction and drug trafficking. Provided that any unencumbered portion of this funding increase that results from a delay in filling the positions by June 30, 2018, may be transferred to increase support for the DOJ treatment and diversion program, subject to approval by the Joint Committee on Finance under a 14-day passive review process.

Act 59 (the 2017-19 biennial budget act). Authorized DHS to provide MA coverage for services provided in an institution for mental disease (IMD) for persons ages of 21 through 64 to the extent permitted under federal law or under waiver agreement, if federal financial participation is available to support these services. (DHS had submitted a federal waiver to allow the state to receive federal matching funds for IMD services for persons requiring substance abuse treatment.)

Act 202. Authorized the Department of Children and Families (DCF) to provide grants to counties and Indian tribes to establish and operate evidence-based treatment programs, including substance abuse treatment services, to develop intake and court procedures that screen, assess, and provide dispositional alternatives for parents whose children have come under a court's jurisdiction. Specified requirements for grantees and reporting requirements for DCF.

Act 261. Provided $750,000 GPR annually, beginning in 2017-18, for DHS to distribute as grants to counties and tribes to provide nonnarcotic, nonaddictive, injectable medically assisted treatment to jail inmates who voluntarily receive the treatment within the five days immediately preceding release from jail. Required participating counties and tribes to ensure that all program participants are enrolled in Medicaid and will continue to receive treatment after an inmate leaves county or tribal jail custody.

Provided $500,000 FED from the temporary assistance to needy families (TANF) block grant annually, beginning in 2018-19, for DCF to provide as grants for evidence-based programs and practices for substance abuse prevention to at-risk youth and their families. Prohibited DCF from awarding a grant to county or a tribe that offered these services in the preceding fiscal year unless these services were previously funded under this grant program.

Provided $250,000 GPR annually, beginning in 2017-18, to fund family and juvenile treatment court grants program created in 2017 Act 202.

Provided $1,000,000 GPR annually, beginning in 2018-19, for DOJ to fund grants to Wisconsin and tribal law enforcement agencies to support law enforcement response to drug trafficking, and directed DOJ to establish policies and procedures for the distribution of these grants. Limited grant awards to $50,000 per application and $100,000 per agency. Required applicants to use grant funds for new programs or purposes within an agency, and prohibited grant recipients from using the awards to supplement an existing program.

Provided $300,000 GPR annually, beginning in 2017-18, to fund 2.0 attorney five-year project positions to assist the DOJ Division of Criminal

Investigation in the field offices of Wausau and Appleton and to assist district attorneys in prosecuting drug-related offenses. Directed DOJ to submit an annual report to the Joint Committee on Finance describing the activities and assessing the effectiveness of these positions.

Authorized a court to order a person who pleads guilty or is found guilty of a drug violation to attend a program, such as a victim impact panel, that demonstrates the adverse effects of substance abuse on an individual or an individual's family. Authorized the court to order the person to pay a reasonable fee, based on the person's ability to pay, to offset the costs of assembling and hosting the program.

2019 Session

Act 9 (the 2019-21 biennial budget act). Provided DOJ $1,000,000 GPR in both 2019-20 and 2020-21 in one-time funding to increase support for the treatment alternatives and diversion (TAD) program.

Provided DOJ $261,000 GPR annually in both 2019-20 and 2020-21 to continue funding for the nonviolent offender treatment diversion pilot program created in 2017 Act 32. Extended the repeal of the program to July 1, 2021, from July 1, 2019.

Provided the Department of Safety and Professional Services $186,300 FED in 2019-20 and $52,500 FED in 2020-21 to create a data exchange between the Wisconsin Ambulance Run Data System (WARDS) and the PDMP so that Naloxone administered by ambulance service providers can be entered into the PDMP database. Provided $17,500 FED in 2019-20 and $4,400 FED in 2020-21 to create opioid naïve alerts that notify prescribers that a patient may never have been prescribed opioids before.

Repealed a provision that prevented the regional comprehensive opioid treatment programs, funded from DHS, from offering methadone treatment.

Act 121. Extended for five years, from April 1, 2020 to April 1, 2025, the requirement that a practitioner review a patient's records under the PDMP before issuing a prescription order for a monitored prescription. Extended for five years, from October 30, 2020 to October 30, 2025, the requirement that the Controlled Substances Board conduct a quarterly review of the PDMP to evaluate actual outcomes of the PDMP, compared with projected outcomes.

2021 Session

Act 57. Created provisions that govern the allocation of funding the state and local governments will receive under a settlement agreement resulting from the National Prescription Opiate Litigation. Required the Attorney General to cooperate with local governments that are party to the litigation if: (a) the Joint Committee on Finance approves the proposed settlement agreement; (b) 70% of the settlement proceeds are payable to the local governments that are party to the agreement; and (c) 30% of the settlement proceeds are payable to the state. Required DHS to submit a spending plan for the state's share of the proceeds to the Joint Committee on Finance annually on April for the next fiscal year, under a l4-day passive review process. Established requirements relating to the administration of settlement proceeds paid to local governments.

Act 58. Provided $500,000 GPR in 2021-22 and $1,000,000 GPR in 2022-23 in the Joint Committee on Finance program supplements appropriation to support medication assisted treatment.

[On February 22, 2022, the Committee approved the transfer of this funding to DHS to support one or more mobile medication assisted treatment units that would offer treatment services to individuals who live in areas where there are few

treatment providers within a reasonable driving distance.]

Act 58. Provided $300,000 GPR in 2022-23 in the Joint Committee on Finance program supplements appropriation to fund the development of an online public resource identifying substance use disorder treatment providers in the state.

[On February 22, 2022, the Committee approved the transfer of this funding to DHS to support an online system that would identify SUD health care providers and facilities by type of service, and information on the availability of age-specific services, and payment sources acceptable to SUD providers.]

Act 155. Required intoxicated driver program assessors to recommend the evaluation of medication assisted treatment as a requirement of a driver safety plan if the driver is found to have a suspected dependency, dependency, or dependency in remission

Act 179. Created penalties for the manufacture, distribution, delivery, or possession (with intent to manufacture, distribute, or deliver) of fentanyl and fentanyl analogs, so that: (a) a Class E felony is committed if the amount involves 10 grams or less; (b) a Class D felony is committed if the amount involves more than l0 grams, but less than 50 grams; and (c) a Class C felony is committed if the amount involves more than 50 grams.

Act 181. Required the Department of Administration to issue a request for proposals, subject to approval by the Joint Committee on Finance under a 14-day passive review process, to establish and maintain an opioid and methamphetamine data system to collect, format, analyze, and disseminate information on opioid and methamphetamine use in the state. Prior to issuing the proposal, directed DOA, in collaboration with DHS and DSPS, to request the Committee to approve a supplement of up to $1.5 million to any DHS, DSPS, or DOA appropriation to fund the data system. Specified all of the type of information that would be included in the system. Directed DOA to submit annual reports, by January, 31, 2024, to the Committee summarizing the information in the system, and analyzing trends in the information across years of data collection.

Treatment and Services

In its 2021 report to Congress on the state opioid response (SOR) grant program, SAMHSA identified several evidence-based practices that have been shown to be effective in addressing opioid abuse, and are commonly funded by states with their SOR grants and other federal, state and local funds. Each of these practices, as described in the report, is presented below.

Medication-Assisted Treatment (MAT). MAT serves as the standard of care for the treatment of opioid use disorder. All SOR grantees are required to make available MAT to any individual with an OUD served by the SOR program. Grantees are required to ensure that all three FDA-approved medications—methadone, buprenorphine, and naltrexone—are provided as part of the SOR grant. These medications are provided in combination with evidence-based psychosocial services. Individuals with OUD primarily access MAT through opioid treatment programs and office-based opioid treatment.

Opioid Treatment Programs (OTPs). OTPs are accredited treatment programs, certified by SAMHSA and registered by the Drug Enforcement Administration (DEA) to administer and dispense methadone, buprenorphine, and injectable naltrexone to treat OUD (methadone, buprenorphine, and injectable naltrexone). OTPs must provide adequate medical, counseling, vocational, educational, mental health and other assessment and treatment services either onsite or by referral to an

outside agency or practitioner through a formal agreement.

Office-Based Opioid Treatment (OBOT). OBOT provides medication for OUD in outpatient settings other than OTPs. OBOT stabilizes clients on buprenorphine or injectable naltrexone, and providers focus on medication management and treatment of other substance use, mental disorders, medical comorbidities, and psychosocial needs.

"Hub and Spoke" Model. The "Hub and Spoke" model provides clients seeking care for OUD with an individualized assessment and initiation of treatment at a "hub" location, which specializes in addiction treatment. Referrals are made to community-based "spokes" for ongoing treatment to meet client-specific needs, including evaluation and treatment of mental disorders and general medical conditions. In some instances, clients with less complex needs may begin their treatment at a spoke location rather than a hub location.

Cognitive Behavioral Therapy (CBT). CBT helps individuals learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop substance use and address a range of other problems that often co-occur with it. CBT is used by clinicians in MAT programs to help people with OUD understand patterns of their substance use; manage drug cravings; recognize and change thoughts associated with substance use; increase problem solving and decision-making skills; and utilize alternative coping mechanisms to reduce risk of return to drug use.

Motivational Interviewing. Motivational interviewing is a clinical approach that helps people with mental and substance use disorders and other chronic conditions make positive behavioral changes to support better health. By exploring ambivalence and highlighting problem areas, providers can help clients discover their own motivations for change.

Contingency Management (CM). CM is a psychosocial treatment strategy used as a behavior modification intervention in order to establish a connection between new, targeted behavior and the opportunity to obtain a desired reward.

Peer Recovery Support Services. Peer recovery services include a wide range of services provided by peer support specialists. A peer support specialist is someone who combines their own lived experience of recovery with formal training and education to assist others in initiating and maintaining recovery.

Opioid Overdose Education and Naloxone Distribution (OEND). OEND activities aim to increase awareness about the use of naloxone and educate individuals on recognizing potential overdose symptoms. Key components of OEND activities include education and training on recognition and prevention of opioid overdose, opioid overdose rescue response, and distributing naloxone products.

Wisconsin's Opioid Treatment Programs and "Hub and Spoke" Health Home Service Pilot

A wide range of opioid treatment and recovery service options are available in Wisconsin, including clinical supports (inpatient or residential treatment services and outpatient counseling services provided by licensed professionals) and peer support services (recovery residences and centers, respite services and mutual support groups) staffed by people in recovery from opioid use disorder. This section provides information on opioid treatment programs in Wisconsin, and the "hub and spoke" health home pilot program DHS recently implemented.

Opioid Treatment Programs. As of October, 2022, there were 24 local and seven regional clinics in Wisconsin that were accredited by SAMHSA and registered by the FDA as opioid treatment programs. Each of these programs must meet opioid treatment standards codified in federal

regulations (42 CFR 8.12) and comply with federal guidelines issued by SAMHSA.

Appendix 2 lists these clinics, their locations, and the areas served by the regional opioid treatment centers.

In spring, 2022, DHS offered a grant funding opportunity to fund OPT mobile units as the means of expanding coverage of opioid treatment program services in underserved and high need geographic areas of the state.

"*Hub and Spoke" Health Home Pilot Project.* DHS has begun offering a new benefit for individuals enrolled in the state's medical assistance (MA) program that have substance use disorder (SUD) and at least one other health condition. The benefit, referred to as integrated recovery support services, is intended to address both the individual's SUD and other health care needs.

Under the program, three "hub" sites serve as lead agencies that provide access to specialized SUD treatment and support services, including assessments, MAT, behavioral health care, and other services. The "spokes" are community organizations that provide additional support and case management services.

The three hub sites are the Family Health Center of Marshfield, a federally-qualified health center (FQHC) that provides services through the Minocqua Alcohol and Drug Recovery Center, the Oneida Nation Behavioral Health Center, an FQHC that serves Native Americans in the Oneida Nation, and Brown and Outagamie Counties, and Wisconsin Community Services, Inc., a nonprofit community based organization that provides services in Milwaukee County.

Wisconsin's Enhanced Prescription Drug Monitoring Program (ePDMP)

2009 Wisconsin Act 362 directed the Pharmacy Examining Board to develop, by rule, a program to monitor dispensing of controlled substances in Wisconsin that have the potential for abuse. The act specified various program requirements for the prescription drug monitoring program (PDMP), provided certain legal protections for prescribers and pharmacists that used the program, and directed the Department of Regulation and Licensing [now, the Department of Safety and Professional Services (DSPS)] to seek federal funding for the development and operation of the program. The program began operating in June of 2013. DSPS developed an enhanced version of the program, the ePDMP, which began operating in 2017.

The program is authorized under s. 961.385 of the statutes, and its operations are governed by the Controlled Substances Board (CSB), based on rules promulgated under CSB 4.

The program requires dispensers (pharmacists and health care providers authorized to dispense monitored prescription drugs) to compile specified information each time they dispense a monitored drug, including the date a drug was dispensed, the quantity, the estimated days of drug therapy, the number of refills authorized by the prescriber, and the patient's name, address, and date of birth. Dispensers may delegate this reporting responsibility to a managing pharmacist of the pharmacy or an agent or employee of a practitioner. Dispensers are required to submit the information electronically to the ePDMP by 11:59 p.m. of the next business day after dispensing a monitored drug. If a dispenser did not dispense a monitored drug on the previous day, he or she is required to submit a "zero report," that accounts for

each business day on which the dispenser did not dispense a monitored drug. The rules specify several exemptions to the submission requirements, including: (a) drugs administered directly to a patient; (b) drugs that the dispenser prepares, but that are not delivered to a patient; and (c) drugs that are not narcotic drugs that are dispensed pursuant to a prescription order that is intended to last the patient seven days or less.

The CSB is authorized to refer any dispenser or delegate that fails to submit dispensing information or zero reports, or submits false dispensing information, to the appropriate licensing or regulatory board for disciplinary action. Healthcare professionals may access monitored drug history reports if they are directly treating or rendering assistance to a patient, or if the healthcare professional is being consulted regarding the health of a patient, by an individual who is directly treating or rendering assistance to the patient.

Law enforcement agencies are required to submit reports to the PDMP under the following circumstances: (a) when an officer suspects that a person violated the federal Controlled Substances Act with a prescription drug; (b) when a person is suspected of having experienced a fatal or non-fatal opioid-related overdose; or (c) when a person reports to the agency that his or her controlled substance prescription has been stolen. The PDMP provides summary information on these alerts by time period, county, and type of alert.

The statutes require the CSB to submit quarterly reports to DSPS that includes specified information, such as the program's impact on referrals of pharmacists, pharmacies, and practitioners to licensing or regulatory boards for discipline and to law enforcement agencies for investigation and possible prosecution, and assessment of the trends and changes in the use of monitored prescription drugs in this state. In addition, DSPS has created an interactive dashboard that provides aggregated information on the dispensing of controlled substances, utilization of the PDMP, law enforcement alerts, and a statistics archive. The dashboard can be accessed at https://pdmp.wi.gov/statistics.

The costs of operating and maintaining the ePDMP are supported from a combination of federal funds (primarily from the U.S. Department of Justice's Harold Rogers Prescription Drug Monitoring Grant Program) and program revenues collected by DSPS. In state fiscal year 2021-22, ePDMP costs totaled $1,584,500 ($783,700 FED and $800,800 PR). DSPS contracts with NIC, which uses its PDMP, RxGov as a public health platform for Wisconsin's ePDMP. State staffing includes 2.0 full-time program and planning analyst positions and a portion of management positions' staff time allocated to the program.

In federal fiscal year (FFY) 2019-20, DSPS was awarded a federal grant, totaling $1,945,700, from BJA under the Harold Rogers prescription drug monitoring program to develop and deploy security enhancements, geolocation mapping upgrades, and other enhancements to the system.

In FFY 2020-21, BJA awarded DSPS $1,648,500 from the Harold Rogers prescription drug monitoring program to eliminate technological and cost barriers to the ePDMP system for underserviced users and qualifying health systems.

Trends in Opioid Prescribing, Opioid-Related Medical Emergencies and Deaths

The PDMP statistics dashboard presents data on prescribing patterns for opioids and other monitored drugs for the past several years. Table 2 shows the number of prescriptions filled for all monitored drugs, including opioids, by drug class in each year from 2016 through 2021. Notably, the number of prescriptions dispensed for opioids decreased each year during this period.

The PDMP uses data analytics to assess a

Table 2: Number of Prescriptions Dispensed, by Drug Class

	Calendar Year					
	2016	2017	2018	2019	2020	2021*
Opioids	4,709,813	4,062,133	3,569,147	3,319,308	3,098,088	2,998,274
Benzodiazepines	2,287,051	2,065,815	1,879,410	1,764,997	1,699,961	1,598,874
Stimulants	1,719,575	1,709,511	1,707,048	1,747,747	1,775,533	1,884,688
Other	1,388,612	1,287,585	1,195,616	1,139,702	1,130,879	1,616,654
Total	10,105,051	9,125,044	8,351,221	7,971,754	7,704,461	8,098,490

*Beginning in September, 2021, Gabapentin, a drug used in combination with other drugs to prevent and control seizures, was added to the list of "other" monitored drugs. In 2021, 491,217 prescriptions of Gabapentin were dispensed, accounting for the significant increase in "other" ePDMP monitored drugs.

Table 3: Average Monthly Number of Patients Meeting PDMP Alert Criteria

Type of Alert	2018	2019	2020	2021
Early Refill	16,680	14,070	17,501	20,781
Concurrent Benzodiazepine and Opioid	17,968	18,421	20,287	24,153
Long Term Opioid Therapy	24,574	25,103	25,683	28,056
Multiple Prescribers or Pharmacies	13,502	11,706	13,312	15,185
Multiple Same Day Prescriptions	825	795	1,216	1,357
High Opioid Daily Dose	12,442	13,687	18,571	24,405
Total	85,991	83,781	96,570	113,937

patient's controlled substance prescription history and provides monthly reports on the number of patients who met the criteria for each type of patient history alert. Table 3 shows the number of patients that met the criteria for a PDMP alert in the month of January in 2018, 2019, 2020, and 2021, by type of alert.

Wisconsin hospitals are required to submit, on a quarterly basis, administrative billing data on their discharges, including emergency room and inpatient services they provide. These data are collected on behalf of the state by the Wisconsin Hospital Association Information Center, and are combined with other information on the hospital services provided in neighboring states to Wisconsin residents.

Table 4 shows the number of Wisconsin residents who were discharged from emergency rooms and hospital inpatient services in calendar years 2016 through 2021 due to opioid poisonings (overdoses).

The DHS Office of Health Informatics collects information from Wisconsin death certificates to summarize the cause of death of Wisconsin residents. Table 5 shows the number of opioid-related deaths of Wisconsin residents, including the steep increase in deaths involving synthetic opioids, such as fentanyl, between calendar year 2014 and 2021.

National and State Prescription Opiate Litigation

States and local governments from across the country have filed numerous lawsuits against manufacturers, retailers, distributors, and other entities involved in fueling the opioid epidemic.

Table 4: Opioid Poisonings Resulting in Hospitalizations -- Wisconsin Residents, by Opioid Type

	2016	2017	2018	2019	2020	2021
Emergency Room Discharges						
Heroin	1,352	1,738	1,386	1,409	1,580	1,433
Methadone	30	31	25	21	20	21
Other Opioids	1,122	1,303	1,024	1,141	1,442	1,696
Total*	2,485	3,050	2,426	2,549	3,027	3,133
Inpatient Discharges						
Heroin	420	481	359	382	383	347
Methadone	85	78	50	38	54	19
Other Opioids	1,265	1,183	852	780	758	778
Total*	1,733	1,707	1,245	1,181	1,160	1,123

*Numbers in rows do not add to total because some patients are hospitalized due to multiple types of opioids.

Table 5: Deaths of Wisconsin Residents due to Opioid Overdoses

Opioid Source	2014	2015	2016	2017	2018	2019	2020	2021
Heroin	269	281	381	415	327	285	263	150
Prescription Opioids	336	298	376	369	297	282	335	238
Synthetic Opioids	90	112	283	468	504	651	1,052	1,293
Total*	628	613	850	932	839	916	1,227	1,427

*Numbers in rows do not add to total because some deaths are due to multiple types of opioids.

Among other things, the lawsuits allege inappropriate marketing of opioid products, and failure to detect, question, and report suspicious orders of prescription opioids.

Multi-District Litigation and 2021 Wisconsin Act 57

In response to over 2,000 of these lawsuits brought by local governments, the United States Judicial Panel on Multi-District Litigation assigned a federal district judge of the Northern District of Ohio, Judge Dan Polster, to oversee consolidated litigation, known as the National Prescription Opiate Litigation.

In September, 2019, Judge Polster approved a plan to establish a "negotiation class" that authorized attorneys from 49 local governments to negotiate a settlement on behalf of every city and county that filed a lawsuit, unless a city or county chooses to opt out of the agreement. Any settlement agreement negotiation by the attorneys and a company must be approved by a vote of the negotiation class, which would resolve all of the consolidated federal lawsuits against the company, and prevent cities and counties from filing future lawsuits in federal court against the company.

In July, 2021, the plaintiffs' Executive Committee, several State Attorneys General, and four major defendants announced agreement on terms of proposed nationwide settlements to resolve all opioids litigation brought by states and local political subdivisions against the three largest pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and one manufacturer (Janssen Pharmaceuticals and its parent company, Johnson and Johnson). The settlements provide for maximum nationwide payments of up to $26 billion, with approximately $23.9 billion available to fund opioid abatement uses. The funds are to be

distributed according to the allocation agreement reached between the states. Wisconsin's share of the funds is 1.7582560561 percent of the total amounts. The settlements also included certain injunctive terms for the defendants, including prohibiting Janssen from selling, manufacturing, and promoting opioids or opioid products, and requiring that the distributors establish thresholds to identify potentially suspicious orders of controlled substances and report suspicious orders to states.

Also in July, 2021, Wisconsin enacted 2021 Act 57 in anticipation of these proposed settlements. 2021 Wisconsin Act 57 specified that the proceeds from settlement agreements involving the National Prescription Opiate Litigation will be divided between local governments in Wisconsin (70%) and the state (30%). Act 57 directed DHS to submit annual plans, by April 1 of each year, that describe how DHS intends to expend the state's share of these funds it expects to receive in each calendar year. Each annual submission is subject to review and approval by the Joint Committee on Finance under a passive review and approval process.

In September, 2022, the Committee met to review the first plan submitted by the DHS. The DHS plan described how the agency would allocate approximately $31 million in funding the state was expected to receive in calendar year 2022 under a settlement agreement with three pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and one manufacturer (Janssen Pharmaceuticals (and its parent company, Johnson and Johnson).

The plan approved by the Committee allocated the funding as follows.

- $3.0 million to expand the Narcan Direct program and broaden the list of community agencies that may participate in the program. DHS is directed to expand program eligibility and prioritize distributions to law enforcement agencies and first responders.

- $2.0 million to establish and fund a program to distribute fentanyl testing strips. DHS is directed to make available and prioritize distributions to law enforcement agencies and first responders.

- $10.0 million to fund capital projects to expand prevention, harm reduction, treatment, and recovery services through the construction of new facilities, and to renovate existing facilities to improve services. DHS must allocate funding for a capital project to support the expansion of bed capacity for inpatient treatment and, in particular, support the expansion of available beds for treatment of pregnant and post-partum women in a family-centered treatment environment. Further, DHS must distribute at least 30% of the remaining funds for projects in counties with fewer than 500,000 residents.

- $6.0 million to federally-recognized tribes in Wisconsin, with the requirement that tribes identify strategies across the continuum of prevention, harm reduction, treatment and recovery for which they plan to use the funds, including culturally-relevant strategies to prevent opioid use, promote health, and community practices.

- $500,000 to improve the central alert system, creating a near real-time overdose surveillance and alert system for use by counties, tribes and other providers statewide. In addition, DHS may use this funding to upgrade the prescription drug monitoring program (PDMP) administered by the Department of Safety and Professional Services.

- $250,000 to school districts, independent charter schools, and private choice schools to implement evidence-based substance use prevention programming. The Department of Public Instruction must distribute this funding to eligible entities in the same manner as under the current Alcohol and Other Drug Abuse (AODA) grants program. None of this funding may be expended to support state operations costs of administering the program.

- $2.0 million to increase medication assisted treatment services.

- $2.5 million to fund room and board costs for Medicaid recipients who receive services under Medicaid's residential substance use disorder treatment program.

- $3.0 million for DHS to distribute to law enforcement agencies, under a competitive grant program, for the following purposes: (a) medication-assisted treatment education and awareness training; (b) community drug disposal programs; (c) treatment of jail inmates with opioid use disorder (OUD); (d) supporting pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring substance use disorder or mental health conditions; and (e) any other permissible uses under the settlement agreements. Of this funding, at least $1.0 million is reserved for grants to law enforcement agencies in counties or municipalities with 70,000 or fewer residents.

- $750,000 for DHS to provide as a grant to a community-based organization that serves afterschool youth for the purpose of implementing and expanding opioid prevention programs. The organization must use local law enforcement partnerships in its effort to reduce opioid abuse.

- $1.0 million for DHS to expand the "Hub and Spoke" Health Home Pilot Project to facilitate the creation of additional lead agencies ("hubs") that provide specialized substance use disorder (SUD) treatment and support services ("integrated recovery support services"), including assessments, medication-assisted treatment, behavioral health care, and other services to medical assistance beneficiaries with SUD and at least one other health condition.

In addition, DHS is required to submit a report to the Joint Committee on Finance by December 31, 2022, and on a quarterly basis thereafter, that includes the following information regarding the opioid settlement funds received from proceedings under the National Prescription Opiate Litigation, Case MDL 2804: (a) the amount of opioid settlement funds received by the state, during the quarter for which the report is prepared and cumulatively for the settlement agreements; (b) the amount of that funding that has been awarded or allocated by the Department during the quarter and cumulatively, by category of use; (c) the amount of funding that has been expended by recipients during the quarter and cumulatively, by category; a listing of individual recipients of awarded funds and the amount awarded to each recipient; and an account of program accomplishments or other relevant metrics resulting from the awarded funds.

Purdue Pharma

In May, 2019, the Wisconsin Department of Justice filed a lawsuit in the Dane County Circuit Court against Purdue Pharma LP, Purdue Pharma Inc. and Mr. Richard Sackler (the former president of Purdue Pharma, Inc.). The complaint asks the Court to: (a) to permanently enjoin the defendants, their agents, employees and others from engaging in untrue, misleading, and deceptive practices in the marketing, promotion, selling and distributing of their opioid products; (b) order the defendants to pay civil penalties of between $50 to $200 for each violation of Wisconsin's laws prohibiting false representations and fraudulent drug advertising; (c) order the defendants to pay all consumer protection surcharges, attorney fees, supplemental forfeitures and amounts reasonably necessary to remedy the harmful effects of the state violations; (d) order the defendants to abate the nuisance, to reimburse the cost of Wisconsin's abatement efforts, and to pay compensatory damages; and (e) grant such further relief as the Court deems necessary or appropriate to remedy the effects of the defendants' conduct.

The case is not yet resolved, but may be dismissed pending the resolution of a proposed nationwide settlement. That proposal was announced in March, 2022, and could be worth more than $10

billion, with payments to be made beginning after Purdue exits bankruptcy proceedings and concluding in 2039. The proposed settlement creates a $750 million fund to be shared by victims of opiate abuse and their survivors, with the remainder of the settlement going to states and local governments. The settlement also requires the Sackler family to give up control of Purdue Pharma so that it may be turned into a new entity named Knoa Pharma that will use its profits to address the opiate crisis. As of November 2022, the proposed nationwide settlement has not yet received final court approval.

Other Litigation

In addition to the National Prescription Opiate Litigation and the lawsuits against Purdue Pharma, states and local governments nationwide have brought numerous lawsuits against other entities involved in the opioid crisis. In recent years, several of these lawsuits have reached tentative settlements after using a small group of state and local governments to lead settlement negotiations. Typically, these proposed settlements require the approval of a certain number of participating states or local governments to become final.

In February 2021, McKinsey & Company reached settlements with 49 state attorneys general, including Wisconsin, related to the consulting firm's past work advising opioid manufacturers. McKinsey agreed to pay nearly $600 million total, with Wisconsin receiving roughly $10.4 million over five years, to be paid to DHS to abate problems caused by opioids. McKinsey also agreed not to advise clients on opioid-related business anywhere in the world.

In November 2022, CVS Health and Walgreens announced proposed agreements with state and local governments to settle thousands of lawsuits regarding their roles in dispensing prescriptions throughout the opioid epidemic. Under the proposed settlements, CVS will pay $4.9 billion nationally and Walgreens will pay $4.8 billion over the next ten years. The amount of Wisconsin's share is not yet known.

In November 2022, the Wisconsin Department of Justice announced that the state was part of a coalition of states and local governments that reached an agreement to resolve allegations against Walmart, pending approval of other states. The states and local governments alleged that Walmart contributed to the opioid epidemic by failing appropriately to oversee the dispensing of opioids at its stores. Under the agreement, Walmart will provide $3.1 billion, which will be divided by states that sign on to the agreement, local governments, and tribes to provide treatment and recovery services to people with opioid use disorder. The amount of Wisconsin's share is not yet known.

APPENDIX I

Comprehensive Opioid, Stimulant, and Substance Abuse Grant Awards -- Wisconsin FFYs 2018-19, 2019-20, and 2020-21

Grant Recipient	Description	Year Grant was Awarded 2018-19	2019-20	2020-21
City of Milwaukee	*Milwaukee Overdose Response Initiative (MORI).* MORI collects and analyzes EMS and dispatch data on all fatal and non-fatal overdoses in the city. These data are used to deploy the MORI Team, which includes community paramedics and certified peer support specialists. The grant funding is intended to expand the MORI team, formalize evaluation support from the Medical College of Wisconsin, and fund peer support specialists from WisHope, Community Medical Services, and CleanSlate.			$1,200,000
City of Menominee	*Project Hope*. Funds several programs focused on prevention, treatment, harm reduction and enforcement, including Botvin LifeSkills program for juveniles, quick response teams, youth diversion, removal of zero-tolerance policing strategies, an amnesty program that includes treatment opportunities, creating a sworn behavioral health officer position, and establishing a system to potential clients in need of treatment and mentoring services for juveniles.			584,200
City of West Allis	*Mobile Integrated Health MAT Access Advocation Program (MAAP).* Increase support for the West Allis Fire Department's mobile integrated health team to increase enrollments in medication assisted treatment (MAT) programs, decrease illicit drug use and opioid misuse, increase the number of first responder agencies engaged in connecting people with OUD to MAT, and completing a study related to first responders initiating MAT with buprenorphine in the field.			900,000
Winnebago County	*Stimulant and Opioid Addiction Recovery (SOAR).* SOAR will develop a diversion strategy for people with substance use disorder (SUD) and felony drug possession cases. The project includes improving data collection to better respond to persons with SUD, and improving coordination of services, including agencies that provide peer support services and recovery coaches.			897,900

		Year Grant was Awarded		
Grant Recipient	Description	2018-19	2019-20	2020-21
Lac Courte Oreilles Band of Lake Superior Chippewa Indians	*Opioid Treatment*. Provide evidence-based opioid treatment to tribal members in need of transitional or recovery support services, including MAT and recovery.		$590,000	
Milwaukee County	*Milwaukee Overdose Public Health and Safety Team.* Expand the delivery and analysis of near real-time data between public health and public safety agencies, use case reviews to develop strategies and recommendations for changes to reduce likelihood of future overdoses, increase capacity to deliver timely toxicology findings to agencies, increase understanding of fatal overdose risk factors through expanded next-to-kin interviews, and connect families affected by overdoses, especially children, to mitigate the effect of the trauma they experience.		1,200,000	
Juneau County	*Jail-Based Substance Use Disorder Program.* Establish a jail-based SUD program in collaboration with the Juneau County Department of Human Services. Support a coordinator to provide expanded case management services, a full-time jail-based therapist to develop treatment plans and provide individual and group therapy, and referrals to community-based MAT services.	$600,000		
City of Madison	*Madison Police Department Diversion Program.* Create additional pathways to treatment that include self-referrals, active outreach, a quick response team, and officer prevention and intervention. Fund additional staff, and to purchase naloxone for community distribution.	1,200,000		
Milwaukee County	*Medication Assisted Treatment Pilot Project*. Fund MAT for sentenced and sanctioned offenders in custody at the Milwaukee County House of Corrections to provide MAT and support their transition to community-based services once they are released from custody.	1,200,000		
Wisconsin Department of Justice	*Wisconsin 2019 Comprehensive Opioid Abuse Site-Based Program.* Support the implementation of local law enforcement assisted diversion (LEAD) programs and MAT programs in jails. Fund five pre-booking sites using the LEAD model to provider diversion to treatment at pre-arrest or post-arrest stage. Fund nine jail-based sites to provide nonnarcotic, non-addictive injectable MAT to inmates in the days immediately preceding their reentry to the community. Support community-based care coordination for inmates exiting county and tribal jails.	5,000,000		

APPENDIX II

Opioid Treatment Programs in Wisconsin
October, 2022

Local Opioid Treatment Centers	Location
Appleton Comprehensive Treatment Center	Appleton
Beloit Comprehensive Treatment Center	Beloit
Eau Claire Comprehensive Treatment Center	Eau Claire
Community Medical Services	Fond du Lac
Addiction Services and Pharmacotherapy	Kenosha
Green Bay Comprehensive Treatment Center	Green Bay
Addiction Medical Solutions of Wisconsin	Janesville
Gundersen Lutheran Medical Center	La Crosse
Addiction Services and Pharmacotherapy	Madison
Psychological Addiction Services	Madison
Madison East Comprehensive Treatment Center	Madison
Madison West Comprehensive Treatment Center	Madison
10th Street Comprehensive Treatment Center	Milwaukee
River's Shore Comprehensive Treatment Center	Milwaukee
Addiction Medical Solutions of Wisconsin	Onalaska
Addiction Medical Solutions of Wisconsin	Oshkosh
Racine Comprehensive Treatment Center	Racine
Sheboygan Comprehensive Treatment Center	Sheboygan
Community Medical Services	South Milwaukee
Waukesha Comprehensive Treatment Center	Waukesha
Wausau Comprehensive Treatment Center	Wausau
Community Medical Services	West Allis
Addiction Services and Pharmacotherapy	West Allis
West Milwaukee Comprehensive Treatment Center	West Milwaukee

Regional Opioid Treatment Centers	Service Area
Family Health La Clinica	Adams, Juneau, and Marquette Counties
NorthLakes Community Clinic	Ashland, Barron, Bayfield, Burnett, Florence, Iron, Langlade, Oconto, Polk, Price, Sawyer, and Washburn Counties; Bad River Band, Lac Courte Oreilles Band and Red Cliff Band of Lake Superior Chippewa, St. Croix Chippewa Indians of Wisconsin
Ladysmith Alcohol and Drug Recovery Center	Price, Rusk, Sawyer, and Washburn County; Lac Courte Oreilles and Lac du Flambeau Band of Lake Superior Chippewa.
Hope Consortium	Clark, Forest, Jackson, Oneida, Portage, Price, Vilas and Wood Counties; Forest County Potawatomi, Ho-Chunk Nation, Lac du Flambeau Band of Lake Superior Chippewa, and the Sokaogon Chippewa Community.

Regional Opioid Treatment Centers	Service Area
Opioid Treatment Center	Dodge and Fond du Lac Counties
Lake Superior Community Health Center	Douglas County
Northeast Wisconsin Heroin Opioid Prevention Education (HOPE) Consortium -- HSHS St. Vincent Hospital and Libertas Treatment Center	Florence, Manitowoc, Marinette, Menominee, Oconto and Shawano

Additional Resources

Additional state and federal information on the opioid epidemic is available through the following resources:

Wisconsin Department of Health Services -- Opioids Home Page (includes links to data, reports and studies related to opioid use in Wisconsin)
https://www.dhs.wisconsin.gov/opioids/index.htm.

Wisconsin Department of Health Services -- Annual Progress Report to the Legislature on Opioid and Methamphetamine Treatment Programs (June, 2022)
2022_06_01_health_services_opioid_and_methamphetamine_treatment_programs (wisconsin.gov)

Wisconsin Department of Safety and Professional Services -- ePDMP
https://pdmp.wi.gov/.

Wisconsin Department of Safety and Professional Services -- Annual Report on Efforts to Address Opioid Abuse submitted by Professional Boards
https://docs.legis.wisconsin.gov/misc/mandatedreports/2021/department_of_safety_and_professional_services.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration -- Home Page
https://www.samhsa.gov/.

U.S. Department of Health and Human Services
2021 Annual Report to Congress on State Opioid Response Grants
https://www.samhsa.gov/sites/default/files/2021-state-opioid-response-grants-report.pdf.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention -- Opioids
https://www.cdc.gov/opioids/index.html.

National Institute on Drug Abuse -- Opioids
https://nida.nih.gov/drug-topics/opioids.