

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. Opioid use disorder treatment expansion and modernization.

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.

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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.

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.

Subtitle C—Complementary and Integrative Health

Sec. 931. Expansion of research and education on and delivery of complementary and integrative health to veterans.

1 (A) the Department of Health and Human
2 Services and relevant agencies within the De-
3 partment of Health and Human Services;

4 (B) the Department of Veterans Affairs;

5 (C) the Department of Defense; and

6 (D) the Office of National Drug Control
7 Policy;

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

10 (3) currently licensed and practicing phar-
11 macists and pharmacies;

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

15 (5) representatives of—

16 (A) pain management professional organi-
17 zations;

18 (B) the mental health treatment commu-
19 nity;

20 (C) the addiction treatment community, in-
21 cluding individuals in recovery from substance
22 use disorder;

23 (D) pain advocacy groups, including pa-
24 tients;

25 (E) veteran service organizations;

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

3 (G) State medical boards; and

4 (H) hospitals;

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

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

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

12 (e) DUTIES.—The task force shall—

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

18 (2) not later than 1 year after the date on
19 which the task force is convened under subsection
20 (b), propose updates to best practices and rec-
21 ommendations on addressing gaps or inconsistencies
22 identified under paragraph (1), as appropriate, and
23 submit to relevant Federal agencies and the general
24 public such proposed updates and recommendations,
25 taking into consideration—

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

3 (B) recommendations from relevant con-
4 ferences and existing relevant evidence-based
5 guidelines;

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

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

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

22 (F) private sector, State, and local govern-
23 ment efforts related to pain management and
24 prescribing pain medication;

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

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

8 (f) **LIMITATION.**—The task force shall not have rule-
9 making authority.

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

12 **SEC. 102. AWARENESS CAMPAIGNS.**

13 (a) **IN GENERAL.**—The Secretary of Health and
14 Human Services, in coordination with the heads of other
15 departments and agencies, as appropriate, shall, as appro-
16 priate, through existing programs and activities, advance
17 the education and awareness of the public (including pro-
18 viders, patients, and consumers) and other appropriate en-
19 tities regarding the risk of abuse of prescription opioids
20 if such drugs are not taken as prescribed.

21 (b) **TOPICS.**—The education and awareness cam-
22 paigns under subsection (a) shall address—

23 (1) the dangers of opioid abuse;

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

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

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

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

11 (2) emphasize—

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

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

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

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

21 (a) DEFINITIONS.—In this section:

22 (1) ADMINISTRATOR.—The term “Adminis-
23 trator” means the Administrator of the Substance
24 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 drug 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 Principals 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 may 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 ated—

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

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(e)).

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 may
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 may 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 may
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 **SEC. 303. OPIOID USE DISORDER TREATMENT EXPANSION**
22 **AND MODERNIZATION.**

23 (a) OPIOID USE DISORDER TREATMENT MOD-
24 ERNIZATION.—

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

4 (A) in subparagraph (B), by striking
5 clauses (i), (ii), and (iii) and inserting the fol-
6 lowing:

7 “(i) The practitioner is a qualifying practitioner
8 (as defined in subparagraph (G)).

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

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

19 “(II) appropriate counseling and other ap-
20 propriate ancillary services.

21 “(iii)(I) The total number of such patients of
22 the practitioner at any one time will not exceed the
23 applicable number. Except as provided in subclause
24 (II), the applicable number is 30.

1 (II) by striking “physician” and
2 inserting “practitioner”;

3 (C) in subparagraph (G)—

4 (i) by amending clause (ii)(IV) to read
5 as follows:

6 “(IV) The physician has, with respect to
7 the treatment and management of opiate-de-
8 pendent patients, completed not less than 8
9 hours of training (through classroom situations,
10 seminars at professional society meetings, elec-
11 tronic communications, or otherwise) that is
12 provided by the American Society of Addiction
13 Medicine, the American Academy of Addiction
14 Psychiatry, the American Medical Association,
15 the American Osteopathic Association, the
16 American Psychiatric Association, or any other
17 organization that the Secretary determines is
18 appropriate for purposes of this subclause. Such
19 training shall include—

20 “(aa) opioid maintenance and detoxi-
21 fication;

22 “(bb) appropriate clinical use of all
23 drugs approved by the Food and Drug Ad-
24 ministration for the treatment of opioid
25 use disorder;

1 “(cc) initial and periodic patient as-
2 sessments (including substance use moni-
3 toring);

4 “(dd) individualized treatment plan-
5 ning, overdose reversal, and relapse pre-
6 vention;

7 “(ee) counseling and recovery support
8 services;

9 “(ff) staffing roles and considerations;

10 “(gg) diversion control; and

11 “(hh) other best practices, as identi-
12 fied by the Secretary.”; and

13 (ii) by adding at the end the fol-
14 lowing:

15 “(iii) The term ‘qualifying practitioner’
16 means—

17 “(I) a qualifying physician, as defined in
18 clause (ii); or

19 “(II) during the period beginning on the
20 date of enactment of the Comprehensive Addic-
21 tion and Recovery Act of 2016 and ending on
22 October 1, 2021, a qualifying other practi-
23 tioner, as defined in clause (iv).

1 “(iv) The term ‘qualifying other practitioner’
2 means a nurse practitioner or physician assistant
3 who satisfies each of the following:

4 “(I) The nurse practitioner or physician
5 assistant is licensed under State law to pre-
6 scribe schedule III, IV, or V medications for the
7 treatment of pain.

8 “(II) The nurse practitioner or physician
9 assistant has—

10 “(aa) completed not fewer than 24
11 hours of initial training addressing each of
12 the topics listed in clause (ii)(IV) (through
13 classroom situations, seminars at profes-
14 sional society meetings, electronic commu-
15 nications, or otherwise) provided by the
16 American Society of Addiction Medicine,
17 the American Academy of Addiction Psy-
18 chiatry, the American Medical Association,
19 the American Osteopathic Association, the
20 American Nurses Credentialing Center, the
21 American Psychiatric Association, the
22 American Association of Nurse Practi-
23 tioners, the American Academy of Physi-
24 cian Assistants, or any other organization

1 that the Secretary determines is appro-
2 priate for purposes of this subclause; or

3 “(bb) has such other training or expe-
4 rience as the Secretary determines will
5 demonstrate the ability of the nurse practi-
6 tioner or physician assistant to treat and
7 manage opiate-dependent patients.

8 “(III) The nurse practitioner or physician
9 assistant is supervised by, or works in collabo-
10 ration with, a qualifying physician, if the nurse
11 practitioner or physician assistant is required
12 by State law to prescribe medications for the
13 treatment of opioid use disorder in collaboration
14 with or under the supervision of a physician.

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

18 (D) in subparagraph (H)—

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

21 “(III) Such other elements of the requirements
22 under this paragraph as the Secretary determines
23 necessary for purposes of implementing such re-
24 quirements.”; and

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

3 “(ii) Not later than 18 months after the date of en-
4 actment of the Opioid Use Disorder Treatment Expansion
5 and Modernization Act, the Secretary shall update the
6 treatment improvement protocol containing best practice
7 guidelines for the treatment of opioid-dependent patients
8 in office-based settings. The Secretary shall update such
9 protocol in consultation with experts in opioid use disorder
10 research and treatment.”.

11 (2) OPIOID DEFINED.—Section 102(18) of the
12 Controlled Substances Act (21 U.S.C. 802(18)) is
13 amended by inserting “or ‘opioid’” after “The term
14 ‘opiate’”.

15 (3) REPORTS TO CONGRESS.—

16 (A) IN GENERAL.—Not later than 2 years
17 after the date of enactment of this Act and not
18 less frequently than over every 5 years there-
19 after, the Secretary of Health and Human
20 Services, in consultation with the Drug En-
21 forcement Administration and experts in opioid
22 use disorder research and treatment, shall—

23 (i) perform a thorough review of the
24 provision of opioid use disorder treatment
25 services in the United States, including

1 services provided in opioid treatment pro-
2 grams and other specialty and nonspecialty
3 settings; and

4 (ii) submit a report to the Congress
5 on the findings and conclusions of such re-
6 view.

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

9 (i) compliance with the requirements
10 of section 303(g)(2) of the Controlled Sub-
11 stances Act (21 U.S.C. 823(g)(2)), as
12 amended by this section;

13 (ii) the measures taken by the Sec-
14 retary of Health and Human Services to
15 ensure such compliance;

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

22 (iv) the extent to which, and propor-
23 tions with which, the full range of Food
24 and Drug Administration-approved treat-
25 ments for opioid use disorder are used in

1 routine health care settings and specialty
2 substance use disorder treatment settings;

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

7 (vi) changes in State or local policies
8 and legislation relating to opioid use dis-
9 order treatment;

10 (vii) the use of prescription drug mon-
11 itoring programs by practitioners who are
12 permitted to dispense narcotic drugs to in-
13 dividuals pursuant to a waiver described in
14 clause (iii);

15 (viii) the findings resulting from in-
16 spections by the Drug Enforcement Ad-
17 ministration of practitioners described in
18 clause (vii); and

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

24 (b) STATE FLEXIBILITY.—Section 303(g)(2) of the
25 Controlled Substances Act (21 U.S.C. 823(g)(2)) is

1 amended by striking subparagraphs (I) and (J), and in-
2 serting the following:

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

6 “(i) permits a qualifying practitioner to dis-
7 pense narcotic drugs in schedule III, IV, or V, or
8 combinations of such drugs, for maintenance or de-
9 toxification treatment in accordance with this para-
10 graph to a total number of patients that is more
11 than 30 or less than the total number applicable to
12 the qualifying practitioner under subparagraph
13 (B)(iii)(II) if a State enacts a law modifying such
14 total number and the Attorney General is notified by
15 the State of such modification; or

16 “(ii) requires a qualifying practitioner to com-
17 ply with additional requirements relating to the dis-
18 pensing of narcotic drugs in schedule III, IV, or V,
19 or combinations of such drugs, including require-
20 ments relating to the practice setting in which the
21 qualifying practitioner practices and education,
22 training, and reporting requirements.”.

23 (c) UPDATE REGULATIONS.—Not later than 18
24 months after the date of enactment of this Act, the Attor-
25 ney General and the Secretary of Health and Human

1 Services, as appropriate, shall update regulations regard-
2 ing practitioners described in subsection (a)(3)(B)(vii) (as
3 amended by this section) to include nurse practitioners
4 and physician assistants to ensure the quality of patient
5 care and prevent diversion.

6 **TITLE IV—ADDRESSING**
7 **COLLATERAL CONSEQUENCES**

8 **SEC. 401. GAO REPORT ON RECOVERY AND COLLATERAL**
9 **CONSEQUENCES.**

10 (a) REPORT REQUIRED.—Not later than 1 year after
11 the date of enactment of this Act, the Comptroller General
12 of the United States shall submit to the Committee on
13 the Judiciary of the Senate and the Committee on the Ju-
14 diciary of the House of Representatives a report that—

15 (1) describes the collateral consequences for in-
16 dividuals with convictions for nonviolent drug-related
17 offenses;

18 (2) describes the effect of the collateral con-
19 sequences described in paragraph (1) on individuals
20 in resuming their personal and professional activi-
21 ties, especially, to the extent data are available, the
22 effect on individuals who are participating in or have
23 completed a recovery program for a substance use
24 disorder;

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

5 (4) provides perspectives on the potential for
6 mitigating the effect of the collateral consequences
7 described in paragraph (1) on individuals who are
8 participating in or have completed a recovery pro-
9 gram, while also taking into account the policy inter-
10 ests described in paragraph (3).

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

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

16 (A) automatically by operation of law; or

17 (B) by authorized action of an administra-
18 tive agency or court on a case-by-case basis;
19 and

20 (2) does not include a direct consequence im-
21 posed as part of the judgment of a court at sen-
22 tencing, including a term of imprisonment or com-
23 munity supervision, or a fine.

1 **TITLE V—ADDICTION AND**
2 **TREATMENT SERVICES FOR**
3 **WOMEN, FAMILIES, AND VET-**
4 **ERANS**

5 **SEC. 501. IMPROVING TREATMENT FOR PREGNANT AND**
6 **POSTPARTUM WOMEN.**

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

11 (1) in subsection (a)—

12 (A) in the matter preceding paragraph

13 (1)—

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

17 (ii) by striking “grants, cooperative
18 agreement,” and inserting “grants, includ-
19 ing the grants under subsection (r), coop-
20 erative agreements”; and

21 (iii) by striking “for substance abuse”
22 and inserting “for substance use dis-
23 orders”; and

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

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

6 (3) in subsection (c)—

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

10 (B) in paragraph (2)—

11 (i) in subparagraph (A), by striking
12 “substance abuse” and inserting “sub-
13 stance use disorders”; and

14 (ii) in subparagraph (B), by striking
15 “such abuse” and inserting “such a dis-
16 order”;

17 (4) in subsection (d)—

18 (A) in paragraph (3)(A), by striking “ma-
19 ternal substance abuse” and inserting “a ma-
20 ternal substance use disorder”;

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

23 “(4) Providing therapeutic, comprehensive child
24 care for children during the periods in which the

1 woman is engaged in therapy or in other necessary
2 health and rehabilitative activities.”;

3 (C) in paragraphs (9), (10), and (11), by
4 striking “women” each place such term appears
5 and inserting “woman”;

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

8 (E) in paragraph (11)—

9 (i) in subparagraph (A), by striking
10 “their children” and inserting “any child
11 of such woman”;

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

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

16 (iv) by adding at the end the fol-
17 lowing:

18 “(D) family reunification with children in
19 kinship or foster care arrangements, where safe
20 and appropriate.”;

21 (5) in subsection (e)—

22 (A) in paragraph (1)—

23 (i) in the matter preceding subpara-
24 graph (A), by striking “substance abuse”

1 and inserting “substance use disorders”;

2 and

3 (ii) in subparagraph (B), by striking

4 “substance abuse” and inserting “sub-

5 stance use disorders”; and

6 (B) in paragraph (2)—

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

9 “(A) IN GENERAL.—Subject”;

10 (ii) in subparagraph (B)—

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

13 “(B) WAIVER OF PARTICIPATION AGREE-
14 MENTS.—

15 “(i) IN GENERAL.—In the case”; and

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

18 “(ii) DONATIONS.—A determination”;

19 and

20 (iii) by striking “(C) With respect”
21 and inserting the following:

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

24 (6) in subsection (g)—

1 (A) by striking “who are engaging in sub-
2 stance abuse” and inserting “who have a sub-
3 stance use disorder”; and

4 (B) by striking “such abuse” and inserting
5 “such disorder”;

6 (7) in subsection (j)—

7 (A) in the matter preceding paragraph (1),
8 by striking “to on” and inserting “to or on”;
9 and

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

12 (8) by amending subsection (m) to read as fol-
13 lows:

14 “(m) ALLOCATION OF AWARDS.—In making awards
15 under subsection (a), the Director shall give priority to
16 an applicant that agrees to use the award for a program
17 serving an area that is a rural area, an area designated
18 under section 332 by the Secretary as a health profes-
19 sional shortage area, or an area determined by the Direc-
20 tor to have a shortage of family-based substance use dis-
21 order treatment options.”; and

22 (9) in subsection (q)—

23 (A) in paragraph (3), by striking “funding
24 agreement under subsection (a)” and inserting
25 “funding agreement”; and

1 (B) in paragraph (4), by striking “sub-
2 stance abuse” and inserting “a substance use
3 disorder”.

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

7 (1) in subsection (p), in the first sentence, by
8 inserting “(other than subsection (r))” after “sec-
9 tion”; and

10 (2) in subsection (r), by striking “such sums”
11 and all that follows through “2003” and inserting
12 “\$16,900,000 for each of fiscal years 2017 through
13 2021”.

14 (c) PILOT PROGRAM GRANTS FOR STATE SUB-
15 STANCE ABUSE AGENCIES.—

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

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

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

24 “(r) PILOT PROGRAM FOR STATE SUBSTANCE
25 ABUSE AGENCIES.—

1 “(1) IN GENERAL.—From amounts made avail-
2 able under subsection (s), the Director of the Center
3 for Substance Abuse Treatment shall carry out a
4 pilot program under which competitive grants are
5 made by the Director to State substance abuse agen-
6 cies—

7 “(A) to enhance flexibility in the use of
8 funds designed to support family-based services
9 for pregnant and postpartum women with a pri-
10 mary diagnosis of a substance use disorder, in-
11 cluding opioid use disorders;

12 “(B) to help State substance abuse agen-
13 cies address identified gaps in services fur-
14 nished to such women along the continuum of
15 care, including services provided to women in
16 nonresidential-based settings; and

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

21 “(2) REQUIREMENTS.—In carrying out the
22 pilot program under this subsection, the Director
23 shall—

24 “(A) require State substance abuse agen-
25 cies to submit to the Director applications, in

1 such form and manner and containing such in-
2 formation as specified by the Director, to be eli-
3 gible to receive a grant under the program;

4 “(B) identify, based on such submitted ap-
5 plications, State substance abuse agencies that
6 are eligible for such grants;

7 “(C) require services proposed to be fur-
8 nished through such a grant to support family-
9 based treatment and other services for pregnant
10 and postpartum women with a primary diag-
11 nosis of a substance use disorder, including
12 opioid use disorders;

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

16 “(E) not require that grant recipients
17 under the program make available through use
18 of the grant all the services described in sub-
19 section (d); and

20 “(F) consider not applying the require-
21 ments described in paragraphs (1) and (2) of
22 subsection (f) to an applicant, depending on the
23 circumstances of the applicant.

24 “(3) REQUIRED SERVICES.—

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

6 “(i) shall include the services require-
7 ments described in subsection (c) and be
8 based on the recommendations submitted
9 under subparagraph (B); and

10 “(ii) may be selected from among the
11 services described in subsection (d) and in-
12 clude other services as appropriate.

13 “(B) STAKEHOLDER INPUT.—The Director
14 shall convene and solicit recommendations from
15 stakeholders, including State substance abuse
16 agencies, health care providers, persons in re-
17 covery from substance abuse, and other appro-
18 priate individuals, for the minimum set of serv-
19 ices described in subparagraph (A).

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

22 “(5) EVALUATION AND REPORT TO CON-
23 GRESS.—

24 “(A) IN GENERAL.—The Director of the
25 Center for Behavioral Health Statistics and

1 Quality shall evaluate the pilot program at the
2 conclusion of the first grant cycle funded by the
3 pilot program.

4 “(B) REPORT.—The Director of the Cen-
5 ter for Behavioral Health Statistics and Qual-
6 ity, in coordination with the Director of the
7 Center for Substance Abuse Treatment shall
8 submit to the relevant committees of jurisdic-
9 tion of the House of Representatives and the
10 Senate a report on the evaluation under sub-
11 paragraph (A). The report shall include, at a
12 minimum—

13 “(i) outcomes information from the
14 pilot program, including any resulting re-
15 ductions in the use of alcohol and other
16 drugs;

17 “(ii) engagement in treatment serv-
18 ices;

19 “(iii) retention in the appropriate level
20 and duration of services;

21 “(iv) increased access to the use of
22 medications approved by the Food and
23 Drug Administration for the treatment of
24 substance use disorders in combination
25 with counseling; and

1 “(v) other appropriate measures.

2 “(C) RECOMMENDATION.—The report
3 under subparagraph (B) shall include a rec-
4 ommendation by the Director of the Center for
5 Substance Abuse Treatment as to whether the
6 pilot program under this subsection should be
7 extended.

8 “(6) STATE SUBSTANCE ABUSE AGENCIES DE-
9 FINED.—For purposes of this subsection, the term
10 ‘State substance abuse agency’ means, with respect
11 to a State, the agency in such State that manages
12 the Substance Abuse Prevention and Treatment
13 Block Grant under part B of title XIX.”.

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

1 unless the amount made available to carry out this
2 section for such fiscal year is more than the amount
3 made available to carry out this section for fiscal
4 year 2016.”.

5 **SEC. 502. VETERANS TREATMENT COURTS.**

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

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

10 (2) by inserting after subsection (h) the fol-
11 lowing:

12 “(i) ASSISTING VETERANS.—

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

14 “(A) PEER-TO-PEER SERVICES OR PRO-
15 GRAMS.—The term ‘peer-to-peer services or pro-
16 grams’ means services or programs that connect
17 qualified veterans with other veterans for the
18 purpose of providing support and mentorship to
19 assist qualified veterans in obtaining treatment,
20 recovery, stabilization, or rehabilitation.

21 “(B) QUALIFIED VETERAN.—The term
22 ‘qualified veteran’ means a preliminarily quali-
23 fied offender who—

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

4 “(ii) was discharged or released from
5 such service under conditions other than
6 dishonorable, unless the reason for the dis-
7 honorably discharge was attributable to a
8 substance abuse disorder.

9 “(C) VETERANS TREATMENT COURT PRO-
10 GRAM.—The term ‘veterans treatment court
11 program’ means a court program involving col-
12 laboration among criminal justice, veterans, and
13 mental health and substance abuse agencies
14 that provides qualified veterans with—

15 “(i) intensive judicial supervision and
16 case management, which may include ran-
17 dom and frequent drug testing where ap-
18 propriate;

19 “(ii) a full continuum of treatment
20 services, including mental health services,
21 substance abuse services, medical services,
22 and services to address trauma;

23 “(iii) alternatives to incarceration; or

24 “(iv) other appropriate services, in-
25 cluding housing, transportation, mentoring,

1 employment, job training, education, or as-
2 sistance in applying for and obtaining
3 available benefits.

4 “(2) VETERANS ASSISTANCE PROGRAM.—

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

9 “(i) veterans treatment court pro-
10 grams;

11 “(ii) peer-to-peer services or programs
12 for qualified veterans;

13 “(iii) practices that identify and pro-
14 vide treatment, rehabilitation, legal, transi-
15 tional, and other appropriate services to
16 qualified veterans who have been incarcer-
17 ated; or

18 “(iv) training programs to teach
19 criminal justice, law enforcement, correc-
20 tions, mental health, and substance abuse
21 personnel how to identify and appro-
22 priately respond to incidents involving
23 qualified veterans.

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

4 “(i) demonstrate collaboration be-
5 tween and joint investments by criminal
6 justice, mental health, substance abuse,
7 and veterans service agencies;

8 “(ii) promote effective strategies to
9 identify and reduce the risk of harm to
10 qualified veterans and public safety; and

11 “(iii) propose interventions with em-
12 pirical support to improve outcomes for
13 qualified veterans.”.

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

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

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

21 (2) by inserting after paragraph (4) the fol-
22 lowing:

23 “(5) maintain and disseminate information
24 about the requirements of section 106(b)(2)(B)(iii)
25 and best practices relating to the development of

1 plans of safe care as described in such section for
2 infants born and identified as being affected by sub-
3 stance abuse or withdrawal symptoms, or a Fetal Al-
4cohol Spectrum Disorder;”.

5 (b) STATE PLANS.—Section 106(b)(2)(B) of the
6 Child Abuse Prevention and Treatment Act (42 U.S.C.
7 5106a(b)(2)(B)) is amended—

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

10 (2) in clause (iii)—

11 (A) by striking “illegal substance abuse”
12 and inserting “substance abuse”; and

13 (B) by inserting before the semicolon at
14 the end the following: “to ensure the safety and
15 well-being of such infant following release from
16 the care of health care providers, including
17 through—

18 “(I) addressing the health and sub-
19 stance use disorder treatment needs of the
20 infant and affected family or caregiver;
21 and

22 “(II) the development and implemen-
23 tation by the State of monitoring systems
24 regarding the implementation of such
25 plans to determine whether and in what

1 manner local entities are providing, in ac-
2 cordance with State requirements, referrals
3 to and delivery of appropriate services for
4 the infant and affected family or care-
5 giver”.

6 (c) DATA REPORTS.—

7 (1) IN GENERAL.—Section 106(d) of the Child
8 Abuse Prevention and Treatment Act (42 U.S.C.
9 5106a(d)) is amended by adding at the end of the
10 following:

11 “(17) The number of infants—

12 “(A) identified under subsection
13 (b)(2)(B)(ii);

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

16 “(C) for whom a referral was made for ap-
17 propriate services, including services for the af-
18 fected family or caregiver, under subsection
19 (b)(2)(B)(iii).”.

20 (2) REDESIGNATION.—Effective on May 29,
21 2017, section 106(d) of the Child Abuse Prevention
22 and Treatment Act (42 U.S.C. 5106a(d)) is amend-
23 ed by redesignating paragraph (17) (as added by
24 paragraph (1)) as paragraph (18).

25 (d) MONITORING AND OVERSIGHT.—

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

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

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

9 ““(1) shall—

10 ““(A) be in addition to the review of the
11 State plan upon its submission under section
12 106(b)(1)(A); and

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

16 ““(2) may include—

17 ““(A) a comparison of activities carried out
18 by the State to comply with the requirements of
19 section 106(b) with the State plan most re-
20 cently approved under section 432 of the Social
21 Security Act;

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

1 and the Committee on Finance and the Committee on
2 Health, Education, Labor, and Pensions of the Senate a
3 report on neonatal abstinence syndrome (in this section
4 referred to as “NAS”) in the United States.

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

7 (1) The prevalence of NAS in the United
8 States, including the proportion of children born in
9 the United States with NAS who are eligible for
10 medical assistance under State Medicaid programs
11 under title XIX of the Social Security Act (42
12 U.S.C. 1396 et seq.) at birth, and the costs associ-
13 ated with coverage under such programs for treat-
14 ment of infants with NAS.

15 (2) The services for which coverage is available
16 under State Medicaid programs for treatment of in-
17 fants with NAS.

18 (3) The settings (including inpatient, out-
19 patient, hospital-based, and other settings) for the
20 treatment of infants with NAS and the reimburse-
21 ment methodologies and costs associated with such
22 treatment in such settings.

23 (4) The prevalence of utilization of various care
24 settings under State Medicaid programs for treat-
25 ment of infants with NAS and any Federal barriers

1 to treating such infants under such programs, par-
2 ticularly in non-hospital-based settings.

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

5 (c) RECOMMENDATIONS.—Such report also shall in-
6 clude such recommendations as the Comptroller General
7 determines appropriate for improvements that will ensure
8 access to treatment for infants with NAS under State
9 Medicaid programs.

10 **TITLE VI—INCENTIVIZING STATE**
11 **COMPREHENSIVE INITIA-**
12 **TIVES TO ADDRESS PRE-**
13 **SCRIPTION OPIOID ABUSE**

14 **SEC. 601. STATE DEMONSTRATION GRANTS FOR COM-**
15 **PREHENSIVE OPIOID ABUSE RESPONSE.**

16 Part D of title V of the Public Health Service Act
17 (42 U.S.C. 290dd et seq.), as amended by section 302,
18 is further amended by adding at the end the following:

19 **“SEC. 548. STATE DEMONSTRATION GRANTS FOR COM-**
20 **PREHENSIVE OPIOID ABUSE RESPONSE.**

21 “(a) DEFINITIONS.—In this section:

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

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

4 “(3) PRESCRIBER OF A SCHEDULE II, III, OR IV
5 CONTROLLED SUBSTANCE.—The term ‘prescriber of
6 a schedule II, III, or IV controlled substance’ does
7 not include a prescriber of a schedule II, III, or IV
8 controlled substance that dispenses the substance—

9 “(A) for use on the premises on which the
10 substance is dispensed;

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

13 “(C) for a certified opioid treatment pro-
14 gram; or

15 “(D) in other situations as the Secretary
16 may reasonably determine.

17 “(4) SCHEDULE II, III, OR IV CONTROLLED
18 SUBSTANCE.—The term ‘schedule II, III, or IV con-
19 trolled substance’ means a controlled substance that
20 is listed on schedule II, schedule III, or schedule IV
21 of section 202(c) of the Controlled Substances Act.

22 “(b) GRANTS FOR COMPREHENSIVE OPIOID ABUSE
23 RESPONSE.—

24 “(1) IN GENERAL.—The Secretary may award
25 grants to States, and combinations of States, to im-

1 stances to access the prescription drug
2 monitoring program of the State;

3 “(C) developing, implementing, or expand-
4 ing prescription drug and opioid addiction
5 treatment programs by—

6 “(i) expanding the availability of
7 treatment for prescription drug and opioid
8 addiction, including medication-assisted
9 treatment and behavioral health therapy,
10 as appropriate;

11 “(ii) developing, implementing, or ex-
12 panding screening for individuals in treat-
13 ment for prescription drug and opioid ad-
14 diction for hepatitis C and HIV, and treat-
15 ing or referring those individuals if clini-
16 cally appropriate; or

17 “(iii) developing, implementing, or ex-
18 panding recovery support services and pro-
19 grams at high schools or institutions of
20 higher education;

21 “(D) developing, implementing, and ex-
22 panding efforts to prevent overdose death from
23 opioid abuse or addiction to prescription medi-
24 cations and opioids; and

1 “(E) advancing the education and aware-
2 ness of the public, providers, patients, con-
3 sumers, and other appropriate entities regard-
4 ing the dangers of opioid abuse, safe disposal of
5 prescription medications, and detection of early
6 warning signs of opioid use disorders.

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

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

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

21 “(A)(i) provides civil liability protection for
22 first responders, health professionals, and fam-
23 ily members who have received appropriate
24 training in administering a drug or device ap-
25 proved or cleared under the Federal Food,

1 Drug, and Cosmetic Act for emergency treat-
2 ment of known or suspected opioid overdose;
3 and

4 “(ii) submits to the Secretary a certifi-
5 cation by the attorney general of the State that
6 the attorney general has—

7 “(I) reviewed any applicable civil li-
8 ability protection law to determine the ap-
9 plicability of the law with respect to first
10 responders, health care professionals, fam-
11 ily members, and other individuals who—

12 “(aa) have received appropriate
13 training in administering a drug or
14 device approved or cleared under the
15 Federal Food, Drug, and Cosmetic
16 Act for emergency treatment of
17 known or suspected opioid overdose;
18 and

19 “(bb) may administer a drug or
20 device approved or cleared under the
21 Federal Food, Drug, and Cosmetic
22 Act for emergency treatment of
23 known or suspected opioid overdose;
24 and

1 “(II) concluded that the law described
2 in subclause (I) provides adequate civil li-
3 ability protection applicable to such per-
4 sons;

5 “(B) has a process for enrollment in serv-
6 ices and benefits necessary by criminal justice
7 agencies to initiate or continue treatment in the
8 community, under which an individual who is
9 incarcerated may, while incarcerated, enroll in
10 services and benefits that are necessary for the
11 individual to continue treatment upon release
12 from incarceration;

13 “(C) ensures the capability of data sharing
14 with other States, where applicable, such as by
15 making data available to a prescription moni-
16 toring hub;

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

21 “(E) ensures that the prescription drug
22 monitoring program of the State notifies pre-
23 scribers and dispensers of schedule II, III, or
24 IV controlled substances when overuse or mis-

1 use of such controlled substances by patients is
2 suspected; and

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

8 “(6) STATES WITHOUT PRESCRIPTION DRUG
9 MONITORING PROGRAM.—

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

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

1 local government within the state and with
2 other States, as applicable.

3 “(c) AUTHORIZATION OF FUNDING.—For the pur-
4 pose of carrying out this section, there are authorized to
5 be appropriated \$5,000,000 for each of fiscal years 2017
6 through 2021.”.

7 **TITLE VII—MISCELLANEOUS**

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

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

14 **“SEC. 3026. GRANT ACCOUNTABILITY.**

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

17 “(1) the Committee on the Judiciary of the
18 Senate; and

19 “(2) the Committee on the Judiciary of the
20 House of Representatives.

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

24 “(1) AUDIT REQUIREMENT.—

1 “(A) DEFINITION.—In this paragraph, the
2 term ‘unresolved audit finding’ means a finding
3 in the final audit report of the Inspector Gen-
4 eral of the Department of Justice that the au-
5 dited grantee has utilized grant funds for an
6 unauthorized expenditure or otherwise unallow-
7 able cost that is not closed or resolved within
8 12 months after the date on which the final
9 audit report is issued.

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

20 “(C) MANDATORY EXCLUSION.—A recipi-
21 ent of grant funds under this part that is found
22 to have an unresolved audit finding shall not be
23 eligible to receive grant funds under this part
24 during the first 2 fiscal years beginning after

1 the end of the 12-month period described in
2 subparagraph (A).

3 “(D) PRIORITY.—In awarding grants
4 under this part, the Attorney General shall give
5 priority to eligible applicants that did not have
6 an unresolved audit finding during the 3 fiscal
7 years before submitting an application for a
8 grant under this part.

9 “(E) REIMBURSEMENT.—If an entity is
10 awarded grant funds under this part during the
11 2-fiscal-year period during which the entity is
12 barred from receiving grants under subpara-
13 graph (C), the Attorney General shall—

14 “(i) deposit an amount equal to the
15 amount of the grant funds that were im-
16 properly awarded to the grantee into the
17 General Fund of the Treasury; and

18 “(ii) seek to recoup the costs of the
19 repayment to the fund from the grant re-
20 cipient that was erroneously awarded grant
21 funds.

22 “(2) NONPROFIT ORGANIZATION REQUIRE-
23 MENTS.—

24 “(A) DEFINITION.—For purposes of this
25 paragraph and the grant programs under this

1 part, the term ‘nonprofit organization’ means
2 an organization that is described in section
3 501(c)(3) of the Internal Revenue Code of 1986
4 and is exempt from taxation under section
5 501(a) of such Code.

6 “(B) PROHIBITION.—A nonprofit organiza-
7 tion that holds money in offshore accounts for
8 the purpose of avoiding paying the tax de-
9 scribed in section 511(a) of the Internal Rev-
10 enue Code of 1986 may not—

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

13 “(ii) receive a subaward under section
14 3021(b).

15 “(C) DISCLOSURE.—Each nonprofit orga-
16 nization that receives a subaward or is party to
17 a contract entered into under section 3021(b)
18 and uses the procedures prescribed in regula-
19 tions to create a rebuttable presumption of rea-
20 sonableness for the compensation of its officers,
21 directors, trustees, and key employees, shall dis-
22 close, in the application for such contract or
23 subaward, the process for determining such
24 compensation, including the independent per-
25 sons involved in reviewing and approving such

1 compensation, the comparability data used, and
2 contemporaneous substantiation of the delibera-
3 tion and decision. Upon request, the Attorney
4 General shall make the information disclosed
5 under this subparagraph available for public in-
6 spection.

7 “(3) CONFERENCE EXPENDITURES.—

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

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

1 “(C) REPORT.—The Deputy Attorney Gen-
2 eral shall submit to the applicable committees
3 an annual report on all conference expenditures
4 approved by the Attorney General under this
5 paragraph.

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

11 “(A) indicating whether—

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

17 “(ii) all mandatory exclusions required
18 under paragraph (1)(C) have been issued;
19 and

20 “(iii) all reimbursements required
21 under paragraph (1)(E) have been made;
22 and

23 “(B) that includes a list of any grant re-
24 cipients excluded under paragraph (1) from the
25 previous year.

1 “(c) PREVENTING DUPLICATIVE GRANTS.—

2 “(1) IN GENERAL.—Before the Attorney Gen-
3 eral awards a grant to an applicant under this part,
4 the Attorney General shall compare potential grant
5 awards with other grants awarded under this part
6 by the Attorney General to determine if duplicate
7 grant awards are awarded for the same purpose.

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

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

16 “(B) the reason the Attorney General
17 awarded the duplicate grants.”.

18 (b) EVALUATION OF PERFORMANCE OF DEPART-
19 MENT OF JUSTICE PROGRAMS.—

20 (1) EVALUATION OF JUSTICE DEPARTMENT
21 COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—

22 Not later than 5 years after the date of enactment
23 of this Act, the Attorney General shall complete an
24 evaluation of the effectiveness of the Comprehensive
25 Opioid Abuse Grant Program under part LL of title

1 I of the Omnibus Crime Control and Safe Streets
2 Act of 1968, as added by section 201, administered
3 by the Department of Justice based upon the infor-
4 mation reported under paragraph (4).

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

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

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

1 tice data based upon the metrics identified under
2 paragraph (3).

3 (5) PUBLICATION OF DATA AND FINDINGS.—

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

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

22 (6) INDEPENDENT EVALUATION.—For purposes
23 of paragraphs (1), (2), and (3), the Attorney Gen-
24 eral shall—

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

3 (B) enter into a contract or cooperative
4 agreement with an entity that is not an agency
5 of the Federal Government, and is qualified to
6 conduct and evaluate research pertaining to
7 opioid use and abuse, and draw conclusions
8 about overall opioid use and abuse on the basis
9 of that research.

10 (c) DEPARTMENT OF HEALTH AND HUMAN SERV-
11 ICES GRANT ACCOUNTABILITY.—

12 (1) DEFINITIONS.—In this subsection:

13 (A) APPLICABLE COMMITTEES.—The term
14 “applicable committees” means—

15 (i) the Committee on Health, Edu-
16 cation, Labor and Pensions of the Senate;
17 and

18 (ii) the Committee on Energy and
19 Commerce of the House of Representa-
20 tives.

21 (B) COVERED GRANT.—The term “covered
22 grant” means a grant awarded by the Secretary
23 under a program established under this Act (or
24 an amendment made by this Act, other than
25 sections 703 through 707), including any grant

1 administered by the Administrator of the Sub-
2 stance Abuse and Mental Health Services Ad-
3 ministration under section 103.

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

6 (D) SECRETARY.—The term “Secretary”
7 means the Secretary of Health and Human
8 Services.

9 (2) ACCOUNTABILITY MEASURES.—Each cov-
10 ered grant shall be subject to the following account-
11 ability requirements:

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

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

24 (i) IN GENERAL.—Not later than 1
25 year after the date of the enactment of this

1 Act, the Secretary, in coordination with the
2 Inspector General of the Department of
3 Health and Human Services, shall submit
4 to the applicable committees a report on
5 the policies and procedures the Depart-
6 ment has in place to prevent waste, fraud,
7 and abuse in the administration of covered
8 grants.

9 (ii) CONTENTS.—The policies and
10 procedures referred to in clause (i) shall
11 include policies and procedures that are de-
12 signed to—

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

18 (II) ensure grantees will not re-
19 ceive unwarranted duplicate grants for
20 the same purpose.

21 (C) CONFERENCE EXPENDITURES.—

22 (i) IN GENERAL.—No amounts made
23 available to the Secretary under this Act
24 (or in a provision of law amended by this
25 Act, other than sections 703 through 707)

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

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

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

1 (1) EVALUATIONS.—

2 (A) IN GENERAL.—Not later than 5 years
3 after the date of enactment of this Act, except
4 as otherwise provided in this section, the Sec-
5 retary of Health and Human Services (in this
6 subsection referred to as the “Secretary”) shall
7 complete an evaluation of any program adminis-
8 tered by the Secretary included in this Act (or
9 an amendment made by this Act, excluding sec-
10 tions 703 through 707), including any grant ad-
11 ministered by the Administrator of the Sub-
12 stance Abuse and Mental Health Services Ad-
13 ministration under section 103, that provides
14 grants for the primary purpose of providing as-
15 sistance in addressing problems pertaining to
16 opioid abuse based upon the outcomes and
17 metrics identified under paragraph (2).

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

1 along with the data used to make such evalua-
2 tion.

3 (2) METRICS AND OUTCOMES.—

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

7 (i) outcomes that are to be achieved
8 by activities funded by the programs de-
9 scribed in paragraph (1)(A); and

10 (ii) the metrics by which the achieve-
11 ment of such outcomes shall be deter-
12 mined.

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

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

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

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

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

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

7 (ii) is qualified to conduct and evalu-
8 ate research pertaining to opioid use and
9 abuse and draw conclusions about overall
10 opioid use and abuse on the basis of that
11 research.

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

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

1 (f) NO ADDITIONAL FUNDS AUTHORIZED.—No addi-
2 tional funds are authorized to be appropriated to carry
3 out this section.

4 **SEC. 702. PARTIAL FILLS OF SCHEDULE II CONTROLLED**
5 **SUBSTANCES.**

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

9 “(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED
10 SUBSTANCES.—

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

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

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

18 “(C) the partial fill is requested by the pa-
19 tient or the practitioner that wrote the prescrip-
20 tion; and

21 “(D) the total quantity dispensed in all
22 partial fillings does not exceed the total quan-
23 tity prescribed.

24 “(2) REMAINING PORTIONS.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), remaining portions of a par-
3 tially filled prescription for a controlled sub-
4 stance in schedule II—

5 “(i) may be filled; and

6 “(ii) shall be filled not later than 30
7 days after the date on which the prescrip-
8 tion is written.

9 “(B) EMERGENCY SITUATIONS.—In emer-
10 gency situations, as described in subsection (a),
11 the remaining portions of a partially filled pre-
12 scription for a controlled substance in schedule
13 II—

14 “(i) may be filled; and

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

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

24 (b) RULE OF CONSTRUCTION.—Nothing in this sec-
25 tion shall be construed to affect the authority of the Attor-

1 ney General to allow a prescription for a controlled sub-
2 stance in schedule III, IV, or V of section 202(c) of the
3 Controlled Substances Act (21 U.S.C. 812(c)) to be par-
4 tially filled.

5 **SEC. 703. GOOD SAMARITAN ASSESSMENT.**

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

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

23 (1) the extent to which the Director of National
24 Drug Control Policy has reviewed Good Samaritan
25 laws, and any findings from such a review, including

1 findings related to the potential effects of such laws,
2 if available;

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

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

8 (c) DEFINITIONS.—In this section—

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

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

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

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

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

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

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

20 “(B) REQUIREMENT FOR NOTICES.—

21 “(i) IN GENERAL.—A PDP sponsor
22 may not limit the access of an at-risk ben-
23 eficiary for prescription drug abuse to cov-
24 erage for frequently abused drugs under a

1 prescription drug plan until such spon-
2 sor—

3 “(I) provides to the beneficiary
4 an initial notice described in clause
5 (ii) and a second notice described in
6 clause (iii); and

7 “(II) verifies with the providers
8 of the beneficiary that the beneficiary
9 is an at-risk beneficiary for prescrip-
10 tion drug abuse.

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

14 “(I) notice that the PDP sponsor
15 has identified the beneficiary as po-
16 tentially being an at-risk beneficiary
17 for prescription drug abuse;

18 “(II) information describing all
19 State and Federal public health re-
20 sources that are designed to address
21 prescription drug abuse to which the
22 beneficiary has access, including men-
23 tal health services and other coun-
24 seling services;

1 “(III) notice of, and information
2 about, the right of the beneficiary to
3 appeal such identification under sub-
4 section (h) and the option of an auto-
5 matic escalation to external review;

6 “(IV) a request for the bene-
7 ficiary to submit to the PDP sponsor
8 preferences for which prescribers and
9 pharmacies the beneficiary would pre-
10 fer the PDP sponsor to select under
11 subparagraph (D) in the case that the
12 beneficiary is identified as an at-risk
13 beneficiary for prescription drug
14 abuse as described in clause (iii)(I);

15 “(V) an explanation of the mean-
16 ing and consequences of the identi-
17 fication of the beneficiary as poten-
18 tially being an at-risk beneficiary for
19 prescription drug abuse, including an
20 explanation of the drug management
21 program established by the PDP
22 sponsor pursuant to subparagraph
23 (A);

24 “(VI) clear instructions that ex-
25 plain how the beneficiary can contact

1 the PDP sponsor in order to submit
2 to the PDP sponsor the preferences
3 described in subclause (IV) and any
4 other communications relating to the
5 drug management program for at-risk
6 beneficiaries established by the PDP
7 sponsor; and

8 “(VII) contact information for
9 other organizations that can provide
10 the beneficiary with assistance regard-
11 ing such drug management program
12 (similar to the information provided
13 by the Secretary in other standardized
14 notices provided to part D eligible in-
15 dividuals enrolled in prescription drug
16 plans under this part).

17 “(iii) SECOND NOTICE.—A second no-
18 tice described in this clause is a notice that
19 provides to the beneficiary notice—

20 “(I) that the PDP sponsor has
21 identified the beneficiary as an at-risk
22 beneficiary for prescription drug
23 abuse;

24 “(II) that such beneficiary is
25 subject to the requirements of the

1 drug management program for at-risk
2 beneficiaries established by such PDP
3 sponsor for such plan;

4 “(III) of the prescriber (or pre-
5 scribers) and pharmacy (or phar-
6 macies) selected for such individual
7 under subparagraph (D);

8 “(IV) of, and information about,
9 the beneficiary’s right to appeal such
10 identification under subsection (h)
11 and the option of an automatic esca-
12 lation to external review;

13 “(V) that the beneficiary can, in
14 the case that the beneficiary has not
15 previously submitted to the PDP
16 sponsor preferences for which pre-
17 scribers and pharmacies the bene-
18 ficiary would prefer the PDP sponsor
19 select under subparagraph (D), sub-
20 mit such preferences to the PDP
21 sponsor; and

22 “(VI) that includes clear instruc-
23 tions that explain how the beneficiary
24 can contact the PDP sponsor.

25 “(iv) TIMING OF NOTICES.—

1 “(I) IN GENERAL.—Subject to
2 subclause (II), a second notice de-
3 scribed in clause (iii) shall be provided
4 to the beneficiary on a date that is
5 not less than 30 days after an initial
6 notice described in clause (ii) is pro-
7 vided to the beneficiary.

8 “(II) EXCEPTION.—In the case
9 that the PDP sponsor, in conjunction
10 with the Secretary, determines that
11 concerns identified through rule-
12 making by the Secretary regarding
13 the health or safety of the beneficiary
14 or regarding significant drug diversion
15 activities require the PDP sponsor to
16 provide a second notice described in
17 clause (iii) to the beneficiary on a
18 date that is earlier than the date de-
19 scribed in subclause (I), the PDP
20 sponsor may provide such second no-
21 tice on such earlier date.

22 “(C) AT-RISK BENEFICIARY FOR PRE-
23 SCRIPTION DRUG ABUSE.—

24 “(i) IN GENERAL.—For purposes of
25 this paragraph, the term ‘at-risk bene-

1 identified under this paragraph to be
2 an at-risk beneficiary for prescription
3 drug abuse under the prescription
4 drug plan in which such individual
5 was most recently previously enrolled
6 and such identification has not been
7 terminated under subparagraph (F).

8 “(ii) EXEMPTED INDIVIDUAL DE-
9 SCRIBED.—An exempted individual de-
10 scribed in this clause is an individual
11 who—

12 “(I) receives hospice care under
13 this title;

14 “(II) is a resident of a long-term
15 care facility, of a facility described in
16 section 1905(d), or of another facility
17 for which frequently abused drugs are
18 dispensed for residents through a con-
19 tract with a single pharmacy; or

20 “(III) the Secretary elects to
21 treat as an exempted individual for
22 purposes of clause (i).

23 “(iii) PROGRAM SIZE.—The Secretary
24 shall establish policies, including the guide-
25 lines developed under clause (i)(I) and the

1 exemptions under clause (ii)(III), to ensure
2 that the population of enrollees in a drug
3 management program for at-risk bene-
4 ficiaries operated by a prescription drug
5 plan can be effectively managed by such
6 plans.

7 “(iv) CLINICAL CONTACT.—With re-
8 spect to each at-risk beneficiary for pre-
9 scription drug abuse enrolled in a prescrip-
10 tion drug plan offered by a PDP sponsor,
11 the PDP sponsor shall contact the bene-
12 ficiary’s providers who have prescribed fre-
13 quently abused drugs regarding whether
14 prescribed medications are appropriate for
15 such beneficiary’s medical conditions.

16 “(D) SELECTION OF PRESCRIBERS AND
17 PHARMACIES.—

18 “(i) IN GENERAL.—With respect to
19 each at-risk beneficiary for prescription
20 drug abuse enrolled in a prescription drug
21 plan offered by such sponsor, a PDP spon-
22 sor shall, based on the preferences sub-
23 mitted to the PDP sponsor by the bene-
24 ficiary pursuant to clauses (ii)(IV) and
25 (iii)(V) of subparagraph (B) (except as

1 otherwise provided in this subparagraph)
2 select—

3 “(I) one, or, if the PDP sponsor
4 reasonably determines it necessary to
5 provide the beneficiary with reason-
6 able access under clause (ii), more
7 than one, individual who is authorized
8 to prescribe frequently abused drugs
9 (referred to in this paragraph as a
10 ‘prescriber’) who may write prescrip-
11 tions for such drugs for such bene-
12 ficiary; and

13 “(II) one, or, if the PDP sponsor
14 reasonably determines it necessary to
15 provide the beneficiary with reason-
16 able access under clause (ii), more
17 than one, pharmacy that may dis-
18 pense such drugs to such beneficiary.

19 For purposes of subclause (II), in the case
20 of a pharmacy that has multiple locations
21 that share real-time electronic data, all
22 such locations of the pharmacy shall collec-
23 tively be treated as one pharmacy.

1 select in response to a notice under sub-
2 paragraph (B), the PDP sponsor shall—

3 “(I) review such preferences;

4 “(II) select or change the selec-
5 tion of prescribers and pharmacies for
6 the beneficiary based on such pref-
7 erences; and

8 “(III) inform the beneficiary of
9 such selection or change of selection.

10 “(iv) EXCEPTION REGARDING BENE-
11 FICIARY PREFERENCES.—In the case that
12 the PDP sponsor determines that a change
13 to the selection of prescriber or pharmacy
14 under clause (iii)(II) by the PDP sponsor
15 is contributing or would contribute to pre-
16 scription drug abuse or drug diversion by
17 the beneficiary, the PDP sponsor may
18 change the selection of prescriber or phar-
19 macy for the beneficiary without regard to
20 the preferences of the beneficiary described
21 in clause (iii). If the PDP sponsor changes
22 the selection pursuant to the preceding
23 sentence, the PDP sponsor shall provide
24 the beneficiary with—

1 “(I) at least 30 days written no-
2 tice of the change of selection; and

3 “(II) a rationale for the change.

4 “(v) CONFIRMATION.—Before select-
5 ing a prescriber or pharmacy under this
6 subparagraph, a PDP sponsor must notify
7 the prescriber and pharmacy that the bene-
8 ficiary involved has been identified for in-
9 clusion in the drug management program
10 for at-risk beneficiaries and that the pre-
11 scriber and pharmacy has been selected as
12 the beneficiary’s designated prescriber and
13 pharmacy.

14 “(E) TERMINATIONS AND APPEALS.—The
15 identification of an individual as an at-risk ben-
16 eficiary for prescription drug abuse under this
17 paragraph, a coverage determination made
18 under a drug management program for at-risk
19 beneficiaries, the selection of prescriber or phar-
20 macy under subparagraph (D), and information
21 to be shared under subparagraph (I), with re-
22 spect to such individual, shall be subject to re-
23 consideration and appeal under subsection (h)
24 and the option of an automatic escalation to ex-

1 ternal review to the extent provided by the Sec-
2 retary.

3 “(F) TERMINATION OF IDENTIFICATION.—

4 “(i) IN GENERAL.—The Secretary
5 shall develop standards for the termination
6 of identification of an individual as an at-
7 risk beneficiary for prescription drug abuse
8 under this paragraph. Under such stand-
9 ards such identification shall terminate as
10 of the earlier of—

11 “(I) the date the individual dem-
12 onstrates that the individual is no
13 longer likely, in the absence of the re-
14 strictions under this paragraph, to be
15 an at-risk beneficiary for prescription
16 drug abuse described in subparagraph
17 (C)(i); and

18 “(II) the end of such maximum
19 period of identification as the Sec-
20 retary may specify.

21 “(ii) RULE OF CONSTRUCTION.—

22 Nothing in clause (i) shall be construed as
23 preventing a plan from identifying an indi-
24 vidual as an at-risk beneficiary for pre-
25 scription drug abuse under subparagraph

1 (C)(i) after such termination on the basis
2 of additional information on drug use oc-
3 ccurring after the date of notice of such ter-
4 mination.

5 “(G) FREQUENTLY ABUSED DRUG.—For
6 purposes of this subsection, the term ‘frequently
7 abused drug’ means a drug that is a controlled
8 substance that the Secretary determines to be
9 frequently abused or diverted.

10 “(H) DATA DISCLOSURE.—

11 “(i) DATA ON DECISION TO IMPOSE
12 LIMITATION.—In the case of an at-risk
13 beneficiary for prescription drug abuse (or
14 an individual who is a potentially at-risk
15 beneficiary for prescription drug abuse)
16 whose access to coverage for frequently
17 abused drugs under a prescription drug
18 plan has been limited by a PDP sponsor
19 under this paragraph, the Secretary shall
20 establish rules and procedures to require
21 the PDP sponsor to disclose data, includ-
22 ing any necessary individually identifiable
23 health information, in a form and manner
24 specified by the Secretary, about the deci-
25 sion to impose such limitations and the

1 limitations imposed by the sponsor under
2 this part.

3 “(ii) DATA TO REDUCE FRAUD,
4 ABUSE, AND WASTE.—The Secretary shall
5 establish rules and procedures to require
6 PDP sponsors operating a drug manage-
7 ment program for at-risk beneficiaries
8 under this paragraph to provide the Sec-
9 retary with such data as the Secretary de-
10 termines appropriate for purposes of iden-
11 tifying patterns of prescription drug utili-
12 zation for plan enrollees that are outside
13 normal patterns and that may indicate
14 fraudulent, medically unnecessary, or un-
15 safe use.

16 “(I) SHARING OF INFORMATION FOR SUB-
17 SEQUENT PLAN ENROLLMENTS.—The Secretary
18 shall establish procedures under which PDP
19 sponsors who offer prescription drug plans shall
20 share information with respect to individuals
21 who are at-risk beneficiaries for prescription
22 drug abuse (or individuals who are potentially
23 at-risk beneficiaries for prescription drug
24 abuse) and enrolled in a prescription drug plan
25 and who subsequently disenroll from such plan

1 and enroll in another prescription drug plan of-
2 fered by another PDP sponsor.

3 “(J) PRIVACY ISSUES.—Prior to the imple-
4 mentation of the rules and procedures under
5 this paragraph, the Secretary shall clarify pri-
6 vacy requirements, including requirements
7 under the regulations promulgated pursuant to
8 section 264(c) of the Health Insurance Port-
9 ability and Accountability Act of 1996 (42
10 U.S.C. 1320d–2 note), related to the sharing of
11 data under subparagraphs (H) and (I) by PDP
12 sponsors. Such clarification shall provide that
13 the sharing of such data shall be considered to
14 be protected health information in accordance
15 with the requirements of the regulations pro-
16 mulgated pursuant to such section 264(c).

17 “(K) EDUCATION.—The Secretary shall
18 provide education to enrollees in prescription
19 drug plans of PDP sponsors and providers re-
20 garding the drug management program for at-
21 risk beneficiaries described in this paragraph,
22 including education—

23 “(i) provided by Medicare administra-
24 tive contractors through the improper pay-

1 ment outreach and education program de-
2 scribed in section 1874A(h); and

3 “(ii) through current education efforts
4 (such as State health insurance assistance
5 programs described in subsection (a)(1)(A)
6 of section 119 of the Medicare Improve-
7 ments for Patients and Providers Act of
8 2008 (42 U.S.C. 1395b–3 note)) and ma-
9 terials directed toward such enrollees.

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

18 “(M) CMS COMPLIANCE REVIEW.—The
19 Secretary shall ensure that existing plan spon-
20 sor compliance reviews and audit processes in-
21 clude the drug management programs for at-
22 risk beneficiaries under this paragraph, includ-
23 ing appeals processes under such programs.”.

24 (2) INFORMATION FOR CONSUMERS.—Section
25 1860D–4(a)(1)(B) of the Social Security Act (42

1 U.S.C. 1395w-104(a)(1)(B)) is amended by adding
2 at the end the following:

3 “(v) The drug management program
4 for at-risk beneficiaries under subsection
5 (c)(5).”.

6 (3) DUAL ELIGIBLES.—Section 1860D-
7 1(b)(3)(D) of the Social Security Act (42 U.S.C.
8 1395w-101(b)(3)(D)) is amended by inserting “,
9 subject to such limits as the Secretary may establish
10 for individuals identified pursuant to section
11 1860D-4(c)(5)” after “the Secretary”.

12 (b) UTILIZATION MANAGEMENT PROGRAMS.—Sec-
13 tion 1860D-4(c) of the Social Security Act (42 U.S.C.
14 1395w-104(c)), as amended by subsection (a)(1), is fur-
15 ther amended—

16 (1) in paragraph (1), by inserting after sub-
17 paragraph (D) the following new subparagraph:

18 “(E) A utilization management tool to pre-
19 vent drug abuse (as described in paragraph
20 (6)(A)).”; and

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

23 “(6) UTILIZATION MANAGEMENT TOOL TO PRE-
24 VENT DRUG ABUSE.—

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

3 “(i) A utilization tool designed to pre-
4 vent the abuse of frequently abused drugs
5 by individuals and to prevent the diversion
6 of such drugs at pharmacies.

7 “(ii) Retrospective utilization review
8 to identify—

9 “(I) individuals that receive fre-
10 quently abused drugs at a frequency
11 or in amounts that are not clinically
12 appropriate; and

13 “(II) providers of services or sup-
14 pliers that may facilitate the abuse or
15 diversion of frequently abused drugs
16 by beneficiaries.

17 “(iii) Consultation with the contractor
18 described in subparagraph (B) to verify if
19 an individual enrolling in a prescription
20 drug plan offered by a PDP sponsor has
21 been previously identified by another PDP
22 sponsor as an individual described in
23 clause (ii)(I).

24 “(B) REPORTING.—A PDP sponsor offer-
25 ing a prescription drug plan (and an MA orga-

1 nization offering an MA–PD plan) in a State
2 shall submit to the Secretary and the Medicare
3 drug integrity contractor with which the Sec-
4 retary has entered into a contract under section
5 1893 with respect to such State a report, on a
6 monthly basis, containing information on—

7 “(i) any provider of services or sup-
8 plier described in subparagraph (A)(ii)(II)
9 that is identified by such plan sponsor (or
10 organization) during the 30-day period be-
11 fore such report is submitted; and

12 “(ii) the name and prescription
13 records of individuals described in para-
14 graph (5)(C).

15 “(C) CMS COMPLIANCE REVIEW.—The
16 Secretary shall ensure that plan sponsor compli-
17 ance reviews and program audits biennially in-
18 clude a certification that utilization manage-
19 ment tools under this paragraph are in compli-
20 ance with the requirements for such tools.”.

21 (c) EXPANDING ACTIVITIES OF MEDICARE DRUG IN-
22 TEGRITY CONTRACTORS (MEDICS).—

23 (1) IN GENERAL.—Section 1893 of the Social
24 Security Act (42 U.S.C. 1395ddd) is amended by
25 adding at the end the following new subsection:

1 “(j) EXPANDING ACTIVITIES OF MEDICARE DRUG
2 INTEGRITY CONTRACTORS (MEDICs).—

3 “(1) ACCESS TO INFORMATION.—Under con-
4 tracts entered into under this section with Medicare
5 drug integrity contractors (including any successor
6 entity to a Medicare drug integrity contractor), the
7 Secretary shall authorize such contractors to directly
8 accept prescription and necessary medical records
9 from entities such as pharmacies, prescription drug
10 plans, MA–PD plans, and physicians with respect to
11 an individual in order for such contractors to pro-
12 vide information relevant to the determination of
13 whether such individual is an at-risk beneficiary for
14 prescription drug abuse, as defined in section
15 1860D–4(e)(5)(C).

16 “(2) REQUIREMENT FOR ACKNOWLEDGMENT
17 OF REFERRALS.—If a PDP sponsor or MA organiza-
18 tion refers information to a contractor described in
19 paragraph (1) in order for such contractor to assist
20 in the determination described in such paragraph,
21 the contractor shall—

22 “(A) acknowledge to the sponsor or organi-
23 zation receipt of the referral; and

24 “(B) in the case that any PDP sponsor or
25 MA organization contacts the contractor re-

1 questing to know the determination by the con-
2 tractor of whether or not an individual has been
3 determined to be an individual described such
4 paragraph, shall inform such sponsor or organi-
5 zation of such determination on a date that is
6 not later than 15 days after the date on which
7 the sponsor or organization contacts the con-
8 tractor.

9 “(3) MAKING DATA AVAILABLE TO OTHER EN-
10 TITIES.—

11 “(A) IN GENERAL.—For purposes of car-
12 rying out this subsection, subject to subpara-
13 graph (B), the Secretary shall authorize MED-
14 ICs to respond to requests for information from
15 PDP sponsors and MA organizations, State
16 prescription drug monitoring programs, and
17 other entities delegated by such sponsors or or-
18 ganizations using available programs and sys-
19 tems in the effort to prevent fraud, waste, and
20 abuse.

21 “(B) HIPAA COMPLIANT INFORMATION
22 ONLY.—Information may only be disclosed by a
23 MEDIC under subparagraph (A) if the disclo-
24 sure of such information is permitted under the
25 Federal regulations (concerning the privacy of

1 individually identifiable health information) pro-
2 mulgated under section 264(c) of the Health
3 Insurance Portability and Accountability Act of
4 1996 (42 U.S.C. 1320d-2 note).”.

5 (2) **OIG STUDY AND REPORT ON EFFECTIVE-**
6 **NESS OF MEDICS.—**

7 (A) **STUDY.—**The Inspector General of the
8 Department of Health and Human Services
9 shall conduct a study on the effectiveness of
10 Medicare drug integrity contractors with which
11 the Secretary of Health and Human Services
12 has entered into a contract under section 1893
13 of the Social Security Act (42 U.S.C. 1395ddd)
14 in identifying, combating, and preventing fraud
15 under the Medicare program, including under
16 the authority provided under section 1893(j) of
17 the Social Security Act, added by paragraph
18 (1).

19 (B) **REPORT.—**Not later than 1 year after
20 the date of the enactment of this Act, the In-
21 spector General shall submit to Congress a re-
22 port on the study conducted under subpara-
23 graph (A). Such report shall include such rec-
24 ommendations for improvements in the effec-

1 tiveness of such contractors as the Inspector
2 General determines appropriate.

3 (d) TREATMENT OF CERTAIN COMPLAINTS FOR PUR-
4 POSES OF QUALITY OR PERFORMANCE ASSESSMENT.—
5 Section 1860D–42 of the Social Security Act (42 U.S.C.
6 1395w–152) is amended by adding at the end the fol-
7 lowing new subsection:

8 “(d) TREATMENT OF CERTAIN COMPLAINTS FOR
9 PURPOSES OF QUALITY OR PERFORMANCE ASSESS-
10 MENT.—In conducting a quality or performance assess-
11 ment of a PDP sponsor, the Secretary shall develop or
12 utilize existing screening methods for reviewing and con-
13 sidering complaints that are received from enrollees in a
14 prescription drug plan offered by such PDP sponsor and
15 that are complaints regarding the lack of access by the
16 individual to prescription drugs due to a drug manage-
17 ment program for at-risk beneficiaries.”.

18 (e) SENSE OF CONGRESS REGARDING USE OF TECH-
19 NOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of
20 Congress that MA organizations and PDP sponsors
21 should consider using e-prescribing and other health infor-
22 mation technology tools to support combating fraud under
23 MA–PD plans and prescription drug plans under parts C
24 and D of the Medicare program.

25 (f) REPORTS.—

1 (1) REPORT BY SECRETARY ON APPEALS PROC-
2 ESS.—

3 (A) IN GENERAL.—Not later than 12
4 months after the date of the enactment of this
5 Act, the Secretary of Health and Human Serv-
6 ices shall submit to the appropriate committees
7 of jurisdiction of Congress a report on ways to
8 improve upon the appeals process for Medicare
9 beneficiaries with respect to prescription drug
10 coverage under part D of title XVIII of the So-
11 cial Security Act. Such report shall include an
12 analysis comparing appeals processes under
13 parts C and D of such title XVIII.

14 (B) FEEDBACK.—In development of the
15 report described in subparagraph (A), the Sec-
16 retary of Health and Human Services shall so-
17 licit feedback on the current appeals process
18 from stakeholders, such as beneficiaries, con-
19 sumer advocates, plan sponsors, pharmacy ben-
20 efit managers, pharmacists, providers, inde-
21 pendent review entity evaluators, and pharma-
22 ceutical manufacturers.

23 (2) GAO STUDY AND REPORT.—

24 (A) STUDY.—The Comptroller General of
25 the United States shall conduct a study on the

1 implementation of the amendments made by
2 this section, including the effectiveness of the
3 at-risk beneficiaries for prescription drug abuse
4 drug management programs authorized by sec-
5 tion 1860D-4(c)(5) of the Social Security Act
6 (42 U.S.C. 1395w-10(c)(5)), as added by sub-
7 section (a)(1). Such study shall include an anal-
8 ysis of—

9 (i) the impediments, if any, that im-
10 pair the ability of individuals described in
11 subparagraph (C) of such section 1860D-
12 4(c)(5) to access clinically appropriate lev-
13 els of prescription drugs;

14 (ii) the effectiveness of the reasonable
15 access protections under subparagraph
16 (D)(ii) of such section 1860D-4(c)(5), in-
17 cluding the impact on beneficiary access
18 and health;

19 (iii) the types of—

20 (I) individuals who, in the imple-
21 mentation of such section, are deter-
22 mined to be individuals described in
23 such subparagraph (C); and

1 (II) prescribers and pharmacies
2 that are selected under subparagraph
3 (D) of such section; and
4 (iv) other areas determined appro-
5 priate by the Comptroller General.

6 (B) REPORT.—Not later than July 1,
7 2019, the Comptroller General of the United
8 States shall submit to the appropriate commit-
9 tees of jurisdiction of Congress a report on the
10 study conducted under subparagraph (A), to-
11 gether with recommendations for such legisla-
12 tion and administrative action as the Comp-
13 troller General determines to be appropriate.

14 (g) EFFECTIVE DATE; RULEMAKING.—

15 (1) IN GENERAL.—The amendments made by
16 this section shall apply to prescription drug plans
17 (and MA–PD plans) for plan years beginning on or
18 after January 1, 2019.

19 (2) STAKEHOLDER MEETINGS PRIOR TO EFFEC-
20 TIVE DATE.—

21 (A) IN GENERAL.—Not later than January
22 1, 2017, the Secretary of Health and Human
23 Services shall convene stakeholders, including
24 individuals entitled to benefits under part A of
25 title XVIII of the Social Security Act or en-

1 rolled under part B of such title, advocacy
2 groups representing such individuals, physi-
3 cians, pharmacists, and other clinicians, retail
4 pharmacies, plan sponsors, entities delegated by
5 plan sponsors, and biopharmaceutical manufac-
6 turers for input regarding the topics described
7 in subparagraph (B). The input described in
8 the preceding sentence shall be provided to the
9 Secretary in sufficient time in order for the
10 Secretary to take such input into account in
11 promulgating the regulations pursuant to para-
12 graph (3).

13 (B) TOPICS DESCRIBED.—The topics de-
14 scribed in this subparagraph are the topics of—

15 (i) the anticipated impact of drug
16 management programs for at-risk bene-
17 ficiaries under paragraph (5) of section
18 1860D–4(c) of the Social Security Act (42
19 U.S.C. 1395w–104(c)) on cost-sharing and
20 ensuring accessibility to prescription drugs
21 for enrollees in prescription drug plans of
22 PDP sponsors, and enrollees in MA–PD
23 plans, who are at-risk beneficiaries for pre-
24 scription drug abuse (as defined in sub-
25 paragraph (C) of such paragraph);

1 (ii) the use of an expedited appeals
2 process under which such an enrollee may
3 appeal an identification of such enrollee as
4 an at-risk beneficiary for prescription drug
5 abuse under such paragraph (similar to the
6 processes established under the Medicare
7 Advantage program under part C of title
8 XVIII of the Social Security Act that allow
9 an automatic escalation to external review
10 of claims submitted under such part);

11 (iii) the types of enrollees that should
12 be treated as exempted individuals, as de-
13 scribed in subparagraph (C)(ii) of such
14 paragraph;

15 (iv) the manner in which terms and
16 definitions in such paragraph should be ap-
17 plied, such as the use of clinical appro-
18 priateness in determining whether an en-
19 rollee is an at-risk beneficiary for prescrip-
20 tion drug abuse as defined in subpara-
21 graph (C) of such paragraph;

22 (v) the information to be included in
23 the notices described in subparagraph (B)
24 of such paragraph and the standardization
25 of such notices;

1 (vi) with respect to a PDP sponsor
2 (or Medicare Advantage organization) that
3 establishes a drug management program
4 for at-risk beneficiaries under such para-
5 graph, the responsibilities of such PDP
6 sponsor (or organization) with respect to
7 the implementation of such program;

8 (vii) notices for plan enrollees at the
9 point of sale that would explain why an at-
10 risk beneficiary has been prohibited from
11 receiving a prescription at a location out-
12 side of the designated pharmacy;

13 (viii) evidence-based prescribing guide-
14 lines for opiates; and

15 (ix) the sharing of claims data under
16 parts A and B of title XVIII of the Social
17 Security Act with PDP sponsors.

18 (3) RULEMAKING.—Not later than one year
19 after the date of the enactment of this Act, the Sec-
20 retary of Health and Human Services shall, taking
21 into account the input gathered pursuant to para-
22 graph (2)(A) and after providing notice and an op-
23 portunity to comment, promulgate regulations to
24 carry out the provisions of, and amendments made
25 by this section.

1 (h) DEPOSIT OF SAVINGS INTO MEDICARE IMPROVE-
2 MENT FUND.—Section 1898(b)(1) of the Social Security
3 Act (42 U.S.C. 1395iii(b)(1)) is amended by striking
4 “during and after fiscal year 2020, \$0” and inserting
5 “during and after fiscal year 2021, \$140,000,000”.

6 **SEC. 705. EXCLUDING ABUSE-DETERRENT FORMULATIONS**
7 **OF PRESCRIPTION DRUGS FROM THE MED-**
8 **ICAID ADDITIONAL REBATE REQUIREMENT**
9 **FOR NEW FORMULATIONS OF PRESCRIPTION**
10 **DRUGS.**

11 (a) IN GENERAL.—The last sentence of section
12 1927(c)(2)(C) of the Social Security Act (42 U.S.C.
13 1396r–8(c)(2)(C)) is amended by inserting before the pe-
14 riod at the end the following: “, but does not include an
15 abuse-deterrent formulation of the drug (as determined by
16 the Secretary), regardless of whether such abuse-deterrent
17 formulation is an extended release formulation”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) shall apply to drugs that are paid for by
20 a State in calendar quarters beginning on or after the date
21 of the enactment of this Act.

1 **SEC. 706. LIMITING DISCLOSURE OF PREDICTIVE MOD-**
2 **ELING AND OTHER ANALYTICS TECH-**
3 **NOLOGIES TO IDENTIFY AND PREVENT**
4 **WASTE, FRAUD, AND ABUSE.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 is amended by inserting after section 1128J (42 U.S.C.
7 1320a–7k) the following new section:

8 **“SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND**
9 **OTHER ANALYTICS TECHNOLOGIES TO IDEN-**
10 **TIFY AND PREVENT WASTE, FRAUD, AND**
11 **ABUSE.**

12 “(a) REFERENCE TO PREDICTIVE MODELING TECH-
13 NOLOGIES REQUIREMENTS.—For provisions relating to
14 the use of predictive modeling and other analytics tech-
15 nologies to identify and prevent waste, fraud, and abuse
16 with respect to the Medicare program under title XVIII,
17 the Medicaid program under title XIX, and the Children’s
18 Health Insurance Program under title XXI, see section
19 4241 of the Small Business Jobs Act of 2010 (42 U.S.C.
20 1320a–7m).

21 “(b) LIMITING DISCLOSURE OF PREDICTIVE MOD-
22 ELING TECHNOLOGIES.—In implementing such provisions
23 under such section 4241 with respect to covered algo-
24 rithms (as defined in subsection (c)), the following shall
25 apply:

1 “(1) NONAPPLICATION OF FOIA.—The covered
2 algorithms used or developed for purposes of such
3 section 4241 (including by the Secretary or a State
4 (or an entity operating under a contract with a
5 State)) shall be exempt from disclosure under sec-
6 tion 552(b)(3) of title 5, United States Code.

7 “(2) LIMITATION WITH RESPECT TO USE AND
8 DISCLOSURE OF INFORMATION BY STATE AGEN-
9 CIES.—

10 “(A) IN GENERAL.—A State agency may
11 not use or disclose covered algorithms used or
12 developed for purposes of such section 4241 ex-
13 cept for purposes of administering the State
14 plan (or a waiver of the plan) under the Med-
15 icaid program under title XIX or the State
16 child health plan (or a waiver of the plan)
17 under the Children’s Health Insurance Program
18 under title XXI, including by enabling an entity
19 operating under a contract with a State to as-
20 sist the State to identify or prevent waste,
21 fraud, and abuse with respect to such pro-
22 grams.

23 “(B) INFORMATION SECURITY.—A State
24 agency shall have in effect data security and
25 control policies that the Secretary finds ade-

1 quate to ensure the security of covered algo-
2 rithms used or developed for purposes of such
3 section 4241 and to ensure that access to such
4 information is restricted to authorized persons
5 for purposes of authorized uses and disclosures
6 described in subparagraph (A).

7 “(C) PROCEDURAL REQUIREMENTS.—
8 State agencies to which information is disclosed
9 pursuant to such section 4241 shall adhere to
10 uniform procedures established by the Sec-
11 retary.

12 “(c) COVERED ALGORITHM DEFINED.—In this sec-
13 tion, the term ‘covered algorithm’—

14 “(1) means a predictive modeling or other ana-
15 lytics technology, as used for purposes of section
16 4241(a) of the Small Business Jobs Act of 2010 (42
17 U.S.C. 1320a–7m(a)) to identify and prevent waste,
18 fraud, and abuse with respect to the Medicare pro-
19 gram under title XVIII, the Medicaid program
20 under title XIX, and the Children’s Health Insur-
21 ance Program under title XXI; and

22 “(2) includes the mathematical expressions uti-
23 lized in the application of such technology and the
24 means by which such technology is developed.”.

25 (b) CONFORMING AMENDMENTS.—

1 (1) MEDICAID STATE PLAN REQUIREMENT.—
2 Section 1902(a) of the Social Security Act (42
3 U.S.C. 1396a(a)) is amended—

4 (A) in paragraph (80), by striking “and”
5 at the end;

6 (B) in paragraph (81), by striking the pe-
7 riod at the end and inserting “; and”; and

8 (C) by inserting after paragraph (81) the
9 following new paragraph:

10 “(82) provide that the State agency responsible
11 for administering the State plan under this title pro-
12 vides assurances to the Secretary that the State
13 agency is in compliance with subparagraphs (A),
14 (B), and (C) of section 1128K(b)(2).”.

15 (2) STATE CHILD HEALTH PLAN REQUIRE-
16 MENT.—Section 2102(a)(7) of the Social Security
17 Act (42 U.S.C. 1397bb(a)(7)) is amended—

18 (A) in subparagraph (A), by striking “,
19 and” at the end and inserting a semicolon;

20 (B) in subparagraph (B), by striking the
21 period at the end and inserting “; and”; and

22 (C) by adding at the end the following new
23 subparagraph:

1 “(C) to ensure that the State agency in-
 2 volved is in compliance with subparagraphs (A),
 3 (B), and (C) of section 1128K(b)(2).”.

4 **SEC. 707. MEDICAID IMPROVEMENT FUND.**

5 Section 1941(b)(1) of the Social Security Act (42
 6 U.S.C. 1396w-1(b)(1)) is amended to read as follows:

7 “(1) IN GENERAL.—There shall be available to
 8 the Fund, for expenditures from the Fund for fiscal
 9 year 2021 and thereafter, \$5,000,000.”.

10 **TITLE VIII—KINGPIN**
 11 **DESIGNATION IMPROVEMENT**

12 **SEC. 801. PROTECTION OF CLASSIFIED INFORMATION IN**
 13 **FEDERAL COURT CHALLENGES RELATING TO**
 14 **DESIGNATIONS UNDER THE NARCOTICS**
 15 **KINGPIN DESIGNATION ACT.**

16 Section 804 of the Foreign Narcotics Kingpin Des-
 17 ignation Act (21 U.S.C. 1903) is amended by adding at
 18 the end the following:

19 “(i) PROTECTION OF CLASSIFIED INFORMATION IN
 20 FEDERAL COURT CHALLENGES RELATING TO DESIGNA-
 21 TIONS.—In any judicial review of a determination made
 22 under this section, if the determination was based on clas-
 23 sified information (as defined in section 1(a) of the Classi-
 24 fied Information Procedures Act) such information may
 25 be submitted to the reviewing court ex parte and in cam-

1 era. This subsection does not confer or imply any right
2 to judicial review.”.

3 **TITLE IX—DEPARTMENT OF**
4 **VETERANS AFFAIRS**

5 **SEC. 901. SHORT TITLE.**

6 This title may be cited as the “Jason Simeakoski Me-
7 morial and Promise Act”.

8 **SEC. 902. DEFINITIONS.**

9 In this title:

10 (1) The term “controlled substance” has the
11 meaning given that term in section 102 of the Con-
12 trolled Substances Act (21 U.S.C. 802).

13 (2) The term “State” means each of the several
14 States, territories, and possessions of the United
15 States, the District of Columbia, and the Common-
16 wealth of Puerto Rico.

17 (3) The term “complementary and integrative
18 health” has the meaning given that term, or any
19 successor term, by the National Institutes of Health.

20 (4) The term “opioid receptor antagonist”
21 means a drug or device approved or cleared under
22 the Federal Food, Drug, and Cosmetic Act (21
23 U.S.C. 301 et seq.) for emergency treatment of
24 known or suspected opioid overdose.

1 **Subtitle A—Opioid Therapy and**
2 **Pain Management**

3 **SEC. 911. IMPROVEMENT OF OPIOID SAFETY MEASURES BY**
4 **DEPARTMENT OF VETERANS AFFAIRS.**

5 (a) EXPANSION OF OPIOID SAFETY INITIATIVE.—

6 (1) INCLUSION OF ALL MEDICAL FACILITIES.—

7 Not later than 180 days after the date of the enact-
8 ment of this Act, the Secretary of Veterans Affairs
9 shall expand the Opioid Safety Initiative of the De-
10 partment of Veterans Affairs to include all medical
11 facilities of the Department.

12 (2) GUIDANCE.—The Secretary shall establish

13 guidance that each health care provider of the De-
14 partment of Veterans Affairs, before initiating opioid
15 therapy to treat a patient as part of the comprehen-
16 sive assessment conducted by the health care pro-
17 vider, use the Opioid Therapy Risk Report tool of
18 the Department of Veterans Affairs (or any subse-
19 quent tool), which shall include information from the
20 prescription drug monitoring program of each par-
21 ticipating State as applicable, that includes the most
22 recent information to date relating to the patient
23 that accessed such program to assess the risk for
24 adverse outcomes of opioid therapy for the patient,
25 including the concurrent use of controlled substances

1 such as benzodiazepines, as part of the comprehen-
2 sive assessment conducted by the health care pro-
3 vider.

4 (3) ENHANCED STANDARDS.—The Secretary
5 shall establish enhanced standards with respect to
6 the use of routine and random urine drug tests for
7 all patients before and during opioid therapy to help
8 prevent substance abuse, dependence, and diversion,
9 including—

10 (A) that such tests occur not less fre-
11 quently than once each year or as otherwise de-
12 termined according to treatment protocols; and

13 (B) that health care providers appro-
14 priately order, interpret and respond to the re-
15 sults from such tests to tailor pain therapy,
16 safeguards, and risk management strategies to
17 each patient.

18 (b) PAIN MANAGEMENT EDUCATION AND TRAIN-
19 ING.—

20 (1) IN GENERAL.—In carrying out the Opioid
21 Safety Initiative of the Department, the Secretary
22 shall require all employees of the Department re-
23 sponsible for prescribing opioids to receive education
24 and training described in paragraph (2).

1 (2) EDUCATION AND TRAINING.—Education
2 and training described in this paragraph is edu-
3 cation and training on pain management and safe
4 opioid prescribing practices for purposes of safely
5 and effectively managing patients with chronic pain,
6 including education and training on the following:

7 (A) The implementation of and full compli-
8 ance with the VA/DOD Clinical Practice Guide-
9 line for Management of Opioid Therapy for
10 Chronic Pain, including any update to such
11 guideline.

12 (B) The use of evidence-based pain man-
13 agement therapies and complementary and inte-
14 grative health services, including cognitive-be-
15 havioral therapy, non-opioid alternatives, and
16 non-drug methods and procedures to managing
17 pain and related health conditions including, to
18 the extent practicable, medical devices approved
19 or cleared by the Food and Drug Administra-
20 tion for the treatment of patients with chronic
21 pain and related health conditions.

22 (C) Screening and identification of patients
23 with substance use disorder, including drug-
24 seeking behavior, before prescribing opioids, as-
25 sessment of risk potential for patients devel-

1 oping an addiction, and referral of patients to
2 appropriate addiction treatment professionals if
3 addiction is identified or strongly suspected.

4 (D) Communication with patients on the
5 potential harm associated with the use of
6 opioids and other controlled substances, includ-
7 ing the need to safely store and dispose of sup-
8 plies relating to the use of opioids and other
9 controlled substances.

10 (E) Such other education and training as
11 the Secretary considers appropriate to ensure
12 that veterans receive safe and high-quality pain
13 management care from the Department.

14 (3) USE OF EXISTING PROGRAM.—In providing
15 education and training described in paragraph (2),
16 the Secretary shall use the Interdisciplinary Chronic
17 Pain Management Training Team Program of the
18 Department (or successor program).

19 (c) PAIN MANAGEMENT TEAMS.—

20 (1) IN GENERAL.—In carrying out the Opioid
21 Safety Initiative of the Department, the director of
22 each medical facility of the Department shall iden-
23 tify and designate a pain management team of
24 health care professionals, which may include board
25 certified pain medicine specialists, responsible for co-

1 ordinating and overseeing pain management therapy
2 at such facility for patients experiencing acute and
3 chronic pain that is non-cancer related.

4 (2) ESTABLISHMENT OF PROTOCOLS.—

5 (A) IN GENERAL.—In consultation with
6 the Directors of each Veterans Integrated Serv-
7 ice Network, the Secretary shall establish
8 standard protocols for the designation of pain
9 management teams at each medical facility
10 within the Department.

11 (B) CONSULTATION ON PRESCRIPTION OF
12 OPIOIDS.—Each protocol established under sub-
13 paragraph (A) shall ensure that any health care
14 provider without expertise in prescribing anal-
15 gesics or who has not completed the education
16 and training under subsection (b), including a
17 mental health care provider, does not prescribe
18 opioids to a patient unless that health care pro-
19 vider—

20 (i) consults with a health care pro-
21 vider with pain management expertise or
22 who is on the pain management team of
23 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 ex-
12 amine whether the Clinical Practical Guideline
13 should include 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 cluding 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 SCRIPTION 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 concur-
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 such prescrip-
14 tion rate for all health care providers at the fa-
15 cility;

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 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 Advoca-
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 **Subtitle C—Complementary and**
12 **Integrative Health**

13 **SEC. 931. EXPANSION OF RESEARCH AND EDUCATION ON**
14 **AND DELIVERY OF COMPLEMENTARY AND IN-**
15 **TEGRATIVE HEALTH TO VETERANS.**

16 (a) ESTABLISHMENT.—There is established a com-
17 mission to be known as the “Creating Options for Vet-
18 erans’ Expedited Recovery” or the “COVER Commission”
19 (in this section referred to as the “Commission”). The
20 Commission shall examine the evidence-based therapy
21 treatment model used by the Secretary of Veterans Affairs
22 for treating mental health conditions of veterans and the
23 potential benefits of incorporating complementary and in-
24 tegrative health treatments available in non-Department

1 facilities (as defined in section 1701 of title 38, United
2 States Code).

3 (b) DUTIES.—The Commission shall perform the fol-
4 lowing duties:

5 (1) Examine the efficacy of the evidence-based
6 therapy model used by the Secretary for treating
7 mental health illnesses of veterans and identify areas
8 to improve wellness-based outcomes.

9 (2) Conduct a patient-centered survey within
10 each of the Veterans Integrated Service Networks to
11 examine—

12 (A) the experience of veterans with the De-
13 partment of Veterans Affairs when seeking
14 medical assistance for mental health issues
15 through the health care system of the Depart-
16 ment;

17 (B) the experience of veterans with non-
18 Department facilities and health professionals
19 for treating mental health issues;

20 (C) the preference of veterans regarding
21 available treatment for mental health issues and
22 which methods the veterans believe to be most
23 effective;

24 (D) the experience, if any, of veterans with
25 respect to the complementary and integrative

1 health treatment therapies described in para-
2 graph (3);

3 (E) the prevalence of prescribing prescrip-
4 tion medication among veterans seeking treat-
5 ment through the health care system of the De-
6 partment as remedies for addressing mental
7 health issues; and

8 (F) the outreach efforts of the Secretary
9 regarding the availability of benefits and treat-
10 ments for veterans for addressing mental health
11 issues, including by identifying ways to reduce
12 barriers to gaps in such benefits and treat-
13 ments.

14 (3) Examine available research on complemen-
15 tary and integrative health treatment therapies for
16 mental health issues and identify what benefits could
17 be made with the inclusion of such treatments for
18 veterans, including with respect to—

19 (A) music therapy;

20 (B) equine therapy;

21 (C) training and caring for service dogs;

22 (D) yoga therapy;

23 (E) acupuncture therapy;

24 (F) meditation therapy;

25 (G) outdoor sports therapy;

- 1 (H) hyperbaric oxygen therapy;
- 2 (I) accelerated resolution therapy;
- 3 (J) art therapy;
- 4 (K) magnetic resonance therapy; and
- 5 (L) other therapies the Commission deter-
- 6 mines appropriate.

7 (4) Study the sufficiency of the resources of the
8 Department to ensure the delivery of quality health
9 care for mental health issues among veterans seek-
10 ing treatment within the Department.

11 (5) Study the current treatments and resources
12 available within the Department and assess—

13 (A) the effectiveness of such treatments
14 and resources in decreasing the number of sui-
15 cides per day by veterans;

16 (B) the number of veterans who have been
17 diagnosed with mental health issues;

18 (C) the percentage of veterans using the
19 resources of the Department who have been di-
20 agnosed with mental health issues;

21 (D) the percentage of veterans who have
22 completed counseling sessions offered by the
23 Department; and

24 (E) the efforts of the Department to ex-
25 pand complementary and integrative health

1 treatments viable to the recovery of veterans
2 with mental health issues as determined by the
3 Secretary to improve the effectiveness of treat-
4 ments offered by the Department.

5 (c) MEMBERSHIP.—

6 (1) IN GENERAL.—The Commission shall be
7 composed of 10 members, appointed as follows:

8 (A) Two members appointed by the Speak-
9 er of the House of Representatives, at least one
10 of whom shall be a veteran.

11 (B) Two members appointed by the minor-
12 ity leader of the House of Representatives, at
13 least one of whom shall be a veteran.

14 (C) Two members appointed by the major-
15 ity leader of the Senate, at least one of whom
16 shall be a veteran.

17 (D) Two members appointed by the minor-
18 ity leader of the Senate, at least one of whom
19 shall be a veteran.

20 (E) Two members appointed by the Presi-
21 dent, at least one of whom shall be a veteran.

22 (2) QUALIFICATIONS.—Members of the Com-
23 mission shall be individuals who—

1 (A) are of recognized standing and distinc-
2 tion within the medical community with a back-
3 ground in treating mental health;

4 (B) have experience working with the mili-
5 tary and veteran population; and

6 (C) do not have a financial interest in any
7 of the complementary and integrative health
8 treatments reviewed by the Commission.

9 (3) CHAIRMAN.—The President shall designate
10 a member of the Commission to be the Chairman.

11 (4) PERIOD OF APPOINTMENT.—Members of
12 the Commission shall be appointed for the life of the
13 Commission.

14 (5) VACANCY.—A vacancy in the Commission
15 shall be filled in the manner in which the original
16 appointment was made.

17 (6) APPOINTMENT DEADLINE.—The appoint-
18 ment of members of the Commission in this section
19 shall be made not later than 90 days after the date
20 of the enactment of this Act.

21 (d) POWERS OF COMMISSION.—

22 (1) MEETINGS.—

23 (A) INITIAL MEETING.—The Commission
24 shall hold its first meeting not later than 30

1 days after a majority of members are appointed
2 to the Commission.

3 (B) MEETING.—The Commission shall reg-
4 ularly meet at the call of the Chairman. Such
5 meetings may be carried out through the use of
6 telephonic or other appropriate telecommuni-
7 cation technology if the Commission determines
8 that such technology will allow the members to
9 communicate simultaneously.

10 (2) HEARINGS.—The Commission may hold
11 such hearings, sit and act at such times and places,
12 take such testimony, and receive evidence as the
13 Commission considers advisable to carry out the re-
14 sponsibilities of the Commission.

15 (3) INFORMATION FROM FEDERAL AGENCIES.—
16 The Commission may secure directly from any de-
17 partment or agency of the Federal Government such
18 information as the Commission considers necessary
19 to carry out the duties of the Commission.

20 (4) INFORMATION FROM NONGOVERNMENTAL
21 ORGANIZATIONS.—In carrying out its duties, the
22 Commission may seek guidance through consultation
23 with foundations, veteran service organizations, non-
24 profit groups, faith-based organizations, private and
25 public institutions of higher education, and other or-

1 organizations as the Commission determines appro-
2 priate.

3 (5) COMMISSION RECORDS.—The Commission
4 shall keep an accurate and complete record of the
5 actions and meetings of the Commission. Such
6 record shall be made available for public inspection
7 and the Comptroller General of the United States
8 may audit and examine such record.

9 (6) PERSONNEL RECORDS.—The Commission
10 shall keep an accurate and complete record of the
11 actions and meetings of the Commission. Such
12 record shall be made available for public inspection
13 and the Comptroller General of the United States
14 may audit and examine such records.

15 (7) COMPENSATION OF MEMBERS; TRAVEL EX-
16 PENSES.—Each member shall serve without pay but
17 shall receive travel expenses to perform the duties of
18 the Commission, including per diem in lieu of sub-
19 stances, at rates authorized under subchapter I of
20 chapter 57 of title 5, United States Code.

21 (8) STAFF.—The Chairman, in accordance with
22 rules agreed upon the Commission, may appoint and
23 fix the compensation of a staff director and such
24 other personnel as may be necessary to enable the
25 Commission to carry out its functions, without re-

1 gard to the provisions of title 5, United States Code,
2 governing appointments in the competitive service,
3 without regard to the provision of chapter 51 and
4 subchapter III of chapter 53 of such title relating to
5 classification and General Schedule pay rates, except
6 that no rate of pay fixed under this paragraph may
7 exceed the equivalent of that payable for a position
8 at level IV of the Executive Schedule under section
9 5315 of title 5, United States Code.

10 (9) PERSONNEL AS FEDERAL EMPLOYEES.—

11 (A) IN GENERAL.—The executive director
12 and any personnel of the Commission are em-
13 ployees under section 2105 of title 5, United
14 States Code, for purpose of chapters 63, 81, 83,
15 84, 85, 87, 89, and 90 of such title.

16 (B) MEMBERS OF THE COMMISSION.—

17 Subparagraph (A) shall not be construed to
18 apply to members of the Commission.

19 (10) CONTRACTING.—The Commission may, to
20 such extent and in such amounts as are provided in
21 appropriations Acts, enter into contracts to enable
22 the Commission to discharge the duties of the Com-
23 mission under this Act.

24 (11) EXPERT AND CONSULTANT SERVICE.—The
25 Commission may procure the services of experts and

1 consultants in accordance with section 3109 of title
2 5, United States Code, at rates not to exceed the
3 daily rate paid to a person occupying a position at
4 level IV of the Executive Schedule under section
5 5315 of title 5, United States Code.

6 (12) POSTAL SERVICE.—The Commission may
7 use the United States mails in the same manner and
8 under the same conditions as departments and agen-
9 cies of the United States.

10 (13) PHYSICAL FACILITIES AND EQUIPMENT.—
11 Upon the request of the Commission, the Adminis-
12 trator of General Services shall provide to the Com-
13 mission, on a reimbursable basis, the administrative
14 support services necessary for the Commission to
15 carry out its responsibilities under this Act. These
16 administrative services may include human resource
17 management, budget, leasing accounting, and payroll
18 services.

19 (e) REPORT.—

20 (1) INTERIM REPORTS.—

21 (A) IN GENERAL.—Not later than 60 days
22 after the date on which the Commission first
23 meets, and each 30-day period thereafter end-
24 ing on the date on which the Commission sub-
25 mits the final report under paragraph (2), the

1 Commission shall submit to the Committees on
2 Veterans' Affairs of the House of Representa-
3 tives and the Senate and the President a report
4 detailing the level of cooperation the Secretary
5 of Veterans Affairs (and the heads of other de-
6 partments or agencies of the Federal Govern-
7 ment) has provided to the Commission.

8 (B) OTHER REPORTS.—In carrying out its
9 duties, at times that the Commission deter-
10 mines appropriate, the Commission shall submit
11 to the Committees on Veterans' Affairs of the
12 House of Representatives and the Senate and
13 any other appropriate entities an interim report
14 with respect to the findings identified by the
15 Commission.

16 (2) FINAL REPORT.—Not later than 18 months
17 after the first meeting of the Commission, the Com-
18 mission shall submit to the Committee on Veterans'
19 Affairs of the House of Representatives and the Sen-
20 ate, the President, and the Secretary of Veterans Af-
21 fairs a final report on the findings of the Commis-
22 sion. Such report shall include the following:

23 (A) Recommendations to implement in a
24 feasible, timely, and cost-efficient manner the
25 solutions and remedies identified within the

1 findings of the Commission pursuant to sub-
2 section (b).

3 (B) An analysis of the evidence-based ther-
4 apy model used by the Secretary of Veterans
5 Affairs for treating veterans with mental health
6 care issues, and an examination of the preva-
7 lence and efficacy of prescription drugs as a
8 means for treatment.

9 (C) The findings of the patient-centered
10 survey conducted within each of the Veterans
11 Integrated Service Networks pursuant to sub-
12 section (b)(2).

13 (D) An examination of complementary and
14 integrative health treatments described in sub-
15 section (b)(3) and the potential benefits of in-
16 corporating such treatments in the therapy
17 models used by the Secretary for treating vet-
18 erans with mental health issues.

19 (3) PLAN.—Not later than 90 days after the
20 date on which the Commission submits the final re-
21 port under paragraph (2), the Secretary of Veterans
22 Affairs shall submit to the Committees on Veterans'
23 Affairs of the House of Representatives and the Sen-
24 ate a report on the following:

1 (A) An action plan for implementing the
2 recommendations established by the Commis-
3 sion on such solutions and remedies for improv-
4 ing wellness-based outcomes for veterans with
5 mental health care issues.

6 (B) A feasible timeframe on when the com-
7 plementary and integrative health treatments
8 described in subsection (b)(3) can be imple-
9 mented Department-wide.

10 (C) With respect to each recommendation
11 established by the Commission, including any
12 complementary and integrative health treat-
13 ment, that the Secretary determines is not ap-
14 propriate or feasible to implement, a justifica-
15 tion for such determination and an alternative
16 solution to improve the efficacy of the therapy
17 models used by the Secretary for treating vet-
18 erans with mental health issues.

19 (f) TERMINATION OF COMMISSION.—The Commis-
20 sion shall terminate 30 days after the Commission submits
21 the final report under subsection (e)(2).

1 **SEC. 932. PILOT PROGRAM ON INTEGRATION OF COM-**
2 **PLEMENTARY AND INTEGRATIVE HEALTH**
3 **AND RELATED ISSUES FOR VETERANS AND**
4 **FAMILY MEMBERS OF VETERANS.**

5 (a) PILOT PROGRAM.—

6 (1) IN GENERAL.—Not later than 180 days
7 after the date on which the Secretary of Veterans
8 Affairs receives the final report under section
9 931(e)(2), the Secretary shall commence a pilot pro-
10 gram to assess the feasibility and advisability of
11 using complementary and integrative health and
12 wellness-based programs (as defined by the Sec-
13 retary) to complement the provision of pain manage-
14 ment and related health care services, including
15 mental health care services, to veterans.

16 (2) MATTERS ADDRESSED.—In carrying out the
17 pilot program, the Secretary shall assess the fol-
18 lowing:

19 (A) Means of improving coordination be-
20 tween Federal, State, local, and community pro-
21 viders of health care in the provision of pain
22 management and related health care services to
23 veterans.

24 (B) Means of enhancing outreach, and co-
25 ordination of outreach, by and among providers
26 of health care referred to in subparagraph (A)

1 on the pain management and related health
2 care services available to veterans.

3 (C) Means of using complementary and in-
4 tegrative health and wellness-based programs of
5 providers of health care referred to in subpara-
6 graph (A) as complements to the provision by
7 the Department of Veterans Affairs of pain
8 management and related health care services to
9 veterans.

10 (D) Whether complementary and integra-
11 tive health and wellness-based programs de-
12 scribed in subparagraph (C)—

13 (i) are effective in enhancing the qual-
14 ity of life and well-being of veterans;

15 (ii) are effective in increasing the ad-
16 herence of veterans to the primary pain
17 management and related health care serv-
18 ices provided such veterans by the Depart-
19 ment;

20 (iii) have an effect on the sense of
21 well-being of veterans who receive primary
22 pain management and related health care
23 services from the Department; and

1 (iv) are effective in encouraging vet-
2 erans receiving health care from the De-
3 partment to adopt a more healthy lifestyle.

4 (b) DURATION.—The Secretary shall carry out the
5 pilot program under subsection (a)(1) for a period of three
6 years.

7 (c) LOCATIONS.—

8 (1) FACILITIES.—The Secretary shall carry out
9 the pilot program under subsection (a)(1) at facili-
10 ties of the Department providing pain management
11 and related health care services, including mental
12 health care services, to veterans. In selecting such
13 facilities to carry out the pilot program, the Sec-
14 retary shall select not fewer than 15 geographically
15 diverse medical centers of the Department, of which
16 not fewer than two shall be polytrauma rehabilita-
17 tion centers of the Department.

18 (2) MEDICAL CENTERS WITH PRESCRIPTION
19 RATES OF OPIOIDS THAT CONFLICT WITH CARE
20 STANDARDS.—In selecting the medical centers under
21 paragraph (1), the Secretary shall give priority to
22 medical centers of the Department at which there is
23 a prescription rate of opioids that conflicts with or
24 is otherwise inconsistent with the standards of ap-
25 propriate and safe care.

1 (d) PROVISION OF SERVICES.—Under the pilot pro-
2 gram under subsection (a)(1), the Secretary shall provide
3 covered services to covered veterans by integrating com-
4 plementary and integrative health services with other serv-
5 ices provided by the Department at the medical centers
6 selected under subsection (c).

7 (e) COVERED VETERANS.—For purposes of the pilot
8 program under subsection (a)(1), a covered veteran is any
9 veteran who—

10 (1) has a mental health condition diagnosed by
11 a clinician of the Department;

12 (2) experiences chronic pain;

13 (3) has a chronic condition being treated by a
14 clinician of the Department; or

15 (4) is not described in paragraph (1), (2), or
16 (3) and requests to participate in the pilot program
17 or is referred by a clinician of the Department who
18 is treating the veteran.

19 (f) COVERED SERVICES.—

20 (1) IN GENERAL.—For purposes of the pilot
21 program, covered services are services consisting of
22 complementary and integrative health services as se-
23 lected by the Secretary.

1 (2) ADMINISTRATION OF SERVICES.—Covered
2 services shall be administered under the pilot pro-
3 gram as follows:

4 (A) Covered services shall be administered
5 by professionals or other instructors with ap-
6 propriate training and expertise in complemen-
7 tary and integrative health services who are em-
8 ployees of the Department or with whom the
9 Department enters into an agreement to pro-
10 vide such services.

11 (B) Covered services shall be included as
12 part of the Patient Aligned Care Teams initia-
13 tive of the Office of Patient Care Services, Pri-
14 mary Care Program Office, in coordination with
15 the Office of Patient Centered Care and Cul-
16 tural Transformation.

17 (C) Covered services shall be made avail-
18 able to—

19 (i) covered veterans who have received
20 conventional treatments from the Depart-
21 ment for the conditions for which the cov-
22 ered veteran seeks complementary and in-
23 tegrative health services under the pilot
24 program; and

1 (ii) covered veterans who have not re-
2 ceived conventional treatments from the
3 Department for such conditions.

4 (g) REPORTS.—

5 (1) IN GENERAL.—Not later than 30 months
6 after the date on which the Secretary commences the
7 pilot program under subsection (a)(1), the Secretary
8 shall submit to the Committee on Veterans' Affairs
9 of the Senate and the Committee on Veterans' Af-
10 fairs of the House of Representatives a report on the
11 pilot program.

12 (2) ELEMENTS.—The report under paragraph
13 (1) shall include the following:

14 (A) The findings and conclusions of the
15 Secretary with respect to the pilot program
16 under subsection (a)(1), including with respect
17 to—

18 (i) the use and efficacy of the com-
19 plementary and integrative health services
20 established under the pilot program;

21 (ii) the outreach conducted by the
22 Secretary to inform veterans and commu-
23 nity organizations about the pilot program;
24 and

1 (iii) an assessment of the benefit of
2 the pilot program to covered veterans in
3 mental health diagnoses, pain manage-
4 ment, and treatment of chronic illness.

5 (B) Identification of any unresolved bar-
6 riers that impede the ability of the Secretary to
7 incorporate complementary and integrative
8 health services with other health care services
9 provided by the Department.

10 (C) Such recommendations for the continu-
11 ation or expansion of the pilot program as the
12 Secretary considers appropriate.

13 **Subtitle D—Fitness of Health Care**
14 **Providers**

15 **SEC. 941. ADDITIONAL REQUIREMENTS FOR HIRING OF**
16 **HEALTH CARE PROVIDERS BY DEPARTMENT**
17 **OF VETERANS AFFAIRS.**

18 As part of the hiring process for each health care pro-
19 vider considered for a position at the Department of Vet-
20 erans Affairs after the date of the enactment of the Act,
21 the Secretary of Veterans Affairs shall require from the
22 medical board of each State in which the health care pro-
23 vider has or had a medical license—

24 (1) information on any violation of the require-
25 ments of the medical license of the health care pro-

1 vider during the 20-year period preceding the con-
2 sideration of the health care provider by the Depart-
3 ment; and

4 (2) information on whether the health care pro-
5 vider has entered into any settlement agreement for
6 a disciplinary charge relating to the practice of med-
7 icine by the health care provider.

8 **SEC. 942. PROVISION OF INFORMATION ON HEALTH CARE**
9 **PROVIDERS OF DEPARTMENT OF VETERANS**
10 **AFFAIRS TO STATE MEDICAL BOARDS.**

11 Notwithstanding section 552a of title 5, United
12 States Code, with respect to each health care provider of
13 the Department of Veterans Affairs who has violated a
14 requirement of the medical license of the health care pro-
15 vider, the Secretary of Veterans Affairs shall provide to
16 the medical board of each State in which the health care
17 provider is licensed detailed information with respect to
18 such violation, regardless of whether such board has for-
19 mally requested such information.

1 **SEC. 943. REPORT ON COMPLIANCE BY DEPARTMENT OF**
2 **VETERANS AFFAIRS WITH REVIEWS OF**
3 **HEALTH CARE PROVIDERS LEAVING THE DE-**
4 **PARTMENT OR TRANSFERRING TO OTHER**
5 **FACILITIES.**

6 Not later than 180 days after the date of the enact-
7 ment of this Act, the Secretary of Veterans Affairs shall
8 submit to the Committee on Veterans' Affairs of the Sen-
9 ate and the Committee on Veterans' Affairs of the House
10 of Representatives a report on the compliance by the De-
11 partment of Veterans Affairs with the policy of the De-
12 partment—

13 (1) to conduct a review of each health care pro-
14 vider of the Department who transfers to another
15 medical facility of the Department, resigns, retires,
16 or is terminated to determine whether there are any
17 concerns, complaints, or allegations of violations re-
18 lating to the medical practice of the health care pro-
19 vider; and

20 (2) to take appropriate action with respect to
21 any such concern, complaint, or allegation.

1 **Subtitle E—Other Matters**

2 **SEC. 951. MODIFICATION TO LIMITATION ON AWARDS AND**
3 **BONUSES.**

4 Section 705 of the Veterans Access, Choice, and Ac-
5 countability Act of 2014 (Public Law 113–146; 38 U.S.C.
6 703 note) is amended to read as follows:

7 **“SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO**
8 **EMPLOYEES OF DEPARTMENT OF VETERANS**
9 **AFFAIRS.**

10 “The Secretary of Veterans Affairs shall ensure that
11 the aggregate amount of awards and bonuses paid by the
12 Secretary in a fiscal year under chapter 45 or 53 of title
13 5, United States Code, or any other awards or bonuses
14 authorized under such title or title 38, United States
15 Code, does not exceed the following amounts:

16 “(1) With respect to each of fiscal years 2017
17 through 2018, \$230,000,000.

18 “(2) With respect to each of fiscal years 2019
19 through 2021, \$225,000,000.

20 “(3) With respect to each of fiscal years 2022
21 through 2024, \$360,000,000.”.