HOUSE OF REPRESENTATIVES
FILING COPY

114TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { 114—___

COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016

_____, 2016.—Ordered to be printed

Mr. UPTON, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 524]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 524), to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment, insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Comprehensive Addiction and Recovery Act of 2016".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—PREVENTION AND EDUCATION

SEC. 101. TASK FORCE ON PAIN MANAGEMENT.

(a) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(2) TASK FORCE.—The term ''task force'' means the Pain Management Best Practices Inter-Agency Task Force convened under subsection (b).

(b) INTER-AGENCY TASK FORCE.—Not later than 2 years after the date of enactment of this Act, the Secretary, in cooperation with the Secretary of Veterans Affairs and the Secretary of Defense, shall convene a Pain Management Best Practices Inter-Agency Task Force.

(c) MEMBERSHIP.—The task force shall be comprised of—

(1) representatives of—

(A) the Department of Health and Human Services and relevant agencies within the Department of Health and Human Services;

(B) the Department of Veterans Affairs;

(C) the Department of Defense; and

(D) the Office of National Drug Control Policy;

(2) currently licensed and practicing physicians, dentists, and nonphysician prescribers;

(3) currently licensed and practicing pharmacists and pharmacies;

(4) experts in the fields of pain research and addiction research, including adolescent and young adult addiction research;

(5) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment community, including individuals in recovery from substance use disorder;

(D) pain advocacy groups, including patients;

(E) veteran service organizations;

(F) groups with expertise on overdose reversal, including first responders;

(G) State medical boards; and

(H) hospitals;

(6) experts on the health of, and prescription opioid use disorders in, members of the Armed Forces and veterans; and

(7) experts in the field of minority health.

(d) REPRESENTATION.—The Secretary shall ensure that the membership of the task force includes individuals representing rural and underserved areas.

(e) DUTIES.—The task force shall—

(1) identify, review, and, as appropriate, determine whether there are gaps in or inconsistencies between best practices for pain management (including chronic and acute pain) developed or adopted by Federal agencies;

(2) not later than 1 year after the date on which the task force is convened under subsection (b), propose updates to best practices and recommendations on addressing gaps or inconsistencies identified under paragraph (1), as appropriate, and

submit to relevant Federal agencies and the general public such proposed updates and recommendations, taking into consideration—

(A) existing pain management research and other relevant research;

(B) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(C) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of differences within and between classes of opioids, the availability of opioids with abuse deterrent technology, and pharmacological, nonpharmacological, and medical device alternatives to opioids to reduce opioid monotherapy in appropriate cases;

(D) the management of high-risk populations who receive opioids in the course of medical care, other than for pain management;

(E) the 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention; and

(F) private sector, State, and local government efforts related to pain management and prescribing pain medication;

(3) provide the public with at least 90 days to submit comments on any proposed updates and recommendations under paragraph (2); and

(4) develop a strategy for disseminating information about best practices for pain management (including chronic and acute pain) to stakeholders, if appropriate.

(f) LIMITATION.—The task force shall not have rulemaking authority.

(g) SUNSET.—The task force under this section shall sunset after 3 years.

SEC. 102. AWARENESS CAMPAIGNS.

(a) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the heads of other departments and agencies, shall, as appropriate, through existing programs and activities, advance the education and awareness of the public (including providers, patients, and consumers) and other appropriate entities regarding the risk of abuse of prescription opioids if such drugs are not taken as prescribed.

(b) TOPICS.—The education and awareness campaigns under subsection (a) shall address—

(1) the dangers of opioid abuse;

(2) the prevention of opioid abuse, including through safe disposal of prescription medications and other safety precautions; and

(3) the detection of early warning signs of addiction.

(c) OTHER REQUIREMENTS.—The education and awareness campaigns under subsection (a) shall, as appropriate—

(1) take into account any association between prescription opioid abuse and heroin use;

(2) emphasize—

(A) the similarities between heroin and prescription opioids; and

(B) the effects of heroin and prescription opioids on the human body; and

(3) bring greater public awareness to the dangerous effects of fentanyl when mixed with heroin or abused in a similar manner.

SEC. 103. COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO ADDRESS LOCAL DRUG CRISES.

(a) DEFINITIONS.—In this section:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Substance Abuse and Mental Health Services Administration.

(2) DIRECTOR.—The term ''Director'' means the Director of the Office of National Drug Control Policy.

(3) DRUG-FREE COMMUNITIES ACT OF 1997.—The term ''Drug-Free Communities Act of 1997'' means chapter 2 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1521 et seq.).

(4) ELIGIBLE ENTITY.—The term ''eligible entity'' means an organization that—

(A) on or before the date of submitting an application for a grant under this section, receives or has received a grant under the Drug-Free Communities Act of 1997; and

(B) has documented, using local data, rates of abuse of opioids or methamphetamines at levels that are—

(i) significantly higher than the national average as determined by the Secretary (including appropriate consideration of the results of the Monitoring the Future Survey published by the National Institute on Drug Abuse and the National Survey on Drug Use and Health published by the Substance Abuse and Mental Health Services Administration); or

(ii) higher than the national average, as determined by the Secretary (including appropriate consideration of the results of the surveys described in clause (i)), over a sustained period of time.

(5) EMERGING DRUG ABUSE ISSUE.—The term ''emerging drug abuse issue'' means a substance use disorder within an area involving—

(A) a sudden increase in demand for particular drug abuse treatment services relative to previous demand; and

(B) a lack of resources in the area to address the emerging problem.

(6) LOCAL DRUG CRISIS.—The term ''local drug crisis'' means, with respect to the area served by an eligible entity—

(A) a sudden increase in the abuse of opioids or methamphetamines, as documented by local data;

(B) the abuse of prescription medications, specifically opioids or methamphetamines, that is significantly higher than the national average, over a sustained period of time, as documented by local data; or

(C) a sudden increase in opioid-related deaths, as documented by local data.

(7) OPIOID.—The term ''opioid'' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

(b) PROGRAM AUTHORIZED.—The Director, in coordination with the Administrator, may make grants to eligible entities to implement comprehensive community-wide strategies that address local drug crises and emerging drug abuse issues within the area served by the eligible entity.

(c) APPLICATION.—

(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(2) CRITERIA.—As part of an application for a grant under this section, the Director shall require an eligible entity to submit a detailed, comprehensive, multisector plan for addressing the local drug crisis or emerging drug abuse issue within the area served by the eligible entity.

(d) USE OF FUNDS.—An eligible entity shall use a grant received under this section—

(1) for programs designed to implement comprehensive community-wide prevention strategies to address the local drug crisis in the area served by the eligible entity, in accordance with the plan submitted under subsection (c)(2);

(2) to obtain specialized training and technical assistance from the organization funded under section 4 of Public Law 107–82 (21 U.S.C. 1521 note); and

(3) for programs designed to implement comprehensive community-wide strategies to address emerging drug abuse issues in the community.

(e) SUPPLEMENT NOT SUPPLANT.—An eligible entity shall use Federal funds received under this section only to supplement the funds that would, in the absence of those Federal funds, be made available from other Federal and non-Federal sources for the activities described in this section, and not to supplant those funds.

(f) EVALUATION.—A grant under this section shall be subject to the same evaluation requirements and procedures as the evaluation requirements and procedures imposed on the recipient of a grant under the Drug-Free Communities Act of 1997, and may also include an evalua-

tion of the effectiveness at reducing abuse of opioids or methamphetamines.

(g) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 8 percent of the amounts made available to carry out this section for a fiscal year may be used to pay for administrative expenses.

(h) DELEGATION AUTHORITY.—The Director may enter into an interagency agreement with the Administrator to delegate authority for the execution of grants and for such other activities as may be necessary to carry out this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2017 through 2021.

SEC. 104. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

(a) REPORT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, not later than 24 months after the date of the enactment of this section, make publicly available on the appropriate website of the Department of Health and Human Services a report determining the extent to which informational materials and resources described in subsection (c)

are available to teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups.

(b) DEVELOPMENT OF INFORMATIONAL MATERIALS AND RESOURCES.—The Secretary may, for purposes of preventing substance use disorder in teenagers and adolescents who are injured playing youth sports and are subsequently prescribed an opioid, not later than 12 months after the report is made publicly available under subsection (a), and taking into consideration the findings of such report and in coordination with relevant health care provider groups, facilitate the development of informational materials and resources described in subsection (c) for teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups.

(c) MATERIALS AND RESOURCES DESCRIBED.—For purposes of this section, the informational materials and resources described in this subsection are informational materials and resources with respect to youth sports injuries for which opioids are potentially prescribed, including materials and resources focused on the risks associated with opioid use and misuse, treatment options for such

injuries that do not involve the use of opioids, and how to seek treatment for addiction.

(d) NO ADDITIONAL FUNDS.—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.

SEC. 105. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENT FOR BECOMING CIVILIAN HEALTH CARE PROFESSIONALS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

"SEC. 315. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN HEALTH CARE PROFESSIONALS.

''(a) PROGRAM.—

''(1) IN GENERAL.—The Secretary may establish a program, in consultation with the Secretary of Labor, consisting of awarding demonstration grants to States to streamline State requirements and procedures in order to assist veterans who held certain military occupational specialties related to medical care or who have completed certain medical training

while serving in the Armed Forces of the United States to meet certification, licensure, and other requirements applicable to civilian health care professions (such as emergency medical technician, paramedic, licensed practical nurse, registered nurse, physical therapy assistant, or physician assistant professions) in the State.

''(2) CONSULTATION AND COLLABORATION.—In determining the eligible military occupational specialties or training courses and the assistance required as described in paragraph (1), the Secretary shall consult with the Secretary of Defense, the Secretary of Veterans Affairs, and the Assistant Secretary of Labor for Veterans' Employment and Training, and shall collaborate with the initiatives carried out under section 4114 of title 38, United States Code, and sections 1142 through 1144 of title 10, United States Code.

''(b) USE OF FUNDS.—Amounts received as a demonstration grant under this section shall be used to—

''(1) prepare and implement a plan to streamline State requirements and procedures as described in subsection (a), including by—

''(A) determining the extent to which the requirements for the education, training, and

skill level of civilian health care professions (such as emergency medical technicians, paramedics, licensed practical nurses, registered nurses, physical therapy assistants, or physician assistants) in the State are equivalent to requirements for the education, training, and skill level of veterans who served in medical related fields while a member of the Armed Forces of the United States; and

''(B) identifying methods, such as waivers, for veterans who served in medical related fields while a member of the Armed Forces of the United States to forgo or meet any such equivalent State requirements; and

''(2) if necessary to meet workforce shortages or address gaps in education, training, or skill level to meet certification, licensure or other requirements applicable to becoming a civilian health care professional (such as an emergency medical technician, paramedic, licensed practical nurse, registered nurse, physical therapy assistant, or physician assistant professions) in the State, develop or expand career pathways at institutions of higher education to support veterans in meeting such requirements.

''(c) REPORT.—Upon the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program.

''(d) FUNDING.—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.

''(e) SUNSET.—The demonstration program under this section shall not exceed 5 years.''.

SEC. 106. FDA OPIOID ACTION PLAN.

(a) IN GENERAL.—

(1) NEW DRUG APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), prior to the approval pursuant to an application submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) of a new drug that is an opioid, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall refer the application to an advisory committee of the Food and Drug Administration to seek recommendations from such advisory committee.

(B) PUBLIC HEALTH EXEMPTION.—A referral to an advisory committee under subpara-

graph (A) is not required with respect to a new opioid drug or drugs if the Secretary—

(i) finds that such a referral is not in the interest of protecting and promoting public health;

(ii) finds that such a referral is not necessary based on a review of the relevant scientific information; and

(iii) submits a notice containing the rationale for such findings to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

(2) PEDIATRIC OPIOID LABELING.—The Secretary shall convene the Pediatric Advisory Committee of the Food and Drug Administration to seek recommendations from such Committee regarding a framework for the inclusion of information in the labeling of drugs that are opioids relating to the use of such drugs in pediatric populations before the Secretary approves any labeling or change to labeling for any drug that is an opioid intended for use in a pediatric population.

(3) SUNSET.—The requirements of paragraphs (1) and (2) shall cease to be effective on October 1, 2022.

(b) PRESCRIBER EDUCATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary, acting through the Commissioner of Food and Drugs, as part of the Food and Drug Administration's evaluation of the Extended-Release/Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, and in consultation with relevant stakeholders, shall develop recommendations regarding education programs for prescribers of opioids pursuant to section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1), including recommendations on—

(1) which prescribers should participate in such programs; and

(2) how often participation in such programs is necessary.

(c) GUIDANCE ON EVALUATING THE ABUSE DETERRENCE OF GENERIC SOLID ORAL OPIOID DRUG PRODUCTS.—Not later than 18 months after the end of the period for public comment on the draft guidance entitled ''General Principles for Evaluating the Abuse Deterrence of Generic Solid Oral Opioid Drug Products'' issued by the Center for Drug Evaluation and Research of the Food

and Drug Administration in March 2016, the Commissioner of Food and Drugs shall publish in the Federal Register a final version of such guidance.

SEC. 107. IMPROVING ACCESS TO OVERDOSE TREATMENT.

(a) GRANTS FOR REDUCING OVERDOSE DEATHS.—Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

"SEC. 544. GRANTS FOR REDUCING OVERDOSE DEATHS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall award grants to eligible entities to expand access to drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(2) MAXIMUM GRANT AMOUNT.—A grant awarded under this section may not be for more than $200,000 per grant year.

''(3) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' means a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), an opioid treatment program under part 8 of title 42, Code of Federal Regulations, any practitioner dispensing narcotic drugs pursuant to section 303(g) of the

Controlled Substances Act, or any other entity that the Secretary deems appropriate.

''(4) PRESCRIBING.—For purposes of this section, the term 'prescribing' means, with respect to a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, the practice of prescribing such drug or device—

''(A) in conjunction with an opioid prescription for patients at an elevated risk of overdose;

''(B) in conjunction with an opioid agonist approved under section 505 of the Federal Food, Drug, and Cosmetic Act for the treatment of opioid use disorder;

''(C) to the caregiver or a close relative of patients at an elevated risk of overdose from opioids; or

''(D) in other circumstances in which a provider identifies a patient is at an elevated risk for an intentional or unintentional drug overdose from heroin or prescription opioid therapies.

''(b) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity shall submit to the

Secretary, in such form and manner as specified by the Secretary, an application that describes—

''(1) the extent to which the area to which the entity will furnish services through use of the grant is experiencing significant morbidity and mortality caused by opioid abuse;

''(2) the criteria that will be used to identify eligible patients to participate in such program; and

''(3) a plan for sustaining the program after Federal support for the program has ended.

''(c) USE OF FUNDS.—An eligible entity receiving a grant under this section may use amounts under the grant for any of the following activities, but may use not more than 20 percent of the grant funds for activities described in paragraphs (3) and (4):

''(1) To establish a program for prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(2) To train and provide resources for health care providers and pharmacists on the prescribing of drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(3) To purchase drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, for distribution under the program described in paragraph (1).

''(4) To offset the co-payments and other cost sharing associated with drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(5) To establish protocols to connect patients who have experienced a drug overdose with appropriate treatment, including medication-assisted treatment and appropriate counseling and behavioral therapies.

''(d) EVALUATIONS BY RECIPIENTS.—As a condition of receipt of a grant under this section, an eligible entity shall, for each year for which the grant is received, submit to the Secretary an evaluation of activities funded by the grant which contains such information as the Secretary may reasonably require.

''(e) REPORTS BY THE SECRETARY.—Not later than 5 years after the date on which the first grant under this section is awarded, the Secretary shall submit to the appropriate committees of the House of Representatives and

of the Senate a report aggregating the information received from the grant recipients for such year under subsection (d) and evaluating the outcomes achieved by the programs funded by grants awarded under this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for the period of fiscal years 2017 through 2021.''.

(b) IMPROVING ACCESS TO OVERDOSE TREATMENT.—

(1) INFORMATION ON BEST PRACTICES.—Not later than 180 days after the date of enactment of this Act:

(A) The Secretary of Health and Human Services may provide information to prescribers within Federally qualified health centers (as defined in paragraph (4) of section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), and the health care facilities of the Indian Health Service, on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chron-

ic opioid therapy and patients being treated for opioid use disorders.

(B) The Secretary of Defense may provide information to prescribers within Department of Defense medical facilities on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(C) The Secretary of Veterans Affairs may provide information to prescribers within Department of Veterans Affairs medical facilities on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection should be construed to establish or contribute to a medical standard of care.

SEC. 108. NIH OPIOID RESEARCH.

(a) IN GENERAL.—The Director of the National Institutes of Health (referred to in this section as the ''NIH'') may intensify and coordinate fundamental, translational, and clinical research of the NIH with respect to—

(1) the understanding of pain;

(2) the discovery and development of therapies for chronic pain; and

(3) the development of alternatives to opioids for effective pain treatments.

(b) PRIORITY AND DIRECTION.—The prioritization and direction of the Federally funded portfolio of pain research studies shall consider recommendations made by the Interagency Pain Research Coordinating Committee in concert with the Pain Management Best Practices Inter-Agency Task Force, and in accordance with the National Pain Strategy, the Federal Pain Research Strategy, and the NIH-Wide Strategic Plan for Fiscal Years 2016–2020, the latter of which calls for the relative burdens of individual diseases and medical disorders to be regarded

as crucial considerations in balancing the priorities of the Federal research portfolio.

SEC. 109. NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING REAUTHORIZATION.

(a) AMENDMENT TO PURPOSE.—Paragraph (1) of section 2 of the National All Schedules Prescription Electronic Reporting Act of 2005 (Public Law 109–60) is amended to read as follows:

''(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and''.

(b) AMENDMENTS TO CONTROLLED SUBSTANCE MONITORING PROGRAM.—Section 399O of the Public Health Service Act (42 U.S.C. 280g–3) is amended—

(1) in subsection (a)(1)—

(A) in the matter preceding subparagraph (A), by inserting '', in consultation with the Administrator of the Substance Abuse and Mental Health Services Administration and Director of

the Centers for Disease Control and Prevention,'' after ''the Secretary'';

(B) in subparagraph (A), by striking ''or'';

(C) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(D) by adding at the end the following:

''(C) to maintain an existing State-controlled substance monitoring program.'';

(2) by amending subsection (b) to read as follows:

''(b) MINIMUM REQUIREMENTS.—The Secretary shall maintain and, as appropriate, supplement or revise (after publishing proposed additions and revisions in the Federal Register and receiving public comments thereon) minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).'';

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in the matter preceding clause (i), by striking ''(a)(1)(B)'' and inserting ''(a)(1)(B) or (a)(1)(C)'';

(ii) in clause (i), by striking ''program to be improved'' and inserting ''program to be improved or maintained'';

(iii) by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively;

(iv) by inserting after clause (ii), the following:

''(iii) a plan to apply the latest advances in health information technology, to the extent practicable, in order to incorporate prescription drug monitoring program data directly into the workflow of prescribers and dispensers to ensure timely access to patients' controlled prescription drug history;'';

(v) in clause (iv) (as so redesignated), by striking ''; and'' and inserting the following: ''and at least one health information technology system such as electronic health records, health information exchanges, or e-prescribing systems;'';

(vi) in clause (v) (as so redesignated)—

(I) by striking ''public health'' and inserting ''public health or safety''; and

(II) by striking the period and inserting ''; and''; and

(vii) by adding at the end the following:

''(vi) information, where applicable, on how the controlled substance monitoring program jointly works with the applicant's respective State substance abuse agency to ensure information collected and maintained by the controlled substance monitoring program is used to inform the provision of clinically appropriate substance use disorder services to individuals in need.'';

(B) in paragraph (3)—

(i) by striking ''If a State that submits'' and inserting the following:

''(A) IN GENERAL.—If a State that submits'';

(ii) by inserting before the period at the end ''and include timelines for full implementation of such interoperability. The State shall also describe the manner in which it will achieve interoperability between its monitoring program and health information technology systems, as allowable under State law, and include timelines

for the implementation of such interoperability''; and

(iii) by adding at the end the following:

''(B) MONITORING OF EFFORTS.—The Secretary shall monitor State efforts to achieve interoperability, as described in subparagraph (A).''; and

(C) in paragraph (5)—

(i) by striking ''implement or improve'' and inserting ''establish, improve, or maintain''; and

(ii) by adding at the end the following: ''The Secretary shall redistribute any funds that are so returned among the remaining grantees under this section in accordance with the formula described in subsection (a)(2)(B).'';

(4) in subsection (d)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''In implementing or improving'' and all that follows through ''(a)(1)(B)'' and inserting ''In establishing, improving, or maintaining a controlled sub-

stance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subparagraph (B) or (C) of subsection (a)(1)''; and

(ii) by striking ''public health'' and inserting ''public health or safety''; and

(B) by adding at the end the following:

''(5) The State shall report on interoperability with the controlled substance monitoring program of Federal agencies, where appropriate, interoperability with health information technology systems such as electronic health records, health information exchanges, and e-prescribing, where appropriate, and whether or not the State provides automatic, up-to-date, or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.'';

(5) in subsections (e), (f)(1), and (g), by striking ''implementing or improving'' each place it appears and inserting ''establishing, improving, or maintaining'';

(6) in subsection (f)—

(A) in paragraph (1)—

(i) in subparagraph (B), by striking ''misuse of a schedule II, III, or IV substance'' and inserting ''misuse of a controlled substance included in schedule II, III, or IV of section 202(c) of the Controlled Substances Act''; and

(ii) in subparagraph (D)—

(I) by inserting ''a State substance abuse agency,'' after ''State health department,''; and

(II) by striking ''such department, program, or administration'' each place it appears and inserting ''such department, program, agency, or administration'' in each such place; and

(B) by adding at the end the following:

''(3) EVALUATION AND REPORTING.—Subject to subsection (g), a State receiving a grant under subsection (a) shall provide the Secretary with aggregate data to enable the Secretary—

''(A) to evaluate the success of the State's program in achieving its purposes; or

''(B) to prepare and submit the report to Congress required by subsection (k)(2).

''(4) RESEARCH BY OTHER ENTITIES.—A department, program, agency, or administration receiving nonidentifiable information under paragraph (1)(D) may make such information available to other entities for research purposes.'';

(7) by striking subsection (k);

(8) by redesignating subsections (h) through (j) as subsections (i) through (k), respectively;

(9) in subsections (c)(1)(A)(iv) and (d)(4), by striking ''subsection (h)'' each place it appears and inserting ''subsection (i)'';

(10) by inserting after subsection (g) the following:

''(h) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving a grant under subsection (a) shall take steps to—

''(1) facilitate prescriber and dispenser use of the State's controlled substance monitoring system, to the extent practicable; and

''(2) educate prescribers and dispensers on the benefits of the system.'';

(11) in subsection (k)(2)(A), as so redesignated—

(A) in clause (ii), by striking ''or affected'' and inserting '', established or strengthened ini-

tiatives to ensure linkages to substance use disorder services, or affected''; and

(B) in clause (iii), by striking ''including an assessment'' and inserting ''and between controlled substance monitoring programs and health information technology systems, including an assessment'';

(12) in subsection (l)(1), by striking ''establishment, implementation, or improvement'' and inserting ''establishment, improvement, or maintenance'';

(13) in subsection (m)(8), by striking ''and the District of Columbia'' and inserting '', the District of Columbia, and any commonwealth or territory of the United States''; and

(14) by amending subsection (n) to read as follows:

''(n) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated, $10,000,000 for each of fiscal years 2017 through 2021.''.

SEC. 110. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

(a) IN GENERAL.—Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended

by section 107, is further amended by adding at the end the following:

"SEC. 545. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

''(a) GRANTS TO STATES.—The Secretary shall make grants to States to—

''(1) implement strategies for pharmacists to dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, as appropriate, pursuant to a standing order;

''(2) encourage pharmacies to dispense opioid overdose reversal medication pursuant to a standing order;

''(3) develop or provide training materials that persons authorized to prescribe or dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose may use to educate the public concerning—

''(A) when and how to safely administer such drug or device; and

''(B) steps to be taken after administering such drug or device; and

''(4) educate the public concerning the availability of drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose without a person-specific prescription.

''(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders to be issued for drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary may give preference to States that have a significantly higher rate of opioid overdoses than the national average, and that—

''(1) have not implemented standing orders regarding drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose;

''(2) authorize standing orders to be issued that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer drugs or devices approved or cleared under the Federal Food, Drug,

and Cosmetic Act for emergency treatment of known or suspected opioid overdose; or

''(3) authorize standing orders to be issued that permit police, fire, or emergency medical services agencies to acquire and administer drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

''(d) GRANT TERMS.—

''(1) NUMBER.—A State may not receive more than one grant under this section at a time.

''(2) PERIOD.—A grant under this section shall be for a period of 3 years.

''(3) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(4).

''(e) APPLICATIONS.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may reasonably require, including detailed proposed expenditures of grant funds.

''(f) REPORTING.—A State that receives a grant under this section shall, at least annually for the duration of the grant, submit a report to the Secretary evaluating the progress of the activities supported through the grant.

Such reports shall include information on the number of pharmacies in the State that dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose under a standing order, and other information as the Secretary determines appropriate to evaluate the use of grant funds.

''(g) DEFINITIONS.—In this section the term 'standing order' means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.

''(h) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated $5,000,000 for the period of fiscal years 2017 through 2019.

''(2) ADMINISTRATIVE COSTS.—Not more than 3 percent of the amounts made available to carry out this section may be used by the Secretary for administrative expenses of carrying out this section.''.

(b) TECHNICAL CLARIFICATION.—Effective as if included in the enactment of the Children's Health Act of 2000 (Public Law 106–310), section 3405(a) of such Act (114 Stat. 1221) is amended by striking ''Part E of title

III'' and inserting ''Part E of title III of the Public Health Service Act''.

TITLE II—LAW ENFORCEMENT AND TREATMENT

SEC. 201. COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

(a) COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—

(1) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended by adding at the end the following:

''PART LL—COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM

''SEC. 3021. DESCRIPTION.

''(a) GRANTS AUTHORIZED.—From amounts made available to carry out this part, the Attorney General may make grants to States, units of local government, and Indian tribes, for use by the State, unit of local government, or Indian tribe to provide services primarily relating to opioid abuse, including for any one or more of the following:

''(1) Developing, implementing, or expanding a treatment alternative to incarceration program, which may include—

''(A) prebooking or postbooking components, which may include the activities described in part DD or HH of this title;

''(B) training for criminal justice agency personnel on substance use disorders and co-occurring mental illness and substance use disorders;

''(C) a mental health court, including the activities described in part V of this title;

''(D) a drug court, including the activities described in part EE of this title;

''(E) a veterans treatment court program, including the activities described in subsection (i) of section 2991 of this title;

''(F) a focus on parents whose incarceration could result in their children entering the child welfare system; and

''(G) a community-based substance use diversion program sponsored by a law enforcement agency.

''(2) In the case of a State, facilitating or enhancing planning and collaboration between State criminal justice agencies and State substance abuse agencies in order to more efficiently and effectively carry out activities or services described in any para-

graph of this subsection that address problems related to opioid abuse.

''(3) Providing training and resources for first responders on carrying and administering an opioid overdose reversal drug or device approved or cleared by the Food and Drug Administration, and purchasing such a drug or device for first responders who have received such training to so carry and administer.

''(4) Locating or investigating illicit activities related to the unlawful distribution of opioids.

''(5) Developing, implementing, or expanding a medication-assisted treatment program used or operated by a criminal justice agency, which may include training criminal justice agency personnel on medication-assisted treatment, and carrying out the activities described in part S of this title.

''(6) In the case of a State, developing, implementing, or expanding a prescription drug monitoring program to collect and analyze data related to the prescribing of schedules II, III, and IV controlled substances through a centralized database administered by an authorized State agency, which includes tracking the dispensation of such substances, and providing for interoperability and data

sharing with each other such program in each other State, and with any interstate entity that shares information between such programs.

''(7) Developing, implementing, or expanding a program to prevent and address opioid abuse by juveniles.

''(8) Developing, implementing, or expanding a program (which may include demonstration projects) to utilize technology that provides a secure container for prescription drugs that would prevent or deter individuals, particularly adolescents, from gaining access to opioid medications that are lawfully prescribed for other individuals.

''(9) Developing, implementing, or expanding a prescription drug take-back program.

''(10) Developing, implementing, or expanding an integrated and comprehensive opioid abuse response program.

''(b) CONTRACTS AND SUBAWARDS.—A State, unit of local government, or Indian tribe may, in using a grant under this part for purposes authorized by subsection (a), use all or a portion of that grant to contract with, or make one or more subawards to, one or more—

''(1) local or regional organizations that are private and nonprofit, including faith-based organizations;

''(2) units of local government; or

''(3) tribal organizations.

''(c) PROGRAM ASSESSMENT COMPONENT; WAIVER.—

''(1) PROGRAM ASSESSMENT COMPONENT.—Each program funded under this part shall contain a program assessment component, developed pursuant to guidelines established by the Attorney General, in coordination with the National Institute of Justice.

''(2) WAIVER.—The Attorney General may waive the requirement of paragraph (1) with respect to a program if, in the opinion of the Attorney General, the program is not of sufficient size to justify a full program assessment.

''(d) ADMINISTRATIVE COSTS.—Not more than 10 percent of a grant made under this part may be used for costs incurred to administer such grant.

''(e) PERIOD.—The period of a grant made under this part may not be longer than 4 years, except that renewals and extensions beyond that period may be granted at the discretion of the Attorney General.

"SEC. 3022. APPLICATIONS.

"To request a grant under this part, the chief executive officer of a State, unit of local government, or Indian tribe shall submit an application to the Attorney General at such time and in such form as the Attorney General may require. Such application shall include the following:

"(1) A certification that Federal funds made available under this part will not be used to supplant State, local, or tribal funds, but will be used to increase the amounts of such funds that would, in the absence of Federal funds, be made available for the activities described in section 3021(a).

"(2) An assurance that, for each fiscal year covered by an application, the applicant shall maintain and report such data, records, and information (programmatic and financial) as the Attorney General may reasonably require.

"(3) A certification, made in a form acceptable to the Attorney General and executed by the chief executive officer of the applicant (or by another officer of the applicant, if qualified under regulations promulgated by the Attorney General), that—

"(A) the activities or services to be funded by the grant meet all the requirements of this part;

''(B) all the information contained in the application is correct;

''(C) there has been appropriate coordination with affected agencies; and

''(D) the applicant will comply with all provisions of this part and all other applicable Federal laws.

''(4) An assurance that the applicant will work with the Drug Enforcement Administration to develop an integrated and comprehensive strategy to address opioid abuse.

''SEC. 3023. REVIEW OF APPLICATIONS.

''The Attorney General shall not finally disapprove any application (or any amendment to that application) submitted under this part without first affording the applicant reasonable notice of any deficiencies in the application and an opportunity for correction of any such deficiencies and reconsideration.

''SEC. 3024. EQUITABLE DISTRIBUTION OF FUNDS.

''In awarding grants under this part, the Attorney General shall distribute funds in a manner that—

''(1) equitably addresses the needs of underserved populations, including rural and tribal communities; and

''(2) focuses on communities that have been disproportionately impacted by opioid abuse as evidenced in part by—

''(A) high rates of primary treatment admissions for heroin and other opioids;

''(B) high rates of drug poisoning deaths from heroin and other opioids; and

''(C) a lack of accessibility to treatment providers and facilities and to emergency medical services.

''SEC. 3025. DEFINITIONS.

''In this part:

''(1) The term 'first responder' includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of his or her professional duties, responds to fire, medical, hazardous material, or other similar emergencies.

''(2) The term 'medication-assisted treatment' means the use of medications approved by the Food and Drug Administration for the treatment of opioid abuse.

''(3) The term 'opioid' means any drug, including heroin, having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

''(4) The term 'schedule II, III, or IV controlled substance' means a controlled substance that is listed on schedule II, schedule III, or schedule IV of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)).

''(5) The terms 'drug' and 'device' have the meanings given those terms in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321).

''(6) The term 'criminal justice agency' means a State, local, or tribal—

''(A) court;

''(B) prison;

''(C) jail;

''(D) law enforcement agency; or

''(E) other agency that performs the administration of criminal justice, including prosecution, pretrial services, and community supervision.

''(7) The term 'tribal organization' has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(8) The term 'State substance abuse agency' has the meaning given that term in section 508(r)(6) of the Public Health Service Act (42 U.S.C. 290bb–1).''.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793(a)) is amended by inserting after paragraph (26) the following:

''(27) There are authorized to be appropriated to carry out part LL $103,000,000 for each of fiscal years 2017 through 2021.''.

(b) EMERGENCY FEDERAL LAW ENFORCEMENT ASSISTANCE.—Section 609Y(a) of the Justice Assistance Act of 1984 (42 U.S.C. 10513(a)) is amended by striking ''September 30, 1984'' and inserting ''September 30, 2021''.

(c) INCLUSION OF SERVICES FOR PREGNANT WOMEN UNDER FAMILY-BASED SUBSTANCE ABUSE GRANTS.—Part DD of title I of the Omnibus Crime Control and Safe Streets Act (42 U.S.C. 3797s et seq.) is amended—

(1) in section 2921(2), by inserting before the period at the end ''or pregnant women''; and

(2) in section 2927—

(A) in paragraph (1)(A), by inserting ''pregnant or'' before ''a parent''; and

(B) in paragraph (3), by inserting ''or pregnant women'' after ''incarcerated parents''.

(d) GAO STUDY AND REPORT ON FEDERAL AGENCY PROGRAMS AND RESEARCH RELATIVE TO SUBSTANCE USE AND SUBSTANCE USE DISORDERS AMONG ADOLESCENTS AND YOUNG ADULTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on how Federal agencies, through grant programs, are addressing prevention of, treatment for, and recovery from, substance use by, and substance use disorders among, adolescents and young adults. Such study shall include an analysis of each of the following:

(A) The research that has been, and is being, conducted or supported pursuant to grant programs operated by Federal agencies on prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of—

(i) such research relative to any unique circumstances (including social and biological circumstances) of adolescents and young adults that may make adolescent-specific and young adult-specific treatment protocols necessary, including any effects that substance use and substance use disorders may have on brain development and the implications for treatment and recovery; and

(ii) areas of such research in which greater investment or focus is necessary relative to other areas of such research.

(B) Federal agency nonresearch programs and activities that address prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of the effectiveness of such programs and activities in preventing substance use by and substance use disorders among adolescents and young adults, treating such adolescents and young adults in a way that accounts for any unique circumstances faced by adolescents and young

adults, and supports long-term recovery among adolescents and young adults.

(C) Gaps that have been identified by officials of Federal agencies or experts in the efforts supported by grant programs operated by Federal agencies relating to prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including gaps in research, data collection, and measures to evaluate the effectiveness of such efforts, and the reasons for such gaps.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to the appropriate committees of the Congress a report containing the results of the study conducted under paragraph (1), including—

(A) a summary of the findings of the study; and

(B) recommendations based on the results of the study, including recommendations for such areas of research and legislative and administrative action as the Comptroller General determines appropriate.

SEC. 202. FIRST RESPONDER TRAINING.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 110, is further amended by adding at the end the following:

"SEC. 546. FIRST RESPONDER TRAINING.

"(a) PROGRAM AUTHORIZED.—The Secretary shall make grants to States, local governmental entities, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) to allow first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

"(b) APPLICATION.—

"(1) IN GENERAL.—An entity seeking a grant under this section shall submit an application to the Secretary—

"(A) that meets the criteria under paragraph (2); and

"(B) at such time, in such manner, and accompanied by such information as the Secretary may require.

"(2) CRITERIA.—An entity, in submitting an application under paragraph (1), shall—

"(A) describe the evidence-based methodology and outcome measurements that will be used to evaluate the program funded with a grant under this section, and specifically explain how such measurements will provide valid measures of the impact of the program;

"(B) describe how the program could be broadly replicated if demonstrated to be effective;

"(C) identify the governmental and community agencies with which the entity will coordinate to implement the program; and

"(D) describe how the entity will ensure that law enforcement agencies will coordinate with their corresponding State substance abuse and mental health agencies to identify protocols and resources that are available to overdose victims and families, including information on treatment and recovery resources.

"(c) USE OF FUNDS.—An entity shall use a grant received under this section to—

"(1) make a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose available to be carried and administered by

first responders and members of other key community sectors;

''(2) train and provide resources for first responders and members of other key community sectors on carrying and administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

''(3) establish processes, protocols, and mechanisms for referral to appropriate treatment, which may include an outreach coordinator or team to connect individuals receiving opioid overdose reversal drugs to followup services.

''(d) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall make a grant for the purpose of providing technical assistance and training on the use of a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, and mechanisms for referral to appropriate treatment for an entity receiving a grant under this section.

''(e) GEOGRAPHIC DISTRIBUTION.—In making grants under this section, the Secretary shall ensure that not less than 20 percent of grant funds are awarded to eligible entities that are not located in metropolitan statis-

tical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

''(f) EVALUATION.—The Secretary shall conduct an evaluation of grants made under this section to determine—

''(1) the number of first responders and members of other key community sectors equipped with a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose;

''(2) the number of opioid and heroin overdoses reversed by first responders and members of other key community sectors receiving training and supplies of a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, through a grant received under this section;

''(3) the number of responses to requests for services by the entity or subgrantee, to opioid and heroin overdose; and

''(4) the extent to which overdose victims and families receive information about treatment services and available data describing treatment admissions.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $12,000,000 for each of fiscal years 2017 through 2021.''.

SEC. 203. PRESCRIPTION DRUG TAKE BACK EXPANSION.

(a) DEFINITION OF COVERED ENTITY.—In this section, the term ''covered entity'' means—

(1) a State, local, or tribal law enforcement agency;

(2) a manufacturer, distributor, or reverse distributor of prescription medications;

(3) a retail pharmacy;

(4) a registered narcotic treatment program;

(5) a hospital or clinic with an onsite pharmacy;

(6) an eligible long-term care facility; or

(7) any other entity authorized by the Drug Enforcement Administration to dispose of prescription medications.

(b) PROGRAM AUTHORIZED.—The Attorney General, in coordination with the Administrator of the Drug Enforcement Administration, the Secretary of Health and Human Services, and the Director of the Office of Na-

tional Drug Control Policy, shall coordinate with covered entities in expanding or making available disposal sites for unwanted prescription medications.

TITLE III—TREATMENT AND RECOVERY

SEC. 301. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by adding at the end the following:

"SEC. 514B. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

''(a) GRANTS TO EXPAND ACCESS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants, contracts, or cooperative agreements to State substance abuse agencies, units of local government, nonprofit organizations, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) that have a high rate, or have had a rapid increase, in the use of heroin or other opioids, in order to permit such entities to expand activities, including an expansion in the

availability of evidence-based medication-assisted treatment and other clinically appropriate services, with respect to the treatment of addiction in the specific geographical areas of such entities where there is a high rate or rapid increase in the use of heroin or other opioids, such as in rural areas.

''(2) NATURE OF ACTIVITIES.—Funds awarded under paragraph (1) shall be used for activities that are based on reliable scientific evidence of efficacy in the treatment of problems related to heroin or other opioids.

''(b) APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(c) EVALUATION.—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or agreement a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and an evaluation at the completion of such project as the Secretary determines to be appropriate.

''(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall ensure that not less than 15 percent of funds are awarded to eligible entities that are not located in metropolitan statistical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

''(e) ADDITIONAL ACTIVITIES.—In administering grants, contracts, and cooperative agreements under subsection (a), the Secretary shall—

''(1) evaluate the activities supported under such subsection;

''(2) disseminate information, as appropriate, derived from evaluations as the Secretary considers appropriate;

''(3) provide States, Indian tribes and tribal organizations, and providers with technical assistance in connection with the provision of treatment of problems related to heroin and other opioids; and

''(4) fund only those applications that specifically support recovery services as a critical component of the program involved.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $25,000,000 for each of fiscal years 2017 through 2021.''.

SEC. 302. BUILDING COMMUNITIES OF RECOVERY.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 202, is further amended by adding at the end the following:

''SEC. 547. BUILDING COMMUNITIES OF RECOVERY.

''(a) DEFINITION.—In this section, the term 'recovery community organization' means an independent nonprofit organization that—

''(1) mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from substance use disorders; and

''(2) is wholly or principally governed by people in recovery for substance use disorders who reflect the community served.

''(b) GRANTS AUTHORIZED.—The Secretary shall award grants to recovery community organizations to en-

able such organizations to develop, expand, and enhance recovery services.

''(c) FEDERAL SHARE.—The Federal share of the costs of a program funded by a grant under this section may not exceed 50 percent.

''(d) USE OF FUNDS.—Grants awarded under subsection (b)—

''(1) shall be used to develop, expand, and enhance community and statewide recovery support services; and

''(2) may be used to—

''(A) build connections between recovery networks, between recovery community organizations, and with other recovery support services, including—

''(i) behavioral health providers;

''(ii) primary care providers and physicians;

''(iii) the criminal justice system;

''(iv) employers;

''(v) housing services;

''(vi) child welfare agencies; and

''(vii) other recovery support services that facilitate recovery from substance use disorders;

"(B) reduce the stigma associated with substance use disorders; and

"(C) conduct outreach on issues relating to substance use disorders and recovery, including—

"(i) identifying the signs of addiction;

"(ii) the resources available to individuals struggling with addiction and to families with a family member struggling with, or being treated for, addiction, including programs that mentor and provide support services to children;

"(iii) the resources available to help support individuals in recovery; and

"(iv) related medical outcomes of substance use disorders, the potential of acquiring an infectious disease from intravenous drug use, and neonatal abstinence syndrome among infants exposed to opioids during pregnancy.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2017 through 2021.".

SEC. 303. MEDICATION-ASSISTED TREATMENT FOR RECOVERY FROM ADDICTION.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended—

(A) in subparagraph (B), by striking clauses (i), (ii), and (iii) and inserting the following:

''(i) The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

''(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary—

''(I) all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention; and

''(II) appropriate counseling and other appropriate ancillary services.

''(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the

applicable number. Except as provided in subclause (II), the applicable number is 30.

''(II) The applicable number is 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients.

''(III) The Secretary may by regulation change such applicable number.

''(IV) The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.'';

(B) in subparagraph (D)—

(i) in clause (ii), by striking ''Upon receiving a notification under subparagraph (B)'' and inserting ''Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B)''; and

(ii) in clause (iii)—

(I) by inserting ''and shall forward such determination to the Attor-

ney General'' before the period at the end of the first sentence; and

(II) by striking ''physician'' and inserting ''practitioner'';

(C) in subparagraph (G)—

(i) by amending clause (ii)(I) to read as follows:

''(I) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.'';

(ii) by amending clause (ii)(II) to read as follows:

''(II) The physician holds an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine.'';

(iii) in clause (ii)(III), by striking ''subspecialty'';

(iv) by amending clause (ii)(IV) to read as follows:

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than 8

hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall include—

''(aa) opioid maintenance and detoxification;

''(bb) appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

''(cc) initial and periodic patient assessments (including substance use monitoring);

''(dd) individualized treatment planning, overdose reversal, and relapse prevention;

''(ee) counseling and recovery support services;

''(ff) staffing roles and considerations;

''(gg) diversion control; and

''(hh) other best practices, as identified by the Secretary.''; and

(v) by adding at the end the following:

''(iii) The term 'qualifying practitioner' means—

''(I) a qualifying physician, as defined in clause (ii); or

''(II) during the period beginning on the date of enactment of the Comprehensive Addiction and Recovery Act of 2016 and ending on October 1, 2021, a qualifying other practitioner, as defined in clause (iv).

''(iv) The term 'qualifying other practitioner' means a nurse practitioner or physician assistant who satisfies each of the following:

''(I) The nurse practitioner or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

''(II) The nurse practitioner or physician assistant has—

''(aa) completed not fewer than 24 hours of initial training addressing each of

the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or

''(bb) has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

''(III) The nurse practitioner or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the

treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may, by regulation, revise the requirements for being a qualifying other practitioner under this clause.''; and

(D) in subparagraph (H)—

(i) in clause (i), by inserting after subclause (II) the following:

''(III) Such other elements of the requirements under this paragraph as the Secretary determines necessary for purposes of implementing such requirements.''; and

(ii) by amending clause (ii) to read as follows:

''(ii) Not later than 18 months after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.''.

(2) OPIOID DEFINED.—Section 102(18) of the Controlled Substances Act (21 U.S.C. 802(18)) is

amended by inserting ''or 'opioid' '' after ''The term 'opiate' ''.

(3) REPORTS TO CONGRESS.—

(A) IN GENERAL.—Not later than 3 years after the date of enactment of this Act and not later than 3 years thereafter, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration and experts in opioid use disorder research and treatment, shall—

(i) perform a thorough review of the provision of opioid use disorder treatment services in the United States, including services provided in opioid treatment programs and other specialty and nonspecialty settings; and

(ii) submit a report to the Congress on the findings and conclusions of such review.

(B) CONTENTS.—Each report under subparagraph (A) shall include an assessment of—

(i) compliance with the requirements of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), as amended by this section;

(ii) the measures taken by the Secretary of Health and Human Services to ensure such compliance;

(iii) whether there is further need to increase or decrease the number of patients a practitioner, pursuant to a waiver under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), is permitted to treat;

(iv) the extent to which, and proportions with which, the full range of Food and Drug Administration-approved treatments for opioid use disorder are used in routine health care settings and specialty substance use disorder treatment settings;

(v) access to, and use of, counseling and recovery support services, including the percentage of patients receiving such services;

(vi) changes in State or local policies and legislation relating to opioid use disorder treatment;

(vii) the use of prescription drug monitoring programs by practitioners who are permitted to dispense narcotic drugs to in-

dividuals pursuant to a waiver described in clause (iii);

(viii) the findings resulting from inspections by the Drug Enforcement Administration of practitioners described in clause (vii); and

(ix) the effectiveness of cross-agency collaboration between Department of Health and Human Services and the Drug Enforcement Administration for expanding effective opioid use disorder treatment.

(b) STATE FLEXIBILITY.—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended by striking subparagraphs (I) and (J), and inserting the following:

''(I) Notwithstanding section 708, nothing in this paragraph shall be construed to preempt any State law that—

''(i) permits a qualifying practitioner to dispense narcotic drugs in schedule III, IV, or V, or combinations of such drugs, for maintenance or detoxification treatment in accordance with this paragraph to a total number of patients that is more than 30 or less than the total number applicable to the qualifying practitioner under subparagraph

(B)(iii)(II) if a State enacts a law modifying such total number and the Attorney General is notified by the State of such modification; or

''(ii) requires a qualifying practitioner to comply with additional requirements relating to the dispensing of narcotic drugs in schedule III, IV, or V, or combinations of such drugs, including requirements relating to the practice setting in which the qualifying practitioner practices and education, training, and reporting requirements.''.

(c) UPDATE REGULATIONS.—Not later than 18 months after the date of enactment of this Act, the Attorney General and the Secretary of Health and Human Services, as appropriate, shall update regulations regarding practitioners described in subsection (a)(3)(B)(vii) (as amended by this section) to include nurse practitioners and physician assistants to ensure the quality of patient care and prevent diversion.

TITLE IV—ADDRESSING COLLATERAL CONSEQUENCES

SEC. 401. GAO REPORT ON RECOVERY AND COLLATERAL CONSEQUENCES.

(a) REPORT REQUIRED.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on

the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that—

(1) describes the collateral consequences for individuals with convictions for nonviolent drug-related offenses;

(2) describes the effect of the collateral consequences described in paragraph (1) on individuals in resuming their personal and professional activities, especially, to the extent data are available, the effect on individuals who are participating in or have completed a recovery program for a substance use disorder;

(3) discusses policy bases and justifications for imposing collateral consequences on individuals convicted of nonviolent drug-related offenses identified under paragraph (1); and

(4) provides perspectives on the potential for mitigating the effect of the collateral consequences described in paragraph (1) on individuals who are participating in or have completed a recovery program, while also taking into account the policy interests described in paragraph (3).

(b) DEFINITION.—In this section, the term ''collateral consequence''—

(1) means a penalty, disability, or disadvantage imposed upon an individual as a result of a criminal conviction for a drug-related offense—

(A) automatically by operation of law; or

(B) by authorized action of an administrative agency or court on a case-by-case basis; and

(2) does not include a direct consequence imposed as part of the judgment of a court at sentencing, including a term of imprisonment or community supervision, or a fine.

TITLE V—ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

SEC. 501. IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN.

(a) GENERAL AMENDMENTS TO THE RESIDENTIAL TREATMENT PROGRAM FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by inserting ''(referred to in this section as the 'Director')'' after ''Substance Abuse Treatment'';

(ii) by striking ''grants, cooperative agreement,'' and inserting ''grants, including the grants under subsection (r), cooperative agreements''; and

(iii) by striking ''for substance abuse'' and inserting ''for substance use disorders''; and

(B) in paragraph (1), by inserting ''or receive outpatient treatment services from'' after ''reside in'';

(2) in subsection (b)(2), by inserting ''and her children'' before the period at the end;

(3) in subsection (c)—

(A) in paragraph (1), by striking ''to the woman of the services'' and inserting ''of services for the woman and her children''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(ii) in subparagraph (B), by striking ''such abuse'' and inserting ''such a disorder'';

(4) in subsection (d)—

(A) in paragraph (3)(A), by striking ''maternal substance abuse'' and inserting ''a maternal substance use disorder'';

(B) by amending paragraph (4) to read as follows:

''(4) Providing therapeutic, comprehensive child care for children during the periods in which the woman is engaged in therapy or in other necessary health and rehabilitative activities.'';

(C) in paragraphs (9), (10), and (11), by striking ''women'' each place such term appears and inserting ''woman'';

(D) in paragraph (9), by striking ''units'' and inserting ''unit''; and

(E) in paragraph (11)—

(i) in subparagraph (A), by striking ''their children'' and inserting ''any child of such woman'';

(ii) in subparagraph (B), by striking ''; and'' and inserting a semicolon;

(iii) in subparagraph (C), by striking the period and inserting ''; and''; and

(iv) by adding at the end the following:

''(D) family reunification with children in kinship or foster care arrangements, where safe and appropriate.'';

(5) in subsection (e)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(ii) in subparagraph (B), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(B) in paragraph (2)—

(i) by striking ''(A) Subject'' and inserting the following:

''(A) IN GENERAL.—Subject'';

(ii) in subparagraph (B)—

(I) by striking ''(B)(i) In the case'' and inserting the following:

''(B) WAIVER OF PARTICIPATION AGREEMENTS.—

''(i) IN GENERAL.—In the case''; and

(II) by striking ''(ii) A determination'' and inserting the following: ''(ii) DONATIONS.—A determination''; and

(iii) by striking ''(C) With respect'' and inserting the following: ''(C) NONAPPLICATION OF CERTAIN REQUIREMENTS.—With respect'';

(6) in subsection (g)—

(A) by striking ''who are engaging in substance abuse'' and inserting ''who have a substance use disorder''; and

(B) by striking ''such abuse'' and inserting ''such disorder'';

(7) in subsection (j)—

(A) in the matter preceding paragraph (1), by striking ''to on'' and inserting ''to or on''; and

(B) in paragraph (3), by striking ''Office for'' and inserting ''Office of'';

(8) by amending subsection (m) to read as follows:

''(m) ALLOCATION OF AWARDS.—In making awards under subsection (a), the Director shall give priority to

an applicant that agrees to use the award for a program serving an area that is a rural area, an area designated under section 332 by the Secretary as a health professional shortage area, or an area determined by the Director to have a shortage of family-based substance use disorder treatment options.''; and

(9) in subsection (q)—

(A) in paragraph (3), by striking ''funding agreement under subsection (a)'' and inserting ''funding agreement''; and

(B) in paragraph (4), by striking ''substance abuse'' and inserting ''a substance use disorder''.

(b) REAUTHORIZATION OF PROGRAM.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1), as amended by subsection (a), is further amended—

(1) in subsection (p), in the first sentence, by inserting ''(other than subsection (r))'' after ''section''; and

(2) in subsection (r), by striking ''such sums'' and all that follows through ''2003'' and inserting ''$16,900,000 for each of fiscal years 2017 through 2021''.

(c) PILOT PROGRAM GRANTS FOR STATE SUBSTANCE ABUSE AGENCIES.—

(1) IN GENERAL.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1), as amended by subsections (a) and (b), is further amended—

(A) by redesignating subsection (r), as amended by subsection (b), as subsection (s); and

(B) by inserting after subsection (q) the following new subsection:

''(r) PILOT PROGRAM FOR STATE SUBSTANCE ABUSE AGENCIES.—

''(1) IN GENERAL.—From amounts made available under subsection (s), the Director of the Center for Substance Abuse Treatment shall carry out a pilot program under which competitive grants are made by the Director to State substance abuse agencies—

''(A) to enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

''(B) to help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of

care, including services provided to women in nonresidential-based settings; and

''(C) to promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery.

''(2) REQUIREMENTS.—In carrying out the pilot program under this subsection, the Director shall—

''(A) require State substance abuse agencies to submit to the Director applications, in such form and manner and containing such information as specified by the Director, to be eligible to receive a grant under the program;

''(B) identify, based on such submitted applications, State substance abuse agencies that are eligible for such grants;

''(C) require services proposed to be furnished through such a grant to support family-based treatment and other services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

"(D) not require that services furnished through such a grant be provided solely to women that reside in facilities;

"(E) not require that grant recipients under the program make available through use of the grant all the services described in subsection (d); and

"(F) consider not applying the requirements described in paragraphs (1) and (2) of subsection (f) to an applicant, depending on the circumstances of the applicant.

"(3) REQUIRED SERVICES.—

"(A) IN GENERAL.—The Director shall specify a minimum set of services required to be made available to eligible women through a grant awarded under the pilot program under this subsection. Such minimum set of services—

"(i) shall include the services requirements described in subsection (c) and be based on the recommendations submitted under subparagraph (B); and

"(ii) may be selected from among the services described in subsection (d) and include other services as appropriate.

''(B) STAKEHOLDER INPUT.—The Director shall convene and solicit recommendations from stakeholders, including State substance abuse agencies, health care providers, persons in recovery from substance abuse, and other appropriate individuals, for the minimum set of services described in subparagraph (A).

''(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

''(5) EVALUATION AND REPORT TO CONGRESS.—

''(A) IN GENERAL.—The Director of the Center for Behavioral Health Statistics and Quality shall evaluate the pilot program at the conclusion of the first grant cycle funded by the pilot program.

''(B) REPORT.—The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on the evaluation under subparagraph (A). The report shall include, at a minimum—

"(i) outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs;

"(ii) engagement in treatment services;

"(iii) retention in the appropriate level and duration of services;

"(iv) increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and

"(v) other appropriate measures.

"(C) RECOMMENDATION.—The report under subparagraph (B) shall include a recommendation by the Director of the Center for Substance Abuse Treatment as to whether the pilot program under this subsection should be extended.

"(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term 'State substance abuse agency' means, with respect to a State, the agency in such State that manages

the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.''.

(2) FUNDING.—Subsection (s) of section 508 of the Public Health Service Act (42 U.S.C. 290bb–1), as amended by subsection (a) and redesignated by paragraph (1), is further amended by adding at the end the following new sentences: ''Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.''.

SEC. 502. VETERANS TREATMENT COURTS.

Section 2991 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is amended—

(1) by redesignating subsection (i) as subsection (j); and

(2) by inserting after subsection (h) the following:

''(i) ASSISTING VETERANS.—

''(1) DEFINITIONS.—In this subsection:

''(A) PEER-TO-PEER SERVICES OR PROGRAMS.—The term 'peer-to-peer services or programs' means services or programs that connect qualified veterans with other veterans for the purpose of providing support and mentorship to assist qualified veterans in obtaining treatment, recovery, stabilization, or rehabilitation.

''(B) QUALIFIED VETERAN.—The term 'qualified veteran' means a preliminarily qualified offender who—

''(i) served on active duty in any branch of the Armed Forces, including the National Guard or Reserves; and

''(ii) was discharged or released from such service under conditions other than dishonorable, unless the reason for the dishonorable discharge was attributable to a substance abuse disorder.

''(C) VETERANS TREATMENT COURT PROGRAM.—The term 'veterans treatment court program' means a court program involving collaboration among criminal justice, veterans, and

mental health and substance abuse agencies that provides qualified veterans with—

"(i) intensive judicial supervision and case management, which may include random and frequent drug testing where appropriate;

"(ii) a full continuum of treatment services, including mental health services, substance abuse services, medical services, and services to address trauma;

"(iii) alternatives to incarceration; or

"(iv) other appropriate services, including housing, transportation, mentoring, employment, job training, education, or assistance in applying for and obtaining available benefits.

"(2) VETERANS ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The Attorney General, in consultation with the Secretary of Veterans Affairs, may award grants under this subsection to applicants to establish or expand—

"(i) veterans treatment court programs;

"(ii) peer-to-peer services or programs for qualified veterans;

"(iii) practices that identify and provide treatment, rehabilitation, legal, transitional, and other appropriate services to qualified veterans who have been incarcerated; or

"(iv) training programs to teach criminal justice, law enforcement, corrections, mental health, and substance abuse personnel how to identify and appropriately respond to incidents involving qualified veterans.

"(B) PRIORITY.—In awarding grants under this subsection, the Attorney General shall give priority to applications that—

"(i) demonstrate collaboration between and joint investments by criminal justice, mental health, substance abuse, and veterans service agencies;

"(ii) promote effective strategies to identify and reduce the risk of harm to qualified veterans and public safety; and

"(iii) propose interventions with empirical support to improve outcomes for qualified veterans.".

SEC. 503. INFANT PLAN OF SAFE CARE.

(a) BEST PRACTICES FOR DEVELOPMENT OF PLANS OF SAFE CARE.—Section 103(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5104(b)) is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively; and

(2) by inserting after paragraph (4) the following:

''(5) maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;''.

(b) STATE PLANS.—Section 106(b)(2)(B) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)) is amended—

(1) in clause (ii), by striking ''illegal substance abuse'' and inserting ''substance abuse''; and

(2) in clause (iii)—

(A) by striking ''illegal substance abuse'' and inserting ''substance abuse''; and

(B) by inserting before the semicolon at the end the following: ''to ensure the safety and

well-being of such infant following release from the care of health care providers, including through—

''(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

''(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver''.

(c) DATA REPORTS.—

(1) IN GENERAL.—Section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by adding at the end of the following:

''(17) The number of infants—

''(A) identified under subsection (b)(2)(B)(ii);

''(B) for whom a plan of safe care was developed under subsection (b)(2)(B)(iii); and

''(C) for whom a referral was made for appropriate services, including services for the affected family or caregiver, under subsection (b)(2)(B)(iii).''.

(2) REDESIGNATION.—Effective on May 29, 2017, section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by redesignating paragraph (17) (as added by paragraph (1)) as paragraph (18).

(d) MONITORING AND OVERSIGHT.—

(1) AMENDMENT.—Title I of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq.) is amended by adding at the end the following:

''SEC. 114. MONITORING AND OVERSIGHT.

''The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which—

''(1) shall—

''(A) be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and

''(B) include monitoring of State policies and procedures required under clauses (ii) and (iii) of section 106(b)(2)(B); and

''(2) may include—

''(A) a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;

''(B) a review of information available on the website of the State relating to its compliance with the requirements of section 106(b);

''(C) site visits, as may be necessary to carry out such monitoring; and

''(D) a review of information available in the State's Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).''.

(2) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 note) is amended by inserting after the item relating to section 113, the following:

''Sec. 114. Monitoring and oversight.''.

(e) RULE OF CONSTRUCTION.—Nothing in this section, or the amendments made by this section, shall be construed to authorize the Secretary of Health and Human Services or any other officer of the Federal Government to add new requirements to section 106(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)), as amended by this section.

SEC. 504. GAO REPORT ON NEONATAL ABSTINENCE SYNDROME (NAS).

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate a report on neonatal abstinence syndrome (in this section referred to as ''NAS'') in the United States.

(b) INFORMATION TO BE INCLUDED IN REPORT.—Such report shall include information on the following:

(1) The prevalence of NAS in the United States, including the proportion of children born in the United States with NAS who are eligible for medical assistance under State Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) at birth, and the costs associ-

ated with coverage under such programs for treatment of infants with NAS.

(2) The services for which coverage is available under State Medicaid programs for treatment of infants with NAS.

(3) The settings (including inpatient, outpatient, hospital-based, and other settings) for the treatment of infants with NAS and the reimbursement methodologies and costs associated with such treatment in such settings.

(4) The prevalence of utilization of various care settings under State Medicaid programs for treatment of infants with NAS and any Federal barriers to treating such infants under such programs, particularly in non-hospital-based settings.

(5) What is known about best practices for treating infants with NAS.

(c) RECOMMENDATIONS.—Such report also shall include such recommendations as the Comptroller General determines appropriate for improvements that will ensure access to treatment for infants with NAS under State Medicaid programs.

TITLE VI—INCENTIVIZING STATE COMPREHENSIVE INITIATIVES TO ADDRESS PRESCRIPTION OPIOID ABUSE

SEC. 601. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 302, is further amended by adding at the end the following:

"SEC. 548. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.

''(a) DEFINITIONS.—In this section:

''(1) DISPENSER.—The term 'dispenser' has the meaning given the term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

''(2) PRESCRIBER.—The term 'prescriber' means a dispenser who prescribes a controlled substance, or the agent of such a dispenser.

''(3) PRESCRIBER OF A SCHEDULE II, III, OR IV CONTROLLED SUBSTANCE.—The term 'prescriber of a schedule II, III, or IV controlled substance' does not include a prescriber of a schedule II, III, or IV controlled substance that dispenses the substance—

''(A) for use on the premises on which the substance is dispensed;

"(B) in a hospital emergency room, when the substance is in short supply;

"(C) for a certified opioid treatment program; or

"(D) in other situations as the Secretary may reasonably determine.

"(4) SCHEDULE II, III, OR IV CONTROLLED SUBSTANCE.—The term 'schedule II, III, or IV controlled substance' means a controlled substance that is listed on schedule II, schedule III, or schedule IV of section 202(c) of the Controlled Substances Act.

"(b) GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.—

"(1) IN GENERAL.—The Secretary shall award grants to States, and combinations of States, to implement an integrated opioid abuse response initiative.

"(2) PURPOSES.—A State receiving a grant under this section shall establish a comprehensive response plan to opioid abuse, which may include—

"(A) education efforts around opioid use, treatment, and addiction recovery, including education of residents, medical students, and physicians and other prescribers of schedule II, III, or IV controlled substances on relevant pre-

scribing guidelines, the prescription drug monitoring program of the State described in subparagraph (B), and overdose prevention methods;

''(B) establishing, maintaining, or improving a comprehensive prescription drug monitoring program to track dispensing of schedule II, III, or IV controlled substances, which may—

''(i) provide for data sharing with other States; and

''(ii) allow all individuals authorized by the State to write prescriptions for schedule II, III, or IV controlled substances to access the prescription drug monitoring program of the State;

''(C) developing, implementing, or expanding prescription drug and opioid addiction treatment programs by—

''(i) expanding the availability of treatment for prescription drug and opioid addiction, including medication-assisted treatment and behavioral health therapy, as appropriate;

''(ii) developing, implementing, or expanding screening for individuals in treatment for prescription drug and opioid addiction for hepatitis C and HIV, and treating or referring those individuals if clinically appropriate; or

''(iii) developing, implementing, or expanding recovery support services and programs at high schools or institutions of higher education;

''(D) developing, implementing, and expanding efforts to prevent overdose death from opioid abuse or addiction to prescription medications and opioids; and

''(E) advancing the education and awareness of the public, providers, patients, consumers, and other appropriate entities regarding the dangers of opioid abuse, safe disposal of prescription medications, and detection of early warning signs of opioid use disorders.

''(3) APPLICATION.—A State seeking a grant under this section shall submit to the Secretary an application in such form, and containing such information, as the Secretary may reasonably require.

''(4) USE OF FUNDS.—A State that receives a grant under this section shall use the grant for the cost, including the cost for technical assistance, training, and administration expenses, of carrying out an integrated opioid abuse response initiative as outlined by the State's comprehensive response plan to opioid abuse established under paragraph (2).

''(5) PRIORITY CONSIDERATIONS.—In awarding grants under this section, the Secretary shall, as appropriate, give priority to a State that—

''(A)(i) provides civil liability protection for first responders, health professionals, and family members who have received appropriate training in administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

''(ii) submits to the Secretary a certification by the attorney general of the State that the attorney general has—

''(I) reviewed any applicable civil liability protection law to determine the applicability of the law with respect to first

responders, health care professionals, family members, and other individuals who—

''(aa) have received appropriate training in administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

''(bb) may administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

''(II) concluded that the law described in subclause (I) provides adequate civil liability protection applicable to such persons;

''(B) has a process for enrollment in services and benefits necessary by criminal justice agencies to initiate or continue treatment in the community, under which an individual who is incarcerated may, while incarcerated, enroll in services and benefits that are necessary for the

individual to continue treatment upon release from incarceration;

"(C) ensures the capability of data sharing with other States, where applicable, such as by making data available to a prescription monitoring hub;

"(D) ensures that data recorded in the prescription drug monitoring program database of the State are regularly updated, to the extent possible;

"(E) ensures that the prescription drug monitoring program of the State notifies prescribers and dispensers of schedule II, III, or IV controlled substances when overuse or misuse of such controlled substances by patients is suspected; and

"(F) has in effect one or more statutes or implements policies that maximize use of prescription drug monitoring programs by individuals authorized by the State to prescribe schedule II, III, or IV controlled substances.

"(6) EVALUATION.—In conducting an evaluation of the program under this section pursuant to section 701 of the Comprehensive Addiction and Recovery Act of 2016, with respect to a State, the Sec-

retary shall report on State legislation or policies related to maximizing the use of prescription drug monitoring programs and the incidence of opioid use disorders and overdose deaths in such State.

''(7) STATES WITH LOCAL PRESCRIPTION DRUG MONITORING PROGRAMS.—

''(A) IN GENERAL.—In the case of a State that does not have a prescription drug monitoring program, a county or other unit of local government within the State that has a prescription drug monitoring program shall be treated as a State for purposes of this section, including for purposes of eligibility for grants under paragraph (1).

''(B) PLAN FOR INTEROPERABILITY.—In submitting an application to the Secretary under paragraph (3), a county or other unit of local government shall submit a plan outlining the methods such county or unit of local government shall use to ensure the capability of data sharing with other counties and units of local government within the state and with other States, as applicable.

''(c) AUTHORIZATION OF FUNDING.—For the purpose of carrying out this section, there are authorized to

be appropriated $5,000,000 for each of fiscal years 2017 through 2021.''.

TITLE VII—MISCELLANEOUS

SEC. 701. GRANT ACCOUNTABILITY AND EVALUATIONS.

(a) DEPARTMENT OF JUSTICE GRANT ACCOUNTABILITY.—Part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as added by section 201, is amended by adding at the end the following:

''SEC. 3026. GRANT ACCOUNTABILITY.

''(a) DEFINITION OF APPLICABLE COMMITTEES.—In this section, the term 'applicable committees' means—

''(1) the Committee on the Judiciary of the Senate; and

''(2) the Committee on the Judiciary of the House of Representatives.

''(b) ACCOUNTABILITY.—All grants awarded by the Attorney General under this part shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of the Department of Justice that the audited grantee has utilized grant funds for an

unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months after the date on which the final audit report is issued.

''(B) AUDIT.—Beginning in the first fiscal year beginning after the date of enactment of this section, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of recipients of grants awarded by the Attorney General under this part to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) MANDATORY EXCLUSION.—A recipient of grant funds under this part that is found to have an unresolved audit finding shall not be eligible to receive grant funds under this part during the first 2 fiscal years beginning after the end of the 12-month period described in subparagraph (A).

''(D) PRIORITY.—In awarding grants under this part, the Attorney General shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal

years before submitting an application for a grant under this part.

''(E) REIMBURSEMENT.—If an entity is awarded grant funds under this part during the 2-fiscal-year period during which the entity is barred from receiving grants under subparagraph (C), the Attorney General shall—

''(i) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

''(2) NONPROFIT ORGANIZATION REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant programs under this part, the term 'nonprofit organization' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

"(B) PROHIBITION.—A nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986 may not—

"(i) be party to a contract entered into under section 3021(b); or

"(ii) receive a subaward under section 3021(b).

"(C) DISCLOSURE.—Each nonprofit organization that receives a subaward or is party to a contract entered into under section 3021(b) and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose, in the application for such contract or subaward, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed

under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—No amounts made available to the Attorney General under this part may be used by the Attorney General, or by any State, unit of local government, or entity awarded a grant, subaward, or contract under this part, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the Attorney General, unless the head of the relevant agency, bureau, or program office provides prior written authorization that the funds may be expended to host or support the conference.

''(B) WRITTEN AUTHORIZATION.—Written authorization under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—The Deputy Attorney General shall submit to the applicable committees an annual report on all conference expenditures

approved by the Attorney General under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this section, the Attorney General shall submit to the applicable committees an annual certification—

''(A) indicating whether—

''(i) all audits issued by the Inspector General of the Department of Justice under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

''(ii) all mandatory exclusions required under paragraph (1)(C) have been issued; and

''(iii) all reimbursements required under paragraph (1)(E) have been made; and

''(B) that includes a list of any grant recipients excluded under paragraph (1) from the previous year.

''(c) PREVENTING DUPLICATIVE GRANTS.—

''(1) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this part,

the Attorney General shall compare potential grant awards with other grants awarded under this part by the Attorney General to determine if duplicate grant awards are awarded for the same purpose.

''(2) REPORT.—If the Attorney General awards duplicate grants under this part to the same applicant for the same purpose, the Attorney General shall submit to the applicable committees a report that includes—

''(A) a list of all duplicate grants awarded under this part, including the total dollar amount of any duplicate grants awarded; and

''(B) the reason the Attorney General awarded the duplicate grants.''.

(b) EVALUATION OF PERFORMANCE OF DEPARTMENT OF JUSTICE PROGRAMS.—

(1) EVALUATION OF JUSTICE DEPARTMENT COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—Not later than 5 years after the date of enactment of this Act, the Attorney General shall complete an evaluation of the effectiveness of the Comprehensive Opioid Abuse Grant Program under part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968, as added by section 201, administered

by the Department of Justice based upon the information reported under paragraph (4).

(2) INTERIM EVALUATION.—Not later than 3 years after the date of enactment of this Act, the Attorney General shall complete an interim evaluation assessing the nature and extent of the incidence of opioid abuse and illegal opioid distribution in the United States.

(3) METRICS AND OUTCOMES FOR EVALUATION.—Not later than 180 days after the date of enactment of this Act, the Attorney General shall identify outcomes that are to be achieved by activities funded by the Comprehensive Opioid Abuse Grant Program and the metrics by which the achievement of such outcomes shall be determined.

(4) METRICS DATA COLLECTION.—The Attorney General shall require grantees under the Comprehensive Opioid Abuse Grant Program (and those receiving subawards under section 3021(b) of part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968, as added by section 201) to collect and annually report to the Department of Justice data based upon the metrics identified under paragraph (3).

(5) PUBLICATION OF DATA AND FINDINGS.—

(A) PUBLICATION OF OUTCOMES AND METRICS.—The Attorney General shall, not later than 30 days after completion of the requirement under paragraph (3), publish the outcomes and metrics identified under that paragraph.

(B) PUBLICATION OF EVALUATION.—In the case of the interim evaluation under paragraph (2), and the final evaluation under paragraph (1), the entity conducting the evaluation shall, not later than 90 days after such an evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate. Such report shall also be published along with the data used to make such evaluation.

(6) INDEPENDENT EVALUATION.—For purposes of paragraphs (1), (2), and (3), the Attorney General shall—

(A) enter into an arrangement with the National Academy of Sciences; or

(B) enter into a contract or cooperative agreement with an entity that is not an agency

of the Federal Government, and is qualified to conduct and evaluate research pertaining to opioid use and abuse, and draw conclusions about overall opioid use and abuse on the basis of that research.

(c) DEPARTMENT OF HEALTH AND HUMAN SERVICES GRANT ACCOUNTABILITY.—

(1) DEFINITIONS.—In this subsection:

(A) APPLICABLE COMMITTEES.—The term ''applicable committees'' means—

(i) the Committee on Health, Education, Labor and Pensions of the Senate; and

(ii) the Committee on Energy and Commerce of the House of Representatives.

(B) COVERED GRANT.—The term ''covered grant'' means a grant awarded by the Secretary under a program established under this Act (or an amendment made by this Act, other than sections 703 through 707), including any grant administered by the Administrator of the Substance Abuse and Mental Health Services Administration under section 103.

(C) GRANTEE.—The term ''grantee'' means the recipient of a covered grant.

(D) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(2) ACCOUNTABILITY MEASURES.—Each covered grant shall be subject to the following accountability requirements:

(A) EFFECTIVENESS REPORT.—The Secretary shall require grantees to report on the effectiveness of the activities carried out with amounts made available to carry out the program under which the covered grant is awarded, including the number of persons served by such grant, if applicable, the number of persons seeking services who could not be served by such grant, and such other information as the Secretary may prescribe.

(B) REPORT ON PREVENTION OF FRAUD, WASTE, AND ABUSE.—

(i) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall submit

to the applicable committees a report on the policies and procedures the Department has in place to prevent waste, fraud, and abuse in the administration of covered grants.

(ii) CONTENTS.—The policies and procedures referred to in clause (i) shall include policies and procedures that are designed to—

(I) prevent grantees from utilizing funds awarded through a covered grant for unauthorized expenditures or otherwise unallowable costs; and

(II) ensure grantees will not receive unwarranted duplicate grants for the same purpose.

(C) CONFERENCE EXPENDITURES.—

(i) IN GENERAL.—No amounts made available to the Secretary under this Act (or in a provision of law amended by this Act, other than sections 703 through 707) may be used by the Secretary, or by any individual or entity awarded discretionary funds through a cooperative agreement

under a program established under this Act (or in a provision of law amended by this Act), to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the Secretary, unless the head of the relevant operating division or program office provides prior written authorization that the funds may be expended to host or support the conference. Such written authorization shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

(ii) REPORT.—The Secretary (or the Secretary's designee) shall submit to the applicable committees an annual report on all conference expenditures approved by the Secretary under this subparagraph.

(d) EVALUATION OF PERFORMANCE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS.—

(1) EVALUATIONS.—

(A) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, except

as otherwise provided in this section, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall complete an evaluation of any program administered by the Secretary included in this Act (or an amendment made by this Act, excluding sections 703 through 707), including any grant administered by the Administrator of the Substance Abuse and Mental Health Services Administration under section 103, that provides grants for the primary purpose of providing assistance in addressing problems pertaining to opioid abuse based upon the outcomes and metrics identified under paragraph (2).

(B) PUBLICATION.—With respect to each evaluation completed under subparagraph (A), the Secretary shall, not later than 90 days after the date on which such evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the appropriate committees. Such report shall also be published along with the data used to make such evaluation.

(2) METRICS AND OUTCOMES.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary shall identify—

(i) outcomes that are to be achieved by activities funded by the programs described in paragraph (1)(A); and

(ii) the metrics by which the achievement of such outcomes shall be determined.

(B) PUBLICATION.—The Secretary shall, not later than 30 days after completion of the requirement under subparagraph (A), publish the outcomes and metrics identified under such subparagraph.

(3) METRICS DATA COLLECTION.—The Secretary shall require grantees under the programs described in paragraph (1)(A) to collect, and annually report to the Secretary, data based upon the metrics identified under paragraph (2)(A).

(4) INDEPENDENT EVALUATION.—For purposes of paragraph (1), the Secretary shall—

(A) enter into an arrangement with the National Academy of Sciences; or

(B) enter into a contract or cooperative agreement with an entity that—

(i) is not an agency of the Federal Government; and

(ii) is qualified to conduct and evaluate research pertaining to opioid use and abuse and draw conclusions about overall opioid use and abuse on the basis of that research.

(5) EXCEPTION.—If a program described in paragraph (1)(A) is subject to an evaluation similar to the evaluation required under such paragraph pursuant to another provision of Federal law, the Secretary may opt not to conduct an evaluation under such paragraph with respect to such program.

(e) ADDITIONAL REPORT.—In the case of a report submitted under subsection (c) to the applicable committees, if such report pertains to a grant under section 103, that report shall also be submitted, in the same manner and at the same time, to the Committee on Oversight and Government Reform of the House of Representatives and to the Committee on the Judiciary of the Senate.

(f) NO ADDITIONAL FUNDS AUTHORIZED.—No additional funds are authorized to be appropriated to carry out this section.

SEC. 702. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

''(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.—

''(1) PARTIAL FILLS.—A prescription for a controlled substance in schedule II may be partially filled if—

''(A) it is not prohibited by State law;

''(B) the prescription is written and filled in accordance with this title, regulations prescribed by the Attorney General, and State law;

''(C) the partial fill is requested by the patient or the practitioner that wrote the prescription; and

''(D) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

''(2) REMAINING PORTIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

"(ii) shall be filled not later than 30 days after the date on which the prescription is written.

"(B) EMERGENCY SITUATIONS.—In emergency situations, as described in subsection (a), the remaining portions of a partially filled prescription for a controlled substance in schedule II—

"(i) may be filled; and

"(ii) shall be filled not later than 72 hours after the prescription is issued.

"(3) CURRENTLY LAWFUL PARTIAL FILLS.—Notwithstanding paragraph (1) or (2), in any circumstance in which, as of the day before the date of enactment of this subsection, a prescription for a controlled substance in schedule II may be lawfully partially filled, the Attorney General may allow such a prescription to be partially filled.".

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Attorney General to allow a prescription for a controlled substance in schedule III, IV, or V of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) to be partially filled.

SEC. 703. GOOD SAMARITAN ASSESSMENT.

(a) FINDING.—The Congress finds that the executive branch, including the Office of National Drug Control Policy, has a policy focus on preventing and addressing prescription drug misuse and heroin use, and has worked with States and municipalities to enact Good Samaritan laws that would protect caregivers, law enforcement personnel, and first responders who administer opioid overdose reversal drugs or devices.

(b) GAO STUDY ON GOOD SAMARITAN LAWS PERTAINING TO TREATMENT OF OPIOID OVERDOSES.—The Comptroller General of the United States shall submit to the Committee on the Judiciary of the House of Representatives, the Committee on Oversight and Government Reform of the House of Representatives, the Committee on the Judiciary of the Senate, and the Committee on Homeland Security and Governmental Affairs of the Senate a report on—

(1) the extent to which the Director of National Drug Control Policy has reviewed Good Samaritan laws, and any findings from such a review, including findings related to the potential effects of such laws, if available;

(2) efforts by the Director to encourage the enactment of Good Samaritan laws; and

(3) a compilation of Good Samaritan laws in effect in the States, the territories, and the District of Columbia.

(c) DEFINITIONS.—In this section—

(1) the term ''Good Samaritan law'' means a law of a State or unit of local government that exempts from criminal or civil liability any individual who administers an opioid overdose reversal drug or device, or who contacts emergency services providers in response to an overdose; and

(2) the term ''opioid'' means any drug, including heroin, having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

SEC. 704. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER MEDICARE PARTS C AND D.

(a) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

(1) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–10(c)) is amended by adding at the end the following:

''(5) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

"(A) AUTHORITY TO ESTABLISH.—A PDP sponsor may establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary's access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by one or more prescribers selected under subparagraph (D), and dispensed for such beneficiary by one or more pharmacies selected under such subparagraph.

"(B) REQUIREMENT FOR NOTICES.—

"(i) IN GENERAL.—A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

"(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

"(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse.

"(ii) INITIAL NOTICE.—An initial notice described in this clause is a notice that provides to the beneficiary—

"(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

"(II) information describing all State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary has access, including mental health services and other counseling services;

"(III) notice of, and information about, the right of the beneficiary to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

"(IV) a request for the beneficiary to submit to the PDP sponsor

preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

''(V) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

''(VI) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor; and

''(VII) contact information for other organizations that can provide the beneficiary with assistance regarding such drug management program (similar to the information provided by the Secretary in other standardized notices provided to part D eligible individuals enrolled in prescription drug plans under this part).

''(iii) SECOND NOTICE.—A second notice described in this clause is a notice that provides to the beneficiary notice—

''(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

''(II) that such beneficiary is subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

''(III) of the prescriber (or prescribers) and pharmacy (or pharmacies) selected for such individual under subparagraph (D);

"(IV) of, and information about, the beneficiary's right to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

"(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subparagraph (D), submit such preferences to the PDP sponsor; and

"(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor.

"(iv) TIMING OF NOTICES.—

"(I) IN GENERAL.—Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 30 days after an initial notice described in clause (ii) is provided to the beneficiary.

"(II) EXCEPTION.—In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rule-making by the Secretary regarding the health or safety of the beneficiary or regarding significant drug diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (I), the PDP sponsor may provide such second notice on such earlier date.

"(C) AT-RISK BENEFICIARY FOR PRESCRIPTION DRUG ABUSE.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'at-risk beneficiary for prescription drug abuse' means a part D eligible individual who is not an exempted individual described in clause (ii) and—

"(I) who is identified as such an at-risk beneficiary through the use of clinical guidelines that indicate misuse

or abuse of prescription drugs described in subparagraph (G) and that are developed by the Secretary in consultation with PDP sponsors and other stakeholders, including individuals entitled to benefits under part A or enrolled under part B, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers; or

''(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under the prescription drug plan in which such individual was most recently previously enrolled and such identification has not been terminated under subparagraph (F).

"(ii) EXEMPTED INDIVIDUAL DESCRIBED.—An exempted individual described in this clause is an individual who—

"(I) receives hospice care under this title;

"(II) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

"(III) the Secretary elects to treat as an exempted individual for purposes of clause (i).

"(iii) PROGRAM SIZE.—The Secretary shall establish policies, including the guidelines developed under clause (i)(I) and the exemptions under clause (ii)(III), to ensure that the population of enrollees in a drug management program for at-risk beneficiaries operated by a prescription drug plan can be effectively managed by such plans.

''(iv) CLINICAL CONTACT.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by a PDP sponsor, the PDP sponsor shall contact the beneficiary's providers who have prescribed frequently abused drugs regarding whether prescribed medications are appropriate for such beneficiary's medical conditions.

''(D) SELECTION OF PRESCRIBERS AND PHARMACIES.—

''(i) IN GENERAL.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(IV) and (iii)(V) of subparagraph (B) (except as otherwise provided in this subparagraph) select—

''(I) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more

than one, individual who is authorized to prescribe frequently abused drugs (referred to in this paragraph as a 'prescriber') who may write prescriptions for such drugs for such beneficiary; and

"(II) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, pharmacy that may dispense such drugs to such beneficiary.

For purposes of subclause (II), in the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy.

"(ii) REASONABLE ACCESS.—In making the selections under this subparagraph—

"(I) a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to frequently abused drugs (as defined in subparagraph (G)), taking into account geographic

location, beneficiary preference, impact on costsharing, and reasonable travel time; and

''(II) a PDP sponsor shall ensure such access (including access to prescribers and pharmacies with respect to frequently abused drugs) in the case of individuals with multiple residences, in the case of natural disasters and similar situations, and in the case of the provision of emergency services.

''(iii) BENEFICIARY PREFERENCES.—If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

''(I) review such preferences;

''(II) select or change the selection of prescribers and pharmacies for the beneficiary based on such preferences; and

"(III) inform the beneficiary of such selection or change of selection.

"(iv) EXCEPTION REGARDING BENEFICIARY PREFERENCES.—In the case that the PDP sponsor determines that a change to the selection of prescriber or pharmacy under clause (iii)(II) by the PDP sponsor is contributing or would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in clause (iii). If the PDP sponsor changes the selection pursuant to the preceding sentence, the PDP sponsor shall provide the beneficiary with—

"(I) at least 30 days written notice of the change of selection; and

"(II) a rationale for the change.

"(v) CONFIRMATION.—Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must notify the prescriber and pharmacy that the beneficiary involved has been identified for in-

clusion in the drug management program for at-risk beneficiaries and that the prescriber and pharmacy has been selected as the beneficiary's designated prescriber and pharmacy.

"(E) TERMINATIONS AND APPEALS.—The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, the selection of prescriber or pharmacy under subparagraph (D), and information to be shared under subparagraph (I), with respect to such individual, shall be subject to reconsideration and appeal under subsection (h) and the option of an automatic escalation to external review to the extent provided by the Secretary.

"(F) TERMINATION OF IDENTIFICATION.—

"(i) IN GENERAL.—The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such stand-

ards such identification shall terminate as of the earlier of—

"(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); and

"(II) the end of such maximum period of identification as the Secretary may specify.

"(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph (C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

"(G) FREQUENTLY ABUSED DRUG.—For purposes of this subsection, the term 'frequently abused drug' means a drug that is a controlled

substance that the Secretary determines to be frequently abused or diverted.

''(H) DATA DISCLOSURE.—

''(i) DATA ON DECISION TO IMPOSE LIMITATION.—In the case of an at-risk beneficiary for prescription drug abuse (or an individual who is a potentially at-risk beneficiary for prescription drug abuse) whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, the Secretary shall establish rules and procedures to require the PDP sponsor to disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part.

''(ii) DATA TO REDUCE FRAUD, ABUSE, AND WASTE.—The Secretary shall establish rules and procedures to require PDP sponsors operating a drug management program for at-risk beneficiaries

under this paragraph to provide the Secretary with such data as the Secretary determines appropriate for purposes of identifying patterns of prescription drug utilization for plan enrollees that are outside normal patterns and that may indicate fraudulent, medically unnecessary, or unsafe use.

''(I) SHARING OF INFORMATION FOR SUBSEQUENT PLAN ENROLLMENTS.—The Secretary shall establish procedures under which PDP sponsors who offer prescription drug plans shall share information with respect to individuals who are at-risk beneficiaries for prescription drug abuse (or individuals who are potentially at-risk beneficiaries for prescription drug abuse) and enrolled in a prescription drug plan and who subsequently disenroll from such plan and enroll in another prescription drug plan offered by another PDP sponsor.

''(J) PRIVACY ISSUES.—Prior to the implementation of the rules and procedures under this paragraph, the Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to

section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subparagraphs (H) and (I) by PDP sponsors. Such clarification shall provide that the sharing of such data shall be considered to be protected health information in accordance with the requirements of the regulations promulgated pursuant to such section 264(c).

''(K) EDUCATION.—The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

''(i) provided by Medicare administrative contractors through the improper payment outreach and education program described in section 1874A(h); and

''(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of

2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.

''(L) APPLICATION UNDER MA–PD PLANS.—Pursuant to section 1860D–21(c)(1), the provisions of this paragraph apply under part D to MA organizations offering MA–PD plans to MA eligible individuals in the same manner as such provisions apply under this part to a PDP sponsor offering a prescription drug plan to a part D eligible individual.

''(M) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that existing plan sponsor compliance reviews and audit processes include the drug management programs for at-risk beneficiaries under this paragraph, including appeals processes under such programs.''.

(2) INFORMATION FOR CONSUMERS.—Section 1860D–4(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–104(a)(1)(B)) is amended by adding at the end the following:

''(v) The drug management program for at-risk beneficiaries under subsection (c)(5).''.

(3) DUAL ELIGIBLES.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C.

1395w–101(b)(3)(D)) is amended by inserting ", subject to such limits as the Secretary may establish for individuals identified pursuant to section 1860D–4(c)(5)" after "the Secretary".

(b) UTILIZATION MANAGEMENT PROGRAMS.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)), as amended by subsection (a)(1), is further amended—

(1) in paragraph (1), by inserting after subparagraph (D) the following new subparagraph:

"(E) A utilization management tool to prevent drug abuse (as described in paragraph (6)(A))."; and

(2) by adding at the end the following new paragraph:

"(6) UTILIZATION MANAGEMENT TOOL TO PREVENT DRUG ABUSE.—

"(A) IN GENERAL.—A tool described in this paragraph is any of the following:

"(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

"(ii) Retrospective utilization review to identify—

''(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

''(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

''(iii) Consultation with the contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

''(B) REPORTING.—A PDP sponsor offering a prescription drug plan (and an MA organization offering an MA–PD plan) in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1893 with respect to such State a report, on a monthly basis, containing information on—

''(i) any provider of services or supplier described in subparagraph (A)(ii)(II)

that is identified by such plan sponsor (or organization) during the 30-day period before such report is submitted; and

''(ii) the name and prescription records of individuals described in paragraph (5)(C).

''(C) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that plan sponsor compliance reviews and program audits biennially include a certification that utilization management tools under this paragraph are in compliance with the requirements for such tools.''.

(c) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

(1) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(j) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

''(1) ACCESS TO INFORMATION.—Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records

from entities such as pharmacies, prescription drug plans, MA–PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1860D–4(c)(5)(C).

''(2) REQUIREMENT FOR ACKNOWLEDGMENT OF REFERRALS.—If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

''(A) acknowledge to the sponsor or organization receipt of the referral; and

''(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described in such paragraph, shall inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

''(3) MAKING DATA AVAILABLE TO OTHER ENTITIES.—

''(A) IN GENERAL.—For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

''(B) HIPAA COMPLIANT INFORMATION ONLY.—Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).''.

(2) OIG STUDY AND REPORT ON EFFECTIVENESS OF MEDICS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services

shall conduct a study on the effectiveness of Medicare drug integrity contractors with which the Secretary of Health and Human Services has entered into a contract under section 1893 of the Social Security Act (42 U.S.C. 1395ddd) in identifying, combating, and preventing fraud under the Medicare program, including under the authority provided under section 1893(j) of the Social Security Act, added by paragraph (1).

(B) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A). Such report shall include such recommendations for improvements in the effectiveness of such contractors as the Inspector General determines appropriate.

(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—Section 1860D–42 of the Social Security Act (42 U.S.C. 1395w–152) is amended by adding at the end the following new subsection:

''(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESS-

MENT.—In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.''.

(e) SENSE OF CONGRESS REGARDING USE OF TECHNOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of Congress that MA organizations and PDP sponsors should consider using e-prescribing and other health information technology tools to support combating fraud under MA–PD plans and prescription drug plans under parts C and D of the Medicare program.

(f) REPORTS.—

(1) REPORT BY SECRETARY ON APPEALS PROCESS.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of Congress a report on ways to improve upon the appeals process for Medicare beneficiaries with respect to prescription drug

coverage under part D of title XVIII of the Social Security Act. Such report shall include an analysis comparing appeals processes under parts C and D of such title XVIII.

(B) FEEDBACK.—In development of the report described in subparagraph (A), the Secretary of Health and Human Services shall solicit feedback on the current appeals process from stakeholders, such as beneficiaries, consumer advocates, plan sponsors, pharmacy benefit managers, pharmacists, providers, independent review entity evaluators, and pharmaceutical manufacturers.

(2) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the implementation of the amendments made by this section, including the effectiveness of the at-risk beneficiaries for prescription drug abuse drug management programs authorized by section 1860D–4(c)(5) of the Social Security Act (42 U.S.C. 1395w–10(c)(5)), as added by subsection (a)(1). Such study shall include an analysis of—

(i) the impediments, if any, that impair the ability of individuals described in subparagraph (C) of such section 1860D–4(c)(5) to access clinically appropriate levels of prescription drugs;

(ii) the effectiveness of the reasonable access protections under subparagraph (D)(ii) of such section 1860D–4(c)(5), including the impact on beneficiary access and health;

(iii) the types of—

(I) individuals who, in the implementation of such section, are determined to be individuals described in such subparagraph (C); and

(II) prescribers and pharmacies that are selected under subparagraph (D) of such section; and

(iv) other areas determined appropriate by the Comptroller General.

(B) REPORT.—Not later than July 1, 2019, the Comptroller General of the United States shall submit to the appropriate committees of jurisdiction of Congress a report on the study conducted under subparagraph (A), to-

gether with recommendations for such legislation and administrative action as the Comptroller General determines to be appropriate.

(g) EFFECTIVE DATE; RULEMAKING.—

(1) IN GENERAL.—The amendments made by this section shall apply to prescription drug plans (and MA–PD plans) for plan years beginning on or after January 1, 2019.

(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

(A) IN GENERAL.—Not later than January 1, 2017, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B). The input described in the preceding sentence shall be provided to the Secretary in sufficient time in order for the Secretary to take such input into account in

promulgating the regulations pursuant to paragraph (3).

(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

(i) the anticipated impact of drug management programs for at-risk beneficiaries under paragraph (5) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors, and enrollees in MA–PD plans, who are at-risk beneficiaries for prescription drug abuse (as defined in subparagraph (C) of such paragraph);

(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act that allow an automatic escalation to external review of claims submitted under such part);

(iii) the types of enrollees that should be treated as exempted individuals, as described in subparagraph (C)(ii) of such paragraph;

(iv) the manner in which terms and definitions in such paragraph should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph;

(v) the information to be included in the notices described in subparagraph (B) of such paragraph and the standardization of such notices;

(vi) with respect to a PDP sponsor (or Medicare Advantage organization) that establishes a drug management program for at-risk beneficiaries under such paragraph, the responsibilities of such PDP sponsor (or organization) with respect to the implementation of such program;

(vii) notices for plan enrollees at the point of sale that would explain why an at-risk beneficiary has been prohibited from

receiving a prescription at a location outside of the designated pharmacy;

(viii) evidence-based prescribing guidelines for opiates; and

(ix) the sharing of claims data under parts A and B of title XVIII of the Social Security Act with PDP sponsors.

(3) RULEMAKING.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall, taking into account the input gathered pursuant to paragraph (2)(A) and after providing notice and an opportunity to comment, promulgate regulations to carry out the provisions of, and amendments made by this section.

(h) DEPOSIT OF SAVINGS INTO MEDICARE IMPROVEMENT FUND.—Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''during and after fiscal year 2020, $0'' and inserting ''during and after fiscal year 2021, $140,000,000''.

SEC. 705. EXCLUDING ABUSE-DETERRENT FORMULATIONS OF PRESCRIPTION DRUGS FROM THE MEDICAID ADDITIONAL REBATE REQUIREMENT FOR NEW FORMULATIONS OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—The last sentence of section 1927(c)(2)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)(C)) is amended by inserting before the period at the end the following: ‘‘, but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act.

SEC. 706. LIMITING DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1128J (42 U.S.C. 1320a–7k) the following new section:

"SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

''(a) REFERENCE TO PREDICTIVE MODELING TECHNOLOGIES REQUIREMENTS.—For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI, see section 4241 of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m).

''(b) LIMITING DISCLOSURE OF PREDICTIVE MODELING TECHNOLOGIES.—In implementing such provisions under such section 4241 with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

''(1) NONAPPLICATION OF FOIA.—The covered algorithms used or developed for purposes of such section 4241 (including by the Secretary or a State (or an entity operating under a contract with a State)) shall be exempt from disclosure under section 552(b)(3) of title 5, United States Code.

"(2) LIMITATION WITH RESPECT TO USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.—

"(A) IN GENERAL.—A State agency may not use or disclose covered algorithms used or developed for purposes of such section 4241 except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under title XIX or the State child health plan (or a waiver of the plan) under the Children's Health Insurance Program under title XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud, and abuse with respect to such programs.

"(B) INFORMATION SECURITY.—A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered algorithms used or developed for purposes of such section 4241 and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

''(C) PROCEDURAL REQUIREMENTS.—State agencies to which information is disclosed pursuant to such section 4241 shall adhere to uniform procedures established by the Secretary.

''(c) COVERED ALGORITHM DEFINED.—In this section, the term 'covered algorithm'—

''(1) means a predictive modeling or other analytics technology, as used for purposes of section 4241(a) of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m(a)) to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI; and

''(2) includes the mathematical expressions utilized in the application of such technology and the means by which such technology is developed.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (80), by striking ''and'' at the end;

(B) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (81) the following new paragraph:

''(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

(2) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7) of the Social Security Act (42 U.S.C. 1397bb(a)(7)) is amended—

(A) in subparagraph (A), by striking '', and'' at the end and inserting a semicolon;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) to ensure that the State agency involved is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

SEC. 707. MEDICAID IMPROVEMENT FUND.

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended to read as follows:

''(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for fiscal year 2021 and thereafter, $5,000,000.''.

SEC. 708. SENSE OF THE CONGRESS REGARDING TREATMENT OF SUBSTANCE ABUSE EPIDEMICS.

It is the sense of the Congress that decades of experience and research have demonstrated that a fiscally responsible approach to addressing the opioid abuse epidemic and other substance abuse epidemics requires treating such epidemics as a public health emergency emphasizing prevention, treatment, and recovery.

TITLE VIII—KINGPIN DESIGNATION IMPROVEMENT

SEC. 801. PROTECTION OF CLASSIFIED INFORMATION IN FEDERAL COURT CHALLENGES RELATING TO DESIGNATIONS UNDER THE NARCOTICS KINGPIN DESIGNATION ACT.

Section 804 of the Foreign Narcotics Kingpin Designation Act (21 U.S.C. 1903) is amended by adding at the end the following:

''(i) PROTECTION OF CLASSIFIED INFORMATION IN FEDERAL COURT CHALLENGES RELATING TO DESIGNATIONS.—In any judicial review of a determination made under this section, if the determination was based on classified information (as defined in section 1(a) of the Classi-

fied Information Procedures Act) such information may be submitted to the reviewing court ex parte and in camera. This subsection does not confer or imply any right to judicial review.''.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

SEC. 901. SHORT TITLE.

This title may be cited as the ''Jason Simcakoski Memorial and Promise Act''.

SEC. 902. DEFINITIONS.

In this title:

(1) The term ''controlled substance'' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term ''State'' means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

(3) The term ''complementary and integrative health'' has the meaning given that term, or any successor term, by the National Institutes of Health.

(4) The term ''opioid receptor antagonist'' means a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21

U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose.

Subtitle A—Opioid Therapy and Pain Management

SEC. 911. IMPROVEMENT OF OPIOID SAFETY MEASURES BY DEPARTMENT OF VETERANS AFFAIRS.

(a) EXPANSION OF OPIOID SAFETY INITIATIVE.—

(1) INCLUSION OF ALL MEDICAL FACILITIES.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall expand the Opioid Safety Initiative of the Department of Veterans Affairs to include all medical facilities of the Department.

(2) GUIDANCE.—The Secretary shall establish guidance that each health care provider of the Department of Veterans Affairs, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or any subsequent tool), which shall include information from the prescription drug monitoring program of each participating State as applicable, that includes the most recent information to date relating to the patient that accessed such program to assess the risk for

adverse outcomes of opioid therapy for the patient, including the concurrent use of controlled substances such as benzodiazepines, as part of the comprehensive assessment conducted by the health care provider.

(3) ENHANCED STANDARDS.—The Secretary shall establish enhanced standards with respect to the use of routine and random urine drug tests for all patients before and during opioid therapy to help prevent substance abuse, dependence, and diversion, including—

(A) that such tests occur not less frequently than once each year or as otherwise determined according to treatment protocols; and

(B) that health care providers appropriately order, interpret and respond to the results from such tests to tailor pain therapy, safeguards, and risk management strategies to each patient.

(b) PAIN MANAGEMENT EDUCATION AND TRAINING.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the Secretary shall require all employees of the Department re-

sponsible for prescribing opioids to receive education and training described in paragraph (2).

(2) EDUCATION AND TRAINING.—Education and training described in this paragraph is education and training on pain management and safe opioid prescribing practices for purposes of safely and effectively managing patients with chronic pain, including education and training on the following:

(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.

(B) The use of evidence-based pain management therapies and complementary and integrative health services, including cognitive-behavioral therapy, non-opioid alternatives, and non-drug methods and procedures to managing pain and related health conditions including, to the extent practicable, medical devices approved or cleared by the Food and Drug Administration for the treatment of patients with chronic pain and related health conditions.

(C) Screening and identification of patients with substance use disorder, including drug-

seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appropriate addiction treatment professionals if addiction is identified or strongly suspected.

(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other controlled substances.

(E) Such other education and training as the Secretary considers appropriate to ensure that veterans receive safe and high-quality pain management care from the Department.

(3) USE OF EXISTING PROGRAM.—In providing education and training described in paragraph (2), the Secretary shall use the Interdisciplinary Chronic Pain Management Training Team Program of the Department (or successor program).

(c) PAIN MANAGEMENT TEAMS.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of

health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related.

(2) ESTABLISHMENT OF PROTOCOLS.—

(A) IN GENERAL.—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department.

(B) CONSULTATION ON PRESCRIPTION OF OPIOIDS.—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

(3) REPORT.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the director of each medical facility of the Department shall submit to the Under Secretary for Health and the director of the Veterans Integrated Service Network in which the medical facility is located a report identifying the health care professionals that have been designated as members of the pain management team at the medical facility pursuant to paragraph (1).

(B) ELEMENTS.—Each report submitted under subparagraph (A) with respect to a medical facility of the Department shall include—

(i) a certification as to whether all members of the pain management team at the medical facility have completed the education and training required under subsection (b);

(ii) a plan for the management and referral of patients to such pain management team if health care providers without

expertise in prescribing analgesics prescribe opioid medications to treat acute and chronic pain that is non-cancer related; and

(iii) a certification as to whether the medical facility—

(I) fully complies with the stepped-care model, or successor models, of pain management and other pain management policies of the Department; or

(II) does not fully comply with such stepped-care model, or successor models, of pain management and other pain management policies but is carrying out a corrective plan of action to ensure such full compliance.

(d) TRACKING AND MONITORING OF OPIOID USE.—

(1) PRESCRIPTION DRUG MONITORING PROGRAMS OF STATES.—In carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool of the Department, the Secretary shall—

(A) ensure access by health care providers of the Department to information on controlled substances, including opioids and

benzodiazepines, prescribed to veterans who receive care outside the Department through the prescription drug monitoring program of each State with such a program, including by seeking to enter into memoranda of understanding with States to allow shared access of such information between States and the Department;

(B) include such information in the Opioid Therapy Risk Report tool; and

(C) require health care providers of the Department to submit to the prescription drug monitoring program of each State with such a program information on prescriptions of controlled substances received by veterans in that State under the laws administered by the Secretary.

(2) REPORT ON TRACKING OF DATA ON OPIOID USE.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of improving the Opioid Therapy Risk Report tool of the Department to allow for

more advanced real-time tracking of and access to data on—

(A) the key clinical indicators with respect to the totality of opioid use by veterans;

(B) concurrent prescribing by health care providers of the Department of opioids in different health care settings, including data on concurrent prescribing of opioids to treat mental health disorders other than opioid use disorder; and

(C) mail-order prescriptions of opioids prescribed to veterans under the laws administered by the Secretary.

(e) AVAILABILITY OF OPIOID RECEPTOR ANTAGONISTS.—

(1) INCREASED AVAILABILITY AND USE.—

(A) IN GENERAL.—The Secretary shall maximize the availability of opioid receptor antagonists, including naloxone, to veterans.

(B) AVAILABILITY, TRAINING, AND DISTRIBUTING.—In carrying out subparagraph (A), not later than 90 days after the date of the enactment of this Act, the Secretary shall—

(i) equip each pharmacy of the Department with opioid receptor antagonists

to be dispensed to outpatients as needed; and

(ii) expand the Overdose Education and Naloxone Distribution program of the Department to ensure that all veterans in receipt of health care under laws administered by the Secretary who are at risk of opioid overdose may access such opioid receptor antagonists and training on the proper administration of such opioid receptor antagonists.

(C) VETERANS WHO ARE AT RISK.—For purposes of subparagraph (B), veterans who are at risk of opioid overdose include—

(i) veterans receiving long-term opioid therapy;

(ii) veterans receiving opioid therapy who have a history of substance use disorder or prior instances of overdose; and

(iii) veterans who are at risk as determined by a health care provider who is treating the veteran.

(2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs

of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on carrying out paragraph (1), including an assessment of any remaining steps to be carried out by the Secretary to carry out such paragraph.

(f) INCLUSION OF CERTAIN INFORMATION AND CAPABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF THE DEPARTMENT.—

(1) INFORMATION.—The Secretary shall include in the Opioid Therapy Risk Report tool of the Department—

(A) information on the most recent time the tool was accessed by a health care provider of the Department with respect to each veteran; and

(B) information on the results of the most recent urine drug test for each veteran.

(2) CAPABILITIES.—The Secretary shall include in the Opioid Therapy Risk Report tool the ability of the health care providers of the Department to determine whether a health care provider of the Department prescribed opioids to a veteran without checking the information in the tool with respect to the veteran.

(g) NOTIFICATIONS OF RISK IN COMPUTERIZED HEALTH RECORD.—The Secretary shall modify the computerized patient record system of the Department to ensure that any health care provider that accesses the record of a veteran, regardless of the reason the veteran seeks care from the health care provider, will be immediately notified whether the veteran—

(1) is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose;

(2) has a history of opioid abuse; or

(3) is at risk of developing an opioid use disorder, as determined by a health care provider who is treating the veteran.

SEC. 912. STRENGTHENING OF JOINT WORKING GROUP ON PAIN MANAGEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the Pain Management Working Group of the Health Executive Committee of the Department of Veterans Affairs–Department of Defense Joint Executive Committee (Pain Management Working Group) established under section

320 of title 38, United States Code, includes a focus on the following:

(1) The opioid prescribing practices of health care providers of each Department.

(2) The ability of each Department to manage acute and chronic pain among individuals receiving health care from the Department, including training health care providers with respect to pain management.

(3) The use by each Department of complementary and integrative health in treating such individuals.

(4) The concurrent use and practice by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines.

(5) The use of care transition plans by health care providers of each Department to address case management issues for patients receiving opioid therapy who transition between inpatient and outpatient care.

(6) The coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from the

Department of Defense to receiving health care from the Department of Veterans Affairs.

(7) The ability of each Department to properly screen, identify, refer, and treat patients with substance use disorders who are seeking treatment for acute and chronic pain management conditions.

(b) COORDINATION AND CONSULTATION.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a)—

(1) coordinates the activities of the working group with other relevant working groups established under section 320 of title 38, United States Code;

(2) consults with other relevant Federal agencies, including the Centers for Disease Control and Prevention, with respect to the activities of the working group; and

(3) consults with the Department of Veterans Affairs and the Department of Defense with respect to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, or any successor guideline, and reviews and provides comments before any update to the guideline is released.

(c) CLINICAL PRACTICE GUIDELINES.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall issue an update to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(2) MATTERS INCLUDED.—In conducting the update under paragraph (1), the Pain Management Working Group, in coordination with the Clinical Practice Guideline VA/DoD Management of Opioid Therapy for Chronic Pain Working Group, shall work to ensure that the Clinical Practical Guideline includes the following:

(A) Enhanced guidance with respect to—

(i) the co-administration of an opioid and other drugs, including benzodiazepines, that may result in life-limiting drug interactions;

(ii) the treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; and

(iii) the use of opioid therapy to treat mental health disorders other than opioid use disorder.

(B) Enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, such as post-traumatic stress disorder or other psychiatric disorders, or a history of substance abuse or addiction, that requires a consultation or co-management of opioid therapy with one or more specialists in pain management, mental health, or addictions.

(C) Enhanced guidance with respect to health care providers—

(i) conducting an effective assessment for patients beginning or continuing opioid therapy, including understanding and setting realistic goals with respect to achieving and maintaining an expected level of pain relief, improved function, or a clinically appropriate combination of both; and

(ii) effectively assessing whether opioid therapy is achieving or maintaining the established treatment goals of the patient or whether the patient and health care provider should discuss adjusting, augmenting, or discontinuing the opioid therapy.

(D) Guidelines to inform the methodologies used by health care providers of the Department of Veterans Affairs and the Department of Defense to safely taper opioid therapy when adjusting or discontinuing the use of opioid therapy, including—

(i) prescription of the lowest effective dose based on patient need;

(ii) use of opioids only for a limited time; and

(iii) augmentation of opioid therapy with other pain management therapies and modalities.

(E) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient health care settings, which may include the use of care transition plans.

(F) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition from receiving care during active duty to post-military health care networks.

(G) Guidelines with respect to providing options, before initiating opioid therapy, for

pain management therapies without the use of opioids and options to augment opioid therapy with other clinical and complementary and integrative health services to minimize opioid dependence.

(H) Guidelines with respect to the provision of evidence-based non-opioid treatments within the Department of Veterans Affairs and the Department of Defense, including medical devices and other therapies approved or cleared by the Food and Drug Administration for the treatment of chronic pain as an alternative to or to augment opioid therapy.

(I) Guidelines developed by the Centers for Disease Control and Prevention for safely prescribing opioids for the treatment of chronic, non-cancer related pain in outpatient settings.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the Secretary of Veterans Affairs and the Secretary of Defense from considering all relevant evidence, as appropriate, in updating the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, as required under paragraph (1), or from ensuring that the final clinical practice guide-

line updated under such paragraph remains applicable to the patient populations of the Department of Veterans Affairs and the Department of Defense.

SEC. 913. REVIEW, INVESTIGATION, AND REPORT ON USE OF OPIOIDS IN TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMPTROLLER GENERAL REPORT.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Opioid Safety Initiative of the Department of Veterans Affairs and the opioid prescribing practices of health care providers of the Department.

(2) ELEMENTS.—The report submitted under paragraph (1) shall include the following:

(A) An assessment of the implementation and monitoring by the Veterans Health Administration of the Opioid Safety Initiative of the Department, including examining, as appropriate, the following:

(i) How the Department monitors the key clinical outcomes of such safety initia-

tive (for example, the percentage of unique veterans visiting each medical center of the Department that are prescribed an opioid or an opioid and benzodiazepine concurrently) and how the Department uses that information—

(I) to improve prescribing practices; and

(II) to identify high prescribing or otherwise inappropriate prescribing practices by health care providers.

(ii) How the Department monitors the use of the Opioid Therapy Risk Report tool of the Department (as developed through such safety initiative) and compliance with such tool by medical facilities and health care providers of the Department, including any findings by the Department of prescription rates or prescription practices by medical facilities or health care providers that are inappropriate.

(iii) The implementation of academic detailing programs within the Veterans Integrated Service Networks of the Department and how such programs are being

used to improve opioid prescribing practices.

(iv) Recommendations on such improvements to the Opioid Safety Initiative of the Department as the Comptroller General considers appropriate.

(B) Information made available under the Opioid Therapy Risk Report tool with respect to—

(i) deaths resulting from sentinel events involving veterans prescribed opioids by a health care provider;

(ii) overall prescription rates and, if applicable, indications used by health care providers for prescribing chronic opioid therapy to treat non-cancer, non-palliative, and non-hospice care patients;

(iii) the prescription rates and indications used by health care providers for prescribing benzodiazepines and opioids concomitantly;

(iv) the practice by health care providers of prescribing opioids to treat patients without any pain, including to treat

patients with mental health disorders other than opioid use disorder; and

(v) the effectiveness of opioid therapy for patients receiving such therapy, including the effectiveness of long-term opioid therapy.

(C) An evaluation of processes of the Department in place to oversee opioid use among veterans, including procedures to identify and remedy potential over-prescribing of opioids by health care providers of the Department.

(D) An assessment of the implementation by the Secretary of Veterans Affairs of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any figures or approaches used by the Department to assess compliance with such guidelines by medical centers of the Department and identify any medical centers of the Department operating action plans to improve compliance with such guidelines.

(E) An assessment of the data that the Department has developed to review the opioid prescribing practices of health care providers of the Department, as required by this subtitle, in-

cluding a review of how the Department identifies the practices of individual health care providers that warrant further review based on prescribing levels, health conditions for which the health care provider is prescribing opioids or opioids and benzodiazepines concurrently, or other practices of the health care provider.

(b) SEMI-ANNUAL PROGRESS REPORT ON IMPLEMENTATION OF COMPTROLLER GENERAL RECOMMENDATIONS.—Not later than 180 days after the date of the submittal of the report required under subsection (a), and not less frequently than annually thereafter until the Comptroller General of the United States determines that all recommended actions are closed, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a progress report detailing the actions by the Secretary to address any outstanding findings and recommendations by the Comptroller General of the United States under subsection (a) with respect to the Veterans Health Administration.

(c) ANNUAL REPORT ON OPIOID THERAPY AND PRESCRIPTION RATES.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually for the following five years, the Secretary

shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on opioid therapy and prescription rates for the one-year period preceding the date of the submission of the report. Each such report shall include each of the following:

(1) The number of patients and the percentage of the patient population of the Department who were prescribed benzodiazepines and opioids concurrently by a health care provider of the Department.

(2) The number of patients and the percentage of the patient population of the Department without any pain who were prescribed opioids by a health care provider of the Department, including those who were prescribed benzodiazepines and opioids concurrently.

(3) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were treated with opioids by a health care provider of the Department on an inpatient-basis and who also received prescription opioids by mail from the Department while being treated on an inpatient-basis.

(4) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of

such patients who were prescribed opioids concurrently by a health care provider of the Department and a health care provider that is not a health care provider of the Department.

(5) With respect to each medical facility of the Department, the collected and reviewed information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients, including—

(A) the prescription rate at which each health care provider at the facility prescribed benzodiazepines and opioids concurrently to such patients and the aggregate of such prescription rate for all health care providers at the facility;

(B) the prescription rate at which each health care provider at the facility prescribed benzodiazepines or opioids to such patients to treat conditions for which benzodiazepines or opioids are not approved treatment and the aggregate of such prescription rate for all health care providers at the facility;

(C) the prescription rate at which each health care provider at the facility prescribed or dispensed mail-order prescriptions of opioids to

such patients while such patients were being treated with opioids on an inpatient-basis and the aggregate of such prescription rate for all health care providers at the facility; and

(D) the prescription rate at which each health care provider at the facility prescribed opioids to such patients who were also concurrently prescribed opioids by a health care provider that is not a health care provider of the Department and the aggregate of such prescription rates for all health care providers at the facility.

(6) With respect to each medical facility of the Department, the number of times a pharmacist at the facility overrode a critical drug interaction warning with respect to an interaction between opioids and another medication before dispensing such medication to a veteran.

(d) INVESTIGATION OF PRESCRIPTION RATES.—If the Secretary determines that a prescription rate with respect to a health care provider or medical facility of the Department conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, the Secretary shall—

(1) immediately notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of such determination, including information relating to such determination, prescription rate, and health care provider or medical facility, as the case may be; and

(2) through the Office of the Medical Inspector of the Veterans Health Administration, conduct a full investigation of the health care provider or medical facility, as the case may be.

(e) PRESCRIPTION RATE DEFINED.—In this section, the term ''prescription rate'' means, with respect to a health care provider or medical facility of the Department, each of the following:

(1) The number of patients treated with opioids by the health care provider or at the medical facility, as the case may be, divided by the total number of pharmacy users of that health care provider or medical facility.

(2) The average number of morphine equivalents per day prescribed by the health care provider or at the medical facility, as the case may be, to patients being treated with opioids.

(3) Of the patients being treated with opioids by the health care provider or at the medical facility, as the case may be, the average number of prescriptions of opioids per patient.

SEC. 914. MANDATORY DISCLOSURE OF CERTAIN VETERAN INFORMATION TO STATE CONTROLLED SUBSTANCE MONITORING PROGRAMS.

Section 5701(l) of title 38, United States Code, is amended by striking ''may'' and inserting ''shall''.

SEC. 915. ELIMINATION OF COPAYMENT REQUIREMENT FOR VETERANS RECEIVING OPIOID ANTAGONISTS OR EDUCATION ON USE OF OPIOID ANTAGONISTS.

(a) COPAYMENT FOR OPIOID ANTAGONISTS.—Section 1722A(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

''(4) Paragraph (1) does not apply to opioid antagonists furnished under this chapter to a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose.''.

(b) COPAYMENT FOR EDUCATION ON USE OF OPIOID ANTAGONISTS.—Section 1710(g)(3) of such title is amended—

(1) by striking ''with respect to home health services'' and inserting ''with respect to the following:''

''(A) Home health services''; and

(2) by adding at the end the following subparagraph:

''(B) Education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances.''.

Subtitle B—Patient Advocacy

SEC. 921. COMMUNITY MEETINGS ON IMPROVING CARE FURNISHED BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMMUNITY MEETINGS.—

(1) MEDICAL CENTERS.—Not later than 90 days after the date of the enactment of this Act, and not less frequently than once every 90 days thereafter, the Secretary shall ensure that each medical facility of the Department of Veterans Affairs hosts a community meeting open to the public on improving health care furnished by the Secretary.

(2) COMMUNITY-BASED OUTPATIENT CLINICS.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually thereafter, the Secretary shall ensure that

each community-based outpatient clinic of the Department hosts a community meeting open to the public on improving health care furnished by the Secretary.

(b) ATTENDANCE BY DIRECTOR OF VETERANS INTEGRATED SERVICE NETWORK OR DESIGNEE.—

(1) IN GENERAL.—Each community meeting hosted by a medical facility or community-based outpatient clinic under subsection (a) shall be attended by the Director of the Veterans Integrated Service Network in which the medical facility or community-based outpatient clinic, as the case may be, is located. Subject to paragraph (2), the Director may delegate such attendance only to an employee who works in the Office of the Director.

(2) ATTENDANCE BY DIRECTOR.—Each Director of a Veterans Integrated Service Network shall personally attend not less than one community meeting under subsection (a) hosted by each medical facility located in the Veterans Integrated Service Network each year.

(c) NOTICE.—The Secretary shall notify the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and each Member of Congress (as defined in section 902) who

represents the area in which the medical facility is located of a community meeting under subsection (a) by not later than 10 days before such community meeting occurs.

SEC. 922. IMPROVEMENT OF AWARENESS OF PATIENT ADVOCACY PROGRAM AND PATIENT BILL OF RIGHTS OF DEPARTMENT OF VETERANS AFFAIRS.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients and family members of patients at each medical facility of the Department of Veterans Affairs—

(1) display the purposes of the Patient Advocacy Program of the Department and the contact information for the patient advocate at such medical facility; and

(2) display the rights and responsibilities of—

(A) patients and family members of patients at such medical facility; and

(B) with respect to community living centers and other residential facilities of the Department, residents and family members of residents at such medical facility.

SEC. 923. COMPTROLLER GENERAL REPORT ON PATIENT ADVOCACY PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Patient Advocacy Program of the Department of Veterans Affairs (in this section referred to as the ''Program'').

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) A description of the Program, including—

(A) the purpose of the Program;

(B) the activities carried out under the Program; and

(C) the sufficiency of the Program in achieving the purpose of the Program.

(2) An assessment of the sufficiency of staffing of employees of the Department responsible for carrying out the Program.

(3) An assessment of the sufficiency of the training of such employees.

(4) An assessment of—

(A) the awareness of the Program among veterans and family members of veterans; and

(B) the use of the Program by veterans and family members of veterans.

(5) Such recommendations and proposals for improving or modifying the Program as the Comptroller General considers appropriate.

(6) Such other information with respect to the Program as the Comptroller General considers appropriate.

SEC. 924. ESTABLISHMENT OF OFFICE OF PATIENT ADVOCACY OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Subchapter I of chapter 73 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 7309A. Office of Patient Advocacy

''(a) ESTABLISHMENT.—There is established in the Department within the Office of the Under Secretary for Health an office to be known as the 'Office of Patient Advocacy' (in this section referred to as the 'Office').

''(b) HEAD.—(1) The Director of the Office of Patient Advocacy shall be the head of the Office.

''(2) The Director of the Office of Patient Advocacy shall be appointed by the Under Secretary for Health from

among individuals qualified to perform the duties of the position and shall report directly to the Under Secretary for Health.

''(c) FUNCTION.—(1) The function of the Office is to carry out the Patient Advocacy Program of the Department.

''(2) In carrying out the Patient Advocacy Program of the Department, the Director shall ensure that patient advocates of the Department—

''(A) advocate on behalf of veterans with respect to health care received and sought by veterans under the laws administered by the Secretary;

''(B) carry out the responsibilities specified in subsection (d); and

''(C) receive training in patient advocacy.

''(d) PATIENT ADVOCACY RESPONSIBILITIES.—The responsibilities of each patient advocate at a medical facility of the Department are the following:

''(1) To resolve complaints by veterans with respect to health care furnished under the laws administered by the Secretary that cannot be resolved at the point of service or at a higher level easily accessible to the veteran.

''(2) To present at various meetings and to various committees the issues experienced by veterans in receiving such health care at such medical facility.

''(3) To express to veterans their rights and responsibilities as patients in receiving such health care.

''(4) To manage the Patient Advocate Tracking System of the Department at such medical facility.

''(5) To compile data at such medical facility of complaints made by veterans with respect to the receipt of such health care at such medical facility and the satisfaction of veterans with such health care at such medical facility to determine whether there are trends in such data.

''(6) To ensure that a process is in place for the distribution of the data compiled under paragraph (5) to appropriate leaders, committees, services, and staff of the Department.

''(7) To identify, not less frequently than quarterly, opportunities for improvements in the furnishing of such health care to veterans at such medical facility based on complaints by veterans.

''(8) To ensure that any significant complaint by a veteran with respect to such health care is brought to the attention of appropriate staff of the

Department to trigger an assessment of whether there needs to be a further analysis of the problem at the facility-wide level.

''(9) To support any patient advocacy programs carried out by the Department.

''(10) To ensure that all appeals and final decisions with respect to the receipt of such health care are entered into the Patient Advocate Tracking System of the Department.

''(11) To understand all laws, directives, and other rules with respect to the rights and responsibilities of veterans in receiving such health care, including the appeals processes available to veterans.

''(12) To ensure that veterans receiving mental health care, or the surrogate decision-makers for such veterans, are aware of the rights of veterans to seek representation from systems established under section 103 of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10803) to protect and advocate the rights of individuals with mental illness and to investigate incidents of abuse and neglect of such individuals.

''(13) To fulfill requirements established by the Secretary with respect to the inspection of controlled substances.

''(14) To document potentially threatening behavior and report such behavior to appropriate authorities.

''(e) TRAINING.—In providing training to patient advocates under subsection (c)(2)(C), the Director shall ensure that such training is consistent throughout the Department.

''(f) CONTROLLED SUBSTANCE DEFINED.—In this section, the term 'controlled substance' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of such title is amended by inserting after the item relating to section 7309 the following new item:

''7309A. Office of Patient Advocacy.''.

(c) DATE FULLY OPERATIONAL.—The Secretary of Veterans Affairs shall ensure that the Office of Patient Advocacy established under section 7309A of title 38, United States Code, as added by subsection (a), is fully operational not later than the date that is one year after the date of the enactment of this Act.

Subtitle C—Complementary and Integrative Health

SEC. 931. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

(a) ESTABLISHMENT.—There is established a commission to be known as the ''Creating Options for Veterans' Expedited Recovery'' or the ''COVER Commission'' (in this section referred to as the ''Commission''). The Commission shall examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health treatments available in non-Department facilities (as defined in section 1701 of title 38, United States Code).

(b) DUTIES.—The Commission shall perform the following duties:

(1) Examine the efficacy of the evidence-based therapy model used by the Secretary for treating mental health illnesses of veterans and identify areas to improve wellness-based outcomes.

(2) Conduct a patient-centered survey within each of the Veterans Integrated Service Networks to examine—

(A) the experience of veterans with the Department of Veterans Affairs when seeking medical assistance for mental health issues through the health care system of the Department;

(B) the experience of veterans with non-Department facilities and health professionals for treating mental health issues;

(C) the preference of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective;

(D) the experience, if any, of veterans with respect to the complementary and integrative health treatment therapies described in paragraph (3);

(E) the prevalence of prescribing prescription medication among veterans seeking treatment through the health care system of the Department as remedies for addressing mental health issues; and

(F) the outreach efforts of the Secretary regarding the availability of benefits and treatments for veterans for addressing mental health issues, including by identifying ways to reduce

barriers to gaps in such benefits and treatments.

(3) Examine available research on complementary and integrative health treatment therapies for mental health issues and identify what benefits could be made with the inclusion of such treatments for veterans, including with respect to—

(A) music therapy;

(B) equine therapy;

(C) training and caring for service dogs;

(D) yoga therapy;

(E) acupuncture therapy;

(F) meditation therapy;

(G) outdoor sports therapy;

(H) hyperbaric oxygen therapy;

(I) accelerated resolution therapy;

(J) art therapy;

(K) magnetic resonance therapy; and

(L) other therapies the Commission determines appropriate.

(4) Study the sufficiency of the resources of the Department to ensure the delivery of quality health care for mental health issues among veterans seeking treatment within the Department.

(5) Study the current treatments and resources available within the Department and assess—

(A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans;

(B) the number of veterans who have been diagnosed with mental health issues;

(C) the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues;

(D) the percentage of veterans who have completed counseling sessions offered by the Department; and

(E) the efforts of the Department to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by the Department.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 10 members, appointed as follows:

(A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(B) Two members appointed by the minority leader of the House of Representatives, at least one of whom shall be a veteran.

(C) Two members appointed by the majority leader of the Senate, at least one of whom shall be a veteran.

(D) Two members appointed by the minority leader of the Senate, at least one of whom shall be a veteran.

(E) Two members appointed by the President, at least one of whom shall be a veteran.

(2) QUALIFICATIONS.—Members of the Commission shall be individuals who—

(A) are of recognized standing and distinction within the medical community with a background in treating mental health;

(B) have experience working with the military and veteran population; and

(C) do not have a financial interest in any of the complementary and integrative health treatments reviewed by the Commission.

(3) CHAIRMAN.—The President shall designate a member of the Commission to be the Chairman.

(4) PERIOD OF APPOINTMENT.—Members of the Commission shall be appointed for the life of the Commission.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(6) APPOINTMENT DEADLINE.—The appointment of members of the Commission in this section shall be made not later than 90 days after the date of the enactment of this Act.

(d) POWERS OF COMMISSION.—

(1) MEETINGS.—

(A) INITIAL MEETING.—The Commission shall hold its first meeting not later than 30 days after a majority of members are appointed to the Commission.

(B) MEETING.—The Commission shall regularly meet at the call of the Chairman. Such meetings may be carried out through the use of telephonic or other appropriate telecommunication technology if the Commission determines that such technology will allow the members to communicate simultaneously.

(2) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places,

take such testimony, and receive evidence as the Commission considers advisable to carry out the responsibilities of the Commission.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission.

(4) INFORMATION FROM NONGOVERNMENTAL ORGANIZATIONS.—In carrying out its duties, the Commission may seek guidance through consultation with foundations, veteran service organizations, nonprofit groups, faith-based organizations, private and public institutions of higher education, and other organizations as the Commission determines appropriate.

(5) COMMISSION RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such record.

(6) PERSONNEL RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such

record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such records.

(7) COMPENSATION OF MEMBERS; TRAVEL EXPENSES.—Each member shall serve without pay but shall receive travel expenses to perform the duties of the Commission, including per diem in lieu of substances, at rates authorized under subchapter I of chapter 57 of title 5, United States Code.

(8) STAFF.—The Chairman, in accordance with rules agreed upon the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(9) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The executive director and any personnel of the Commission are employees under section 2105 of title 5, United States Code, for purpose of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of such title.

(B) MEMBERS OF THE COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(10) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided in appropriations Acts, enter into contracts to enable the Commission to discharge the duties of the Commission under this Act.

(11) EXPERT AND CONSULTANT SERVICE.—The Commission may procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, at rates not to exceed the daily rate paid to a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(12) POSTAL SERVICE.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

(13) PHYSICAL FACILITIES AND EQUIPMENT.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act. These administrative services may include human resource management, budget, leasing accounting, and payroll services.

(e) REPORT.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—Not later than 60 days after the date on which the Commission first meets, and each 30-day period thereafter ending on the date on which the Commission submits the final report under paragraph (2), the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the President a report detailing the level of cooperation the Secretary of Veterans Affairs (and the heads of other departments or agencies of the Federal Government) has provided to the Commission.

(B) OTHER REPORTS.—In carrying out its duties, at times that the Commission deter-

mines appropriate, the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and any other appropriate entities an interim report with respect to the findings identified by the Commission.

(2) FINAL REPORT.—Not later than 18 months after the first meeting of the Commission, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate, the President, and the Secretary of Veterans Affairs a final report on the findings of the Commission. Such report shall include the following:

(A) Recommendations to implement in a feasible, timely, and cost-efficient manner the solutions and remedies identified within the findings of the Commission pursuant to subsection (b).

(B) An analysis of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating veterans with mental health care issues, and an examination of the prevalence and efficacy of prescription drugs as a means for treatment.

(C) The findings of the patient-centered survey conducted within each of the Veterans Integrated Service Networks pursuant to subsection (b)(2).

(D) An examination of complementary and integrative health treatments described in subsection (b)(3) and the potential benefits of incorporating such treatments in the therapy models used by the Secretary for treating veterans with mental health issues.

(3) PLAN.—Not later than 90 days after the date on which the Commission submits the final report under paragraph (2), the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the following:

(A) An action plan for implementing the recommendations established by the Commission on such solutions and remedies for improving wellness-based outcomes for veterans with mental health care issues.

(B) A feasible timeframe on when the complementary and integrative health treatments described in subsection (b)(3) can be implemented Department-wide.

(C) With respect to each recommendation established by the Commission, including any complementary and integrative health treatment, that the Secretary determines is not appropriate or feasible to implement, a justification for such determination and an alternative solution to improve the efficacy of the therapy models used by the Secretary for treating veterans with mental health issues.

(f) TERMINATION OF COMMISSION.—The Commission shall terminate 30 days after the Commission submits the final report under subsection (e)(2).

SEC. 932. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

(a) DEVELOPMENT OF PLAN TO EXPAND RESEARCH, EDUCATION, AND DELIVERY.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall develop a plan to expand materially and substantially the scope of the effectiveness of research and education on, and delivery and integration of, complementary and integrative health services into the health care services provided to veterans.

(b) ELEMENTS.—The plan required by subsection (a) shall provide for the following:

(1) Research on the following:

(A) The effectiveness of various complementary and integrative health services, including the effectiveness of such services integrated with clinical services.

(B) Approaches to integrating complementary and integrative health services into other health care services provided by the Department of Veterans Affairs.

(2) Education and training for health care professionals of the Department on the following:

(A) Complementary and integrative health services selected by the Secretary for purposes of the plan.

(B) Appropriate uses of such services.

(C) Integration of such services into the delivery of health care to veterans.

(3) Research, education, and clinical activities on complementary and integrative health at centers of innovation at medical centers of the Department.

(4) Identification or development of metrics and outcome measures to evaluate the effectiveness of the provision and integration of complementary and integrative health services into the delivery of health care to veterans.

(5) Integration and delivery of complementary and integrative health services with other health care services provided by the Department.

(c) CONSULTATION.—

(1) IN GENERAL.—In carrying out subsection (a), the Secretary shall consult with the following:

(A) The Director of the National Center for Complementary and Integrative Health of the National Institutes of Health.

(B) The Commissioner of Food and Drugs.

(C) Institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and integrative health and the integration of complementary and integrative health practices into the delivery of health care.

(D) Nationally recognized providers of complementary and integrative health.

(E) Such other officials, entities, and individuals with expertise on complementary and integrative health as the Secretary considers appropriate.

(2) SCOPE OF CONSULTATION.—The Secretary shall undertake consultation under paragraph (1) in

carrying out subsection (a) with respect to the following:

(A) To develop the plan.

(B) To identify specific complementary and integrative health practices that, on the basis of research findings or promising clinical interventions, are appropriate to include as services to veterans.

(C) To identify barriers to the effective provision and integration of complementary and integrative health services into the delivery of health care to veterans, and to identify mechanisms for overcoming such barriers.

SEC. 933. PILOT PROGRAM ON INTEGRATION OF COMPLEMENTARY AND INTEGRATIVE HEALTH AND RELATED ISSUES FOR VETERANS AND FAMILY MEMBERS OF VETERANS.

(a) PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the date on which the Secretary of Veterans Affairs receives the final report under section 931(e)(2), the Secretary shall commence a pilot program to assess the feasibility and advisability of using complementary and integrative health and wellness-based programs (as defined by the Sec-

retary) to complement the provision of pain management and related health care services, including mental health care services, to veterans.

(2) MATTERS ADDRESSED.—In carrying out the pilot program, the Secretary shall assess the following:

(A) Means of improving coordination between Federal, State, local, and community providers of health care in the provision of pain management and related health care services to veterans.

(B) Means of enhancing outreach, and coordination of outreach, by and among providers of health care referred to in subparagraph (A) on the pain management and related health care services available to veterans.

(C) Means of using complementary and integrative health and wellness-based programs of providers of health care referred to in subparagraph (A) as complements to the provision by the Department of Veterans Affairs of pain management and related health care services to veterans.

(D) Whether complementary and integrative health and wellness-based programs described in subparagraph (C)—

(i) are effective in enhancing the quality of life and well-being of veterans;

(ii) are effective in increasing the adherence of veterans to the primary pain management and related health care services provided such veterans by the Department;

(iii) have an effect on the sense of well-being of veterans who receive primary pain management and related health care services from the Department; and

(iv) are effective in encouraging veterans receiving health care from the Department to adopt a more healthy lifestyle.

(b) DURATION.—The Secretary shall carry out the pilot program under subsection (a)(1) for a period of three years.

(c) LOCATIONS.—

(1) FACILITIES.—The Secretary shall carry out the pilot program under subsection (a)(1) at facilities of the Department providing pain management and related health care services, including mental

health care services, to veterans. In selecting such facilities to carry out the pilot program, the Secretary shall select not fewer than 15 geographically diverse medical centers of the Department, of which not fewer than two shall be polytrauma rehabilitation centers of the Department.

(2) MEDICAL CENTERS WITH PRESCRIPTION RATES OF OPIOIDS THAT CONFLICT WITH CARE STANDARDS.—In selecting the medical centers under paragraph (1), the Secretary shall give priority to medical centers of the Department at which there is a prescription rate of opioids that conflicts with or is otherwise inconsistent with the standards of appropriate and safe care.

(d) PROVISION OF SERVICES.—Under the pilot program under subsection (a)(1), the Secretary shall provide covered services to covered veterans by integrating complementary and integrative health services with other services provided by the Department at the medical centers selected under subsection (c).

(e) COVERED VETERANS.—For purposes of the pilot program under subsection (a)(1), a covered veteran is any veteran who—

(1) has a mental health condition diagnosed by a clinician of the Department;

(2) experiences chronic pain;

(3) has a chronic condition being treated by a clinician of the Department; or

(4) is not described in paragraph (1), (2), or (3) and requests to participate in the pilot program or is referred by a clinician of the Department who is treating the veteran.

(f) COVERED SERVICES.—

(1) IN GENERAL.—For purposes of the pilot program, covered services are services consisting of complementary and integrative health services as selected by the Secretary.

(2) ADMINISTRATION OF SERVICES.—Covered services shall be administered under the pilot program as follows:

(A) Covered services shall be administered by professionals or other instructors with appropriate training and expertise in complementary and integrative health services who are employees of the Department or with whom the Department enters into an agreement to provide such services.

(B) Covered services shall be included as part of the Patient Aligned Care Teams initiative of the Office of Patient Care Services, Pri-

mary Care Program Office, in coordination with the Office of Patient Centered Care and Cultural Transformation.

(C) Covered services shall be made available to—

(i) covered veterans who have received conventional treatments from the Department for the conditions for which the covered veteran seeks complementary and integrative health services under the pilot program; and

(ii) covered veterans who have not received conventional treatments from the Department for such conditions.

(g) REPORTS.—

(1) IN GENERAL.—Not later than 30 months after the date on which the Secretary commences the pilot program under subsection (a)(1), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the pilot program.

(2) ELEMENTS.—The report under paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program under subsection (a)(1), including with respect to—

(i) the use and efficacy of the complementary and integrative health services established under the pilot program;

(ii) the outreach conducted by the Secretary to inform veterans and community organizations about the pilot program; and

(iii) an assessment of the benefit of the pilot program to covered veterans in mental health diagnoses, pain management, and treatment of chronic illness.

(B) Identification of any unresolved barriers that impede the ability of the Secretary to incorporate complementary and integrative health services with other health care services provided by the Department.

(C) Such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

Subtitle D—Fitness of Health Care Providers

SEC. 941. ADDITIONAL REQUIREMENTS FOR HIRING OF HEALTH CARE PROVIDERS BY DEPARTMENT OF VETERANS AFFAIRS.

As part of the hiring process for each health care provider considered for a position at the Department of Veterans Affairs after the date of the enactment of the Act, the Secretary of Veterans Affairs shall require from the medical board of each State in which the health care provider has or had a medical license—

(1) information on any violation of the requirements of the medical license of the health care provider during the 20-year period preceding the consideration of the health care provider by the Department; and

(2) information on whether the health care provider has entered into any settlement agreement for a disciplinary charge relating to the practice of medicine by the health care provider.

SEC. 942. PROVISION OF INFORMATION ON HEALTH CARE PROVIDERS OF DEPARTMENT OF VETERANS AFFAIRS TO STATE MEDICAL BOARDS.

Notwithstanding section 552a of title 5, United States Code, with respect to each health care provider of

the Department of Veterans Affairs who has violated a requirement of the medical license of the health care provider, the Secretary of Veterans Affairs shall provide to the medical board of each State in which the health care provider is licensed detailed information with respect to such violation, regardless of whether such board has formally requested such information.

SEC. 943. REPORT ON COMPLIANCE BY DEPARTMENT OF VETERANS AFFAIRS WITH REVIEWS OF HEALTH CARE PROVIDERS LEAVING THE DEPARTMENT OR TRANSFERRING TO OTHER FACILITIES.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the compliance by the Department of Veterans Affairs with the policy of the Department—

(1) to conduct a review of each health care provider of the Department who transfers to another medical facility of the Department, resigns, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations re-

lating to the medical practice of the health care provider; and

(2) to take appropriate action with respect to any such concern, complaint, or allegation.

Subtitle E—Other Matters

SEC. 951. MODIFICATION TO LIMITATION ON AWARDS AND BONUSES.

Section 705 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 703 note) is amended to read as follows:

"SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

''(a) LIMITATION.—The Secretary of Veterans Affairs shall ensure that the aggregate amount of awards and bonuses paid by the Secretary in a fiscal year under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title or title 38, United States Code, does not exceed the following amounts:

''(1) With respect to each of fiscal years 2017 through 2018, $230,000,000.

''(2) With respect to each of fiscal years 2019 through 2021, $225,000,000.

''(3) With respect to each of fiscal years 2022 through 2024, $360,000,000.

''(b) SENSE OF CONGRESS.—It is the sense of Congress that the limitation under subsection (a) should not disproportionately impact lower-wage employees and that the Department of Veterans Affairs is encouraged to use bonuses to incentivize high-performing employees in areas in which retention is challenging.''.

S. 524

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
For consideration of the Senate bill and the House amendments, and modifications committed to conference:	
Mr. Upton	
Mr. Pitts	
Mr. Lance	
Mr. Guthrie	
Mr. Kinzinger of Illinois	
Mr. Bucshon	
Mrs. Brooks of Indiana	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
Mr. Goodlatte	
Mr. Sensenbrenner	
Mr. Smith of Texas	
Mr. Marino	
Mr. Collins of Georgia	
Mr. Trott	
Mr. Bishop of Michigan	
Mr. McCarthy	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
~~Mr. Pallone~~	
~~Mr. Ben Ray Luján of New Mexico~~	
~~Mr. Sarbanes~~	
~~Mr. Gene Green of Texas~~	
~~Mr. Conyers~~	
~~Ms. Jackson Lee~~	
~~Ms. Judy Chu of California~~	
~~Mr. Cohen~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
~~Ms. Esty~~	
~~Ms. Kuster~~	
~~Mr. Courtney~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Education and the Workforce, for consideration of title VII of the House amendment, and modifications committed to conference:	
Mr. Barletta	
Mr. Carter of Georgia	
~~Mr. Scott of Virginia~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Veterans' Affairs, for consideration of title III of the House amendment, and modifications committed to conference:	
Mr. Bilirakis	
Mrs. Walorski	
~~Mr. Ruiz~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Ways and Means, for consideration of sec. 705 of the Senate bill, and sec. 804 of the House amendment, and modifications committed to conference:	
Mr. Meehan	
Mr. Dold	
~~Mr. McDermott~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
	Mr. Grassley
	Mr. Alexander
	Mr. Hatch
	Mr. [illegible]
	[redacted]
	[redacted]
	[redacted]

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 524), to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment to the text of the bill struck all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment that is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

Joint Explanatory Statement of the Committee of the Conference

S. 524, the Comprehensive Addiction and Recovery Act (CARA), authorizes the Attorney General and the Secretary of Health and Human Services to award grants to address the national epidemics of addiction to heroin and prescription opioids, and makes various other changes to Federal law to combat opioid addiction and abuse.

TITLE I – PREVENTION AND EDUCATION

Section 101 – Task force on Pain Management

S. 524 included a task force to review best practices for chronic and acute pain management and prescribing pain medication. It was unclear which best practices the task force would review, modify, and update. The task force would have been required to convene not later than December 14, 2018, and within 180 days, modify and update such best practices, as appropriate, and amend them further, if appropriate, after soliciting and taking into consideration public comment. Not later than 90 days after that, the task force would have been required to submit a report to Congress, including a strategy for disseminating best practices as reviewed, modified, or updated.

The House amendment included the same timeframes and underlying activities but added a number of participants to the task force. The House amendment also added considerations that the task force would have been required to take into account while reviewing, modifying, and updating best practices, several of which extended beyond the scope of chronic and acute pain management.

Section 101 of the conference report requires the Secretary of Health and Human Services (HHS), within two years of enactment, to convene a task force comprised of federal agencies and non-governmental stakeholders to identify, review, and as appropriate, determine whether there are gaps or inconsistencies between best practices for chronic and acute pain management that have been developed or adopted by Federal agencies. The task force is required to consider a number of factors, existing research, and related efforts, and, within one year of convening, propose any updates to such best practices and recommendations on addressing gaps or inconsistencies after providing the public with at least 90 days to submit comments. The task force would also develop a strategy for disseminating information about best practices prior to disbanding three years after enactment.

Section 102 – Awareness Campaigns

Section 102 requires that the Secretary of HHS, as appropriate, to advance education and awareness of issues related to opioid abuse. The Secretary is directed to carry out these activities through existing programs and activities. The awareness campaigns should address information on prevention and detection of opioid abuse. Section 102 of S. 524 included a similar provision.

Section 103 – Community-Based Coalition Enhancement Grants to Address Local Drug Crises

Section 103 authorizes the Office of National Drug Control Policy (ONDCP) to award grants to implement community-wide prevention strategies for addressing the local drug crisis or emerging drug abuse issue in areas with high rates of opioid or methamphetamine abuse. The section authorizes the appropriation of $5 million for each of fiscal years 2017 through 2021, and allows ONDCP to delegate authority for carrying out the grant program. Section 103 of S. 524 included a similar provision.

Section 104 – Information Materials and Resources to Prevent Addiction Related to Youth Sports Injuries

Section 104 directs the Secretary of HHS to make publically available a report determining the extent to which informational materials and resources are available with respect to youth sports injuries for which opioids are potentially prescribed. The Secretary may then facilitate the development of materials if gaps are found in resources that are currently available. Teenage athletes who are prescribed an opioid are uniquely susceptible to opioid addiction. The House amendment included similar language.

Section 105 – Assisting Veterans with Military Emergency Medical Training to Meet Requirements for Becoming Civilian Health Care Professionals

Section 105 would award demonstration grants to states to streamline the licensure requirements for veterans who held military occupational specialties related to medical care or who completed certain military medical training to more easily meet civilian health care licensure requirements. The House amendment included similar language that applied only to military emergency medical technicians.

Section 106 – FDA Opioid Action Plan

Section 106 requires that the Food and Drug Administration (FDA) consult with advisory committees prior to approval or labeling of certain new opioids in pediatric populations. FDA must also issue final guidance for generic drugs that claim abuse deterrence within 18 months of the date of enactment, and develop recommendations regarding educational programs for prescribers of opioids. The House amendment included similar language.

Section 107 – Improving Access to Overdose Treatment

Currently, there are questions as to when co-prescribing or prescribing of opioid reversal drugs approved by the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose is appropriate. Section 107 would allow the Secretary of HHS, the Secretary of Veterans Affairs (VA), and the Secretary of Defense, 180 days after enactment, to provide information to prescribers on co-prescribing or prescribing a drug or device for emergency treatment of known or suspected opioid overdose. It explicitly states that the best

practices in this section are not to be construed as or to establish a medical standard of care. This section also establishes a grant program to increase access to opioid overdose treatment. The House amendment included similar language.

Section 108 – NIH Opioid Research

Section 108 allows the National Institutes of Health (NIH) to intensify and coordinate fundamental, translational, and clinical research with respect to the understanding of pain, the discovery and development of therapies for chronic pain, and the development of alternatives to opioids for effective pain treatments in order to advance the discovery and development of novel, safe, non-addictive, effective, and affordable pharmaceuticals and other therapies for chronic pain.

Section 109 – National All Schedules Prescription Electronic Reporting Reauthorization

Section 109 reauthorizes the National All Schedules Prescription Electronic Reporting (NASPER) Act within HHS to provide grants to states to establish, implement, and improve state-based prescription drug monitoring programs (PDMPs). NASPER first became law in 2005 but expired in 2010. CARA will extend funding for NASPER for five years at $10 million a year for FY 2017 through FY 2021. The House amendment included similar language.

Section 110 – Opioid Overdose Reversal Medication Access and Education Grant Programs

Section 110 would allow the Secretary of HHS to make grants available for states to implement standing orders for opioid reversal drugs approved by the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose. These grants may target states that have a significantly higher per-capita rate of opioid overdoses than the national average. Each state that is awarded a grant under this program must submit a report to the Secretary of HHS evaluating the grant and the services that were provided. The House amendment included similar language.

TITLE II – LAW ENFORCEMENT AND TREATMENT

Section 201 – Comprehensive Opioid Abuse Grant Program

Section 201 includes the provisions of Title II of the House amendment to S. 524. It creates a comprehensive grant program at the Department of Justice (DOJ) to address the problems of opioid addiction and abuse. Though there is no corresponding provision in S. 524 as passed by the Senate, the program created by this section includes several "allowable uses" that are similar to provisions in that bill. Minor changes have been made to the conference provisions for clarity. The allowable uses of grant funds include:

(1) Alternatives to incarceration programs, which replaces Section 201 of the Senate bill. The list of allowable alternatives to incarceration programs is very similar to the programs in the

Senate bill, including pre- and post-booking treatment programs such as drug courts and veterans treatment courts, and criminal justice training programs.
(2) Collaboration between criminal justice agencies and substance abuse systems, which is nearly identical to Section 201 of the Senate bill;
(3) Training for first responders in carrying and administering opioid overdose reversal drugs and purchasing such drugs for first responders who have received training;
(4) Investigative purposes related to the unlawful distribution of opioids;
(5) Medication-assisted treatment by criminal justice agencies, which is highlighted in Section 302 of the Senate bill;
(6) Prescription drug monitoring programs administered by states;
(7) Programs that address juvenile opioid abuse, which does not have a Senate companion;
(8) Initiatives to prevent pilfering of prescription opioids, which does not have a Senate companion;
(9) Prescription drug take-back programs; and
(10) Development of a jurisdiction's own comprehensive opioid abuse reduction program.

$103,000,000 is authorized to be appropriated for each of fiscal years 2017 through 2021 to carry out this grant program. This discretionary authorization is fully offset in accordance with the House's CUTGO protocol.

This section also allows grantees to make subawards to local or regional nonprofit organizations, including faith-based organizations, units of local government, and tribal organizations. This section would permit organizations that are private and nonprofit to receive subawards, including organizations that provide alternative complementary mental health services.

This section requires that the Attorney General ensure equitable distribution of funds, taking into consideration the needs of underserved populations such as rural and tribal communities, and the prevalence of opioid abuse in a community. It also ensures that entities that provide services to pregnant women are eligible for grants under the Family-Based Substance Abuse Grant Program.

Finally, this section directs the Government Accountability Office (GAO) to study and report on how federal agencies, including ONDCP, through grant programs, are addressing prevention, treatment, and recovery from substance abuse disorders on the part of adolescents and young adults.

Section 202 – First Responder Training

Section 201 of the conference report codifies an existing grant program at the Substance Abuse and Mental Health Services Administration (SAMSHA) to expand access to life-saving opioid overdose reversal drugs by supporting the purchase and distribution of opioid overdose reversal drugs and training for first responders and other key community sectors. S. 524 included similar language.

Section 203 – Prescription Drug Take-Back Expansion

This section, identical to Section 203 of the Senate bill, authorizes the Attorney General, in coordination with the Administrator of the Drug Enforcement Administration (DEA), the Secretary of HHS, and the Director of ONDCP, to coordinate with certain entities in expanding or making available disposal sites for unwanted prescription medications. These entities include state and local law enforcement agencies, manufacturers and distributors of prescription medications, retail pharmacies, narcotic treatment programs, hospitals with on-site pharmacies, and long-term care facilities.

TITLE III – TREATMENT AND RECOVERY

Section 301 – Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration

Section 301 of the conference report codifies an existing grant program at SAMHSA to support states in expanding access to addiction treatment services for individuals with an opioid use disorder, including evidence-based medication assisted treatment. This program is targeted toward areas where there is a high rate or a rapid increase in the use of heroin or other opioids, including rural areas. S. 524 included this language.

Section 302 – Building Communities of Recovery

Section 302 of the conference report allows HHS to provide grants to community organizations to develop, expand, and enhance recovery services and build connections between recovery networks, including physicians, the criminal justice system, employers, and other recovery support systems. Recovery services help individuals with a substance use disorder get and stay well and increase long-term recovery from substance use disorders. S. 524 included this language.

Section 303 – Medication-Assisted Treatment for Recovery From Addiction

The House amendment included provisions amending the Controlled Substances Act to permit nurse practitioners and physician assistants (NPs and PAs) who meet certain criteria to receive a waiver from SAMHSA to dispense certain drugs for maintenance or detoxification treatment in an office-based setting to up to 30 patients in the first year and up to 100 patients after the first year and going forward. In states where NPs and PAs are required to practice in collaboration with, or under the supervision of a physician, such physician would also need to be a qualifying practitioner (i.e., have their own waiver from SAMHSA). This new authority for NPs and PAs would sunset three years after the date of enactment.

Section 303 of the conference report includes similar operative language to the House amendment, though it requires the implementing regulations to be updated no later than 18 months after the date of enactment and the new authority for NPs and PAs expires October 1, 2021. Further, this section would not preempt any state law that establishes a lower limit on the number of patients a qualifying practitioner can treat at any given time or requires a qualifying practitioner to comply with additional requirements relating to the dispensing of such drugs.

TITLE IV – ADDRESING COLLATORAL CONSEQUENCES

Section 401 – GAO Report on Recovery and Collateral Consequences

This section directs GAO to submit a report to the Senate and House Judiciary Committees on recovery and the collateral consequences of drug-related criminal convictions within one year of the date of the Act's enactment. The report will study the collateral consequences for individuals with convictions for non-violent drug-related offenses and the effects of these collateral consequences on individuals in recovery on their ability to resume their personal and professional activities. The report will also discuss the policy bases and justifications for imposing these collateral consequences and provide perspectives on the potential for mitigating the effect of these collateral consequences on individuals in recovery.

TITLE V- ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

Section 501 – Improving Treatment for Pregnant and Postpartum Women

Section 501 reauthorizes a grant program for residential treatment for pregnant and postpartum women who have an opioid use disorder. This program also provides services for the children of such women, including those who may be born with neonatal abstinence syndrome. It creates a new pilot program to enhance the flexibility of the funds so states can more broadly support family-based services for pregnant and postpartum women and their children. S. 524 included language to reauthorize this program and create a pilot program but at a lower authorized level than the language included in the House amendment.

Section 502 – Veterans Treatment Courts

The language in this section is drawn from the House amendment to S. 524, and replaces the language from Section 503 of the Senate bill. However, consistent with the Senate bill, this section defines "qualified veterans" for purposes of the DOJ grant program as those who have served on active duty in any branch of the Armed Services and have been discharged under conditions other than dishonorable, unless the reason for the dishonorable discharge was attributable to a substance abuse disorder.

Additionally, this section provides a definitional framework for "peer-to peer" programs, "veterans treatment court" programs, and "veterans assistance" programs that are eligible under this section. This section is cross-referenced in the "alternatives to incarceration" piece of section 201 of the conference report, and should provide guidance on how grantees are to use grant funds received for veterans courts.

Section 503 – Infant Plan of Safe Care

Section 503 incorporates text originally passed as part of the House amendment to S. 524 and responds to concerns about the increased number of infants born suffering from opioid withdrawal symptoms and ensures states are in compliance with the *Child Abuse Prevention and*

Treatment Act (CAPTA). No corresponding provision was included in S. 524. This section requires the Department of HHS to review and confirm states have CAPTA policies in place as required under the law, strengthens protections for infants born with substance exposure by clarifying the intent of safe care plans, and requires the HHS Secretary to share best practices for developing plans to keep infants and their caregivers safe and healthy. It also improves accountability related to the care of infants and their families by requiring additional information be shared on incidents of infants exposed and their subsequent care. Additionally, it encourages the use of information made available through other child welfare laws in verifying CAPTA compliance. Finally, section 503 prevents HHS from adding new requirements to state assurances and plans.

Section 504 – GAO Report on Neonatal Abstinence Syndrome (NAS)

Section 504 requires the Comptroller General of the United States to, one year after enactment, issue a report on neonatal abstinence syndrome (NAS), including information on the treatment for infants with NAS under Medicaid. Specifically, the report will examine what is known about the prevalence of NAS in the country; the Medicaid-reimbursable services available to treat NAS; the types of, and reimbursement for care settings in which infants with NAS receive care; and any federal policy barriers for treating infants with NAS and what is known about best practices for caring for infants with NAS. Similar language was included in the House amendment.

TITLE VI – INCENTIVIZING STATE COMPREHENSIVE INITIATIVES TO ADDRESS PRESCRIPTION OPIOID ABUSE

Section 601 – State Demonstration Grants for Comprehensive Opioid Abuse Response

Section 601 of the conference report supports State efforts to combat opioid abuse by authorizing HHS to award grants to States and combinations of States to carry out a comprehensive opioid abuse response, including education, treatment, and recovery efforts, maintaining prescription drug monitoring programs, and efforts to prevent overdose deaths. S. 524 included this language; there was no corresponding legislation in the House amendment.

TITLE VII – MISCELLANEOUS

Section 701 – Grant Accountability and Evaluations

This section combines language that originated in both the House and Senate on grant oversight. It requires the DOJ Inspector General, at his or her discretion, to conduct audits of covered grantees to prevent waste, fraud, and abuse of funds. This section prohibits grantees with unresolved audit findings from receiving grants in the following fiscal year, and prioritizes grantees that do not have unresolved audit findings. If a grantee nevertheless receives funds inappropriately, this section also compels DOJ to reimburse the Department of the Treasury for the amount awarded, and to seek to recoup the funds from the grantee.

With respect to nonprofit organizations, this section prohibits nonprofits that hold money in offshore accounts for the purpose of avoiding certain federal taxes from receiving subawards from grant recipients. It also requires nonprofit organizations to disclose, in a grant application, the compensation of its board of directors. Finally, this section limits the use of grant funds for conference expenditures, and prevents the awarding of duplicative grants.

This section also contains the provisions applicable to DOJ from Title VI of the House amendment to S. 524, the Opioid Program Evaluation (OPEN) Act, which did not have a Senate companion. It requires the Attorney General to complete an evaluation of the effectiveness of the Comprehensive Opioid Abuse Grant Program based upon the information reported by grantees not later than 5 years after the enactment of the Act. It requires the Attorney General to identify outcomes to be achieved under the Comprehensive Opioid Grant Abuse Program, and the metrics by which the achievement of such outcomes shall be determined, not later than 180 days after the enactment of the Act.

This section provides that the Attorney General must require grantees and those receiving subawards to collect and annually report data on the activities conducted using their grant funding. It requires that the Attorney General publish the outcomes and metrics to be used to evaluate the program not later than 30 days after identifying such outcomes and metrics, and that the entity conducting the evaluation publish the results and issue a report to the House and Senate Judiciary Committees not later than 90 days after completion of the evaluation. It further requires the data collected from grantees to be published along with the report.

Finally, this section requires that the Attorney General enter into an arrangement with the National Academy of Sciences—or another non-government entity with expertise in conducting and evaluating research pertaining to opioid use and abuse and drawing conclusions about overall opioid use and abuse on the basis of that research—to identify the outcomes to be achieved, the metrics by which performance will be evaluated, and the evaluation of the Comprehensive Opioid Abuse Grant Program.

Section 701 also authorizes HHS to evaluate grants authorized within the Comprehensive Addiction Recovery Act and identify outcomes to be achieved by the programs, and metrics by which to measure those outcomes.

This section also places restrictions on conference expenditures using funding under a grant program in this Act.

Section 702 – Partial Fill of Schedule II Controlled Substances

Section 702 clarifies that if a doctor or patient requests a prescription for a Schedule II substance (such as an opioid) not be filled in its entirety, in accordance with state law; pharmacists are permitted to dispense only part of the prescription. This change could lead to fewer opioids being dispensed. The House amendment to CARA permitted more flexibility in filling Schedule II prescriptions such as opioids.

Section 703 – Good Samaritan Assessment

This section includes the provisions of Title V of the House amendment to S. 524, the Good Samaritan Assessment Act, which did not have a Senate companion. It directs the GAO to issue a report to the House and Senate Judiciary Committees, the House Oversight and Government Reform Committee, and the Senate Homeland Security and Governmental Affairs Committee, on the extent to which ONDCP has reviewed Good Samaritan laws and the findings from such a review; efforts by the ONDCP Director to encourage the enactment of Good Samaritan laws; and a compilation of Good Samaritan laws in effect in the States, the territories, and the District of Columbia.

Currently, more than half the states and the District of Columbia have some form of Good Samaritan law on the books, to protect citizens who render help to someone in need – or, in the context of opioids, to exempt from criminal or civil liability someone who administers an opioid overdose reversal drug or device, such as naloxone, or who calls 911 to report an overdose.

Given the widespread activity in state legislatures on this issue, and the differences between individual state statutes, this section directs GAO to study and report to Congress on the effects of the various Good Samaritan laws at the state level, and efforts by ONDCP to address the issue.

Section 704 – Programs to Prevent Prescription Drug Abuse under Medicare Parts C and D

Section 704 would allow prescription drug plans in Medicare, including Medicare Part D plans as well as standalone Medicare Advantage Prescription Drug Plans, to develop a safe prescribing and dispensing program for beneficiaries that are at risk of abuse or diversion of drugs that are frequently abused or diverted. The provision allows the Secretary of HHS to work with private drug plan sponsors to facilitate the creation and management of "lock-in" programs to curb identified fraud, abuse, and misuse of prescribed medications while at the same time ensuring that legitimate beneficiary access to needed medications is not impeded.

Such controls would prevent doctor/pharmacy shopping as well as duplicative and inappropriate drug therapies that can lead to prescription drug abuse. The conference report gives the Secretary responsibility to define an at-risk beneficiary using clinical guidelines developed in consultation with stakeholders. Plans would be able to identify enrolled Medicare beneficiaries deemed at high risk of abusing prescription drugs, and to limit such beneficiaries' choice of prescribers or pharmacies in order to better monitor their use of these medications. For example, restrictions might be placed on beneficiaries suspected of abusing or reselling certain controlled substances, but not placed on beneficiaries with cancer or other conditions for which those drugs are considered appropriate. Plan sponsors, under the conference report, would have to take into consideration where an at-risk beneficiary lives and works, as well as other relevant factors when assigning providers and pharmacies and would also consider the beneficiary's preferences unless it is deemed the cause of potential abuse. Plan sponsors also will have to comply with a number of beneficiary protections including ensuring access, notifications and disclosure requirements, as well as appeal rights. S. 524 included similar language.

Sections 705-707 – Exempting Abuse-Deterrent Formulations of Prescription Drugs from the Medicaid Additional Rebate Requirement for New Formulations of Prescription Drugs; Limiting Disclosure of Predictive Modeling and Other Analytics Technologies to Identify and Prevent Fraud, Waste, and Abuse; and Medicaid Improvement Fund

Sections 705-707 would exempt abuse deterrent formulations of opioid drugs (ADFs) from the definition of "line extension" for the purpose of calculating Medicaid rebates. In its Opioids Action Plan, FDA said its goal is to "expand access to abuse deterrent formulations to discourage abuse." And in its ADF guidance to manufacturers, the agency has said it "considers the development of these products a high public health priority." This policy was also included in the President's FY 2017 Budget, which noted that this statutory change would "incentivize continued development of abuse deterrent formulations."

The budgetary impact of the ADF policy is being offset by a policy from the President's budget that prevents the public disclosure of program integrity algorithms used to identify and predict waste, fraud, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and places the remaining savings in a Medicaid Improvement Fund. The mathematical algorithms and predictive technologies the Centers for Medicare and Medicaid Services (CMS) uses in Medicare, Medicaid, and CHIP are vital to uncovering fraud, waste, and abuse. However, if various aspects of these algorithms were to become publicly known, fraudsters could utilize the information to re-direct their schemes to other areas of the Medicare, Medicaid, and CHIP programs or adjust their schemes to avoid detection. This policy would simply prevent the disclosure of these anti-fraud tools through FOIA-related laws while still allowing CMS and state Medicaid and CHIP programs to freely share algorithms and other predictive analytical tools.

The conference provision is the same as the provision included in the House amendment.

Section 708 – Sense of Congress Regarding Treatment of Substance Abuse Epidemics

This section includes a Sense of Congress that decades of experience and research have demonstrated that a fiscally responsible approach to addressing the opioid abuse epidemic and other substance abuse epidemics requires treating such epidemics as a public health emergency emphasizing prevention, treatment, and recovery.

TITLE VIII – KINGPIN DESIGNATION IMPROVEMENT

Section 801 – Protection of Classified Information

This section incorporates the provisions of Title IV of the House amendment to S. 524, which passed the House on May 10, 2016, and its Senate companion, S. 2914, the "Kingpin Designation Improvement Act." The section amends Section 804 of the Foreign Narcotics Kingpin Designation Act to include language to protect classified information from disclosure during a federal court challenge by a designee.

Under current law, the Treasury Department's Office of Foreign Assets Control (OFAC) uses the International Emergency Economic Powers Act (IEEPA) and the Foreign Narcotics Kingpin Designation Act (the "Kingpin Act") to target and apply sanctions to international narcotics traffickers and their organizations. The Kingpin Act is the principal mechanism by which OFAC sanctions foreign persons tied to global narcotics trafficking.

OFAC's designations are often based upon classified information. Unlike in a related federal statute, the Kingpin Act does not contain such a mechanism to protect classified information from release during a "de-listing" process. That means OFAC may lose the opportunity to designate a high-level drug kingpin because it cannot risk the disclosure of classified information.

This section clarifies that OFAC can submit classified information to defend its designations *ex parte* and *in camera* in the relevant U.S. district court, thereby ensuring classified information can be protected from disclosure.

TITLE IX – DEPARTMENT OF VETERANS AFFAIRS

Section 901 – Short Title

Includes the title "Jason Simcakoski Memorial and Promise Act.''

Section 902 – Definitions

This section includes various definitions of terms used throughout Title IX.

Section 911 – Improvement of Opioid Safety Measures by the Department of Veterans Affairs

This provision requires the Secretary to expand the Opioid Safety Initiative to include all VA medical facilities within 180 days of enactment of this act, and would require that all VA employees who prescribe opioids receive education and training on pain management and safe opioid prescribing practices. The Secretary would also be required to establish enhanced standards with respect to the use of routine and random drug tests for all patients before and during opioid therapy. Directors of each medical facility will be required to designate a pain management team of health care professionals responsible for coordinating and overseeing pain management therapy and will provide an annual report identifying the members of the facility's pain management team, certification as to education and training, and compliance with the stepped-care model or other pain management policies. This provision also requires participation in state prescription drug monitoring programs; a report on the feasibility and advisability of advanced real-time tracking of opioid use data in the Opioid Therapy Risk Report tool; an increase in the availability of opioid receptor antagonists such as naloxone and a report on compliance; inclusion in the Opioid Therapy Risk Report tool of information identifying when health care providers access the tool and the most recent urine drug test for each veteran; and notification of opioid abuse risk in the computerized patient record system.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 912 – Strengthening of Joint Working Group on Pain Management of the Department of Veterans Affairs and the Department of Defense

H.R. 4063 and S. 2921, as reported, require that VA and the Department of Defense (DOD) ensure that the Health Executive Committee's Pain Management Working Group (PMWG) includes a focus on the opioid prescribing practices of health care providers of each Department; the ability of each Department to manage acute and chronic pain, including training health care providers with respect to pain management; the use by each Department of complementary and integrative health; the concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines; the use of care transition plans by health care providers of each Department to address case management issues for patients receiving opioid therapy who transition between inpatient and outpatient settings; coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from DOD to VA; and the ability of each Department to screen, identify, and treat patients with substance use disorders who are seeking treatment for acute and chronic pain.

This provision also ensures the PMWG coordinates its activities with other relevant working groups; consults with other relevant federal agencies, including the Centers for Disease Control and Prevention; consults with the VA and DOD with respect to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; and reviews and comments on the guideline before any update to such guideline is released.

This provision requires VA and DOD to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain within 180 days of enactment. This provision requires that the PMWG, in coordination with the Clinical Practice Guideline VA/DOD Management of Opioid Therapy for Chronic Pain Working Group, examine whether the guidelines should include numerous elements. The elements to be considered include, but are not limited to, enhanced guidance with respect to: opioid and other drug prescription practices; treatment of patients with behaviors or comorbidities that require co-management of opioid therapy; patient status assessments conducted by providers; governance of the methodologies used by VA and DOD providers to taper opioid therapy; appropriate case management for opioid patients transitioning from an inpatient setting to an outpatient setting; appropriate case management for opioid patients transitioning from active duty to post-military health care networks; how providers should discuss with patients options for pain management therapies before initiating opioid therapy; provision of evidence-based non-opioid treatments within VA and DOD; and consideration of guidelines developed by CDC for safely prescribing opioids.

Section 913 – Review, Investigation, and Report on Use of Opioids in Treatment by Department Of Veterans Affairs

This provision requires GAO, not later than 2 years after enactment, to submit a report on the Opioid Safety Initiative and the opioid prescribing practices of VA health care providers. This provision also requires semi-annual progress reports on the implementation of any GAO

recommendations generated by this report. The Secretary must also review and report annually on the patient population receiving opioid therapy and the prescription rates of each medical facility and conduct investigations, through the Office of the Medical Inspector, on prescription rates that conflict with or are otherwise inconsistent with the standards of appropriate and safe care.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 914 – Mandatory Disclosure of Certain Veteran Information to State Controlled Substance Monitoring Programs

This provision includes the H.R. 4063, as reported, language requiring that VA providers shall disclose certain veteran information to state controlled substance monitoring programs.

Section 915 – Elimination of Copayment Requirement for Veterans Receiving Opioid Antagonists or Education on Use of Opioid Antagonists

This provision includes the S. 2921, as reported, language that would eliminate the copayment requirement for veterans receiving opioid antagonists or education on the use of opioid antagonists.

Section 921 – Community Meetings on Improving Care Furnished by Department of Veterans Affairs

This provision requires that, within 90 days of the enactment of this act, and quarterly thereafter, each VA medical facility hosts a public community meeting on improving VA health care; and within one year of the enactment of this act, and at least annually thereafter, that each community-based outpatient clinic (CBOC) hosts such a community meeting. These meetings will require regular senior leadership attendance and notice will be given to the Committees on Veterans' Affairs of the House and of the Senate and the Members of Congress who represent the area in which the facility is located at least ten days in advance.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 922 – Improvement of Awareness of Patient Advocacy Program and Patient Bill of Rights of Department of Veterans Affairs

This provision would require, within 90 days of the enactment of this act, the display of, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients at each VA medical facility: (1) the purposes of the VA Patient Advocacy Program and the contact information for the patient advocate at each medical facility; and (2) the rights and responsibilities of patients and family members and, with respect to community living centers and other VA residential facilities.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 923 – Comptroller General Report on Patient Advocacy Programs of Department of Veterans Affairs

Both H.R. 4063 and S.2921 require that, within two years of the enactment of this act, GAO submit a report on the VA Patient Advocacy Program to the Committees on Veterans' Affairs of the House and of the Senate. The report will include: (1) a description of the Program, including the Program's purpose, activities, and sufficiency in achieving its purpose; (2) an assessment of the sufficiency of the Program's staffing; (3) an assessment of the Program's employee training; (4) an assessment of veterans' and family members' awareness of and utilization of the Program; (5) recommendations for improving the Program; and (6) any other information the GAO considers appropriate.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 924 – Establishment of Office of Patient Advocacy of the Department of Veterans Affairs

This section establishes an office of patient advocacy within the Office of the Undersecretary for Heath of the Department of Veterans Affairs. This office will ensure patient advocates appropriately advocate for veteran patients and are trained in their responsibilities.

Section 931 – Expansion of Research and Education on and Delivery of Complementary and Integrative Health to Veterans

H.R. 4063, as reported, establishes a Commission to examine the evidence-based therapy treatment model used by VA for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health as standard practice throughout the Department. The Commission would: (1) examine the efficacy of the evidence-based therapy model used by VA to treat mental health illnesses and identify areas of improvement; (2) conduct a patient-centered survey within each VISN to examine: the experiences of veterans with VA facilities regarding mental health care, the experiences of veterans with non-VA facilities regarding mental health care, the preferences of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective, the experience, if any, of veterans with respect to the complementary and integrative health treatment therapies, the prevalence of prescribing medication to veterans seeking treatment for mental health disorders through VA, and the outreach efforts of VA regarding the availability of benefits and treatments for veterans for addressing mental health issues; (3) examine available research on complementary and integrative health for mental health disorders in areas of therapy including: music therapy, equine therapy, training and caring for service dogs, yoga therapy, acupuncture therapy, meditation therapy, outdoor sports therapy, hyperbaric oxygen therapy, accelerated resolution therapy, art therapy, magnetic resonance therapy, and others; (4) study the sufficiency of VA resources to deliver quality mental health care; and (5) study the current treatments and resources available within VA and assess: the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans, the number of veterans who have been diagnosed with mental health issues, the percentage of veterans who have

completed VA counseling sessions, and the efforts of VA to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by VA.

Section 932 – Pilot Program on Integration of Complementary and Integrative Health and Related Issues for Veterans and Family Members of Veterans

The provision requires that the Secretary, informed by the Commission's findings, commence a pilot program to assess the feasibility and advisability of using wellness-based programs to complement pain management and related health care services. The pilot program would last for three years and be carried out at no fewer than 15 VA facilities providing pain management, two of which must be polytrauma centers. The Secretary should prioritize medical centers at which there is a prescription rate that is inconsistent with the standards of appropriate care when selecting medical centers for the pilot. The Secretary will report on findings and conclusions regarding the use and efficacy of complementary and integrative health services established under the pilot program, the outreach conducted by VA about the pilot, and an assessment of the benefit of the pilot program to covered veterans, as well as identify any unresolved barriers to VA's use of complementary and integrative medicine, and make recommendations for the continuation or expansion of the pilot program.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 941 – Additional Requirements for Hiring of Health Care Providers by Department of Veterans Affairs

This provision would require that, as part of the hiring process for all heath care providers considered for a position after the date of the enactment of this act, that the Secretary require from the medical board of the State in which the applicant is licensed: (1) information on any violations of the requirements of medical license over the previous 20 years; and (2) information on whether the provider has entered into any settlement agreements for disciplinary charges related to the practice of medicine.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 942 – Provision of Information on Health Care Providers of Department of Veterans Affairs to State Medical Boards

This provision would require that VA provide to the medical board of each State in which the provider is licensed information regarding violations, regardless of whether the board has requested such information.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 943 – Report on Compliance by Department of Veterans Affairs with Reviews of Health Care Providers Leaving the Department or Transferring to Other Facilities

This provision would require that, within 180 days of the enactment of this act, that the Secretary submit to the Committees on Veterans' Affairs of the House and of the Senate a report on VA's compliance with VA policy to conduct a review of each provider who transfers from another VA medical facility, retires, or is terminated, and to take appropriate actions with respect to any concerns, complaints, or allegations against the provider.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 951 – Modification to Limitation on Bonus and Awards

This provision limits the amounts of funds available for payment as bonuses and awards and directs those amounts now available within the budget toward the payment for the programs and services directed in this title.

This section also includes a Sense of Congress that states the limitation under this subsection should not disproportionately impact lower-wage employees within the VA.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of Rule XXI of the Rules of the House of Representatives, the conference report and joint explanatory statement contain no earmarks, limited tax benefits, or limited tariff benefits.

CONSTITUTIONAL STATEMENT OF AUTHORITY

Congress has the power to enact this legislation pursuant to the following: Article I, Section 8, Clause 3 of the United States Constitution.

S. 524

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
For consideration of the Senate bill and the House amendments, and modifications committed to conference:	
Mr. Upton	
Mr. Pitts	
Mr. Lance	
Mr. Guthrie	
Mr. Kinzinger of Illinois	
Mr. Bucshon	
Mrs. Brooks of Indiana	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
Mr. Goodlatte	
Mr. Sensenbrenner	
Mr. Smith of Texas	
Mr. Marino	
Mr. Collins of Georgia	
Mr. Trott	
Mr. Bishop of Michigan	
Mr. McCarthy	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
~~Mr. Pallone~~	
~~Mr. Ben Ray Luján of New Mexico~~	
~~Mr. Sarbanes~~	
~~Mr. Gene Green of Texas~~	
~~Mr. Conyers~~	
~~Ms. Jackson Lee~~	
~~Ms. Judy Chu of California~~	
~~Mr. Cohen~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
~~Ms. Esty~~	
~~Ms. Kuster~~	
~~Mr. Courtney~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Education and the Workforce, for consideration of title VII of the House amendment, and modifications committed to conference:	
Mr. Barletta	
Mr. Carter of Georgia	
~~Mr. Scott of Virginia~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Veterans' Affairs, for consideration of title III of the House amendment, and modifications committed to conference:	
Mr. Bilirakis	
Mrs. Walorski	
~~Mr. Ruiz~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
From the Committee on Ways and Means, for consideration of sec. 705 of the Senate bill, and sec. 804 of the House amendment, and modifications committed to conference:	
Mr. Meehan	
Mr. Dold	
~~Mr. McDermott~~	

S. 524—Continued

Managers on the part of the HOUSE	*Managers on the part of the* SENATE
	Mr. Grassley
	Mr. Alexander
	Mr. Hatch
	Mr. Sessions
	[redacted]
	[redacted]
	[redacted]