

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:

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents.

TITLE I—PREVENTION AND EDUCATION

Sec. 101. Task force on pain management.

Sec. 102. Awareness campaigns.

Sec. 103. Community-based coalition enhancement grants to address local drug
crises.

Sec. 104. Information materials and resources to prevent addiction related to
youth sports injuries.

Sec. 105. Assisting veterans with military emergency medical training to meet
requirement for becoming civilian health care professionals.

Sec. 106. FDA opioid action plan.

Sec. 107. Improving access to overdose treatment.

Sec. 108. NIH opioid research.

Sec. 109. National All Schedules Prescription Electronic Reporting Reauthor-
ization.

Sec. 110. Opioid overdose reversal medication access and education grant pro-
grams.

TITLE II—LAW ENFORCEMENT AND TREATMENT

Sec. 201. Comprehensive Opioid Abuse Grant Program.

Sec. 202. First responder training.

Sec. 203. Prescription drug take back expansion.

TITLE III—TREATMENT AND RECOVERY

Sec. 301. Evidence-based prescription opioid and heroin treatment and inter-
ventions demonstration.

Sec. 302. Building communities of recovery.

Sec. 303. Medication-assisted treatment for recovery from addiction.

TITLE IV—ADDRESSING COLLATERAL CONSEQUENCES

Sec. 401. GAO report on recovery and collateral consequences.

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

Sec. 501. Improving treatment for pregnant and postpartum women.

Sec. 502. Veterans treatment courts.

Sec. 503. Infant plan of safe care.

Sec. 504. GAO report on neonatal abstinence syndrome (NAS).

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

Sec. 601. State demonstration grants for comprehensive opioid abuse response.

TITLE VII—MISCELLANEOUS

Sec. 701. Grant accountability and evaluations.

Sec. 702. Partial fills of schedule II controlled substances.

Sec. 703. Good samaritan assessment.

Sec. 704. Programs to prevent prescription drug abuse under Medicare parts C and D.

Sec. 705. Excluding abuse-deterrent formulations of prescription drugs from the Medicaid additional rebate requirement for new formulations of prescription drugs.

Sec. 706. Limiting disclosure of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse.

Sec. 707. Medicaid Improvement Fund.

Sec. 708. Sense of the Congress regarding treatment of substance abuse epidemics.

TITLE VIII—KINGPIN DESIGNATION IMPROVEMENT

Sec. 801. Protection of classified information in Federal court challenges relating to designations under the Narcotics Kingpin Designation Act.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

Sec. 901. Short title.

Sec. 902. Definitions.

Subtitle A—Opioid Therapy and Pain Management

Sec. 911. Improvement of opioid safety measures by Department of Veterans Affairs.

Sec. 912. Strengthening of joint working group on pain management 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.

Sec. 914. Mandatory disclosure of certain veteran information to State controlled substance monitoring programs.

Sec. 915. Elimination of copayment requirement for veterans receiving opioid antagonists or education on use of opioid antagonists.

Subtitle B—Patient Advocacy

Sec. 921. Community meetings on improving care furnished by Department of Veterans Affairs.

Sec. 922. Improvement of awareness of patient advocacy program and patient bill of rights of Department of Veterans Affairs.

Sec. 923. Comptroller General report on patient advocacy program of Department of Veterans Affairs.

Sec. 924. Establishment of Office of Patient Advocacy of the Department of Veterans Affairs.

Subtitle C—Complementary and Integrative Health

- Sec. 931. Expansion of research and education on and delivery of complementary and integrative health to veterans.
- Sec. 932. Expansion of research and education on and delivery of complementary and integrative health to veterans.
- Sec. 933. Pilot program on integration of complementary and integrative health and related issues for veterans and family members of veterans.

Subtitle D—Fitness of Health Care Providers

- Sec. 941. Additional requirements for hiring of health care providers by Department of Veterans Affairs.
- Sec. 942. Provision of information on health care providers of Department of Veterans Affairs to State medical boards.
- Sec. 943. Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities.

Subtitle E—Other Matters

- Sec. 951. Modification to limitation on awards and bonuses.

1 **TITLE I—PREVENTION AND**
2 **EDUCATION**

3 **SEC. 101. TASK FORCE ON PAIN MANAGEMENT.**

4 (a) DEFINITIONS.—In this section:

5 (1) SECRETARY.—The term “Secretary” means
6 the Secretary of Health and Human Services.

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

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

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

3 (1) representatives of—

4 (A) the Department of Health and Human
5 Services and relevant agencies within the De-
6 partment of Health and Human Services;

7 (B) the Department of Veterans Affairs;

8 (C) the Department of Defense; and

9 (D) the Office of National Drug Control
10 Policy;

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

13 (3) currently licensed and practicing phar-
14 macists and pharmacies;

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

18 (5) representatives of—

19 (A) pain management professional organi-
20 zations;

21 (B) the mental health treatment commu-
22 nity;

23 (C) the addiction treatment community, in-
24 cluding individuals in recovery from substance
25 use disorder;

1 (D) pain advocacy groups, including pa-
2 tients;

3 (E) veteran service organizations;

4 (F) groups with expertise on overdose re-
5 versal, including first responders;

6 (G) State medical boards; and

7 (H) hospitals;

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

11 (7) experts in the field of minority health.

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

15 (e) DUTIES.—The task force shall—

16 (1) identify, review, and, as appropriate, deter-
17 mine whether there are gaps in or inconsistencies be-
18 tween best practices for pain management (including
19 chronic and acute pain) developed or adopted by
20 Federal agencies;

21 (2) not later than 1 year after the date on
22 which the task force is convened under subsection
23 (b), propose updates to best practices and rec-
24 ommendations on addressing gaps or inconsistencies
25 identified under paragraph (1), as appropriate, and

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

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

6 (B) recommendations from relevant con-
7 ferences and existing relevant evidence-based
8 guidelines;

9 (C) ongoing efforts at the State and local
10 levels and by medical professional organizations
11 to develop improved pain management strate-
12 gies, including consideration of differences with-
13 in and between classes of opioids, the avail-
14 ability of opioids with abuse deterrent tech-
15 nology, and pharmacological, nonpharma-
16 cological, and medical device alternatives to
17 opioids to reduce opioid monotherapy in appro-
18 priate cases;

19 (D) the management of high-risk popu-
20 lations who receive opioids in the course of
21 medical care, other than for pain management;

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

1 (F) private sector, State, and local govern-
2 ment efforts related to pain management and
3 prescribing pain medication;

4 (3) provide the public with at least 90 days to
5 submit comments on any proposed updates and rec-
6 ommendations under paragraph (2); and

7 (4) develop a strategy for disseminating infor-
8 mation about best practices for pain management
9 (including chronic and acute pain) to stakeholders,
10 if appropriate.

11 (f) LIMITATION.—The task force shall not have rule-
12 making authority.

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

15 **SEC. 102. AWARENESS CAMPAIGNS.**

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

24 (b) TOPICS.—The education and awareness cam-
25 paigns under subsection (a) shall address—

1 (1) the dangers of opioid abuse;

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

5 (3) the detection of early warning signs of ad-
6 diction.

7 (c) OTHER REQUIREMENTS.—The education and
8 awareness campaigns under subsection (a) shall, as appro-
9 priate—

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

12 (2) emphasize—

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

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

17 (3) bring greater public awareness to the dan-
18 gerous effects of fentanyl when mixed with heroin or
19 abused in a similar manner.

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

22 (a) DEFINITIONS.—In this section:

23 (1) ADMINISTRATOR.—The term “Adminis-
24 trator” means the Administrator of the Substance
25 Abuse and Mental Health Services Administration.

1 (2) DIRECTOR.—The term “Director” means
2 the Director of the Office of National Drug Control
3 Policy.

4 (3) DRUG-FREE COMMUNITIES ACT OF 1997.—
5 The term “Drug-Free Communities Act of 1997”
6 means chapter 2 of the National Narcotics Leader-
7 ship Act of 1988 (21 U.S.C. 1521 et seq.).

8 (4) ELIGIBLE ENTITY.—The term “eligible enti-
9 ty” means an organization that—

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

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

17 (i) significantly higher than the na-
18 tional average as determined by the Sec-
19 retary (including appropriate consideration
20 of the results of the Monitoring the Future
21 Survey published by the National Institute
22 on Drug Abuse and the National Survey
23 on Drug Use and Health published by the
24 Substance Abuse and Mental Health Serv-
25 ices Administration); or

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

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

9 (A) a sudden increase in demand for par-
10 ticular drug abuse treatment services relative to
11 previous demand; and

12 (B) a lack of resources in the area to ad-
13 dress the emerging problem.

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

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

20 (B) the abuse of prescription medications,
21 specifically opioids or methamphetamines, that
22 is significantly higher than the national aver-
23 age, over a sustained period of time, as docu-
24 mented by local data; or

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

3 (7) OPIOID.—The term “opioid” means any
4 drug having an addiction-forming or addiction-sus-
5 taining liability similar to morphine or being capable
6 of conversion into a drug having such addiction-
7 forming or addiction-sustaining liability.

8 (b) PROGRAM AUTHORIZED.—The Director, in co-
9 ordination with the Administrator, may make grants to
10 eligible entities to implement comprehensive community-
11 wide strategies that address local drug crises and emerg-
12 ing drug abuse issues within the area served by the eligible
13 entity.

14 (c) APPLICATION.—

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

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

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

3 (1) for programs designed to implement com-
4 prehensive community-wide prevention strategies to
5 address the local drug crisis in the area served by
6 the eligible entity, in accordance with the plan sub-
7 mitted under subsection (c)(2);

8 (2) to obtain specialized training and technical
9 assistance from the organization funded under sec-
10 tion 4 of Public Law 107–82 (21 U.S.C. 1521 note);
11 and

12 (3) for programs designed to implement com-
13 prehensive community-wide strategies to address
14 emerging drug abuse issues in the community.

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

21 (f) EVALUATION.—A grant under this section shall
22 be subject to the same evaluation requirements and proce-
23 dures as the evaluation requirements and procedures im-
24 posed on the recipient of a grant under the Drug-Free
25 Communities Act of 1997, and may also include an evalua-

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

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

7 (h) DELEGATION AUTHORITY.—The Director may
8 enter into an interagency agreement with the Adminis-
9 trator to delegate authority for the execution of grants and
10 for such other activities as may be necessary to carry out
11 this section.

12 (i) AUTHORIZATION OF APPROPRIATIONS.—For the
13 purpose of carrying out this section, there are authorized
14 to be appropriated \$5,000,000 for each of fiscal years
15 2017 through 2021.

16 **SEC. 104. INFORMATION MATERIALS AND RESOURCES TO**
17 **PREVENT ADDICTION RELATED TO YOUTH**
18 **SPORTS INJURIES.**

19 (a) REPORT.—The Secretary of Health and Human
20 Services (referred to in this section as the “Secretary”)
21 shall, not later than 24 months after the date of the enact-
22 ment of this section, make publicly available on the appro-
23 priate website of the Department of Health and Human
24 Services a report determining the extent to which informa-
25 tional materials and resources described in subsection (c)

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

5 (b) DEVELOPMENT OF INFORMATIONAL MATERIALS
6 AND RESOURCES.—The Secretary may, for purposes of
7 preventing substance use disorder in teenagers and adoles-
8 cents who are injured playing youth sports and are subse-
9 quently prescribed an opioid, not later than 12 months
10 after the report is made publicly available under sub-
11 section (a), and taking into consideration the findings of
12 such report and in coordination with relevant health care
13 provider groups, facilitate the development of informa-
14 tional materials and resources described in subsection (c)
15 for teenagers and adolescents who play youth sports, fami-
16 lies of such teenagers and adolescents, nurses, youth
17 sports groups, and relevant health care provider groups.

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

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

3 (d) NO ADDITIONAL FUNDS.—No additional funds
4 are authorized to be appropriated for the purpose of car-
5 rying out this section. This section shall be carried out
6 using amounts otherwise available for such purpose.

7 **SEC. 105. ASSISTING VETERANS WITH MILITARY EMER-**
8 **GENCY MEDICAL TRAINING TO MEET RE-**
9 **QUIREMENT FOR BECOMING CIVILIAN**
10 **HEALTH CARE PROFESSIONALS.**

11 Part B of title III of the Public Health Service Act
12 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
13 tion 314 the following:

14 **“SEC. 315. ASSISTING VETERANS WITH MILITARY EMER-**
15 **GENCY MEDICAL TRAINING TO MEET RE-**
16 **QUIREMENTS FOR BECOMING CIVILIAN**
17 **HEALTH CARE PROFESSIONALS.**

18 “(a) PROGRAM.—

19 “(1) IN GENERAL.—The Secretary may estab-
20 lish a program, in consultation with the Secretary of
21 Labor, consisting of awarding demonstration grants
22 to States to streamline State requirements and pro-
23 cedures in order to assist veterans who held certain
24 military occupational specialties related to medical
25 care or who have completed certain medical training

1 while serving in the Armed Forces of the United
2 States to meet certification, licensure, and other re-
3 quirements applicable to civilian health care profes-
4 sions (such as emergency medical technician, para-
5 medic, licensed practical nurse, registered nurse,
6 physical therapy assistant, or physician assistant
7 professions) in the State.

8 “(2) CONSULTATION AND COLLABORATION.—In
9 determining the eligible military occupational spe-
10 cialties or training courses and the assistance re-
11 quired as described in paragraph (1), the Secretary
12 shall consult with the Secretary of Defense, the Sec-
13 retary of Veterans Affairs, and the Assistant Sec-
14 retary of Labor for Veterans’ Employment and
15 Training, and shall collaborate with the initiatives
16 carried out under section 4114 of title 38, United
17 States Code, and sections 1142 through 1144 of
18 title 10, United States Code.

19 “(b) USE OF FUNDS.—Amounts received as a dem-
20 onstration grant under this section shall be used to—

21 “(1) prepare and implement a plan to stream-
22 line State requirements and procedures as described
23 in subsection (a), including by—

24 “(A) determining the extent to which the
25 requirements for the education, training, and

1 skill level of civilian health care professions
2 (such as emergency medical technicians, para-
3 medics, licensed practical nurses, registered
4 nurses, physical therapy assistants, or physician
5 assistants) in the State are equivalent to re-
6 quirements for the education, training, and skill
7 level of veterans who served in medical related
8 fields while a member of the Armed Forces of
9 the United States; and

10 “(B) identifying methods, such as waivers,
11 for veterans who served in medical related fields
12 while a member of the Armed Forces of the
13 United States to forgo or meet any such equiva-
14 lent State requirements; and

15 “(2) if necessary to meet workforce shortages
16 or address gaps in education, training, or skill level
17 to meet certification, licensure or other requirements
18 applicable to becoming a civilian health care profes-
19 sional (such as an emergency medical technician,
20 paramedic, licensed practical nurse, registered nurse,
21 physical therapy assistant, or physician assistant
22 professions) in the State, develop or expand career
23 pathways at institutions of higher education to sup-
24 port veterans in meeting such requirements.

1 “(c) REPORT.—Upon the completion of the dem-
2 onstration program under this section, the Secretary shall
3 submit to Congress a report on the program.

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

8 “(e) SUNSET.—The demonstration program under
9 this section shall not exceed 5 years.”.

10 **SEC. 106. FDA OPIOID ACTION PLAN.**

11 (a) IN GENERAL.—

12 (1) NEW DRUG APPLICATION.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (B), prior to the approval pursuant to an
15 application submitted under section 505(b) of
16 the Federal Food, Drug, and Cosmetic Act (21
17 U.S.C. 355(b)) of a new drug that is an opioid,
18 the Secretary of Health and Human Services
19 (referred to in this section as the “Secretary”)
20 shall refer the application to an advisory com-
21 mittee of the Food and Drug Administration to
22 seek recommendations from such advisory com-
23 mittee.

24 (B) PUBLIC HEALTH EXEMPTION.—A re-
25 ferral to an advisory committee under subpara-

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

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

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

9 (iii) submits a notice containing the
10 rationale for such findings to the Com-
11 mittee on Health, Education, Labor, and
12 Pensions of the Senate and the Committee
13 on Energy and Commerce of the House of
14 Representatives.

15 (2) PEDIATRIC OPIOID LABELING.—The Sec-
16 retary shall convene the Pediatric Advisory Com-
17 mittee of the Food and Drug Administration to seek
18 recommendations from such Committee regarding a
19 framework for the inclusion of information in the la-
20 beling of drugs that are opioids relating to the use
21 of such drugs in pediatric populations before the
22 Secretary approves any labeling or change to label-
23 ing for any drug that is an opioid intended for use
24 in a pediatric population.

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

4 (b) PRESCRIBER EDUCATION.—Not later than 1 year
5 after the date of the enactment of this Act, the Secretary,
6 acting through the Commissioner of Food and Drugs, as
7 part of the Food and Drug Administration’s evaluation
8 of the Extended-Release/Long-Acting Opioid Analgesics
9 Risk Evaluation and Mitigation Strategy, and in consulta-
10 tion with relevant stakeholders, shall develop recommenda-
11 tions regarding education programs for prescribers of
12 opioids pursuant to section 505–1 of the Federal Food,
13 Drug, and Cosmetic Act (21 U.S.C. 355–1), including rec-
14 ommendations on—

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

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

19 (c) GUIDANCE ON EVALUATING THE ABUSE DETER-
20 RENCE OF GENERIC SOLID ORAL OPIOID DRUG PROD-
21 UCTS.—Not later than 18 months after the end of the pe-
22 riod for public comment on the draft guidance entitled
23 “General Principles for Evaluating the Abuse Deterrence
24 of Generic Solid Oral Opioid Drug Products” issued by
25 the Center for Drug Evaluation and Research of the Food

1 and Drug Administration in March 2016, the Commis-
2 sioner of Food and Drugs shall publish in the Federal
3 Register a final version of such guidance.

4 **SEC. 107. IMPROVING ACCESS TO OVERDOSE TREATMENT.**

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

9 **“SEC. 544. GRANTS FOR REDUCING OVERDOSE DEATHS.**

10 **“(a) ESTABLISHMENT.—**

11 **“(1) IN GENERAL.—**The Secretary shall award
12 grants to eligible entities to expand access to drugs
13 or devices approved or cleared under the Federal
14 Food, Drug, and Cosmetic Act for emergency treat-
15 ment of known or suspected opioid overdose.

16 **“(2) MAXIMUM GRANT AMOUNT.—**A grant
17 awarded under this section may not be for more
18 than \$200,000 per grant year.

19 **“(3) ELIGIBLE ENTITY.—**For purposes of this
20 section, the term ‘eligible entity’ means a Federally
21 qualified health center (as defined in section
22 1861(aa) of the Social Security Act), an opioid
23 treatment program under part 8 of title 42, Code of
24 Federal Regulations, any practitioner dispensing
25 narcotic drugs pursuant to section 303(g) of the

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

3 “(4) PRESCRIBING.—For purposes of this sec-
4 tion, the term ‘prescribing’ means, with respect to a
5 drug or device approved or cleared under the Fed-
6 eral Food, Drug, and Cosmetic Act for emergency
7 treatment of known or suspected opioid overdose,
8 the practice of prescribing such drug or device—

9 “(A) in conjunction with an opioid pre-
10 scription for patients at an elevated risk of
11 overdose;

12 “(B) in conjunction with an opioid agonist
13 approved under section 505 of the Federal
14 Food, Drug, and Cosmetic Act for the treat-
15 ment of opioid use disorder;

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

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

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

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

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

7 “(2) the criteria that will be used to identify eli-
8 gible patients to participate in such program; and

9 “(3) a plan for sustaining the program after
10 Federal support for the program has ended.

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

16 “(1) To establish a program for prescribing a
17 drug or device approved or cleared under the Fed-
18 eral Food, Drug, and Cosmetic Act for emergency
19 treatment of known or suspected opioid overdose.

20 “(2) To train and provide resources for health
21 care providers and pharmacists on the prescribing of
22 drugs or devices approved or cleared under the Fed-
23 eral Food, Drug, and Cosmetic Act for emergency
24 treatment of known or suspected opioid overdose.

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

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

11 “(5) To establish protocols to connect patients
12 who have experienced a drug overdose with appro-
13 priate treatment, including medication-assisted
14 treatment and appropriate counseling and behavioral
15 therapies.

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

22 “(e) REPORTS BY THE SECRETARY.—Not later than
23 5 years after the date on which the first grant under this
24 section is awarded, the Secretary shall submit to the ap-
25 propriate committees of the House of Representatives and

1 of the Senate a report aggregating the information re-
2 ceived from the grant recipients for such year under sub-
3 section (d) and evaluating the outcomes achieved by the
4 programs funded by grants awarded under this section.

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 is authorized to be appropriated to carry out this section,
7 \$5,000,000 for the period of fiscal years 2017 through
8 2021.”.

9 (b) IMPROVING ACCESS TO OVERDOSE TREAT-
10 MENT.—

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

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

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

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

13 (C) The Secretary of Veterans Affairs may
14 provide information to prescribers within De-
15 partment of Veterans Affairs medical facilities
16 on best practices for prescribing or co-pre-
17 scribing a drug or device approved or cleared
18 under the Federal Food, Drug, and Cosmetic
19 Act (21 U.S.C. 301 et seq.) for emergency
20 treatment of known or suspected opioid over-
21 dose, including for patients receiving chronic
22 opioid therapy and patients being treated for
23 opioid use disorders.

1 (2) RULE OF CONSTRUCTION.—Nothing in this
2 subsection should be construed to establish or con-
3 tribute to a medical standard of care.

4 **SEC. 108. NIH OPIOID RESEARCH.**

5 (a) IN GENERAL.—The Director of the National In-
6 stitutes of Health (referred to in this section as the
7 “NIH”) may intensify and coordinate fundamental,
8 translational, and clinical research of the NIH with re-
9 spect to—

10 (1) the understanding of pain;

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

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

15 (b) PRIORITY AND DIRECTION.—The prioritization
16 and direction of the Federally funded portfolio of pain re-
17 search studies shall consider recommendations made by
18 the Interagency Pain Research Coordinating Committee in
19 concert with the Pain Management Best Practices Inter-
20 Agency Task Force, and in accordance with the National
21 Pain Strategy, the Federal Pain Research Strategy, and
22 the NIH-Wide Strategic Plan for Fiscal Years 2016–
23 2020, the latter of which calls for the relative burdens of
24 individual diseases and medical disorders to be regarded

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

3 **SEC. 109. NATIONAL ALL SCHEDULES PRESCRIPTION ELEC-**
4 **TRONIC REPORTING REAUTHORIZATION.**

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

9 “(1) foster the establishment of State-adminis-
10 tered controlled substance monitoring systems in
11 order to ensure that health care providers have ac-
12 cess to the accurate, timely prescription history in-
13 formation that they may use as a tool for the early
14 identification of patients at risk for addiction in
15 order to initiate appropriate medical interventions
16 and avert the tragic personal, family, and commu-
17 nity consequences of untreated addiction; and”.

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

21 (1) in subsection (a)(1)—

22 (A) in the matter preceding subparagraph
23 (A), by inserting “, in consultation with the Ad-
24 ministrator of the Substance Abuse and Mental
25 Health Services Administration and Director of

1 the Centers for Disease Control and Preven-
2 tion,” after “the Secretary”;

3 (B) in subparagraph (A), by striking “or”;

4 (C) in subparagraph (B), by striking the
5 period at the end and inserting “; or”; and

6 (D) by adding at the end the following:

7 “(C) to maintain an existing State-con-
8 trolled substance monitoring program.”;

9 (2) by amending subsection (b) to read as fol-
10 lows:

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

18 (3) in subsection (c)—

19 (A) in paragraph (1)(B)—

20 (i) in the matter preceding clause (i),
21 by striking “(a)(1)(B)” and inserting
22 “(a)(1)(B) or (a)(1)(C)”;

23 (ii) in clause (i), by striking “program
24 to be improved” and inserting “program to
25 be improved or maintained”;

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

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

5 “(iii) a plan to apply the latest ad-
6 vances in health information technology, to
7 the extent practicable, in order to incor-
8 porate prescription drug monitoring pro-
9 gram data directly into the workflow of
10 prescribers and dispensers to ensure timely
11 access to patients’ controlled prescription
12 drug history;”;

13 (v) in clause (iv) (as so redesignated),
14 by striking “; and” and inserting the fol-
15 lowing: “and at least one health informa-
16 tion technology system such as electronic
17 health records, health information ex-
18 changes, or e-prescribing systems;”;

19 (vi) in clause (v) (as so redesign-
20 ated)—

21 (I) by striking “public health”
22 and inserting “public health or safe-
23 ty”; and

24 (II) by striking the period and
25 inserting “; and”; and

1 (vii) by adding at the end the fol-
2 lowing:

3 “(vi) information, where applicable, on
4 how the controlled substance monitoring
5 program jointly works with the applicant’s
6 respective State substance abuse agency to
7 ensure information collected and main-
8 tained by the controlled substance moni-
9 toring program is used to inform the provi-
10 sion of clinically appropriate substance use
11 disorder services to individuals in need.”;

12 (B) in paragraph (3)—

13 (i) by striking “If a State that sub-
14 mits” and inserting the following:

15 “(A) IN GENERAL.—If a State that sub-
16 mits”;

17 (ii) by inserting before the period at
18 the end “and include timelines for full im-
19 plementation of such interoperability. The
20 State shall also describe the manner in
21 which it will achieve interoperability be-
22 tween its monitoring program and health
23 information technology systems, as allow-
24 able under State law, and include timelines

1 for the implementation of such interoper-
2 ability”; and

3 (iii) by adding at the end the fol-
4 lowing:

5 “(B) MONITORING OF EFFORTS.—The
6 Secretary shall monitor State efforts to achieve
7 interoperability, as described in subparagraph
8 (A).”; and

9 (C) in paragraph (5)—

10 (i) by striking “implement or im-
11 prove” and inserting “establish, improve,
12 or maintain”; and

13 (ii) by adding at the end the fol-
14 lowing: “The Secretary shall redistribute
15 any funds that are so returned among the
16 remaining grantees under this section in
17 accordance with the formula described in
18 subsection (a)(2)(B).”;

19 (4) in subsection (d)—

20 (A) in the matter preceding paragraph
21 (1)—

22 (i) by striking “In implementing or
23 improving” and all that follows through
24 “(a)(1)(B)” and inserting “In establishing,
25 improving, or maintaining a controlled sub-

1 stance monitoring program under this sec-
2 tion, a State shall comply, or with respect
3 to a State that applies for a grant under
4 subparagraph (B) or (C) of subsection
5 (a)(1)”; and

6 (ii) by striking “public health” and in-
7 serting “public health or safety”; and

8 (B) by adding at the end the following:

9 “(5) The State shall report on interoperability
10 with the controlled substance monitoring program of
11 Federal agencies, where appropriate, interoperability
12 with health information technology systems such as
13 electronic health records, health information ex-
14 changes, and e-prescribing, where appropriate, and
15 whether or not the State provides automatic, up-to-
16 date, or daily information about a patient when a
17 practitioner (or the designee of a practitioner, where
18 permitted) requests information about such pa-
19 tient.”;

20 (5) in subsections (e), (f)(1), and (g), by strik-
21 ing “implementing or improving” each place it ap-
22 pears and inserting “establishing, improving, or
23 maintaining”;

24 (6) in subsection (f)—

25 (A) in paragraph (1)—

1 (i) in subparagraph (B), by striking
2 “misuse of a schedule II, III, or IV sub-
3 stance” and inserting “misuse of a con-
4 trolled substance included in schedule II,
5 III, or IV of section 202(c) of the Con-
6 trolled Substances Act”; and

7 (ii) in subparagraph (D)—

8 (I) by inserting “a State sub-
9 stance abuse agency,” after “State
10 health department,”; and

11 (II) by striking “such depart-
12 ment, program, or administration”
13 each place it appears and inserting
14 “such department, program, agency,
15 or administration” in each such place;
16 and

17 (B) by adding at the end the following:

18 “(3) EVALUATION AND REPORTING.—Subject
19 to subsection (g), a State receiving a grant under
20 subsection (a) shall provide the Secretary with ag-
21 gregate data to enable the Secretary—

22 “(A) to evaluate the success of the State’s
23 program in achieving its purposes; or

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

1 “(4) RESEARCH BY OTHER ENTITIES.—A de-
2 partment, program, agency, or administration receiv-
3 ing nonidentifiable information under paragraph
4 (1)(D) may make such information available to
5 other entities for research purposes.”;

6 (7) by striking subsection (k);

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

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

12 (10) by inserting after subsection (g) the fol-
13 lowing:

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

17 “(1) facilitate prescriber and dispenser use of
18 the State’s controlled substance monitoring system,
19 to the extent practicable; and

20 “(2) educate prescribers and dispensers on the
21 benefits of the system.”;

22 (11) in subsection (k)(2)(A), as so redesign-
23 nated—

24 (A) in clause (ii), by striking “or affected”
25 and inserting “, established or strengthened ini-

1 tiatives to ensure linkages to substance use dis-
2 order services, or affected”; and

3 (B) in clause (iii), by striking “including
4 an assessment” and inserting “and between
5 controlled substance monitoring programs and
6 health information technology systems, includ-
7 ing an assessment”;

8 (12) in subsection (l)(1), by striking “establish-
9 ment, implementation, or improvement” and insert-
10 ing “establishment, improvement, or maintenance”;

11 (13) in subsection (m)(8), by striking “and the
12 District of Columbia” and inserting “, the District
13 of Columbia, and any commonwealth or territory of
14 the United States”; and

15 (14) by amending subsection (n) to read as fol-
16 lows:

17 “(n) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there are authorized to be appro-
19 priated, \$10,000,000 for each of fiscal years 2017 through
20 2021.”.

21 **SEC. 110. OPIOID OVERDOSE REVERSAL MEDICATION AC-**
22 **CESS AND EDUCATION GRANT PROGRAMS.**

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

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

3 **“SEC. 545. OPIOID OVERDOSE REVERSAL MEDICATION AC-**
4 **CESS AND EDUCATION GRANT PROGRAMS.**

5 “(a) GRANTS TO STATES.—The Secretary shall make
6 grants to States to—

7 “(1) implement strategies for pharmacists to
8 dispense a drug or device approved or cleared under
9 the Federal Food, Drug, and Cosmetic Act for emer-
10 gency treatment of known or suspected opioid over-
11 dose, as appropriate, pursuant to a standing order;

12 “(2) encourage pharmacies to dispense opioid
13 overdose reversal medication pursuant to a standing
14 order;

15 “(3) develop or provide training materials that
16 persons authorized to prescribe or dispense a drug
17 or device approved or cleared under the Federal
18 Food, Drug, and Cosmetic Act for emergency treat-
19 ment of known or suspected opioid overdose may use
20 to educate the public concerning—

21 “(A) when and how to safely administer
22 such drug or device; and

23 “(B) steps to be taken after administering
24 such drug or device; and

1 “(4) educate the public concerning the avail-
2 ability of drugs or devices approved or cleared under
3 the Federal Food, Drug, and Cosmetic Act for emer-
4 gency treatment of known or suspected opioid over-
5 dose without a person-specific prescription.

6 “(b) CERTAIN REQUIREMENT.—A grant may be
7 made under this section only if the State involved has au-
8 thorized standing orders to be issued for drugs or devices
9 approved or cleared under the Federal Food, Drug, and
10 Cosmetic Act for emergency treatment of known or sus-
11 pected opioid overdose.

12 “(c) PREFERENCE IN MAKING GRANTS.—In making
13 grants under this section, the Secretary may give pref-
14 erence to States that have a significantly higher rate of
15 opioid overdoses than the national average, and that—

16 “(1) have not implemented standing orders re-
17 garding drugs or devices approved or cleared under
18 the Federal Food, Drug, and Cosmetic Act for emer-
19 gency treatment of known or suspected opioid over-
20 dose;

21 “(2) authorize standing orders to be issued that
22 permit community-based organizations, substance
23 abuse programs, or other nonprofit entities to ac-
24 quire, dispense, or administer drugs or devices ap-
25 proved or cleared under the Federal Food, Drug,

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

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

9 “(d) GRANT TERMS.—

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

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

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

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

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

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

8 “(g) DEFINITIONS.—In this section the term ‘stand-
9 ing order’ means a document prepared by a person author-
10 ized to prescribe medication that permits another person
11 to acquire, dispense, or administer medication without a
12 person-specific prescription.

13 “(h) AUTHORIZATION OF APPROPRIATIONS.—

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

17 “(2) ADMINISTRATIVE COSTS.—Not more than
18 3 percent of the amounts made available to carry
19 out this section may be used by the Secretary for
20 administrative expenses of carrying out this sec-
21 tion.”.

22 (b) TECHNICAL CLARIFICATION.—Effective as if in-
23 cluded in the enactment of the Children’s Health Act of
24 2000 (Public Law 106–310), section 3405(a) of such Act
25 (114 Stat. 1221) is amended by striking “Part E of title

1 III” and inserting “Part E of title III of the Public Health
2 Service Act”.

3 **TITLE II—LAW ENFORCEMENT**
4 **AND TREATMENT**

5 **SEC. 201. COMPREHENSIVE OPIOID ABUSE GRANT PRO-**
6 **GRAM.**

7 (a) COMPREHENSIVE OPIOID ABUSE GRANT PRO-
8 GRAM.—

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

13 **“PART LL—COMPREHENSIVE OPIOID ABUSE**
14 **GRANT PROGRAM**

15 **“SEC. 3021. DESCRIPTION.**

16 “(a) GRANTS AUTHORIZED.—From amounts made
17 available to carry out this part, the Attorney General may
18 make grants to States, units of local government, and In-
19 dian tribes, for use by the State, unit of local government,
20 or Indian tribe to provide services primarily relating to
21 opioid abuse, including for any one or more of the fol-
22 lowing:

23 “(1) Developing, implementing, or expanding a
24 treatment alternative to incarceration program,
25 which may include—

1 “(A) prebooking or postbooking compo-
2 nents, which may include the activities de-
3 scribed in part DD or HH of this title;

4 “(B) training for criminal justice agency
5 personnel on substance use disorders and co-oc-
6 curring mental illness and substance use dis-
7 orders;

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

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

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

15 “(F) a focus on parents whose incarcer-
16 ation could result in their children entering the
17 child welfare system; and

18 “(G) a community-based substance use di-
19 version program sponsored by a law enforce-
20 ment agency.

21 “(2) In the case of a State, facilitating or en-
22 hancing planning and collaboration between State
23 criminal justice agencies and State substance abuse
24 agencies in order to more efficiently and effectively
25 carry out activities or services described in any para-

1 graph of this subsection that address problems re-
2 lated to opioid abuse.

3 “(3) Providing training and resources for first
4 responders on carrying and administering an opioid
5 overdose reversal drug or device approved or cleared
6 by the Food and Drug Administration, and pur-
7 chasing such a drug or device for first responders
8 who have received such training to so carry and ad-
9 minister.

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

12 “(5) Developing, implementing, or expanding a
13 medication-assisted treatment program used or oper-
14 ated by a criminal justice agency, which may include
15 training criminal justice agency personnel on medi-
16 cation-assisted treatment, and carrying out the ac-
17 tivities described in part S of this title.

18 “(6) In the case of a State, developing, imple-
19 menting, or expanding a prescription drug moni-
20 toring program to collect and analyze data related to
21 the prescribing of schedules II, III, and IV con-
22 trolled substances through a centralized database
23 administered by an authorized State agency, which
24 includes tracking the dispensation of such sub-
25 stances, and providing for interoperability and data

1 sharing with each other such program in each other
2 State, and with any interstate entity that shares in-
3 formation between such programs.

4 “(7) Developing, implementing, or expanding a
5 program to prevent and address opioid abuse by ju-
6 veniles.

7 “(8) Developing, implementing, or expanding a
8 program (which may include demonstration projects)
9 to utilize technology that provides a secure container
10 for prescription drugs that would prevent or deter
11 individuals, particularly adolescents, from gaining
12 access to opioid medications that are lawfully pre-
13 scribed for other individuals.

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

16 “(10) Developing, implementing, or expanding
17 an integrated and comprehensive opioid abuse re-
18 sponse program.

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

1 “(1) local or regional organizations that are pri-
2 vate and nonprofit, including faith-based organiza-
3 tions;

4 “(2) units of local government; or

5 “(3) tribal organizations.

6 “(c) PROGRAM ASSESSMENT COMPONENT; WAIV-
7 ER.—

8 “(1) PROGRAM ASSESSMENT COMPONENT.—

9 Each program funded under this part shall contain
10 a program assessment component, developed pursu-
11 ant to guidelines established by the Attorney Gen-
12 eral, in coordination with the National Institute of
13 Justice.

14 “(2) WAIVER.—The Attorney General may
15 waive the requirement of paragraph (1) with respect
16 to a program if, in the opinion of the Attorney Gen-
17 eral, the program is not of sufficient size to justify
18 a full program assessment.

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

22 “(e) PERIOD.—The period of a grant made under
23 this part may not be longer than 4 years, except that re-
24 newals and extensions beyond that period may be granted
25 at the discretion of the Attorney General.

1 **“SEC. 3022. APPLICATIONS.**

2 “To request a grant under this part, the chief execu-
3 tive officer of a State, unit of local government, or Indian
4 tribe shall submit an application to the Attorney General
5 at such time and in such form as the Attorney General
6 may require. Such application shall include the following:

7 “(1) A certification that Federal funds made
8 available under this part will not be used to supplant
9 State, local, or tribal funds, but will be used to in-
10 crease the amounts of such funds that would, in the
11 absence of Federal funds, be made available for the
12 activities described in section 3021(a).

13 “(2) An assurance that, for each fiscal year
14 covered by an application, the applicant shall main-
15 tain and report such data, records, and information
16 (programmatic and financial) as the Attorney Gen-
17 eral may reasonably require.

18 “(3) A certification, made in a form acceptable
19 to the Attorney General and executed by the chief
20 executive officer of the applicant (or by another offi-
21 cer of the applicant, if qualified under regulations
22 promulgated by the Attorney General), that—

23 “(A) the activities or services to be funded
24 by the grant meet all the requirements of this
25 part;

1 “(B) all the information contained in the
2 application is correct;

3 “(C) there has been appropriate coordina-
4 tion with affected agencies; and

5 “(D) the applicant will comply with all
6 provisions of this part and all other applicable
7 Federal laws.

8 “(4) An assurance that the applicant will work
9 with the Drug Enforcement Administration to de-
10 velop an integrated and comprehensive strategy to
11 address opioid abuse.

12 **“SEC. 3023. REVIEW OF APPLICATIONS.**

13 “The Attorney General shall not finally disapprove
14 any application (or any amendment to that application)
15 submitted under this part without first affording the ap-
16 plicant reasonable notice of any deficiencies in the applica-
17 tion and an opportunity for correction of any such defi-
18 ciencies and reconsideration.

19 **“SEC. 3024. EQUITABLE DISTRIBUTION OF FUNDS.**

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

22 “(1) equitably addresses the needs of under-
23 served populations, including rural and tribal com-
24 munities; and

1 “(2) focuses on communities that have been dis-
2 proportionately impacted by opioid abuse as evi-
3 denced in part by—

4 “(A) high rates of primary treatment ad-
5 missions for heroin and other opioids;

6 “(B) high rates of drug poisoning deaths
7 from heroin and other opioids; and

8 “(C) a lack of accessibility to treatment
9 providers and facilities and to emergency med-
10 ical services.

11 **“SEC. 3025. DEFINITIONS.**

12 “In this part:

13 “(1) The term ‘first responder’ includes a fire-
14 fighter, law enforcement officer, paramedic, emer-
15 gency medical technician, or other individual (includ-
16 ing an employee of a legally organized and recog-
17 nized volunteer organization, whether compensated
18 or not), who, in the course of his or her professional
19 duties, responds to fire, medical, hazardous material,
20 or other similar emergencies.

21 “(2) The term ‘medication-assisted treatment’
22 means the use of medications approved by the Food
23 and Drug Administration for the treatment of opioid
24 abuse.

1 “(3) The term ‘opioid’ means any drug, includ-
2 ing heroin, having an addiction-forming or addiction-
3 sustaining liability similar to morphine or being ca-
4 pable of conversion into a drug having such addic-
5 tion-forming or addiction-sustaining liability.

6 “(4) The term ‘schedule II, III, or IV controlled
7 substance’ means a controlled substance that is list-
8 ed on schedule II, schedule III, or schedule IV of
9 section 202(c) of the Controlled Substances Act (21
10 U.S.C. 812(c)).

11 “(5) The terms ‘drug’ and ‘device’ have the
12 meanings given those terms in section 201 of the
13 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
14 321).

15 “(6) The term ‘criminal justice agency’ means
16 a State, local, or tribal—

17 “(A) court;

18 “(B) prison;

19 “(C) jail;

20 “(D) law enforcement agency; or

21 “(E) other agency that performs the ad-
22 ministration of criminal justice, including pros-
23 ecution, pretrial services, and community super-
24 vision.

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

5 “(8) The term ‘State substance abuse agency’
6 has the meaning given that term in section
7 508(r)(6) of the Public Health Service Act (42
8 U.S.C. 290bb-1).”.

9 (2) AUTHORIZATION OF APPROPRIATIONS.—
10 Section 1001(a) of title I of the Omnibus Crime
11 Control and Safe Streets Act of 1968 (42 U.S.C.
12 3793(a)) is amended by inserting after paragraph
13 (26) the following:

14 “(27) There are authorized to be appropriated
15 to carry out part LL \$103,000,000 for each of fiscal
16 years 2017 through 2021.”.

17 (b) EMERGENCY FEDERAL LAW ENFORCEMENT AS-
18 SISTANCE.—Section 609Y(a) of the Justice Assistance Act
19 of 1984 (42 U.S.C. 10513(a)) is amended by striking
20 “September 30, 1984” and inserting “September 30,
21 2021”.

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

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

3 (2) in section 2927—

4 (A) in paragraph (1)(A), by inserting
5 “pregnant or” before “a parent”; and

6 (B) in paragraph (3), by inserting “or
7 pregnant women” after “incarcerated parents”.

8 (d) GAO STUDY AND REPORT ON FEDERAL AGENCY
9 PROGRAMS AND RESEARCH RELATIVE TO SUBSTANCE
10 USE AND SUBSTANCE USE DISORDERS AMONG ADOLES-
11 CENTS AND YOUNG ADULTS.—

12 (1) STUDY.—The Comptroller General of the
13 United States shall conduct a study on how Federal
14 agencies, through grant programs, are addressing
15 prevention of, treatment for, and recovery from, sub-
16 stance use by, and substance use disorders among,
17 adolescents and young adults. Such study shall in-
18 clude an analysis of each of the following:

19 (A) The research that has been, and is
20 being, conducted or supported pursuant to
21 grant programs operated by Federal agencies
22 on prevention of, treatment for, and recovery
23 from substance use by and substance use dis-
24 orders among adolescents and young adults, in-
25 cluding an assessment of—

1 (i) such research relative to any
2 unique circumstances (including social and
3 biological circumstances) of adolescents
4 and young adults that may make adoles-
5 cent-specific and young adult-specific treat-
6 ment protocols necessary, including any ef-
7 fects that substance use and substance use
8 disorders may have on brain development
9 and the implications for treatment and re-
10 covery; and

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

14 (B) Federal agency nonresearch programs
15 and activities that address prevention of, treat-
16 ment for, and recovery from substance use by
17 and substance use disorders among adolescents
18 and young adults, including an assessment of
19 the effectiveness of such programs and activities
20 in preventing substance use by and substance
21 use disorders among adolescents and young
22 adults, treating such adolescents and young
23 adults in a way that accounts for any unique
24 circumstances faced by adolescents and young

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

3 (C) Gaps that have been identified by offi-
4 cials of Federal agencies or experts in the ef-
5 forts supported by grant programs operated by
6 Federal agencies relating to prevention of,
7 treatment for, and recovery from substance use
8 by and substance use disorders among adoles-
9 cents and young adults, including gaps in re-
10 search, data collection, and measures to evalu-
11 ate the effectiveness of such efforts, and the
12 reasons for such gaps.

13 (2) REPORT.—Not later than 2 years after the
14 date of enactment of this Act, the Comptroller Gen-
15 eral shall submit to the appropriate committees of
16 the Congress a report containing the results of the
17 study conducted under paragraph (1), including—

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

20 (B) recommendations based on the results
21 of the study, including recommendations for
22 such areas of research and legislative and ad-
23 ministrative action as the Comptroller General
24 determines appropriate.

1 **SEC. 202. FIRST RESPONDER TRAINING.**

2 Part D of title V of the Public Health Service Act
3 (42 U.S.C. 290dd et seq.), as amended by section 110,
4 is further amended by adding at the end the following:

5 **“SEC. 546. FIRST RESPONDER TRAINING.**

6 “(a) PROGRAM AUTHORIZED.—The Secretary shall
7 make grants to States, local governmental entities, and In-
8 dian tribes and tribal organizations (as defined in section
9 4 of the Indian Self-Determination and Education Assist-
10 ance Act) to allow first responders and members of other
11 key community sectors to administer a drug or device ap-
12 proved or cleared under the Federal Food, Drug, and Cos-
13 metic Act for emergency treatment of known or suspected
14 opioid overdose.

15 “(b) APPLICATION.—

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

19 “(A) that meets the criteria under para-
20 graph (2); and

21 “(B) at such time, in such manner, and
22 accompanied by such information as the Sec-
23 retary may require.

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

1 “(A) describe the evidence-based method-
2 ology and outcome measurements that will be
3 used to evaluate the program funded with a
4 grant under this section, and specifically ex-
5 plain how such measurements will provide valid
6 measures of the impact of the program;

7 “(B) describe how the program could be
8 broadly replicated if demonstrated to be effec-
9 tive;

10 “(C) identify the governmental and com-
11 munity agencies with which the entity will co-
12 ordinate to implement the program; and

13 “(D) describe how the entity will ensure
14 that law enforcement agencies will coordinate
15 with their corresponding State substance abuse
16 and mental health agencies to identify protocols
17 and resources that are available to overdose vic-
18 tims and families, including information on
19 treatment and recovery resources.

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

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

1 first responders and members of other key commu-
2 nity sectors;

3 “(2) train and provide resources for first re-
4 sponders and members of other key community sec-
5 tors on carrying and administering a drug or device
6 approved or cleared under the Federal Food, Drug,
7 and Cosmetic Act for emergency treatment of known
8 or suspected opioid overdose; and

9 “(3) establish processes, protocols, and mecha-
10 nisms for referral to appropriate treatment, which
11 may include an outreach coordinator or team to con-
12 nect individuals receiving opioid overdose reversal
13 drugs to followup services.

14 “(d) TECHNICAL ASSISTANCE GRANTS.—The Sec-
15 retary shall make a grant for the purpose of providing
16 technical assistance and training on the use of a drug or
17 device approved or cleared under the Federal Food, Drug,
18 and Cosmetic Act for emergency treatment of known or
19 suspected opioid overdose, and mechanisms for referral to
20 appropriate treatment for an entity receiving a grant
21 under this section.

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

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

7 “(f) EVALUATION.—The Secretary shall conduct an
8 evaluation of grants made under this section to deter-
9 mine—

10 “(1) the number of first responders and mem-
11 bers of other key community sectors equipped with
12 a drug or device approved or cleared under the Fed-
13 eral Food, Drug, and Cosmetic Act for emergency
14 treatment of known or suspected opioid overdose;

15 “(2) the number of opioid and heroin overdoses
16 reversed by first responders and members of other
17 key community sectors receiving training and sup-
18 plies of a drug or device approved or cleared under
19 the Federal Food, Drug, and Cosmetic Act for emer-
20 gency treatment of known or suspected opioid over-
21 dose, through a grant received under this section;

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

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

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are authorized to be appro-
6 priated \$12,000,000 for each of fiscal years 2017 through
7 2021.”.

8 **SEC. 203. PRESCRIPTION DRUG TAKE BACK EXPANSION.**

9 (a) DEFINITION OF COVERED ENTITY.—In this sec-
10 tion, the term “covered entity” means—

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

13 (2) a manufacturer, distributor, or reverse dis-
14 tributor of prescription medications;

15 (3) a retail pharmacy;

16 (4) a registered narcotic treatment program;

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

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

19 (7) any other entity authorized by the Drug
20 Enforcement Administration to dispose of prescrip-
21 tion medications.

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

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

4 **TITLE III—TREATMENT AND** 5 **RECOVERY**

6 **SEC. 301. EVIDENCE-BASED PRESCRIPTION OPIOID AND** 7 **HEROIN TREATMENT AND INTERVENTIONS** 8 **DEMONSTRATION.**

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

12 **“SEC. 514B. EVIDENCE-BASED PRESCRIPTION OPIOID AND** 13 **HEROIN TREATMENT AND INTERVENTIONS** 14 **DEMONSTRATION.**

15 “(a) GRANTS TO EXPAND ACCESS.—

16 “(1) AUTHORITY TO AWARD GRANTS.—The
17 Secretary shall award grants, contracts, or coopera-
18 tive agreements to State substance abuse agencies,
19 units of local government, nonprofit organizations,
20 and Indian tribes and tribal organizations (as de-
21 fined in section 4 of the Indian Self-Determination
22 and Education Assistance Act) that have a high
23 rate, or have had a rapid increase, in the use of her-
24 oin or other opioids, in order to permit such entities
25 to expand activities, including an expansion in the

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

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

12 “(b) APPLICATION.—To be eligible for a grant, con-
13 tract, or cooperative agreement under subsection (a), an
14 entity shall submit an application to the Secretary at such
15 time, in such manner, and accompanied by such informa-
16 tion as the Secretary may reasonably require.

17 “(c) EVALUATION.—An entity that receives a grant,
18 contract, or cooperative agreement under subsection (a)
19 shall submit, in the application for such grant, contract,
20 or agreement a plan for the evaluation of any project un-
21 dertaken with funds provided under this section. Such en-
22 tity shall provide the Secretary with periodic evaluations
23 of the progress of such project and an evaluation at the
24 completion of such project as the Secretary determines to
25 be appropriate.

1 “(d) GEOGRAPHIC DISTRIBUTION.—In awarding
2 grants, contracts, and cooperative agreements under this
3 section, the Secretary shall ensure that not less than 15
4 percent of funds are awarded to eligible entities that are
5 not located in metropolitan statistical areas (as defined by
6 the Office of Management and Budget). The Secretary
7 shall take into account the unique needs of rural commu-
8 nities, including communities with an incidence of individ-
9 uals with opioid use disorder that is above the national
10 average and communities with a shortage of prevention
11 and treatment services.

12 “(e) ADDITIONAL ACTIVITIES.—In administering
13 grants, contracts, and cooperative agreements under sub-
14 section (a), the Secretary shall—

15 “(1) evaluate the activities supported under
16 such subsection;

17 “(2) disseminate information, as appropriate,
18 derived from evaluations as the Secretary considers
19 appropriate;

20 “(3) provide States, Indian tribes and tribal or-
21 ganizations, and providers with technical assistance
22 in connection with the provision of treatment of
23 problems related to heroin and other opioids; and

1 “(4) fund only those applications that specifi-
2 cally support recovery services as a critical compo-
3 nent of the program involved.

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are authorized to be appro-
6 priated \$25,000,000 for each of fiscal years 2017 through
7 2021.”.

8 **SEC. 302. BUILDING COMMUNITIES OF RECOVERY.**

9 Part D of title V of the Public Health Service Act
10 (42 U.S.C. 290dd et seq.), as amended by section 202,
11 is further amended by adding at the end the following:

12 **“SEC. 547. BUILDING COMMUNITIES OF RECOVERY.**

13 “(a) DEFINITION.—In this section, the term ‘recov-
14 ery community organization’ means an independent non-
15 profit organization that—

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

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

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

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

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

6 “(d) USE OF FUNDS.—Grants awarded under sub-
7 section (b)—

8 “(1) shall be used to develop, expand, and en-
9 hance community and statewide recovery support
10 services; and

11 “(2) may be used to—

12 “(A) build connections between recovery
13 networks, between recovery community organi-
14 zations, and with other recovery support serv-
15 ices, including—

16 “(i) behavioral health providers;

17 “(ii) primary care providers and phy-
18 sicians;

19 “(iii) the criminal justice system;

20 “(iv) employers;

21 “(v) housing services;

22 “(vi) child welfare agencies; and

23 “(vii) other recovery support services
24 that facilitate recovery from substance use
25 disorders;

1 “(B) reduce the stigma associated with
2 substance use disorders; and

3 “(C) conduct outreach on issues relating to
4 substance use disorders and recovery, includ-
5 ing—

6 “(i) identifying the signs of addiction;

7 “(ii) the resources available to individ-
8 uals struggling with addiction and to fami-
9 lies with a family member struggling with,
10 or being treated for, addiction, including
11 programs that mentor and provide support
12 services to children;

13 “(iii) the resources available to help
14 support individuals in recovery; and

15 “(iv) related medical outcomes of sub-
16 stance use disorders, the potential of ac-
17 quiring an infectious disease from intra-
18 venous drug use, and neonatal abstinence
19 syndrome among infants exposed to opioids
20 during pregnancy.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 \$1,000,000 for each of fiscal years 2017 through 2021.”.

1 **SEC. 303. MEDICATION-ASSISTED TREATMENT FOR RECOV-**
2 **ERY FROM ADDICTION.**

3 (a) IN GENERAL.—

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

7 (A) in subparagraph (B), by striking
8 clauses (i), (ii), and (iii) and inserting the fol-
9 lowing:

10 “(i) The practitioner is a qualifying practitioner
11 (as defined in subparagraph (G)).

12 “(ii) With respect to patients to whom the prac-
13 titioner will provide such drugs or combinations of
14 drugs, the practitioner has the capacity to provide
15 directly, by referral, or in such other manner as de-
16 termined by the Secretary—

17 “(I) all drugs approved by the Food and
18 Drug Administration for the treatment of
19 opioid use disorder, including for maintenance,
20 detoxification, overdose reversal, and relapse
21 prevention; and

22 “(II) appropriate counseling and other ap-
23 propriate ancillary services.

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

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

3 “(II) The applicable number is 100 if, not soon-
4 er than 1 year after the date on which the practi-
5 tioner submitted the initial notification, the practi-
6 tioner submits a second notification to the Secretary
7 of the need and intent of the practitioner to treat up
8 to 100 patients.

9 “(III) The Secretary may by regulation change
10 such applicable number.

11 “(IV) The Secretary may exclude from the ap-
12 plicable number patients to whom such drugs or
13 combinations of drugs are directly administered by
14 the qualifying practitioner in the office setting.”;

15 (B) in subparagraph (D)—

16 (i) in clause (ii), by striking “Upon
17 receiving a notification under subpara-
18 graph (B)” and inserting “Upon receiving
19 a determination from the Secretary under
20 clause (iii) finding that a practitioner
21 meets all requirements for a waiver under
22 subparagraph (B)”;

23 (ii) in clause (iii)—

24 (I) by inserting “and shall for-
25 ward such determination to the Attor-

1 ney General” before the period at the
2 end of the first sentence; and

3 (II) by striking “physician” and
4 inserting “practitioner”;

5 (C) in subparagraph (G)—

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

8 “(I) The physician holds a board
9 certification in addiction psychiatry or
10 addiction medicine from the American
11 Board of Medical Specialties.”;

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

14 “(II) The physician holds an ad-
15 diction certification or board certifi-
16 cation from the American Society of
17 Addiction Medicine or the American
18 Board of Addiction Medicine.”;

19 (iii) in clause (ii)(III), by striking
20 “subspecialty”;

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

23 “(IV) The physician has, with respect to
24 the treatment and management of opiate-de-
25 pendent patients, completed not less than 8

1 hours of training (through classroom situations,
2 seminars at professional society meetings, elec-
3 tronic communications, or otherwise) that is
4 provided by the American Society of Addiction
5 Medicine, the American Academy of Addiction
6 Psychiatry, the American Medical Association,
7 the American Osteopathic Association, the
8 American Psychiatric Association, or any other
9 organization that the Secretary determines is
10 appropriate for purposes of this subclause. Such
11 training shall include—

12 “(aa) opioid maintenance and detoxi-
13 fication;

14 “(bb) appropriate clinical use of all
15 drugs approved by the Food and Drug Ad-
16 ministration for the treatment of opioid
17 use disorder;

18 “(cc) initial and periodic patient as-
19 sessments (including substance use moni-
20 toring);

21 “(dd) individualized treatment plan-
22 ning, overdose reversal, and relapse pre-
23 vention;

24 “(ee) counseling and recovery support
25 services;

1 “(ff) staffing roles and considerations;

2 “(gg) diversion control; and

3 “(hh) other best practices, as identi-

4 fied by the Secretary.”; and

5 (v) by adding at the end the following:

6 “(iii) The term ‘qualifying practitioner’

7 means—

8 “(I) a qualifying physician, as defined in

9 clause (ii); or

10 “(II) during the period beginning on the

11 date of enactment of the Comprehensive Addic-

12 tion and Recovery Act of 2016 and ending on

13 October 1, 2021, a qualifying other practi-

14 tioner, as defined in clause (iv).

15 “(iv) The term ‘qualifying other practitioner’

16 means a nurse practitioner or physician assistant

17 who satisfies each of the following:

18 “(I) The nurse practitioner or physician

19 assistant is licensed under State law to pre-

20 scribe schedule III, IV, or V medications for the

21 treatment of pain.

22 “(II) The nurse practitioner or physician

23 assistant has—

24 “(aa) completed not fewer than 24

25 hours of initial training addressing each of

1 the topics listed in clause (ii)(IV) (through
2 classroom situations, seminars at profes-
3 sional society meetings, electronic commu-
4 nications, or otherwise) provided by the
5 American Society of Addiction Medicine,
6 the American Academy of Addiction Psy-
7 chiatry, the American Medical Association,
8 the American Osteopathic Association, the
9 American Nurses Credentialing Center, the
10 American Psychiatric Association, the
11 American Association of Nurse Practi-
12 tioners, the American Academy of Physi-
13 cian Assistants, or any other organization
14 that the Secretary determines is appro-
15 priate for purposes of this subclause; or

16 “(bb) has such other training or expe-
17 rience as the Secretary determines will
18 demonstrate the ability of the nurse practi-
19 tioner or physician assistant to treat and
20 manage opiate-dependent patients.

21 “(III) The nurse practitioner or physician
22 assistant is supervised by, or works in collabo-
23 ration with, a qualifying physician, if the nurse
24 practitioner or physician assistant is required
25 by State law to prescribe medications for the

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

3 The Secretary may, by regulation, revise the require-
4 ments for being a qualifying other practitioner under
5 this clause.”; and

6 (D) in subparagraph (H)—

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

9 “(III) Such other elements of the requirements
10 under this paragraph as the Secretary determines
11 necessary for purposes of implementing such re-
12 quirements.”; and

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

15 “(ii) Not later than 18 months after the date of en-
16 actment of the Opioid Use Disorder Treatment Expansion
17 and Modernization Act, the Secretary shall update the
18 treatment improvement protocol containing best practice
19 guidelines for the treatment of opioid-dependent patients
20 in office-based settings. The Secretary shall update such
21 protocol in consultation with experts in opioid use disorder
22 research and treatment.”.

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

1 amended by inserting “or ‘opioid’” after “The term
2 ‘opiate’”.

3 (3) REPORTS TO CONGRESS.—

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

11 (i) perform a thorough review of the
12 provision of opioid use disorder treatment
13 services in the United States, including
14 services provided in opioid treatment pro-
15 grams and other specialty and nonspecialty
16 settings; and

17 (ii) submit a report to the Congress
18 on the findings and conclusions of such re-
19 view.

20 (B) CONTENTS.—Each report under sub-
21 paragraph (A) shall include an assessment of—

22 (i) compliance with the requirements
23 of section 303(g)(2) of the Controlled Sub-
24 stances Act (21 U.S.C. 823(g)(2)), as
25 amended by this section;

1 (ii) the measures taken by the Sec-
2 retary of Health and Human Services to
3 ensure such compliance;

4 (iii) whether there is further need to
5 increase or decrease the number of pa-
6 tients a practitioner, pursuant to a waiver
7 under section 303(g)(2) of the Controlled
8 Substances Act (21 U.S.C. 823(g)(2)), is
9 permitted to treat;

10 (iv) the extent to which, and propor-
11 tions with which, the full range of Food
12 and Drug Administration-approved treat-
13 ments for opioid use disorder are used in
14 routine health care settings and specialty
15 substance use disorder treatment settings;

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

20 (vi) changes in State or local policies
21 and legislation relating to opioid use dis-
22 order treatment;

23 (vii) the use of prescription drug mon-
24 itoring programs by practitioners who are
25 permitted to dispense narcotic drugs to in-

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

3 (viii) the findings resulting from in-
4 spections by the Drug Enforcement Ad-
5 ministration of practitioners described in
6 clause (vii); and

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

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

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

19 “(i) permits a qualifying practitioner to dis-
20 pense narcotic drugs in schedule III, IV, or V, or
21 combinations of such drugs, for maintenance or de-
22 toxification treatment in accordance with this para-
23 graph to a total number of patients that is more
24 than 30 or less than the total number applicable to
25 the qualifying practitioner under subparagraph

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

4 “(ii) requires a qualifying practitioner to com-
5 ply with additional requirements relating to the dis-
6 pensing of narcotic drugs in schedule III, IV, or V,
7 or combinations of such drugs, including require-
8 ments relating to the practice setting in which the
9 qualifying practitioner practices and education,
10 training, and reporting requirements.”.

11 (c) UPDATE REGULATIONS.—Not later than 18
12 months after the date of enactment of this Act, the Attor-
13 ney General and the Secretary of Health and Human
14 Services, as appropriate, shall update regulations regard-
15 ing practitioners described in subsection (a)(3)(B)(vii) (as
16 amended by this section) to include nurse practitioners
17 and physician assistants to ensure the quality of patient
18 care and prevent diversion.

19 **TITLE IV—ADDRESSING** 20 **COLLATERAL CONSEQUENCES**

21 **SEC. 401. GAO REPORT ON RECOVERY AND COLLATERAL** 22 **CONSEQUENCES.**

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

1 the Judiciary of the Senate and the Committee on the Ju-
2 diciary of the House of Representatives a report that—

3 (1) describes the collateral consequences for in-
4 dividuals with convictions for nonviolent drug-related
5 offenses;

6 (2) describes the effect of the collateral con-
7 sequences described in paragraph (1) on individuals
8 in resuming their personal and professional activi-
9 ties, especially, to the extent data are available, the
10 effect on individuals who are participating in or have
11 completed a recovery program for a substance use
12 disorder;

13 (3) discusses policy bases and justifications for
14 imposing collateral consequences on individuals con-
15 victed of nonviolent drug-related offenses identified
16 under paragraph (1); and

17 (4) provides perspectives on the potential for
18 mitigating the effect of the collateral consequences
19 described in paragraph (1) on individuals who are
20 participating in or have completed a recovery pro-
21 gram, while also taking into account the policy inter-
22 ests described in paragraph (3).

23 (b) DEFINITION.—In this section, the term “collat-
24 eral consequence”—

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

4 (A) automatically by operation of law; or

5 (B) by authorized action of an administra-
6 tive agency or court on a case-by-case basis;
7 and

8 (2) does not include a direct consequence im-
9 posed as part of the judgment of a court at sen-
10 tencing, including a term of imprisonment or com-
11 munity supervision, or a fine.

12 **TITLE V—ADDICTION AND**
13 **TREATMENT SERVICES FOR**
14 **WOMEN, FAMILIES, AND VET-**
15 **ERANS**

16 **SEC. 501. IMPROVING TREATMENT FOR PREGNANT AND**
17 **POSTPARTUM WOMEN.**

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

22 (1) in subsection (a)—

23 (A) in the matter preceding paragraph

24 (1)—

1 (i) by inserting “(referred to in this
2 section as the ‘Director’)” after “Sub-
3 stance Abuse Treatment”;

4 (ii) by striking “grants, cooperative
5 agreement,” and inserting “grants, includ-
6 ing the grants under subsection (r), coop-
7 erative agreements”; and

8 (iii) by striking “for substance abuse”
9 and inserting “for substance use dis-
10 orders”; and

11 (B) in paragraph (1), by inserting “or re-
12 ceive outpatient treatment services from” after
13 “reside in”;

14 (2) in subsection (b)(2), by inserting “and her
15 children” before the period at the end;

16 (3) in subsection (c)—

17 (A) in paragraph (1), by striking “to the
18 woman of the services” and inserting “of serv-
19 ices for the woman and her children”; and

20 (B) in paragraph (2)—

21 (i) in subparagraph (A), by striking
22 “substance abuse” and inserting “sub-
23 stance use disorders”; and

1 (ii) in subparagraph (B), by striking
2 “such abuse” and inserting “such a dis-
3 order”;

4 (4) in subsection (d)—

5 (A) in paragraph (3)(A), by striking “ma-
6 ternal substance abuse” and inserting “a ma-
7 ternal substance use disorder”;

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

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

14 (C) in paragraphs (9), (10), and (11), by
15 striking “women” each place such term appears
16 and inserting “woman”;

17 (D) in paragraph (9), by striking “units”
18 and inserting “unit”; and

19 (E) in paragraph (11)—

20 (i) in subparagraph (A), by striking
21 “their children” and inserting “any child
22 of such woman”;

23 (ii) in subparagraph (B), by striking
24 “; and” and inserting a semicolon;

1 (iii) in subparagraph (C), by striking
2 the period and inserting “; and”; and

3 (iv) by adding at the end the fol-
4 lowing:

5 “(D) family reunification with children in
6 kinship or foster care arrangements, where safe
7 and appropriate.”;

8 (5) in subsection (e)—

9 (A) in paragraph (1)—

10 (i) in the matter preceding subpara-
11 graph (A), by striking “substance abuse”
12 and inserting “substance use disorders”;
13 and

14 (ii) in subparagraph (B), by striking
15 “substance abuse” and inserting “sub-
16 stance use disorders”; and

17 (B) in paragraph (2)—

18 (i) by striking “(A) Subject” and in-
19 serting the following:

20 “(A) IN GENERAL.—Subject”;

21 (ii) in subparagraph (B)—

22 (I) by striking “(B)(i) In the
23 case” and inserting the following:

24 “(B) WAIVER OF PARTICIPATION AGREE-
25 MENTS.—

1 “(i) IN GENERAL.—In the case”; and

2 (II) by striking “(ii) A deter-
3 mination” and inserting the following:

4 “(ii) DONATIONS.—A determination”;

5 and

6 (iii) by striking “(C) With respect”

7 and inserting the following:

8 “(C) NONAPPLICATION OF CERTAIN RE-
9 QUIREMENTS.—With respect”;

10 (6) in subsection (g)—

11 (A) by striking “who are engaging in sub-
12 stance abuse” and inserting “who have a sub-
13 stance use disorder”; and

14 (B) by striking “such abuse” and inserting
15 “such disorder”;

16 (7) in subsection (j)—

17 (A) in the matter preceding paragraph (1),
18 by striking “to on” and inserting “to or on”;
19 and

20 (B) in paragraph (3), by striking “Office
21 for” and inserting “Office of”;

22 (8) by amending subsection (m) to read as fol-
23 lows:

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

1 an applicant that agrees to use the award for a program
2 serving an area that is a rural area, an area designated
3 under section 332 by the Secretary as a health profes-
4 sional shortage area, or an area determined by the Direc-
5 tor to have a shortage of family-based substance use dis-
6 order treatment options.”; and

7 (9) in subsection (q)—

8 (A) in paragraph (3), by striking “funding
9 agreement under subsection (a)” and inserting
10 “funding agreement”; and

11 (B) in paragraph (4), by striking “sub-
12 stance abuse” and inserting “a substance use
13 disorder”.

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

17 (1) in subsection (p), in the first sentence, by
18 inserting “(other than subsection (r))” after “sec-
19 tion”; and

20 (2) in subsection (r), by striking “such sums”
21 and all that follows through “2003” and inserting
22 “\$16,900,000 for each of fiscal years 2017 through
23 2021”.

24 (c) PILOT PROGRAM GRANTS FOR STATE SUB-
25 STANCE ABUSE AGENCIES.—

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

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

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

9 “(r) PILOT PROGRAM FOR STATE SUBSTANCE
10 ABUSE AGENCIES.—

11 “(1) IN GENERAL.—From amounts made avail-
12 able under subsection (s), the Director of the Center
13 for Substance Abuse Treatment shall carry out a
14 pilot program under which competitive grants are
15 made by the Director to State substance abuse agen-
16 cies—

17 “(A) to enhance flexibility in the use of
18 funds designed to support family-based services
19 for pregnant and postpartum women with a pri-
20 mary diagnosis of a substance use disorder, in-
21 cluding opioid use disorders;

22 “(B) to help State substance abuse agen-
23 cies address identified gaps in services fur-
24 nished to such women along the continuum of

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

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

7 “(2) REQUIREMENTS.—In carrying out the
8 pilot program under this subsection, the Director
9 shall—

10 “(A) require State substance abuse agen-
11 cies to submit to the Director applications, in
12 such form and manner and containing such in-
13 formation as specified by the Director, to be eli-
14 gible to receive a grant under the program;

15 “(B) identify, based on such submitted ap-
16 plications, State substance abuse agencies that
17 are eligible for such grants;

18 “(C) require services proposed to be fur-
19 nished through such a grant to support family-
20 based treatment and other services for pregnant
21 and postpartum women with a primary diag-
22 nosis of a substance use disorder, including
23 opioid use disorders;

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

4 “(E) not require that grant recipients
5 under the program make available through use
6 of the grant all the services described in sub-
7 section (d); and

8 “(F) consider not applying the require-
9 ments described in paragraphs (1) and (2) of
10 subsection (f) to an applicant, depending on the
11 circumstances of the applicant.

12 “(3) REQUIRED SERVICES.—

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

18 “(i) shall include the services require-
19 ments described in subsection (c) and be
20 based on the recommendations submitted
21 under subparagraph (B); and

22 “(ii) may be selected from among the
23 services described in subsection (d) and in-
24 clude other services as appropriate.

1 “(B) STAKEHOLDER INPUT.—The Director
2 shall convene and solicit recommendations from
3 stakeholders, including State substance abuse
4 agencies, health care providers, persons in re-
5 covery from substance abuse, and other appro-
6 priate individuals, for the minimum set of serv-
7 ices described in subparagraph (A).

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

10 “(5) EVALUATION AND REPORT TO CON-
11 GRESS.—

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

17 “(B) REPORT.—The Director of the Cen-
18 ter for Behavioral Health Statistics and Qual-
19 ity, in coordination with the Director of the
20 Center for Substance Abuse Treatment shall
21 submit to the relevant committees of jurisdic-
22 tion of the House of Representatives and the
23 Senate a report on the evaluation under sub-
24 paragraph (A). The report shall include, at a
25 minimum—

1 “(i) outcomes information from the
2 pilot program, including any resulting re-
3 ductions in the use of alcohol and other
4 drugs;

5 “(ii) engagement in treatment serv-
6 ices;

7 “(iii) retention in the appropriate level
8 and duration of services;

9 “(iv) increased access to the use of
10 medications approved by the Food and
11 Drug Administration for the treatment of
12 substance use disorders in combination
13 with counseling; and

14 “(v) other appropriate measures.

15 “(C) RECOMMENDATION.—The report
16 under subparagraph (B) shall include a rec-
17 ommendation by the Director of the Center for
18 Substance Abuse Treatment as to whether the
19 pilot program under this subsection should be
20 extended.

21 “(6) STATE SUBSTANCE ABUSE AGENCIES DE-
22 FINED.—For purposes of this subsection, the term
23 ‘State substance abuse agency’ means, with respect
24 to a State, the agency in such State that manages

1 the Substance Abuse Prevention and Treatment
2 Block Grant under part B of title XIX.”.

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

19 **SEC. 502. VETERANS TREATMENT COURTS.**

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

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

24 (2) by inserting after subsection (h) the fol-
25 lowing:

1 “(i) ASSISTING VETERANS.—

2 “(1) DEFINITIONS.—In this subsection:

3 “(A) PEER-TO-PEER SERVICES OR PRO-
4 GRAMS.—The term ‘peer-to-peer services or pro-
5 grams’ means services or programs that connect
6 qualified veterans with other veterans for the
7 purpose of providing support and mentorship to
8 assist qualified veterans in obtaining treatment,
9 recovery, stabilization, or rehabilitation.

10 “(B) QUALIFIED VETERAN.—The term
11 ‘qualified veteran’ means a preliminarily quali-
12 fied offender who—

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

16 “(ii) was discharged or released from
17 such service under conditions other than
18 dishonorable, unless the reason for the dis-
19 honorable discharge was attributable to a
20 substance abuse disorder.

21 “(C) VETERANS TREATMENT COURT PRO-
22 GRAM.—The term ‘veterans treatment court
23 program’ means a court program involving col-
24 laboration among criminal justice, veterans, and

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

3 “(i) intensive judicial supervision and
4 case management, which may include ran-
5 dom and frequent drug testing where ap-
6 propriate;

7 “(ii) a full continuum of treatment
8 services, including mental health services,
9 substance abuse services, medical services,
10 and services to address trauma;

11 “(iii) alternatives to incarceration; or

12 “(iv) other appropriate services, in-
13 cluding housing, transportation, mentoring,
14 employment, job training, education, or as-
15 sistance in applying for and obtaining
16 available benefits.

17 “(2) VETERANS ASSISTANCE PROGRAM.—

18 “(A) IN GENERAL.—The Attorney General,
19 in consultation with the Secretary of Veterans
20 Affairs, may award grants under this sub-
21 section to applicants to establish or expand—

22 “(i) veterans treatment court pro-
23 grams;

24 “(ii) peer-to-peer services or programs
25 for qualified veterans;

1 “(iii) practices that identify and pro-
2 vide treatment, rehabilitation, legal, transi-
3 tional, and other appropriate services to
4 qualified veterans who have been incarcer-
5 ated; or

6 “(iv) training programs to teach
7 criminal justice, law enforcement, correc-
8 tions, mental health, and substance abuse
9 personnel how to identify and appro-
10 priately respond to incidents involving
11 qualified veterans.

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

15 “(i) demonstrate collaboration be-
16 tween and joint investments by criminal
17 justice, mental health, substance abuse,
18 and veterans service agencies;

19 “(ii) promote effective strategies to
20 identify and reduce the risk of harm to
21 qualified veterans and public safety; and

22 “(iii) propose interventions with em-
23 pirical support to improve outcomes for
24 qualified veterans.”.

1 **SEC. 503. INFANT PLAN OF SAFE CARE.**

2 (a) BEST PRACTICES FOR DEVELOPMENT OF PLANS
3 OF SAFE CARE.—Section 103(b) of the Child Abuse Pre-
4 vention and Treatment Act (42 U.S.C. 5104(b)) is amend-
5 ed—

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

8 (2) by inserting after paragraph (4) the fol-
9 lowing:

10 “(5) maintain and disseminate information
11 about the requirements of section 106(b)(2)(B)(iii)
12 and best practices relating to the development of
13 plans of safe care as described in such section for
14 infants born and identified as being affected by sub-
15 stance abuse or withdrawal symptoms, or a Fetal Al-
16 cohol Spectrum Disorder;”.

17 (b) STATE PLANS.—Section 106(b)(2)(B) of the
18 Child Abuse Prevention and Treatment Act (42 U.S.C.
19 5106a(b)(2)(B)) is amended—

20 (1) in clause (ii), by striking “illegal substance
21 abuse” and inserting “substance abuse”; and

22 (2) in clause (iii)—

23 (A) by striking “illegal substance abuse”
24 and inserting “substance abuse”; and

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

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

4 “(I) addressing the health and sub-
5 stance use disorder treatment needs of the
6 infant and affected family or caregiver;
7 and

8 “(II) the development and implemen-
9 tation by the State of monitoring systems
10 regarding the implementation of such
11 plans to determine whether and in what
12 manner local entities are providing, in ac-
13 cordance with State requirements, referrals
14 to and delivery of appropriate services for
15 the infant and affected family or care-
16 giver”.

17 (c) DATA REPORTS.—

18 (1) IN GENERAL.—Section 106(d) of the Child
19 Abuse Prevention and Treatment Act (42 U.S.C.
20 5106a(d)) is amended by adding at the end of the
21 following:

22 “(17) The number of infants—

23 “(A) identified under subsection
24 (b)(2)(B)(ii);

1 “(B) for whom a plan of safe care was de-
2 veloped under subsection (b)(2)(B)(iii); and

3 “(C) for whom a referral was made for ap-
4 propriate services, including services for the af-
5 fected family or caregiver, under subsection
6 (b)(2)(B)(iii).”.

7 (2) REDESIGNATION.—Effective on May 29,
8 2017, section 106(d) of the Child Abuse Prevention
9 and Treatment Act (42 U.S.C. 5106a(d)) is amend-
10 ed by redesignating paragraph (17) (as added by
11 paragraph (1)) as paragraph (18).

12 (d) MONITORING AND OVERSIGHT.—

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

16 **“SEC. 114. MONITORING AND OVERSIGHT.**

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

21 “(1) shall—

22 “(A) be in addition to the review of the
23 State plan upon its submission under section
24 106(b)(1)(A); and

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

4 “(2) may include—

5 “(A) a comparison of activities carried out
6 by the State to comply with the requirements of
7 section 106(b) with the State plan most re-
8 cently approved under section 432 of the Social
9 Security Act;

10 “(B) a review of information available on
11 the website of the State relating to its compli-
12 ance with the requirements of section 106(b);

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

15 “(D) a review of information available in
16 the State’s Annual Progress and Services Re-
17 port most recently submitted under section
18 1357.16 of title 45, Code of Federal Regula-
19 tions (or successor regulations).”.

20 (2) TABLE OF CONTENTS.—The table of con-
21 tents in section 1(b) of the Child Abuse Prevention
22 and Treatment Act (42 U.S.C. 5101 note) is amend-
23 ed by inserting after the item relating to section
24 113, the following:

“Sec. 114. Monitoring and oversight.”.

1 (e) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion, or the amendments made by this section, shall be
3 construed to authorize the Secretary of Health and
4 Human Services or any other officer of the Federal Gov-
5 ernment to add new requirements to section 106(b) of the
6 Child Abuse Prevention and Treatment Act (42 U.S.C.
7 5106a(b)), as amended by this section.

8 **SEC. 504. GAO REPORT ON NEONATAL ABSTINENCE SYN-**
9 **DROME (NAS).**

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

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

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

1 ated with coverage under such programs for treat-
2 ment of infants with NAS.

3 (2) The services for which coverage is available
4 under State Medicaid programs for treatment of in-
5 fants with NAS.

6 (3) The settings (including inpatient, out-
7 patient, hospital-based, and other settings) for the
8 treatment of infants with NAS and the reimburse-
9 ment methodologies and costs associated with such
10 treatment in such settings.

11 (4) The prevalence of utilization of various care
12 settings under State Medicaid programs for treat-
13 ment of infants with NAS and any Federal barriers
14 to treating such infants under such programs, par-
15 ticularly in non-hospital-based settings.

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

18 (c) RECOMMENDATIONS.—Such report also shall in-
19 clude such recommendations as the Comptroller General
20 determines appropriate for improvements that will ensure
21 access to treatment for infants with NAS under State
22 Medicaid programs.

1 **TITLE VI—INCENTIVIZING STATE**
2 **COMPREHENSIVE INITIA-**
3 **TIVES TO ADDRESS PRE-**
4 **SCRIPTION OPIOID ABUSE**

5 **SEC. 601. STATE DEMONSTRATION GRANTS FOR COM-**
6 **PREHENSIVE OPIOID ABUSE RESPONSE.**

7 Part D of title V of the Public Health Service Act
8 (42 U.S.C. 290dd et seq.), as amended by section 302,
9 is further amended by adding at the end the following:

10 **“SEC. 548. STATE DEMONSTRATION GRANTS FOR COM-**
11 **PREHENSIVE OPIOID ABUSE RESPONSE.**

12 “(a) DEFINITIONS.—In this section:

13 “(1) DISPENSER.—The term ‘dispenser’ has the
14 meaning given the term in section 102 of the Con-
15 trolled Substances Act (21 U.S.C. 802).

16 “(2) PRESCRIBER.—The term ‘prescriber’
17 means a dispenser who prescribes a controlled sub-
18 stance, or the agent of such a dispenser.

19 “(3) PRESCRIBER OF A SCHEDULE II, III, OR IV
20 CONTROLLED SUBSTANCE.—The term ‘prescriber of
21 a schedule II, III, or IV controlled substance’ does
22 not include a prescriber of a schedule II, III, or IV
23 controlled substance that dispenses the substance—

24 “(A) for use on the premises on which the
25 substance is dispensed;

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

3 “(C) for a certified opioid treatment pro-
4 gram; or

5 “(D) in other situations as the Secretary
6 may reasonably determine.

7 “(4) SCHEDULE II, III, OR IV CONTROLLED
8 SUBSTANCE.—The term ‘schedule II, III, or IV con-
9 trolled substance’ means a controlled substance that
10 is listed on schedule II, schedule III, or schedule IV
11 of section 202(c) of the Controlled Substances Act.

12 “(b) GRANTS FOR COMPREHENSIVE OPIOID ABUSE
13 RESPONSE.—

14 “(1) IN GENERAL.—The Secretary shall award
15 grants to States, and combinations of States, to im-
16 plement an integrated opioid abuse response initia-
17 tive.

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

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

1 scribing guidelines, the prescription drug moni-
2 toring program of the State described in sub-
3 paragraph (B), and overdose prevention meth-
4 ods;

5 “(B) establishing, maintaining, or improv-
6 ing a comprehensive prescription drug moni-
7 toring program to track dispensing of schedule
8 II, III, or IV controlled substances, which
9 may—

10 “(i) provide for data sharing with
11 other States; and

12 “(ii) allow all individuals authorized
13 by the State to write prescriptions for
14 schedule II, III, or IV controlled sub-
15 stances to access the prescription drug
16 monitoring program of the State;

17 “(C) developing, implementing, or expand-
18 ing prescription drug and opioid addiction
19 treatment programs by—

20 “(i) expanding the availability of
21 treatment for prescription drug and opioid
22 addiction, including medication-assisted
23 treatment and behavioral health therapy,
24 as appropriate;

1 “(ii) developing, implementing, or ex-
2 panding screening for individuals in treat-
3 ment for prescription drug and opioid ad-
4 diction for hepatitis C and HIV, and treat-
5 ing or referring those individuals if clini-
6 cally appropriate; or

7 “(iii) developing, implementing, or ex-
8 panding recovery support services and pro-
9 grams at high schools or institutions of
10 higher education;

11 “(D) developing, implementing, and ex-
12 panding efforts to prevent overdose death from
13 opioid abuse or addiction to prescription medi-
14 cations and opioids; and

15 “(E) advancing the education and aware-
16 ness of the public, providers, patients, con-
17 sumers, and other appropriate entities regard-
18 ing the dangers of opioid abuse, safe disposal of
19 prescription medications, and detection of early
20 warning signs of opioid use disorders.

21 “(3) APPLICATION.—A State seeking a grant
22 under this section shall submit to the Secretary an
23 application in such form, and containing such infor-
24 mation, as the Secretary may reasonably require.

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

8 “(5) PRIORITY CONSIDERATIONS.—In awarding
9 grants under this section, the Secretary shall, as ap-
10 propriate, give priority to a State that—

11 “(A)(i) provides civil liability protection for
12 first responders, health professionals, and fam-
13 ily members who have received appropriate
14 training in administering a drug or device ap-
15 proved or cleared under the Federal Food,
16 Drug, and Cosmetic Act for emergency treat-
17 ment of known or suspected opioid overdose;
18 and

19 “(ii) submits to the Secretary a certifi-
20 cation by the attorney general of the State that
21 the attorney general has—

22 “(I) reviewed any applicable civil li-
23 ability protection law to determine the ap-
24 plicability of the law with respect to first

1 responders, health care professionals, fam-
2 ily members, and other individuals who—

3 “(aa) have received appropriate
4 training in administering a drug or
5 device approved or cleared under the
6 Federal Food, Drug, and Cosmetic
7 Act for emergency treatment of
8 known or suspected opioid overdose;
9 and

10 “(bb) may administer a drug or
11 device approved or cleared under the
12 Federal Food, Drug, and Cosmetic
13 Act for emergency treatment of
14 known or suspected opioid overdose;
15 and

16 “(II) concluded that the law described
17 in subclause (I) provides adequate civil li-
18 ability protection applicable to such per-
19 sons;

20 “(B) has a process for enrollment in serv-
21 ices and benefits necessary by criminal justice
22 agencies to initiate or continue treatment in the
23 community, under which an individual who is
24 incarcerated may, while incarcerated, enroll in
25 services and benefits that are necessary for the

1 individual to continue treatment upon release
2 from incarceration;

3 “(C) ensures the capability of data sharing
4 with other States, where applicable, such as by
5 making data available to a prescription moni-
6 toring hub;

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

11 “(E) ensures that the prescription drug
12 monitoring program of the State notifies pre-
13 scribers and dispensers of schedule II, III, or
14 IV controlled substances when overuse or mis-
15 use of such controlled substances by patients is
16 suspected; and

17 “(F) has in effect one or more statutes or
18 implements policies that maximize use of pre-
19 scription drug monitoring programs by individ-
20 uals authorized by the State to prescribe sched-
21 ule II, III, or IV controlled substances.

22 “(6) EVALUATION.—In conducting an evalua-
23 tion of the program under this section pursuant to
24 section 701 of the Comprehensive Addiction and Re-
25 covery Act of 2016, with respect to a State, the Sec-

1 retary shall report on State legislation or policies re-
2 lated to maximizing the use of prescription drug
3 monitoring programs and the incidence of opioid use
4 disorders and overdose deaths in such State.

5 “(7) STATES WITH LOCAL PRESCRIPTION DRUG
6 MONITORING PROGRAMS.—

7 “(A) IN GENERAL.—In the case of a State
8 that does not have a prescription drug moni-
9 toring program, a county or other unit of local
10 government within the State that has a pre-
11 scription drug monitoring program shall be
12 treated as a State for purposes of this section,
13 including for purposes of eligibility for grants
14 under paragraph (1).

15 “(B) PLAN FOR INTEROPERABILITY.—In
16 submitting an application to the Secretary
17 under paragraph (3), a county or other unit of
18 local government shall submit a plan outlining
19 the methods such county or unit of local gov-
20 ernment shall use to ensure the capability of
21 data sharing with other counties and units of
22 local government within the state and with
23 other States, as applicable.

24 “(c) AUTHORIZATION OF FUNDING.—For the pur-
25 pose of carrying out this section, there are authorized to

1 be appropriated \$5,000,000 for each of fiscal years 2017
2 through 2021.”.

3 **TITLE VII—MISCELLANEOUS**

4 **SEC. 701. GRANT ACCOUNTABILITY AND EVALUATIONS.**

5 (a) DEPARTMENT OF JUSTICE GRANT ACCOUNT-
6 ABILITY.—Part LL of title I of the Omnibus Crime Con-
7 trol and Safe Streets Act of 1968 (42 U.S.C. 3711 et
8 seq.), as added by section 201, is amended by adding at
9 the end the following:

10 **“SEC. 3026. GRANT ACCOUNTABILITY.**

11 “(a) DEFINITION OF APPLICABLE COMMITTEES.—In
12 this section, the term ‘applicable committees’ means—

13 “(1) the Committee on the Judiciary of the
14 Senate; and

15 “(2) the Committee on the Judiciary of the
16 House of Representatives.

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

20 “(1) AUDIT REQUIREMENT.—

21 “(A) DEFINITION.—In this paragraph, the
22 term ‘unresolved audit finding’ means a finding
23 in the final audit report of the Inspector Gen-
24 eral of the Department of Justice that the au-
25 dited grantee has utilized grant funds for an

1 unauthorized expenditure or otherwise unallow-
2 able cost that is not closed or resolved within
3 12 months after the date on which the final
4 audit report is issued.

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

15 “(C) MANDATORY EXCLUSION.—A recipi-
16 ent of grant funds under this part that is found
17 to have an unresolved audit finding shall not be
18 eligible to receive grant funds under this part
19 during the first 2 fiscal years beginning after
20 the end of the 12-month period described in
21 subparagraph (A).

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

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

3 “(E) REIMBURSEMENT.—If an entity is
4 awarded grant funds under this part during the
5 2-fiscal-year period during which the entity is
6 barred from receiving grants under subpara-
7 graph (C), the Attorney General shall—

8 “(i) deposit an amount equal to the
9 amount of the grant funds that were im-
10 properly awarded to the grantee into the
11 General Fund of the Treasury; and

12 “(ii) seek to recoup the costs of the
13 repayment to the fund from the grant re-
14 cipient that was erroneously awarded grant
15 funds.

16 “(2) NONPROFIT ORGANIZATION REQUIRE-
17 MENTS.—

18 “(A) DEFINITION.—For purposes of this
19 paragraph and the grant programs under this
20 part, the term ‘nonprofit organization’ means
21 an organization that is described in section
22 501(c)(3) of the Internal Revenue Code of 1986
23 and is exempt from taxation under section
24 501(a) of such Code.

1 “(B) PROHIBITION.—A nonprofit organiza-
2 tion that holds money in offshore accounts for
3 the purpose of avoiding paying the tax de-
4 scribed in section 511(a) of the Internal Rev-
5 enue Code of 1986 may not—

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

8 “(ii) receive a subaward under section
9 3021(b).

10 “(C) DISCLOSURE.—Each nonprofit orga-
11 nization that receives a subaward or is party to
12 a contract entered into under section 3021(b)
13 and uses the procedures prescribed in regula-
14 tions to create a rebuttable presumption of rea-
15 sonableness for the compensation of its officers,
16 directors, trustees, and key employees, shall dis-
17 close, in the application for such contract or
18 subaward, the process for determining such
19 compensation, including the independent per-
20 sons involved in reviewing and approving such
21 compensation, the comparability data used, and
22 contemporaneous substantiation of the delibera-
23 tion and decision. Upon request, the Attorney
24 General shall make the information disclosed

1 under this subparagraph available for public in-
2 spection.

3 “(3) CONFERENCE EXPENDITURES.—

4 “(A) LIMITATION.—No amounts made
5 available to the Attorney General under this
6 part may be used by the Attorney General, or
7 by any State, unit of local government, or entity
8 awarded a grant, subaward, or contract under
9 this part, to host or support any expenditure
10 for conferences that uses more than \$20,000 in
11 funds made available by the Attorney General,
12 unless the head of the relevant agency, bureau,
13 or program office provides prior written author-
14 ization that the funds may be expended to host
15 or support the conference.

16 “(B) WRITTEN AUTHORIZATION.—Written
17 authorization under subparagraph (A) shall in-
18 clude a written estimate of all costs associated
19 with the conference, including the cost of all
20 food, beverages, audio-visual equipment, hono-
21 raria for speakers, and entertainment.

22 “(C) REPORT.—The Deputy Attorney Gen-
23 eral shall submit to the applicable committees
24 an annual report on all conference expenditures

1 approved by the Attorney General under this
2 paragraph.

3 “(4) ANNUAL CERTIFICATION.—Beginning in
4 the first fiscal year beginning after the date of en-
5 actment of this section, the Attorney General shall
6 submit to the applicable committees an annual cer-
7 tification—

8 “(A) indicating whether—

9 “(i) all audits issued by the Inspector
10 General of the Department of Justice
11 under paragraph (1) have been completed
12 and reviewed by the appropriate Assistant
13 Attorney General or Director;

14 “(ii) all mandatory exclusions required
15 under paragraph (1)(C) have been issued;
16 and

17 “(iii) all reimbursements required
18 under paragraph (1)(E) have been made;
19 and

20 “(B) that includes a list of any grant re-
21 cipients excluded under paragraph (1) from the
22 previous year.

23 “(c) PREVENTING DUPLICATIVE GRANTS.—

24 “(1) IN GENERAL.—Before the Attorney Gen-
25 eral awards a grant to an applicant under this part,

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

5 “(2) REPORT.—If the Attorney General awards
6 duplicate grants under this part to the same appli-
7 cant for the same purpose, the Attorney General
8 shall submit to the applicable committees a report
9 that includes—

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

13 “(B) the reason the Attorney General
14 awarded the duplicate grants.”.

15 (b) EVALUATION OF PERFORMANCE OF DEPART-
16 MENT OF JUSTICE PROGRAMS.—

17 (1) EVALUATION OF JUSTICE DEPARTMENT
18 COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—

19 Not later than 5 years after the date of enactment
20 of this Act, the Attorney General shall complete an
21 evaluation of the effectiveness of the Comprehensive
22 Opioid Abuse Grant Program under part LL of title
23 I of the Omnibus Crime Control and Safe Streets
24 Act of 1968, as added by section 201, administered

1 by the Department of Justice based upon the infor-
2 mation reported under paragraph (4).

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

9 (3) METRICS AND OUTCOMES FOR EVALUA-
10 TION.—Not later than 180 days after the date of en-
11 actment of this Act, the Attorney General shall iden-
12 tify outcomes that are to be achieved by activities
13 funded by the Comprehensive Opioid Abuse Grant
14 Program and the metrics by which the achievement
15 of such outcomes shall be determined.

16 (4) METRICS DATA COLLECTION.—The Attor-
17 ney General shall require grantees under the Com-
18 prehensive Opioid Abuse Grant Program (and those
19 receiving subawards under section 3021(b) of part
20 LL of title I of the Omnibus Crime Control and Safe
21 Streets Act of 1968, as added by section 201) to col-
22 lect and annually report to the Department of Jus-
23 tice data based upon the metrics identified under
24 paragraph (3).

25 (5) PUBLICATION OF DATA AND FINDINGS.—

1 (A) PUBLICATION OF OUTCOMES AND
2 METRICS.—The Attorney General shall, not
3 later than 30 days after completion of the re-
4 quirement under paragraph (3), publish the
5 outcomes and metrics identified under that
6 paragraph.

7 (B) PUBLICATION OF EVALUATION.—In
8 the case of the interim evaluation under para-
9 graph (2), and the final evaluation under para-
10 graph (1), the entity conducting the evaluation
11 shall, not later than 90 days after such an eval-
12 uation is completed, publish the results of such
13 evaluation and issue a report on such evaluation
14 to the Committee on the Judiciary of the House
15 of Representatives and the Committee on the
16 Judiciary of the Senate. Such report shall also
17 be published along with the data used to make
18 such evaluation.

19 (6) INDEPENDENT EVALUATION.—For purposes
20 of paragraphs (1), (2), and (3), the Attorney Gen-
21 eral shall—

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

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

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

6 (c) DEPARTMENT OF HEALTH AND HUMAN SERV-
7 ICES GRANT ACCOUNTABILITY.—

8 (1) DEFINITIONS.—In this subsection:

9 (A) APPLICABLE COMMITTEES.—The term
10 “applicable committees” means—

11 (i) the Committee on Health, Edu-
12 cation, Labor and Pensions of the Senate;
13 and

14 (ii) the Committee on Energy and
15 Commerce of the House of Representa-
16 tives.

17 (B) COVERED GRANT.—The term “covered
18 grant” means a grant awarded by the Secretary
19 under a program established under this Act (or
20 an amendment made by this Act, other than
21 sections 703 through 707), including any grant
22 administered by the Administrator of the Sub-
23 stance Abuse and Mental Health Services Ad-
24 ministration under section 103.

1 (C) GRANTEE.—The term “grantee”
2 means the recipient of a covered grant.

3 (D) SECRETARY.—The term “Secretary”
4 means the Secretary of Health and Human
5 Services.

6 (2) ACCOUNTABILITY MEASURES.—Each cov-
7 ered grant shall be subject to the following account-
8 ability requirements:

9 (A) EFFECTIVENESS REPORT.—The Sec-
10 retary shall require grantees to report on the
11 effectiveness of the activities carried out with
12 amounts made available to carry out the pro-
13 gram under which the covered grant is award-
14 ed, including the number of persons served by
15 such grant, if applicable, the number of persons
16 seeking services who could not be served by
17 such grant, and such other information as the
18 Secretary may prescribe.

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

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

1 to the applicable committees a report on
2 the policies and procedures the Depart-
3 ment has in place to prevent waste, fraud,
4 and abuse in the administration of covered
5 grants.

6 (ii) CONTENTS.—The policies and
7 procedures referred to in clause (i) shall
8 include policies and procedures that are de-
9 signed to—

10 (I) prevent grantees from uti-
11 lizing funds awarded through a cov-
12 ered grant for unauthorized expendi-
13 tures or otherwise unallowable costs;
14 and

15 (II) ensure grantees will not re-
16 ceive unwarranted duplicate grants for
17 the same purpose.

18 (C) CONFERENCE EXPENDITURES.—

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

1 under a program established under this
2 Act (or in a provision of law amended by
3 this Act), to host or support any expendi-
4 ture for conferences that uses more than
5 \$20,000 in funds made available by the
6 Secretary, unless the head of the relevant
7 operating division or program office pro-
8 vides prior written authorization that the
9 funds may be expended to host or support
10 the conference. Such written authorization
11 shall include a written estimate of all costs
12 associated with the conference, including
13 the cost of all food, beverages, audio-visual
14 equipment, honoraria for speakers, and en-
15 tertainment.

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

21 (d) EVALUATION OF PERFORMANCE OF DEPART-
22 MENT OF HEALTH AND HUMAN SERVICES PROGRAMS.—

23 (1) EVALUATIONS.—

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

1 as otherwise provided in this section, the Sec-
2 retary of Health and Human Services (in this
3 subsection referred to as the “Secretary”) shall
4 complete an evaluation of any program adminis-
5 tered by the Secretary included in this Act (or
6 an amendment made by this Act, excluding sec-
7 tions 703 through 707), including any grant ad-
8 ministered by the Administrator of the Sub-
9 stance Abuse and Mental Health Services Ad-
10 ministration under section 103, that provides
11 grants for the primary purpose of providing as-
12 sistance in addressing problems pertaining to
13 opioid abuse based upon the outcomes and
14 metrics identified under paragraph (2).

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

24 (2) METRICS AND OUTCOMES.—

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

4 (i) outcomes that are to be achieved
5 by activities funded by the programs de-
6 scribed in paragraph (1)(A); and

7 (ii) the metrics by which the achieve-
8 ment of such outcomes shall be deter-
9 mined.

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

15 (3) METRICS DATA COLLECTION.—The Sec-
16 retary shall require grantees under the programs de-
17 scribed in paragraph (1)(A) to collect, and annually
18 report to the Secretary, data based upon the metrics
19 identified under paragraph (2)(A).

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

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

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

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

3 (ii) is qualified to conduct and evalu-
4 ate research pertaining to opioid use and
5 abuse and draw conclusions about overall
6 opioid use and abuse on the basis of that
7 research.

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

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

21 (f) NO ADDITIONAL FUNDS AUTHORIZED.—No addi-
22 tional funds are authorized to be appropriated to carry
23 out this section.

1 **SEC. 702. PARTIAL FILLS OF SCHEDULE II CONTROLLED**
2 **SUBSTANCES.**

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

6 “(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED
7 SUBSTANCES.—

8 “(1) PARTIAL FILLS.—A prescription for a con-
9 trolled substance in schedule II may be partially
10 filled if—

11 “(A) it is not prohibited by State law;

12 “(B) the prescription is written and filled
13 in accordance with this title, regulations pre-
14 scribed by the Attorney General, and State law;

15 “(C) the partial fill is requested by the pa-
16 tient or the practitioner that wrote the prescrip-
17 tion; and

18 “(D) the total quantity dispensed in all
19 partial fillings does not exceed the total quan-
20 tity prescribed.

21 “(2) REMAINING PORTIONS.—

22 “(A) IN GENERAL.—Except as provided in
23 subparagraph (B), remaining portions of a par-
24 tially filled prescription for a controlled sub-
25 stance in schedule II—

26 “(i) may be filled; and

1 “(ii) shall be filled not later than 30
2 days after the date on which the prescrip-
3 tion is written.

4 “(B) EMERGENCY SITUATIONS.—In emer-
5 gency situations, as described in subsection (a),
6 the remaining portions of a partially filled pre-
7 scription for a controlled substance in schedule
8 II—

9 “(i) may be filled; and

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

12 “(3) CURRENTLY LAWFUL PARTIAL FILLS.—
13 Notwithstanding paragraph (1) or (2), in any cir-
14 cumstance in which, as of the day before the date
15 of enactment of this subsection, a prescription for a
16 controlled substance in schedule II may be lawfully
17 partially filled, the Attorney General may allow such
18 a prescription to be partially filled.”.

19 (b) RULE OF CONSTRUCTION.—Nothing in this sec-
20 tion shall be construed to affect the authority of the Attor-
21 ney General to allow a prescription for a controlled sub-
22 stance in schedule III, IV, or V of section 202(c) of the
23 Controlled Substances Act (21 U.S.C. 812(c)) to be par-
24 tially filled.

1 **SEC. 703. GOOD SAMARITAN ASSESSMENT.**

2 (a) FINDING.—The Congress finds that the executive
3 branch, including the Office of National Drug Control Pol-
4 icy, has a policy focus on preventing and addressing pre-
5 scription drug misuse and heroin use, and has worked with
6 States and municipalities to enact Good Samaritan laws
7 that would protect caregivers, law enforcement personnel,
8 and first responders who administer opioid overdose rever-
9 sal drugs or devices.

10 (b) GAO STUDY ON GOOD SAMARITAN LAWS PER-
11 TAINING TO TREATMENT OF OPIOID OVERDOSES.—The
12 Comptroller General of the United States shall submit to
13 the Committee on the Judiciary of the House of Rep-
14 resentatives, the Committee on Oversight and Government
15 Reform of the House of Representatives, the Committee
16 on the Judiciary of the Senate, and the Committee on
17 Homeland Security and Governmental Affairs of the Sen-
18 ate a report on—

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

24 (2) efforts by the Director to encourage the en-
25 actment of Good Samaritan laws; and

1 (3) a compilation of Good Samaritan laws in ef-
2 fect in the States, the territories, and the District of
3 Columbia.

4 (c) DEFINITIONS.—In this section—

5 (1) the term “Good Samaritan law” means a
6 law of a State or unit of local government that ex-
7 empts from criminal or civil liability any individual
8 who administers an opioid overdose reversal drug or
9 device, or who contacts emergency services providers
10 in response to an overdose; and

11 (2) the term “opioid” means any drug, includ-
12 ing heroin, having an addiction-forming or addiction-
13 sustaining liability similar to morphine or being ca-
14 pable of conversion into a drug having such addic-
15 tion-forming or addiction-sustaining liability.

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

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

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

23 “(5) DRUG MANAGEMENT PROGRAM FOR AT-
24 RISK BENEFICIARIES.—

1 “(A) AUTHORITY TO ESTABLISH.—A PDP
2 sponsor may establish a drug management pro-
3 gram for at-risk beneficiaries under which, sub-
4 ject to subparagraph (B), the PDP sponsor
5 may, in the case of an at-risk beneficiary for
6 prescription drug abuse who is an enrollee in a
7 prescription drug plan of such PDP sponsor,
8 limit such beneficiary’s access to coverage for
9 frequently abused drugs under such plan to fre-
10 quently abused drugs that are prescribed for
11 such beneficiary by one or more prescribers se-
12 lected under subparagraph (D), and dispensed
13 for such beneficiary by one or more pharmacies
14 selected under such subparagraph.

15 “(B) REQUIREMENT FOR NOTICES.—

16 “(i) IN GENERAL.—A PDP sponsor
17 may not limit the access of an at-risk ben-
18 eficiary for prescription drug abuse to cov-
19 erage for frequently abused drugs under a
20 prescription drug plan until such spon-
21 sor—

22 “(I) provides to the beneficiary
23 an initial notice described in clause
24 (ii) and a second notice described in
25 clause (iii); and

1 “(II) verifies with the providers
2 of the beneficiary that the beneficiary
3 is an at-risk beneficiary for prescrip-
4 tion drug abuse.

5 “(ii) INITIAL NOTICE.—An initial no-
6 tice described in this clause is a notice that
7 provides to the beneficiary—

8 “(I) notice that the PDP sponsor
9 has identified the beneficiary as po-
10 tentially being an at-risk beneficiary
11 for prescription drug abuse;

12 “(II) information describing all
13 State and Federal public health re-
14 sources that are designed to address
15 prescription drug abuse to which the
16 beneficiary has access, including men-
17 tal health services and other coun-
18 seling services;

19 “(III) notice of, and information
20 about, the right of the beneficiary to
21 appeal such identification under sub-
22 section (h) and the option of an auto-
23 matic escalation to external review;

24 “(IV) a request for the bene-
25 ficiary to submit to the PDP sponsor

1 preferences for which prescribers and
2 pharmacies the beneficiary would pre-
3 fer the PDP sponsor to select under
4 subparagraph (D) in the case that the
5 beneficiary is identified as an at-risk
6 beneficiary for prescription drug
7 abuse as described in clause (iii)(I);

8 “(V) an explanation of the mean-
9 ing and consequences of the identi-
10 fication of the beneficiary as poten-
11 tially being an at-risk beneficiary for
12 prescription drug abuse, including an
13 explanation of the drug management
14 program established by the PDP
15 sponsor pursuant to subparagraph
16 (A);

17 “(VI) clear instructions that ex-
18 plain how the beneficiary can contact
19 the PDP sponsor in order to submit
20 to the PDP sponsor the preferences
21 described in subclause (IV) and any
22 other communications relating to the
23 drug management program for at-risk
24 beneficiaries established by the PDP
25 sponsor; and

1 “(VII) contact information for
2 other organizations that can provide
3 the beneficiary with assistance regard-
4 ing such drug management program
5 (similar to the information provided
6 by the Secretary in other standardized
7 notices provided to part D eligible in-
8 dividuals enrolled in prescription drug
9 plans under this part).

10 “(iii) SECOND NOTICE.—A second no-
11 tice described in this clause is a notice that
12 provides to the beneficiary notice—

13 “(I) that the PDP sponsor has
14 identified the beneficiary as an at-risk
15 beneficiary for prescription drug
16 abuse;

17 “(II) that such beneficiary is
18 subject to the requirements of the
19 drug management program for at-risk
20 beneficiaries established by such PDP
21 sponsor for such plan;

22 “(III) of the prescriber (or pre-
23 scribers) and pharmacy (or phar-
24 macies) selected for such individual
25 under subparagraph (D);

1 “(IV) of, and information about,
2 the beneficiary’s right to appeal such
3 identification under subsection (h)
4 and the option of an automatic esca-
5 lation to external review;

6 “(V) that the beneficiary can, in
7 the case that the beneficiary has not
8 previously submitted to the PDP
9 sponsor preferences for which pre-
10 scribers and pharmacies the bene-
11 ficiary would prefer the PDP sponsor
12 select under subparagraph (D), sub-
13 mit such preferences to the PDP
14 sponsor; and

15 “(VI) that includes clear instruc-
16 tions that explain how the beneficiary
17 can contact the PDP sponsor.

18 “(iv) TIMING OF NOTICES.—

19 “(I) IN GENERAL.—Subject to
20 subclause (II), a second notice de-
21 scribed in clause (iii) shall be provided
22 to the beneficiary on a date that is
23 not less than 30 days after an initial
24 notice described in clause (ii) is pro-
25 vided to the beneficiary.

1 “(II) EXCEPTION.—In the case
2 that the PDP sponsor, in conjunction
3 with the Secretary, determines that
4 concerns identified through rule-
5 making by the Secretary regarding
6 the health or safety of the beneficiary
7 or regarding significant drug diversion
8 activities require the PDP sponsor to
9 provide a second notice described in
10 clause (iii) to the beneficiary on a
11 date that is earlier than the date de-
12 scribed in subclause (I), the PDP
13 sponsor may provide such second no-
14 tice on such earlier date.

15 “(C) AT-RISK BENEFICIARY FOR PRE-
16 SCRIPTION DRUG ABUSE.—

17 “(i) IN GENERAL.—For purposes of
18 this paragraph, the term ‘at-risk bene-
19 ficiary for prescription drug abuse’ means
20 a part D eligible individual who is not an
21 exempted individual described in clause (ii)
22 and—

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

1 or abuse of prescription drugs de-
2 scribed in subparagraph (G) and that
3 are developed by the Secretary in con-
4 sultation with PDP sponsors and
5 other stakeholders, including individ-
6 uals entitled to benefits under part A
7 or enrolled under part B, advocacy
8 groups representing such individuals,
9 physicians, pharmacists, and other cli-
10 nicians, retail pharmacies, plan spon-
11 sors, entities delegated by plan spon-
12 sors, and biopharmaceutical manufac-
13 turers; or

14 “(II) with respect to whom the
15 PDP sponsor of a prescription drug
16 plan, upon enrolling such individual in
17 such plan, received notice from the
18 Secretary that such individual was
19 identified under this paragraph to be
20 an at-risk beneficiary for prescription
21 drug abuse under the prescription
22 drug plan in which such individual
23 was most recently previously enrolled
24 and such identification has not been
25 terminated under subparagraph (F).

1 “(ii) EXEMPTED INDIVIDUAL DE-
2 SCRIBED.—An exempted individual de-
3 scribed in this clause is an individual
4 who—

5 “(I) receives hospice care under
6 this title;

7 “(II) is a resident of a long-term
8 care facility, of a facility described in
9 section 1905(d), or of another facility
10 for which frequently abused drugs are
11 dispensed for residents through a con-
12 tract with a single pharmacy; or

13 “(III) the Secretary elects to
14 treat as an exempted individual for
15 purposes of clause (i).

16 “(iii) PROGRAM SIZE.—The Secretary
17 shall establish policies, including the guide-
18 lines developed under clause (i)(I) and the
19 exemptions under clause (ii)(III), to ensure
20 that the population of enrollees in a drug
21 management program for at-risk bene-
22 ficiaries operated by a prescription drug
23 plan can be effectively managed by such
24 plans.

1 “(iv) CLINICAL CONTACT.—With re-
2 spect to each at-risk beneficiary for pre-
3 scription drug abuse enrolled in a prescrip-
4 tion drug plan offered by a PDP sponsor,
5 the PDP sponsor shall contact the bene-
6 ficiary’s providers who have prescribed fre-
7 quently abused drugs regarding whether
8 prescribed medications are appropriate for
9 such beneficiary’s medical conditions.

10 “(D) SELECTION OF PRESCRIBERS AND
11 PHARMACIES.—

12 “(i) IN GENERAL.—With respect to
13 each at-risk beneficiary for prescription
14 drug abuse enrolled in a prescription drug
15 plan offered by such sponsor, a PDP spon-
16 sor shall, based on the preferences sub-
17 mitted to the PDP sponsor by the bene-
18 ficiary pursuant to clauses (ii)(IV) and
19 (iii)(V) of subparagraph (B) (except as
20 otherwise provided in this subparagraph)
21 select—

22 “(I) one, or, if the PDP sponsor
23 reasonably determines it necessary to
24 provide the beneficiary with reason-
25 able access under clause (ii), more

1 than one, individual who is authorized
2 to prescribe frequently abused drugs
3 (referred to in this paragraph as a
4 ‘prescriber’) who may write prescrip-
5 tions for such drugs for such bene-
6 ficiary; and

7 “(II) one, or, if the PDP sponsor
8 reasonably determines it necessary to
9 provide the beneficiary with reason-
10 able access under clause (ii), more
11 than one, pharmacy that may dis-
12 pense such drugs to such beneficiary.

13 For purposes of subclause (II), in the case
14 of a pharmacy that has multiple locations
15 that share real-time electronic data, all
16 such locations of the pharmacy shall collec-
17 tively be treated as one pharmacy.

18 “(ii) REASONABLE ACCESS.—In mak-
19 ing the selections under this subpara-
20 graph—

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

1 location, beneficiary preference, im-
2 pact on costsharing, and reasonable
3 travel time; and

4 “(II) a PDP sponsor shall ensure
5 such access (including access to pre-
6 scribers and pharmacies with respect
7 to frequently abused drugs) in the
8 case of individuals with multiple resi-
9 dences, in the case of natural disas-
10 ters and similar situations, and in the
11 case of the provision of emergency
12 services.

13 “(iii) BENEFICIARY PREFERENCES.—
14 If an at-risk beneficiary for prescription
15 drug abuse submits preferences for which
16 in-network prescribers and pharmacies the
17 beneficiary would prefer the PDP sponsor
18 select in response to a notice under sub-
19 paragraph (B), the PDP sponsor shall—

20 “(I) review such preferences;

21 “(II) select or change the selec-
22 tion of prescribers and pharmacies for
23 the beneficiary based on such pref-
24 erences; and

1 “(III) inform the beneficiary of
2 such selection or change of selection.

3 “(iv) EXCEPTION REGARDING BENE-
4 FICIARY PREFERENCES.—In the case that
5 the PDP sponsor determines that a change
6 to the selection of prescriber or pharmacy
7 under clause (iii)(II) by the PDP sponsor
8 is contributing or would contribute to pre-
9 scription drug abuse or drug diversion by
10 the beneficiary, the PDP sponsor may
11 change the selection of prescriber or phar-
12 macy for the beneficiary without regard to
13 the preferences of the beneficiary described
14 in clause (iii). If the PDP sponsor changes
15 the selection pursuant to the preceding
16 sentence, the PDP sponsor shall provide
17 the beneficiary with—

18 “(I) at least 30 days written no-
19 tice of the change of selection; and

20 “(II) a rationale for the change.

21 “(v) CONFIRMATION.—Before select-
22 ing a prescriber or pharmacy under this
23 subparagraph, a PDP sponsor must notify
24 the prescriber and pharmacy that the bene-
25 ficiary involved has been identified for in-

1 clusion in the drug management program
2 for at-risk beneficiaries and that the pre-
3 scriber and pharmacy has been selected as
4 the beneficiary's designated prescriber and
5 pharmacy.

6 “(E) TERMINATIONS AND APPEALS.—The
7 identification of an individual as an at-risk ben-
8 eficiary for prescription drug abuse under this
9 paragraph, a coverage determination made
10 under a drug management program for at-risk
11 beneficiaries, the selection of prescriber or phar-
12 macy under subparagraph (D), and information
13 to be shared under subparagraph (I), with re-
14 spect to such individual, shall be subject to re-
15 consideration and appeal under subsection (h)
16 and the option of an automatic escalation to ex-
17 ternal review to the extent provided by the Sec-
18 retary.

19 “(F) TERMINATION OF IDENTIFICATION.—

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

1 ards such identification shall terminate as
2 of the earlier of—

3 “(I) the date the individual dem-
4 onstrates that the individual is no
5 longer likely, in the absence of the re-
6 strictions under this paragraph, to be
7 an at-risk beneficiary for prescription
8 drug abuse described in subparagraph
9 (C)(i); and

10 “(II) the end of such maximum
11 period of identification as the Sec-
12 retary may specify.

13 “(ii) RULE OF CONSTRUCTION.—
14 Nothing in clause (i) shall be construed as
15 preventing a plan from identifying an indi-
16 vidual as an at-risk beneficiary for pre-
17 scription drug abuse under subparagraph
18 (C)(i) after such termination on the basis
19 of additional information on drug use oc-
20 curring after the date of notice of such ter-
21 mination.

22 “(G) FREQUENTLY ABUSED DRUG.—For
23 purposes of this subsection, the term ‘frequently
24 abused drug’ means a drug that is a controlled

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

3 “(H) DATA DISCLOSURE.—

4 “(i) DATA ON DECISION TO IMPOSE
5 LIMITATION.—In the case of an at-risk
6 beneficiary for prescription drug abuse (or
7 an individual who is a potentially at-risk
8 beneficiary for prescription drug abuse)
9 whose access to coverage for frequently
10 abused drugs under a prescription drug
11 plan has been limited by a PDP sponsor
12 under this paragraph, the Secretary shall
13 establish rules and procedures to require
14 the PDP sponsor to disclose data, includ-
15 ing any necessary individually identifiable
16 health information, in a form and manner
17 specified by the Secretary, about the deci-
18 sion to impose such limitations and the
19 limitations imposed by the sponsor under
20 this part.

21 “(ii) DATA TO REDUCE FRAUD,
22 ABUSE, AND WASTE.—The Secretary shall
23 establish rules and procedures to require
24 PDP sponsors operating a drug manage-
25 ment program for at-risk beneficiaries

1 under this paragraph to provide the Sec-
2 retary with such data as the Secretary de-
3 termines appropriate for purposes of iden-
4 tifying patterns of prescription drug utili-
5 zation for plan enrollees that are outside
6 normal patterns and that may indicate
7 fraudulent, medically unnecessary, or un-
8 safe use.

9 “(I) SHARING OF INFORMATION FOR SUB-
10 SEQUENT PLAN ENROLLMENTS.—The Secretary
11 shall establish procedures under which PDP
12 sponsors who offer prescription drug plans shall
13 share information with respect to individuals
14 who are at-risk beneficiaries for prescription
15 drug abuse (or individuals who are potentially
16 at-risk beneficiaries for prescription drug
17 abuse) and enrolled in a prescription drug plan
18 and who subsequently disenroll from such plan
19 and enroll in another prescription drug plan of-
20 fered by another PDP sponsor.

21 “(J) PRIVACY ISSUES.—Prior to the imple-
22 mentation of the rules and procedures under
23 this paragraph, the Secretary shall clarify pri-
24 vacy requirements, including requirements
25 under the regulations promulgated pursuant to

1 section 264(c) of the Health Insurance Port-
2 ability and Accountability Act of 1996 (42
3 U.S.C. 1320d–2 note), related to the sharing of
4 data under subparagraphs (H) and (I) by PDP
5 sponsors. Such clarification shall provide that
6 the sharing of such data shall be considered to
7 be protected health information in accordance
8 with the requirements of the regulations pro-
9 mulgated pursuant to such section 264(c).

10 “(K) EDUCATION.—The Secretary shall
11 provide education to enrollees in prescription
12 drug plans of PDP sponsors and providers re-
13 garding the drug management program for at-
14 risk beneficiaries described in this paragraph,
15 including education—

16 “(i) provided by Medicare administra-
17 tive contractors through the improper pay-
18 ment outreach and education program de-
19 scribed in section 1874A(h); and

20 “(ii) through current education efforts
21 (such as State health insurance assistance
22 programs described in subsection (a)(1)(A)
23 of section 119 of the Medicare Improve-
24 ments for Patients and Providers Act of

1 2008 (42 U.S.C. 1395b–3 note)) and ma-
2 terials directed toward such enrollees.

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

11 “(M) CMS COMPLIANCE REVIEW.—The
12 Secretary shall ensure that existing plan spon-
13 sor compliance reviews and audit processes in-
14 clude the drug management programs for at-
15 risk beneficiaries under this paragraph, includ-
16 ing appeals processes under such programs.”.

17 (2) INFORMATION FOR CONSUMERS.—Section
18 1860D–4(a)(1)(B) of the Social Security Act (42
19 U.S.C. 1395w–104(a)(1)(B)) is amended by adding
20 at the end the following:

21 “(v) The drug management program
22 for at-risk beneficiaries under subsection
23 (c)(5).”.

24 (3) DUAL ELIGIBLES.—Section 1860D–
25 1(b)(3)(D) of the Social Security Act (42 U.S.C.

1 1395w–101(b)(3)(D)) is amended by inserting “,
2 subject to such limits as the Secretary may establish
3 for individuals identified pursuant to section
4 1860D–4(c)(5)” after “the Secretary”.

5 (b) UTILIZATION MANAGEMENT PROGRAMS.—Sec-
6 tion 1860D–4(c) of the Social Security Act (42 U.S.C.
7 1395w–104(c)), as amended by subsection (a)(1), is fur-
8 ther amended—

9 (1) in paragraph (1), by inserting after sub-
10 paragraph (D) the following new subparagraph:

11 “(E) A utilization management tool to pre-
12 vent drug abuse (as described in paragraph
13 (6)(A)).”; and

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

16 “(6) UTILIZATION MANAGEMENT TOOL TO PRE-
17 VENT DRUG ABUSE.—

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

20 “(i) A utilization tool designed to pre-
21 vent the abuse of frequently abused drugs
22 by individuals and to prevent the diversion
23 of such drugs at pharmacies.

24 “(ii) Retrospective utilization review
25 to identify—

1 “(I) individuals that receive fre-
2 quently abused drugs at a frequency
3 or in amounts that are not clinically
4 appropriate; and

5 “(II) providers of services or sup-
6 pliers that may facilitate the abuse or
7 diversion of frequently abused drugs
8 by beneficiaries.

9 “(iii) Consultation with the contractor
10 described in subparagraph (B) to verify if
11 an individual enrolling in a prescription
12 drug plan offered by a PDP sponsor has
13 been previously identified by another PDP
14 sponsor as an individual described in
15 clause (ii)(I).

16 “(B) REPORTING.—A PDP sponsor offer-
17 ing a prescription drug plan (and an MA orga-
18 nization offering an MA–PD plan) in a State
19 shall submit to the Secretary and the Medicare
20 drug integrity contractor with which the Sec-
21 retary has entered into a contract under section
22 1893 with respect to such State a report, on a
23 monthly basis, containing information on—

24 “(i) any provider of services or sup-
25 plier described in subparagraph (A)(ii)(II)

1 that is identified by such plan sponsor (or
2 organization) during the 30-day period be-
3 fore such report is submitted; and

4 “(ii) the name and prescription
5 records of individuals described in para-
6 graph (5)(C).

7 “(C) CMS COMPLIANCE REVIEW.—The
8 Secretary shall ensure that plan sponsor compli-
9 ance reviews and program audits biennially in-
10 clude a certification that utilization manage-
11 ment tools under this paragraph are in compli-
12 ance with the requirements for such tools.”.

13 (c) EXPANDING ACTIVITIES OF MEDICARE DRUG IN-
14 TEGRITY CONTRACTORS (MEDICs).—

15 (1) IN GENERAL.—Section 1893 of the Social
16 Security Act (42 U.S.C. 1395ddd) is amended by
17 adding at the end the following new subsection:

18 “(j) EXPANDING ACTIVITIES OF MEDICARE DRUG
19 INTEGRITY CONTRACTORS (MEDICs).—

20 “(1) ACCESS TO INFORMATION.—Under con-
21 tracts entered into under this section with Medicare
22 drug integrity contractors (including any successor
23 entity to a Medicare drug integrity contractor), the
24 Secretary shall authorize such contractors to directly
25 accept prescription and necessary medical records

1 from entities such as pharmacies, prescription drug
2 plans, MA–PD plans, and physicians with respect to
3 an individual in order for such contractors to pro-
4 vide information relevant to the determination of
5 whether such individual is an at-risk beneficiary for
6 prescription drug abuse, as defined in section
7 1860D–4(c)(5)(C).

8 “(2) REQUIREMENT FOR ACKNOWLEDGMENT
9 OF REFERRALS.—If a PDP sponsor or MA organiza-
10 tion refers information to a contractor described in
11 paragraph (1) in order for such contractor to assist
12 in the determination described in such paragraph,
13 the contractor shall—

14 “(A) acknowledge to the sponsor or organi-
15 zation receipt of the referral; and

16 “(B) in the case that any PDP sponsor or
17 MA organization contacts the contractor re-
18 questing to know the determination by the con-
19 tractor of whether or not an individual has been
20 determined to be an individual described in
21 such paragraph, shall inform such sponsor or
22 organization of such determination on a date
23 that is not later than 15 days after the date on
24 which the sponsor or organization contacts the
25 contractor.

1 “(3) MAKING DATA AVAILABLE TO OTHER EN-
2 TITIES.—

3 “(A) IN GENERAL.—For purposes of car-
4 rying out this subsection, subject to subpara-
5 graph (B), the Secretary shall authorize MED-
6 ICs to respond to requests for information from
7 PDP sponsors and MA organizations, State
8 prescription drug monitoring programs, and
9 other entities delegated by such sponsors or or-
10 ganizations using available programs and sys-
11 tems in the effort to prevent fraud, waste, and
12 abuse.

13 “(B) HIPAA COMPLIANT INFORMATION
14 ONLY.—Information may only be disclosed by a
15 MEDIC under subparagraph (A) if the disclo-
16 sure of such information is permitted under the
17 Federal regulations (concerning the privacy of
18 individually identifiable health information) pro-
19 mulgated under section 264(c) of the Health
20 Insurance Portability and Accountability Act of
21 1996 (42 U.S.C. 1320d–2 note).”.

22 (2) OIG STUDY AND REPORT ON EFFECTIVE-
23 NESS OF MEDICS.—

24 (A) STUDY.—The Inspector General of the
25 Department of Health and Human Services

1 shall conduct a study on the effectiveness of
2 Medicare drug integrity contractors with which
3 the Secretary of Health and Human Services
4 has entered into a contract under section 1893
5 of the Social Security Act (42 U.S.C. 1395ddd)
6 in identifying, combating, and preventing fraud
7 under the Medicare program, including under
8 the authority provided under section 1893(j) of
9 the Social Security Act, added by paragraph
10 (1).

11 (B) REPORT.—Not later than 24 months
12 after the date of the enactment of this Act, the
13 Inspector General shall submit to Congress a
14 report on the study conducted under subpara-
15 graph (A). Such report shall include such rec-
16 ommendations for improvements in the effec-
17 tiveness of such contractors as the Inspector
18 General determines appropriate.

19 (d) TREATMENT OF CERTAIN COMPLAINTS FOR PUR-
20 POSES OF QUALITY OR PERFORMANCE ASSESSMENT.—
21 Section 1860D–42 of the Social Security Act (42 U.S.C.
22 1395w–152) is amended by adding at the end the fol-
23 lowing new subsection:

24 “(d) TREATMENT OF CERTAIN COMPLAINTS FOR
25 PURPOSES OF QUALITY OR PERFORMANCE ASSESS-

1 MENT.—In conducting a quality or performance assess-
2 ment of a PDP sponsor, the Secretary shall develop or
3 utilize existing screening methods for reviewing and con-
4 sidering complaints that are received from enrollees in a
5 prescription drug plan offered by such PDP sponsor and
6 that are complaints regarding the lack of access by the
7 individual to prescription drugs due to a drug manage-
8 ment program for at-risk beneficiaries.”.

9 (e) SENSE OF CONGRESS REGARDING USE OF TECH-
10 NOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of
11 Congress that MA organizations and PDP sponsors
12 should consider using e-prescribing and other health infor-
13 mation technology tools to support combating fraud under
14 MA–PD plans and prescription drug plans under parts C
15 and D of the Medicare program.

16 (f) REPORTS.—

17 (1) REPORT BY SECRETARY ON APPEALS PROC-
18 ESS.—

19 (A) IN GENERAL.—Not later than 12
20 months after the date of the enactment of this
21 Act, the Secretary of Health and Human Serv-
22 ices shall submit to the appropriate committees
23 of jurisdiction of Congress a report on ways to
24 improve upon the appeals process for Medicare
25 beneficiaries with respect to prescription drug

1 coverage under part D of title XVIII of the So-
2 cial Security Act. Such report shall include an
3 analysis comparing appeals processes under
4 parts C and D of such title XVIII.

5 (B) FEEDBACK.—In development of the
6 report described in subparagraph (A), the Sec-
7 retary of Health and Human Services shall so-
8 licit feedback on the current appeals process
9 from stakeholders, such as beneficiaries, con-
10 sumer advocates, plan sponsors, pharmacy ben-
11 efit managers, pharmacists, providers, inde-
12 pendent review entity evaluators, and pharma-
13 ceutical manufacturers.

14 (2) GAO STUDY AND REPORT.—

15 (A) STUDY.—The Comptroller General of
16 the United States shall conduct a study on the
17 implementation of the amendments made by
18 this section, including the effectiveness of the
19 at-risk beneficiaries for prescription drug abuse
20 drug management programs authorized by sec-
21 tion 1860D–4(c)(5) of the Social Security Act
22 (42 U.S.C. 1395w–10(c)(5)), as added by sub-
23 section (a)(1). Such study shall include an anal-
24 ysis of—

1 (i) the impediments, if any, that im-
2 pair the ability of individuals described in
3 subparagraph (C) of such section 1860D–
4 4(c)(5) to access clinically appropriate lev-
5 els of prescription drugs;

6 (ii) the effectiveness of the reasonable
7 access protections under subparagraph
8 (D)(ii) of such section 1860D–4(c)(5), in-
9 cluding the impact on beneficiary access
10 and health;

11 (iii) the types of—

12 (I) individuals who, in the imple-
13 mentation of such section, are deter-
14 mined to be individuals described in
15 such subparagraph (C); and

16 (II) prescribers and pharmacies
17 that are selected under subparagraph
18 (D) of such section; and

19 (iv) other areas determined appro-
20 priate by the Comptroller General.

21 (B) REPORT.—Not later than July 1,
22 2019, the Comptroller General of the United
23 States shall submit to the appropriate commit-
24 tees of jurisdiction of Congress a report on the
25 study conducted under subparagraph (A), to-

1 gether with recommendations for such legisla-
2 tion and administrative action as the Comp-
3 troller General determines to be appropriate.

4 (g) EFFECTIVE DATE; RULEMAKING.—

5 (1) IN GENERAL.—The amendments made by
6 this section shall apply to prescription drug plans
7 (and MA–PD plans) for plan years beginning on or
8 after January 1, 2019.

9 (2) STAKEHOLDER MEETINGS PRIOR TO EFFEC-
10 TIVE DATE.—

11 (A) IN GENERAL.—Not later than January
12 1, 2017, the Secretary of Health and Human
13 Services shall convene stakeholders, including
14 individuals entitled to benefits under part A of
15 title XVIII of the Social Security Act or en-
16 rolled under part B of such title, advocacy
17 groups representing such individuals, physi-
18 cians, pharmacists, and other clinicians, retail
19 pharmacies, plan sponsors, entities delegated by
20 plan sponsors, and biopharmaceutical manufac-
21 turers for input regarding the topics described
22 in subparagraph (B). The input described in
23 the preceding sentence shall be provided to the
24 Secretary in sufficient time in order for the
25 Secretary to take such input into account in

1 promulgating the regulations pursuant to para-
2 graph (3).

3 (B) TOPICS DESCRIBED.—The topics de-
4 scribed in this subparagraph are the topics of—

5 (i) the anticipated impact of drug
6 management programs for at-risk bene-
7 ficiaries under paragraph (5) of section
8 1860D–4(c) of the Social Security Act (42
9 U.S.C. 1395w–104(c)) on cost-sharing and
10 ensuring accessibility to prescription drugs
11 for enrollees in prescription drug plans of
12 PDP sponsors, and enrollees in MA–PD
13 plans, who are at-risk beneficiaries for pre-
14 scription drug abuse (as defined in sub-
15 paragraph (C) of such paragraph);

16 (ii) the use of an expedited appeals
17 process under which such an enrollee may
18 appeal an identification of such enrollee as
19 an at-risk beneficiary for prescription drug
20 abuse under such paragraph (similar to the
21 processes established under the Medicare
22 Advantage program under part C of title
23 XVIII of the Social Security Act that allow
24 an automatic escalation to external review
25 of claims submitted under such part);

1 (iii) the types of enrollees that should
2 be treated as exempted individuals, as de-
3 scribed in subparagraph (C)(ii) of such
4 paragraph;

5 (iv) the manner in which terms and
6 definitions in such paragraph should be ap-
7 plied, such as the use of clinical appro-
8 priateness in determining whether an en-
9 rollee is an at-risk beneficiary for prescrip-
10 tion drug abuse as defined in subpara-
11 graph (C) of such paragraph;

12 (v) the information to be included in
13 the notices described in subparagraph (B)
14 of such paragraph and the standardization
15 of such notices;

16 (vi) with respect to a PDP sponsor
17 (or Medicare Advantage organization) that
18 establishes a drug management program
19 for at-risk beneficiaries under such para-
20 graph, the responsibilities of such PDP
21 sponsor (or organization) with respect to
22 the implementation of such program;

23 (vii) notices for plan enrollees at the
24 point of sale that would explain why an at-
25 risk beneficiary has been prohibited from

1 receiving a prescription at a location out-
2 side of the designated pharmacy;
3 (viii) evidence-based prescribing guide-
4 lines for opiates; and
5 (ix) the sharing of claims data under
6 parts A and B of title XVIII of the Social
7 Security Act with PDP sponsors.

8 (3) RULEMAKING.—Not later than one year
9 after the date of the enactment of this Act, the Sec-
10 retary of Health and Human Services shall, taking
11 into account the input gathered pursuant to para-
12 graph (2)(A) and after providing notice and an op-
13 portunity to comment, promulgate regulations to
14 carry out the provisions of, and amendments made
15 by this section.

16 (h) DEPOSIT OF SAVINGS INTO MEDICARE IMPROVE-
17 MENT FUND.—Section 1898(b)(1) of the Social Security
18 Act (42 U.S.C. 1395iii(b)(1)) is amended by striking
19 “during and after fiscal year 2020, \$0” and inserting
20 “during and after fiscal year 2021, \$140,000,000”.

1 **SEC. 705. EXCLUDING ABUSE-DETERRENT FORMULATIONS**
2 **OF PRESCRIPTION DRUGS FROM THE MED-**
3 **ICAID ADDITIONAL REBATE REQUIREMENT**
4 **FOR NEW FORMULATIONS OF PRESCRIPTION**
5 **DRUGS.**

6 (a) IN GENERAL.—The last sentence of section
7 1927(c)(2)(C) of the Social Security Act (42 U.S.C.
8 1396r–8(c)(2)(C)) is amended by inserting before the pe-
9 riod at the end the following: “, but does not include an
10 abuse-deterrent formulation of the drug (as determined by
11 the Secretary), regardless of whether such abuse-deterrent
12 formulation is an extended release formulation”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall apply to drugs that are paid for by
15 a State in calendar quarters beginning on or after the date
16 of the enactment of this Act.

17 **SEC. 706. LIMITING DISCLOSURE OF PREDICTIVE MOD-**
18 **ELING AND OTHER ANALYTICS TECH-**
19 **NOLOGIES TO IDENTIFY AND PREVENT**
20 **WASTE, FRAUD, AND ABUSE.**

21 (a) IN GENERAL.—Title XI of the Social Security Act
22 is amended by inserting after section 1128J (42 U.S.C.
23 1320a–7k) the following new section:

1 **“SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND**
2 **OTHER ANALYTICS TECHNOLOGIES TO IDEN-**
3 **TIFY AND PREVENT WASTE, FRAUD, AND**
4 **ABUSE.**

5 “(a) REFERENCE TO PREDICTIVE MODELING TECH-
6 NOLOGIES REQUIREMENTS.—For provisions relating to
7 the use of predictive modeling and other analytics tech-
8 nologies to identify and prevent waste, fraud, and abuse
9 with respect to the Medicare program under title XVIII,
10 the Medicaid program under title XIX, and the Children’s
11 Health Insurance Program under title XXI, see section
12 4241 of the Small Business Jobs Act of 2010 (42 U.S.C.
13 1320a–7m).

14 “(b) LIMITING DISCLOSURE OF PREDICTIVE MOD-
15 ELING TECHNOLOGIES.—In implementing such provisions
16 under such section 4241 with respect to covered algo-
17 rithms (as defined in subsection (c)), the following shall
18 apply:

19 “(1) NONAPPLICATION OF FOIA.—The covered
20 algorithms used or developed for purposes of such
21 section 4241 (including by the Secretary or a State
22 (or an entity operating under a contract with a
23 State)) shall be exempt from disclosure under sec-
24 tion 552(b)(3) of title 5, United States Code.

1 “(2) LIMITATION WITH RESPECT TO USE AND
2 DISCLOSURE OF INFORMATION BY STATE AGEN-
3 CIES.—

4 “(A) IN GENERAL.—A State agency may
5 not use or disclose covered algorithms used or
6 developed for purposes of such section 4241 ex-
7 cept for purposes of administering the State
8 plan (or a waiver of the plan) under the Med-
9 icaid program under title XIX or the State
10 child health plan (or a waiver of the plan)
11 under the Children’s Health Insurance Program
12 under title XXI, including by enabling an entity
13 operating under a contract with a State to as-
14 sist the State to identify or prevent waste,
15 fraud, and abuse with respect to such pro-
16 grams.

17 “(B) INFORMATION SECURITY.—A State
18 agency shall have in effect data security and
19 control policies that the Secretary finds ade-
20 quate to ensure the security of covered algo-
21 rithms used or developed for purposes of such
22 section 4241 and to ensure that access to such
23 information is restricted to authorized persons
24 for purposes of authorized uses and disclosures
25 described in subparagraph (A).

1 “(C) PROCEDURAL REQUIREMENTS.—
2 State agencies to which information is disclosed
3 pursuant to such section 4241 shall adhere to
4 uniform procedures established by the Sec-
5 retary.

6 “(c) COVERED ALGORITHM DEFINED.—In this sec-
7 tion, the term ‘covered algorithm’—

8 “(1) means a predictive modeling or other ana-
9 lytics technology, as used for purposes of section
10 4241(a) of the Small Business Jobs Act of 2010 (42
11 U.S.C. 1320a–7m(a)) to identify and prevent waste,
12 fraud, and abuse with respect to the Medicare pro-
13 gram under title XVIII, the Medicaid program
14 under title XIX, and the Children’s Health Insur-
15 ance Program under title XXI; and

16 “(2) includes the mathematical expressions uti-
17 lized in the application of such technology and the
18 means by which such technology is developed.”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) MEDICAID STATE PLAN REQUIREMENT.—
21 Section 1902(a) of the Social Security Act (42
22 U.S.C. 1396a(a)) is amended—

23 (A) in paragraph (80), by striking “and”
24 at the end;

1 (B) in paragraph (81), by striking the pe-
2 riod at the end and inserting “; and”; and

3 (C) by inserting after paragraph (81) the
4 following new paragraph:

5 “(82) provide that the State agency responsible
6 for administering the State plan under this title pro-
7 vides assurances to the Secretary that the State
8 agency is in compliance with subparagraphs (A),
9 (B), and (C) of section 1128K(b)(2).”.

10 (2) STATE CHILD HEALTH PLAN REQUIRE-
11 MENT.—Section 2102(a)(7) of the Social Security
12 Act (42 U.S.C. 1397bb(a)(7)) is amended—

13 (A) in subparagraph (A), by striking “,
14 and” at the end and inserting a semicolon;

15 (B) in subparagraph (B), by striking the
16 period at the end and inserting “; and”; and

17 (C) by adding at the end the following new
18 subparagraph:

19 “(C) to ensure that the State agency in-
20 volved is in compliance with subparagraphs (A),
21 (B), and (C) of section 1128K(b)(2).”.

22 **SEC. 707. MEDICAID IMPROVEMENT FUND.**

23 Section 1941(b)(1) of the Social Security Act (42
24 U.S.C. 1396w–1(b)(1)) is amended to read as follows:

1 “(1) IN GENERAL.—There shall be available to
2 the Fund, for expenditures from the Fund for fiscal
3 year 2021 and thereafter, \$5,000,000.”.

4 **SEC. 708. SENSE OF THE CONGRESS REGARDING TREAT-**
5 **MENT OF SUBSTANCE ABUSE EPIDEMICS.**

6 It is the sense of the Congress that decades of experi-
7 ence and research have demonstrated that a fiscally re-
8 sponsible approach to addressing the opioid abuse epi-
9 demic and other substance abuse epidemics requires treat-
10 ing such epidemics as a public health emergency empha-
11 sizing prevention, treatment, and recovery.

12 **TITLE VIII—KINGPIN**
13 **DESIGNATION IMPROVEMENT**

14 **SEC. 801. PROTECTION OF CLASSIFIED INFORMATION IN**
15 **FEDERAL COURT CHALLENGES RELATING TO**
16 **DESIGNATIONS UNDER THE NARCOTICS**
17 **KINGPIN DESIGNATION ACT.**

18 Section 804 of the Foreign Narcotics Kingpin Des-
19 ignation Act (21 U.S.C. 1903) is amended by adding at
20 the end the following:

21 “(i) PROTECTION OF CLASSIFIED INFORMATION IN
22 FEDERAL COURT CHALLENGES RELATING TO DESIGNA-
23 TIONS.—In any judicial review of a determination made
24 under this section, if the determination was based on clas-
25 sified information (as defined in section 1(a) of the Classi-

1 fied Information Procedures Act) such information may
2 be submitted to the reviewing court ex parte and in cam-
3 era. This subsection does not confer or imply any right
4 to judicial review.”.

5 **TITLE IX—DEPARTMENT OF** 6 **VETERANS AFFAIRS**

7 **SEC. 901. SHORT TITLE.**

8 This title may be cited as the “Jason Simcakoski Me-
9 morial and Promise Act”.

10 **SEC. 902. DEFINITIONS.**

11 In this title:

12 (1) The term “controlled substance” has the
13 meaning given that term in section 102 of the Con-
14 trolled Substances Act (21 U.S.C. 802).

15 (2) The term “State” means each of the several
16 States, territories, and possessions of the United
17 States, the District of Columbia, and the Common-
18 wealth of Puerto Rico.

19 (3) The term “complementary and integrative
20 health” has the meaning given that term, or any
21 successor term, by the National Institutes of Health.

22 (4) The term “opioid receptor antagonist”
23 means a drug or device approved or cleared under
24 the Federal Food, Drug, and Cosmetic Act (21

1 U.S.C. 301 et seq.) for emergency treatment of
2 known or suspected opioid overdose.

3 **Subtitle A—Opioid Therapy and**
4 **Pain Management**

5 **SEC. 911. IMPROVEMENT OF OPIOID SAFETY MEASURES BY**
6 **DEPARTMENT OF VETERANS AFFAIRS.**

7 (a) EXPANSION OF OPIOID SAFETY INITIATIVE.—

8 (1) INCLUSION OF ALL MEDICAL FACILITIES.—

9 Not later than 180 days after the date of the enact-
10 ment of this Act, the Secretary of Veterans Affairs
11 shall expand the Opioid Safety Initiative of the De-
12 partment of Veterans Affairs to include all medical
13 facilities of the Department.

14 (2) GUIDANCE.—The Secretary shall establish
15 guidance that each health care provider of the De-
16 partment of Veterans Affairs, before initiating opioid
17 therapy to treat a patient as part of the comprehen-
18 sive assessment conducted by the health care pro-
19 vider, use the Opioid Therapy Risk Report tool of
20 the Department of Veterans Affairs (or any subse-
21 quent tool), which shall include information from the
22 prescription drug monitoring program of each par-
23 ticipating State as applicable, that includes the most
24 recent information to date relating to the patient
25 that accessed such program to assess the risk for

1 adverse outcomes of opioid therapy for the patient,
2 including the concurrent use of controlled substances
3 such as benzodiazepines, as part of the comprehen-
4 sive assessment conducted by the health care pro-
5 vider.

6 (3) ENHANCED STANDARDS.—The Secretary
7 shall establish enhanced standards with respect to
8 the use of routine and random urine drug tests for
9 all patients before and during opioid therapy to help
10 prevent substance abuse, dependence, and diversion,
11 including—

12 (A) that such tests occur not less fre-
13 quently than once each year or as otherwise de-
14 termined according to treatment protocols; and

15 (B) that health care providers appro-
16 priately order, interpret and respond to the re-
17 sults from such tests to tailor pain therapy,
18 safeguards, and risk management strategies to
19 each patient.

20 (b) PAIN MANAGEMENT EDUCATION AND TRAIN-
21 ING.—

22 (1) IN GENERAL.—In carrying out the Opioid
23 Safety Initiative of the Department, the Secretary
24 shall require all employees of the Department re-

1 sponsible for prescribing opioids to receive education
2 and training described in paragraph (2).

3 (2) EDUCATION AND TRAINING.—Education
4 and training described in this paragraph is edu-
5 cation and training on pain management and safe
6 opioid prescribing practices for purposes of safely
7 and effectively managing patients with chronic pain,
8 including education and training on the following:

9 (A) The implementation of and full compli-
10 ance with the VA/DOD Clinical Practice Guide-
11 line for Management of Opioid Therapy for
12 Chronic Pain, including any update to such
13 guideline.

14 (B) The use of evidence-based pain man-
15 agement therapies and complementary and inte-
16 grative health services, including cognitive-be-
17 havioral therapy, non-opioid alternatives, and
18 non-drug methods and procedures to managing
19 pain and related health conditions including, to
20 the extent practicable, medical devices approved
21 or cleared by the Food and Drug Administra-
22 tion for the treatment of patients with chronic
23 pain and related health conditions.

24 (C) Screening and identification of patients
25 with substance use disorder, including drug-

1 seeking behavior, before prescribing opioids, as-
2 sessment of risk potential for patients devel-
3 oping an addiction, and referral of patients to
4 appropriate addiction treatment professionals if
5 addiction is identified or strongly suspected.

6 (D) Communication with patients on the
7 potential harm associated with the use of
8 opioids and other controlled substances, includ-
9 ing the need to safely store and dispose of sup-
10 plies relating to the use of opioids and other
11 controlled substances.

12 (E) Such other education and training as
13 the Secretary considers appropriate to ensure
14 that veterans receive safe and high-quality pain
15 management care from the Department.

16 (3) USE OF EXISTING PROGRAM.—In providing
17 education and training described in paragraph (2),
18 the Secretary shall use the Interdisciplinary Chronic
19 Pain Management Training Team Program of the
20 Department (or successor program).

21 (c) PAIN MANAGEMENT TEAMS.—

22 (1) IN GENERAL.—In carrying out the Opioid
23 Safety Initiative of the Department, the director of
24 each medical facility of the Department shall iden-
25 tify and designate a pain management team of

1 health care professionals, which may include board
2 certified pain medicine specialists, responsible for co-
3 ordinating and overseeing pain management therapy
4 at such facility for patients experiencing acute and
5 chronic pain that is non-cancer related.

6 (2) ESTABLISHMENT OF PROTOCOLS.—

7 (A) IN GENERAL.—In consultation with
8 the Directors of each Veterans Integrated Serv-
9 ice Network, the Secretary shall establish
10 standard protocols for the designation of pain
11 management teams at each medical facility
12 within the Department.

13 (B) CONSULTATION ON PRESCRIPTION OF
14 OPIOIDS.—Each protocol established under sub-
15 paragraph (A) shall ensure that any health care
16 provider without expertise in prescribing anal-
17 gesics or who has not completed the education
18 and training under subsection (b), including a
19 mental health care provider, does not prescribe
20 opioids to a patient unless that health care pro-
21 vider—

22 (i) consults with a health care pro-
23 vider with pain management expertise or
24 who is on the pain management team of
25 the medical facility; and

1 (ii) refers the patient to the pain man-
2 agement team for any subsequent prescrip-
3 tions and related therapy.

4 (3) REPORT.—

5 (A) IN GENERAL.—Not later than one year
6 after the date of enactment of this Act, the di-
7 rector of each medical facility of the Depart-
8 ment shall submit to the Under Secretary for
9 Health and the director of the Veterans Inte-
10 grated Service Network in which the medical fa-
11 cility is located a report identifying the health
12 care professionals that have been designated as
13 members of the pain management team at the
14 medical facility pursuant to paragraph (1).

15 (B) ELEMENTS.—Each report submitted
16 under subparagraph (A) with respect to a med-
17 ical facility of the Department shall include—

18 (i) a certification as to whether all
19 members of the pain management team at
20 the medical facility have completed the
21 education and training required under sub-
22 section (b);

23 (ii) a plan for the management and
24 referral of patients to such pain manage-
25 ment team if health care providers without

1 expertise in prescribing analgesics pre-
2 scribe opioid medications to treat acute
3 and chronic pain that is non-cancer re-
4 lated; and

5 (iii) a certification as to whether the
6 medical facility—

7 (I) fully complies with the
8 stepped-care model, or successor mod-
9 els, of pain management and other
10 pain management policies of the De-
11 partment; or

12 (II) does not fully comply with
13 such stepped-care model, or successor
14 models, of pain management and
15 other pain management policies but is
16 carrying out a corrective plan of ac-
17 tion to ensure such full compliance.

18 (d) TRACKING AND MONITORING OF OPIOID USE.—

19 (1) PRESCRIPTION DRUG MONITORING PRO-
20 GRAMS OF STATES.—In carrying out the Opioid
21 Safety Initiative and the Opioid Therapy Risk Re-
22 port tool of the Department, the Secretary shall—

23 (A) ensure access by health care providers
24 of the Department to information on controlled
25 substances, including opioids and

1 benzodiazepines, prescribed to veterans who re-
2 ceive care outside the Department through the
3 prescription drug monitoring program of each
4 State with such a program, including by seek-
5 ing to enter into memoranda of understanding
6 with States to allow shared access of such infor-
7 mation between States and the Department;

8 (B) include such information in the Opioid
9 Therapy Risk Report tool; and

10 (C) require health care providers of the
11 Department to submit to the prescription drug
12 monitoring program of each State with such a
13 program information on prescriptions of con-
14 trolled substances received by veterans in that
15 State under the laws administered by the Sec-
16 retary.

17 (2) REPORT ON TRACKING OF DATA ON OPIOID
18 USE.—Not later than 18 months after the date of
19 the enactment of this Act, the Secretary shall submit
20 to the Committee on Veterans' Affairs of the Senate
21 and the Committee on Veterans' Affairs of the
22 House of Representatives a report on the feasibility
23 and advisability of improving the Opioid Therapy
24 Risk Report tool of the Department to allow for

1 more advanced real-time tracking of and access to
2 data on—

3 (A) the key clinical indicators with respect
4 to the totality of opioid use by veterans;

5 (B) concurrent prescribing by health care
6 providers of the Department of opioids in dif-
7 ferent health care settings, including data on
8 concurrent prescribing of opioids to treat men-
9 tal health disorders other than opioid use dis-
10 order; and

11 (C) mail-order prescriptions of opioids pre-
12 scribed to veterans under the laws administered
13 by the Secretary.

14 (e) AVAILABILITY OF OPIOID RECEPTOR ANTAGO-
15 NISTS.—

16 (1) INCREASED AVAILABILITY AND USE.—

17 (A) IN GENERAL.—The Secretary shall
18 maximize the availability of opioid receptor an-
19 tagonists, including naloxone, to veterans.

20 (B) AVAILABILITY, TRAINING, AND DIS-
21 TRIBUTING.—In carrying out subparagraph
22 (A), not later than 90 days after the date of the
23 enactment of this Act, the Secretary shall—

24 (i) equip each pharmacy of the De-
25 partment with opioid receptor antagonists

1 to be dispensed to outpatients as needed;
2 and

3 (ii) expand the Overdose Education
4 and Naloxone Distribution program of the
5 Department to ensure that all veterans in
6 receipt of health care under laws adminis-
7 tered by the Secretary who are at risk of
8 opioid overdose may access such opioid re-
9 ceptor antagonists and training on the
10 proper administration of such opioid recep-
11 tor antagonists.

12 (C) VETERANS WHO ARE AT RISK.—For
13 purposes of subparagraph (B), veterans who are
14 at risk of opioid overdose include—

15 (i) veterans receiving long-term opioid
16 therapy;

17 (ii) veterans receiving opioid therapy
18 who have a history of substance use dis-
19 order or prior instances of overdose; and

20 (iii) veterans who are at risk as deter-
21 mined by a health care provider who is
22 treating the veteran.

23 (2) REPORT.—Not later than 120 days after
24 the date of the enactment of this Act, the Secretary
25 shall submit to the Committee on Veterans' Affairs

1 of the Senate and the Committee on Veterans' Af-
2 fairs of the House of Representatives a report on
3 carrying out paragraph (1), including an assessment
4 of any remaining steps to be carried out by the Sec-
5 retary to carry out such paragraph.

6 (f) INCLUSION OF CERTAIN INFORMATION AND CA-
7 PABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF
8 THE DEPARTMENT.—

9 (1) INFORMATION.—The Secretary shall include
10 in the Opioid Therapy Risk Report tool of the De-
11 partment—

12 (A) information on the most recent time
13 the tool was accessed by a health care provider
14 of the Department with respect to each veteran;
15 and

16 (B) information on the results of the most
17 recent urine drug test for each veteran.

18 (2) CAPABILITIES.—The Secretary shall include
19 in the Opioid Therapy Risk Report tool the ability
20 of the health care providers of the Department to
21 determine whether a health care provider of the De-
22 partment prescribed opioids to a veteran without
23 checking the information in the tool with respect to
24 the veteran.

1 (g) NOTIFICATIONS OF RISK IN COMPUTERIZED
2 HEALTH RECORD.—The Secretary shall modify the com-
3 puterized patient record system of the Department to en-
4 sure that any health care provider that accesses the record
5 of a veteran, regardless of the reason the veteran seeks
6 care from the health care provider, will be immediately no-
7 tified whether the veteran—

8 (1) is receiving opioid therapy and has a history
9 of substance use disorder or prior instances of over-
10 dose;

11 (2) has a history of opioid abuse; or

12 (3) is at risk of developing an opioid use dis-
13 order, as determined by a health care provider who
14 is treating the veteran.

15 **SEC. 912. STRENGTHENING OF JOINT WORKING GROUP ON**
16 **PAIN MANAGEMENT OF THE DEPARTMENT**
17 **OF VETERANS AFFAIRS AND THE DEPART-**
18 **MENT OF DEFENSE.**

19 (a) IN GENERAL.—Not later than 90 days after the
20 date of enactment of this Act, the Secretary of Veterans
21 Affairs and the Secretary of Defense shall ensure that the
22 Pain Management Working Group of the Health Execu-
23 tive Committee of the Department of Veterans Affairs—
24 Department of Defense Joint Executive Committee (Pain
25 Management Working Group) established under section

1 320 of title 38, United States Code, includes a focus on
2 the following:

3 (1) The opioid prescribing practices of health
4 care providers of each Department.

5 (2) The ability of each Department to manage
6 acute and chronic pain among individuals receiving
7 health care from the Department, including training
8 health care providers with respect to pain manage-
9 ment.

10 (3) The use by each Department of complemen-
11 tary and integrative health in treating such individ-
12 uals.

13 (4) The concurrent use and practice by health
14 care providers of each Department of opioids and
15 prescription drugs to treat mental health disorders,
16 including benzodiazepines.

17 (5) The use of care transition plans by health
18 care providers of each Department to address case
19 management issues for patients receiving opioid
20 therapy who transition between inpatient and out-
21 patient care.

22 (6) The coordination in coverage of and con-
23 sistent access to medications prescribed for patients
24 transitioning from receiving health care from the

1 Department of Defense to receiving health care from
2 the Department of Veterans Affairs.

3 (7) The ability of each Department to properly
4 screen, identify, refer, and treat patients with sub-
5 stance use disorders who are seeking treatment for
6 acute and chronic pain management conditions.

7 (b) COORDINATION AND CONSULTATION.—The Sec-
8 retary of Veterans Affairs and the Secretary of Defense
9 shall ensure that the working group described in sub-
10 section (a)—

11 (1) coordinates the activities of the working
12 group with other relevant working groups estab-
13 lished under section 320 of title 38, United States
14 Code;

15 (2) consults with other relevant Federal agen-
16 cies, including the Centers for Disease Control and
17 Prevention, with respect to the activities of the
18 working group; and

19 (3) consults with the Department of Veterans
20 Affairs and the Department of Defense with respect
21 to the VA/DOD Clinical Practice Guideline for Man-
22 agement of Opioid Therapy for Chronic Pain, or any
23 successor guideline, and reviews and provides com-
24 ments before any update to the guideline is released.

25 (c) CLINICAL PRACTICE GUIDELINES.—

1 (1) IN GENERAL.—Not later than 180 days
2 after the date of the enactment of this Act, the Sec-
3 retary of Veterans Affairs and the Secretary of De-
4 fense shall issue an update to the VA/DOD Clinical
5 Practice Guideline for Management of Opioid Ther-
6 apy for Chronic Pain.

7 (2) MATTERS INCLUDED.—In conducting the
8 update under paragraph (1), the Pain Management
9 Working Group, in coordination with the Clinical
10 Practice Guideline VA/DoD Management of Opioid
11 Therapy for Chronic Pain Working Group, shall
12 work to ensure that the Clinical Practical Guideline
13 includes the following:

14 (A) Enhanced guidance with respect to—

15 (i) the co-administration of an opioid
16 and other drugs, including
17 benzodiazepines, that may result in life-
18 limiting drug interactions;

19 (ii) the treatment of patients with
20 current acute psychiatric instability or sub-
21 stance use disorder or patients at risk of
22 suicide; and

23 (iii) the use of opioid therapy to treat
24 mental health disorders other than opioid
25 use disorder.

1 (B) Enhanced guidance with respect to the
2 treatment of patients with behaviors or
3 comorbidities, such as post-traumatic stress dis-
4 order or other psychiatric disorders, or a his-
5 tory of substance abuse or addiction, that re-
6 quires a consultation or co-management of
7 opioid therapy with one or more specialists in
8 pain management, mental health, or addictions.

9 (C) Enhanced guidance with respect to
10 health care providers—

11 (i) conducting an effective assessment
12 for patients beginning or continuing opioid
13 therapy, including understanding and set-
14 ting realistic goals with respect to achiev-
15 ing and maintaining an expected level of
16 pain relief, improved function, or a clini-
17 cally appropriate combination of both; and

18 (ii) effectively assessing whether
19 opioid therapy is achieving or maintaining
20 the established treatment goals of the pa-
21 tient or whether the patient and health
22 care provider should discuss adjusting,
23 augmenting, or discontinuing the opioid
24 therapy.

1 (D) Guidelines to inform the methodologies
2 used by health care providers of the Depart-
3 ment of Veterans Affairs and the Department
4 of Defense to safely taper opioid therapy when
5 adjusting or discontinuing the use of opioid
6 therapy, including—

7 (i) prescription of the lowest effective
8 dose based on patient need;

9 (ii) use of opioids only for a limited
10 time; and

11 (iii) augmentation of opioid therapy
12 with other pain management therapies and
13 modalities.

14 (E) Guidelines with respect to appropriate
15 case management for patients receiving opioid
16 therapy who transition between inpatient and
17 outpatient health care settings, which may in-
18 clude the use of care transition plans.

19 (F) Guidelines with respect to appropriate
20 case management for patients receiving opioid
21 therapy who transition from receiving care dur-
22 ing active duty to post-military health care net-
23 works.

24 (G) Guidelines with respect to providing
25 options, before initiating opioid therapy, for

1 pain management therapies without the use of
2 opioids and options to augment opioid therapy
3 with other clinical and complementary and inte-
4 grative health services to minimize opioid de-
5 pendence.

6 (H) Guidelines with respect to the provi-
7 sion of evidence-based non-opioid treatments
8 within the Department of Veterans Affairs and
9 the Department of Defense, including medical
10 devices and other therapies approved or cleared
11 by the Food and Drug Administration for the
12 treatment of chronic pain as an alternative to
13 or to augment opioid therapy.

14 (I) Guidelines developed by the Centers for
15 Disease Control and Prevention for safely pre-
16 scribing opioids for the treatment of chronic,
17 non-cancer related pain in outpatient settings.

18 (3) RULE OF CONSTRUCTION.—Nothing in this
19 subsection shall be construed to prevent the Sec-
20 retary of Veterans Affairs and the Secretary of De-
21 fense from considering all relevant evidence, as ap-
22 propriate, in updating the VA/DOD Clinical Practice
23 Guideline for Management of Opioid Therapy for
24 Chronic Pain, as required under paragraph (1), or
25 from ensuring that the final clinical practice guide-

1 line updated under such paragraph remains applica-
2 ble to the patient populations of the Department of
3 Veterans Affairs and the Department of Defense.

4 **SEC. 913. REVIEW, INVESTIGATION, AND REPORT ON USE**
5 **OF OPIOIDS IN TREATMENT BY DEPARTMENT**
6 **OF VETERANS AFFAIRS.**

7 (a) COMPTROLLER GENERAL REPORT.—

8 (1) IN GENERAL.—Not later than two years
9 after the date of the enactment of this Act, the
10 Comptroller General of the United States shall sub-
11 mit to the Committee on Veterans' Affairs of the
12 Senate and the Committee on Veterans' Affairs of
13 the House of Representatives a report on the Opioid
14 Safety Initiative of the Department of Veterans Af-
15 fairs and the opioid prescribing practices of health
16 care providers of the Department.

17 (2) ELEMENTS.—The report submitted under
18 paragraph (1) shall include the following:

19 (A) An assessment of the implementation
20 and monitoring by the Veterans Health Admin-
21 istration of the Opioid Safety Initiative of the
22 Department, including examining, as appro-
23 priate, the following:

24 (i) How the Department monitors the
25 key clinical outcomes of such safety initia-

1 tive (for example, the percentage of unique
2 veterans visiting each medical center of the
3 Department that are prescribed an opioid
4 or an opioid and benzodiazepine concu-
5 rently) and how the Department uses that
6 information—

7 (I) to improve prescribing prac-
8 tices; and

9 (II) to identify high prescribing
10 or otherwise inappropriate prescribing
11 practices by health care providers.

12 (ii) How the Department monitors the
13 use of the Opioid Therapy Risk Report tool
14 of the Department (as developed through
15 such safety initiative) and compliance with
16 such tool by medical facilities and health
17 care providers of the Department, includ-
18 ing any findings by the Department of pre-
19 scription rates or prescription practices by
20 medical facilities or health care providers
21 that are inappropriate.

22 (iii) The implementation of academic
23 detailing programs within the Veterans In-
24 tegrated Service Networks of the Depart-
25 ment and how such programs are being

1 used to improve opioid prescribing prac-
2 tices.

3 (iv) Recommendations on such im-
4 provements to the Opioid Safety Initiative
5 of the Department as the Comptroller Gen-
6 eral considers appropriate.

7 (B) Information made available under the
8 Opioid Therapy Risk Report tool with respect
9 to—

10 (i) deaths resulting from sentinel
11 events involving veterans prescribed opioids
12 by a health care provider;

13 (ii) overall prescription rates and, if
14 applicable, indications used by health care
15 providers for prescribing chronic opioid
16 therapy to treat non-cancer, non-palliative,
17 and non-hospice care patients;

18 (iii) the prescription rates and indica-
19 tions used by health care providers for pre-
20 scribing benzodiazepines and opioids con-
21 comitantly;

22 (iv) the practice by health care pro-
23 viders of prescribing opioids to treat pa-
24 tients without any pain, including to treat

1 patients with mental health disorders other
2 than opioid use disorder; and

3 (v) the effectiveness of opioid therapy
4 for patients receiving such therapy, includ-
5 ing the effectiveness of long-term opioid
6 therapy.

7 (C) An evaluation of processes of the De-
8 partment in place to oversee opioid use among
9 veterans, including procedures to identify and
10 remedy potential over-prescribing of opioids by
11 health care providers of the Department.

12 (D) An assessment of the implementation
13 by the Secretary of Veterans Affairs of the VA/
14 DOD Clinical Practice Guideline for Manage-
15 ment of Opioid Therapy for Chronic Pain, in-
16 cluding any figures or approaches used by the
17 Department to assess compliance with such
18 guidelines by medical centers of the Depart-
19 ment and identify any medical centers of the
20 Department operating action plans to improve
21 compliance with such guidelines.

22 (E) An assessment of the data that the
23 Department has developed to review the opioid
24 prescribing practices of health care providers of
25 the Department, as required by this subtitle, in-

1 including a review of how the Department identi-
2 fies the practices of individual health care pro-
3 viders that warrant further review based on
4 prescribing levels, health conditions for which
5 the health care provider is prescribing opioids
6 or opioids and benzodiazepines concurrently, or
7 other practices of the health care provider.

8 (b) SEMI-ANNUAL PROGRESS REPORT ON IMPLE-
9 MENTATION OF COMPTROLLER GENERAL RECOMMENDA-
10 TIONS.—Not later than 180 days after the date of the sub-
11 mittal of the report required under subsection (a), and not
12 less frequently than annually thereafter until the Comp-
13 troller General of the United States determines that all
14 recommended actions are closed, the Secretary of Veterans
15 Affairs shall submit to the Committee on Veterans' Affairs
16 of the Senate and the Committee on Veterans' Affairs of
17 the House of Representatives a progress report detailing
18 the actions by the Secretary to address any outstanding
19 findings and recommendations by the Comptroller General
20 of the United States under subsection (a) with respect to
21 the Veterans Health Administration.

22 (c) ANNUAL REPORT ON OPIOID THERAPY AND PRE-
23 SCRIPTON RATES.—Not later than one year after the
24 date of the enactment of this Act, and not less frequently
25 than annually for the following five years, the Secretary

1 shall submit to the Committee on Veterans' Affairs of the
2 Senate and the Committee on Veterans' Affairs of the
3 House of Representatives a report on opioid therapy and
4 prescription rates for the one-year period preceding the
5 date of the submission of the report. Each such report
6 shall include each of the following:

7 (1) The number of patients and the percentage
8 of the patient population of the Department who
9 were prescribed benzodiazepines and opioids concu-
10 rently by a health care provider of the Department.

11 (2) The number of patients and the percentage
12 of the patient population of the Department without
13 any pain who were prescribed opioids by a health
14 care provider of the Department, including those
15 who were prescribed benzodiazepines and opioids
16 concurrently.

17 (3) The number of non-cancer, non-palliative,
18 and non-hospice care patients and the percentage of
19 such patients who were treated with opioids by a
20 health care provider of the Department on an inpa-
21 tient-basis and who also received prescription opioids
22 by mail from the Department while being treated on
23 an inpatient-basis.

24 (4) The number of non-cancer, non-palliative,
25 and non-hospice care patients and the percentage of

1 such patients who were prescribed opioids concur-
2 rently by a health care provider of the Department
3 and a health care provider that is not a health care
4 provider of the Department.

5 (5) With respect to each medical facility of the
6 Department, the collected and reviewed information
7 on opioids prescribed by health care providers at the
8 facility to treat non-cancer, non-palliative, and non-
9 hospice care patients, including—

10 (A) the prescription rate at which each
11 health care provider at the facility prescribed
12 benzodiazepines and opioids concurrently to
13 such patients and the aggregate of such pre-
14 scription rate for all health care providers at
15 the facility;

16 (B) the prescription rate at which each
17 health care provider at the facility prescribed
18 benzodiazepines or opioids to such patients to
19 treat conditions for which benzodiazepines or
20 opioids are not approved treatment and the ag-
21 gregate of such prescription rate for all health
22 care providers at the facility;

23 (C) the prescription rate at which each
24 health care provider at the facility prescribed or
25 dispensed mail-order prescriptions of opioids to

1 such patients while such patients were being
2 treated with opioids on an inpatient-basis and
3 the aggregate of such prescription rate for all
4 health care providers at the facility; and

5 (D) the prescription rate at which each
6 health care provider at the facility prescribed
7 opioids to such patients who were also concur-
8 rently prescribed opioids by a health care pro-
9 vider that is not a health care provider of the
10 Department and the aggregate of such prescrip-
11 tion rates for all health care providers at the fa-
12 cility.

13 (6) With respect to each medical facility of the
14 Department, the number of times a pharmacist at
15 the facility overrode a critical drug interaction warn-
16 ing with respect to an interaction between opioids
17 and another medication before dispensing such medi-
18 cation to a veteran.

19 (d) INVESTIGATION OF PRESCRIPTION RATES.—If
20 the Secretary determines that a prescription rate with re-
21 spect to a health care provider or medical facility of the
22 Department conflicts with or is otherwise inconsistent
23 with the standards of appropriate and safe care, the Sec-
24 retary shall—

1 (1) immediately notify the Committee on Vet-
2 erans' Affairs of the Senate and the Committee on
3 Veterans' Affairs of the House of Representatives of
4 such determination, including information relating to
5 such determination, prescription rate, and health
6 care provider or medical facility, as the case may be;
7 and

8 (2) through the Office of the Medical Inspector
9 of the Veterans Health Administration, conduct a
10 full investigation of the health care provider or med-
11 ical facility, as the case may be.

12 (e) PRESCRIPTION RATE DEFINED.—In this section,
13 the term “prescription rate” means, with respect to a
14 health care provider or medical facility of the Department,
15 each of the following:

16 (1) The number of patients treated with opioids
17 by the health care provider or at the medical facility,
18 as the case may be, divided by the total number of
19 pharmacy users of that health care provider or med-
20 ical facility.

21 (2) The average number of morphine equiva-
22 lents per day prescribed by the health care provider
23 or at the medical facility, as the case may be, to pa-
24 tients being treated with opioids.

1 (3) Of the patients being treated with opioids
2 by the health care provider or at the medical facility,
3 as the case may be, the average number of prescrip-
4 tions of opioids per patient.

5 **SEC. 914. MANDATORY DISCLOSURE OF CERTAIN VETERAN**
6 **INFORMATION TO STATE CONTROLLED SUB-**
7 **STANCE MONITORING PROGRAMS.**

8 Section 5701(l) of title 38, United States Code, is
9 amended by striking “may” and inserting “shall”.

10 **SEC. 915. ELIMINATION OF COPAYMENT REQUIREMENT**
11 **FOR VETERANS RECEIVING OPIOID ANTAGO-**
12 **NISTS OR EDUCATION ON USE OF OPIOID AN-**
13 **TAGONISTS.**

14 (a) COPAYMENT FOR OPIOID ANTAGONISTS.—Sec-
15 tion 1722A(a) of title 38, United States Code, is amended
16 by adding at the end the following new paragraph:

17 “(4) Paragraph (1) does not apply to opioid antago-
18 nists furnished under this chapter to a veteran who is at
19 high risk for overdose of a specific medication or substance
20 in order to reverse the effect of such an overdose.”.

21 (b) COPAYMENT FOR EDUCATION ON USE OF OPIOID
22 ANTAGONISTS.—Section 1710(g)(3) of such title is
23 amended—

1 (1) by striking “with respect to home health
2 services” and inserting “with respect to the fol-
3 lowing:”

4 “(A) Home health services”; and

5 (2) by adding at the end the following subpara-
6 graph:

7 “(B) Education on the use of opioid antagonists
8 to reverse the effects of overdoses of specific medica-
9 tions or substances.”.

10 **Subtitle B—Patient Advocacy**

11 **SEC. 921. COMMUNITY MEETINGS ON IMPROVING CARE**

12 **FURNISHED BY DEPARTMENT OF VETERANS**

13 **AFFAIRS.**

14 (a) COMMUNITY MEETINGS.—

15 (1) MEDICAL CENTERS.—Not later than 90
16 days after the date of the enactment of this Act, and
17 not less frequently than once every 90 days there-
18 after, the Secretary shall ensure that each medical
19 facility of the Department of Veterans Affairs hosts
20 a community meeting open to the public on improv-
21 ing health care furnished by the Secretary.

22 (2) COMMUNITY-BASED OUTPATIENT CLIN-
23 ICS.—Not later than one year after the date of the
24 enactment of this Act, and not less frequently than
25 annually thereafter, the Secretary shall ensure that

1 each community-based outpatient clinic of the De-
2 partment hosts a community meeting open to the
3 public on improving health care furnished by the
4 Secretary.

5 (b) ATTENDANCE BY DIRECTOR OF VETERANS INTE-
6 GRATED SERVICE NETWORK OR DESIGNEE.—

7 (1) IN GENERAL.—Each community meeting
8 hosted by a medical facility or community-based out-
9 patient clinic under subsection (a) shall be attended
10 by the Director of the Veterans Integrated Service
11 Network in which the medical facility or community-
12 based outpatient clinic, as the case may be, is lo-
13 cated. Subject to paragraph (2), the Director may
14 delegate such attendance only to an employee who
15 works in the Office of the Director.

16 (2) ATTENDANCE BY DIRECTOR.—Each Direc-
17 tor of a Veterans Integrated Service Network shall
18 personally attend not less than one community meet-
19 ing under subsection (a) hosted by each medical fa-
20 cility located in the Veterans Integrated Service Net-
21 work each year.

22 (c) NOTICE.—The Secretary shall notify the Com-
23 mittee on Veterans' Affairs of the Senate, the Committee
24 on Veterans' Affairs of the House of Representatives, and
25 each Member of Congress (as defined in section 902) who

1 represents the area in which the medical facility is located
2 of a community meeting under subsection (a) by not later
3 than 10 days before such community meeting occurs.

4 **SEC. 922. IMPROVEMENT OF AWARENESS OF PATIENT AD-**
5 **VOCACY PROGRAM AND PATIENT BILL OF**
6 **RIGHTS OF DEPARTMENT OF VETERANS AF-**
7 **FAIRS.**

8 Not later than 90 days after the date of the enact-
9 ment of this Act, the Secretary of Veterans Affairs shall,
10 in as many prominent locations as the Secretary deter-
11 mines appropriate to be seen by the largest percentage of
12 patients and family members of patients at each medical
13 facility of the Department of Veterans Affairs—

14 (1) display the purposes of the Patient Advo-
15 cacy Program of the Department and the contact in-
16 formation for the patient advocate at such medical
17 facility; and

18 (2) display the rights and responsibilities of—

19 (A) patients and family members of pa-
20 tients at such medical facility; and

21 (B) with respect to community living cen-
22 ters and other residential facilities of the De-
23 partment, residents and family members of resi-
24 dents at such medical facility.

1 **SEC. 923. COMPTROLLER GENERAL REPORT ON PATIENT**
2 **ADVOCACY PROGRAM OF DEPARTMENT OF**
3 **VETERANS AFFAIRS.**

4 (a) IN GENERAL.—Not later than two years after the
5 date of the enactment of this Act, the Comptroller General
6 of the United States shall submit to the Committee on
7 Veterans' Affairs of the Senate and the Committee on Vet-
8 erans' Affairs of the House of Representatives a report
9 on the Patient Advocacy Program of the Department of
10 Veterans Affairs (in this section referred to as the "Pro-
11 gram").

12 (b) ELEMENTS.—The report required by subsection
13 (a) shall include the following:

14 (1) A description of the Program, including—

15 (A) the purpose of the Program;

16 (B) the activities carried out under the
17 Program; and

18 (C) the sufficiency of the Program in
19 achieving the purpose of the Program.

20 (2) An assessment of the sufficiency of staffing
21 of employees of the Department responsible for car-
22 rying out the Program.

23 (3) An assessment of the sufficiency of the
24 training of such employees.

25 (4) An assessment of—

1 (A) the awareness of the Program among
2 veterans and family members of veterans; and

3 (B) the use of the Program by veterans
4 and family members of veterans.

5 (5) Such recommendations and proposals for
6 improving or modifying the Program as the Comp-
7 troller General considers appropriate.

8 (6) Such other information with respect to the
9 Program as the Comptroller General considers ap-
10 propriate.

11 **SEC. 924. ESTABLISHMENT OF OFFICE OF PATIENT ADVOCACY OF THE DEPARTMENT OF VETERANS AFFAIRS.**

12
13
14 (a) IN GENERAL.—Subchapter I of chapter 73 of title
15 38, United States Code, is amended by adding at the end
16 the following new section:

17 **“§ 7309A. Office of Patient Advocacy**

18 “(a) ESTABLISHMENT.—There is established in the
19 Department within the Office of the Under Secretary for
20 Health an office to be known as the ‘Office of Patient Ad-
21 vocacy’ (in this section referred to as the ‘Office’).

22 “(b) HEAD.—(1) The Director of the Office of Pa-
23 tient Advocacy shall be the head of the Office.

24 “(2) The Director of the Office of Patient Advocacy
25 shall be appointed by the Under Secretary for Health from

1 among individuals qualified to perform the duties of the
2 position and shall report directly to the Under Secretary
3 for Health.

4 “(c) FUNCTION.—(1) The function of the Office is
5 to carry out the Patient Advocacy Program of the Depart-
6 ment.

7 “(2) In carrying out the Patient Advocacy Program
8 of the Department, the Director shall ensure that patient
9 advocates of the Department—

10 “(A) advocate on behalf of veterans with re-
11 spect to health care received and sought by veterans
12 under the laws administered by the Secretary;

13 “(B) carry out the responsibilities specified in
14 subsection (d); and

15 “(C) receive training in patient advocacy.

16 “(d) PATIENT ADVOCACY RESPONSIBILITIES.—The
17 responsibilities of each patient advocate at a medical facil-
18 ity of the Department are the following:

19 “(1) To resolve complaints by veterans with re-
20 spect to health care furnished under the laws admin-
21 istered by the Secretary that cannot be resolved at
22 the point of service or at a higher level easily acces-
23 sible to the veteran.

1 “(2) To present at various meetings and to var-
2 ious committees the issues experienced by veterans
3 in receiving such health care at such medical facility.

4 “(3) To express to veterans their rights and re-
5 sponsibilities as patients in receiving such health
6 care.

7 “(4) To manage the Patient Advocate Tracking
8 System of the Department at such medical facility.

9 “(5) To compile data at such medical facility of
10 complaints made by veterans with respect to the re-
11 ceipt of such health care at such medical facility and
12 the satisfaction of veterans with such health care at
13 such medical facility to determine whether there are
14 trends in such data.

15 “(6) To ensure that a process is in place for the
16 distribution of the data compiled under paragraph
17 (5) to appropriate leaders, committees, services, and
18 staff of the Department.

19 “(7) To identify, not less frequently than quar-
20 terly, opportunities for improvements in the fur-
21 nishing of such health care to veterans at such med-
22 ical facility based on complaints by veterans.

23 “(8) To ensure that any significant complaint
24 by a veteran with respect to such health care is
25 brought to the attention of appropriate staff of the

1 Department to trigger an assessment of whether
2 there needs to be a further analysis of the problem
3 at the facility-wide level.

4 “(9) To support any patient advocacy programs
5 carried out by the Department.

6 “(10) To ensure that all appeals and final deci-
7 sions with respect to the receipt of such health care
8 are entered into the Patient Advocate Tracking Sys-
9 tem of the Department.

10 “(11) To understand all laws, directives, and
11 other rules with respect to the rights and respon-
12 sibilities of veterans in receiving such health care,
13 including the appeals processes available to veterans.

14 “(12) To ensure that veterans receiving mental
15 health care, or the surrogate decision-makers for
16 such veterans, are aware of the rights of veterans to
17 seek representation from systems established under
18 section 103 of the Protection and Advocacy for Men-
19 tally Ill Individuals Act of 1986 (42 U.S.C. 10803)
20 to protect and advocate the rights of individuals with
21 mental illness and to investigate incidents of abuse
22 and neglect of such individuals.

23 “(13) To fulfill requirements established by the
24 Secretary with respect to the inspection of controlled
25 substances.

1 “(14) To document potentially threatening be-
2 havior and report such behavior to appropriate au-
3 thorities.

4 “(e) TRAINING.—In providing training to patient ad-
5 vocates under subsection (c)(2)(C), the Director shall en-
6 sure that such training is consistent throughout the De-
7 partment.

8 “(f) CONTROLLED SUBSTANCE DEFINED.—In this
9 section, the term ‘controlled substance’ has the meaning
10 given that term in section 102 of the Controlled Sub-
11 stances Act (21 U.S.C. 802).”.

12 (b) CLERICAL AMENDMENT.—The table of sections
13 at the beginning of chapter 73 of such title is amended
14 by inserting after the item relating to section 7309 the
15 following new item:

 “7309A. Office of Patient Advocacy.”.

16 (c) DATE FULLY OPERATIONAL.—The Secretary of
17 Veterans Affairs shall ensure that the Office of Patient
18 Advocacy established under section 7309A of title 38,
19 United States Code, as added by subsection (a), is fully
20 operational not later than the date that is one year after
21 the date of the enactment of this Act.

1 **Subtitle C—Complementary and**
2 **Integrative Health**

3 **SEC. 931. EXPANSION OF RESEARCH AND EDUCATION ON**
4 **AND DELIVERY OF COMPLEMENTARY AND IN-**
5 **TEGRATIVE HEALTH TO VETERANS.**

6 (a) **ESTABLISHMENT.**—There is established a com-
7 mission to be known as the “Creating Options for Vet-
8 erans’ Expedited Recovery” or the “COVER Commission”
9 (in this section referred to as the “Commission”). The
10 Commission shall examine the evidence-based therapy
11 treatment model used by the Secretary of Veterans Affairs
12 for treating mental health conditions of veterans and the
13 potential benefits of incorporating complementary and in-
14 tegrative health treatments available in non-Department
15 facilities (as defined in section 1701 of title 38, United
16 States Code).

17 (b) **DUTIES.**—The Commission shall perform the fol-
18 lowing duties:

19 (1) Examine the efficacy of the evidence-based
20 therapy model used by the Secretary for treating
21 mental health illnesses of veterans and identify areas
22 to improve wellness-based outcomes.

23 (2) Conduct a patient-centered survey within
24 each of the Veterans Integrated Service Networks to
25 examine—

1 (A) the experience of veterans with the De-
2 partment of Veterans Affairs when seeking
3 medical assistance for mental health issues
4 through the health care system of the Depart-
5 ment;

6 (B) the experience of veterans with non-
7 Department facilities and health professionals
8 for treating mental health issues;

9 (C) the preference of veterans regarding
10 available treatment for mental health issues and
11 which methods the veterans believe to be most
12 effective;

13 (D) the experience, if any, of veterans with
14 respect to the complementary and integrative
15 health treatment therapies described in para-
16 graph (3);

17 (E) the prevalence of prescribing prescrip-
18 tion medication among veterans seeking treat-
19 ment through the health care system of the De-
20 partment as remedies for addressing mental
21 health issues; and

22 (F) the outreach efforts of the Secretary
23 regarding the availability of benefits and treat-
24 ments for veterans for addressing mental health
25 issues, including by identifying ways to reduce

1 barriers to gaps in such benefits and treat-
2 ments.

3 (3) Examine available research on complemen-
4 tary and integrative health treatment therapies for
5 mental health issues and identify what benefits could
6 be made with the inclusion of such treatments for
7 veterans, including with respect to—

8 (A) music therapy;
9 (B) equine therapy;
10 (C) training and caring for service dogs;
11 (D) yoga therapy;
12 (E) acupuncture therapy;
13 (F) meditation therapy;
14 (G) outdoor sports therapy;
15 (H) hyperbaric oxygen therapy;
16 (I) accelerated resolution therapy;
17 (J) art therapy;
18 (K) magnetic resonance therapy; and
19 (L) other therapies the Commission deter-
20 mines appropriate.

21 (4) Study the sufficiency of the resources of the
22 Department to ensure the delivery of quality health
23 care for mental health issues among veterans seek-
24 ing treatment within the Department.

1 (5) Study the current treatments and resources
2 available within the Department and assess—

3 (A) the effectiveness of such treatments
4 and resources in decreasing the number of sui-
5 cides per day by veterans;

6 (B) the number of veterans who have been
7 diagnosed with mental health issues;

8 (C) the percentage of veterans using the
9 resources of the Department who have been di-
10 agnosed with mental health issues;

11 (D) the percentage of veterans who have
12 completed counseling sessions offered by the
13 Department; and

14 (E) the efforts of the Department to ex-
15 pand complementary and integrative health
16 treatments viable to the recovery of veterans
17 with mental health issues as determined by the
18 Secretary to improve the effectiveness of treat-
19 ments offered by the Department.

20 (c) MEMBERSHIP.—

21 (1) IN GENERAL.—The Commission shall be
22 composed of 10 members, appointed as follows:

23 (A) Two members appointed by the Speak-
24 er of the House of Representatives, at least one
25 of whom shall be a veteran.

1 (B) Two members appointed by the minor-
2 ity leader of the House of Representatives, at
3 least one of whom shall be a veteran.

4 (C) Two members appointed by the major-
5 ity leader of the Senate, at least one of whom
6 shall be a veteran.

7 (D) Two members appointed by the minor-
8 ity leader of the Senate, at least one of whom
9 shall be a veteran.

10 (E) Two members appointed by the Presi-
11 dent, at least one of whom shall be a veteran.

12 (2) QUALIFICATIONS.—Members of the Com-
13 mission shall be individuals who—

14 (A) are of recognized standing and distine-
15 tion within the medical community with a back-
16 ground in treating mental health;

17 (B) have experience working with the mili-
18 tary and veteran population; and

19 (C) do not have a financial interest in any
20 of the complementary and integrative health
21 treatments reviewed by the Commission.

22 (3) CHAIRMAN.—The President shall designate
23 a member of the Commission to be the Chairman.

1 (4) PERIOD OF APPOINTMENT.—Members of
2 the Commission shall be appointed for the life of the
3 Commission.

4 (5) VACANCY.—A vacancy in the Commission
5 shall be filled in the manner in which the original
6 appointment was made.

7 (6) APPOINTMENT DEADLINE.—The appoint-
8 ment of members of the Commission in this section
9 shall be made not later than 90 days after the date
10 of the enactment of this Act.

11 (d) POWERS OF COMMISSION.—

12 (1) MEETINGS.—

13 (A) INITIAL MEETING.—The Commission
14 shall hold its first meeting not later than 30
15 days after a majority of members are appointed
16 to the Commission.

17 (B) MEETING.—The Commission shall reg-
18 ularly meet at the call of the Chairman. Such
19 meetings may be carried out through the use of
20 telephonic or other appropriate telecommuni-
21 cation technology if the Commission determines
22 that such technology will allow the members to
23 communicate simultaneously.

24 (2) HEARINGS.—The Commission may hold
25 such hearings, sit and act at such times and places,

1 take such testimony, and receive evidence as the
2 Commission considers advisable to carry out the re-
3 sponsibilities of the Commission.

4 (3) INFORMATION FROM FEDERAL AGENCIES.—
5 The Commission may secure directly from any de-
6 partment or agency of the Federal Government such
7 information as the Commission considers necessary
8 to carry out the duties of the Commission.

9 (4) INFORMATION FROM NONGOVERNMENTAL
10 ORGANIZATIONS.—In carrying out its duties, the
11 Commission may seek guidance through consultation
12 with foundations, veteran service organizations, non-
13 profit groups, faith-based organizations, private and
14 public institutions of higher education, and other or-
15 ganizations as the Commission determines appro-
16 priate.

17 (5) COMMISSION RECORDS.—The Commission
18 shall keep an accurate and complete record of the
19 actions and meetings of the Commission. Such
20 record shall be made available for public inspection
21 and the Comptroller General of the United States
22 may audit and examine such record.

23 (6) PERSONNEL RECORDS.—The Commission
24 shall keep an accurate and complete record of the
25 actions and meetings of the Commission. Such

1 record shall be made available for public inspection
2 and the Comptroller General of the United States
3 may audit and examine such records.

4 (7) COMPENSATION OF MEMBERS; TRAVEL EX-
5 PENSES.—Each member shall serve without pay but
6 shall receive travel expenses to perform the duties of
7 the Commission, including per diem in lieu of sub-
8 stances, at rates authorized under subchapter I of
9 chapter 57 of title 5, United States Code.

10 (8) STAFF.—The Chairman, in accordance with
11 rules agreed upon the Commission, may appoint and
12 fix the compensation of a staff director and such
13 other personnel as may be necessary to enable the
14 Commission to carry out its functions, without re-
15 gard to the provisions of title 5, United States Code,
16 governing appointments in the competitive service,
17 without regard to the provision of chapter 51 and
18 subchapter III of chapter 53 of such title relating to
19 classification and General Schedule pay rates, except
20 that no rate of pay fixed under this paragraph may
21 exceed the equivalent of that payable for a position
22 at level IV of the Executive Schedule under section
23 5315 of title 5, United States Code.

24 (9) PERSONNEL AS FEDERAL EMPLOYEES.—

1 (A) IN GENERAL.—The executive director
2 and any personnel of the Commission are em-
3 ployees under section 2105 of title 5, United
4 States Code, for purpose of chapters 63, 81, 83,
5 84, 85, 87, 89, and 90 of such title.

6 (B) MEMBERS OF THE COMMISSION.—
7 Subparagraph (A) shall not be construed to
8 apply to members of the Commission.

9 (10) CONTRACTING.—The Commission may, to
10 such extent and in such amounts as are provided in
11 appropriations Acts, enter into contracts to enable
12 the Commission to discharge the duties of the Com-
13 mission under this Act.

14 (11) EXPERT AND CONSULTANT SERVICE.—The
15 Commission may procure the services of experts and
16 consultants in accordance with section 3109 of title
17 5, United States Code, at rates not to exceed the
18 daily rate paid to a person occupying a position at
19 level IV of the Executive Schedule under section
20 5315 of title 5, United States Code.

21 (12) POSTAL SERVICE.—The Commission may
22 use the United States mails in the same manner and
23 under the same conditions as departments and agen-
24 cies of the United States.

1 (13) PHYSICAL FACILITIES AND EQUIPMENT.—

2 Upon the request of the Commission, the Adminis-
3 trator of General Services shall provide to the Com-
4 mission, on a reimbursable basis, the administrative
5 support services necessary for the Commission to
6 carry out its responsibilities under this Act. These
7 administrative services may include human resource
8 management, budget, leasing accounting, and payroll
9 services.

10 (e) REPORT.—

11 (1) INTERIM REPORTS.—

12 (A) IN GENERAL.—Not later than 60 days
13 after the date on which the Commission first
14 meets, and each 30-day period thereafter end-
15 ing on the date on which the Commission sub-
16 mits the final report under paragraph (2), the
17 Commission shall submit to the Committees on
18 Veterans' Affairs of the House of Representa-
19 tives and the Senate and the President a report
20 detailing the level of cooperation the Secretary
21 of Veterans Affairs (and the heads of other de-
22 partments or agencies of the Federal Govern-
23 ment) has provided to the Commission.

24 (B) OTHER REPORTS.—In carrying out its
25 duties, at times that the Commission deter-

1 mines appropriate, the Commission shall submit
2 to the Committees on Veterans' Affairs of the
3 House of Representatives and the Senate and
4 any other appropriate entities an interim report
5 with respect to the findings identified by the
6 Commission.

7 (2) FINAL REPORT.—Not later than 18 months
8 after the first meeting of the Commission, the Com-
9 mission shall submit to the Committee on Veterans'
10 Affairs of the House of Representatives and the Sen-
11 ate, the President, and the Secretary of Veterans Af-
12 fairs a final report on the findings of the Commis-
13 sion. Such report shall include the following:

14 (A) Recommendations to implement in a
15 feasible, timely, and cost-efficient manner the
16 solutions and remedies identified within the
17 findings of the Commission pursuant to sub-
18 section (b).

19 (B) An analysis of the evidence-based ther-
20 apy model used by the Secretary of Veterans
21 Affairs for treating veterans with mental health
22 care issues, and an examination of the preva-
23 lence and efficacy of prescription drugs as a
24 means for treatment.

1 (C) The findings of the patient-centered
2 survey conducted within each of the Veterans
3 Integrated Service Networks pursuant to sub-
4 section (b)(2).

5 (D) An examination of complementary and
6 integrative health treatments described in sub-
7 section (b)(3) and the potential benefits of in-
8 corporating such treatments in the therapy
9 models used by the Secretary for treating vet-
10 erans with mental health issues.

11 (3) PLAN.—Not later than 90 days after the
12 date on which the Commission submits the final re-
13 port under paragraph (2), the Secretary of Veterans
14 Affairs shall submit to the Committees on Veterans’
15 Affairs of the House of Representatives and the Sen-
16 ate a report on the following:

17 (A) An action plan for implementing the
18 recommendations established by the Commis-
19 sion on such solutions and remedies for improv-
20 ing wellness-based outcomes for veterans with
21 mental health care issues.

22 (B) A feasible timeframe on when the com-
23plementary and integrative health treatments
24described in subsection (b)(3) can be imple-
25mented Department-wide.

1 (C) With respect to each recommendation
2 established by the Commission, including any
3 complementary and integrative health treat-
4 ment, that the Secretary determines is not ap-
5 propriate or feasible to implement, a justifica-
6 tion for such determination and an alternative
7 solution to improve the efficacy of the therapy
8 models used by the Secretary for treating vet-
9 erans with mental health issues.

10 (f) TERMINATION OF COMMISSION.—The Commis-
11 sion shall terminate 30 days after the Commission submits
12 the final report under subsection (e)(2).

13 **SEC. 932. EXPANSION OF RESEARCH AND EDUCATION ON**
14 **AND DELIVERY OF COMPLEMENTARY AND IN-**
15 **TEGRATIVE HEALTH TO VETERANS.**

16 (a) DEVELOPMENT OF PLAN TO EXPAND RE-
17 SEARCH, EDUCATION, AND DELIVERY.—Not later than
18 180 days after the date of the enactment of this Act, the
19 Secretary of Veterans Affairs shall develop a plan to ex-
20 pand materially and substantially the scope of the effec-
21 tiveness of research and education on, and delivery and
22 integration of, complementary and integrative health serv-
23 ices into the health care services provided to veterans.

24 (b) ELEMENTS.—The plan required by subsection (a)
25 shall provide for the following:

1 (1) Research on the following:

2 (A) The effectiveness of various com-
3 plementary and integrative health services, in-
4 cluding the effectiveness of such services inte-
5 grated with clinical services.

6 (B) Approaches to integrating complemen-
7 tary and integrative health services into other
8 health care services provided by the Depart-
9 ment of Veterans Affairs.

10 (2) Education and training for health care pro-
11 fessionals of the Department on the following:

12 (A) Complementary and integrative health
13 services selected by the Secretary for purposes
14 of the plan.

15 (B) Appropriate uses of such services.

16 (C) Integration of such services into the
17 delivery of health care to veterans.

18 (3) Research, education, and clinical activities
19 on complementary and integrative health at centers
20 of innovation at medical centers of the Department.

21 (4) Identification or development of metrics and
22 outcome measures to evaluate the effectiveness of
23 the provision and integration of complementary and
24 integrative health services into the delivery of health
25 care to veterans.

1 (5) Integration and delivery of complementary
2 and integrative health services with other health care
3 services provided by the Department.

4 (c) CONSULTATION.—

5 (1) IN GENERAL.—In carrying out subsection
6 (a), the Secretary shall consult with the following:

7 (A) The Director of the National Center
8 for Complementary and Integrative Health of
9 the National Institutes of Health.

10 (B) The Commissioner of Food and Drugs.

11 (C) Institutions of higher education, pri-
12 vate research institutes, and individual re-
13 searchers with extensive experience in com-
14 plementary and integrative health and the inte-
15 gration of complementary and integrative health
16 practices into the delivery of health care.

17 (D) Nationally recognized providers of
18 complementary and integrative health.

19 (E) Such other officials, entities, and indi-
20 viduals with expertise on complementary and
21 integrative health as the Secretary considers ap-
22 propriate.

23 (2) SCOPE OF CONSULTATION.—The Secretary
24 shall undertake consultation under paragraph (1) in

1 carrying out subsection (a) with respect to the fol-
2 lowing:

3 (A) To develop the plan.

4 (B) To identify specific complementary and
5 integrative health practices that, on the basis of
6 research findings or promising clinical interven-
7 tions, are appropriate to include as services to
8 veterans.

9 (C) To identify barriers to the effective
10 provision and integration of complementary and
11 integrative health services into the delivery of
12 health care to veterans, and to identify mecha-
13 nisms for overcoming such barriers.

14 **SEC. 933. PILOT PROGRAM ON INTEGRATION OF COM-**
15 **PLEMENTARY AND INTEGRATIVE HEALTH**
16 **AND RELATED ISSUES FOR VETERANS AND**
17 **FAMILY MEMBERS OF VETERANS.**

18 (a) PILOT PROGRAM.—

19 (1) IN GENERAL.—Not later than 180 days
20 after the date on which the Secretary of Veterans
21 Affairs receives the final report under section
22 931(e)(2), the Secretary shall commence a pilot pro-
23 gram to assess the feasibility and advisability of
24 using complementary and integrative health and
25 wellness-based programs (as defined by the Sec-

1 retary) to complement the provision of pain manage-
2 ment and related health care services, including
3 mental health care services, to veterans.

4 (2) MATTERS ADDRESSED.—In carrying out the
5 pilot program, the Secretary shall assess the fol-
6 lowing:

7 (A) Means of improving coordination be-
8 tween Federal, State, local, and community pro-
9 viders of health care in the provision of pain
10 management and related health care services to
11 veterans.

12 (B) Means of enhancing outreach, and co-
13 ordination of outreach, by and among providers
14 of health care referred to in subparagraph (A)
15 on the pain management and related health
16 care services available to veterans.

17 (C) Means of using complementary and in-
18 tegrative health and wellness-based programs of
19 providers of health care referred to in subpara-
20 graph (A) as complements to the provision by
21 the Department of Veterans Affairs of pain
22 management and related health care services to
23 veterans.

1 (D) Whether complementary and integra-
2 tive health and wellness-based programs de-
3 scribed in subparagraph (C)—

4 (i) are effective in enhancing the qual-
5 ity of life and well-being of veterans;

6 (ii) are effective in increasing the ad-
7 herence of veterans to the primary pain
8 management and related health care serv-
9 ices provided such veterans by the Depart-
10 ment;

11 (iii) have an effect on the sense of
12 well-being of veterans who receive primary
13 pain management and related health care
14 services from the Department; and

15 (iv) are effective in encouraging vet-
16 erans receiving health care from the De-
17 partment to adopt a more healthy lifestyle.

18 (b) DURATION.—The Secretary shall carry out the
19 pilot program under subsection (a)(1) for a period of three
20 years.

21 (c) LOCATIONS.—

22 (1) FACILITIES.—The Secretary shall carry out
23 the pilot program under subsection (a)(1) at facili-
24 ties of the Department providing pain management
25 and related health care services, including mental

1 health care services, to veterans. In selecting such
2 facilities to carry out the pilot program, the Sec-
3 retary shall select not fewer than 15 geographically
4 diverse medical centers of the Department, of which
5 not fewer than two shall be polytrauma rehabilita-
6 tion centers of the Department.

7 (2) MEDICAL CENTERS WITH PRESCRIPTION
8 RATES OF OPIOIDS THAT CONFLICT WITH CARE
9 STANDARDS.—In selecting the medical centers under
10 paragraph (1), the Secretary shall give priority to
11 medical centers of the Department at which there is
12 a prescription rate of opioids that conflicts with or
13 is otherwise inconsistent with the standards of ap-
14 propriate and safe care.

15 (d) PROVISION OF SERVICES.—Under the pilot pro-
16 gram under subsection (a)(1), the Secretary shall provide
17 covered services to covered veterans by integrating com-
18 plementary and integrative health services with other serv-
19 ices provided by the Department at the medical centers
20 selected under subsection (c).

21 (e) COVERED VETERANS.—For purposes of the pilot
22 program under subsection (a)(1), a covered veteran is any
23 veteran who—

24 (1) has a mental health condition diagnosed by
25 a clinician of the Department;

1 (2) experiences chronic pain;

2 (3) has a chronic condition being treated by a
3 clinician of the Department; or

4 (4) is not described in paragraph (1), (2), or
5 (3) and requests to participate in the pilot program
6 or is referred by a clinician of the Department who
7 is treating the veteran.

8 (f) COVERED SERVICES.—

9 (1) IN GENERAL.—For purposes of the pilot
10 program, covered services are services consisting of
11 complementary and integrative health services as se-
12 lected by the Secretary.

13 (2) ADMINISTRATION OF SERVICES.—Covered
14 services shall be administered under the pilot pro-
15 gram as follows:

16 (A) Covered services shall be administered
17 by professionals or other instructors with ap-
18 propriate training and expertise in complemen-
19 tary and integrative health services who are em-
20 ployees of the Department or with whom the
21 Department enters into an agreement to pro-
22 vide such services.

23 (B) Covered services shall be included as
24 part of the Patient Aligned Care Teams initia-
25 tive of the Office of Patient Care Services, Pri-

1 mary Care Program Office, in coordination with
2 the Office of Patient Centered Care and Cul-
3 tural Transformation.

4 (C) Covered services shall be made avail-
5 able to—

6 (i) covered veterans who have received
7 conventional treatments from the Depart-
8 ment for the conditions for which the cov-
9 ered veteran seeks complementary and in-
10 tegrative health services under the pilot
11 program; and

12 (ii) covered veterans who have not re-
13 ceived conventional treatments from the
14 Department for such conditions.

15 (g) REPORTS.—

16 (1) IN GENERAL.—Not later than 30 months
17 after the date on which the Secretary commences the
18 pilot program under subsection (a)(1), the Secretary
19 shall submit to the Committee on Veterans' Affairs
20 of the Senate and the Committee on Veterans' Af-
21 fairs of the House of Representatives a report on the
22 pilot program.

23 (2) ELEMENTS.—The report under paragraph
24 (1) shall include the following:

1 (A) The findings and conclusions of the
2 Secretary with respect to the pilot program
3 under subsection (a)(1), including with respect
4 to—

5 (i) the use and efficacy of the com-
6plementary and integrative health services
7established under the pilot program;

8 (ii) the outreach conducted by the
9Secretary to inform veterans and commu-
10nity organizations about the pilot program;
11and

12 (iii) an assessment of the benefit of
13the pilot program to covered veterans in
14mental health diagnoses, pain manage-
15ment, and treatment of chronic illness.

16 (B) Identification of any unresolved bar-
17riers that impede the ability of the Secretary to
18incorporate complementary and integrative
19health services with other health care services
20provided by the Department.

21 (C) Such recommendations for the continu-
22ation or expansion of the pilot program as the
23Secretary considers appropriate.

1 **Subtitle D—Fitness of Health Care**
2 **Providers**

3 **SEC. 941. ADDITIONAL REQUIREMENTS FOR HIRING OF**
4 **HEALTH CARE PROVIDERS BY DEPARTMENT**
5 **OF VETERANS AFFAIRS.**

6 As part of the hiring process for each health care pro-
7 vider considered for a position at the Department of Vet-
8 erans Affairs after the date of the enactment of the Act,
9 the Secretary of Veterans Affairs shall require from the
10 medical board of each State in which the health care pro-
11 vider has or had a medical license—

12 (1) information on any violation of the require-
13 ments of the medical license of the health care pro-
14 vider during the 20-year period preceding the con-
15 sideration of the health care provider by the Depart-
16 ment; and

17 (2) information on whether the health care pro-
18 vider has entered into any settlement agreement for
19 a disciplinary charge relating to the practice of med-
20 icine by the health care provider.

21 **SEC. 942. PROVISION OF INFORMATION ON HEALTH CARE**
22 **PROVIDERS OF DEPARTMENT OF VETERANS**
23 **AFFAIRS TO STATE MEDICAL BOARDS.**

24 Notwithstanding section 552a of title 5, United
25 States Code, with respect to each health care provider of

1 the Department of Veterans Affairs who has violated a
2 requirement of the medical license of the health care pro-
3 vider, the Secretary of Veterans Affairs shall provide to
4 the medical board of each State in which the health care
5 provider is licensed detailed information with respect to
6 such violation, regardless of whether such board has for-
7 mally requested such information.

8 **SEC. 943. REPORT ON COMPLIANCE BY DEPARTMENT OF**
9 **VETERANS AFFAIRS WITH REVIEWS OF**
10 **HEALTH CARE PROVIDERS LEAVING THE DE-**
11 **PARTMENT OR TRANSFERRING TO OTHER**
12 **FACILITIES.**

13 Not later than 180 days after the date of the enact-
14 ment of this Act, the Secretary of Veterans Affairs shall
15 submit to the Committee on Veterans' Affairs of the Sen-
16 ate and the Committee on Veterans' Affairs of the House
17 of Representatives a report on the compliance by the De-
18 partment of Veterans Affairs with the policy of the De-
19 partment—

20 (1) to conduct a review of each health care pro-
21 vider of the Department who transfers to another
22 medical facility of the Department, resigns, retires,
23 or is terminated to determine whether there are any
24 concerns, complaints, or allegations of violations re-

1 lating to the medical practice of the health care pro-
2 vider; and

3 (2) to take appropriate action with respect to
4 any such concern, complaint, or allegation.

5 **Subtitle E—Other Matters**

6 **SEC. 951. MODIFICATION TO LIMITATION ON AWARDS AND**
7 **BONUSES.**

8 Section 705 of the Veterans Access, Choice, and Ac-
9 countability Act of 2014 (Public Law 113–146; 38 U.S.C.
10 703 note) is amended to read as follows:

11 **“SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO**
12 **EMPLOYEES OF DEPARTMENT OF VETERANS**
13 **AFFAIRS.**

14 “(a) **LIMITATION.**—The Secretary of Veterans Af-
15 fairs shall ensure that the aggregate amount of awards
16 and bonuses paid by the Secretary in a fiscal year under
17 chapter 45 or 53 of title 5, United States Code, or any
18 other awards or bonuses authorized under such title or
19 title 38, United States Code, does not exceed the following
20 amounts:

21 “(1) With respect to each of fiscal years 2017
22 through 2018, \$230,000,000.

23 “(2) With respect to each of fiscal years 2019
24 through 2021, \$225,000,000.

1 “(3) With respect to each of fiscal years 2022
2 through 2024, \$360,000,000.

3 “(b) SENSE OF CONGRESS.—It is the sense of Con-
4 gress that the limitation under subsection (a) should not
5 disproportionately impact lower-wage employees and that
6 the Department of Veterans Affairs is encouraged to use
7 bonuses to incentivize high-performing employees in areas
8 in which retention is challenging.”.

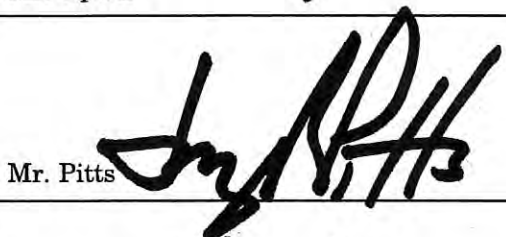
S. 524

*Managers on the part of the
HOUSE**Managers on the part of the
SENATE*

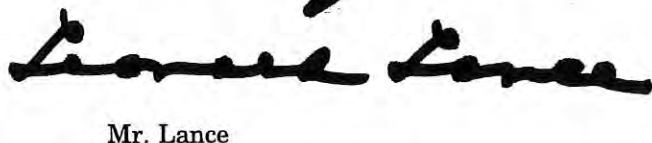
For consideration of the Senate bill and the House
amendments, and modifications committed to
conference:



Mr. Upton



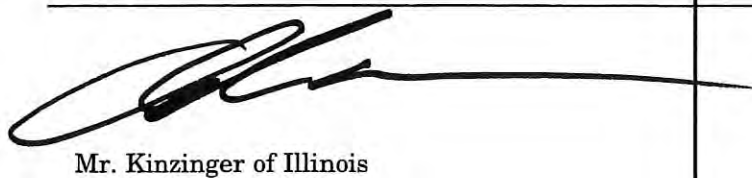
Mr. Pitts



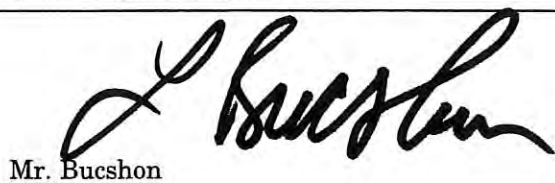
Mr. Lance



Mr. Guthrie



Mr. Kinzinger of Illinois


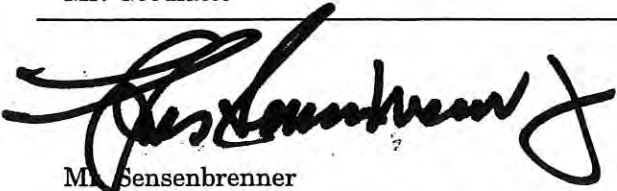
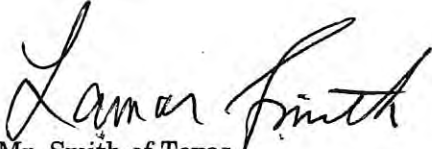



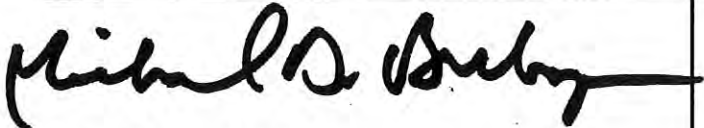
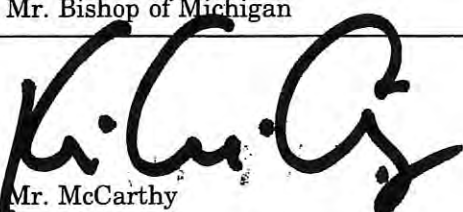


Mr. Bucshon



Mrs. Brooks of Indiana



S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
 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


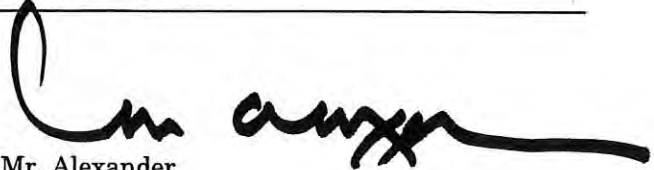





<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
Mr. Fallaw	
Mr. Don Ray, Injuria of New Mexico	
Mr. Sarbanes	
Mr. Gene Green of Texas	
Mr. Conyers	
Ms. Jackson Lee	
Ms. Judy Chu of California	
Mr. Cohen	

S. 524—Continued

Managers on the part of the HOUSE	Managers on the part of the SENATE
From the Committee on Education and the Work- force, for consideration of title VII of the House amendment, and modifications committed to con- ference:	
 Mr. Barletta	
 Mr. Carter of Georgia	
Mr. Scott of Virginia	

Batman & Muehl

S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	 Mr. Grassley
	 Mr. Alexander
	 Mr. Hatch
	 Mr. Sessions
	
	
	

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 – ADDRESSING 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 Health 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 health 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.

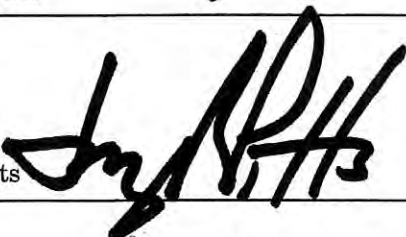
S. 524

*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



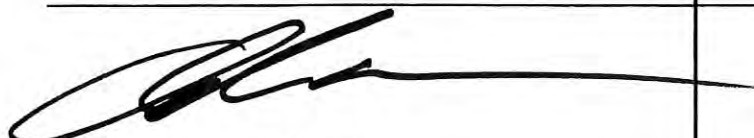
Mr. Pitts




Mr. Lance



Mr. Guthrie



Mr. Kinzinger of Illinois


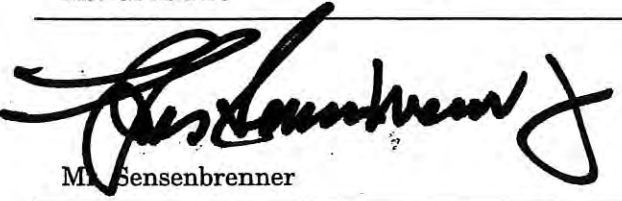
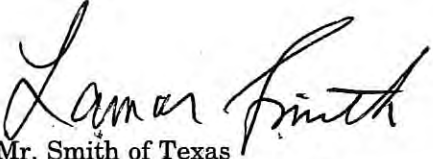

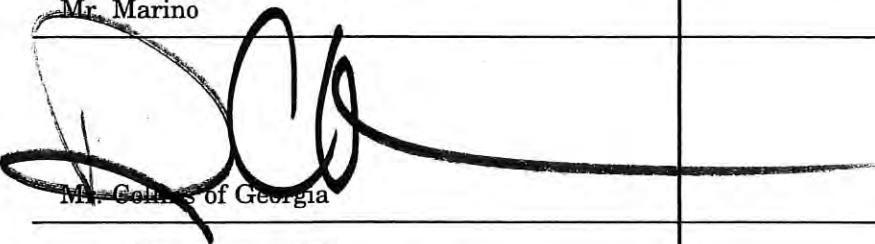

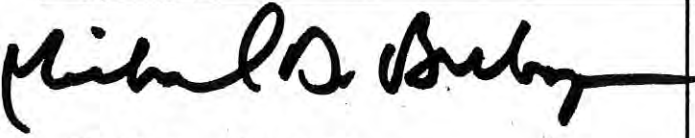
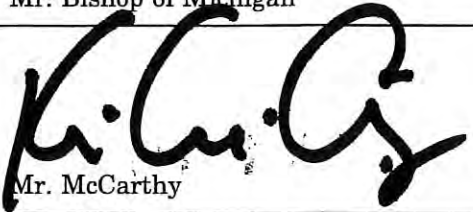


Mr. Bucshon



Mrs. Brooks of Indiana

S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
 Mr. Goodlatte	
 Mr. Sensenbrenner	
 Mr. Smith of Texas	
 Mr. Marino	
 Mr. Collins of Georgia	
 Mr. Trott	
 Mr. Bishop of Michigan	
 Mr. McCarthy	


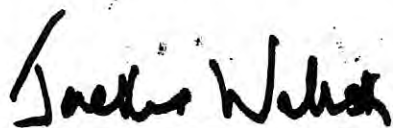
S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
Mr. Puller	
Mr. Don Ray, Engr. of New Mexico	
Mr. Sarbanes	
Mr. Cono, Green of Texas	
Mr. Conyers	
Ms. Jackson Lee	
Ms. Judy Chu of California	
Mr. Cohen	

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S. 524—Continued

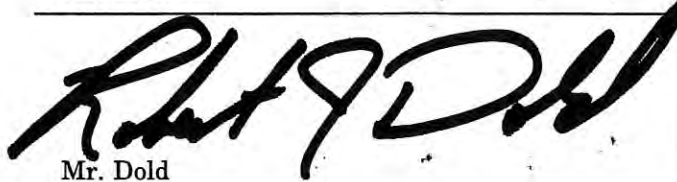
<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Veterans' Affairs, for consideration of title III of the House amendment, and modifications committed to conference:	
Mr. Bilirakis 	
Mrs. Walorski 	
Mr. Ruiz	

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:




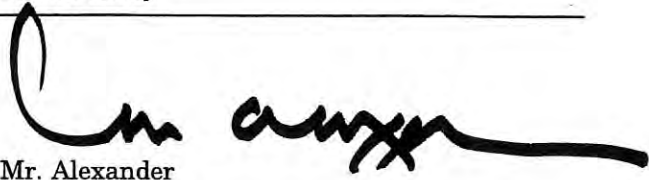


Mr. Meehan



Mr. Dold

~~Mr. McDermott~~

S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	 Mr. Grassley
	 Mr. Alexander
	 Mr. Hatch
	 Mr. Sessions
	