

**AMENDMENT TO THE SENATE AMENDMENT TO
H.R. 6
OFFERED BY M . _____**

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

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Substance Use–Disorder Prevention that Promotes
4 Opioid Recovery and Treatment for Patients and Commu-
5 nities Act” or the “SUPPORT for Patients and Commu-
6 nities Act”.

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

Sec. 1. Short title; table of contents.

**TITLE I—MEDICAID PROVISIONS TO ADDRESS THE OPIOID
CRISIS**

Sec. 1001. At-risk youth Medicaid protection.

Sec. 1002. Health insurance for former foster youth.

Sec. 1003. Demonstration project to increase substance use provider capacity
under the Medicaid program.

Sec. 1004. Medicaid drug review and utilization.

Sec. 1005. Guidance to improve care for infants with neonatal abstinence syn-
drome and their mothers; GAO study on gaps in Medicaid cov-
erage for pregnant and postpartum women with substance use
disorder.

Sec. 1006. Medicaid health homes for substance-use-disorder Medicaid enroll-
ees.

Sec. 1007. Caring recovery for infants and babies.

Sec. 1008. Peer support enhancement and evaluation review.

Sec. 1009. Medicaid substance use disorder treatment via telehealth.

Sec. 1010. Enhancing patient access to non-opioid treatment options.

Sec. 1011. Assessing barriers to opioid use disorder treatment.

Sec. 1012. Help for moms and babies.

- Sec. 1013. Securing flexibility to treat substance use disorders.
- Sec. 1014. MACPAC study and report on MAT utilization controls under State Medicaid programs.
- Sec. 1015. Opioid addiction treatment programs enhancement.
- Sec. 1016. Better data sharing to combat the opioid crisis.
- Sec. 1017. Report on innovative State initiatives and strategies to provide housing-related services and supports to individuals struggling with substance use disorders under Medicaid.
- Sec. 1018. Technical assistance and support for innovative State strategies to provide housing-related supports under Medicaid.

TITLE II—MEDICARE PROVISIONS TO ADDRESS THE OPIOID CRISIS

- Sec. 2001. Expanding the use of telehealth services for the treatment of opioid use disorder and other substance use disorders.
- Sec. 2002. Comprehensive screenings for seniors.
- Sec. 2003. Every prescription conveyed securely.
- Sec. 2004. Requiring prescription drug plan sponsors under Medicare to establish drug management programs for at-risk beneficiaries.
- Sec. 2005. Medicare coverage of certain services furnished by opioid treatment programs.
- Sec. 2006. Encouraging appropriate prescribing under Medicare for victims of opioid overdose.
- Sec. 2007. Automatic escalation to external review under a Medicare part D drug management program for at-risk beneficiaries.
- Sec. 2008. Suspension of payments by Medicare prescription drug plans and MA–PD plans pending investigations of credible allegations of fraud by pharmacies.

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- Sec. 3001. Clarifying FDA regulation of non-addictive pain products.
- Sec. 3002. Evidence-based opioid analgesic prescribing guidelines and report.

CHAPTER 2—STOP COUNTERFEIT DRUGS BY REGULATING AND ENHANCING ENFORCEMENT NOW

- Sec. 3011. Short title.
- Sec. 3012. Notification, nondistribution, and recall of controlled substances.
- Sec. 3013. Single source pattern of imported illegal drugs.
- Sec. 3014. Strengthening FDA and CBP coordination and capacity.

CHAPTER 3—STOP ILLICIT DRUG IMPORTATION

- Sec. 3021. Short title.
- Sec. 3022. Restricting entrance of illicit drugs.

CHAPTER 4—SECURING OPIOIDS AND UNUSED NARCOTICS WITH DELIBERATE DISPOSAL AND PACKAGING

- Sec. 3031. Short title.
- Sec. 3032. Safety-enhancing packaging and disposal features.

CHAPTER 5—POSTAPPROVAL STUDY REQUIREMENTS

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- Sec. 7021. Establishment of substance use disorder information dashboard.
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1 TITLE I—MEDICAID PROVISIONS

2 TO ADDRESS THE OPIOID CRISIS

3 SEC. 1001. AT-RISK YOUTH MEDICAID PROTECTION.

4 (a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

6 (1) in subsection (a)—

7 (A) by striking “and” at the end of paragraph (82);

1 (B) by striking the period at the end of
2 paragraph (83) and inserting “; and”; and

3 (C) by inserting after paragraph (83) the
4 following new paragraph:

5 “(84) provide that—

6 (A) the State shall not terminate eligi-
7 bility for medical assistance under the State
8 plan for an individual who is an eligible juvenile
9 (as defined in subsection (nn)(2)) because the
10 juvenile is an inmate of a public institution (as
11 defined in subsection (nn)(3)), but may suspend
12 coverage during the period the juvenile is such
13 an inmate;

14 (B) in the case of an individual who is an
15 eligible juvenile described in paragraph (2)(A)
16 of subsection (nn), the State shall, prior to the
17 individual’s release from such a public institu-
18 tion, conduct a redetermination of eligibility for
19 such individual with respect to such medical as-
20 sistance (without requiring a new application
21 from the individual) and, if the State deter-
22 mines pursuant to such redetermination that
23 the individual continues to meet the eligibility
24 requirements for such medical assistance, the
25 State shall restore coverage for such medical

1 assistance to such an individual upon the indi-
2 vidual's release from such public institution;
3 and

4 “(C) in the case of an individual who is an
5 eligible juvenile described in paragraph (2)(B)
6 of subsection (nn), the State shall process any
7 application for medical assistance submitted by,
8 or on behalf of, such individual such that the
9 State makes a determination of eligibility for
10 such individual with respect to such medical as-
11 sistance upon release of such individual from
12 such public institution.”; and

13 (2) by adding at the end the following new sub-
14 section:

15 “(nn) **JUVENILE; ELIGIBLE JUVENILE; PUBLIC IN-**
16 **STITUTION.**—For purposes of subsection (a)(84) and this
17 subsection:

18 “(1) **JUVENILE.**—The term ‘juvenile’ means an
19 individual who is—

20 “(A) under 21 years of age; or

21 “(B) described in subsection
22 (a)(10)(A)(i)(IX).

23 “(2) **ELIGIBLE JUVENILE.**—The term ‘eligible
24 juvenile’ means a juvenile who is an inmate of a
25 public institution and who—

1 “(A) was determined eligible for medical
2 assistance under the State plan immediately be-
3 fore becoming an inmate of such a public insti-
4 tution; or

5 “(B) is determined eligible for such med-
6 ical assistance while an inmate of a public insti-
7 tution.

8 “(3) INMATE OF A PUBLIC INSTITUTION.—The
9 term ‘inmate of a public institution’ has the meaning
10 given such term for purposes of applying the sub-
11 division (A) following paragraph (29) of section
12 1905(a), taking into account the exception in such
13 subdivision for a patient of a medical institution.”.

14 (b) NO CHANGE IN EXCLUSION FROM MEDICAL AS-
15 SISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—
16 Nothing in this section shall be construed as changing the
17 exclusion from medical assistance under the subdivision
18 (A) following paragraph (29) of section 1905(a) of the So-
19 cial Security Act (42 U.S.C. 1396d(a)), including any ap-
20 plicable restrictions on a State submitting claims for Fed-
21 eral financial participation under title XIX of such Act
22 for such assistance.

23 (c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BE-
24 FORE ADJUDICATION OR SENTENCING.—Nothing in this
25 section shall be construed to mandate, encourage, or sug-

1 gest that a State suspend or terminate coverage for indi-
2 viduals before they have been adjudicated or sentenced.

3 (d) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by subsection (a)
6 shall apply to eligibility of juveniles who become in-
7 mates of public institutions on or after the date that
8 is 1 year after the date of the enactment of this Act.

9 (2) RULE FOR CHANGES REQUIRING STATE
10 LEGISLATION.—In the case of a State plan for med-
11 ical assistance under title XIX of the Social Security
12 Act which the Secretary of Health and Human Serv-
13 ices determines requires State legislation (other than
14 legislation appropriating funds) in order for the plan
15 to meet the additional requirements imposed by the
16 amendments made by subsection (a), the State plan
17 shall not be regarded as failing to comply with the
18 requirements of such title solely on the basis of its
19 failure to meet these additional requirements before
20 the first day of the first calendar quarter beginning
21 after the close of the first regular session of the
22 State legislature that begins after the date of the en-
23 actment of this Act. For purposes of the previous
24 sentence, in the case of a State that has a 2-year
25 legislative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 **SEC. 1002. HEALTH INSURANCE FOR FORMER FOSTER**
4 **YOUTH.**

5 (a) COVERAGE CONTINUITY FOR FORMER FOSTER
6 CARE CHILDREN UP TO AGE 26.—

7 (1) IN GENERAL.—Section
8 1902(a)(10)(A)(i)(IX) of the Social Security Act (42
9 U.S.C. 1396a(a)(10)(A)(i)(IX)) is amended—

10 (A) in item (bb), by striking “are not de-
11 scribed in or enrolled under” and inserting “are
12 not described in and are not enrolled under”;

13 (B) in item (cc), by striking “responsibility
14 of the State” and inserting “responsibility of a
15 State”; and

16 (C) in item (dd), by striking “the State
17 plan under this title or under a waiver of the”
18 and inserting “a State plan under this title or
19 under a waiver of such a”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by this subsection shall take effect with respect to
22 foster youth who attain 18 years of age on or after
23 January 1, 2023.

24 (b) GUIDANCE.—Not later than 1 year after the date
25 of the enactment of this Act, the Secretary of Health and

1 Human Services shall issue guidance to States, with re-
2 spect to the State Medicaid programs of such States—

3 (1) on best practices for—

4 (A) removing barriers and ensuring
5 streamlined, timely access to Medicaid coverage
6 for former foster youth up to age 26; and

7 (B) conducting outreach and raising
8 awareness among such youth regarding Med-
9 icaid coverage options for such youth; and

10 (2) which shall include examples of States that
11 have successfully extended Medicaid coverage to
12 former foster youth up to age 26.

13 **SEC. 1003. DEMONSTRATION PROJECT TO INCREASE SUB-**
14 **STANCE USE PROVIDER CAPACITY UNDER**
15 **THE MEDICAID PROGRAM.**

16 Section 1903 of the Social Security Act (42 U.S.C.
17 1396b) is amended by adding at the end the following new
18 subsection:

19 “(aa) DEMONSTRATION PROJECT TO INCREASE SUB-
20 STANCE USE PROVIDER CAPACITY.—

21 “(1) IN GENERAL.—Not later than the date
22 that is 180 days after the date of the enactment of
23 this subsection, the Secretary shall, in consultation,
24 as appropriate, with the Director of the Agency for
25 Healthcare Research and Quality and the Assistant

1 Secretary for Mental Health and Substance Use,
2 conduct a 54-month demonstration project for the
3 purpose described in paragraph (2) under which the
4 Secretary shall—

5 “(A) for the first 18-month period of such
6 project, award planning grants described in
7 paragraph (3); and

8 “(B) for the remaining 36-month period of
9 such project, provide to each State selected
10 under paragraph (4) payments in accordance
11 with paragraph (5).

12 “(2) PURPOSE.—The purpose described in this
13 paragraph is for each State selected under para-
14 graph (4) to increase the treatment capacity of pro-
15 viders participating under the State plan (or a waiv-
16 er of such plan) to provide substance use disorder
17 treatment or recovery services under such plan (or
18 waiver) through the following activities:

19 “(A) For the purpose described in para-
20 graph (3)(C)(i), activities that support an ongo-
21 ing assessment of the behavioral health treat-
22 ment needs of the State, taking into account
23 the matters described in subclauses (I) through
24 (IV) of such paragraph.

1 “(B) Activities that, taking into account
2 the results of the assessment described in sub-
3 paragraph (A), support the recruitment, train-
4 ing, and provision of technical assistance for
5 providers participating under the State plan (or
6 a waiver of such plan) that offer substance use
7 disorder treatment or recovery services.

8 “(C) Improved reimbursement for and ex-
9 pansion of, through the provision of education,
10 training, and technical assistance, the number
11 or treatment capacity of providers participating
12 under the State plan (or waiver) that—

13 “(i) are authorized to dispense drugs
14 approved by the Food and Drug Adminis-
15 tration for individuals with a substance use
16 disorder who need withdrawal management
17 or maintenance treatment for such dis-
18 order;

19 “(ii) have in effect a registration or
20 waiver under section 303(g) of the Con-
21 trolled Substances Act for purposes of dis-
22 pensing narcotic drugs to individuals for
23 maintenance treatment or detoxification
24 treatment and are in compliance with any
25 regulation promulgated by the Assistant

1 Secretary for Mental Health and Sub-
2 stance Use for purposes of carrying out
3 the requirements of such section 303(g);
4 and

5 “(iii) are qualified under applicable
6 State law to provide substance use disorder
7 treatment or recovery services.

8 “(D) Improved reimbursement for and ex-
9 pansion of, through the provision of education,
10 training, and technical assistance, the number
11 or treatment capacity of providers participating
12 under the State plan (or waiver) that have the
13 qualifications to address the treatment or recov-
14 ery needs of—

15 “(i) individuals enrolled under the
16 State plan (or a waiver of such plan) who
17 have neonatal abstinence syndrome, in ac-
18 cordance with guidelines issued by the
19 American Academy of Pediatrics and
20 American College of Obstetricians and
21 Gynecologists relating to maternal care
22 and infant care with respect to neonatal
23 abstinence syndrome;

24 “(ii) pregnant women, postpartum
25 women, and infants, particularly the con-

1 current treatment, as appropriate, and
2 comprehensive case management of preg-
3 nant women, postpartum women and in-
4 fants, enrolled under the State plan (or a
5 waiver of such plan);

6 “(iii) adolescents and young adults be-
7 tween the ages of 12 and 21 enrolled
8 under the State plan (or a waiver of such
9 plan); or

10 “(iv) American Indian and Alaska Na-
11 tive individuals enrolled under the State
12 plan (or a waiver of such plan).

13 “(3) PLANNING GRANTS.—

14 “(A) IN GENERAL.—The Secretary shall,
15 with respect to the first 18-month period of the
16 demonstration project conducted under para-
17 graph (1), award planning grants to at least 10
18 States selected in accordance with subpara-
19 graph (B) for purposes of preparing an applica-
20 tion described in paragraph (4)(C) and carrying
21 out the activities described in subparagraph
22 (C).

23 “(B) SELECTION.—In selecting States for
24 purposes of this paragraph, the Secretary
25 shall—

1 “(i) select States that have a State
2 plan (or waiver of the State plan) approved
3 under this title;

4 “(ii) select States in a manner that
5 ensures geographic diversity; and

6 “(iii) give preference to States with a
7 prevalence of substance use disorders (in
8 particular opioid use disorders) that is
9 comparable to or higher than the national
10 average prevalence, as measured by aggregate
11 per capita drug overdoses, or any
12 other measure that the Secretary deems
13 appropriate.

14 “(C) ACTIVITIES DESCRIBED.—Activities
15 described in this subparagraph are, with respect
16 to a State, each of the following:

17 “(i) Activities that support the devel-
18 opment of an initial assessment of the be-
19 havioral health treatment needs of the
20 State to determine the extent to which pro-
21 viders are needed (including the types of
22 such providers and geographic area of
23 need) to improve the network of providers
24 that treat substance use disorders under

1 the State plan (or waiver), including the
2 following:

3 “(I) An estimate of the number
4 of individuals enrolled under the State
5 plan (or a waiver of such plan) who
6 have a substance use disorder.

7 “(II) Information on the capacity
8 of providers to provide substance use
9 disorder treatment or recovery serv-
10 ices to individuals enrolled under the
11 State plan (or waiver), including in-
12 formation on providers who provide
13 such services and their participation
14 under the State plan (or waiver).

15 “(III) Information on the gap in
16 substance use disorder treatment or
17 recovery services under the State plan
18 (or waiver) based on the information
19 described in subclauses (I) and (II).

20 “(IV) Projections regarding the
21 extent to which the State partici-
22 pating under the demonstration
23 project would increase the number of
24 providers offering substance use dis-
25 order treatment or recovery services

1 under the State plan (or waiver) dur-
2 ing the period of the demonstration
3 project.

4 “(ii) Activities that, taking into ac-
5 count the results of the assessment de-
6 scribed in clause (i), support the develop-
7 ment of State infrastructure to, with re-
8 spect to the provision of substance use dis-
9 order treatment or recovery services under
10 the State plan (or a waiver of such plan),
11 recruit prospective providers and provide
12 training and technical assistance to such
13 providers.

14 “(D) FUNDING.—For purposes of subpara-
15 graph (A), there is appropriated, out of any
16 funds in the Treasury not otherwise appro-
17 priated, \$50,000,000, to remain available until
18 expended.

19 “(4) POST-PLANNING STATES.—

20 “(A) IN GENERAL.—The Secretary shall,
21 with respect to the remaining 36-month period
22 of the demonstration project conducted under
23 paragraph (1), select not more than 5 States in
24 accordance with subparagraph (B) for purposes
25 of carrying out the activities described in para-

1 graph (2) and receiving payments in accordance
2 with paragraph (5).

3 “(B) SELECTION.—In selecting States for
4 purposes of this paragraph, the Secretary
5 shall—

6 “(i) select States that received a plan-
7 ning grant under paragraph (3);

8 “(ii) select States that submit to the
9 Secretary an application in accordance
10 with the requirements in subparagraph
11 (C), taking into consideration the quality
12 of each such application;

13 “(iii) select States in a manner that
14 ensures geographic diversity; and

15 “(iv) give preference to States with a
16 prevalence of substance use disorders (in
17 particular opioid use disorders) that is
18 comparable to or higher than the national
19 average prevalence, as measured by aggre-
20 gate per capita drug overdoses, or any
21 other measure that the Secretary deems
22 appropriate.

23 “(C) APPLICATIONS.—

24 “(i) IN GENERAL.—A State seeking to
25 be selected for purposes of this paragraph

1 shall submit to the Secretary, at such time
2 and in such form and manner as the Sec-
3 retary requires, an application that in-
4 cludes such information, provisions, and
5 assurances, as the Secretary may require,
6 in addition to the following:

7 “(I) A proposed process for car-
8 rying out the ongoing assessment de-
9 scribed in paragraph (2)(A), taking
10 into account the results of the initial
11 assessment described in paragraph
12 (3)(C)(i).

13 “(II) A review of reimbursement
14 methodologies and other policies re-
15 lated to substance use disorder treat-
16 ment or recovery services under the
17 State plan (or waiver) that may create
18 barriers to increasing the number of
19 providers delivering such services.

20 “(III) The development of a plan,
21 taking into account activities carried
22 out under paragraph (3)(C)(ii), that
23 will result in long-term and sustain-
24 able provider networks under the
25 State plan (or waiver) that will offer

1 a continuum of care for substance use
2 disorders. Such plan shall include the
3 following:

4 “(aa) Specific activities to
5 increase the number of providers
6 (including providers that spe-
7 cialize in providing substance use
8 disorder treatment or recovery
9 services, hospitals, health care
10 systems, Federally qualified
11 health centers, and, as applicable,
12 certified community behavioral
13 health clinics) that offer sub-
14 stance use disorder treatment, re-
15 covery, or support services, in-
16 cluding short-term detoxification
17 services, outpatient substance use
18 disorder services, and evidence-
19 based peer recovery services.

20 “(bb) Strategies that will
21 incentivize providers described in
22 subparagraphs (C) and (D) of
23 paragraph (2) to obtain the nec-
24 essary training, education, and
25 support to deliver substance use

1 disorder treatment or recovery
2 services in the State.

3 “(cc) Milestones and timeli-
4 ness for implementing activities
5 set forth in the plan.

6 “(dd) Specific measurable
7 targets for increasing the sub-
8 stance use disorder treatment
9 and recovery provider network
10 under the State plan (or a waiver
11 of such plan).

12 “(IV) A proposed process for re-
13 porting the information required
14 under paragraph (6)(A), including in-
15 formation to assess the effectiveness
16 of the efforts of the State to expand
17 the capacity of providers to deliver
18 substance use disorder treatment or
19 recovery services during the period of
20 the demonstration project under this
21 subsection.

22 “(V) The expected financial im-
23 pact of the demonstration project
24 under this subsection on the State.

1 “(VI) A description of all funding
2 sources available to the State to pro-
3 vide substance use disorder treatment
4 or recovery services in the State.

5 “(VII) A preliminary plan for
6 how the State will sustain any in-
7 crease in the capacity of providers to
8 deliver substance use disorder treat-
9 ment or recovery services resulting
10 from the demonstration project under
11 this subsection after the termination
12 of such demonstration project.

13 “(VIII) A description of how the
14 State will coordinate the goals of the
15 demonstration project with any waiver
16 granted (or submitted by the State
17 and pending) pursuant to section
18 1115 for the delivery of substance use
19 services under the State plan, as ap-
20 plicable.

21 “(ii) CONSULTATION.—In completing
22 an application under clause (i), a State
23 shall consult with relevant stakeholders, in-
24 cluding Medicaid managed care plans,
25 health care providers, and Medicaid bene-

1 ficiary advocates, and include in such ap-
2 plication a description of such consultation.

3 “(5) PAYMENT.—

4 “(A) IN GENERAL.—For each quarter oc-
5 curring during the period for which the dem-
6 onstration project is conducted (after the first
7 18 months of such period), the Secretary shall
8 pay under this subsection, subject to subpara-
9 graph (C), to each State selected under para-
10 graph (4) an amount equal to 80 percent of so
11 much of the qualified sums expended during
12 such quarter.

13 “(B) QUALIFIED SUMS DEFINED.—For
14 purposes of subparagraph (A), the term ‘quali-
15 fied sums’ means, with respect to a State and
16 a quarter, the amount equal to the amount (if
17 any) by which the sums expended by the State
18 during such quarter attributable to substance
19 use disorder treatment or recovery services fur-
20 nished by providers participating under the
21 State plan (or a waiver of such plan) exceeds 1/
22 4 of such sums expended by the State during
23 fiscal year 2018 attributable to substance use
24 disorder treatment or recovery services.

1 “(C) NON-DUPLICATION OF PAYMENT.—In
2 the case that payment is made under subpara-
3 graph (A) with respect to expenditures for sub-
4 stance use disorder treatment or recovery serv-
5 ices furnished by providers participating under
6 the State plan (or a waiver of such plan), pay-
7 ment may not also be made under subsection
8 (a) with respect to expenditures for the same
9 services so furnished.

10 “(6) REPORTS.—

11 “(A) STATE REPORTS.—A State receiving
12 payments under paragraph (5) shall, for the pe-
13 riod of the demonstration project under this
14 subsection, submit to the Secretary a quarterly
15 report, with respect to expenditures for sub-
16 stance use disorder treatment or recovery serv-
17 ices for which payment is made to the State
18 under this subsection, on the following:

19 “(i) The specific activities with re-
20 spect to which payment under this sub-
21 section was provided.

22 “(ii) The number of providers that de-
23 livered substance use disorder treatment or
24 recovery services in the State under the
25 demonstration project compared to the es-

1 timated number of providers that would
2 have otherwise delivered such services in
3 the absence of such demonstration project.

4 “(iii) The number of individuals en-
5 rolled under the State plan (or a waiver of
6 such plan) who received substance use dis-
7 order treatment or recovery services under
8 the demonstration project compared to the
9 estimated number of such individuals who
10 would have otherwise received such services
11 in the absence of such demonstration
12 project.

13 “(iv) Other matters as determined by
14 the Secretary.

15 “(B) CMS REPORTS.—

16 “(i) INITIAL REPORT.—Not later than
17 October 1, 2020, the Administrator of the
18 Centers for Medicare & Medicaid Services
19 shall, in consultation with the Director of
20 the Agency for Healthcare Research and
21 Quality and the Assistant Secretary for
22 Mental Health and Substance Use, submit
23 to Congress an initial report on—

24 “(I) the States awarded planning
25 grants under paragraph (3);

1 “(II) the criteria used in such se-
2 lection; and

3 “(III) the activities carried out
4 by such States under such planning
5 grants.

6 “(ii) INTERIM REPORT.—Not later
7 than October 1, 2022, the Administrator
8 of the Centers for Medicare & Medicaid
9 Services shall, in consultation with the Di-
10 rector of the Agency for Healthcare Re-
11 search and Quality and the Assistant Sec-
12 retary for Mental Health and Substance
13 Use, submit to Congress an interim re-
14 port—

15 “(I) on activities carried out
16 under the demonstration project
17 under this subsection;

18 “(II) on the extent to which
19 States selected under paragraph (4)
20 have achieved the stated goals sub-
21 mitted in their applications under sub-
22 paragraph (C) of such paragraph;

23 “(III) with a description of the
24 strengths and limitations of such dem-
25 onstration project; and

1 “(IV) with a plan for the sustain-
2 ability of such project.

3 “(iii) FINAL REPORT.—Not later than
4 October 1, 2024, the Administrator of the
5 Centers for Medicare & Medicaid Services
6 shall, in consultation with the Director of
7 the Agency for Healthcare Research and
8 Quality and the Assistant Secretary for
9 Mental Health and Substance Use, submit
10 to Congress a final report—

11 “(I) providing updates on the
12 matters reported in the interim report
13 under clause (ii);

14 “(II) including a description of
15 any changes made with respect to the
16 demonstration project under this sub-
17 section after the submission of such
18 interim report; and

19 “(III) evaluating such dem-
20 onstration project.

21 “(C) AHRQ REPORT.—Not later than 3
22 years after the date of the enactment of this
23 subsection, the Director of the Agency for
24 Healthcare Research and Quality, in consulta-
25 tion with the Administrator of the Centers for

1 Medicare & Medicaid Services, shall submit to
2 Congress a summary on the experiences of
3 States awarded planning grants under para-
4 graph (3) and States selected under paragraph
5 (4).

6 “(7) DATA SHARING AND BEST PRACTICES.—
7 During the period of the demonstration project
8 under this subsection, the Secretary shall, in collabo-
9 ration with States selected under paragraph (4), fa-
10 cilitate data sharing and the development of best
11 practices between such States and States that were
12 not so selected.

13 “(8) CMS FUNDING.—There is appropriated,
14 out of any funds in the Treasury not otherwise ap-
15 propriated, \$5,000,000 to the Centers for Medicare
16 & Medicaid Services for purposes of implementing
17 this subsection. Such amount shall remain available
18 until expended.”.

19 **SEC. 1004. MEDICAID DRUG REVIEW AND UTILIZATION.**

20 (a) **MEDICAID DRUG UTILIZATION REVIEW.—**

21 (1) **STATE PLAN REQUIREMENT.—**Section
22 1902(a) of the Social Security Act (42 U.S.C.
23 1396a(a)), as amended by section 1001, is further
24 amended—

1 (A) in paragraph (83), at the end, by
2 striking “and”;

3 (B) in paragraph (84), at the end, by
4 striking the period and inserting “; and”; and

5 (C) by inserting after paragraph (84) the
6 following new paragraph:

7 “(85) provide that the State is in compliance
8 with the drug review and utilization requirements
9 under subsection (oo)(1).”.

10 (2) DRUG REVIEW AND UTILIZATION REQUIRE-
11 MENTS.—Section 1902 of the Social Security Act
12 (42 U.S.C. 1396a), as amended by section 1001, is
13 further amended by adding at the end the following
14 new subsection:

15 “(oo) DRUG REVIEW AND UTILIZATION REQUIRE-
16 MENTS.—

17 “(1) IN GENERAL.—For purposes of subsection
18 (a)(85), the drug review and utilization requirements
19 under this subsection are, subject to paragraph (3)
20 and beginning October 1, 2019, the following:

21 “(A) CLAIMS REVIEW LIMITATIONS.—

22 “(i) IN GENERAL.—The State has in
23 place—

24 “(I) safety edits (as specified by
25 the State) for subsequent fills for

1 opioids and a claims review automated
2 process (as designed and implemented
3 by the State) that indicates when an
4 individual enrolled under the State
5 plan (or under a waiver of the State
6 plan) is prescribed a subsequent fill of
7 opioids in excess of any limitation
8 that may be identified by the State;

9 “(II) safety edits (as specified by
10 the State) on the maximum daily mor-
11 phine equivalent that can be pre-
12 scribed to an individual enrolled under
13 the State plan (or under a waiver of
14 the State plan) for treatment of
15 chronic pain and a claims review auto-
16 mated process (as designed and imple-
17 mented by the State) that indicates
18 when an individual enrolled under the
19 plan (or waiver) is prescribed the mor-
20 phine equivalent for such treatment in
21 excess of any limitation that may be
22 identified by the State; and

23 “(III) a claims review automated
24 process (as designed and implemented
25 by the State) that monitors when an

1 individual enrolled under the State
2 plan (or under a waiver of the State
3 plan) is concurrently prescribed
4 opioids and—

5 “(aa) benzodiazepines; or

6 “(bb) antipsychotics.

7 “(ii) MANAGED CARE ENTITIES.—The
8 State requires each managed care entity
9 (as defined in section 1932(a)(1)(B)) with
10 respect to which the State has a contract
11 under section 1903(m) or under section
12 1905(t)(3) to have in place, subject to
13 paragraph (3), with respect to individuals
14 who are eligible for medical assistance
15 under the State plan (or under a waiver of
16 the State plan) and who are enrolled with
17 the entity, the limitations described in sub-
18 clauses (I) and (II) of clause (i) and a
19 claims review automated process described
20 in subclause (III) of such clause.

21 “(iii) RULES OF CONSTRUCTION.—
22 Nothing in this subparagraph may be con-
23 strued as prohibiting a State or managed
24 care entity from designing and imple-
25 menting a claims review automated process

1 under this subparagraph that provides for
2 prospective or retrospective reviews of
3 claims. Nothing in this subparagraph shall
4 be understood as prohibiting the exercise
5 of clinical judgment from a provider en-
6 rolled as a participating provider in a
7 State plan (or waiver of the State plan) or
8 contracting with a managed care entity re-
9 garding the best items and services for an
10 individual enrolled under such State plan
11 (or waiver).

12 “(B) PROGRAM TO MONITOR
13 ANTIPSYCHOTIC MEDICATIONS BY CHILDREN.—
14 The State has in place a program (as designed
15 and implemented by the State) to monitor and
16 manage the appropriate use of antipsychotic
17 medications by children enrolled under the
18 State plan (or under a waiver of the State plan)
19 and submits annually to the Secretary such in-
20 formation as the Secretary may require on ac-
21 tivities carried out under such program for indi-
22 viduals not more than the age of 18 years gen-
23 erally and children in foster care specifically.

24 “(C) FRAUD AND ABUSE IDENTIFICA-
25 TION.—The State has in place a process (as de-

1 signed and implemented by the State) that
2 identifies potential fraud or abuse of controlled
3 substances by individuals enrolled under the
4 State plan (or under a waiver of the State
5 plan), health care providers prescribing drugs
6 to individuals so enrolled, and pharmacies dis-
7 pensing drugs to individuals so enrolled.

8 “(D) REPORTS.—The State shall include
9 in the annual report submitted to the Secretary
10 under section 1927(g)(3)(D) information on the
11 limitations, requirement, program, and proc-
12 esses applied by the State under subparagraphs
13 (A) through (C) in accordance with such man-
14 ner and time as specified by the Secretary.

15 “(E) CLARIFICATION.—Nothing shall pre-
16 vent a State from satisfying the requirement—

17 “(i) described in subparagraph (A) by
18 having safety edits or a claims review auto-
19 mated process described in such subpara-
20 graph that was in place before October 1,
21 2019;

22 “(ii) described in subparagraph (B)
23 by having a program described in such
24 subparagraph that was in place before
25 such date; or

1 “(iii) described in subparagraph (C)
2 by having a process described in such sub-
3 paragraph that was in place before such
4 date.

5 “(2) ANNUAL REPORT BY SECRETARY.—For
6 each fiscal year beginning with fiscal year 2020, the
7 Secretary shall submit to Congress a report on the
8 most recent information submitted by States under
9 paragraph (1)(D).

10 “(3) EXCEPTIONS.—

11 “(A) CERTAIN INDIVIDUALS EXEMPTED.—
12 The drug review and utilization requirements
13 under this subsection shall not apply with re-
14 spect to an individual who—

15 “(i) is receiving—

16 “(I) hospice or palliative care; or

17 “(II) treatment for cancer;

18 “(ii) is a resident of a long-term care
19 facility, of a facility described in section
20 1905(d), or of another facility for which
21 frequently abused drugs are dispensed for
22 residents through a contract with a single
23 pharmacy; or

24 “(iii) the State elects to treat as ex-
25 empted from such requirements.

1 “(B) EXCEPTION RELATING TO ENSURING
2 ACCESS.—In order to ensure reasonable access
3 to health care, the Secretary shall waive the
4 drug review and utilization requirements under
5 this subsection, with respect to a State, in the
6 case of natural disasters and similar situations,
7 and in the case of the provision of emergency
8 services (as defined for purposes of section
9 1860D–4(c)(5)(D)(ii)(II)).”.

10 (3) MANAGED CARE ENTITIES.—Section 1932
11 of the Social Security Act (42 U.S.C. 1396u–2) is
12 amended by adding at the end the following new
13 subsection:

14 “(i) DRUG UTILIZATION REVIEW ACTIVITIES AND
15 REQUIREMENTS.—Beginning not later than October 1,
16 2019, each contract under a State plan with a managed
17 care entity (other than a primary care case manager)
18 under section 1903(m) shall provide that the entity is in
19 compliance with the applicable provisions of section
20 438.3(s)(2) of title 42, Code of Federal Regulations, sec-
21 tion 483.3(s)(4) of such title, and section 483.3(s)(5) of
22 such title, as such provisions were in effect on March 31,
23 2018.”.

1 (b) IDENTIFYING AND ADDRESSING INAPPROPRIATE
2 PRESCRIBING AND BILLING PRACTICES UNDER MED-
3 ICAID.—

4 (1) IN GENERAL.—Section 1927(g) of the So-
5 cial Security Act (42 U.S.C. 1396r–8(g)) is amend-
6 ed—

7 (A) in paragraph (1)(A)—

8 (i) by striking “of section
9 1903(i)(10)(B)” and inserting “of section
10 1902(a)(54)”;

11 (ii) by striking “, by not later than
12 January 1, 1993,”;

13 (iii) by inserting after “gross over-
14 use,” the following: “excessive utilization,”;
15 and

16 (iv) by striking “or inappropriate or
17 medically unnecessary care” and inserting
18 “inappropriate or medically unnecessary
19 care, or prescribing or billing practices
20 that indicate abuse or excessive utiliza-
21 tion”; and

22 (B) in paragraph (2)(B)—

23 (i) by inserting after “gross overuse,”
24 the following: “excessive utilization,”; and

1 (ii) by striking “or inappropriate or
2 medically unnecessary care” and inserting
3 “inappropriate or medically unnecessary
4 care, or prescribing or billing practices
5 that indicate abuse or excessive utiliza-
6 tion”.

7 (2) EFFECTIVE DATE.—The amendments made
8 by paragraph (1) shall take effect with respect to
9 retrospective drug use reviews conducted on or after
10 October 1, 2020.

11 **SEC. 1005. GUIDANCE TO IMPROVE CARE FOR INFANTS**
12 **WITH NEONATAL ABSTINENCE SYNDROME**
13 **AND THEIR MOTHERS; GAO STUDY ON GAPS**
14 **IN MEDICAID COVERAGE FOR PREGNANT**
15 **AND POSTPARTUM WOMEN WITH SUBSTANCE**
16 **USE DISORDER.**

17 (a) GUIDANCE.—Not later than 1 year after the date
18 of the enactment of this Act, the Secretary of Health and
19 Human Services shall issue guidance to improve care for
20 infants with neonatal abstinence syndrome and their fami-
21 lies. Such guidance shall include—

22 (1) best practices from States with respect to
23 innovative or evidenced-based payment models that
24 focus on prevention, screening, treatment, plans of
25 safe care, and postdischarge services for mothers

1 and fathers with substance use disorders and babies
2 with neonatal abstinence syndrome that improve
3 care and clinical outcomes;

4 (2) recommendations for States on available fi-
5 nancing options under the Medicaid program under
6 title XIX of such Act and under the Children’s
7 Health Insurance Program under title XXI of such
8 Act for Children’s Health Insurance Program
9 Health Services Initiative funds for parents with
10 substance use disorders, infants with neonatal absti-
11 nence syndrome, and home-visiting services;

12 (3) guidance and technical assistance to State
13 Medicaid agencies regarding additional flexibilities
14 and incentives related to screening, prevention, and
15 postdischarge services, including parenting supports,
16 and infant-caregiver bonding, including
17 breastfeeding when it is appropriate; and

18 (4) guidance regarding suggested terminology
19 and ICD codes to identify infants with neonatal ab-
20 stinence syndrome and neonatal opioid withdrawal
21 syndrome, which could include opioid-exposure,
22 opioid withdrawal not requiring pharmacotherapy,
23 and opioid withdrawal requiring pharmacotherapy.

24 (b) GAO STUDY.—Not later than 1 year after the
25 date of the enactment of this Act, the Comptroller General

1 of the United States shall conduct a study, and submit
2 to Congress a report, addressing gaps in coverage for
3 pregnant women with substance use disorder under the
4 Medicaid program under title XIX of the Social Security
5 Act, and gaps in coverage for postpartum women with sub-
6 stance use disorder who had coverage during their preg-
7 nancy under the Medicaid program under such title.

8 **SEC. 1006. MEDICAID HEALTH HOMES FOR SUBSTANCE-**
9 **USE-DISORDER MEDICAID ENROLLEES.**

10 (a) EXTENSION OF ENHANCED FMAP FOR CERTAIN
11 HEALTH HOMES FOR INDIVIDUALS WITH SUBSTANCE
12 USE DISORDERS.—Section 1945(c) of the Social Security
13 Act (42 U.S.C. 1396w–4(c)) is amended—

14 (1) in paragraph (1), by inserting “subject to
15 paragraph (4),” after “except that,”; and

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

18 “(4) SPECIAL RULE RELATING TO SUBSTANCE
19 USE DISORDER HEALTH HOMES.—

20 “(A) IN GENERAL.—In the case of a State
21 with an SUD-focused State plan amendment
22 approved by the Secretary on or after October
23 1, 2018, the Secretary may, at the request of
24 the State, extend the application of the Federal
25 medical assistance percentage described in

1 paragraph (1) to payments for the provision of
2 health home services to SUD-eligible individuals
3 under such State plan amendment, in addition
4 to the first 8 fiscal year quarters the State plan
5 amendment is in effect, for the subsequent 2
6 fiscal year quarters that the State plan amend-
7 ment is in effect. Nothing in this section shall
8 be construed as prohibiting a State with a State
9 plan amendment that is approved under this
10 section and that is not an SUD-focused State
11 plan amendment from additionally having ap-
12 proved on or after such date an SUD-focused
13 State plan amendment under this section, in-
14 cluding for purposes of application of this para-
15 graph.

16 “(B) REPORT REQUIREMENTS.—In the
17 case of a State with an SUD-focused State plan
18 amendment for which the application of the
19 Federal medical assistance percentage has been
20 extended under subparagraph (A), such State
21 shall, at the end of the period of such State
22 plan amendment, submit to the Secretary a re-
23 port on the following, with respect to SUD-eli-
24 gible individuals provided health home services
25 under such State plan amendment:

1 “(i) The quality of health care pro-
2 vided to such individuals, with a focus on
3 outcomes relevant to the recovery of each
4 such individual.

5 “(ii) The access of such individuals to
6 health care.

7 “(iii) The total expenditures of such
8 individuals for health care.

9 For purposes of this subparagraph, the Sec-
10 retary shall specify all applicable measures for
11 determining quality, access, and expenditures.

12 “(C) BEST PRACTICES.—Not later than
13 October 1, 2020, the Secretary shall make pub-
14 licly available on the internet website of the
15 Centers for Medicare & Medicaid Services best
16 practices for designing and implementing an
17 SUD-focused State plan amendment, based on
18 the experiences of States that have State plan
19 amendments approved under this section that
20 include SUD-eligible individuals.

21 “(D) DEFINITIONS.—For purposes of this
22 paragraph:

23 “(i) SUD-ELIGIBLE INDIVIDUALS.—
24 The term ‘SUD-eligible individual’ means,

1 with respect to a State, an individual who
2 satisfies all of the following:

3 “(I) The individual is an eligible
4 individual with chronic conditions.

5 “(II) The individual is an indi-
6 vidual with a substance use disorder.

7 “(III) The individual has not pre-
8 viously received health home services
9 under any other State plan amend-
10 ment approved for the State under
11 this section by the Secretary.

12 “(ii) SUD-FOCUSED STATE PLAN
13 AMENDMENT.—The term ‘SUD-focused
14 State plan amendment’ means a State plan
15 amendment under this section that is de-
16 signed to provide health home services pri-
17 marily to SUD-eligible individuals.”

18 (b) REQUIREMENT FOR STATE MEDICAID PLANS TO
19 PROVIDE COVERAGE FOR MEDICATION-ASSISTED TREAT-
20 MENT.—

21 (1) REQUIREMENT FOR STATE MEDICAID PLANS
22 TO PROVIDE COVERAGE FOR MEDICATION-ASSISTED
23 TREATMENT.—Section 1902(a)(10)(A) of the Social
24 Security Act (42 U.S.C. 1396a(a)(10)(A)) is amend-

1 ed, in the matter preceding clause (i), by striking
2 “and (28)” and inserting “(28), and (29)”.

3 (2) INCLUSION OF MEDICATION-ASSISTED
4 TREATMENT AS MEDICAL ASSISTANCE.—Section
5 1905(a) of the Social Security Act (42 U.S.C.
6 1396d(a)) is amended—

7 (A) in paragraph (28), by striking “and”
8 at the end;

9 (B) by redesignating paragraph (29) as
10 paragraph (30); and

11 (C) by inserting after paragraph (28) the
12 following new paragraph:

13 “(29) subject to paragraph (2) of subsection
14 (ee), for the period beginning October 1, 2020, and
15 ending September 30, 2025, medication-assisted
16 treatment (as defined in paragraph (1) of such sub-
17 section); and”.

18 (3) MEDICATION-ASSISTED TREATMENT DE-
19 FINED; WAIVERS.—Section 1905 of the Social Secu-
20 rity Act (42 U.S.C. 1396d) is amended by adding at
21 the end the following new subsection:

22 “(ee) MEDICATION-ASSISTED TREATMENT.—

23 “(1) DEFINITION.—For purposes of subsection
24 (a)(29), the term ‘medication-assisted treatment’—

1 “(A) means all drugs approved under sec-
2 tion 505 of the Federal Food, Drug, and Cos-
3 metic Act (21 U.S.C. 355), including metha-
4 done, and all biological products licensed under
5 section 351 of the Public Health Service Act
6 (42 U.S.C. 262) to treat opioid use disorders;
7 and

8 “(B) includes, with respect to the provision
9 of such drugs and biological products, coun-
10 seling services and behavioral therapy.

11 “(2) EXCEPTION.—The provisions of paragraph
12 (29) of subsection (a) shall not apply with respect to
13 a State for the period specified in such paragraph,
14 if before the beginning of such period the State cer-
15 tifies to the satisfaction of the Secretary that imple-
16 menting such provisions statewide for all individuals
17 eligible to enroll in the State plan (or waiver of the
18 State plan) would not be feasible by reason of a
19 shortage of qualified providers of medication-assisted
20 treatment, or facilities providing such treatment,
21 that will contract with the State or a managed care
22 entity with which the State has a contract under
23 section 1903(m) or under section 1905(t)(3).”.

24 (4) EFFECTIVE DATE.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (B), the amendments made by this sub-
3 section shall apply with respect to medical as-
4 sistance provided on or after October 1, 2020,
5 and before October 1, 2025.

6 (B) EXCEPTION FOR STATE LEGISLA-
7 TION.—In the case of a State plan under title
8 XIX of the Social Security Act (42 U.S.C. 1396
9 et seq.) that the Secretary of Health and
10 Human Services determines requires State leg-
11 islation in order for the respective plan to meet
12 any requirement imposed by the amendments
13 made by this subsection, the respective plan
14 shall not be regarded as failing to comply with
15 the requirements of such title solely on the
16 basis of its failure to meet such an additional
17 requirement before the first day of the first cal-
18 endar quarter beginning after the close of the
19 first regular session of the State legislature that
20 begins after the date of the enactment of this
21 Act. For purposes of the previous sentence, in
22 the case of a State that has a 2-year legislative
23 session, each year of the session shall be consid-
24 ered to be a separate regular session of the
25 State legislature.

1 **SEC. 1007. CARING RECOVERY FOR INFANTS AND BABIES.**

2 (a) STATE PLAN AMENDMENT.—Section 1902(a) of
3 the Social Security Act (42 U.S.C. 1396a(a)), as amended
4 by sections 1001 and 1004, is further amended—

5 (1) in paragraph (84)(C), by striking “and”
6 after the semicolon;

7 (2) in paragraph (85), by striking the period at
8 the end and inserting “; and”; and

9 (3) by inserting after paragraph (85), the fol-
10 lowing new paragraph:

11 “(86) provide, at the option of the State, for
12 making medical assistance available on an inpatient
13 or outpatient basis at a residential pediatric recovery
14 center (as defined in subsection (pp)) to infants with
15 neonatal abstinence syndrome.”.

16 (b) RESIDENTIAL PEDIATRIC RECOVERY CENTER
17 DEFINED.—Section 1902 of such Act (42 U.S.C. 1396a),
18 as amended by sections 1001 and 1004, is further amend-
19 ed by adding at the end the following new subsection:

20 “(pp) RESIDENTIAL PEDIATRIC RECOVERY CENTER
21 DEFINED.—

22 “(1) IN GENERAL.—For purposes of section
23 1902(a)(86), the term ‘residential pediatric recovery
24 center’ means a center or facility that furnishes
25 items and services for which medical assistance is
26 available under the State plan to infants with the di-

1 agnosis of neonatal abstinence syndrome without any
2 other significant medical risk factors.

3 “(2) COUNSELING AND SERVICES.—A residen-
4 tial pediatric recovery center may offer counseling
5 and other services to mothers (and other appropriate
6 family members and caretakers) of infants receiving
7 treatment at such centers if such services are other-
8 wise covered under the State plan under this title or
9 under a waiver of such plan. Such other services
10 may include the following:

11 “(A) Counseling or referrals for services.

12 “(B) Activities to encourage caregiver-in-
13 fant bonding.

14 “(C) Training on caring for such infants.”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section take effect on the date of enactment of this
17 Act and shall apply to medical assistance furnished on or
18 after that date, without regard to final regulations to carry
19 out such amendments being promulgated as of such date.

20 **SEC. 1008. PEER SUPPORT ENHANCEMENT AND EVALUA-**
21 **TION REVIEW.**

22 (a) IN GENERAL.—Not later than 2 years after the
23 date of the enactment of this Act, the Comptroller General
24 of the United States shall submit to the Committee on
25 Energy and Commerce of the House of Representatives,

1 the Committee on Finance of the Senate, and the Com-
2 mittee on Health, Education, Labor and Pensions of the
3 Senate a report on the provision of peer support services
4 under the Medicaid program.

5 (b) CONTENT OF REPORT.—

6 (1) IN GENERAL.—The report required under
7 subsection (a) shall include the following informa-
8 tion:

9 (A) Information on State coverage of peer
10 support services under Medicaid, including—

11 (i) the mechanisms through which
12 States may provide such coverage, includ-
13 ing through existing statutory authority or
14 through waivers;

15 (ii) the populations to which States
16 have provided such coverage;

17 (iii) the payment models, including
18 any alternative payment models, used by
19 States to pay providers of such services;
20 and

21 (iv) where available, information on
22 Federal and State spending under Med-
23 icaid for peer support services.

24 (B) Information on selected State experi-
25 ences in providing medical assistance for peer

1 support services under State Medicaid plans
2 and whether States measure the effects of pro-
3 viding such assistance with respect to—

4 (i) improving access to behavioral
5 health services;

6 (ii) improving early detection, and
7 preventing worsening, of behavioral health
8 disorders;

9 (iii) reducing chronic and comorbid
10 conditions; and

11 (iv) reducing overall health costs.

12 (2) RECOMMENDATIONS.—The report required
13 under subsection (a) shall include recommendations,
14 including recommendations for such legislative and
15 administrative actions related to improving services,
16 including peer support services, and access to peer
17 support services under Medicaid as the Comptroller
18 General of the United States determines appro-
19 priate.

20 **SEC. 1009. MEDICAID SUBSTANCE USE DISORDER TREAT-**
21 **MENT VIA TELEHEALTH.**

22 (a) DEFINITIONS.—In this section:

23 (1) COMPTROLLER GENERAL.—The term
24 “Comptroller General” means the Comptroller Gen-
25 eral of the United States.

1 (2) SCHOOL-BASED HEALTH CENTER.—The
2 term “school-based health center” has the meaning
3 given that term in section 2110(c)(9) of the Social
4 Security Act (42 U.S.C. 1397jj(c)(9)).

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

7 (4) UNDERSERVED AREA.—The term “under-
8 served area” means a health professional shortage
9 area (as defined in section 332(a)(1)(A) of the Pub-
10 lic Health Service Act (42 U.S.C. 254e(a)(1)(A)))
11 and a medically underserved area (according to a
12 designation under section 330(b)(3)(A) of the Public
13 Health Service Act (42 U.S.C. 254b(b)(3)(A))).

14 (b) GUIDANCE TO STATES REGARDING FEDERAL RE-
15 IMBURSEMENT FOR FURNISHING SERVICES AND TREAT-
16 MENT FOR SUBSTANCE USE DISORDERS UNDER MED-
17 ICAID USING SERVICES DELIVERED VIA TELEHEALTH,
18 INCLUDING IN SCHOOL-BASED HEALTH CENTERS.—Not
19 later than 1 year after the date of enactment of this Act,
20 the Secretary, acting through the Administrator of the
21 Centers for Medicare & Medicaid Services, shall issue
22 guidance to States on the following:

23 (1) State options for Federal reimbursement of
24 expenditures under Medicaid for furnishing services
25 and treatment for substance use disorders, including

1 assessment, medication-assisted treatment, coun-
2 seling, medication management, and medication ad-
3 herence with prescribed medication regimes, using
4 services delivered via telehealth. Such guidance shall
5 also include guidance on furnishing services and
6 treatments that address the needs of high-risk indi-
7 viduals, including at least the following groups:

8 (A) American Indians and Alaska Natives.

9 (B) Adults under the age of 40.

10 (C) Individuals with a history of non-fatal
11 overdose.

12 (D) Individuals with a co-occurring serious
13 mental illness and substance use disorder.

14 (2) State options for Federal reimbursement of
15 expenditures under Medicaid for education directed
16 to providers serving Medicaid beneficiaries with sub-
17 stance use disorders using the hub and spoke model,
18 through contracts with managed care entities,
19 through administrative claiming for disease manage-
20 ment activities, and under Delivery System Reform
21 Incentive Payment (“DSRIP”) programs.

22 (3) State options for Federal reimbursement of
23 expenditures under Medicaid for furnishing services
24 and treatment for substance use disorders for indi-

1 viduals enrolled in Medicaid in a school-based health
2 center using services delivered via telehealth.

3 (c) GAO EVALUATION OF CHILDREN'S ACCESS TO
4 SERVICES AND TREATMENT FOR SUBSTANCE USE DIS-
5 ORDERS UNDER MEDICAID.—

6 (1) STUDY.—The Comptroller General shall
7 evaluate children's access to services and treatment
8 for substance use disorders under Medicaid. The
9 evaluation shall include an analysis of State options
10 for improving children's access to such services and
11 treatment and for improving outcomes, including by
12 increasing the number of Medicaid providers who
13 offer services or treatment for substance use dis-
14 orders in a school-based health center using services
15 delivered via telehealth, particularly in rural and un-
16 derserved areas. The evaluation shall include an
17 analysis of Medicaid provider reimbursement rates
18 for services and treatment for substance use dis-
19 orders.

20 (2) REPORT.—Not later than 1 year after the
21 date of enactment of this Act, the Comptroller Gen-
22 eral shall submit to Congress a report containing the
23 results of the evaluation conducted under paragraph
24 (1), together with recommendations for such legisla-

1 tion and administrative action as the Comptroller
2 General determines appropriate.

3 (d) REPORT ON REDUCING BARRIERS TO USING
4 SERVICES DELIVERED VIA TELEHEALTH AND REMOTE
5 PATIENT MONITORING FOR PEDIATRIC POPULATIONS
6 UNDER MEDICAID.—

7 (1) IN GENERAL.—Not later than 1 year after
8 the date of enactment of this Act, the Secretary, act-
9 ing through the Administrator of the Centers for
10 Medicare & Medicaid Services, shall issue a report to
11 the Committee on Finance of the Senate and the
12 Committee on Energy and Commerce of the House
13 of Representatives identifying best practices and po-
14 tential solutions for reducing barriers to using serv-
15 ices delivered via telehealth to furnish services and
16 treatment for substance use disorders among pedi-
17 atric populations under Medicaid. The report shall
18 include—

19 (A) analyses of the best practices, barriers,
20 and potential solutions for using services deliv-
21 ered via telehealth to diagnose and provide serv-
22 ices and treatment for children with substance
23 use disorders, including opioid use disorder; and

24 (B) identification and analysis of the dif-
25 ferences, if any, in furnishing services and

1 treatment for children with substance use dis-
2 orders using services delivered via telehealth
3 and using services delivered in person, such as,
4 and to the extent feasible, with respect to—

5 (i) utilization rates;

6 (ii) costs;

7 (iii) avoidable inpatient admissions
8 and readmissions;

9 (iv) quality of care; and

10 (v) patient, family, and provider satis-
11 faction.

12 (2) PUBLICATION.—The Secretary shall publish
13 the report required under paragraph (1) on a public
14 internet website of the Department of Health and
15 Human Services.

16 **SEC. 1010. ENHANCING PATIENT ACCESS TO NON-OPIOID**
17 **TREATMENT OPTIONS.**

18 Not later than January 1, 2019, the Secretary of
19 Health and Human Services, acting through the Adminis-
20 trator of the Centers for Medicare & Medicaid Services,
21 shall issue 1 or more final guidance documents, or update
22 existing guidance documents, to States regarding manda-
23 tory and optional items and services that may be provided
24 under a State plan under title XIX of the Social Security
25 Act (42 U.S.C. 1396 et seq.), or under a waiver of such

1 a plan, for non-opioid treatment and management of pain,
2 including, but not limited to, evidence-based, non-opioid
3 pharmacological therapies and non-pharmacological thera-
4 pies.

5 **SEC. 1011. ASSESSING BARRIERS TO OPIOID USE DISORDER**
6 **TREATMENT.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Comptroller General of
9 the United States (in this section referred to as the
10 “Comptroller General”) shall conduct a study re-
11 garding the barriers to providing medication used in
12 the treatment of substance use disorders under Med-
13 icaid distribution models such as the “buy-and-bill”
14 model, and options for State Medicaid programs to
15 remove or reduce such barriers. The study shall in-
16 clude analyses of each of the following models of dis-
17 tribution of substance use disorder treatment medi-
18 cations, particularly buprenorphine, naltrexone, and
19 buprenorphine-naloxone combinations:

20 (A) The purchasing, storage, and adminis-
21 tration of substance use disorder treatment
22 medications by providers.

23 (B) The dispensing of substance use dis-
24 order treatment medications by pharmacists.

1 (C) The ordering, prescribing, and obtain-
2 ing substance use disorder treatment medica-
3 tions on demand from specialty pharmacies by
4 providers.

5 (2) REQUIREMENTS.—For each model of dis-
6 tribution specified in paragraph (1), the Comptroller
7 General shall evaluate how each model presents bar-
8 riers or could be used by selected State Medicaid
9 programs to reduce the barriers related to the provi-
10 sion of substance use disorder treatment by exam-
11 ining what is known about the effects of the model
12 of distribution on—

13 (A) Medicaid beneficiaries' access to sub-
14 stance use disorder treatment medications;

15 (B) the differential cost to the program be-
16 tween each distribution model for medication-
17 assisted treatment; and

18 (C) provider willingness to provide or pre-
19 scribe substance use disorder treatment medica-
20 tions.

21 (b) REPORT.—Not later than 15 months after the
22 date of the enactment of this Act, the Comptroller General
23 shall submit to Congress a report containing the results
24 of the study conducted under subsection (a), together with

1 recommendations for such legislation and administrative
2 action as the Comptroller General determines appropriate.

3 **SEC. 1012. HELP FOR MOMS AND BABIES.**

4 (a) **MEDICAID STATE PLAN.**—Section 1905(a) of the
5 Social Security Act (42 U.S.C. 1396d(a)), as amended by
6 section 1006, is further amended by adding at the end
7 the following new sentence: “In the case of a woman who
8 is eligible for medical assistance on the basis of being
9 pregnant (including through the end of the month in
10 which the 60-day period beginning on the last day of her
11 pregnancy ends), who is a patient in an institution for
12 mental diseases for purposes of receiving treatment for a
13 substance use disorder, and who was enrolled for medical
14 assistance under the State plan immediately before becom-
15 ing a patient in an institution for mental diseases or who
16 becomes eligible to enroll for such medical assistance while
17 such a patient, the exclusion from the definition of ‘med-
18 ical assistance’ set forth in the subdivision (B) following
19 paragraph (29) of the first sentence of this subsection
20 shall not be construed as prohibiting Federal financial
21 participation for medical assistance for items or services
22 that are provided to the woman outside of the institu-
23 tion.”.

24 (b) **EFFECTIVE DATE.**—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the amendment made by subsection (a)
3 shall take effect on the date of enactment of this
4 Act.

5 (2) RULE FOR CHANGES REQUIRING STATE
6 LEGISLATION.—In the case of a State plan under
7 title XIX of the Social Security Act which the Sec-
8 retary of Health and Human Services determines re-
9 quires State legislation (other than legislation appro-
10 priating funds) in order for the plan to meet the ad-
11 ditional requirements imposed by the amendment
12 made by subsection (a), the State plan shall not be
13 regarded as failing to comply with the requirements
14 of such title solely on the basis of its failure to meet
15 these additional requirements before the first day of
16 the first calendar quarter beginning after the close
17 of the first regular session of the State legislature
18 that begins after the date of the enactment of this
19 Act. For purposes of the previous sentence, in the
20 case of a State that has a 2-year legislative session,
21 each year of such session shall be deemed to be a
22 separate regular session of the State legislature.

1 **SEC. 1013. SECURING FLEXIBILITY TO TREAT SUBSTANCE**
2 **USE DISORDERS.**

3 Section 1903(m) of the Social Security Act (42
4 U.S.C. 1396b(m)) is amended by adding at the end the
5 following new paragraph:

6 “(7) Payment shall be made under this title to a
7 State for expenditures for capitation payments described
8 in section 438.6(e) of title 42, Code of Federal Regula-
9 tions (or any successor regulation).”.

10 **SEC. 1014. MACPAC STUDY AND REPORT ON MAT UTILIZA-**
11 **TION CONTROLS UNDER STATE MEDICAID**
12 **PROGRAMS.**

13 (a) STUDY.—The Medicaid and CHIP Payment and
14 Access Commission shall conduct a study and analysis of
15 utilization control policies applied to medication-assisted
16 treatment for substance use disorders under State Med-
17 icaid programs, including policies and procedures applied
18 both in fee-for-service Medicaid and in risk-based man-
19 aged care Medicaid, which shall—

20 (1) include an inventory of such utilization con-
21 trol policies and related protocols for ensuring access
22 to medically necessary treatment;

23 (2) determine whether managed care utilization
24 control policies and procedures for medication-as-
25 sisted treatment for substance use disorders are con-

1 sistent with section 438.210(a)(4)(ii) of title 42,
2 Code of Federal Regulations; and

3 (3) identify policies that—

4 (A) limit an individual’s access to medica-
5 tion-assisted treatment for a substance use dis-
6 order by limiting the quantity of medication-as-
7 sisted treatment prescriptions, or the number of
8 refills for such prescriptions, available to the in-
9 dividual as part of a prior authorization process
10 or similar utilization protocols; and

11 (B) apply without evaluating individual in-
12 stances of fraud, waste, or abuse.

13 (b) REPORT.—Not later than 1 year after the date
14 of the enactment of this Act, the Medicaid and CHIP Pay-
15 ment and Access Commission shall make publicly available
16 a report containing the results of the study conducted
17 under subsection (a).

18 **SEC. 1015. OPIOID ADDICTION TREATMENT PROGRAMS EN-**
19 **HANCEMENT.**

20 (a) T-MSIS SUBSTANCE USE DISORDER DATA
21 BOOK.—

22 (1) IN GENERAL.—Not later than the date that
23 is 12 months after the date of enactment of this Act,
24 the Secretary of Health and Human Services (in this
25 section referred to as the “Secretary”) shall publish

1 on the public website of the Centers for Medicare &
2 Medicaid Services a report with comprehensive data
3 on the prevalence of substance use disorders in the
4 Medicaid beneficiary population and services pro-
5 vided for the treatment of substance use disorders
6 under Medicaid.

7 (2) CONTENT OF REPORT.—The report re-
8 quired under paragraph (1) shall include, at a min-
9 imum, the following data for each State (including,
10 to the extent available, for the District of Columbia,
11 Puerto Rico, the United States Virgin Islands,
12 Guam, the Northern Mariana Islands, and American
13 Samoa):

14 (A) The number and percentage of individ-
15 uals enrolled in the State Medicaid plan or
16 waiver of such plan in each of the major enroll-
17 ment categories (as defined in a public letter
18 from the Medicaid and CHIP Payment and Ac-
19 cess Commission to the Secretary) who have
20 been diagnosed with a substance use disorder
21 and whether such individuals are enrolled under
22 the State Medicaid plan or a waiver of such
23 plan, including the specific waiver authority
24 under which they are enrolled, to the extent
25 available.

1 (B) A list of the substance use disorder
2 treatment services by each major type of serv-
3 ice, such as counseling, medication-assisted
4 treatment, peer support, residential treatment,
5 and inpatient care, for which beneficiaries in
6 each State received at least 1 service under the
7 State Medicaid plan or a waiver of such plan.

8 (C) The number and percentage of individ-
9 uals with a substance use disorder diagnosis en-
10 rolled in the State Medicaid plan or waiver of
11 such plan who received substance use disorder
12 treatment services under such plan or waiver by
13 each major type of service under subparagraph
14 (B) within each major setting type, such as out-
15 patient, inpatient, residential, and other home-
16 based and community-based settings.

17 (D) The number of services provided under
18 the State Medicaid plan or waiver of such plan
19 per individual with a substance use disorder di-
20 agnosis enrolled in such plan or waiver for each
21 major type of service under subparagraph (B).

22 (E) The number and percentage of individ-
23 uals enrolled in the State Medicaid plan or
24 waiver, by major enrollment category, who re-

1 ceived substance use disorder treatment
2 through—

3 (i) a medicaid managed care entity
4 (as defined in section 1932(a)(1)(B) of the
5 Social Security Act (42 U.S.C. 1396u–
6 2(a)(1)(B))), including the number of such
7 individuals who received such assistance
8 through a prepaid inpatient health plan or
9 a prepaid ambulatory health plan;

10 (ii) a fee-for-service payment model;
11 or

12 (iii) an alternative payment model, to
13 the extent available.

14 (F) The number and percentage of individ-
15 uals with a substance use disorder who receive
16 substance use disorder treatment services in an
17 outpatient or home-based and community-based
18 setting after receiving treatment in an inpatient
19 or residential setting, and the number of serv-
20 ices received by such individuals in the out-
21 patient or home-based and community-based
22 setting.

23 (3) ANNUAL UPDATES.—The Secretary shall
24 issue an updated version of the report required

1 under paragraph (1) not later than January 1 of
2 each calendar year through 2024.

3 (4) USE OF T-MSIS DATA.—The report required
4 under paragraph (1) and updates required under
5 paragraph (3) shall—

6 (A) use data and definitions from the
7 Transformed Medicaid Statistical Information
8 System (“T-MSIS”) data set that is no more
9 than 12 months old on the date that the report
10 or update is published; and

11 (B) as appropriate, include a description
12 with respect to each State of the quality and
13 completeness of the data and caveats describing
14 the limitations of the data reported to the Sec-
15 retary by the State that is sufficient to commu-
16 nicate the appropriate uses for the information.

17 (b) MAKING T-MSIS DATA ON SUBSTANCE USE
18 DISORDERS AVAILABLE TO RESEARCHERS.—

19 (1) IN GENERAL.—The Secretary shall publish
20 in the Federal Register a system of records notice
21 for the data specified in paragraph (2) for the
22 Transformed Medicaid Statistical Information Sys-
23 tem, in accordance with section 552a(e)(4) of title 5,
24 United States Code. The notice shall outline policies
25 that protect the security and privacy of the data

1 that, at a minimum, meet the security and privacy
2 policies of SORN 09–70–0541 for the Medicaid Sta-
3 tistical Information System.

4 (2) REQUIRED DATA.—The data covered by the
5 systems of records notice required under paragraph
6 (1) shall be sufficient for researchers and States to
7 analyze the prevalence of substance use disorders in
8 the Medicaid beneficiary population and the treat-
9 ment of substance use disorders under Medicaid
10 across all States (including the District of Columbia,
11 Puerto Rico, the United States Virgin Islands,
12 Guam, the Northern Mariana Islands, and American
13 Samoa), forms of treatment, and treatment settings.

14 (3) INITIATION OF DATA-SHARING ACTIVI-
15 TIES.—Not later than January 1, 2019, the Sec-
16 retary shall initiate the data-sharing activities out-
17 lined in the notice required under paragraph (1).

18 **SEC. 1016. BETTER DATA SHARING TO COMBAT THE OPIOID**
19 **CRISIS.**

20 (a) IN GENERAL.—Section 1903(m) of the Social Se-
21 curity Act (42 U.S.C. 1396b(m)), as amended by section
22 1013, is further amended by adding at the end the fol-
23 lowing new paragraph:

24 “(8)(A) The State agency administering the State
25 plan under this title may have reasonable access, as deter-

1 mined by the State, to 1 or more prescription drug moni-
2 toring program databases administered or accessed by the
3 State to the extent the State agency is permitted to access
4 such databases under State law.

5 “(B) Such State agency may facilitate reasonable ac-
6 cess, as determined by the State, to 1 or more prescription
7 drug monitoring program databases administered or
8 accessed by the State, to same extent that the State agen-
9 cy is permitted under State law to access such databases,
10 for—

11 “(i) any provider enrolled under the State plan
12 to provide services to Medicaid beneficiaries; and

13 “(ii) any managed care entity (as defined under
14 section 1932(a)(1)(B)) that has a contract with the
15 State under this subsection or under section
16 1905(t)(3).

17 “(C) Such State agency may share information in
18 such databases, to the same extent that the State agency
19 is permitted under State law to share information in such
20 databases, with—

21 “(i) any provider enrolled under the State plan
22 to provide services to Medicaid beneficiaries; and

23 “(ii) any managed care entity (as defined under
24 section 1932(a)(1)(B)) that has a contract with the

1 State under this subsection or under section
2 1905(t)(3).”.

3 (b) SECURITY AND PRIVACY.—All applicable State
4 and Federal security and privacy protections and laws
5 shall apply to any State agency, individual, or entity ac-
6 cessing 1 or more prescription drug monitoring program
7 databases or obtaining information in such databases in
8 accordance with section 1903(m)(9) of the Social Security
9 Act (as added by subsection (a)).

10 (c) EFFECTIVE DATE.—The amendment made by
11 subsection (a) shall take effect on the date of enactment
12 of this Act.

13 **SEC. 1017. REPORT ON INNOVATIVE STATE INITIATIVES**
14 **AND STRATEGIES TO PROVIDE HOUSING-RE-**
15 **LATED SERVICES AND SUPPORTS TO INDI-**
16 **VIDUALS STRUGGLING WITH SUBSTANCE USE**
17 **DISORDERS UNDER MEDICAID.**

18 (a) IN GENERAL.—Not later than 1 year after the
19 date of enactment of this Act, the Secretary of Health and
20 Human Services shall issue a report to Congress describ-
21 ing innovative State initiatives and strategies for providing
22 housing-related services and supports under a State Med-
23 icaid program to individuals with substance use disorders
24 who are experiencing or at risk of experiencing homeless-
25 ness.

1 (b) CONTENT OF REPORT.—The report required
2 under subsection (a) shall describe the following:

3 (1) Existing methods and innovative strategies
4 developed and adopted by State Medicaid programs
5 that have achieved positive outcomes in increasing
6 housing stability among Medicaid beneficiaries with
7 substance use disorders who are experiencing or at
8 risk of experiencing homelessness, including Med-
9 icaid beneficiaries with substance use disorders who
10 are—

11 (A) receiving treatment for substance use
12 disorders in inpatient, residential, outpatient, or
13 home-based and community-based settings;

14 (B) transitioning between substance use
15 disorder treatment settings; or

16 (C) living in supportive housing or another
17 model of affordable housing.

18 (2) Strategies employed by Medicaid managed
19 care organizations, primary care case managers, hos-
20 pitals, accountable care organizations, and other
21 care coordination providers to deliver housing-related
22 services and supports and to coordinate services pro-
23 vided under State Medicaid programs across dif-
24 ferent treatment settings.

1 (3) Innovative strategies and lessons learned by
2 States with Medicaid waivers approved under section
3 1115 or 1915 of the Social Security Act (42 U.S.C.
4 1315, 1396n), including—

5 (A) challenges experienced by States in de-
6 signing, securing, and implementing such waiv-
7 ers or plan amendments;

8 (B) how States developed partnerships
9 with other organizations such as behavioral
10 health agencies, State housing agencies, hous-
11 ing providers, health care services agencies and
12 providers, community-based organizations, and
13 health insurance plans to implement waivers or
14 State plan amendments; and

15 (C) how and whether States plan to pro-
16 vide Medicaid coverage for housing-related serv-
17 ices and supports in the future, including by
18 covering such services and supports under State
19 Medicaid plans or waivers.

20 (4) Existing opportunities for States to provide
21 housing-related services and supports through a
22 Medicaid waiver under sections 1115 or 1915 of the
23 Social Security Act (42 U.S.C. 1315, 1396n) or
24 through a State Medicaid plan amendment, such as
25 the Assistance in Community Integration Service

1 pilot program, which promotes supportive housing
2 and other housing-related supports under Medicaid
3 for individuals with substance use disorders and for
4 which Maryland has a waiver approved under such
5 section 1115 to conduct the program.

6 (5) Innovative strategies and partnerships de-
7 veloped and implemented by State Medicaid pro-
8 grams or other entities to identify and enroll eligible
9 individuals with substance use disorders who are ex-
10 perencing or at risk of experiencing homelessness in
11 State Medicaid programs.

12 **SEC. 1018. TECHNICAL ASSISTANCE AND SUPPORT FOR IN-**
13 **NOVATIVE STATE STRATEGIES TO PROVIDE**
14 **HOUSING-RELATED SUPPORTS UNDER MED-**
15 **ICAID.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services shall provide technical assistance and
18 support to States regarding the development and expan-
19 sion of innovative State strategies (including through
20 State Medicaid demonstration projects) to provide hous-
21 ing-related supports and services and care coordination
22 services under Medicaid to individuals with substance use
23 disorders.

24 (b) REPORT.—Not later than 180 days after the date
25 of enactment of this Act, the Secretary shall issue a report

1 to Congress detailing a plan of action to carry out the
2 requirements of subsection (a).

3 **TITLE II—MEDICARE PROVI-**
4 **SIONS TO ADDRESS THE**
5 **OPIOID CRISIS**

6 **SEC. 2001. EXPANDING THE USE OF TELEHEALTH SERV-**
7 **ICES FOR THE TREATMENT OF OPIOID USE**
8 **DISORDER AND OTHER SUBSTANCE USE DIS-**
9 **ORDERS.**

10 (a) IN GENERAL.—Section 1834(m) of the Social Se-
11 curity Act (42 U.S.C. 1395m(m)) is amended—

12 (1) in paragraph (2)(B)—

13 (A) in clause (i), in the matter preceding
14 subclause (I), by striking “clause (ii)” and in-
15 serting “clause (ii) and paragraph (6)(C)”; and

16 (B) in clause (ii), in the heading, by strik-
17 ing “FOR HOME DIALYSIS THERAPY”;

18 (2) in paragraph (4)(C)—

19 (A) in clause (i), by striking “paragraph
20 (6)” and inserting “paragraphs (5), (6), and
21 (7)”; and

22 (B) in clause (ii)(X), by inserting “or tele-
23 health services described in paragraph (7)” be-
24 fore the period at the end; and

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

3 “(7) TREATMENT OF SUBSTANCE USE DIS-
4 ORDER SERVICES FURNISHED THROUGH TELE-
5 HEALTH.—The geographic requirements described in
6 paragraph (4)(C)(i) shall not apply with respect to
7 telehealth services furnished on or after July 1,
8 2019, to an eligible telehealth individual with a sub-
9 stance use disorder diagnosis for purposes of treat-
10 ment of such disorder or co-occurring mental health
11 disorder, as determined by the Secretary, at an orig-
12 inating site described in paragraph (4)(C)(ii) (other
13 than an originating site described in subclause (IX)
14 of such paragraph).”.

15 (b) IMPLEMENTATION.—The Secretary of Health and
16 Human Services (in this section referred to as the “Sec-
17 retary”) may implement the amendments made by this
18 section by interim final rule.

19 (c) REPORT.—

20 (1) IN GENERAL.—Not later than 5 years after
21 the date of the enactment of this Act, the Secretary
22 shall submit to Congress a report on the impact of
23 the implementation of the amendments made by this
24 section with respect to telehealth services under sec-

1 tion 1834(m) of the Social Security Act (42 U.S.C.
2 1395m(m)) on—

3 (A) the utilization of health care items and
4 services under title XVIII of such Act (42
5 U.S.C. 1395 et seq.) related to substance use
6 disorders, including emergency department vis-
7 its; and

8 (B) health outcomes related to substance
9 use disorders, such as opioid overdose deaths.

10 (2) FUNDING.—For purposes of carrying out
11 paragraph (1), in addition to funds otherwise avail-
12 able, the Secretary shall provide for the transfer,
13 from the Federal Supplementary Medical Insurance
14 Trust Fund under section 1841, of \$3,000,000 to
15 the Centers for Medicare & Medicaid Services Pro-
16 gram Management Account to remain available until
17 expended.

18 **SEC. 2002. COMPREHENSIVE SCREENINGS FOR SENIORS.**

19 (a) INITIAL PREVENTIVE PHYSICAL EXAMINA-
20 TION.—Section 1861(ww) of the Social Security Act (42
21 U.S.C. 1395x(ww)) is amended—

22 (1) in paragraph (1)—

23 (A) by striking “paragraph (2) and” and
24 inserting “paragraph (2),”; and

1 (B) by inserting “and the furnishing of a
2 review of any current opioid prescriptions (as
3 defined in paragraph (4)),” after “upon the
4 agreement with the individual,”; and
5 (2) in paragraph (2)—

6 (A) by redesignating subparagraph (N) as
7 subparagraph (O); and

8 (B) by inserting after subparagraph (M)
9 the following new subparagraph:

10 “(N) Screening for potential substance use
11 disorders.”; and

12 (3) by adding at the end the following new
13 paragraph:

14 “(4) For purposes of paragraph (1), the term ‘a re-
15 view of any current opioid prescriptions’ means, with re-
16 spect to an individual determined to have a current pre-
17 scription for opioids—

18 “(A) a review of the potential risk factors to the
19 individual for opioid use disorder;

20 “(B) an evaluation of the individual’s severity
21 of pain and current treatment plan;

22 “(C) the provision of information on non-opioid
23 treatment options; and

24 “(D) a referral to a specialist, as appropriate.”.

1 (b) ANNUAL WELLNESS VISIT.—Section
2 1861(hhh)(2) of the Social Security Act (42 U.S.C.
3 1395x(hhh)(2)) is amended—

4 (1) by redesignating subparagraph (G) as sub-
5 paragraph (I); and

6 (2) by inserting after subparagraph (F) the fol-
7 lowing new subparagraphs:

8 “(G) Screening for potential substance use
9 disorders and referral for treatment as appro-
10 priate.

11 “(H) The furnishing of a review of any
12 current opioid prescriptions (as defined in sub-
13 section (ww)(4)).”.

14 (c) RULE OF CONSTRUCTION.—Nothing in the
15 amendments made by subsection (a) or (b) shall be con-
16 strued to prohibit separate payment for structured assess-
17 ment and intervention services for substance abuse fur-
18 nished to an individual on the same day as an initial pre-
19 ventive physical examination or an annual wellness visit.

20 (d) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to examinations and visits fur-
22 nished on or after January 1, 2020.

1 **SEC. 2003. EVERY PRESCRIPTION CONVEYED SECURELY.**

2 (a) IN GENERAL.—Section 1860D–4(e) of the Social
3 Security Act (42 U.S.C. 1395w–104(e)) is amended by
4 adding at the end the following:

5 “(7) REQUIREMENT OF E-PRESCRIBING FOR
6 CONTROLLED SUBSTANCES.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graph (B), a prescription for a covered part D
9 drug under a prescription drug plan (or under
10 an MA–PD plan) for a schedule II, III, IV, or
11 V controlled substance shall be transmitted by
12 a health care practitioner electronically in ac-
13 cordance with an electronic prescription drug
14 program that meets the requirements of para-
15 graph (2).

16 “(B) EXCEPTION FOR CERTAIN CIR-
17 CUMSTANCES.—The Secretary shall, through
18 rulemaking, specify circumstances and proc-
19 esses by which the Secretary may waive the re-
20 quirement under subparagraph (A), with re-
21 spect to a covered part D drug, including in the
22 case of—

23 “(i) a prescription issued when the
24 practitioner and dispensing pharmacy are
25 the same entity;

1 “(ii) a prescription issued that cannot
2 be transmitted electronically under the
3 most recently implemented version of the
4 National Council for Prescription Drug
5 Programs SCRIPT Standard;

6 “(iii) a prescription issued by a practi-
7 tioner who received a waiver or a renewal
8 thereof for a period of time as determined
9 by the Secretary, not to exceed one year,
10 from the requirement to use electronic pre-
11 scribing due to demonstrated economic
12 hardship, technological limitations that are
13 not reasonably within the control of the
14 practitioner, or other exceptional cir-
15 cumstance demonstrated by the practi-
16 tioner;

17 “(iv) a prescription issued by a practi-
18 tioner under circumstances in which, not-
19 withstanding the practitioner’s ability to
20 submit a prescription electronically as re-
21 quired by this subsection, such practitioner
22 reasonably determines that it would be im-
23 practical for the individual involved to ob-
24 tain substances prescribed by electronic
25 prescription in a timely manner, and such

1 delay would adversely impact the individ-
2 ual’s medical condition involved;

3 “(v) a prescription issued by a practi-
4 tioner prescribing a drug under a research
5 protocol;

6 “(vi) a prescription issued by a practi-
7 tioner for a drug for which the Food and
8 Drug Administration requires a prescrip-
9 tion to contain elements that are not able
10 to be included in electronic prescribing,
11 such as a drug with risk evaluation and
12 mitigation strategies that include elements
13 to assure safe use;

14 “(vii) a prescription issued by a prac-
15 titioner—

16 “(I) for an individual who re-
17 ceives hospice care under this title;
18 and

19 “(II) that is not covered under
20 the hospice benefit under this title;
21 and

22 “(viii) a prescription issued by a prac-
23 titioner for an individual who is—

1 “(I) a resident of a nursing facil-
2 ity (as defined in section 1919(a));
3 and

4 “(II) dually eligible for benefits
5 under this title and title XIX.

6 “(C) DISPENSING.—(i) Nothing in this
7 paragraph shall be construed as requiring a
8 sponsor of a prescription drug plan under this
9 part, MA organization offering an MA–PD plan
10 under part C, or a pharmacist to verify that a
11 practitioner, with respect to a prescription for a
12 covered part D drug, has a waiver (or is other-
13 wise exempt) under subparagraph (B) from the
14 requirement under subparagraph (A).

15 “(ii) Nothing in this paragraph shall be
16 construed as affecting the ability of the plan to
17 cover or the pharmacists’ ability to continue to
18 dispense covered part D drugs from otherwise
19 valid written, oral, or fax prescriptions that are
20 consistent with laws and regulations.

21 “(iii) Nothing in this paragraph shall be
22 construed as affecting the ability of an indi-
23 vidual who is being prescribed a covered part D
24 drug to designate a particular pharmacy to dis-
25 pense the covered part D drug to the extent

1 “(F) With respect to plan years beginning
2 on or after January 1, 2022, a drug manage-
3 ment program for at-risk beneficiaries described
4 in paragraph (5).”; and

5 (2) in paragraph (5)(A), by inserting “(and for
6 plan years beginning on or after January 1, 2022,
7 a PDP sponsor shall)” after “A PDP sponsor may”.

8 **SEC. 2005. MEDICARE COVERAGE OF CERTAIN SERVICES**
9 **FURNISHED BY OPIOID TREATMENT PRO-**
10 **GRAMS.**

11 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
12 curity Act (42 U.S.C. 1395x(s)(2)) is amended—

13 (1) in subparagraph (FF), by striking at the
14 end “and”;

15 (2) in subparagraph (GG), by inserting at the
16 end “and”; and

17 (3) by adding at the end the following new sub-
18 paragraph:

19 “(HH) opioid use disorder treatment services
20 (as defined in subsection (jjj)).”.

21 (b) **OPIOID USE DISORDER TREATMENT SERVICES**
22 **AND OPIOID TREATMENT PROGRAM DEFINED.**—Section
23 1861 of the Social Security Act (42 U.S.C. 1395x) is
24 amended by adding at the end the following new sub-
25 section:

1 “(jjj) OPIOID USE DISORDER TREATMENT SERV-
2 ICES; OPIOID TREATMENT PROGRAM.—

3 “(1) OPIOID USE DISORDER TREATMENT SERV-
4 ICES.—The term ‘opioid use disorder treatment serv-
5 ices’ means items and services that are furnished by
6 an opioid treatment program for the treatment of
7 opioid use disorder, including—

8 “(A) opioid agonist and antagonist treat-
9 ment medications (including oral, injected, or
10 implanted versions) that are approved by the
11 Food and Drug Administration under section
12 505 of the Federal Food, Drug, and Cosmetic
13 Act for use in the treatment of opioid use dis-
14 order;

15 “(B) dispensing and administration of
16 such medications, if applicable;

17 “(C) substance use counseling by a profes-
18 sional to the extent authorized under State law
19 to furnish such services;

20 “(D) individual and group therapy with a
21 physician or psychologist (or other mental
22 health professional to the extent authorized
23 under State law);

24 “(E) toxicology testing, and

1 “(F) other items and services that the Sec-
2 retary determines are appropriate (but in no
3 event to include meals or transportation).

4 “(2) OPIOID TREATMENT PROGRAM.—The term
5 ‘opioid treatment program’ means an entity that is
6 an opioid treatment program (as defined in section
7 8.2 of title 42 of the Code of Federal Regulations,
8 or any successor regulation) that—

9 “(A) is enrolled under section 1866(j);

10 “(B) has in effect a certification by the
11 Substance Abuse and Mental Health Services
12 Administration for such a program;

13 “(C) is accredited by an accrediting body
14 approved by the Substance Abuse and Mental
15 Health Services Administration; and

16 “(D) meets such additional conditions as
17 the Secretary may find necessary to ensure—

18 “(i) the health and safety of individ-
19 uals being furnished services under such
20 program; and

21 “(ii) the effective and efficient fur-
22 nishing of such services.”.

23 (c) PAYMENT.—

1 (1) IN GENERAL.—Section 1833(a)(1) of the
2 Social Security Act (42 U.S.C. 1395l(a)(1)) is
3 amended—

4 (A) by striking “and (BB)” and inserting
5 “(BB)”; and

6 (B) by inserting before the semicolon at
7 the end the following “, and (CC) with respect
8 to opioid use disorder treatment services fur-
9 nished during an episode of care, the amount
10 paid shall be equal to the amount payable under
11 section 1834(w) less any copayment required as
12 specified by the Secretary”.

13 (2) PAYMENT DETERMINATION.—Section 1834
14 of the Social Security Act (42 U.S.C. 1395m) is
15 amended by adding at the end the following new
16 subsection:

17 “(w) OPIOID USE DISORDER TREATMENT SERV-
18 ICES.—

19 “(1) IN GENERAL.—The Secretary shall pay to
20 an opioid treatment program (as defined in para-
21 graph (2) of section 1861(jjj)) an amount that is
22 equal to 100 percent of a bundled payment under
23 this part for opioid use disorder treatment services
24 (as defined in paragraph (1) of such section) that
25 are furnished by such program to an individual dur-

1 ing an episode of care (as defined by the Secretary)
2 beginning on or after January 1, 2020. The Sec-
3 retary shall ensure, as determined appropriate by
4 the Secretary, that no duplicative payments are
5 made under this part or part D for items and serv-
6 ices furnished by an opioid treatment program.

7 “(2) CONSIDERATIONS.—The Secretary may
8 implement this subsection through one or more bun-
9 dles based on the type of medication provided (such
10 as buprenorphine, methadone, naltrexone, or a new
11 innovative drug), the frequency of services, the scope
12 of services furnished, characteristics of the individ-
13 uals furnished such services, or other factors as the
14 Secretary determine appropriate. In developing such
15 bundles, the Secretary may consider payment rates
16 paid to opioid treatment programs for comparable
17 services under State plans under title XIX or under
18 the TRICARE program under chapter 55 of title 10
19 of the United States Code.

20 “(3) ANNUAL UPDATES.—The Secretary shall
21 provide an update each year to the bundled payment
22 amounts under this subsection.”.

23 (d) INCLUDING OPIOID TREATMENT PROGRAMS AS
24 MEDICARE PROVIDERS.—Section 1866(e) of the Social
25 Security Act (42 U.S.C. 1395cc(e)) is amended—

1 (1) in paragraph (1), by striking at the end
2 “and”;

3 (2) in paragraph (2), by striking the period at
4 the end and inserting “; and”; and

5 (3) by adding at the end the following new
6 paragraph:

7 “(3) opioid treatment programs (as defined in
8 paragraph (2) of section 1861(jjj)), but only with re-
9 spect to the furnishing of opioid use disorder treat-
10 ment services (as defined in paragraph (1) of such
11 section).”.

12 **SEC. 2006. ENCOURAGING APPROPRIATE PRESCRIBING**
13 **UNDER MEDICARE FOR VICTIMS OF OPIOID**
14 **OVERDOSE.**

15 Section 1860D–4(c)(5)(C) of the Social Security Act
16 (42 U.S.C. 1395w–104(c)(5)(C)) is amended—

17 (1) in clause (i), in the matter preceding sub-
18 clause (I), by striking “For purposes” and inserting
19 “Except as provided in clause (v), for purposes”;
20 and

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

23 “(v) TREATMENT OF ENROLLEES
24 WITH A HISTORY OF OPIOID-RELATED
25 OVERDOSE.—

1 “(I) IN GENERAL.—For plan
2 years beginning not later than Janu-
3 ary 1, 2021, a part D eligible indi-
4 vidual who is not an exempted indi-
5 vidual described in clause (ii) and who
6 is identified under this clause as a
7 part D eligible individual with a his-
8 tory of opioid-related overdose (as de-
9 fined by the Secretary) shall be in-
10 cluded as a potentially at-risk bene-
11 ficiary for prescription drug abuse
12 under the drug management program
13 under this paragraph.

14 “(II) IDENTIFICATION AND NO-
15 TICE.—For purposes of this clause,
16 the Secretary shall—

17 “(aa) identify part D eligible
18 individuals with a history of
19 opioid-related overdose (as so de-
20 fined); and

21 “(bb) notify the PDP spon-
22 sor of the prescription drug plan
23 in which such an individual is en-
24 rolled of such identification.”.

1 **SEC. 2007. AUTOMATIC ESCALATION TO EXTERNAL REVIEW**
2 **UNDER A MEDICARE PART D DRUG MANAGE-**
3 **MENT PROGRAM FOR AT-RISK BENE-**
4 **FICIARIES.**

5 (a) IN GENERAL.—Section 1860D–4(c)(5) of the So-
6 cial Security Act (42 U.S.C. 1395ww–10(c)(5)) is amend-
7 ed—

8 (1) in subparagraph (B), in each of clauses
9 (ii)(III) and (iii)(IV), by striking “and the option of
10 an automatic escalation to external review” and in-
11 sserting “, including notice that if on reconsideration
12 a PDP sponsor affirms its denial, in whole or in
13 part, the case shall be automatically forwarded to
14 the independent, outside entity contracted with the
15 Secretary for review and resolution”; and

16 (2) in subparagraph (E), by striking “and the
17 option” and all that follows and inserting the fol-
18 lowing: “and if on reconsideration a PDP sponsor
19 affirms its denial, in whole or in part, the case shall
20 be automatically forwarded to the independent, out-
21 side entity contracted with the Secretary for review
22 and resolution.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply beginning not later January 1,
25 2021.

1 **SEC. 2008. SUSPENSION OF PAYMENTS BY MEDICARE PRE-**
2 **SCRIPTION DRUG PLANS AND MA-PD PLANS**
3 **PENDING INVESTIGATIONS OF CREDIBLE AL-**
4 **LEGATIONS OF FRAUD BY PHARMACIES.**

5 (a) IN GENERAL.—Section 1860D–12(b) of the So-
6 cial Security Act (42 U.S.C. 1395w–112(b)) is amended
7 by adding at the end the following new paragraph:

8 “(7) SUSPENSION OF PAYMENTS PENDING IN-
9 VESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD
10 BY PHARMACIES.—

11 “(A) IN GENERAL.—Section 1862(o)(1)
12 shall apply with respect to a PDP sponsor with
13 a contract under this part, a pharmacy, and
14 payments to such pharmacy under this part in
15 the same manner as such section applies with
16 respect to the Secretary, a provider of services
17 or supplier, and payments to such provider of
18 services or supplier under this title. A PDP
19 sponsor shall notify the Secretary regarding the
20 imposition of any payment suspension pursuant
21 to the previous sentence, such as through the
22 secure internet website portal (or other suc-
23 cessor technology) established under section
24 1859(i).

25 “(B) RULE OF CONSTRUCTION.—Nothing
26 in this paragraph shall be construed as limiting

1 the authority of a PDP sponsor to conduct
2 postpayment review.”.

3 (b) APPLICATION TO MA-PD PLANS.—Section
4 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-
5 27(f)(3)) is amended by adding at the end the following
6 new subparagraph:

7 “(D) SUSPENSION OF PAYMENTS PENDING
8 INVESTIGATION OF CREDIBLE ALLEGATIONS OF
9 FRAUD BY PHARMACIES.—Section 1860D-
10 12(b)(7).”.

11 (c) CONFORMING AMENDMENT.—Section 1862(o)(3)
12 of the Social Security Act (42 U.S.C. 1395y(o)(3)) is
13 amended by inserting “, section 1860D-12(b)(7) (includ-
14 ing as applied pursuant to section 1857(f)(3)(D)),” after
15 “this subsection”.

16 (d) CLARIFICATION RELATING TO CREDIBLE ALLE-
17 GATION OF FRAUD.—Section 1862(o) of the Social Secu-
18 rity Act (42 U.S.C. 1395y(o)) is amended by adding at
19 the end the following new paragraph:

20 “(4) CREDIBLE ALLEGATION OF FRAUD.—In
21 carrying out this subsection, section 1860D-
22 12(b)(7) (including as applied pursuant to section
23 1857(f)(3)(D)), and section 1903(i)(2)(C), a fraud
24 hotline tip (as defined by the Secretary) without fur-

1 ther evidence shall not be treated as sufficient evi-
2 dence for a credible allegation of fraud.”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply with respect to plan years begin-
5 ning on or after January 1, 2020.

6 **TITLE III—FDA AND CON-**
7 **TROLLED SUBSTANCE PROVI-**
8 **SIONS**

9 **Subtitle A—FDA Provisions**

10 **CHAPTER 1—IN GENERAL**

11 **SEC. 3001. CLARIFYING FDA REGULATION OF NON-ADDICT-**
12 **IVE PAIN PRODUCTS.**

13 (a) PUBLIC MEETINGS.—Not later than one year
14 after the date of enactment of this Act, the Secretary of
15 Health and Human Services (referred to in this section
16 as the “Secretary”), acting through the Commissioner of
17 Food and Drugs, shall hold not less than one public meet-
18 ing to address the challenges and barriers of developing
19 non-addictive medical products intended to treat acute or
20 chronic pain or addiction, which may include—

21 (1) the manner by which the Secretary may in-
22 corporate the risks of misuse and abuse of a con-
23 trolled substance (as defined in section 102 of the
24 Controlled Substances Act (21 U.S.C. 802)) into the
25 risk benefit assessments under subsections (d) and

1 (e) of section 505 of the Federal Food, Drug, and
2 Cosmetic Act (21 U.S.C. 355), section 510(k) of
3 such Act (21 U.S.C. 360(k)), or section 515(c) of
4 such Act (21 U.S.C. 360e(c)), as applicable;

5 (2) the application of novel clinical trial designs
6 (consistent with section 3021 of the 21st Century
7 Cures Act (Public Law 114–255)), use of real world
8 evidence (consistent with section 505F of the Fed-
9 eral Food, Drug, and Cosmetic Act (21 U.S.C.
10 355g)), and use of patient experience data (con-
11 sistent with section 569C of the Federal Food,
12 Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c)) for
13 the development of non-addictive medical products
14 intended to treat pain or addiction;

15 (3) the evidentiary standards and the develop-
16 ment of opioid-sparing data for inclusion in the la-
17 beling of medical products intended to treat acute or
18 chronic pain; and

19 (4) the application of eligibility criteria under
20 sections 506 and 515B of the Federal Food, Drug,
21 and Cosmetic Act (21 U.S.C. 356, 360e–3) for non-
22 addictive medical products intended to treat pain or
23 addiction.

24 (b) GUIDANCE.—Not less than one year after the
25 public meetings are conducted under subsection (a) the

1 Secretary shall issue one or more final guidance docu-
2 ments, or update existing guidance documents, to help ad-
3 dress challenges to developing non-addictive medical prod-
4 ucts to treat pain or addiction. Such guidance documents
5 shall include information regarding—

6 (1) how the Food and Drug Administration
7 may apply sections 506 and 515B of the Federal
8 Food, Drug, and Cosmetic Act (21 U.S.C. 356,
9 360e–3) to non-addictive medical products intended
10 to treat pain or addiction, including the cir-
11 cumstances under which the Secretary—

12 (A) may apply the eligibility criteria under
13 such sections 506 and 515B to non-addictive
14 medical products intended to treat pain or ad-
15 diction;

16 (B) considers the risk of addiction of con-
17 trolled substances approved to treat pain when
18 establishing unmet medical need; and

19 (C) considers pain, pain control, or pain
20 management in assessing whether a disease or
21 condition is a serious or life-threatening disease
22 or condition;

23 (2) the methods by which sponsors may evalu-
24 ate acute and chronic pain, endpoints for non-addict-
25 ive medical products intended to treat pain, the

1 manner in which endpoints and evaluations of effi-
2 cacy will be applied across and within review divi-
3 sions, taking into consideration the etiology of the
4 underlying disease, and the manner in which spon-
5 sors may use surrogate endpoints, intermediate
6 endpoints, and real world evidence;

7 (3) the manner in which the Food and Drug
8 Administration will assess evidence to support the
9 inclusion of opioid-sparing data in the labeling of
10 non-addictive medical products intended to treat
11 acute or chronic pain, including—

12 (A) alternative data collection methodolo-
13 gies, including the use of novel clinical trial de-
14 signs (consistent with section 3021 of the 21st
15 Century Cures Act (Public Law 114–255)) and
16 real world evidence (consistent with section
17 505F of the Federal Food, Drug, and Cosmetic
18 Act (21 U.S.C. 355g)), including patient reg-
19 istries and patient reported outcomes, as appro-
20 priate, to support product labeling;

21 (B) ethical considerations of exposing sub-
22 jects to controlled substances in clinical trials to
23 develop opioid-sparing data and considerations
24 on data collection methods that reduce harm,

1 which may include the reduction of opioid use
2 as a clinical benefit;

3 (C) endpoints, including primary, sec-
4 ondary, and surrogate endpoints, to evaluate
5 the reduction of opioid use;

6 (D) best practices for communication be-
7 tween sponsors and the agency on the develop-
8 ment of data collection methods, including the
9 initiation of data collection; and

10 (E) the appropriate format in which to
11 submit such data results to the Secretary; and

12 (4) the circumstances under which the Food
13 and Drug Administration considers misuse and
14 abuse of a controlled substance (as defined in sec-
15 tion 102 of the Controlled Substances Act (21
16 U.S.C. 802)) in making the risk benefit assessment
17 under paragraphs (2) and (4) of subsection (d) of
18 section 505 of the Federal Food, Drug, and Cos-
19 metic Act (21 U.S.C. 355) and in finding that a
20 drug is unsafe under paragraph (1) or (2) of sub-
21 section (e) of such section.

22 (c) DEFINITIONS.—In this section—

23 (1) the term “medical product” means a drug
24 (as defined in section 201(g)(1) of the Federal
25 Food, Drug, and Cosmetic Act (21 U.S.C.

1 321(g)(1))), biological product (as defined in section
2 351(i) of the Public Health Service Act (42 U.S.C.
3 262(i))), or device (as defined in section 201(h) of
4 the Federal Food, Drug, and Cosmetic Act (21
5 U.S.C. 321(h)); and

6 (2) the term “opioid sparing” means reducing,
7 replacing, or avoiding the use of opioids or other
8 controlled substances intended to treat acute or
9 chronic pain.

10 **SEC. 3002. EVIDENCE-BASED OPIOID ANALGESIC PRE-**
11 **SCRIBING GUIDELINES AND REPORT.**

12 (a) GUIDELINES.—The Commissioner of Food and
13 Drugs shall develop evidence-based opioid analgesic pre-
14 scribing guidelines for the indication-specific treatment of
15 acute pain only for the relevant therapeutic areas where
16 such guidelines do not exist.

17 (b) PUBLIC INPUT.—In developing the guidelines
18 under subsection (a), the Commissioner of Food and
19 Drugs shall—

20 (1) consult with stakeholders, which may in-
21 clude conducting a public meeting of medical profes-
22 sional societies (including any State-based societies),
23 health care providers, State medical boards, medical
24 specialties including pain medicine specialty soci-
25 eties, patient groups, pharmacists, academic or med-

1 ical research entities, and other entities with experi-
2 ence in health care, as appropriate;

3 (2) collaborate with the Director of the Centers
4 for Disease Control and Prevention, as applicable
5 and appropriate, and other Federal agencies with
6 relevant expertise as appropriate; and

7 (3) provide for a notice and comment period
8 consistent with section 701(h) of the Federal Food,
9 Drug, and Cosmetic Act (21 U.S.C. 371(h)) for the
10 submission of comments by the public.

11 (c) REPORT.—Not later than 1 year after the date
12 of enactment of this Act, or, if earlier, at the time the
13 guidelines under subsection (a) are finalized, the Commis-
14 sioner of Food and Drugs shall submit to the Committee
15 on Energy and Commerce of the House of Representatives
16 and the Committee on Health, Education, Labor, and
17 Pensions of the Senate, and post on the public website
18 of the Food and Drug Administration, a report on how
19 the Food and Drug Administration will utilize the guide-
20 lines under subsection (a) to protect the public health and
21 a description of the public health need with respect to each
22 such indication-specific treatment guideline.

23 (d) UPDATES.—The Commissioner of Food and
24 Drugs shall periodically—

1 (1) update the guidelines under subsection (a),
2 informed by public input described in subsection (b);
3 and

4 (2) submit to the committees specified in sub-
5 section (c) and post on the public website of the
6 Food and Drug Administration an updated report
7 under subsection (c).

8 (e) STATEMENT TO ACCOMPANY GUIDELINES AND
9 RECOMMENDATIONS.—The Commissioner of Food and
10 Drugs shall ensure that opioid analgesic prescribing guide-
11 lines and other recommendations developed under this sec-
12 tion are accompanied by a clear statement that such
13 guidelines or recommendations, as applicable—

14 (1) are intended to help inform clinical decision-
15 making by prescribers and patients; and

16 (2) are not intended to be used for the purposes
17 of restricting, limiting, delaying, or denying coverage
18 for, or access to, a prescription issued for a legiti-
19 mate medical purpose by an individual practitioner
20 acting in the usual course of professional practice.

1 **CHAPTER 2—STOP COUNTERFEIT DRUGS**
2 **BY REGULATING AND ENHANCING EN-**
3 **FORCEMENT NOW**

4 **SEC. 3011. SHORT TITLE.**

5 This chapter may be cited as the “Stop Counterfeit
6 Drugs by Regulating and Enhancing Enforcement Now
7 Act” or the “SCREEN Act”.

8 **SEC. 3012. NOTIFICATION, NONDISTRIBUTION, AND RECALL**
9 **OF CONTROLLED SUBSTANCES.**

10 (a) PROHIBITED ACTS.—Section 301 of the Federal
11 Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amend-
12 ed by adding at the end the following:

13 “(eee) The failure to comply with any order issued
14 under section 569D.”.

15 (b) NOTIFICATION, NONDISTRIBUTION, AND RECALL
16 OF CONTROLLED SUBSTANCES.—Subchapter E of chapter
17 V of the Federal Food, Drug, and Cosmetic Act (21
18 U.S.C. 360bbb et seq.) is amended by adding at the end
19 the following:

20 **“SEC. 569D. NOTIFICATION, NONDISTRIBUTION, AND RE-**
21 **CALL OF CONTROLLED SUBSTANCES.**

22 “(a) ORDER TO CEASE DISTRIBUTION AND RE-
23 CALL.—

24 “(1) IN GENERAL.—If the Secretary determines
25 there is a reasonable probability that a controlled

1 substance would cause serious adverse health con-
2 sequences or death, the Secretary may, after pro-
3 viding the appropriate person with an opportunity to
4 consult with the agency, issue an order requiring
5 manufacturers, importers, distributors, or phar-
6 macists, who distribute such controlled substance to
7 immediately cease distribution of such controlled
8 substance.

9 “(2) HEARING.—An order under paragraph (1)
10 shall provide the person subject to the order with an
11 opportunity for an informal hearing, to be held not
12 later than 10 days after the date of issuance of the
13 order, on whether adequate evidence exists to justify
14 an amendment to the order, and what actions are
15 required by such amended order pursuant to sub-
16 paragraph (3).

17 “(3) ORDER RESOLUTION.—If, after an order is
18 issued according to the process under paragraphs
19 (1) and (2), the Secretary shall, except as provided
20 in paragraph (4)—

21 “(A) vacate the order, if the Secretary de-
22 termines that inadequate grounds exist to sup-
23 port the actions required by the order;

1 “(B) continue the order ceasing distribu-
2 tion of the controlled substance until a date
3 specified in such order; or

4 “(C) amend the order to require a recall of
5 the controlled substance, including any require-
6 ments to notify appropriate persons, a timetable
7 for the recall to occur, and a schedule for up-
8 dates to be provided to the Secretary regarding
9 such recall.

10 “(4) RISK ASSESSMENT.—If the Secretary de-
11 termines that the risk of recalling a controlled sub-
12 stance presents a greater health risk than the health
13 risk of not recalling such controlled substance from
14 use, an amended order under subparagraph (B) or
15 (C) of paragraph (3) shall not include either a recall
16 order for, or an order to cease distribution of, such
17 controlled substance, as applicable.

18 “(5) ACTION FOLLOWING ORDER.—Any person
19 who is subject to an order pursuant to subparagraph
20 (B) or (C) of paragraph (3) shall immediately cease
21 distribution of or recall, as applicable, the controlled
22 substance and provide notification as required by
23 such order.

24 “(b) NOTICE TO PERSONS AFFECTED.—If the Sec-
25 retary determines necessary, the Secretary may require

1 the person subject to an order pursuant to paragraph (1)
2 or an amended order pursuant to subparagraph (B) or
3 (C) of paragraph (3) to provide either a notice of a recall
4 order for, or an order to cease distribution of, such con-
5 trolled substance, as applicable, under this section to ap-
6 propriate persons, including persons who manufacture,
7 distribute, import, or offer for sale such product that is
8 the subject of an order and to the public. In providing
9 such notice, the Secretary may use the assistance of health
10 professionals who prescribed or dispensed such controlled
11 substances.

12 “(c) NONDELEGATION.—An order described in sub-
13 section (a)(3) shall be ordered by the Secretary or an offi-
14 cial designated by the Secretary. An official may not be
15 so designated under this section unless the official is the
16 Director of the Center for Drug Evaluation and Research
17 or an official senior to such Director.

18 “(d) SAVINGS CLAUSE.—Nothing contained in this
19 section shall be construed as limiting—

20 “(1) the authority of the Secretary to issue an
21 order to cease distribution of, or to recall, any drug
22 under any other provision of this Act or the Public
23 Health Service Act; or

24 “(2) the ability of the Secretary to request any
25 person to perform a voluntary activity related to any

1 drug subject to this Act or the Public Health Service
2 Act.”.

3 (c) CONTROLLED SUBSTANCES SUBJECT TO RE-
4 FUSAL.—The third sentence of section 801(a) of the Fed-
5 eral Food, Drug, and Cosmetic Act (21 U.S.C. 381(a))
6 is amended by inserting “, or is a controlled substance
7 subject to an order under section 569D” before “, or (4)”.

8 (d) EFFECTIVE DATE.—Sections 301(eee) and 569D
9 of the Federal Food, Drug, and Cosmetic Act, as added
10 by subsections (a) and (b), shall be effective beginning on
11 the date of enactment of this Act.

12 **SEC. 3013. SINGLE SOURCE PATTERN OF IMPORTED ILLE-**
13 **GAL DRUGS.**

14 Section 801 of the Federal Food, Drug, and Cosmetic
15 Act (21 U.S.C. 381), as amended, is further amended by
16 adding at the end the following:

17 “(t) SINGLE SOURCE PATTERN OF IMPORTED ILLE-
18 GAL DRUGS.—If the Secretary determines that a person
19 subject to debarment as a result of engaging in a pattern
20 of importing or offering for import controlled substances
21 or drugs as described in section 306(b)(3)(D), and such
22 pattern is identified by the Secretary as being offered for
23 import from the same manufacturer, distributor, or im-
24 porter, the Secretary may by order determine all drugs
25 being offered for import from such person as adulterated

1 or misbranded, unless such person can provide evidence
2 otherwise.”.

3 **SEC. 3014. STRENGTHENING FDA AND CBP COORDINATION**
4 **AND CAPACITY.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services (referred to in this section as the “Sec-
7 retary”), acting through the Commissioner of Food and
8 Drugs, shall coordinate with the Secretary of Homeland
9 Security to carry out activities related to customs and bor-
10 der protection and in response to illegal controlled sub-
11 stances and drug imports, including at sites of import
12 (such as international mail facilities), that will provide im-
13 provements to such facilities, technologies, and inspection
14 capacity. Such Secretaries may carry out such activities
15 through a memorandum of understanding between the
16 Food and Drug Administration and the U.S. Customs and
17 Border Protection.

18 (b) FDA IMPORT FACILITIES AND INSPECTION CA-
19 PACITY.—

20 (1) IN GENERAL.—In carrying out this section,
21 the Secretary shall, in collaboration with the Sec-
22 retary of Homeland Security and the Postmaster
23 General of the United States Postal Service, provide
24 that import facilities in which the Food and Drug
25 Administration operates or carries out activities re-

1 lated to drug imports within the international mail
2 facilities include—

3 (A) facility upgrades and improved capac-
4 ity in order to increase and improve inspection
5 and detection capabilities, which may include,
6 as the Secretary determines appropriate—

7 (i) improvements to facilities, such as
8 upgrades or renovations, and support for
9 the maintenance of existing import facili-
10 ties and sites to improve coordination be-
11 tween Federal agencies;

12 (ii) improvements in equipment and
13 information technology enhancement to
14 identify unapproved, counterfeit, or other
15 unlawful controlled substances for destruc-
16 tion;

17 (iii) the construction of, or upgrades
18 to, laboratory capacity for purposes of de-
19 tection and testing of imported goods;

20 (iv) upgrades to the security of import
21 facilities; and

22 (v) innovative technology and equip-
23 ment to facilitate improved and near-real-
24 time information sharing between the Food
25 and Drug Administration, the Department

1 of Homeland Security, and the United
2 States Postal Service; and

3 (B) innovative technology, including con-
4 trolled substance detection and testing equip-
5 ment and other applicable technology, in order
6 to collaborate with the U.S. Customs and Bor-
7 der Protection to share near-real-time informa-
8 tion, including information about test results,
9 as appropriate.

10 (2) INNOVATIVE TECHNOLOGY.—Any tech-
11 nology used in accordance with paragraph (1)(B)
12 shall be interoperable with technology used by other
13 relevant Federal agencies, including the U.S. Cus-
14 toms and Border Protection, as the Secretary deter-
15 mines appropriate and practicable.

16 (c) REPORT.—Not later than 6 months after the date
17 of enactment of this Act, the Secretary, in consultation
18 with the Secretary of Homeland Security and the Post-
19 master General of the United States Postal Service, shall
20 report to the Committee on Energy and Commerce and
21 the Committee on Homeland Security of the House of
22 Representatives and the Committee on Health, Education,
23 Labor, and Pensions and the Committee on Homeland Se-
24 curity and Governmental Affairs of the Senate on the im-
25 plementation of this section, including a summary of

1 progress made toward near-real-time information sharing
2 and the interoperability of such technologies.

3 **CHAPTER 3—STOP ILLICIT DRUG**
4 **IMPORTATION**

5 **SEC. 3021. SHORT TITLE.**

6 This chapter may be cited as the “Stop Illicit Drug
7 Importation Act of 2018”.

8 **SEC. 3022. RESTRICTING ENTRANCE OF ILLICIT DRUGS.**

9 (a) **FOOD AND DRUG ADMINISTRATION AND U.S.**
10 **CUSTOMS AND BORDER PROTECTION COOPERATION.—**

11 (1) **IN GENERAL.—**The Secretary of Health and
12 Human Services (referred to in this section as the
13 “Secretary”), acting through the Commissioner of
14 Food and Drugs and in consultation with the U.S.
15 Customs and Border Protection, shall develop and
16 periodically update a mutually agreed upon list of
17 the controlled substances that the Secretary will
18 refer to U.S. Customs and Border Protection, unless
19 the Secretary and U.S. Customs and Border Protec-
20 tion agree otherwise, when such substances are of-
21 fered for import via international mail and appear to
22 violate the Controlled Substances Act (21 U.S.C.
23 801 et seq.), the Controlled Substances Import and
24 Export Act (21 U.S.C. 951 et seq.), the Federal
25 Food, Drug, and Cosmetic Act (21 U.S.C. 301 et

1 seq.), or any other applicable law. The Secretary
2 shall transfer controlled substances on such list to
3 the U.S. Customs and Border Protection. If the Sec-
4 retary identifies additional packages that appear to
5 be the same as such package containing a controlled
6 substance, such additional packages may also be
7 transferred to U.S. Customs and Border Protection.
8 The U.S. Customs and Border Protection shall re-
9 ceive such packages consistent with the requirements
10 of the Controlled Substances Act (21 U.S.C. 801 et
11 seq.).

12 (2) REPORT.—Not later than 9 months after
13 the date of enactment of this Act, the Secretary, act-
14 ing through the Commissioner of Food and Drugs
15 and in consultation with the Secretary of Homeland
16 Security, shall report to the Committee on Energy
17 and Commerce of the House of Representatives and
18 the Committee on Health, Education, Labor, and
19 Pensions of the Senate on the implementation of
20 this section.

21 (b) DEPARTMENT, TEMPORARY DENIAL OF AP-
22 PROVAL, AND SUSPENSION.—

23 (1) PROHIBITED ACT.—Section 301(cc) of the
24 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
25 331(cc)) is amended—

1 (A) by inserting “or a drug” after “food”;

2 and

3 (B) by inserting “from such activity” after

4 “person debarred”.

5 (2) DEBARMENT.—Section 306(b) of the Fed-

6 eral Food, Drug, and Cosmetic Act (21 U.S.C.

7 335a(b)) is amended—

8 (A) in paragraph (1)—

9 (i) in the matter preceding subpara-
10 graph (A), by inserting “or (3)” after
11 “paragraph (2)”;

12 (ii) in subparagraph (A), by striking
13 the comma at the end and inserting a
14 semicolon;

15 (iii) in subparagraph (B), by striking
16 “, or” and inserting a semicolon;

17 (iv) in subparagraph (C), by striking
18 the period and inserting “; or”; and

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

20 “(D) a person from importing or offering
21 for import into the United States a drug.”;

22 (B) in paragraph (3)—

23 (i) in the heading, by inserting “OR
24 DRUG” after “FOOD”;

1 (ii) in subparagraph (A), by striking
2 “; or” and inserting a semicolon;

3 (iii) in subparagraph (B), by striking
4 the period and inserting a semicolon; and

5 (iv) by adding at the end the fol-
6 lowing:

7 “(C) the person has been convicted of a
8 felony for conduct relating to the importation
9 into the United States of any drug or controlled
10 substance (as defined in section 102 of the Con-
11 trolled Substances Act);

12 “(D) the person has engaged in a pattern
13 of importing or offering for import—

14 “(i) controlled substances that are
15 prohibited from importation under section
16 401(m) of the Tariff Act of 1930 (19
17 U.S.C. 1401(m)); or

18 “(ii) adulterated or misbranded drugs
19 that are—

20 “(I) not designated in an author-
21 ized electronic data interchange sys-
22 tem as a product that is regulated by
23 the Secretary; or

24 “(II) knowingly or intentionally
25 falsely designated in an authorized

1 electronic data interchange system as
2 a product that is regulated by the
3 Secretary.”; and

4 (C) by adding at the end the following:

5 “(5) DEFINITION.—For purposes of paragraph
6 (3)(D), the term ‘pattern of importing or offering
7 for import’ means importing or offering for import
8 a drug described in clause (i) or (ii) of paragraph
9 (3)(D) in an amount, frequency, or dosage that is
10 inconsistent with personal or household use by the
11 importer.”.

12 (c) IMPORTS AND EXPORTS.—Section 801(a) of the
13 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
14 381(a)), as amended, is further amended—

15 (1) by striking “, then such article shall be re-
16 fused admission” inserting “or (5) such article is
17 being imported or offered for import in violation of
18 section 301(cc), then any such article described in
19 any of clauses (1) through (5) shall be refused ad-
20 mission”;

21 (2) by inserting “If it appears from the exam-
22 ination of such samples or otherwise that the article
23 is a counterfeit drug, such article shall be refused
24 admission.” before “With respect to an article of
25 food, if importation”; and

1 (3) by striking “Clause (2) of the third sen-
2 tence” and all that follows through the period at the
3 end and inserting the following: “Neither clause (2)
4 nor clause (5) of the third sentence of this sub-
5 section shall be construed to prohibit the admission
6 of narcotic drugs, the importation of which is per-
7 mitted under the Controlled Substances Import and
8 Export Act.”.

9 (d) CERTAIN ILLICIT ARTICLES.—Section 801 of the
10 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381),
11 as amended, is amended by adding at the end the fol-
12 lowing—

13 “(u) ILLICIT ARTICLES CONTAINING ACTIVE PHAR-
14 MACEUTICAL INGREDIENTS.—

15 “(1) IN GENERAL.—For purposes of this sec-
16 tion, an article that is being imported or offered for
17 import into the United States may be treated by the
18 Secretary as a drug if the article—

19 “(A) is not—

20 “(i) accompanied by an electronic im-
21 port entry for such article submitted using
22 an authorized electronic data interchange
23 system; and

24 “(ii) designated in such a system as
25 an article regulated by the Secretary

1 (which may include regulation as a drug, a
2 device, a dietary supplement, or other
3 product that is regulated under this Act);
4 and

5 “(B) is an ingredient that presents signifi-
6 cant public health concern and is, or contains—

7 “(i) an active ingredient in a drug—

8 “(I) that is approved under sec-
9 tion 505 or licensed under section 351
10 of the Public Health Service Act; or

11 “(II) for which—

12 “(aa) an investigational use
13 exemption has been authorized
14 under section 505(i) of this Act
15 or section 351(a) of the Public
16 Health Service Act; and

17 “(bb) a substantial clinical
18 investigation has been instituted,
19 and such investigation has been
20 made public; or

21 “(ii) a substance that has a chemical
22 structure that is substantially similar to
23 the chemical structure of an active ingre-
24 dient in a drug or biological product de-

1 scribed in subclause (I) or (II) of clause
2 (i).

3 “(2) EFFECT.—This subsection shall not be
4 construed to bear upon any determination of wheth-
5 er an article is a drug within the meaning of section
6 201(g), other than for the purposes described in
7 paragraph (1).”.

8 **CHAPTER 4—SECURING OPIOIDS AND UN-**
9 **USED NARCOTICS WITH DELIBERATE**
10 **DISPOSAL AND PACKAGING**

11 **SEC. 3031. SHORT TITLE.**

12 This chapter may be cited as the “Securing Opioids
13 and Unused Narcotics with Deliberate Disposal and Pack-
14 aging Act of 2018” or the “SOUND Disposal and Pack-
15 aging Act”.

16 **SEC. 3032. SAFETY-ENHANCING PACKAGING AND DISPOSAL**
17 **FEATURES.**

18 (a) DELIBERATE DISPOSAL AND PACKAGING ELE-
19 MENTS OF STRATEGY.—Section 505–1(e) of the Federal
20 Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(e)) is
21 amended by adding at the end the following:

22 “(4) PACKAGING AND DISPOSAL.—The Sec-
23 retary may require a risk evaluation mitigation
24 strategy for a drug for which there is a serious risk
25 of an adverse drug experience described in subpara-

1 graph (B) or (C) of subsection (b)(1), taking into
2 consideration the factors described in subparagraphs
3 (C) and (D) of subsection (f)(2) and in consultation
4 with other relevant Federal agencies with authorities
5 over drug disposal packaging, which may include re-
6 quiring that—

7 “(A) the drug be made available for dis-
8 pensing to certain patients in unit dose pack-
9 aging, packaging that provides a set duration,
10 or another packaging system that the Secretary
11 determines may mitigate such serious risk; or

12 “(B) the drug be dispensed to certain pa-
13 tients with a safe disposal packaging or safe
14 disposal system for purposes of rendering drugs
15 nonretrievable (as defined in section 1300.05 of
16 title 21, Code of Federal Regulations (or any
17 successor regulation)) if the Secretary deter-
18 mines that such safe disposal packaging or sys-
19 tem may mitigate such serious risk and is suffi-
20 ciently available.”.

21 (b) ASSURING ACCESS AND MINIMIZING BURDEN.—
22 Section 505–1(f)(2)(C) of the Federal Food, Drug, and
23 Cosmetic Act (21 U.S.C. 355–1(f)(2)(C)) is amended—
24 (1) in clause (i) by striking “and” at the end;
25 and

1 (2) by adding at the end the following:

2 “(iii) patients with functional limita-
3 tions; and”.

4 (c) APPLICATION TO ABBREVIATED NEW DRUG AP-
5 PPLICATIONS.—Section 505–1(i) of the Federal Food,
6 Drug, and Cosmetic Act (21 U.S.C. 355–1(i)) is amend-
7 ed—

8 (1) in paragraph (1)—

9 (A) by redesignating subparagraph (B) as
10 subparagraph (C); and

11 (B) inserting after subparagraph (A) the
12 following:

13 “(B) A packaging or disposal requirement,
14 if required under subsection (e)(4) for the ap-
15 plicable listed drug.”; and

16 (2) in paragraph (2)—

17 (A) in subparagraph (A), by striking
18 “and” at the end;

19 (B) by redesignating subparagraph (B) as
20 subparagraph (C); and

21 (C) by inserting after subparagraph (A)
22 the following:

23 “(B) shall permit packaging systems and
24 safe disposal packaging or safe disposal systems
25 that are different from those required for the

1 applicable listed drug under subsection (e)(4);
2 and”.

3 (d) GAO REPORT.—Not later than 12 months after
4 the date of enactment of this Act, the Comptroller General
5 of the United States shall prepare and submit to Congress
6 a report containing—

7 (1) a description of available evidence, if any,
8 on the effectiveness of site-of-use, in-home controlled
9 substance disposal products and packaging tech-
10 nologies;

11 (2) an evaluation of existing reference stand-
12 ards with respect to controlled substance disposal
13 products and packaging technologies, including any
14 such standards established by a standards develop-
15 ment organization, and how such standards should
16 be considered in ensuring effectiveness of such prod-
17 ucts and technologies;

18 (3) identification of ways in which such disposal
19 products intended for use by patients, consumers,
20 and other end users that are not registrants under
21 the Controlled Substances Act (21 U.S.C. 801 et
22 seq.), are made available to the public and any bar-
23 riers to the use of such disposal products;

1 (4) identification of ways in which packaging
2 technologies are made available to the public and
3 any barriers to the use of such technologies;

4 (5) a description of current Federal oversight,
5 if any, of site-of-use, in-home controlled substance
6 disposal products, including—

7 (A) identification of the Federal agencies
8 that oversee such products;

9 (B) identification of the methods of dis-
10 posal of controlled substances recommended by
11 such agencies for site-of-use, in-home disposal;
12 and

13 (C) a description of the effectiveness of
14 such recommendations at preventing the diver-
15 sion of legally prescribed controlled substances;

16 (6) a description of current Federal oversight,
17 if any, of controlled substance packaging tech-
18 nologies, including—

19 (A) identification of the Federal agencies
20 that oversee such technologies;

21 (B) identification of the technologies rec-
22 ommended by such agencies, including unit
23 dose packaging, packaging that provides a set
24 duration, and other packaging systems that
25 may mitigate abuse or misuse; and

1 (C) a description of the effectiveness of
2 such recommendations at preventing the diver-
3 sion of legally prescribed controlled substances;
4 and

5 (7) recommendations, as appropriate, on—

6 (A) whether site-of-use, in-home controlled
7 substance disposal products and packaging
8 technologies require Federal oversight and, if
9 so, which agency or agencies should be respon-
10 sible for such oversight and, as applicable, re-
11 view of such products or technologies; and

12 (B) whether there are applicable standards
13 that should be considered to ensure the effec-
14 tiveness of such products.

15 **CHAPTER 5—POSTAPPROVAL STUDY**

16 **REQUIREMENTS**

17 **SEC. 3041. CLARIFYING FDA POSTMARKET AUTHORITIES.**

18 (a) DEFINITION OF ADVERSE DRUG EXPERIENCE.—
19 Section 505–1(b)(1)(E) of the Federal Food, Drug, and
20 Cosmetic Act (21 U.S.C. 355–1(b)(1)(E)) is amended by
21 striking “of the drug” and inserting “of the drug, which
22 may include reduced effectiveness under the conditions of
23 use prescribed in the labeling of such drug, but which may
24 not include reduced effectiveness that is in accordance
25 with such labeling”.

1 (b) SAFETY LABELING CHANGES.—Section
2 505(o)(4) of the Federal Food, Drug, and Cosmetic Act
3 (21 U.S.C. 355(o)(4)) is amended—

4 (1) in subparagraph (A) by—

5 (A) striking “SAFETY INFORMATION” and
6 inserting “SAFETY OR NEW EFFECTIVENESS IN-
7 FORMATION”; and

8 (B) by striking “If the Secretary becomes”
9 and all that follows through “in the labeling of
10 the drug” and inserting “If the Secretary be-
11 comes aware of new information, including any
12 new safety information or information related
13 to reduced effectiveness, that the Secretary de-
14 termines should be included in the labeling of
15 the drug”;

16 (2) in clause (i) of subparagraph (B), by insert-
17 ing before the semicolon “, or new effectiveness in-
18 formation”;

19 (3) in subparagraph (C) by striking “safety in-
20 formation” and inserting “safety or new effective-
21 ness information”; and

22 (4) in subparagraph (E) by striking “safety in-
23 formation” and inserting “safety or new effective-
24 ness information”.

1 (c) GUIDANCE.—Not less than one year after the date
2 of enactment of this Act, the Secretary of Health and
3 Human Services shall issue guidance regarding the cir-
4 cumstances under which the Food and Drug Administra-
5 tion may require postmarket studies or clinical trials to
6 assess the potential reduction in effectiveness of a drug
7 and how such reduction in effectiveness could result in a
8 change to the benefits of the drug and the risks to the
9 patient. Such guidance shall also address how the Food
10 and Drug Administration may apply this section and the
11 amendments made thereby with respect to circumstances
12 under which the Food and Drug Administration may re-
13 quire postmarket studies or clinical trials and safety label-
14 ing changes related to the use of controlled substances for
15 acute or chronic pain.

1 **Subtitle B—Controlled Substance**
2 **Provisions**

3 **CHAPTER 1—MORE FLEXIBILITY WITH RE-**
4 **SPECT TO MEDICATION-ASSISTED**
5 **TREATMENT FOR OPIOID USE DIS-**
6 **ORDERS**

7 **SEC. 3201. ALLOWING FOR MORE FLEXIBILITY WITH RE-**
8 **SPECT TO MEDICATION-ASSISTED TREAT-**
9 **MENT FOR OPIOID USE DISORDERS.**

10 (a) CONFORMING APPLICABLE NUMBER.—Subclause
11 (II) of section 303(g)(2)(B)(iii) of the Controlled Sub-
12 stances Act (21 U.S.C. 823(g)(2)(B)(iii)) is amended to
13 read as follows:

14 “(II) The applicable number is—

15 “(aa) 100 if, not sooner than 1 year after
16 the date on which the practitioner submitted
17 the initial notification, the practitioner submits
18 a second notification to the Secretary of the
19 need and intent of the practitioner to treat up
20 to 100 patients;

21 “(bb) 100 if the practitioner holds addi-
22 tional credentialing, as defined in section 8.2 of
23 title 42, Code of Federal Regulations (or suc-
24 cessor regulations);

1 “(cc) 100 if the practitioner provides medi-
2 cation-assisted treatment (MAT) using covered
3 medications (as such terms are defined in sec-
4 tion 8.2 of title 42, Code of Federal Regula-
5 tions (or successor regulations)) in a qualified
6 practice setting (as described in section 8.615
7 of title 42, Code of Federal Regulations (or suc-
8 cessor regulations)); or

9 “(dd) 275 if the practitioner meets the re-
10 quirements specified in sections 8.610 through
11 8.655 of title 42, Code of Federal Regulations
12 (or successor regulations).”.

13 (b) ELIMINATING ANY TIME LIMITATION FOR NURSE
14 PRACTITIONERS AND PHYSICIAN ASSISTANTS TO BE-
15 COME QUALIFYING PRACTITIONERS.—Clause (iii) of sec-
16 tion 303(g)(2)(G) of the Controlled Substances Act (21
17 U.S.C. 823(g)(2)(G)) is amended—

18 (1) in subclause (I), by striking “or” at the
19 end; and

20 (2) by amending subclause (II) to read as fol-
21 lows:

22 “(II) a qualifying other practitioner, as de-
23 fined in clause (iv), who is a nurse practitioner
24 or physician assistant; or”.

1 (c) IMPOSING A TIME LIMITATION FOR CLINICAL
2 NURSE SPECIALISTS, CERTIFIED REGISTERED NURSE
3 ANESTHETISTS, AND CERTIFIED NURSE MIDWIVES TO
4 BECOME QUALIFYING PRACTITIONERS.—Clause (iii) of
5 section 303(g)(2)(G) of the Controlled Substances Act (21
6 U.S.C. 823(g)(2)(G)), as amended by subsection (b), is
7 further amended by adding at the end the following:

8 “(III) for the period beginning on October
9 1, 2018, and ending on October 1, 2023, a
10 qualifying other practitioner, as defined in
11 clause (iv), who is a clinical nurse specialist,
12 certified registered nurse anesthetist, or cer-
13 tified nurse midwife.”.

14 (d) DEFINITION OF QUALIFYING OTHER PRACTI-
15 TIONER.—Section 303(g)(2)(G)(iv) of the Controlled Sub-
16 stances Act (21 U.S.C. 823(g)(2)(G)(iv)) is amended by
17 striking “nurse practitioner or physician assistant” each
18 place it appears and inserting “nurse practitioner, clinical
19 nurse specialist, certified registered nurse anesthetist, cer-
20 tified nurse midwife, or physician assistant”.

21 (e) REPORT BY SECRETARY.—Not later than 2 years
22 after the date of the enactment of this Act, the Secretary
23 of Health and Human Services, in consultation with the
24 Drug Enforcement Administration, shall submit to Con-
25 gress a report that assesses the care provided by quali-

1 fying practitioners (as defined in section 303(g)(2)(G)(iii)
2 of the Controlled Substances Act (21 U.S.C.
3 823(g)(2)(G)(iii))) who are treating, in the case of physi-
4 cians, more than 100 patients, and in the case of quali-
5 fying practitioners who are not physicians, more than 30
6 patients. Such report shall include recommendations on
7 future applicable patient number levels and limits. In pre-
8 paring such report, the Secretary shall study, with respect
9 to opioid use disorder treatment—

10 (1) the average frequency with which qualifying
11 practitioners see their patients;

12 (2) the average frequency with which patients
13 receive counseling, including the rates by which such
14 counseling is provided by such a qualifying practi-
15 tioner directly, or by referral;

16 (3) the frequency of toxicology testing, includ-
17 ing the average frequency with which random toxi-
18 cology testing is administered;

19 (4) the average monthly patient caseload for
20 each type of qualifying practitioner;

21 (5) the treatment retention rates for patients;

22 (6) overdose and mortality rates; and

23 (7) any available information regarding the di-
24 version of drugs by patients receiving such treat-
25 ment from such a qualifying practitioner.

1 **SEC. 3202. MEDICATION-ASSISTED TREATMENT FOR RE-**
2 **COVERY FROM SUBSTANCE USE DISORDER.**

3 (a) WAIVERS FOR MAINTENANCE TREATMENT OR
4 DETOXIFICATION.—Section 303(g)(2)(G)(ii) of the Con-
5 trolled Substances Act (21 U.S.C. 823(g)(2)(G)(ii)) is
6 amended by adding at the end the following:

7 “(VIII) The physician graduated in good stand-
8 ing from an accredited school of allopathic medicine
9 or osteopathic medicine in the United States during
10 the 5-year period immediately preceding the date on
11 which the physician submits to the Secretary a writ-
12 ten notification under subparagraph (B) and suc-
13 cessfully completed a comprehensive allopathic or os-
14 teopathic medicine curriculum or accredited medical
15 residency that—

16 “(aa) included not less than 8 hours of
17 training on treating and managing opioid-de-
18 pendent patients; and

19 “(bb) included, at a minimum—

20 “(AA) the training described in items
21 (aa) through (gg) of subclause (IV); and

22 “(BB) training with respect to any
23 other best practice the Secretary deter-
24 mines should be included in the cur-
25 riculum, which may include training on
26 pain management, including assessment

1 and appropriate use of opioid and non-
2 opioid alternatives.”.

3 (b) **TREATMENT FOR CHILDREN.**—The Secretary of
4 Health and Human Services shall consider ways to ensure
5 that an adequate number of qualified practitioners, as de-
6 fined in subparagraph (G)(ii) of section 303(g)(2) of the
7 Controlled Substances Act (21 U.S.C. 823(g)(2)), who
8 have a specialty in pediatrics or the treatment of children
9 or adolescents, are granted a waiver under such section
10 303(g)(2) to treat children and adolescents with substance
11 use disorders.

12 (c) **TECHNICAL AMENDMENT.**—Section 102(24) of
13 the Controlled Substances Act (21 U.S.C. 802(24)) is
14 amended by striking “Health, Education, and Welfare”
15 and inserting “Health and Human Services”.

16 **SEC. 3203. GRANTS TO ENHANCE ACCESS TO SUBSTANCE**
17 **USE DISORDER TREATMENT.**

18 (a) **IN GENERAL.**—The Secretary of Health and
19 Human Services shall establish a grant program under
20 which the Secretary may make grants to accredited
21 schools of allopathic medicine or osteopathic medicine and
22 teaching hospitals located in the United States to support
23 the development of curricula that meet the requirements
24 under subclause (VIII) of section 303(g)(2)(G)(ii) of the

1 Controlled Substances Act, as added by section 3202(a)
2 of this Act.

3 (b) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated, for grants under subsection
5 (a), \$4,000,000 for each of fiscal years 2019 through
6 2023.

7 **SEC. 3204. DELIVERY OF A CONTROLLED SUBSTANCE BY A**
8 **PHARMACY TO BE ADMINISTERED BY INJEC-**
9 **TION OR IMPLANTATION.**

10 (a) IN GENERAL.—The Controlled Substances Act is
11 amended by inserting after section 309 (21 U.S.C. 829)
12 the following:

13 “DELIVERY OF A CONTROLLED SUBSTANCE BY A
14 PHARMACY TO AN ADMINISTERING PRACTITIONER

15 “SEC. 309A. (a) IN GENERAL.—Notwithstanding
16 section 102(10), a pharmacy may deliver a controlled sub-
17 stance to a practitioner in accordance with a prescription
18 that meets the requirements of this title and the regula-
19 tions issued by the Attorney General under this title, for
20 the purpose of administering the controlled substance by
21 the practitioner if—

22 “(1) the controlled substance is delivered by the
23 pharmacy to the prescribing practitioner or the prac-
24 titioner administering the controlled substance, as
25 applicable, at the location listed on the practitioner’s
26 certificate of registration issued under this title;

1 “(2) the controlled substance is to be adminis-
2 tered for the purpose of maintenance or detoxifica-
3 tion treatment under section 303(g)(2) and—

4 “(A) the practitioner who issued the pre-
5 scription is a qualifying practitioner authorized
6 under, and acting within the scope of that sec-
7 tion; and

8 “(B) the controlled substance is to be ad-
9 ministered by injection or implantation;

10 “(3) the pharmacy and the practitioner are au-
11 thorized to conduct the activities specified in this
12 section under the law of the State in which such ac-
13 tivities take place;

14 “(4) the prescription is not issued to supply any
15 practitioner with a stock of controlled substances for
16 the purpose of general dispensing to patients;

17 “(5) except as provided in subsection (b), the
18 controlled substance is to be administered only to
19 the patient named on the prescription not later than
20 14 days after the date of receipt of the controlled
21 substance by the practitioner; and

22 “(6) notwithstanding any exceptions under sec-
23 tion 307, the prescribing practitioner, and the prac-
24 titioner administering the controlled substance, as
25 applicable, maintain complete and accurate records

1 of all controlled substances delivered, received, ad-
2 ministered, or otherwise disposed of under this sec-
3 tion, including the persons to whom controlled sub-
4 stances were delivered and such other information as
5 may be required by regulations of the Attorney Gen-
6 eral.

7 “(b) MODIFICATION OF NUMBER OF DAYS BEFORE
8 WHICH CONTROLLED SUBSTANCE SHALL BE ADMINIS-
9 TERED.—

10 “(1) INITIAL 2-YEAR PERIOD.—During the 2-
11 year period beginning on the date of enactment of
12 this section, the Attorney General, in coordination
13 with the Secretary, may reduce the number of days
14 described in subsection (a)(5) if the Attorney Gen-
15 eral determines that such reduction will—

16 “(A) reduce the risk of diversion; or

17 “(B) protect the public health.

18 “(2) MODIFICATIONS AFTER SUBMISSION OF
19 REPORT.—After the date on which the report de-
20 scribed in section 3204(b) of the SUPPORT for Pa-
21 tients and Communities Act is submitted, the Attor-
22 ney General, in coordination with the Secretary, may
23 modify the number of days described in subsection
24 (a)(5).

1 Human Services, in consultation with the Administrator
2 of the Drug Enforcement Administration, Commissioner
3 of Food and Drugs, Director of the Centers for Disease
4 Control and Prevention, and Assistant Secretary for Men-
5 tal Health and Substance Use, shall develop and dissemi-
6 nate, as appropriate, materials for pharmacists, health
7 care providers, and patients on—

8 (1) circumstances under which a pharmacist
9 may, consistent with section 309 of the Controlled
10 Substances Act (21 U.S.C. 829) and regulations
11 thereunder, including section 1306.04 of title 21,
12 Code of Federal Regulations, decline to fill a pre-
13 scription for a controlled substance because the
14 pharmacist suspects the prescription is fraudulent,
15 forged, or of doubtful, questionable, or suspicious or-
16 igin; and

17 (2) other Federal requirements pertaining to
18 declining to fill a prescription under such cir-
19 cumstances, including the partial fill of prescriptions
20 for certain controlled substances.

21 (b) MATERIALS INCLUDED.—In developing materials
22 under subsection (a), the Secretary of Health and Human
23 Services shall include information for—

1 **SEC. 3222. DISPOSAL OF CONTROLLED SUBSTANCES OF A**
2 **HOSPICE PATIENT BY EMPLOYEES OF A**
3 **QUALIFIED HOSPICE PROGRAM.**

4 (a) IN GENERAL.—Subsection (g) of section 302 of
5 the Controlled Substances Act (21 U.S.C. 822) is amend-
6 ed by adding at the end the following:

7 “(5)(A) In the case of a person receiving hospice care,
8 an employee of a qualified hospice program, acting within
9 the scope of employment, may handle, without being reg-
10 istered under this section, any controlled substance that
11 was lawfully dispensed to the person receiving hospice
12 care, for the purpose of disposal of the controlled sub-
13 stance so long as such disposal occurs onsite in accordance
14 with all applicable Federal, State, Tribal, and local law
15 and—

16 “(i) the disposal occurs after the death of a per-
17 son receiving hospice care;

18 “(ii) the controlled substance is expired; or

19 “(iii)(I) the employee is—

20 “(aa) the physician of the person re-
21 ceiving hospice care; and

22 “(bb) registered under section 303(f);

23 and

24 “(II) the hospice patient no longer requires
25 the controlled substance because the plan of
26 care of the hospice patient has been modified.

1 “(B) For the purposes of this paragraph:

2 “(i) The terms ‘hospice care’ and ‘hospice pro-
3 gram’ have the meanings given to those terms in
4 section 1861(dd) of the Social Security Act.

5 “(ii) The term ‘employee of a qualified hospice
6 program’ means a physician, physician assistant,
7 nurse, or other person who—

8 “(I) is employed by, or pursuant to ar-
9 rangements made by, a qualified hospice pro-
10 gram;

11 “(II)(aa) is licensed to perform medical or
12 nursing services by the jurisdiction in which the
13 person receiving hospice care was located; and

14 “(bb) is acting within the scope of such
15 employment in accordance with applicable State
16 law; and

17 “(III) has completed training through the
18 qualified hospice program regarding the dis-
19 posal of controlled substances in a secure and
20 responsible manner so as to discourage abuse,
21 misuse, or diversion.

22 “(iii) The term ‘qualified hospice program’
23 means a hospice program that—

24 “(I) has written policies and procedures for
25 assisting in the disposal of the controlled sub-

1 stances of a person receiving hospice care after
2 the person's death;

3 “(II) at the time when the controlled sub-
4 stances are first ordered—

5 “(aa) provides a copy of the written
6 policies and procedures to the patient or
7 patient representative and family;

8 “(bb) discusses the policies and proce-
9 dures with the patient or representative
10 and the family in a language and manner
11 that they understand to ensure that these
12 parties are educated regarding the safe
13 disposal of controlled substances; and

14 “(cc) documents in the patient's clin-
15 ical record that the written policies and
16 procedures were provided and discussed;
17 and

18 “(III) at the time following the disposal of
19 the controlled substances—

20 “(aa) documents in the patient's clin-
21 ical record the type of controlled sub-
22 stance, dosage, route of administration,
23 and quantity so disposed; and

24 “(bb) the time, date, and manner in
25 which that disposal occurred.”.

1 (b) GUIDANCE.—The Attorney General may issue
2 guidance to hospice programs (as defined in paragraph (5)
3 of section 302(g) of the Controlled Substances Act (21
4 U.S.C. 822(g)), as added by subsection (a)) to assist the
5 programs in satisfying the requirements under such para-
6 graph (5).

7 (c) RULE OF CONSTRUCTION RELATING TO STATE
8 AND LOCAL LAW.—Nothing in this section or the amend-
9 ments made by this section shall be construed to prevent
10 a State or local government from imposing additional con-
11 trols or restrictions relating to the regulation of the dis-
12 posal of controlled substances in hospice care or hospice
13 programs.

14 **SEC. 3223. GAO STUDY AND REPORT ON HOSPICE SAFE**
15 **DRUG MANAGEMENT.**

16 (a) STUDY.—

17 (1) IN GENERAL.—The Comptroller General of
18 the United States (in this section referred to as the
19 “Comptroller General”) shall conduct a study on the
20 requirements applicable to, and challenges of, hos-
21 pice programs with regard to the management and
22 disposal of controlled substances in the home of an
23 individual.

1 (2) CONTENTS.—In conducting the study under
2 paragraph (1), the Comptroller General shall in-
3 clude—

4 (A) an overview of any challenges encoun-
5 tered by selected hospice programs regarding
6 the disposal of controlled substances, such as
7 opioids, in a home setting, including any key
8 changes in policies, procedures, or best prac-
9 tices for the disposal of controlled substances
10 over time; and

11 (B) a description of Federal requirements,
12 including requirements under the Medicare pro-
13 gram, for hospice programs regarding the dis-
14 posal of controlled substances in a home set-
15 ting, and oversight of compliance with those re-
16 quirements.

17 (b) REPORT.—Not later than 18 months after the
18 date of enactment of this Act, the Comptroller General
19 shall submit to Congress a report containing the results
20 of the study conducted under subsection (a), together with
21 recommendations, if any, for such legislation and adminis-
22 trative action as the Comptroller General determines ap-
23 propriate.

1 **CHAPTER 4—SPECIAL REGISTRATION FOR**
2 **TELEMEDICINE CLARIFICATION**

3 **SEC. 3231. SHORT TITLE.**

4 This chapter may be cited as the “Special Registra-
5 tion for Telemedicine Clarification Act of 2018”.

6 **SEC. 3232. REGULATIONS RELATING TO A SPECIAL REG-**
7 **ISTRATION FOR TELEMEDICINE.**

8 Section 311(h)(2) of the Controlled Substances Act
9 (21 U.S.C. 831(h)(2)) is amended to read as follows:

10 “(2) REGULATIONS.—Not later than 1 year
11 after the date of enactment of the SUPPORT for
12 Patients and Communities Act, in consultation with
13 the Secretary, the Attorney General shall promul-
14 gate final regulations specifying—

15 “(A) the limited circumstances in which a
16 special registration under this subsection may
17 be issued; and

18 “(B) the procedure for obtaining a special
19 registration under this subsection.”.

20 **CHAPTER 5—SYNTHETIC ABUSE AND**
21 **LABELING OF TOXIC SUBSTANCES**

22 **SEC. 3241. CONTROLLED SUBSTANCE ANALOGUES.**

23 Section 203 of the Controlled Substances Act (21
24 U.S.C. 813) is amended—

1 (1) by striking “A controlled” and inserting
2 “(a) IN GENERAL.—A controlled”; and

3 (2) by adding at the end the following:

4 “(b) DETERMINATION.—In determining whether a
5 controlled substance analogue was intended for human
6 consumption under subsection (a), the following factors
7 may be considered, along with any other relevant factors:

8 “(1) The marketing, advertising, and labeling
9 of the substance.

10 “(2) The known efficacy or usefulness of the
11 substance for the marketed, advertised, or labeled
12 purpose.

13 “(3) The difference between the price at which
14 the substance is sold and the price at which the sub-
15 stance it is purported to be or advertised as is nor-
16 mally sold.

17 “(4) The diversion of the substance from legiti-
18 mate channels and the clandestine importation, man-
19 ufacture, or distribution of the substance.

20 “(5) Whether the defendant knew or should
21 have known the substance was intended to be con-
22 sumed by injection, inhalation, ingestion, or any
23 other immediate means.

24 “(6) Any controlled substance analogue that is
25 manufactured, formulated, sold, distributed, or mar-

1 keted with the intent to avoid the provisions of exist-
2 ing drug laws.

3 “(c) LIMITATION.—For purposes of this section, evi-
4 dence that a substance was not marketed, advertised, or
5 labeled for human consumption, by itself, shall not be suf-
6 ficient to establish that the substance was not intended
7 for human consumption.”.

8 **CHAPTER 6—ACCESS TO INCREASED**
9 **DRUG DISPOSAL**

10 **SEC. 3251. SHORT TITLE.**

11 This chapter may be cited as the “Access to In-
12 creased Drug Disposal Act of 2018”.

13 **SEC. 3252. DEFINITIONS.**

14 In this chapter—

15 (1) the term “Attorney General” means the At-
16 torney General, acting through the Assistant Attor-
17 ney General for the Office of Justice Programs;

18 (2) the term “authorized collector” means a
19 narcotic treatment program, a hospital or clinic with
20 an on-site pharmacy, a retail pharmacy, or a reverse
21 distributor, that is authorized as a collector under
22 section 1317.40 of title 21, Code of Federal Regula-
23 tions (or any successor regulation);

24 (3) the term “covered grant” means a grant
25 awarded under section 3003; and

1 (4) the term “eligible collector” means a person
2 who is eligible to be an authorized collector.

3 **SEC. 3253. AUTHORITY TO MAKE GRANTS.**

4 The Attorney General shall award grants to States
5 to enable the States to increase the participation of eligible
6 collectors as authorized collectors.

7 **SEC. 3254. APPLICATION.**

8 A State desiring a covered grant shall submit to the
9 Attorney General an application that, at a minimum—

10 (1) identifies the single State agency that over-
11 sees pharmaceutical care and will be responsible for
12 complying with the requirements of the grant;

13 (2) details a plan to increase participation rates
14 of eligible collectors as authorized collectors; and

15 (3) describes how the State will select eligible
16 collectors to be served under the grant.

17 **SEC. 3255. USE OF GRANT FUNDS.**

18 A State that receives a covered grant, and any sub-
19 recipient of the grant, may use the grant amounts only
20 for the costs of installation, maintenance, training, pur-
21 chasing, and disposal of controlled substances associated
22 with the participation of eligible collectors as authorized
23 collectors.

1 **SEC. 3256. ELIGIBILITY FOR GRANT.**

2 The Attorney General shall award a covered grant to
3 5 States, not less than 3 of which shall be States in the
4 lowest quartile of States based on the participation rate
5 of eligible collectors as authorized collectors, as deter-
6 mined by the Attorney General.

7 **SEC. 3257. DURATION OF GRANTS.**

8 The Attorney General shall determine the period of
9 years for which a covered grant is made to a State.

10 **SEC. 3258. ACCOUNTABILITY AND OVERSIGHT.**

11 A State that receives a covered grant shall submit
12 to the Attorney General a report, at such time and in such
13 manner as the Attorney General may reasonably require,
14 that—

15 (1) lists the ultimate recipients of the grant
16 amounts;

17 (2) describes the activities undertaken by the
18 State using the grant amounts; and

19 (3) contains performance measures relating to
20 the effectiveness of the grant, including changes in
21 the participation rate of eligible collectors as author-
22 ized collectors.

23 **SEC. 3259. DURATION OF PROGRAM.**

24 The Attorney General may award covered grants for
25 each of the first 5 fiscal years beginning after the date
26 of enactment of this Act.

1 **SEC. 3260. AUTHORIZATION OF APPROPRIATIONS.**

2 There is authorized to be appropriated to the Attor-
3 ney General such sums as may be necessary to carry out
4 this chapter.

5 **CHAPTER 7—USING DATA TO PREVENT**
6 **OPIOID DIVERSION**

7 **SEC. 3271. SHORT TITLE.**

8 This chapter may be cited as the “Using Data To
9 Prevent Opioid Diversion Act of 2018”.

10 **SEC. 3272. PURPOSE.**

11 (a) IN GENERAL.—The purpose of this chapter is to
12 provide drug manufacturers and distributors with access
13 to anonymized information through the Automated Re-
14 ports and Consolidated Orders System to help drug manu-
15 facturers and distributors identify, report, and stop sus-
16 picious orders of opioids and reduce diversion rates.

17 (b) RULE OF CONSTRUCTION.—Nothing in this chap-
18 ter should be construed to absolve a drug manufacturer,
19 drug distributor, or other Drug Enforcement Administra-
20 tion registrant from the responsibility of the manufac-
21 turer, distributor, or other registrant to—

22 (1) identify, stop, and report suspicious orders;

23 or

24 (2) maintain effective controls against diversion
25 in accordance with section 303 of the Controlled

1 Substances Act (21 U.S.C. 823) or any successor
2 law or associated regulation.

3 **SEC. 3273. AMENDMENTS.**

4 (a) RECORDS AND REPORTS OF REGISTRANTS.—Sec-
5 tion 307 of the Controlled Substances Act (21 U.S.C. 827)
6 is amended—

7 (1) by redesignating subsections (f), (g), and
8 (h) as subsections (g), (h), and (i), respectively;

9 (2) by inserting after subsection (e) the fol-
10 lowing:

11 “(f)(1) The Attorney General shall, not less fre-
12 quently than quarterly, make the following information
13 available to manufacturer and distributor registrants
14 through the Automated Reports and Consolidated Orders
15 System, or any subsequent automated system developed
16 by the Drug Enforcement Administration to monitor se-
17 lected controlled substances:

18 “(A) The total number of distributor reg-
19 istrants that distribute controlled substances to a
20 pharmacy or practitioner registrant, aggregated by
21 the name and address of each pharmacy and practi-
22 tioner registrant.

23 “(B) The total quantity and type of opioids dis-
24 tributed, listed by Administration Controlled Sub-

1 stances Code Number, to each pharmacy and practi-
2 tioner registrant described in subparagraph (A).

3 “(2) The information required to be made available
4 under paragraph (1) shall be made available not later than
5 the 30th day of the first month following the quarter to
6 which the information relates.

7 “(3)(A) All registered manufacturers and distributors
8 shall be responsible for reviewing the information made
9 available by the Attorney General under this subsection.

10 “(B) In determining whether to initiate proceedings
11 under this title against a registered manufacturer or dis-
12 tributor based on the failure of the registrant to maintain
13 effective controls against diversion or otherwise comply
14 with the requirements of this title or the regulations issued
15 thereunder, the Attorney General may take into account
16 that the information made available under this subsection
17 was available to the registrant.”; and

18 (3) by inserting after subsection (i), as so re-
19 designated, the following:

20 “(j) All of the reports required under this section
21 shall be provided in an electronic format.”.

22 (b) COOPERATIVE ARRANGEMENTS.—Section 503 of
23 the Controlled Substances Act (21 U.S.C. 873) is amend-
24 ed by striking subsection (c) and inserting the following:

1 “(c)(1) The Attorney General shall, once every 6
2 months, prepare and make available to regulatory, licens-
3 ing, attorneys general, and law enforcement agencies of
4 States a standardized report containing descriptive and
5 analytic information on the actual distribution patterns,
6 as gathered through the Automated Reports and Consoli-
7 dated Orders System, or any subsequent automated sys-
8 tem, pursuant to section 307 and which includes detailed
9 amounts, outliers, and trends of distributor and pharmacy
10 registrants, in such States for the controlled substances
11 contained in schedule II, which, in the discretion of the
12 Attorney General, are determined to have the highest
13 abuse.

14 “(2) If the Attorney General publishes the report de-
15 scribed in paragraph (1) once every 6 months as required
16 under paragraph (1), nothing in this subsection shall be
17 construed to bring an action in any court to challenge the
18 sufficiency of the information or to compel the Attorney
19 General to produce any documents or reports referred to
20 in this subsection.”.

21 (c) CIVIL AND CRIMINAL PENALTIES.—Section 402
22 of the Controlled Substances Act (21 U.S.C. 842) is
23 amended—

24 (1) in subsection (a)—

1 (A) in paragraph (15), by striking “or” at
2 the end;

3 (B) in paragraph (16), by striking the pe-
4 riod at the end and inserting “; or”; and

5 (C) by inserting after paragraph (16) the
6 following:

7 “(17) in the case of a registered manufacturer
8 or distributor of opioids, to fail to review the most
9 recent information, directly related to the customers
10 of the manufacturer or distributor, made available
11 by the Attorney General in accordance with section
12 307(f).”; and

13 (2) in subsection (c)—

14 (A) in paragraph (1), by striking subpara-
15 graph (B) and inserting the following:

16 “(B)(i) Except as provided in clause (ii), in the case
17 of a violation of paragraph (5), (10), or (17) of subsection
18 (a), the civil penalty shall not exceed \$10,000.

19 “(ii) In the case of a violation described in clause (i)
20 committed by a registered manufacturer or distributor of
21 opioids and related to the reporting of suspicious orders
22 for opioids, failing to maintain effective controls against
23 diversion of opioids, or failing to review the most recent
24 information made available by the Attorney General in ac-

1 cordance with section 307(f), the penalty shall not exceed
2 \$100,000.”; and

3 (B) in paragraph (2)—

4 (i) in subparagraph (A), by inserting
5 “or (D)” after “subparagraph (B)”;

6 (ii) by adding at the end the fol-
7 lowing:

8 “(D) In the case of a violation described in subpara-
9 graph (A) that was a violation of paragraph (5), (10), or
10 (17) of subsection (a) committed by a registered manufac-
11 turer or distributor of opioids that relates to the reporting
12 of suspicious orders for opioids, failing to maintain effec-
13 tive controls against diversion of opioids, or failing to re-
14 view the most recent information made available by the
15 Attorney General in accordance with section 307(f), the
16 criminal fine under title 18, United States Code, shall not
17 exceed \$500,000.”.

18 **SEC. 3274. REPORT.**

19 Not later than 1 year after the date of enactment
20 of this Act, the Attorney General shall submit to Congress
21 a report that provides information about how the Attorney
22 General is using data in the Automation of Reports and
23 Consolidated Orders System to identify and stop sus-
24 picious activity, including whether the Attorney General
25 is looking at aggregate orders from individual pharmacies

1 to multiple distributors that in total are suspicious, even
2 if no individual order rises to the level of a suspicious
3 order to a given distributor.

4 **CHAPTER 8—OPIOID QUOTA REFORM**

5 **SEC. 3281. SHORT TITLE.**

6 This chapter may be cited as the “Opioid Quota Re-
7 form Act”.

8 **SEC. 3282. STRENGTHENING CONSIDERATIONS FOR DEA** 9 **OPIOID QUOTAS.**

10 (a) IN GENERAL.—Section 306 of the Controlled
11 Substances Act (21 U.S.C. 826) is amended—

12 (1) in subsection (a)—

13 (A) by inserting “(1)” after “(a)”;

14 (B) in the second sentence, by striking
15 “Production” and inserting “Except as pro-
16 vided in paragraph (2), production”; and

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

18 “(2) The Attorney General may, if the Attorney Gen-
19 eral determines it will assist in avoiding the overproduc-
20 tion, shortages, or diversion of a controlled substance, es-
21 tablish an aggregate or individual production quota under
22 this subsection, or a procurement quota established by the
23 Attorney General by regulation, in terms of pharma-
24 ceutical dosage forms prepared from or containing the
25 controlled substance.”;

1 (2) in subsection (b), in the first sentence, by
2 striking “production” and inserting “manufac-
3 turing”;

4 (3) in subsection (c), by striking “October” and
5 inserting “December”; and

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

7 “(i)(1)(A) In establishing any quota under this sec-
8 tion, or any procurement quota established by the Attor-
9 ney General by regulation, for fentanyl, oxycodone,
10 hydrocodone, oxymorphone, or hydromorphone (in this
11 subsection referred to as a ‘covered controlled substance’),
12 the Attorney General shall estimate the amount of diver-
13 sion of the covered controlled substance that occurs in the
14 United States.

15 “(B) In estimating diversion under this paragraph,
16 the Attorney General—

17 “(i) shall consider information the Attorney
18 General, in consultation with the Secretary of
19 Health and Human Services, determines reliable on
20 rates of overdose deaths and abuse and overall pub-
21 lic health impact related to the covered controlled
22 substance in the United States; and

23 “(ii) may take into consideration whatever other
24 sources of information the Attorney General deter-
25 mines reliable.

1 “(C) After estimating the amount of diversion of a
2 covered controlled substance, the Attorney General shall
3 make appropriate quota reductions, as determined by the
4 Attorney General, from the quota the Attorney General
5 would have otherwise established had such diversion not
6 been considered.

7 “(2)(A) For any year for which the approved aggre-
8 gate production quota for a covered controlled substance
9 is higher than the approved aggregate production quota
10 for the covered controlled substance for the previous year,
11 the Attorney General, in consultation with the Secretary
12 of Health and Human Services, shall include in the final
13 order an explanation of why the public health benefits of
14 increasing the quota clearly outweigh the consequences of
15 having an increased volume of the covered controlled sub-
16 stance available for sale, and potential diversion, in the
17 United States.

18 “(B) Not later than 1 year after the date of enact-
19 ment of this subsection, and every year thereafter, the At-
20 torney General shall submit to the Committee on the Judi-
21 ciary, the Committee on Health, Education, Labor, and
22 Pensions, and the Committee on Appropriations of the
23 Senate and the Committee on the Judiciary, the Com-
24 mittee on Energy and Commerce, and the Committee on
25 Appropriations of the House of Representatives the fol-

1 lowing information with regard to each covered controlled
2 substance:

3 “(i) An anonymized count of the total number
4 of manufacturers issued individual manufacturing
5 quotas that year for the covered controlled sub-
6 stance.

7 “(ii) An anonymized count of how many such
8 manufacturers were issued an approved manufac-
9 turing quota that was higher than the quota issued
10 to that manufacturer for the covered controlled sub-
11 stance in the previous year.

12 “(3) Not later than 1 year after the date of enact-
13 ment of this subsection, the Attorney General shall submit
14 to Congress a report on how the Attorney General, when
15 fixing and adjusting production and manufacturing quotas
16 under this section for covered controlled substances, will—

17 “(A) take into consideration changes in the ac-
18 cepted medical use of the covered controlled sub-
19 stances; and

20 “(B) work with the Secretary of Health and
21 Human Services on methods to appropriately and
22 anonymously estimate the type and amount of cov-
23 ered controlled substances that are submitted for
24 collection from approved drug collection receptacles,
25 mail-back programs, and take-back events.”.

1 (b) CONFORMING CHANGE.—The Law Revision
2 Counsel is directed to amend the heading for subsection
3 (b) of section 826 of title 21, United States Code, by strik-
4 ing “PRODUCTION” and inserting “MANUFACTURING”.

5 **CHAPTER 9—PREVENTING DRUG**
6 **DIVERSION**

7 **SEC. 3291. SHORT TITLE.**

8 This chapter may be cited as the “Preventing Drug
9 Diversion Act of 2018”.

10 **SEC. 3292. IMPROVEMENTS TO PREVENT DRUG DIVERSION.**

11 (a) DEFINITION.—Section 102 of the Controlled Sub-
12 stances Act (21 U.S.C. 802) is amended by adding at the
13 end the following:

14 “(57) The term ‘suspicious order’ may include,
15 but is not limited to—

16 “(A) an order of a controlled substance of
17 unusual size;

18 “(B) an order of a controlled substance de-
19 viating substantially from a normal pattern;
20 and

21 “(C) orders of controlled substances of un-
22 usual frequency.”.

23 (b) SUSPICIOUS ORDERS.—Part C of the Controlled
24 Substances Act (21 U.S.C. 821 et seq.) is amended by
25 adding at the end the following:

1 **“SEC. 312. SUSPICIOUS ORDERS.**

2 “(a) REPORTING.—Each registrant shall—

3 “(1) design and operate a system to identify
4 suspicious orders for the registrant;

5 “(2) ensure that the system designed and oper-
6 ated under paragraph (1) by the registrant complies
7 with applicable Federal and State privacy laws; and

8 “(3) upon discovering a suspicious order or se-
9 ries of orders, notify the Administrator of the Drug
10 Enforcement Administration and the Special Agent
11 in Charge of the Division Office of the Drug En-
12 forcement Administration for the area in which the
13 registrant is located or conducts business.

14 “(b) SUSPICIOUS ORDER DATABASE.—

15 “(1) IN GENERAL.—Not later than 1 year after
16 the date of enactment of this section, the Attorney
17 General shall establish a centralized database for
18 collecting reports of suspicious orders.

19 “(2) SATISFACTION OF REPORTING REQUIRE-
20 MENTS.—If a registrant reports a suspicious order
21 to the centralized database established under para-
22 graph (1), the registrant shall be considered to have
23 complied with the requirement under subsection
24 (a)(3) to notify the Administrator of the Drug En-
25 forcement Administration and the Special Agent in
26 Charge of the Division Office of the Drug Enforce-

1 ment Administration for the area in which the reg-
2 istrant is located or conducts business.

3 “(c) SHARING INFORMATION WITH THE STATES.—

4 “(1) IN GENERAL.—The Attorney General shall
5 prepare and make available information regarding
6 suspicious orders in a State, including information
7 in the database established under subsection (b)(1),
8 to the point of contact for purposes of administra-
9 tive, civil, and criminal oversight relating to the di-
10 version of controlled substances for the State, as
11 designated by the Governor or chief executive officer
12 of the State.

13 “(2) TIMING.—The Attorney General shall pro-
14 vide information in accordance with paragraph (1)
15 within a reasonable period of time after obtaining
16 the information.

17 “(3) COORDINATION.—In establishing the proc-
18 ess for the provision of information under this sub-
19 section, the Attorney General shall coordinate with
20 States to ensure that the Attorney General has ac-
21 cess to information, as permitted under State law,
22 possessed by the States relating to prescriptions for
23 controlled substances that will assist in enforcing
24 Federal law.”.

25 (c) REPORTS TO CONGRESS.—

1 (1) DEFINITION.—In this subsection, the term
2 “suspicious order” has the meaning given that term
3 in section 102 of the Controlled Substances Act, as
4 amended by this chapter.

5 (2) ONE-TIME REPORT.—Not later than 1 year
6 after the date of enactment of this Act, the Attorney
7 General shall submit to Congress a report on the re-
8 porting of suspicious orders, which shall include—

9 (A) a description of the centralized data-
10 base established under section 312 of the Con-
11 trolled Substances Act, as added by this sec-
12 tion, to collect reports of suspicious orders;

13 (B) a description of the system and reports
14 established under section 312 of the Controlled
15 Substances Act, as added by this section, to
16 share information with States;

17 (C) information regarding how the Attor-
18 ney General used reports of suspicious orders
19 before the date of enactment of this Act and
20 after the date of enactment of this Act, includ-
21 ing how the Attorney General received the re-
22 ports and what actions were taken in response
23 to the reports; and

1 (D) descriptions of the data analyses con-
2 ducted on reports of suspicious orders to iden-
3 tify, analyze, and stop suspicious activity.

4 (3) ADDITIONAL REPORTS.—Not later than 1
5 year after the date of enactment of this Act, and an-
6 nually thereafter until the date that is 5 years after
7 the date of enactment of this Act, the Attorney Gen-
8 eral shall submit to Congress a report providing, for
9 the previous year—

10 (A) the number of reports of suspicious or-
11 ders;

12 (B) a summary of actions taken in re-
13 sponse to reports, in the aggregate, of sus-
14 picious orders; and

15 (C) a description of the information shared
16 with States based on reports of suspicious or-
17 ders.

18 (4) ONE-TIME GAO REPORT.—Not later than 1
19 year after the date of enactment of this Act, the
20 Comptroller General of the United States, in con-
21 sultation with the Administrator of the Drug En-
22 forcement Administration, shall submit to Congress
23 a report on the reporting of suspicious orders, which
24 shall include an evaluation of the utility of real-time
25 reporting of potential suspicious orders of opioids on

1 a national level using computerized algorithms, in-
2 cluding the extent to which such algorithms—

3 (A) would help ensure that potentially sus-
4 picious orders are more accurately captured,
5 identified, and reported in real time to suppliers
6 before orders are filled;

7 (B) may produce false positives of sus-
8 picious order reports that could result in mar-
9 ket disruptions for legitimate orders of opioids;
10 and

11 (C) would reduce the overall length of an
12 investigation that prevents the diversion of sus-
13 picious orders of opioids.

14 **TITLE IV—OFFSETS**

15 **SEC. 4001. PROMOTING VALUE IN MEDICAID MANAGED** 16 **CARE.**

17 Section 1903(m) of the Social Security Act (42
18 U.S.C. 1396b(m)), as amended by sections 1013 and
19 1016, is further amended by adding at the end the fol-
20 lowing new paragraph:

21 “(9)(A) With respect to expenditures described in
22 subparagraph (B) that are incurred by a State for any
23 fiscal year after fiscal year 2020 (and before fiscal year
24 2024), in determining the pro rata share to which the
25 United States is equitably entitled under subsection

1 (d)(3), the Secretary shall substitute the Federal medical
2 assistance percentage that applies for such fiscal year to
3 the State under section 1905(b) (without regard to any
4 adjustments to such percentage applicable under such sec-
5 tion or any other provision of law) for the percentage that
6 applies to such expenditures under section 1905(y).

7 “(B) Expenditures described in this subparagraph,
8 with respect to a fiscal year to which subparagraph (A)
9 applies, are expenditures incurred by a State for payment
10 for medical assistance provided to individuals described in
11 subclause (VIII) of section 1902(a)(10)(A)(i) by a man-
12 aged care entity, or other specified entity (as defined in
13 subparagraph (D)(iii)), that are treated as remittances be-
14 cause the State—

15 “(i) has satisfied the requirement of section
16 438.8 of title 42, Code of Federal Regulations (or
17 any successor regulation), by electing—

18 “(I) in the case of a State described in
19 subparagraph (C), to apply a minimum medical
20 loss ratio (as defined in subparagraph (D)(ii))
21 that is at least 85 percent but not greater than
22 the minimum medical loss ratio (as so defined)
23 that such State applied as of May 31, 2018; or

1 “(II) in the case of a State not described
2 in subparagraph (C), to apply a minimum med-
3 ical loss ratio that is equal to 85 percent; and
4 “(ii) recovered all or a portion of the expendi-
5 tures as a result of the entity’s failure to meet such
6 ratio.

7 “(C) For purposes of subparagraph (B), a State de-
8 scribed in this subparagraph is a State that as of May
9 31, 2018, applied a minimum medical loss ratio (as cal-
10 culated under subsection (d) of section 438.8 of title 42,
11 Code of Federal Regulations (as in effect on June 1,
12 2018)) for payment for services provided by entities de-
13 scribed in such subparagraph under the State plan under
14 this title (or a waiver of the plan) that is equal to or great-
15 er than 85 percent.

16 “(D) For purposes of this paragraph:

17 “(i) The term ‘managed care entity’ means a
18 medicaid managed care organization described in
19 section 1932(a)(1)(B)(i).

20 “(ii) The term ‘minimum medical loss ratio’
21 means, with respect to a State, a minimum medical
22 loss ratio (as calculated under subsection (d) of sec-
23 tion 438.8 of title 42, Code of Federal Regulations
24 (as in effect on June 1, 2018)) for payment for serv-
25 ices provided by entities described in subparagraph

1 (B) under the State plan under this title (or a waiv-
2 er of the plan).

3 “(iii) The term ‘other specified entity’ means—

4 “(I) a prepaid inpatient health plan, as de-
5 fined in section 438.2 of title 42, Code of Fed-
6 eral Regulations (or any successor regulation);
7 and

8 “(II) a prepaid ambulatory health plan, as
9 defined in such section (or any successor regu-
10 lation).”.

11 **SEC. 4002. REQUIRING REPORTING BY GROUP HEALTH**
12 **PLANS OF PRESCRIPTION DRUG COVERAGE**
13 **INFORMATION FOR PURPOSES OF IDENTI-**
14 **FYING PRIMARY PAYER SITUATIONS UNDER**
15 **THE MEDICARE PROGRAM.**

16 Clause (i) of section 1862(b)(7)(A) of the Social Se-
17 curity Act (42 U.S.C. 1395y(b)(7)(A)) is amended to read
18 as follows:

19 “(i) secure from the plan sponsor and
20 plan participants such information as the
21 Secretary shall specify for the purpose of
22 identifying situations where the group
23 health plan is or has been—

24 “(I) a primary plan to the pro-
25 gram under this title; or

1 “(II) for calendar quarters begin-
2 ning on or after January 1, 2020, a
3 primary payer with respect to benefits
4 relating to prescription drug coverage
5 under part D; and”.

6 **TITLE V—OTHER MEDICAID**
7 **PROVISIONS**

8 **Subtitle A—Mandatory Reporting**
9 **With Respect to Adult Behav-**
10 **ioral Health Measures**

11 **SEC. 5001. MANDATORY REPORTING WITH RESPECT TO**
12 **ADULT BEHAVIORAL HEALTH MEASURES.**

13 Section 1139B of the Social Security Act (42 U.S.C.
14 1320b–9b) is amended—

15 (1) in subsection (b)—

16 (A) in paragraph (3)—

17 (i) by striking “Not later than Janu-
18 ary 1, 2013” and inserting the following:

19 “(A) VOLUNTARY REPORTING.—Not later
20 than January 1, 2013”; and

21 (ii) by adding at the end the fol-
22 lowing:

23 “(B) MANDATORY REPORTING WITH RE-
24 SPECT TO BEHAVIORAL HEALTH MEASURES.—

25 Beginning with the State report required under

1 subsection (d)(1) for 2024, the Secretary shall
2 require States to use all behavioral health meas-
3 ures included in the core set of adult health
4 quality measures and any updates or changes to
5 such measures to report information, using the
6 standardized format for reporting information
7 and procedures developed under subparagraph
8 (A), regarding the quality of behavioral health
9 care for Medicaid eligible adults.”; and

10 (B) in paragraph (5), by adding at the end
11 the following new subparagraph:

12 “(C) BEHAVIORAL HEALTH MEASURES.—
13 Beginning with respect to State reports re-
14 quired under subsection (d)(1) for 2024, the
15 core set of adult health quality measures main-
16 tained under this paragraph (and any updates
17 or changes to such measures) shall include be-
18 havioral health measures.”; and

19 (2) in subsection (d)(1)(A)—

20 (A) by striking “the such plan” and insert-
21 ing “such plan”; and

22 (B) by striking “subsection (a)(5)” and in-
23 serting “subsection (b)(5) and, beginning with
24 the report for 2024, all behavioral health meas-
25 ures included in the core set of adult health

1 quality measures maintained under such sub-
2 section (b)(5) and any updates or changes to
3 such measures (as required under subsection
4 (b)(3))”.

5 **Subtitle B—Medicaid IMD** 6 **Additional Info**

7 **SEC. 5011. SHORT TITLE.**

8 This subtitle may be cited as the “Medicaid Institutes
9 for Mental Disease Are Decisive in Delivering Inpatient
10 Treatment for Individuals but Opportunities for Needed
11 Access are Limited without Information Needed about Fa-
12 cility Obligations Act” or the “Medicaid IMD ADDI-
13 TIONAL INFO Act”.

14 **SEC. 5012. MACPAC EXPLORATORY STUDY AND REPORT ON** 15 **INSTITUTIONS FOR MENTAL DISEASES RE-** 16 **QUIREMENTS AND PRACTICES UNDER MED-** 17 **ICAID.**

18 (a) IN GENERAL.—Not later than January 1, 2020,
19 the Medicaid and CHIP Payment and Access Commission
20 established under section 1900 of the Social Security Act
21 (42 U.S.C. 1396) shall conduct an exploratory study,
22 using data from a representative sample of States, and
23 submit to Congress a report on at least the following infor-
24 mation, with respect to services furnished to individuals
25 enrolled under State plans under the Medicaid program

1 under title XIX of such Act (42 U.S.C. 1396 et seq.) (or
2 waivers of such plans) who are patients in institutions for
3 mental diseases and for which payment is made through
4 fee-for-service or managed care arrangements under such
5 State plans (or waivers):

6 (1) A description of such institutions for mental
7 diseases in each such State, including at a min-
8 imum—

9 (A) the number of such institutions in the
10 State;

11 (B) the facility type of such institutions in
12 the State; and

13 (C) any coverage limitations under each
14 such State plan (or waiver) on scope, duration,
15 or frequency of such services.

16 (2) With respect to each such institution for
17 mental diseases in each such State, a description
18 of—

19 (A) such services provided at such institu-
20 tion;

21 (B) the process, including any timeframe,
22 used by such institution to clinically assess and
23 reassess such individuals; and

24 (C) the discharge process used by such in-
25 stitution, including any care continuum of rel-

1 evant services or facilities provided or used in
2 such process.

3 (3) A description of—

4 (A) any Federal waiver that each such
5 State has for such institutions and the Federal
6 statutory authority for such waiver; and

7 (B) any other Medicaid funding sources
8 used by each such State for funding such insti-
9 tutions, such as supplemental payments.

10 (4) A summary of State requirements (such as
11 certification, licensure, and accreditation) applied by
12 each such State to such institutions in order for
13 such institutions to receive payment under the State
14 plan (or waiver) and how each such State deter-
15 mines if such requirements have been met.

16 (5) A summary of State standards (such as
17 quality standards, clinical standards, and facility
18 standards) that such institutions must meet to re-
19 ceive payment under such State plans (or waivers)
20 and how each such State determines if such stand-
21 ards have been met.

22 (6) If determined appropriate by the Commis-
23 sion, recommendations for policies and actions by
24 Congress and the Centers for Medicare & Medicaid
25 Services, such as on how State Medicaid programs

1 may improve care and improve standards and in-
2 cluding a recommendation for how the Centers for
3 Medicare & Medicaid Services can improve data col-
4 lection from such programs to address any gaps in
5 information.

6 (b) **STAKEHOLDER INPUT.**—In carrying out sub-
7 section (a), the Medicaid and CHIP Payment and Access
8 Commission shall seek input from State Medicaid direc-
9 tors and stakeholders, including at a minimum the Sub-
10 stance Abuse and Mental Health Services Administration,
11 Centers for Medicare & Medicaid Services, State Medicaid
12 officials, State mental health authorities, Medicaid bene-
13 ficiary advocates, health care providers, and Medicaid
14 managed care organizations.

15 (c) **DEFINITIONS.**—In this section:

16 (1) **REPRESENTATIVE SAMPLE OF STATES.**—
17 The term “representative sample of States” means
18 a non-probability sample in which at least two
19 States are selected based on the knowledge and pro-
20 fessional judgment of the selector.

21 (2) **STATE.**—The term “State” means each of
22 the 50 States, the District of Columbia, and any
23 commonwealth or territory of the United States.

24 (3) **INSTITUTION FOR MENTAL DISEASES.**—The
25 term “institution for mental diseases” has the mean-

1 ing given such term in section 435.1009 of title 42,
2 Code of Federal Regulations, or any successor regu-
3 lation.

4 **Subtitle C—CHIP Mental Health**
5 **and Substance Use Disorder Parity**

6 **SEC. 5021. SHORT TITLE.**

7 This subtitle may be cited as the “CHIP Mental
8 Health and Substance Use Disorder Parity Act”.

9 **SEC. 5022. ENSURING ACCESS TO MENTAL HEALTH AND**
10 **SUBSTANCE USE DISORDER SERVICES FOR**
11 **CHILDREN AND PREGNANT WOMEN UNDER**
12 **THE CHILDREN’S HEALTH INSURANCE PRO-**
13 **GRAM.**

14 (a) IN GENERAL.—Section 2103(c)(1) of the Social
15 Security Act (42 U.S.C. 1397cc(e)(1)) is amended by add-
16 ing at the end the following new subparagraph:

17 “(E) Mental health and substance use dis-
18 order services (as defined in paragraph (5)).”.

19 (b) MENTAL HEALTH AND SUBSTANCE USE DIS-
20 ORDER SERVICES.—

21 (1) IN GENERAL.—Section 2103(c) of the So-
22 cial Security Act (42 U.S.C. 1397cc(e)) is amend-
23 ed—

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

4 (B) by inserting after paragraph (4) the
5 following new paragraph:

6 “(5) MENTAL HEALTH AND SUBSTANCE USE
7 DISORDER SERVICES.—Regardless of the type of cov-
8 erage elected by a State under subsection (a), child
9 health assistance provided under such coverage for
10 targeted low-income children and, in the case that
11 the State elects to provide pregnancy-related assist-
12 ance under such coverage pursuant to section 2112,
13 such pregnancy-related assistance for targeted low-
14 income pregnant women (as defined in section
15 2112(d)) shall—

16 “(A) include coverage of mental health
17 services (including behavioral health treatment)
18 necessary to prevent, diagnose, and treat a
19 broad range of mental health symptoms and
20 disorders, including substance use disorders;
21 and

22 “(B) be delivered in a culturally and lin-
23 guistically appropriate manner.”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 2103(a) of the Social Security
2 Act (42 U.S.C. 1397cc(a)) is amended, in the
3 matter before paragraph (1), by striking “para-
4 graphs (5), (6), and (7)” and inserting “para-
5 graphs (5), (6), (7), and (8)”.

6 (B) Section 2110(a) of the Social Security
7 Act (42 U.S.C. 1397jj(a)) is amended—

8 (i) in paragraph (18), by striking
9 “substance abuse” each place it appears
10 and inserting “substance use”; and

11 (ii) in paragraph (19), by striking
12 “substance abuse” and inserting “sub-
13 stance use”.

14 (C) Section 2110(b)(5)(A)(i) of the Social
15 Security Act (42 U.S.C. 1397jj(b)(5)(A)(i)) is
16 amended by striking “subsection (c)(5)” and in-
17 serting “subsection (c)(6)”.

18 (c) ASSURING ACCESS TO CARE.—Section
19 2102(a)(7)(B) of the Social Security Act (42 U.S.C.
20 1397bb(c)(2)) is amended by striking “section
21 2103(c)(5)” and inserting “paragraphs (5) and (6) of sec-
22 tion 2103(c)”.

23 (d) MENTAL HEALTH SERVICES PARITY.—Subpara-
24 graph (A) of paragraph (7) of section 2103(c) of the So-

1 cial Security Act (42 U.S.C. 1397cc(c)) (as redesignated
2 by subsection (b)(1)) is amended to read as follows:

3 “(A) IN GENERAL.—A State child health
4 plan shall ensure that the financial require-
5 ments and treatment limitations applicable to
6 mental health and substance use disorder serv-
7 ices (as described in paragraph (5)) provided
8 under such plan comply with the requirements
9 of section 2726(a) of the Public Health Service
10 Act in the same manner as such requirements
11 or limitations apply to a group health plan
12 under such section.”.

13 (e) EFFECTIVE DATE.—

14 (1) IN GENERAL.—Subject to paragraph (2),
15 the amendments made by this section shall take ef-
16 fect with respect to child health assistance provided
17 on or after the date that is 1 year after the date of
18 the enactment of this Act.

19 (2) EXCEPTION FOR STATE LEGISLATION.—In
20 the case of a State child health plan under title XXI
21 of the Social Security Act (or a waiver of such plan),
22 which the Secretary of Health and Human Services
23 determines requires State legislation in order for the
24 respective plan (or waiver) to meet any requirement
25 imposed by the amendments made by this section,

1 the respective plan (or waiver) shall not be regarded
2 as failing to comply with the requirements of such
3 title solely on the basis of its failure to meet such
4 an additional requirement before the first day of the
5 first calendar quarter beginning after the close of
6 the first regular session of the State legislature that
7 begins after the date of enactment of this section.
8 For purposes of the previous sentence, in the case
9 of a State that has a 2-year legislative session, each
10 year of the session shall be considered to be a sepa-
11 rate regular session of the State legislature.

12 **Subtitle D—Medicaid Reentry**

13 **SEC. 5031. SHORT TITLE.**

14 This subtitle may be cited as the “Medicaid Reentry
15 Act”.

16 **SEC. 5032. PROMOTING STATE INNOVATIONS TO EASE** 17 **TRANSITIONS INTEGRATION TO THE COMMU-** 18 **NITY FOR CERTAIN INDIVIDUALS.**

19 (a) **STAKEHOLDER GROUP DEVELOPMENT OF BEST**
20 **PRACTICES; STATE MEDICAID PROGRAM INNOVATION.—**

21 (1) **STAKEHOLDER GROUP BEST PRACTICES.—**

22 Not later than 6 months after the date of the enact-
23 ment of this Act, the Secretary of Health and
24 Human Services shall convene a stakeholder group
25 of representatives of managed care organizations,

1 Medicaid beneficiaries, health care providers, the
2 National Association of Medicaid Directors, and
3 other relevant representatives from local, State, and
4 Federal jail and prison systems to develop best prac-
5 tices (and submit to the Secretary and Congress a
6 report on such best practices) for States—

7 (A) to ease the health care-related transi-
8 tion of an individual who is an inmate of a pub-
9 lic institution from the public institution to the
10 community, including best practices for ensur-
11 ing continuity of health insurance coverage or
12 coverage under the State Medicaid plan under
13 title XIX of the Social Security Act, as applica-
14 ble, and relevant social services; and

15 (B) to carry out, with respect to such an
16 individual, such health care-related transition
17 not later than 30 days after such individual is
18 released from the public institution.

19 (2) STATE MEDICAID PROGRAM INNOVATION.—
20 The Secretary of Health and Human Services shall
21 work with States on innovative strategies to help in-
22 dividuals who are inmates of public institutions and
23 otherwise eligible for medical assistance under the
24 Medicaid program under title XIX of the Social Se-
25 curity Act transition, with respect to enrollment for

1 medical assistance under such program, seamlessly
2 to the community.

3 (b) GUIDANCE ON INNOVATIVE SERVICE DELIVERY
4 SYSTEMS DEMONSTRATION PROJECT OPPORTUNITIES.—
5 Not later than 1 year after the date of the enactment of
6 this Act, the Secretary of Health and Human Services,
7 through the Administrator of the Centers for Medicare &
8 Medicaid Services, shall issue a State Medicaid Director
9 letter, based on best practices developed under subsection
10 (a)(1), regarding opportunities to design demonstration
11 projects under section 1115 of the Social Security Act (42
12 U.S.C. 1315) to improve care transitions for certain indi-
13 viduals who are soon-to-be former inmates of a public in-
14 stitution and who are otherwise eligible to receive medical
15 assistance under title XIX of such Act, including systems
16 for, with respect to a period (not to exceed 30 days) imme-
17 diately prior to the day on which such individuals are ex-
18 pected to be released from such institution—

19 (1) providing assistance and education for en-
20 rollment under a State plan under the Medicaid pro-
21 gram under title XIX of such Act for such individ-
22 uals during such period; and

23 (2) providing health care services for such indi-
24 viduals during such period.

1 (c) RULE OF CONSTRUCTION.—Nothing under title
2 XIX of the Social Security Act or any other provision of
3 law precludes a State from reclassifying or suspending
4 (rather than terminating) eligibility of an individual for
5 medical assistance under title XIX of the Social Security
6 Act while such individual is an inmate of a public institu-
7 tion.

8 **Subtitle E—Medicaid Partnership**

9 **SEC. 5041. SHORT TITLE.**

10 This subtitle may be cited as the “Medicaid Providers
11 Are Required To Note Experiences in Record Systems to
12 Help In-need Patients Act” or the “Medicaid PARTNER-
13 SHIP Act”.

14 **SEC. 5042. MEDICAID PROVIDERS ARE REQUIRED TO NOTE**

15 **EXPERIENCES IN RECORD SYSTEMS TO HELP**

16 **IN-NEED PATIENTS.**

17 (a) REQUIREMENTS UNDER THE MEDICAID PRO-
18 GRAM RELATING TO QUALIFIED PRESCRIPTION DRUG
19 MONITORING PROGRAMS AND PRESCRIBING CERTAIN
20 CONTROLLED SUBSTANCES.—Title XIX of the Social Se-
21 curity Act (42 U.S.C. 1396 et seq.) is amended by insert-
22 ing after section 1943 the following new section:

1 **“SEC. 1944. REQUIREMENTS RELATING TO QUALIFIED PRE-**
2 **SCRIPTION DRUG MONITORING PROGRAMS**
3 **AND PRESCRIBING CERTAIN CONTROLLED**
4 **SUBSTANCES.**

5 “(a) IN GENERAL.—Subject to subsection (d), begin-
6 ning October 1, 2021, a State—

7 “(1) shall require each covered provider to
8 check, in accordance with such timing, manner, and
9 form as specified by the State, the prescription drug
10 history of a covered individual being treated by the
11 covered provider through a qualified prescription
12 drug monitoring program described in subsection (b)
13 before prescribing to such individual a controlled
14 substance; and

15 “(2) in the case that such a provider is not able
16 to conduct such a check despite a good faith effort
17 by such provider—

18 “(A) shall require the provider to docu-
19 ment such good faith effort, including the rea-
20 sons why the provider was not able to conduct
21 the check; and

22 “(B) may require the provider to submit,
23 upon request, such documentation to the State.

24 “(b) QUALIFIED PRESCRIPTION DRUG MONITORING
25 PROGRAM DESCRIBED.—A qualified prescription drug
26 monitoring program described in this subsection is, with

1 respect to a State, a prescription drug monitoring pro-
2 gram administered by the State that, at a minimum, satis-
3 fies each of the following criteria:

4 “(1) The program facilitates access by a cov-
5 ered provider to, at a minimum, the following infor-
6 mation with respect to a covered individual, in as
7 close to real-time as possible:

8 “(A) Information regarding the prescrip-
9 tion drug history of a covered individual with
10 respect to controlled substances.

11 “(B) The number and type of controlled
12 substances prescribed to and filled for the cov-
13 ered individual during at least the most recent
14 12-month period.

15 “(C) The name, location, and contact in-
16 formation (or other identifying number selected
17 by the State, such as a national provider identi-
18 fier issued by the National Plan and Provider
19 Enumeration System of the Centers for Medi-
20 care & Medicaid Services) of each covered pro-
21 vider who prescribed a controlled substance to
22 the covered individual during at least the most
23 recent 12-month period.

24 “(2) The program facilitates the integration of
25 information described in paragraph (1) into the

1 workflow of a covered provider, which may include
2 the electronic system the covered provider uses to
3 prescribe controlled substances.

4 A qualified prescription drug monitoring program de-
5 scribed in this subsection, with respect to a State, may
6 have in place, in accordance with applicable State and
7 Federal law, a data-sharing agreement with the State
8 Medicaid program that allows the medical director and
9 pharmacy director of such program (and any designee of
10 such a director who reports directly to such director) to
11 access the information described in paragraph (1) in an
12 electronic format. The State Medicaid program under this
13 title may facilitate reasonable and limited access, as deter-
14 mined by the State and ensuring documented beneficiary
15 protections regarding the use of such data, to such quali-
16 fied prescription drug monitoring program for the medical
17 director or pharmacy director of any managed care entity
18 (as defined under section 1932(a)(1)(B)) that has a con-
19 tract with the State under section 1903(m) or under sec-
20 tion 1905(t)(3), or the medical director or pharmacy direc-
21 tor of any entity that has a contract to manage the phar-
22 maceutical benefit with respect to individuals enrolled in
23 the State plan (or under a waiver of the State plan). All
24 applicable State and Federal security and privacy laws
25 shall apply to the directors or designees of such directors

1 of any State Medicaid program or entity accessing a quali-
2 fied prescription drug monitoring program under this sec-
3 tion.

4 “(c) APPLICATION OF PRIVACY RULES CLARIFICA-
5 TION.—The Secretary shall clarify privacy requirements,
6 including requirements under the regulations promulgated
7 pursuant to section 264(c) of the Health Insurance Port-
8 ability and Accountability Act of 1996 (42 U.S.C. 1320d–
9 2 note), related to the sharing of data under subsection
10 (b) in the same manner as the Secretary is required under
11 subparagraph (J) of section 1860D–4(c)(5) to clarify pri-
12 vacy requirements related to the sharing of data described
13 in such subparagraph.

14 “(d) ENSURING ACCESS.—In order to ensure reason-
15 able access to health care, the Secretary shall waive the
16 application of the requirement under subsection (a), with
17 respect to a State, in the case of natural disasters and
18 similar situations, and in the case of the provision of emer-
19 gency services (as defined for purposes of section 1860D–
20 4(c)(5)(D)(ii)(II)).

21 “(e) REPORTS.—

22 “(1) STATE REPORTS.—Each State shall in-
23 clude in the annual report submitted to the Sec-
24 retary under section 1927(g)(3)(D), beginning with
25 such reports submitted for 2023, information includ-

1 ing, at a minimum, the following information for the
2 most recent 12-month period:

3 “(A) The percentage of covered providers
4 (as determined pursuant to a process estab-
5 lished by the State) who checked the prescrip-
6 tion drug history of a covered individual
7 through a qualified prescription drug moni-
8 toring program described in subsection (b) be-
9 fore prescribing to such individual a controlled
10 substance.

11 “(B) Aggregate trends with respect to pre-
12 scribing controlled substances such as—

13 “(i) the quantity of daily morphine
14 milligram equivalents prescribed for con-
15 trolled substances;

16 “(ii) the number and quantity of daily
17 morphine milligram equivalents prescribed
18 for controlled substances per covered indi-
19 vidual; and

20 “(iii) the types of controlled sub-
21 stances prescribed, including the dates of
22 such prescriptions, the supplies authorized
23 (including the duration of such supplies),
24 and the period of validity of such prescrip-
25 tions, in different populations (such as in-

1 dividuals who are elderly, individuals with
2 disabilities, and individuals who are en-
3 rolled under both this title and title
4 XVIII).

5 “(C) Whether or not the State requires
6 (and a detailed explanation as to why the State
7 does or does not require) pharmacists to check
8 the prescription drug history of a covered indi-
9 vidual through a qualified prescription drug
10 monitoring program described in subsection (b)
11 before dispensing a controlled substance to such
12 individual.

13 “(D) An accounting of any data or privacy
14 breach of a qualified prescription drug moni-
15 toring program described in subsection (b), the
16 number of covered individuals impacted by each
17 such breach, and a description of the steps the
18 State has taken to address each such breach,
19 including, to the extent required by State or
20 Federal law or otherwise determined appro-
21 priate by the State, alerting any such impacted
22 individual and law enforcement of the breach.

23 “(2) REPORT BY CMS.—Not later than October
24 1, 2023, the Administrator of the Centers for Medi-
25 care & Medicaid Services shall publish on the pub-

1 licly available website of the Centers for Medicare &
2 Medicaid Services a report including the following
3 information:

4 “(A) Guidance for States on how States
5 can increase the percentage of covered providers
6 who use qualified prescription drug monitoring
7 programs described in subsection (b).

8 “(B) Best practices for how States and
9 covered providers should use such qualified pre-
10 scription drug monitoring programs to reduce
11 the occurrence of abuse of controlled sub-
12 stances.

13 “(f) INCREASE TO FMAP AND FEDERAL MATCHING
14 RATES FOR CERTAIN EXPENDITURES RELATING TO
15 QUALIFIED PRESCRIPTION DRUG MONITORING PRO-
16 GRAMS.—

17 “(1) IN GENERAL.—With respect to a State
18 that meets the condition described in paragraph (2)
19 and any quarter occurring during fiscal year 2019
20 or fiscal year 2020, the Federal medical assistance
21 percentage or Federal matching rate that would oth-
22 erwise apply to such State under section 1903(a) for
23 such quarter, with respect to expenditures by the
24 State for activities under the State plan (or a waiver
25 of such plan) to design, develop, or implement a pre-

1 prescription drug monitoring program (and to make
2 connections to such program) that satisfies the cri-
3 teria described in paragraphs (1) and (2) of sub-
4 section (b), shall be equal to 100 percent.

5 “(2) CONDITION.—The condition described in
6 this paragraph, with respect to a State, is that the
7 State (in this paragraph referred to as the ‘admin-
8 istering State’) has in place agreements with all
9 States that are contiguous to such administering
10 State that, when combined, enable covered providers
11 in all such contiguous States to access, through the
12 prescription drug monitoring program, the informa-
13 tion that is described in subsection (b)(1) of covered
14 individuals of such administering State and that cov-
15 ered providers in such administering State are able
16 to access through such program.

17 “(g) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion prevents a State from requiring pharmacists to check
19 the prescription drug history of covered individuals
20 through a qualified prescription drug monitoring program
21 before dispensing controlled substances to such individ-
22 uals.

23 “(h) DEFINITIONS.—In this section:

24 “(1) CONTROLLED SUBSTANCE.—The term
25 ‘controlled substance’ means a drug that is included

1 in schedule II of section 202(c) of the Controlled
2 Substances Act and, at the option of the State in-
3 volved, a drug included in schedule III or IV of such
4 section.

5 “(2) COVERED INDIVIDUAL.—The term ‘cov-
6 ered individual’ means, with respect to a State, an
7 individual who is enrolled in the State plan (or
8 under a waiver of such plan). Such term does not in-
9 clude an individual who—

10 “(A) is receiving—

11 “(i) hospice or palliative care; or

12 “(ii) treatment for cancer;

13 “(B) is a resident of a long-term care facil-
14 ity, of a facility described in section 1905(d), or
15 of another facility for which frequently abused
16 drugs are dispensed for residents through a
17 contract with a single pharmacy; or

18 “(C) the State elects to treat as exempted
19 from such term.

20 “(3) COVERED PROVIDER.—

21 “(A) IN GENERAL.—The term ‘covered
22 provider’ means, subject to subparagraph (B),
23 with respect to a State, a health care provider
24 who is participating under the State plan (or
25 waiver of the State plan) and licensed, reg-

1 istered, or otherwise permitted by the State to
2 prescribe a controlled substance (or the des-
3 ignee of such provider).

4 “(B) EXCEPTIONS.—

5 “(i) IN GENERAL.—Beginning Octo-
6 ber 1, 2021, for purposes of this section,
7 such term does not include a health care
8 provider included in any type of health
9 care provider determined by the Secretary
10 to be exempt from application of this sec-
11 tion under clause (ii).

12 “(ii) EXCEPTIONS PROCESS.—Not
13 later than October 1, 2020, the Secretary,
14 after consultation with the National Asso-
15 ciation of Medicaid Directors, national
16 health care provider associations, Medicaid
17 beneficiary advocates, and advocates for in-
18 dividuals with rare diseases, shall deter-
19 mine, based on such consultations, the
20 types of health care providers (if any) that
21 should be exempted from the definition of
22 the term ‘covered provider’ for purposes of
23 this section.”.

24 (b) GUIDANCE.—Not later than October 1, 2019, the
25 Administrator of the Centers for Medicare & Medicaid

1 Services, in consultation with the Director of the Centers
2 for Disease Control and Prevention, shall issue guidance
3 on best practices on the uses of prescription drug moni-
4 toring programs required of prescribers and on protecting
5 the privacy of Medicaid beneficiary information main-
6 tained in and accessed through prescription drug moni-
7 toring programs.

8 (c) DEVELOPMENT OF MODEL STATE PRACTICES.—

9 (1) IN GENERAL.—Not later than October 1,
10 2020, the Secretary of Health and Human Services
11 shall develop and publish model practices to assist
12 State Medicaid program operations in identifying
13 and implementing strategies to utilize data-sharing
14 agreements described in the matter following para-
15 graph (2) of section 1944(b) of the Social Security
16 Act, as added by subsection (a), for the following
17 purposes:

18 (A) Monitoring and preventing fraud,
19 waste, and abuse.

20 (B) Improving health care for individuals
21 enrolled in a State plan under title XIX of such
22 Act (or under a waiver of such plan) who—

23 (i) transition in and out of coverage
24 under such title;

1 (ii) may have sources of health care
2 coverage in addition to coverage under
3 such title; or

4 (iii) pay for prescription drugs with
5 cash.

6 (C) Any other purposes specified by the
7 Secretary.

8 (2) ELEMENTS OF MODEL PRACTICES.—The
9 model practices described in paragraph (1)—

10 (A) shall include strategies for assisting
11 States in allowing the medical director or phar-
12 macy director (or designees of such a director)
13 of managed care organizations or pharma-
14 ceutical benefit managers to access information
15 with respect to all covered individuals served by
16 such managed care organizations or pharma-
17 ceutical benefit managers to access as a single
18 data set, in an electronic format; and

19 (B) shall include any appropriate bene-
20 ficiary protections and privacy guidelines.

21 (3) CONSULTATION.—In developing model prac-
22 tices under this subsection, the Secretary shall con-
23 sult with the National Association of Medicaid Di-
24 rectors, managed care entities (as defined in section
25 1932(a)(1)(B) of the Social Security Act) with con-

1 tracts with States pursuant to section 1903(m) of
2 such Act, pharmaceutical benefit managers, physi-
3 cians and other health care providers, beneficiary
4 advocates, and individuals with expertise in health
5 care technology related to prescription drug moni-
6 toring programs and electronic health records.

7 (d) REPORT BY COMPTROLLER GENERAL.—Not later
8 than October 1, 2020, the Comptroller General of the
9 United States shall issue a report examining the operation
10 of prescription drug monitoring programs administered by
11 States, including data security and access standards used
12 by such programs.

13 **Subtitle F—IMD CARE Act**

14 **SEC. 5051. SHORT TITLE.**

15 This title may be cited as the “Individuals in Med-
16 icaid Deserve Care that is Appropriate and Responsible
17 in its Execution Act” or the “IMD CARE Act”.

18 **SEC. 5052. STATE OPTION TO PROVIDE MEDICAID COV- 19 ERAGE FOR CERTAIN INDIVIDUALS WITH 20 SUBSTANCE USE DISORDERS WHO ARE PA- 21 TIENTS IN CERTAIN INSTITUTIONS FOR MEN- 22 TAL DISEASES.**

23 (a) IN GENERAL.—Title XIX of the Social Security
24 Act (42 U.S.C. 1396 et seq.), as amended by preceding
25 sections of this Act, is further amended—

1 (1) in section 1905(a), in the subdivision (B)
2 that follows paragraph (30), by inserting “(except in
3 the case of services provided under a State plan
4 amendment described in section 1915(l))” before the
5 period; and

6 (2) in section 1915, by adding at the end the
7 following new subsection:

8 “(1) STATE PLAN AMENDMENT OPTION TO PROVIDE
9 MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS WHO
10 ARE PATIENTS IN CERTAIN INSTITUTIONS FOR MENTAL
11 DISEASES.—

12 “(1) IN GENERAL.—With respect to calendar
13 quarters beginning during the period beginning Oc-
14 tober 1, 2019, and ending September 30, 2023, a
15 State may elect, through a State plan amendment,
16 to provide medical assistance for items and services
17 furnished to an eligible individual who is a patient
18 in an eligible institution for mental diseases in ac-
19 cordance with the requirements of this subsection.

20 “(2) PAYMENTS.—Subject to paragraphs (3)
21 and (4), amounts expended under a State plan
22 amendment under paragraph (1) for services de-
23 scribed in such paragraph furnished, with respect to
24 a 12-month period, to an eligible individual who is
25 a patient in an eligible institution for mental dis-

1 eases shall be treated as medical assistance for
2 which payment is made under section 1903(a) but
3 only to the extent that such services are furnished
4 for not more than a period of 30 days (whether or
5 not consecutive) during such 12-month period.

6 “(3) MAINTENANCE OF EFFORT.—

7 “(A) IN GENERAL.—As a condition for a
8 State receiving payments under section 1903(a)
9 for medical assistance provided in accordance
10 with this subsection, the State shall (during the
11 period in which it so furnished such medical as-
12 sistance through a State plan amendment under
13 this subsection) maintain on an annual basis a
14 level of funding expended by the State (and po-
15 litical subdivisions thereof) other than under
16 this title from non-Federal funds for—

17 “(i) items and services furnished to el-
18 igible individuals who are patients in eligi-
19 ble institutions for mental diseases that is
20 not less than the level of such funding for
21 such items and services for the most re-
22 cently ended fiscal year as of the date of
23 enactment of this subsection or, if higher,
24 for the most recently ended fiscal year as
25 of the date the State submits a State plan

1 amendment to the Secretary to provide
2 such medical assistance in accordance with
3 this subsection; and

4 “(ii) items and services (including
5 services described in subparagraph (B))
6 furnished to eligible individuals in out-
7 patient and community-based settings that
8 is not less than the level of such funding
9 for such items and services for the most
10 recently ended fiscal year as of the date of
11 enactment of this subsection or, if higher,
12 for the most recently ended fiscal year as
13 of the date the State submits a State plan
14 amendment to the Secretary to provide
15 such medical assistance in accordance with
16 this subsection.

17 “(B) SERVICES DESCRIBED.—For pur-
18 poses of subparagraph (A)(ii), services de-
19 scribed in this subparagraph are the following:

20 “(i) Outpatient and community-based
21 substance use disorder treatment.

22 “(ii) Evidence-based recovery and sup-
23 port services.

24 “(iii) Clinically-directed therapeutic
25 treatment to facilitate recovery skills, re-

1 lapse prevention, and emotional coping
2 strategies.

3 “(iv) Outpatient medication-assisted
4 treatment, related therapies, and pharma-
5 cology.

6 “(v) Counseling and clinical moni-
7 toring.

8 “(vi) Outpatient withdrawal manage-
9 ment and related treatment designed to al-
10 leviate acute emotional, behavioral, cog-
11 nitive, or biomedical distress resulting
12 from, or occurring with, an individual’s use
13 of alcohol and other drugs.

14 “(vii) Routine monitoring of medica-
15 tion adherence.

16 “(viii) Other outpatient and commu-
17 nity-based services for the treatment of
18 substance use disorders, as designated by
19 the Secretary.

20 “(C) STATE REPORTING REQUIREMENT.—

21 “(i) IN GENERAL.—Prior to approval
22 of a State plan amendment under this sub-
23 section, as a condition for a State receiving
24 payments under section 1903(a) for med-
25 ical assistance provided in accordance with

1 this subsection, the State shall report to
2 the Secretary, in accordance with the proc-
3 ess established by the Secretary under
4 clause (ii), the information deemed nec-
5 essary by the Secretary under such clause.

6 “(ii) PROCESS.—Not later than the
7 date that is 8 months after the date of en-
8 actment of this subsection, the Secretary
9 shall establish a process for States to re-
10 port to the Secretary, at such time and in
11 such manner as the Secretary deems ap-
12 propriate, such information as the Sec-
13 retary deems necessary to verify a State’s
14 compliance with subparagraph (A).

15 “(4) ENSURING A CONTINUUM OF SERVICES.—

16 “(A) IN GENERAL.—As a condition for a
17 State receiving payments under section 1903(a)
18 for medical assistance provided in accordance
19 with this subsection, the State shall carry out
20 each of the requirements described in subpara-
21 graphs (B) through (D).

22 “(B) NOTIFICATION.—Prior to approval of
23 a State plan amendment under this subsection,
24 the State shall notify the Secretary of how the
25 State will ensure that eligible individuals receive

1 appropriate evidence-based clinical screening
2 prior to being furnished with items and services
3 in an eligible institution for mental diseases, in-
4 cluding initial and periodic assessments to de-
5 termine the appropriate level of care, length of
6 stay, and setting for such care for each indi-
7 vidual.

8 “(C) OUTPATIENT SERVICES; INPATIENT
9 AND RESIDENTIAL SERVICES.—

10 “(i) OUTPATIENT SERVICES.—The
11 State shall, at a minimum, provide medical
12 assistance for services that could otherwise
13 be covered under the State plan, consistent
14 with each of the following outpatient levels
15 of care:

16 “(I) Early intervention for indi-
17 viduals who, for a known reason, are
18 at risk of developing substance-related
19 problems and for individuals for whom
20 there is not yet sufficient information
21 to document a diagnosable substance
22 use disorder.

23 “(II) Outpatient services for less
24 than 9 hours per week for adults, and
25 for less than 6 hours per week for

1 adolescents, for recovery or motiva-
2 tional enhancement therapies and
3 strategies.

4 “(III) Intensive outpatient serv-
5 ices for 9 hours or more per week for
6 adults, and for 6 hours or more per
7 week for adolescents, to treat multi-
8 dimensional instability.

9 “(IV) Partial hospitalization
10 services for 20 hours or more per
11 week for adults and adolescents to
12 treat multidimensional instability that
13 does not require 24-hour care.

14 “(ii) INPATIENT AND RESIDENTIAL
15 SERVICES.—The State shall provide med-
16 ical assistance for services that could oth-
17 erwise be covered under the State plan,
18 consistent with at least 2 of the following
19 inpatient and residential levels of care:

20 “(I) Clinically managed, low-in-
21 tensity residential services that pro-
22 vide adults and adolescents with 24-
23 hour living support and structure with
24 trained personnel and at least 5 hours

1 of clinical service per week per indi-
2 vidual.

3 “(II) Clinically managed, popu-
4 lation-specific, high-intensity residen-
5 tial services that provide adults with
6 24-hour care with trained counselors
7 to stabilize multidimensional immi-
8 nent danger along with less intense
9 milieu and group treatment for those
10 with cognitive or other impairments
11 unable to use full active milieu or
12 therapeutic community.

13 “(III) Clinically managed, me-
14 dium-intensity residential services for
15 adolescents, and clinically managed,
16 high-intensity residential services for
17 adults, that provide 24-hour care with
18 trained counselors to stabilize multi-
19 dimensional imminent danger and
20 preparation for outpatient treatment.

21 “(IV) Medically monitored, high-
22 intensity inpatient services for adoles-
23 cents, and medically monitored, inten-
24 sive inpatient services withdrawal
25 management for adults, that provide

1 24-hour nursing care, make physi-
2 cians available for significant prob-
3 lems in Dimensions 1, 2, or 3, and
4 provide counseling services 16 hours
5 per day.

6 “(V) Medically managed, inten-
7 sive inpatient services for adolescents
8 and adults that provide 24-hour nurs-
9 ing care and daily physician care for
10 severe, unstable problems in Dimen-
11 sions 1, 2 or 3.

12 “(D) TRANSITION OF CARE.—In order to
13 ensure an appropriate transition for an eligible
14 individual from receiving care in an eligible in-
15 stitution for mental diseases to receiving care at
16 a lower level of clinical intensity within the con-
17 tinuum of care (including outpatient services),
18 the State shall ensure that—

19 “(i) a placement in such eligible insti-
20 tution for mental diseases would allow for
21 an eligible individual’s successful transition
22 to the community, considering such factors
23 as proximity to an individual’s support net-
24 work (such as family members, employ-

1 ment, and counseling and other services
2 near an individual’s residence); and

3 “(ii) all eligible institutions for mental
4 diseases that furnish items and services to
5 individuals for which medical assistance is
6 provided under the State plan—

7 “(I) are able to provide care at
8 such lower level of clinical intensity;
9 or

10 “(II) have an established rela-
11 tionship with another facility or pro-
12 vider that is able to provide care at
13 such lower level of clinical intensity
14 and accepts patients receiving medical
15 assistance under this title under which
16 the eligible institution for mental dis-
17 eases may arrange for individuals to
18 receive such care from such other fa-
19 cility or provider.

20 “(5) APPLICATION TO MANAGED CARE.—Pay-
21 ments for, and limitations to, medical assistance fur-
22 nished in accordance with this subsection shall be in
23 addition to and shall not be construed to limit or su-
24 persede the ability of States to make monthly capita-
25 tion payments to managed care organizations for in-

1 dividuals receiving treatment in institutions for men-
2 tal diseases in accordance with section 438.6(e) of
3 title 42, Code of Federal Regulations (or any suc-
4 cessor regulation).

5 “(6) OTHER MEDICAL ASSISTANCE.—The provi-
6 sion of medical assistance for items and services fur-
7 nished to an eligible individual who is a patient in
8 an eligible institution for mental diseases in accord-
9 ance with the requirements of this subsection shall
10 not prohibit Federal financial participation for med-
11 ical assistance for items or services that are provided
12 to such eligible individual in or away from the eligi-
13 ble institution for mental disease during any period
14 in which the eligible individual is receiving items or
15 services in accordance with this subsection.

16 “(7) DEFINITIONS.—In this subsection:

17 “(A) DIMENSIONS 1, 2, OR 3.—The term
18 ‘Dimensions 1, 2, or 3’ has the meaning given
19 that term for purposes of the publication of the
20 American Society of Addiction Medicine entitled
21 ‘The ASAM Criteria: Treatment Criteria for
22 Addictive Substance-Related, and Co-Occurring
23 Conditions, 2013’.

24 “(B) ELIGIBLE INDIVIDUAL.—The term
25 ‘eligible individual’ means an individual who—

1 “(i) with respect to a State, is en-
2 rolled for medical assistance under the
3 State plan or a waiver of such plan;

4 “(ii) is at least 21 years of age;

5 “(iii) has not attained 65 years of
6 age; and

7 “(iv) has at least 1 substance use dis-
8 order.

9 “(C) ELIGIBLE INSTITUTION FOR MENTAL
10 DISEASES.—The term ‘eligible institution for
11 mental diseases’ means an institution for men-
12 tal diseases that—

13 “(i) follows reliable, evidence-based
14 practices; and

15 “(ii) offers at least 2 forms of medica-
16 tion-assisted treatment for substance use
17 disorders on site, including, in the case of
18 medication-assisted treatment for opioid
19 use disorder, at least 1 antagonist and 1
20 partial agonist.

21 “(D) INSTITUTION FOR MENTAL DIS-
22 EASES.—The term ‘institution for mental dis-
23 eases’ has the meaning given that term in sec-
24 tion 1905(i).”.

1 (b) RULE OF CONSTRUCTION.—Nothing in the
2 amendments made by subsection (a) shall be construed as
3 encouraging a State to place an individual in an inpatient
4 or a residential care setting where a home or community-
5 based care setting would be more appropriate for the indi-
6 vidual, or as preventing a State from conducting or pur-
7 suing a demonstration project under section 1115 of the
8 Social Security Act to improve access to, and the quality
9 of, substance use disorder treatment for eligible popu-
10 lations.

11 **TITLE VI—OTHER MEDICARE**
12 **PROVISIONS**

13 **Subtitle A—Testing of Incentive**
14 **Payments for Behavioral Health**
15 **Providers for Adoption and Use**
16 **of Certified Electronic Health**
17 **Record Technology**

18 **SEC. 6001. TESTING OF INCENTIVE PAYMENTS FOR BEHAV-**
19 **IORAL HEALTH PROVIDERS FOR ADOPTION**
20 **AND USE OF CERTIFIED ELECTRONIC**
21 **HEALTH RECORD TECHNOLOGY.**

22 Section 1115A(b)(2)(B) of the Social Security Act
23 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
24 end the following new clause:

1 “(xxv) Providing, for the adoption and
2 use of certified EHR technology (as de-
3 fined in section 1848(o)(4)) to improve the
4 quality and coordination of care through
5 the electronic documentation and exchange
6 of health information, incentive payments
7 to behavioral health providers (such as
8 psychiatric hospitals (as defined in section
9 1861(f)), community mental health centers
10 (as defined in section 1861(ff)(3)(B)), hos-
11 pitals that participate in a State plan
12 under title XIX or a waiver of such plan,
13 treatment facilities that participate in such
14 a State plan or such a waiver, mental
15 health or substance use disorder providers
16 that participate in such a State plan or
17 such a waiver, clinical psychologists (as de-
18 fined in section 1861(ii)), nurse practi-
19 tioners (as defined in section 1861(aa)(5))
20 with respect to the provision of psychiatric
21 services, and clinical social workers (as de-
22 fined in section 1861(hh)(1))).”.

1 **Subtitle B—Abuse Deterrent Access**

2 **SEC. 6011. SHORT TITLE.**

3 This subtitle may be cited at the “Abuse Deterrent
4 Access Act of 2018”.

5 **SEC. 6012. STUDY ON ABUSE-DETERRENT OPIOID FORMU-** 6 **LATIONS ACCESS BARRIERS UNDER MEDI-** 7 **CARE.**

8 (a) IN GENERAL.—Not later than 1 year after the
9 date of the enactment of this Act, the Secretary of Health
10 and Human Services shall conduct a study and submit to
11 Congress a report on—

12 (1) the adequacy of access to abuse-deterrent
13 opioid formulations for individuals with chronic pain
14 enrolled in an MA–PD plan under part C of title
15 XVIII of the Social Security Act or a prescription
16 drug plan under part D of such title of such Act,
17 taking into account any barriers preventing such in-
18 dividuals from accessing such formulations under
19 such MA–PD or part D plans, such as cost-sharing
20 tiers, fail-first requirements, the price of such for-
21 mulations, and prior authorization requirements;
22 and

23 (2) the effectiveness of abuse-deterrent opioid
24 formulations in preventing opioid abuse or misuse;
25 the impact of the use of abuse-deterrent opioid for-

1 mulations on the use or abuse of other prescription
2 or illicit opioids (including changes in deaths from
3 such opioids); and other public health consequences
4 of the use of abuse-deterrent opioid formulations,
5 such as an increase in rates of human immuno-
6 deficiency virus.

7 (b) DEFINITION OF ABUSE-DETERRENT OPIOID
8 FORMULATION.—In this section, the term “abuse-deter-
9 rent opioid formulation” means an opioid that is a
10 prodrug or that has certain abuse-deterrent properties,
11 such as physical or chemical barriers, agonist or antago-
12 nist combinations, aversion properties, delivery system
13 mechanisms, or other features designed to prevent abuse
14 of such opioid.

15 **Subtitle C—Medicare Opioid Safety** 16 **Education**

17 **SEC. 6021. MEDICARE OPIOID SAFETY EDUCATION.**

18 (a) IN GENERAL.—Section 1804 of the Social Secu-
19 rity Act (42 U.S.C. 1395b–2) is amended by adding at
20 the end the following new subsection:

21 “(d) The notice provided under subsection (a) shall
22 include—

23 “(1) references to educational resources regard-
24 ing opioid use and pain management;

1 sive Addiction and Recovery Act of 2016 (Public Law
2 114–198), shall develop an action plan as described in
3 subsection (b).

4 (b) ACTION PLAN COMPONENTS.—The action plan
5 shall include a review by the Secretary of Medicare and
6 Medicaid payment and coverage policies that may be
7 viewed as potential obstacles to an effective response to
8 the opioid crisis, and recommendations, as determined ap-
9 propriate by the Secretary, on the following:

10 (1) A review of payment and coverage policies
11 under the Medicare program under title XVIII of
12 the Social Security Act and the Medicaid program
13 under title XIX of such Act, including a review of
14 coverage and payment under such programs of all
15 medication-assisted treatment approved by the Food
16 and Drug Administration related to the treatment of
17 opioid use disorder and other therapies that manage
18 chronic and acute pain and treat and minimize risk
19 of opioid misuse and abuse, including in such review,
20 payment under the Medicare prospective payment
21 system for inpatient hospital services under section
22 1886(d) of such Act (42 U.S.C. 1395ww(d)) and the
23 Medicare prospective payment system for hospital
24 outpatient department services under section
25 1833(t) of such Act (42 U.S.C. 1395I(t)), to deter-

1 mine whether those payment policies resulted in in-
2 centives or disincentives that have contributed to the
3 opioid crisis.

4 (2) Recommendations for payment and service
5 delivery models to be tested as appropriate by the
6 Center for Medicare and Medicaid Innovation and
7 other federally authorized demonstration projects,
8 including value-based models, that may encourage
9 the use of appropriate medication-assisted treatment
10 approved by the Food and Drug Administration for
11 the treatment of opioid use disorder and other thera-
12 pies that manage chronic and acute pain and treat
13 and minimize risk of opioid misuse and abuse.

14 (3) Recommendations for data collection that
15 could facilitate research and policy-making regarding
16 prevention of opioid use disorder as well as data that
17 would aid the Secretary in making coverage and
18 payment decisions under the Medicare and Medicaid
19 programs related to the access to appropriate opioid
20 dependence treatments.

21 (4) A review of Medicare and Medicaid bene-
22 ficiaries' access to the full range of medication-as-
23 sisted treatment approved by the Food and Drug
24 Administration for the treatment of opioid use dis-
25 order and other therapies that manage chronic and

1 acute pain and treat and minimize risk of opioid
2 misuse and abuse, including access of beneficiaries
3 residing in rural or medically underserved commu-
4 nities.

5 (5) A review of payment and coverage policies
6 under the Medicare program and the Medicaid pro-
7 gram related to medical devices that are non-opioid
8 based treatments approved by the Food and Drug
9 Administration for the management of acute pain
10 and chronic pain, for monitoring substance use with-
11 drawal and preventing overdoses of controlled sub-
12 stances, and for treating substance use disorder, in-
13 cluding barriers to patient access.

14 (c) STAKEHOLDER MEETINGS.—

15 (1) IN GENERAL.—Beginning not later than 3
16 months after the date of the enactment of this sec-
17 tion, the Secretary shall convene a public stake-
18 holder meeting to solicit public comment on the com-
19 ponents of the action plan described in subsection
20 (b).

21 (2) PARTICIPANTS.—Participants of meetings
22 described in paragraph (1) shall include representa-
23 tives from the Food and Drug Administration and
24 National Institutes of Health, biopharmaceutical in-
25 dustry members, medical researchers, health care

1 providers, the medical device industry, the Medicare
2 program, the Medicaid program, and patient advo-
3 cates.

4 (d) REQUEST FOR INFORMATION.—Not later than 3
5 months after the date of the enactment of this section,
6 the Secretary shall issue a request for information seeking
7 public feedback regarding ways in which the Centers for
8 Medicare & Medicaid Services can help address the opioid
9 crisis through the development of and application of the
10 action plan.

11 (e) REPORT TO CONGRESS.—Not later than June 1,
12 2020, the Secretary shall submit to Congress, and make
13 public, a report that includes—

14 (1) a summary of the results of the Secretary’s
15 review and any recommendations under the action
16 plan;

17 (2) the Secretary’s planned next steps with re-
18 spect to the action plan; and

19 (3) an evaluation of price trends for drugs used
20 to reverse opioid overdoses (such as naloxone), in-
21 cluding recommendations on ways to lower such
22 prices for consumers.

23 (f) DEFINITION OF MEDICATION-ASSISTED TREAT-
24 MENT.—In this section, the term “medication-assisted
25 treatment” includes opioid treatment programs, behav-

1 ioral therapy, and medications to treat substance abuse
2 disorder.

3 **Subtitle E—Advancing High Qual-**
4 **ity Treatment for Opioid Use**
5 **Disorders in Medicare**

6 **SEC. 6041. SHORT TITLE.**

7 This subtitle may be cited as the “Advancing High
8 Quality Treatment for Opioid Use Disorders in Medicare
9 Act”.

10 **SEC. 6042. OPIOID USE DISORDER TREATMENT DEM-**
11 **ONSTRATION PROGRAM.**

12 Title XVIII of the Social Security Act (42 U.S.C.
13 1395 et seq.) is amended by inserting after section 1866E
14 (42 U.S.C. 1395cc–5) the following new section:

15 **“SEC. 1866F. OPIOID USE DISORDER TREATMENT DEM-**
16 **ONSTRATION PROGRAM.**

17 “(a) IMPLEMENTATION OF 4-YEAR DEMONSTRATION
18 PROGRAM.—

19 “(1) IN GENERAL.—Not later than January 1,
20 2021, the Secretary shall implement a 4-year dem-
21 onstration program under this title (in this section
22 referred to as the ‘Program’) to increase access of
23 applicable beneficiaries to opioid use disorder treat-
24 ment services, improve physical and mental health
25 outcomes for such beneficiaries, and to the extent

1 possible, reduce expenditures under this title. Under
2 the Program, the Secretary shall make payments
3 under subsection (e) to participants (as defined in
4 subsection (c)(1)(A)) for furnishing opioid use dis-
5 order treatment services delivered through opioid use
6 disorder care teams, or arranging for such services
7 to be furnished, to applicable beneficiaries partici-
8 pating in the Program.

9 “(2) OPIOID USE DISORDER TREATMENT SERV-
10 ICES.—For purposes of this section, the term ‘opioid
11 use disorder treatment services’—

12 “(A) means, with respect to an applicable
13 beneficiary, services that are furnished for the
14 treatment of opioid use disorders and that uti-
15 lize drugs approved under section 505 of the
16 Federal Food, Drug, and Cosmetic Act for the
17 treatment of opioid use disorders in an out-
18 patient setting; and

19 “(B) includes—

20 “(i) medication-assisted treatment;

21 “(ii) treatment planning;

22 “(iii) psychiatric, psychological, or
23 counseling services (or any combination of
24 such services), as appropriate;

1 “(iv) social support services, as appro-
2 priate; and

3 “(v) care management and care co-
4 ordination services, including coordination
5 with other providers of services and sup-
6 pliers not on an opioid use disorder care
7 team.

8 “(b) PROGRAM DESIGN.—

9 “(1) IN GENERAL.—The Secretary shall design
10 the Program in such a manner to allow for the eval-
11 uation of the extent to which the Program accom-
12 plishes the following purposes:

13 “(A) Reduces hospitalizations and emer-
14 gency department visits.

15 “(B) Increases use of medication-assisted
16 treatment for opioid use disorders.

17 “(C) Improves health outcomes of individ-
18 uals with opioid use disorders, including by re-
19 ducing the incidence of infectious diseases (such
20 as hepatitis C and HIV).

21 “(D) Does not increase the total spending
22 on items and services under this title.

23 “(E) Reduces deaths from opioid overdose.

24 “(F) Reduces the utilization of inpatient
25 residential treatment.

1 “(2) CONSULTATION.—In designing the Pro-
2 gram, including the criteria under subsection
3 (e)(2)(A), the Secretary shall, not later than 3
4 months after the date of the enactment of this sec-
5 tion, consult with specialists in the field of addiction,
6 clinicians in the primary care community, and bene-
7 ficiary groups.

8 “(c) PARTICIPANTS; OPIOID USE DISORDER CARE
9 TEAMS.—

10 “(1) PARTICIPANTS.—

11 “(A) DEFINITION.—In this section, the
12 term ‘participant’ means an entity or indi-
13 vidual—

14 “(i) that is otherwise enrolled under
15 this title and that is—

16 “(I) a physician (as defined in
17 section 1861(r)(1));

18 “(II) a group practice comprised
19 of at least one physician described in
20 subclause (I);

21 “(III) a hospital outpatient de-
22 partment;

23 “(IV) a federally qualified health
24 center (as defined in section
25 1861(aa)(4));

1 “(V) a rural health clinic (as de-
2 fined in section 1861(aa)(2));

3 “(VI) a community mental health
4 center (as defined in section
5 1861(ff)(3)(B));

6 “(VII) a clinic certified as a cer-
7 tified community behavioral health
8 clinic pursuant to section 223 of the
9 Protecting Access to Medicare Act of
10 2014; or

11 “(VIII) any other individual or
12 entity specified by the Secretary;

13 “(ii) that applied for and was selected
14 to participate in the Program pursuant to
15 an application and selection process estab-
16 lished by the Secretary; and

17 “(iii) that establishes an opioid use
18 disorder care team (as defined in para-
19 graph (2)) through employing or con-
20 tracting with health care practitioners de-
21 scribed in paragraph (2)(A), and uses such
22 team to furnish or arrange for opioid use
23 disorder treatment services in the out-
24 patient setting under the Program.

1 “(B) PREFERENCE.—In selecting partici-
2 pants for the Program, the Secretary shall give
3 preference to individuals and entities that are
4 located in areas with a prevalence of opioid use
5 disorders that is higher than the national aver-
6 age prevalence.

7 “(2) OPIOID USE DISORDER CARE TEAMS.—

8 “(A) IN GENERAL.—For purposes of this
9 section, the term ‘opioid use disorder care team’
10 means a team of health care practitioners es-
11 tablished by a participant described in para-
12 graph (1)(A) that—

13 “(i) shall include—

14 “(I) at least one physician (as
15 defined in section 1861(r)(1)) fur-
16 nishing primary care services or ad-
17 diction treatment services to an appli-
18 cable beneficiary; and

19 “(II) at least one eligible practi-
20 tioner (as defined in paragraph (3)),
21 who may be a physician who meets
22 the criterion in subclause (I); and

23 “(ii) may include other practitioners
24 licensed under State law to furnish psy-

1 chiatric, psychological, counseling, and so-
2 cial services to applicable beneficiaries.

3 “(B) REQUIREMENTS FOR RECEIPT OF
4 PAYMENT UNDER PROGRAM.—In order to re-
5 ceive payments under subsection (e), each par-
6 ticipant in the Program shall—

7 “(i) furnish opioid use disorder treat-
8 ment services through opioid use disorder
9 care teams to applicable beneficiaries who
10 agree to receive the services;

11 “(ii) meet minimum criteria, as estab-
12 lished by the Secretary; and

13 “(iii) submit to the Secretary, in such
14 form, manner, and frequency as specified
15 by the Secretary, with respect to each ap-
16 plicable beneficiary for whom opioid use
17 disorder treatment services are furnished
18 by the opioid use disorder care team, data
19 and such other information as the Sec-
20 retary determines appropriate to—

21 “(I) monitor and evaluate the
22 Program;

23 “(II) determine if minimum cri-
24 teria are met under clause (ii); and

1 “(III) determine the incentive
2 payment under subsection (e).

3 “(3) ELIGIBLE PRACTITIONER DEFINED.—For
4 purposes of this section, the term ‘eligible practi-
5 tioner’ means a physician or other health care prac-
6 titioner, such as a nurse practitioner, that—

7 “(A) is enrolled under section 1866(j)(1);

8 “(B) is authorized to prescribe or dispense
9 narcotic drugs to individuals for maintenance
10 treatment or detoxification treatment; and

11 “(C) has in effect a waiver in accordance
12 with section 303(g) of the Controlled Sub-
13 stances Act for such purpose and is otherwise
14 in compliance with regulations promulgated by
15 the Substance Abuse and Mental Health Serv-
16 ices Administration to carry out such section.

17 “(d) PARTICIPATION OF APPLICABLE BENE-
18 FIICIARIES.—

19 “(1) APPLICABLE BENEFICIARY DEFINED.—In
20 this section, the term ‘applicable beneficiary’ means
21 an individual who—

22 “(A) is entitled to, or enrolled for, benefits
23 under part A and enrolled for benefits under
24 part B;

1 “(B) is not enrolled in a Medicare Advan-
2 tage plan under part C;

3 “(C) has a current diagnosis for an opioid
4 use disorder; and

5 “(D) meets such other criteria as the Sec-
6 retary determines appropriate.

7 Such term shall include an individual who is dually
8 eligible for benefits under this title and title XIX if
9 such individual satisfies the criteria described in
10 subparagraphs (A) through (D).

11 “(2) VOLUNTARY BENEFICIARY PARTICIPATION;
12 LIMITATION ON NUMBER OF BENEFICIARIES.—An
13 applicable beneficiary may participate in the Pro-
14 gram on a voluntary basis and may terminate par-
15 ticipation in the Program at any time. Not more
16 than 20,000 applicable beneficiaries may participate
17 in the Program at any time.

18 “(3) SERVICES.—In order to participate in the
19 Program, an applicable beneficiary shall agree to re-
20 ceive opioid use disorder treatment services from a
21 participant. Participation under the Program shall
22 not affect coverage of or payment for any other item
23 or service under this title for the applicable bene-
24 ficiary.

1 “(4) BENEFICIARY ACCESS TO SERVICES.—
2 Nothing in this section shall be construed as encour-
3 aging providers to limit applicable beneficiary access
4 to services covered under this title, and applicable
5 beneficiaries shall not be required to relinquish ac-
6 cess to any benefit under this title as a condition of
7 receiving services from a participant in the Program.

8 “(e) PAYMENTS.—

9 “(1) PER APPLICABLE BENEFICIARY PER
10 MONTH CARE MANAGEMENT FEE.—

11 “(A) IN GENERAL.—The Secretary shall
12 establish a schedule of per applicable bene-
13 ficiary per month care management fees. Such
14 a per applicable beneficiary per month care
15 management fee shall be paid to a participant
16 in addition to any other amount otherwise pay-
17 able under this title to the health care practi-
18 tioners in the participant’s opioid use disorder
19 care team or, if applicable, to the participant.
20 A participant may use such per applicable bene-
21 ficiary per month care management fee to de-
22 liver additional services to applicable bene-
23 ficiaries, including services not otherwise eligi-
24 ble for payment under this title.

1 “(B) PAYMENT AMOUNTS.—In carrying
2 out subparagraph (A), the Secretary may—

3 “(i) consider payments otherwise pay-
4 able under this title for opioid use disorder
5 treatment services and the needs of appli-
6 cable beneficiaries;

7 “(ii) pay a higher per applicable bene-
8 ficiary per month care management fee for
9 an applicable beneficiary who receives more
10 intensive treatment services from a partici-
11 pant and for whom those services are ap-
12 propriate based on clinical guidelines for
13 opioid use disorder care;

14 “(iii) pay a higher per applicable ben-
15 eficiary per month care management fee
16 for the month in which the applicable ben-
17 eficiary begins treatment with a partici-
18 pant than in subsequent months, to reflect
19 the greater time and costs required for the
20 planning and initiation of treatment, as
21 compared to maintenance of treatment;
22 and

23 “(iv) take into account whether a par-
24 ticipant’s opioid use disorder care team re-
25 fers applicable beneficiaries to other sup-

1 pliers or providers for any opioid use dis-
2 order treatment services.

3 “(C) NO DUPLICATE PAYMENT.—The Sec-
4 retary shall make payments under this para-
5 graph to only one participant for services fur-
6 nished to an applicable beneficiary during a cal-
7 endar month.

8 “(2) INCENTIVE PAYMENTS.—

9 “(A) IN GENERAL.—Under the Program,
10 the Secretary shall establish a performance-
11 based incentive payment, which shall be paid
12 (using a methodology established and at a time
13 determined appropriate by the Secretary) to
14 participants based on the performance of par-
15 ticipants with respect to criteria, as determined
16 appropriate by the Secretary, in accordance
17 with subparagraph (B).

18 “(B) CRITERIA.—

19 “(i) IN GENERAL.—Criteria described
20 in subparagraph (A) may include consider-
21 ation of the following:

22 “(I) Patient engagement and re-
23 tention in treatment.

24 “(II) Evidence-based medication-
25 assisted treatment.

1 “(III) Other criteria established
2 by the Secretary.

3 “(ii) REQUIRED CONSULTATION AND
4 CONSIDERATION.—In determining criteria
5 described in subparagraph (A), the Sec-
6 retary shall—

7 “(I) consult with stakeholders,
8 including clinicians in the primary
9 care community and in the field of ad-
10 diction medicine; and

11 “(II) consider existing clinical
12 guidelines for the treatment of opioid
13 use disorders.

14 “(C) NO DUPLICATE PAYMENT.—The Sec-
15 retary shall ensure that no duplicate payments
16 under this paragraph are made with respect to
17 an applicable beneficiary.

18 “(f) MULTIPAYER STRATEGY.—In carrying out the
19 Program, the Secretary shall encourage other payers to
20 provide similar payments and to use similar criteria as ap-
21 plied under the Program under subsection (e)(2)(C). The
22 Secretary may enter into a memorandum of understanding
23 with other payers to align the methodology for payment
24 provided by such a payer related to opioid use disorder

1 treatment services with such methodology for payment
2 under the Program.

3 “(g) EVALUATION.—

4 “(1) IN GENERAL.—The Secretary shall con-
5 duct an intermediate and final evaluation of the pro-
6 gram. Each such evaluation shall determine the ex-
7 tent to which each of the purposes described in sub-
8 section (b) have been accomplished under the Pro-
9 gram.

10 “(2) REPORTS.—The Secretary shall submit to
11 Congress—

12 “(A) a report with respect to the inter-
13 mediate evaluation under paragraph (1) not
14 later than 3 years after the date of the imple-
15 mentation of the Program; and

16 “(B) a report with respect to the final
17 evaluation under paragraph (1) not later than
18 6 years after such date.

19 “(h) FUNDING.—

20 “(1) ADMINISTRATIVE FUNDING.—For the pur-
21 poses of implementing, administering, and carrying
22 out the Program (other than for purposes described
23 in paragraph (2)), \$5,000,000 shall be available
24 from the Federal Supplementary Medical Insurance
25 Trust Fund under section 1841.

1 “(2) CARE MANAGEMENT FEES AND INCEN-
2 TIVES.—For the purposes of making payments
3 under subsection (e), \$10,000,000 shall be available
4 from the Federal Supplementary Medical Insurance
5 Trust Fund under section 1841 for each of fiscal
6 years 2021 through 2024.

7 “(3) AVAILABILITY.—Amounts transferred
8 under this subsection for a fiscal year shall be avail-
9 able until expended.

10 “(i) WAIVERS.—The Secretary may waive any provi-
11 sion of this title as may be necessary to carry out the Pro-
12 gram under this section.”.

13 **Subtitle F—Responsible Education**
14 **Achieves Care and Healthy Out-**
15 **comes for Users’ Treatment**

16 **SEC. 6051. SHORT TITLE.**

17 This subtitle may be cited as the “Responsible Edu-
18 cation Achieves Care and Healthy Outcomes for Users’
19 Treatment Act of 2018” or the “REACH OUT Act of
20 2018”.

21 **SEC. 6052. GRANTS TO PROVIDE TECHNICAL ASSISTANCE**
22 **TO OUTLIER PRESCRIBERS OF OPIOIDS.**

23 (a) GRANTS AUTHORIZED.—The Secretary of Health
24 and Human Services (in this section referred to as the
25 “Secretary”) shall, through the Centers for Medicare &

1 Medicaid Services, award grants, contracts, or cooperative
2 agreements to eligible entities for the purposes described
3 in subsection (b).

4 (b) USE OF FUNDS.—Grants, contracts, and coopera-
5 tive agreements awarded under subsection (a) shall be
6 used to support eligible entities through technical assist-
7 ance—

8 (1) to educate and provide outreach to outlier
9 prescribers of opioids about best practices for pre-
10 scribing opioids;

11 (2) to educate and provide outreach to outlier
12 prescribers of opioids about non-opioid pain manage-
13 ment therapies; and

14 (3) to reduce the amount of opioid prescriptions
15 prescribed by outlier prescribers of opioids.

16 (c) APPLICATION.—Each eligible entity seeking to re-
17 ceive a grant, contract, or cooperative agreement under
18 subsection (a) shall submit to the Secretary an applica-
19 tion, at such time, in such manner, and containing such
20 information as the Secretary may require.

21 (d) GEOGRAPHIC DISTRIBUTION.—In awarding
22 grants, contracts, and cooperative agreements under this
23 section, the Secretary shall prioritize establishing technical
24 assistance resources in each State.

25 (e) DEFINITIONS.—In this section:

1 (1) ELIGIBLE ENTITY.—The term “eligible enti-
2 ty” means—

3 (A) an organization—

4 (i) that has demonstrated experience
5 providing technical assistance to health
6 care professionals on a State or regional
7 basis; and

8 (ii) that has at least—

9 (I) one individual who is a rep-
10 resentative of consumers on its gov-
11 erning body; and

12 (II) one individual who is a rep-
13 resentative of health care providers on
14 its governing body; or

15 (B) an entity that is a quality improve-
16 ment entity with a contract under part B of
17 title XI of the Social Security Act (42 U.S.C.
18 1320c et seq.).

19 (2) OUTLIER PRESCRIBER OF OPIOIDS.—The
20 term “outlier prescriber of opioids” means, with re-
21 spect to a period, a prescriber identified by the Sec-
22 retary under subparagraph (D)(ii) of section
23 1860D–4(c)(4) of the Social Security Act (42 U.S.C.
24 1395w–104(c)(4)), as added by section 6065 of this

1 Act, to be an outlier prescriber of opioids for such
2 period.

3 (3) PRESCRIBERS.—The term “prescriber”
4 means any health care professional, including a
5 nurse practitioner or physician assistant, who is li-
6 censed to prescribe opioids by the State or territory
7 in which such professional practices.

8 (f) FUNDING.—For purposes of implementing this
9 section, \$75,000,000 shall be available from the Federal
10 Supplementary Medical Insurance Trust Fund under sec-
11 tion 1841 of the Social Security Act (42 U.S.C. 1395t),
12 to remain available until expended.

13 **Subtitle G—Preventing Addiction** 14 **for Susceptible Seniors**

15 **SEC. 6061. SHORT TITLE.**

16 This subtitle may be cited as the “Preventing Addic-
17 tion for Susceptible Seniors Act of 2018” or the “PASS
18 Act of 2018”.

19 **SEC. 6062. ELECTRONIC PRIOR AUTHORIZATION FOR COV- 20 ERED PART D DRUGS.**

21 Section 1860D–4(e)(2) of the Social Security Act (42
22 U.S.C. 1395w–104(e)(2)) is amended by adding at the end
23 the following new subparagraph:

24 “(E) ELECTRONIC PRIOR AUTHORIZA-
25 TION.—

1 “(i) IN GENERAL.—Not later than
2 January 1, 2021, the program shall pro-
3 vide for the secure electronic transmission
4 of—

5 “(I) a prior authorization request
6 from the prescribing health care pro-
7 fessional for coverage of a covered
8 part D drug for a part D eligible indi-
9 vidual enrolled in a part D plan (as
10 defined in section 1860D–23(a)(5)) to
11 the PDP sponsor or Medicare Advan-
12 tage organization offering such plan;
13 and

14 “(II) a response, in accordance
15 with this subparagraph, from such
16 PDP sponsor or Medicare Advantage
17 organization, respectively, to such pro-
18 fessional.

19 “(ii) ELECTRONIC TRANSMISSION.—

20 “(I) EXCLUSIONS.—For purposes
21 of this subparagraph, a facsimile, a
22 proprietary payer portal that does not
23 meet standards specified by the Sec-
24 retary, or an electronic form shall not

1 be treated as an electronic trans-
2 mission described in clause (i).

3 “(II) STANDARDS.—In order to
4 be treated, for purposes of this sub-
5 paragraph, as an electronic trans-
6 mission described in clause (i), such
7 transmission shall comply with tech-
8 nical standards adopted by the Sec-
9 retary in consultation with the Na-
10 tional Council for Prescription Drug
11 Programs, other standard setting or-
12 ganizations determined appropriate by
13 the Secretary, and stakeholders in-
14 cluding PDP sponsors, Medicare Ad-
15 vantage organizations, health care
16 professionals, and health information
17 technology software vendors.

18 “(III) APPLICATION.—Notwith-
19 standing any other provision of law,
20 for purposes of this subparagraph, the
21 Secretary may require the use of such
22 standards adopted under subclause
23 (II) in lieu of any other applicable
24 standards for an electronic trans-
25 mission described in clause (i) for a

1 covered part D drug for a part D eli-
2 gible individual.”.

3 **SEC. 6063. PROGRAM INTEGRITY TRANSPARENCY MEAS-**
4 **URES UNDER MEDICARE PARTS C AND D.**

5 (a) IN GENERAL.—Section 1859 of the Social Secu-
6 rity Act (42 U.S.C. 1395w–28) is amended by adding at
7 the end the following new subsection:

8 “(i) PROGRAM INTEGRITY TRANSPARENCY MEAS-
9 URES.—

10 “(1) PROGRAM INTEGRITY PORTAL.—

11 “(A) IN GENERAL.—Not later than 2 years
12 after the date of the enactment of this sub-
13 section, the Secretary shall, after consultation
14 with stakeholders, establish a secure internet
15 website portal (or other successor technology)
16 that would allow a secure path for communica-
17 tion between the Secretary, MA plans under
18 this part, prescription drug plans under part D,
19 and an eligible entity with a contract under sec-
20 tion 1893 (such as a Medicare drug integrity
21 contractor or an entity responsible for carrying
22 out program integrity activities under this part
23 and part D) for the purpose of enabling
24 through such portal (or other successor tech-
25 nology)—

1 “(i) the referral by such plans of sub-
2 stantiated or suspicious activities, as de-
3 fined by the Secretary, of a provider of
4 services (including a prescriber) or supplier
5 related to fraud, waste, and abuse for initi-
6 ating or assisting investigations conducted
7 by the eligible entity; and

8 “(ii) data sharing among such MA
9 plans, prescription drug plans, and the
10 Secretary.

11 “(B) REQUIRED USES OF PORTAL.—The
12 Secretary shall disseminate the following infor-
13 mation to MA plans under this part and pre-
14 scription drug plans under part D through the
15 secure internet website portal (or other suc-
16 cessor technology) established under subpara-
17 graph (A):

18 “(i) Providers of services and sup-
19 pliers that have been referred pursuant to
20 subparagraph (A)(i) during the previous
21 12-month period.

22 “(ii) Providers of services and sup-
23 pliers who are the subject of an active ex-
24 clusion under section 1128 or who are sub-
25 ject to a suspension of payment under this

1 title pursuant to section 1862(o) or other-
2 wise.

3 “(iii) Providers of services and sup-
4 pliers who are the subject of an active rev-
5 ocation of participation under this title, in-
6 cluding for not satisfying conditions of par-
7 ticipation.

8 “(iv) In the case of such a plan that
9 makes a referral under subparagraph
10 (A)(i) through the portal (or other suc-
11 cessor technology) with respect to activities
12 of substantiated or suspicious activities of
13 fraud, waste, or abuse of a provider of
14 services (including a prescriber) or sup-
15 plier, if such provider (including a pre-
16 scriber) or supplier has been the subject of
17 an administrative action under this title or
18 title XI with respect to similar activities, a
19 notification to such plan of such action so
20 taken.

21 “(C) RULEMAKING.—For purposes of this
22 paragraph, the Secretary shall, through rule-
23 making, specify what constitutes substantiated
24 or suspicious activities of fraud, waste, and
25 abuse, using guidance such as what is provided

1 in the Medicare Program Integrity Manual 4.8.
2 In carrying out this subsection, a fraud hotline
3 tip (as defined by the Secretary) without fur-
4 ther evidence shall not be treated as sufficient
5 evidence for substantiated fraud, waste, or
6 abuse.

7 “(D) HIPAA COMPLIANT INFORMATION
8 ONLY.—For purposes of this subsection, com-
9 munications may only occur if the communica-
10 tions are permitted under the Federal regula-
11 tions (concerning the privacy of individually
12 identifiable health information) promulgated
13 under section 264(e) of the Health Insurance
14 Portability and Accountability Act of 1996.

15 “(2) QUARTERLY REPORTS.—Beginning not
16 later than 2 years after the date of the enactment
17 of this subsection, the Secretary shall make available
18 to MA plans under this part and prescription drug
19 plans under part D in a timely manner (but no less
20 frequently than quarterly) and using information
21 submitted to an entity described in paragraph (1)
22 through the portal (or other successor technology)
23 described in such paragraph or pursuant to section
24 1893, information on fraud, waste, and abuse

1 schemes and trends in identifying suspicious activity.

2 Information included in each such report shall—

3 “(A) include administrative actions, perti-
4 nent information related to opioid overpre-
5 scribing, and other data determined appropriate
6 by the Secretary in consultation with stake-
7 holders; and

8 “(B) be anonymized information submitted
9 by plans without identifying the source of such
10 information.

11 “(3) CLARIFICATION.—Nothing in this sub-
12 section shall preclude or otherwise affect referrals to
13 the Inspector General of the Department of Health
14 and Human Services or other law enforcement enti-
15 ties.”.

16 (b) CONTRACT REQUIREMENT TO COMMUNICATE
17 PLAN CORRECTIVE ACTIONS AGAINST OPIOIDS OVER-
18 PRESCRIBERS.—Section 1857(e) of the Social Security
19 Act (42 U.S.C. 1395w–27(e)) is amended by adding at
20 the end the following new paragraph:

21 “(5) COMMUNICATING PLAN CORRECTIVE AC-
22 TIONS AGAINST OPIOIDS OVER-PRESCRIBERS.—

23 “(A) IN GENERAL.—Beginning with plan
24 years beginning on or after January 1, 2021, a
25 contract under this section with an MA organi-

1 zation shall require the organization to submit
2 to the Secretary, through the process estab-
3 lished under subparagraph (B), information on
4 the investigations, credible evidence of sus-
5 picious activities of a provider of services (in-
6 cluding a prescriber) or supplier related to
7 fraud, and other actions taken by such plans re-
8 lated to inappropriate prescribing of opioids.

9 “(B) PROCESS.—Not later than January
10 1, 2021, the Secretary shall, in consultation
11 with stakeholders, establish a process under
12 which MA plans and prescription drug plans
13 shall submit to the Secretary information de-
14 scribed in subparagraph (A).

15 “(C) REGULATIONS.—For purposes of this
16 paragraph, including as applied under section
17 1860D–12(b)(3)(D), the Secretary shall, pursu-
18 ant to rulemaking—

19 “(i) specify a definition for the term
20 ‘inappropriate prescribing’ and a method
21 for determining if a provider of services
22 prescribes inappropriate prescribing; and

23 “(ii) establish the process described in
24 subparagraph (B) and the types of infor-

1 “(II) Beginning January 1,
2 2021, at-risk beneficiaries for pre-
3 scription drug abuse (as defined in
4 paragraph (5)(C)).”.

5 **SEC. 6065. COMMIT TO OPIOID MEDICAL PRESCRIBER AC-**
6 **COUNTABILITY AND SAFETY FOR SENIORS.**

7 Section 1860D–4(c)(4) of the Social Security Act (42
8 U.S.C. 1395w–104(c)(4)) is amended by adding at the end
9 the following new subparagraph:

10 “(D) NOTIFICATION AND ADDITIONAL RE-
11 QUIREMENTS WITH RESPECT TO OUTLIER PRE-
12 SCRIBERS OF OPIOIDS.—

13 “(i) NOTIFICATION.—Not later than
14 January 1, 2021, the Secretary shall, in
15 the case of a prescriber identified by the
16 Secretary under clause (ii) to be an outlier
17 prescriber of opioids, provide, subject to
18 clause (iv), an annual notification to such
19 prescriber that such prescriber has been so
20 identified and that includes resources on
21 proper prescribing methods and other in-
22 formation as specified in accordance with
23 clause (iii).

24 “(ii) IDENTIFICATION OF OUTLIER
25 PRESCRIBERS OF OPIOIDS.—

1 “(I) IN GENERAL.—The Sec-
2 retary shall, subject to subclause (III),
3 using the valid prescriber National
4 Provider Identifiers included pursuant
5 to subparagraph (A) on claims for
6 covered part D drugs for part D eligi-
7 ble individuals enrolled in prescription
8 drug plans under this part or MA–PD
9 plans under part C and based on the
10 thresholds established under subclause
11 (II), identify prescribers that are
12 outlier opioids prescribers for a period
13 of time specified by the Secretary.

14 “(II) ESTABLISHMENT OF
15 THRESHOLDS.—For purposes of sub-
16 clause (I) and subject to subclause
17 (III), the Secretary shall, after con-
18 sultation with stakeholders, establish
19 thresholds, based on prescriber spe-
20 cialty and geographic area, for identi-
21 fying whether a prescriber in a spe-
22 cialty and geographic area is an
23 outlier prescriber of opioids as com-
24 pared to other prescribers of opioids
25 within such specialty and area.

1 “(III) EXCLUSIONS.—The fol-
2 lowing shall not be included in the
3 analysis for identifying outlier pre-
4 scribers of opioids under this clause:

5 “(aa) Claims for covered
6 part D drugs for part D eligible
7 individuals who are receiving hos-
8 pice care under this title.

9 “(bb) Claims for covered
10 part D drugs for part D eligible
11 individuals who are receiving on-
12 cology services under this title.

13 “(cc) Prescribers who are
14 the subject of an investigation by
15 the Centers for Medicare & Med-
16 icaid Services or the Inspector
17 General of the Department of
18 Health and Human Services.

19 “(iii) CONTENTS OF NOTIFICATION.—
20 The Secretary shall include the following
21 information in the notifications provided
22 under clause (i):

23 “(I) Information on how such
24 prescriber compares to other pre-

1 scribers within the same specialty and
2 geographic area.

3 “(II) Information on opioid pre-
4 scribing guidelines, based on input
5 from stakeholders, that may include
6 the Centers for Disease Control and
7 Prevention guidelines for prescribing
8 opioids for chronic pain and guidelines
9 developed by physician organizations.

10 “(III) Other information deter-
11 mined appropriate by the Secretary.

12 “(iv) MODIFICATIONS AND EXPAN-
13 SIONS.—

14 “(I) FREQUENCY.—Beginning 5
15 years after the date of the enactment
16 of this subparagraph, the Secretary
17 may change the frequency of the noti-
18 fications described in clause (i) based
19 on stakeholder input and changes in
20 opioid prescribing utilization and
21 trends.

22 “(II) EXPANSION TO OTHER
23 PRESCRIPTIONS.—The Secretary may
24 expand notifications under this sub-
25 paragraph to include identifications

1 and notifications with respect to con-
2 current prescriptions of covered Part
3 D drugs used in combination with
4 opioids that are considered to have
5 adverse side effects when so used in
6 such combination, as determined by
7 the Secretary.

8 “(v) ADDITIONAL REQUIREMENTS FOR
9 PERSISTENT OUTLIER PRESCRIBERS.—In
10 the case of a prescriber who the Secretary
11 determines is persistently identified under
12 clause (ii) as an outlier prescriber of
13 opioids, the following shall apply:

14 “(I) Such prescriber may be re-
15 quired to enroll in the program under
16 this title under section 1866(j) if such
17 prescriber is not otherwise required to
18 enroll, but only after other appro-
19 priate remedies have been provided,
20 such as the provision of education
21 funded through section 6052 of the
22 SUPPORT for Patients and Commu-
23 nities Act, for a period determined by
24 the Secretary as sufficient to correct
25 the prescribing patterns that lead to

1 identification of such prescriber as a
2 persistent outlier prescriber of opioids.
3 The Secretary shall determine the
4 length of the period for which such
5 prescriber is required to maintain
6 such enrollment, which shall be the
7 minimum period necessary to correct
8 such prescribing patterns.

9 “(II) Not less frequently than
10 annually (and in a form and manner
11 determined appropriate by the Sec-
12 retary), the Secretary, consistent with
13 clause(iv)(I), shall communicate infor-
14 mation on such prescribers to spon-
15 sors of a prescription drug plan and
16 Medicare Advantage organizations of-
17 fering an MA–PD plan.

18 “(vi) PUBLIC AVAILABILITY OF IN-
19 FORMATION.—The Secretary shall make
20 aggregate information under this subpara-
21 graph available on the internet website of
22 the Centers for Medicare & Medicaid Serv-
23 ices. Such information shall be in a form
24 and manner determined appropriate by the
25 Secretary and shall not identify any spe-

1 cific prescriber. In carrying out this clause,
2 the Secretary shall consult with interested
3 stakeholders.

4 “(vii) OPIOIDS DEFINED.—For pur-
5 poses of this subparagraph, the term
6 ‘opioids’ has such meaning as specified by
7 the Secretary.

8 “(viii) OTHER ACTIVITIES.—Nothing
9 in this subparagraph shall preclude the
10 Secretary from conducting activities that
11 provide prescribers with information as to
12 how they compare to other prescribers that
13 are in addition to the activities under this
14 subparagraph, including activities that
15 were being conducted as of the date of the
16 enactment of this subparagraph.”.

17 **SEC. 6066. NO ADDITIONAL FUNDS AUTHORIZED.**

18 No additional funds are authorized to be appro-
19 priated to carry out the requirements of this subtitle and
20 the amendments made by this subtitle. Such requirements
21 shall be carried out using amounts otherwise authorized
22 to be appropriated.

1 **Subtitle H—Expanding Oversight**
2 **of Opioid Prescribing and Payment**

3 **SEC. 6071. SHORT TITLE.**

4 This subtitle may be cited as the “Expanding Over-
5 sight of Opioid Prescribing and Payment Act of 2018”.

6 **SEC. 6072. MEDICARE PAYMENT ADVISORY COMMISSION**
7 **REPORT ON OPIOID PAYMENT, ADVERSE IN-**
8 **CENTIVES, AND DATA UNDER THE MEDICARE**
9 **PROGRAM.**

10 Not later than March 15, 2019, the Medicare Pay-
11 ment Advisory Commission shall submit to Congress a re-
12 port on, with respect to the Medicare program under title
13 XVIII of the Social Security Act, the following:

14 (1) A description of how the Medicare program
15 pays for pain management treatments (both opioid
16 and non-opioid pain management alternatives) in
17 both inpatient and outpatient hospital settings.

18 (2) The identification of incentives under the
19 hospital inpatient prospective payment system under
20 section 1886 of the Social Security Act (42 U.S.C.
21 1395ww) and incentives under the hospital out-
22 patient prospective payment system under section
23 1833(t) of such Act (42 U.S.C. 1395l(t)) for pre-
24 scribing opioids and incentives under each such sys-
25 tem for prescribing non-opioid treatments, and rec-

1 ommendations as the Commission deems appropriate
2 for addressing any of such incentives that are ad-
3 verse incentives.

4 (3) A description of how opioid use is tracked
5 and monitored through Medicare claims data and
6 other mechanisms and the identification of any areas
7 in which further data and methods are needed for
8 improving data and understanding of opioid use.

9 **SEC. 6073. NO ADDITIONAL FUNDS AUTHORIZED.**

10 No additional funds are authorized to be appro-
11 priated to carry out the requirements of this subtitle. Such
12 requirements shall be carried out using amounts otherwise
13 authorized to be appropriated.

14 **Subtitle I—Dr. Todd Graham Pain**
15 **Management, Treatment, and**
16 **Recovery**

17 **SEC. 6081. SHORT TITLE.**

18 This subtitle may be cited as the “Dr. Todd Graham
19 Pain Management, Treatment, and Recovery Act of
20 2018”.

1 **SEC. 6082. REVIEW AND ADJUSTMENT OF PAYMENTS**
2 **UNDER THE MEDICARE OUTPATIENT PRO-**
3 **SPECTIVE PAYMENT SYSTEM TO AVOID FI-**
4 **NANCIAL INCENTIVES TO USE OPIOIDS IN-**
5 **STEAD OF NON-OPIOID ALTERNATIVE TREAT-**
6 **MENTS.**

7 (a) OUTPATIENT PROSPECTIVE PAYMENT SYS-
8 TEM.—Section 1833(t) of the Social Security Act (42
9 U.S.C. 1395l(t)) is amended by adding at the end the fol-
10 lowing new paragraph:

11 “(22) REVIEW AND REVISIONS OF PAYMENTS
12 FOR NON-OPIOID ALTERNATIVE TREATMENTS.—

13 “(A) IN GENERAL.—With respect to pay-
14 ments made under this subsection for covered
15 OPD services (or groups of services), including
16 covered OPD services assigned to a comprehen-
17 sive ambulatory payment classification, the Sec-
18 retary—

19 “(i) shall, as soon as practicable, con-
20 duct a review (part of which may include
21 a request for information) of payments for
22 opioids and evidence-based non-opioid al-
23 ternatives for pain management (including
24 drugs and devices, nerve blocks, surgical
25 injections, and neuromodulation) with a
26 goal of ensuring that there are not finan-

1 cial incentives to use opioids instead of
2 non-opioid alternatives;

3 “(ii) may, as the Secretary determines
4 appropriate, conduct subsequent reviews of
5 such payments; and

6 “(iii) shall consider the extent to
7 which revisions under this subsection to
8 such payments (such as the creation of ad-
9 ditional groups of covered OPD services to
10 classify separately those procedures that
11 utilize opioids and non-opioid alternatives
12 for pain management) would reduce pay-
13 ment incentives to use opioids instead of
14 non-opioid alternatives for pain manage-
15 ment.

16 “(B) PRIORITY.—In conducting the review
17 under clause (i) of subparagraph (A) and con-
18 sidering revisions under clause (iii) of such sub-
19 paragraph, the Secretary shall focus on covered
20 OPD services (or groups of services) assigned
21 to a comprehensive ambulatory payment classi-
22 fication, ambulatory payment classifications
23 that primarily include surgical services, and
24 other services determined by the Secretary

1 which generally involve treatment for pain man-
2 agement.

3 “(C) REVISIONS.—If the Secretary identi-
4 fies revisions to payments pursuant to subpara-
5 graph (A)(iii), the Secretary shall, as deter-
6 mined appropriate, begin making such revisions
7 for services furnished on or after January 1,
8 2020. Revisions under the previous sentence
9 shall be treated as adjustments for purposes of
10 application of paragraph (9)(B).

11 “(D) RULES OF CONSTRUCTION.—Nothing
12 in this paragraph shall be construed to preclude
13 the Secretary—

14 “(i) from conducting a demonstration
15 before making the revisions described in
16 subparagraph (C); or

17 “(ii) prior to implementation of this
18 paragraph, from changing payments under
19 this subsection for covered OPD services
20 (or groups of services) which include
21 opioids or non-opioid alternatives for pain
22 management.”.

23 (b) AMBULATORY SURGICAL CENTERS.—Section
24 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))

1 is amended by adding at the end the following new para-
2 graph:

3 “(8) The Secretary shall conduct a similar type of
4 review as required under paragraph (22) of section
5 1833(t), including the second sentence of subparagraph
6 (C) of such paragraph, to payment for services under this
7 subsection, and make such revisions under this paragraph,
8 in an appropriate manner (as determined by the Sec-
9 retary).”.

10 **SEC. 6083. EXPANDING ACCESS UNDER THE MEDICARE**
11 **PROGRAM TO ADDICTION TREATMENT IN**
12 **FEDERALLY QUALIFIED HEALTH CENTERS**
13 **AND RURAL HEALTH CLINICS.**

14 (a) **FEDERALLY QUALIFIED HEALTH CENTERS.—**
15 Section 1834(o) of the Social Security Act (42 U.S.C.
16 1395m(o)) is amended by adding at the end the following
17 new paragraph:

18 “(3) **ADDITIONAL PAYMENTS FOR CERTAIN**
19 **FQHCS WITH PHYSICIANS OR OTHER PRACTITIONERS**
20 **RECEIVING DATA 2000 WAIVERS.—**

21 “(A) **IN GENERAL.—**In the case of a Fed-
22 erally qualified health center with respect to
23 which, beginning on or after January 1, 2019,
24 Federally qualified health center services (as
25 defined in section 1861(aa)(3)) are furnished

1 for the treatment of opioid use disorder by a
2 physician or practitioner who meets the require-
3 ments described in subparagraph (C), the Sec-
4 retary shall, subject to availability of funds
5 under subparagraph (D), make a payment (at
6 such time and in such manner as specified by
7 the Secretary) to such Federally qualified
8 health center after receiving and approving an
9 application submitted by such Federally quali-
10 fied health center under subparagraph (B).
11 Such a payment shall be in an amount deter-
12 mined by the Secretary, based on an estimate
13 of the average costs of training for purposes of
14 receiving a waiver described in subparagraph
15 (C)(ii). Such a payment may be made only one
16 time with respect to each such physician or
17 practitioner.

18 “(B) APPLICATION.—In order to receive a
19 payment described in subparagraph (A), a Fed-
20 erally qualified health center shall submit to the
21 Secretary an application for such a payment at
22 such time, in such manner, and containing such
23 information as specified by the Secretary. A
24 Federally qualified health center may apply for
25 such a payment for each physician or practi-

1 tioner described in subparagraph (A) furnishing
2 services described in such subparagraph at such
3 center.

4 “(C) REQUIREMENTS.—For purposes of
5 subparagraph (A), the requirements described
6 in this subparagraph, with respect to a physi-
7 cian or practitioner, are the following:

8 “(i) The physician or practitioner is
9 employed by or working under contract
10 with a Federally qualified health center de-
11 scribed in subparagraph (A) that submits
12 an application under subparagraph (B).

13 “(ii) The physician or practitioner
14 first receives a waiver under section 303(g)
15 of the Controlled Substances Act on or
16 after January 1, 2019.

17 “(D) FUNDING.—For purposes of making
18 payments under this paragraph, there are ap-
19 propriated, out of amounts in the Treasury not
20 otherwise appropriated, \$6,000,000, which shall
21 remain available until expended.”.

22 (b) RURAL HEALTH CLINIC.—Section 1833 of the
23 Social Security Act (42 U.S.C. 1395l) is amended—

1 (1) by redesignating the subsection (z) relating
2 to medical review of spinal subluxation services as
3 subsection (aa); and

4 (2) by adding at the end the following new sub-
5 section:

6 “(bb) ADDITIONAL PAYMENTS FOR CERTAIN RURAL
7 HEALTH CLINICS WITH PHYSICIANS OR PRACTITIONERS
8 RECEIVING DATA 2000 WAIVERS.—

9 “(1) IN GENERAL.—In the case of a rural
10 health clinic with respect to which, beginning on or
11 after January 1, 2019, rural health clinic services
12 (as defined in section 1861(aa)(1)) are furnished for
13 the treatment of opioid use disorder by a physician
14 or practitioner who meets the requirements de-
15 scribed in paragraph (3), the Secretary shall, subject
16 to availability of funds under paragraph (4), make
17 a payment (at such time and in such manner as
18 specified by the Secretary) to such rural health clinic
19 after receiving and approving an application de-
20 scribed in paragraph (2). Such payment shall be in
21 an amount determined by the Secretary, based on an
22 estimate of the average costs of training for pur-
23 poses of receiving a waiver described in paragraph
24 (3)(B). Such payment may be made only one time
25 with respect to each such physician or practitioner.

1 “(2) APPLICATION.—In order to receive a pay-
2 ment described in paragraph (1), a rural health clin-
3 ic shall submit to the Secretary an application for
4 such a payment at such time, in such manner, and
5 containing such information as specified by the Sec-
6 retary. A rural health clinic may apply for such a
7 payment for each physician or practitioner described
8 in paragraph (1) furnishing services described in
9 such paragraph at such clinic.

10 “(3) REQUIREMENTS.—For purposes of para-
11 graph (1), the requirements described in this para-
12 graph, with respect to a physician or practitioner,
13 are the following:

14 “(A) The physician or practitioner is em-
15 ployed by or working under contract with a
16 rural health clinic described in paragraph (1)
17 that submits an application under paragraph
18 (2).

19 “(B) The physician or practitioner first re-
20 ceives a waiver under section 303(g) of the
21 Controlled Substances Act on or after January
22 1, 2019.

23 “(4) FUNDING.—For purposes of making pay-
24 ments under this subsection, there are appropriated,
25 out of amounts in the Treasury not otherwise appro-

1 priated, \$2,000,000, which shall remain available
2 until expended.”.

3 **SEC. 6084. STUDYING THE AVAILABILITY OF SUPPLE-**
4 **MENTAL BENEFITS DESIGNED TO TREAT OR**
5 **PREVENT SUBSTANCE USE DISORDERS**
6 **UNDER MEDICARE ADVANTAGE PLANS.**

7 (a) IN GENERAL.—Not later than 2 years after the
8 date of the enactment of this Act, the Secretary of Health
9 and Human Services (in this section referred to as the
10 “Secretary”) shall submit to Congress a report on the
11 availability of supplemental health care benefits (as de-
12 scribed in section 1852(a)(3)(A) of the Social Security Act
13 (42 U.S.C. 1395w–22(a)(3)(A))) designed to treat or pre-
14 vent substance use disorders under Medicare Advantage
15 plans offered under part C of title XVIII of such Act. Such
16 report shall include the analysis described in subsection
17 (c) and any differences in the availability of such benefits
18 under specialized MA plans for special needs individuals
19 (as defined in section 1859(b)(6) of such Act (42 U.S.C.
20 1395w–28(b)(6))) offered to individuals entitled to med-
21 ical assistance under title XIX of such Act and other such
22 Medicare Advantage plans.

23 (b) CONSULTATION.—The Secretary shall develop the
24 report described in subsection (a) in consultation with rel-
25 evant stakeholders, including—

1 (1) individuals entitled to benefits under part A
2 or enrolled under part B of title XVIII of the Social
3 Security Act;

4 (2) entities who advocate on behalf of such indi-
5 viduals;

6 (3) Medicare Advantage organizations;

7 (4) pharmacy benefit managers; and

8 (5) providers of services and suppliers (as such
9 terms are defined in section 1861 of such Act (42
10 U.S.C. 1395x)).

11 (c) CONTENTS.—The report described in subsection
12 (a) shall include an analysis on the following:

13 (1) The extent to which plans described in such
14 subsection offer supplemental health care benefits
15 relating to coverage of—

16 (A) medication-assisted treatments for
17 opioid use, substance use disorder counseling,
18 peer recovery support services, or other forms
19 of substance use disorder treatments (whether
20 furnished in an inpatient or outpatient setting);
21 and

22 (B) non-opioid alternatives for the treat-
23 ment of pain.

24 (2) Challenges associated with such plans offer-
25 ing supplemental health care benefits relating to cov-

1 erage of items and services described in subpara-
2 graph (A) or (B) of paragraph (1).

3 (3) The impact, if any, of increasing the appli-
4 cable rebate percentage determined under section
5 1854(b)(1)(C) of the Social Security Act (42 U.S.C.
6 1395w-24(b)(1)(C)) for plans offering such benefits
7 relating to such coverage would have on the avail-
8 ability of such benefits relating to such coverage of-
9 fered under Medicare Advantage plans.

10 (4) Potential ways to improve upon such cov-
11 erage or to incentivize such plans to offer additional
12 supplemental health care benefits relating to such
13 coverage.

14 **SEC. 6085. CLINICAL PSYCHOLOGIST SERVICES MODELS**
15 **UNDER THE CENTER FOR MEDICARE AND**
16 **MEDICAID INNOVATION; GAO STUDY AND RE-**
17 **PORT.**

18 (a) CMI MODELS.—Section 1115A(b)(2)(B) of the
19 Social Security Act (42 U.S.C. 1315a(b)(2)(B)), as
20 amended by section 6001, is further amended by adding
21 at the end the following new clauses:

22 “(xxvi) Supporting ways to familiarize
23 individuals with the availability of coverage
24 under part B of title XVIII for qualified

1 psychologist services (as defined in section
2 1861(ii)).

3 “(xxvii) Exploring ways to avoid un-
4 necessary hospitalizations or emergency de-
5 partment visits for mental and behavioral
6 health services (such as for treating de-
7 pression) through use of a 24-hour, 7-day
8 a week help line that may inform individ-
9 uals about the availability of treatment op-
10 tions, including the availability of qualified
11 psychologist services (as defined in section
12 1861(ii)).”.

13 (b) GAO STUDY AND REPORT.—Not later than 18
14 months after the date of the enactment of this Act, the
15 Comptroller General of the United States shall conduct
16 a study, and submit to Congress a report, on mental and
17 behavioral health services under the Medicare program
18 under title XVIII of the Social Security Act, including an
19 examination of the following:

20 (1) Information about services furnished by
21 psychiatrists, clinical psychologists, and other profes-
22 sionals.

23 (2) Information about ways that Medicare bene-
24 ficiaries familiarize themselves about the availability
25 of Medicare payment for qualified psychologist serv-

1 ices (as defined in section 1861(ii) of the Social Se-
2 curity Act (42 U.S.C. 1395x(ii)) and ways that the
3 provision of such information could be improved.

4 **SEC. 6086. DR. TODD GRAHAM PAIN MANAGEMENT STUDY.**

5 (a) IN GENERAL.—Not later than 1 year after the
6 date of enactment of this Act, the Secretary of Health and
7 Human Services (referred to in this section as the “Sec-
8 retary”) shall conduct a study analyzing best practices as
9 well as payment and coverage for pain management serv-
10 ices under title XVIII of the Social Security Act and sub-
11 mit to the Committee on Ways and Means and the Com-
12 mittee on Energy and Commerce of the House of Rep-
13 resentatives and the Committee on Finance of the Senate
14 a report containing options for revising payment to pro-
15 viders and suppliers of services and coverage related to
16 the use of multi-disciplinary, evidence-based, non-opioid
17 treatments for acute and chronic pain management for in-
18 dividuals entitled to benefits under part A or enrolled
19 under part B of title XVIII of the Social Security Act.
20 The Secretary shall make such report available on the
21 public website of the Centers for Medicare & Medicaid
22 Services.

23 (b) CONSULTATION.—In developing the report de-
24 scribed in subsection (a), the Secretary shall consult
25 with—

- 1 (1) relevant agencies within the Department of
2 Health and Human Services;
- 3 (2) licensed and practicing osteopathic and
4 allopathic physicians, behavioral health practitioners,
5 physician assistants, nurse practitioners, dentists,
6 pharmacists, and other providers of health services;
- 7 (3) providers and suppliers of services (as such
8 terms are defined in section 1861 of the Social Secu-
9 rity Act (42 U.S.C. 1395x));
- 10 (4) substance abuse and mental health profes-
11 sional organizations;
- 12 (5) pain management professional organizations
13 and advocacy entities, including individuals who per-
14 sonally suffer chronic pain;
- 15 (6) medical professional organizations and med-
16 ical specialty organizations;
- 17 (7) licensed health care providers who furnish
18 alternative pain management services;
- 19 (8) organizations with expertise in the develop-
20 ment of innovative medical technologies for pain
21 management;
- 22 (9) beneficiary advocacy organizations; and
- 23 (10) other organizations with expertise in the
24 assessment, diagnosis, treatment, and management
25 of pain, as determined appropriate by the Secretary.

1 (c) CONTENTS.—The report described in subsection
2 (a) shall include the following:

3 (1) An analysis of payment and coverage under
4 title XVIII of the Social Security Act with respect
5 to the following:

6 (A) Evidence-based treatments and tech-
7 nologies for chronic or acute pain, including
8 such treatments that are covered, not covered,
9 or have limited coverage under such title.

10 (B) Evidence-based treatments and tech-
11 nologies that monitor substance use withdrawal
12 and prevent overdoses of opioids.

13 (C) Evidence-based treatments and tech-
14 nologies that treat substance use disorders.

15 (D) Items and services furnished by practi-
16 tioners through a multi-disciplinary treatment
17 model for pain management, including the pa-
18 tient-centered medical home.

19 (E) Items and services furnished to bene-
20 ficiaries with psychiatric disorders, substance
21 use disorders, or who are at risk of suicide, or
22 have comorbidities and require consultation or
23 management of pain with one or more special-
24 ists in pain management, mental health, or ad-
25 diction treatment.

1 (2) An evaluation of the following:

2 (A) Barriers inhibiting individuals entitled
3 to benefits under part A or enrolled under part
4 B of such title from accessing treatments and
5 technologies described in subparagraphs (A)
6 through (E) of paragraph (1).

7 (B) Costs and benefits associated with po-
8 tential expansion of coverage under such title to
9 include items and services not covered under
10 such title that may be used for the treatment
11 of pain, such as acupuncture, therapeutic mas-
12 sage, and items and services furnished by inte-
13 grated pain management programs.

14 (C) Pain management guidance published
15 by the Federal Government that may be rel-
16 evant to coverage determinations or other cov-
17 erage requirements under title XVIII of the So-
18 cial Security Act.

19 (3) An assessment of all guidance published by
20 the Department of Health and Human Services on
21 or after January 1, 2016, relating to the prescribing
22 of opioids. Such assessment shall consider incor-
23 porating into such guidance relevant elements of the
24 “Va/DoD Clinical Practice Guideline for Opioid
25 Therapy for Chronic Pain” published in February

1 2017 by the Department of Veterans Affairs and
2 Department of Defense, including adoption of ele-
3 ments of the Department of Defense and Depart-
4 ment of Veterans Affairs pain rating scale.

5 (4) The options described in subsection (d).

6 (5) The impact analysis described in subsection
7 (e).

8 (d) OPTIONS.—The options described in this sub-
9 section are, with respect to individuals entitled to benefits
10 under part A or enrolled under part B of title XVIII of
11 the Social Security Act, legislative and administrative op-
12 tions for accomplishing the following:

13 (1) Improving coverage of and payment for pain
14 management therapies without the use of opioids, in-
15 cluding interventional pain therapies, and options to
16 augment opioid therapy with other clinical and com-
17 plementary, integrative health services to minimize
18 the risk of substance use disorder, including in a
19 hospital setting.

20 (2) Improving coverage of and payment for
21 medical devices and non-opioid based pharma-
22 cological and non-pharmacological therapies ap-
23 proved or cleared by the Food and Drug Administra-
24 tion for the treatment of pain as an alternative or
25 augment to opioid therapy.

1 (3) Improving and disseminating treatment
2 strategies for beneficiaries with psychiatric dis-
3 orders, substance use disorders, or who are at risk
4 of suicide, and treatment strategies to address
5 health disparities related to opioid use and opioid
6 abuse treatment.

7 (4) Improving and disseminating treatment
8 strategies for beneficiaries with comorbidities who
9 require a consultation or comanagement of pain with
10 one or more specialists in pain management, mental
11 health, or addiction treatment, including in a hos-
12 pital setting.

13 (5) Educating providers on risks of coadminis-
14 tration of opioids and other drugs, particularly
15 benzodiazepines.

16 (6) Ensuring appropriate case management for
17 beneficiaries who transition between inpatient and
18 outpatient hospital settings, or between opioid ther-
19 apy to non-opioid therapy, which may include the
20 use of care transition plans.

21 (7) Expanding outreach activities designed to
22 educate providers of services and suppliers under the
23 Medicare program and individuals entitled to bene-
24 fits under part A or under part B of such title on

1 alternative, non-opioid therapies to manage and
2 treat acute and chronic pain.

3 (8) Creating a beneficiary education tool on al-
4 ternatives to opioids for chronic pain management.

5 (e) **IMPACT ANALYSIS.**—The impact analysis de-
6 scribed in this subsection consists of an analysis of any
7 potential effects implementing the options described in
8 subsection (d) would have—

9 (1) on expenditures under the Medicare pro-
10 gram; and

11 (2) on preventing or reducing opioid addiction
12 for individuals receiving benefits under the Medicare
13 program.

14 **Subtitle J—Combating Opioid**
15 **Abuse for Care in Hospitals**

16 **SEC. 6091. SHORT TITLE.**

17 This subtitle may be cited as the “Combating Opioid
18 Abuse for Care in Hospitals Act of 2018” or the “COACH
19 Act of 2018”.

20 **SEC. 6092. DEVELOPING GUIDANCE ON PAIN MANAGEMENT**
21 **AND OPIOID USE DISORDER PREVENTION**
22 **FOR HOSPITALS RECEIVING PAYMENT**
23 **UNDER PART A OF THE MEDICARE PROGRAM.**

24 (a) **IN GENERAL.**—Not later than July 1, 2019, the
25 Secretary of Health and Human Services (in this section

1 referred to as the “Secretary”) shall develop and publish
2 on the public website of the Centers for Medicare & Med-
3 icaid Services guidance for hospitals receiving payment
4 under part A of title XVIII of the Social Security Act (42
5 U.S.C. 1395c et seq.) on pain management strategies and
6 opioid use disorder prevention strategies with respect to
7 individuals entitled to benefits under such part.

8 (b) CONSULTATION.—In developing the guidance de-
9 scribed in subsection (a), the Secretary shall consult with
10 relevant stakeholders, including—

11 (1) medical professional organizations;

12 (2) providers and suppliers of services (as such
13 terms are defined in section 1861 of the Social Secu-
14 rity Act (42 U.S.C. 1395x));

15 (3) health care consumers or groups rep-
16 resenting such consumers; and

17 (4) other entities determined appropriate by the
18 Secretary.

19 (c) CONTENTS.—The guidance described in sub-
20 section (a) shall include, with respect to hospitals and indi-
21 viduals described in such subsection, the following:

22 (1) Best practices regarding evidence-based
23 screening and practitioner education initiatives relat-
24 ing to screening and treatment protocols for opioid
25 use disorder, including—

1 (A) methods to identify such individuals
2 at-risk of opioid use disorder, including risk
3 stratification;

4 (B) ways to prevent, recognize, and treat
5 opioid overdoses; and

6 (C) resources available to such individuals,
7 such as opioid treatment programs, peer sup-
8 port groups, and other recovery programs.

9 (2) Best practices for such hospitals to educate
10 practitioners furnishing items and services at such
11 hospital with respect to pain management and sub-
12 stance use disorders, including education on—

13 (A) the adverse effects of prolonged opioid
14 use;

15 (B) non-opioid, evidence-based, non-phar-
16 macological pain management treatments;

17 (C) monitoring programs for individuals
18 who have been prescribed opioids; and

19 (D) the prescribing of naloxone along with
20 an initial opioid prescription.

21 (3) Best practices for such hospitals to make
22 such individuals aware of the risks associated with
23 opioid use (which may include use of the notification
24 template described in paragraph (4)).

1 (4) A notification template developed by the
2 Secretary, for use as appropriate, for such individ-
3 uals who are prescribed an opioid that—

4 (A) explains the risks and side effects asso-
5 ciated with opioid use (including the risks of
6 addiction and overdose) and the importance of
7 adhering to the prescribed treatment regimen,
8 avoiding medications that may have an adverse
9 interaction with such opioid, and storing such
10 opioid safely and securely;

11 (B) highlights multimodal and evidence-
12 based non-opioid alternatives for pain manage-
13 ment;

14 (C) encourages such individuals to talk to
15 their health care providers about such alter-
16 natives;

17 (D) provides for a method (through signa-
18 ture or otherwise) for such an individual, or
19 person acting on such individual's behalf, to ac-
20 knowledge receipt of such notification template;

21 (E) is worded in an easily understandable
22 manner and made available in multiple lan-
23 guages determined appropriate by the Sec-
24 retary; and

1 (F) includes any other information deter-
2 mined appropriate by the Secretary.

3 (5) Best practices for such hospital to track
4 opioid prescribing trends by practitioners furnishing
5 items and services at such hospital, including—

6 (A) ways for such hospital to establish tar-
7 get levels, taking into account the specialties of
8 such practitioners and the geographic area in
9 which such hospital is located, with respect to
10 opioids prescribed by such practitioners;

11 (B) guidance on checking the medical
12 records of such individuals against information
13 included in prescription drug monitoring pro-
14 grams;

15 (C) strategies to reduce long-term opioid
16 prescriptions; and

17 (D) methods to identify such practitioners
18 who may be over-prescribing opioids.

19 (6) Other information the Secretary determines
20 appropriate, including any such information from
21 the Opioid Safety Initiative established by the De-
22 partment of Veterans Affairs or the Opioid Overdose
23 Prevention Toolkit published by the Substance
24 Abuse and Mental Health Services Administration.

1 **SEC. 6093. REQUIRING THE REVIEW OF QUALITY MEAS-**
2 **URES RELATING TO OPIOIDS AND OPIOID**
3 **USE DISORDER TREATMENTS FURNISHED**
4 **UNDER THE MEDICARE PROGRAM AND**
5 **OTHER FEDERAL HEALTH CARE PROGRAMS.**

6 Section 1890A of the Social Security Act (42 U.S.C.
7 1395aaa–1) is amended by adding at the end the following
8 new subsection:

9 “(g) **TECHNICAL EXPERT PANEL REVIEW OF OPIOID**
10 **AND OPIOID USE DISORDER QUALITY MEASURES.**—

11 “(1) **IN GENERAL.**—Not later than 180 days
12 after the date of the enactment of this subsection,
13 the Secretary shall establish a technical expert panel
14 for purposes of reviewing quality measures relating
15 to opioids and opioid use disorders, including care,
16 prevention, diagnosis, health outcomes, and treat-
17 ment furnished to individuals with opioid use dis-
18 orders. The Secretary may use the entity with a con-
19 tract under section 1890(a) and amend such con-
20 tract as necessary to provide for the establishment
21 of such technical expert panel.

22 “(2) **REVIEW AND ASSESSMENT.**—Not later
23 than 1 year after the date the technical expert panel
24 described in paragraph (1) is established (and peri-
25 odically thereafter as the Secretary determines ap-
26 propriate), the technical expert panel shall—

1 “(A) review quality measures that relate to
2 opioids and opioid use disorders, including ex-
3 isting measures and those under development;

4 “(B) identify gaps in areas of quality
5 measurement that relate to opioids and opioid
6 use disorders, and identify measure develop-
7 ment priorities for such measure gaps; and

8 “(C) make recommendations to the Sec-
9 retary on quality measures with respect to
10 opioids and opioid use disorders for purposes of
11 improving care, prevention, diagnosis, health
12 outcomes, and treatment, including rec-
13 ommendations for revisions of such measures,
14 need for development of new measures, and rec-
15 ommendations for including such measures in
16 the Merit-Based Incentive Payment System
17 under section 1848(q), the alternative payment
18 models under section 1833(z)(3)(C), the shared
19 savings program under section 1899, the qual-
20 ity reporting requirements for inpatient hos-
21 pitals under section 1886(b)(3)(B)(viii), and
22 the hospital value-based purchasing program
23 under section 1886(o).

24 “(3) CONSIDERATION OF MEASURES BY SEC-
25 RETARY.—The Secretary shall consider—

1 “(A) using opioid and opioid use disorder
2 measures (including measures used under the
3 Merit-Based Incentive Payment System under
4 section 1848(q), measures recommended under
5 paragraph (2)(C), and other such measures
6 identified by the Secretary) in alternative pay-
7 ment models under section 1833(z)(3)(C) and
8 in the shared savings program under section
9 1899; and

10 “(B) using opioid measures described in
11 subparagraph (A), as applicable, in the quality
12 reporting requirements for inpatient hospitals
13 under section 1886(b)(3)(B)(viii), and in the
14 hospital value-based purchasing program under
15 section 1886(o).

16 “(4) PRIORITIZATION OF MEASURE DEVELOP-
17 MENT.—The Secretary shall prioritize for measure
18 development the gaps in quality measures identified
19 under paragraph (2)(B).

20 “(5) PRIORITIZATION OF MEASURE ENDORSE-
21 MENT.—The Secretary—

22 “(A) during the period beginning on the
23 date of the enactment of this subsection and
24 ending on December 31, 2023, shall prioritize
25 the endorsement of measures relating to opioids

1 and opioid use disorders by the entity with a
2 contract under subsection (a) of section 1890 in
3 connection with endorsement of measures de-
4 scribed in subsection (b)(2) of such section; and
5 “(B) on and after January 1, 2024, may
6 prioritize the endorsement of such measures by
7 such entity.”.

8 **SEC. 6094. TECHNICAL EXPERT PANEL ON REDUCING SUR-**
9 **GICAL SETTING OPIOID USE; DATA COLLEC-**
10 **TION ON PERIOPERATIVE OPIOID USE.**

11 (a) TECHNICAL EXPERT PANEL ON REDUCING SUR-
12 GICAL SETTING OPIOID USE.—

13 (1) IN GENERAL.—Not later than 6 months
14 after the date of the enactment of this Act, the Sec-
15 retary of Health and Human Services shall convene
16 a technical expert panel, including medical and sur-
17 gical specialty societies and hospital organizations,
18 to provide recommendations on reducing opioid use
19 in the inpatient and outpatient surgical settings and
20 on best practices for pain management, including
21 with respect to the following:

22 (A) Approaches that limit patient exposure
23 to opioids during the perioperative period, in-
24 cluding pre-surgical and post-surgical injec-

1 tions, and that identify such patients at risk of
2 opioid use disorder pre-operation.

3 (B) Shared decision making with patients
4 and families on pain management, including a
5 review of payment to ensure payment under the
6 Medicare program under title XVIII of the So-
7 cial Security Act accounts for time spent on
8 shared decision making.

9 (C) Education on the safe use, storage,
10 and disposal of opioids.

11 (D) Prevention of opioid misuse and abuse
12 after discharge.

13 (E) Development of a clinical algorithm to
14 identify and treat at-risk, opiate-tolerant pa-
15 tients and reduce reliance on opioids for acute
16 pain during the perioperative period.

17 (2) REPORT.—Not later than 1 year after the
18 date of the enactment of this Act, the Secretary
19 shall submit to Congress and make public a report
20 containing the recommendations developed under
21 paragraph (1) and an action plan for broader imple-
22 mentation of pain management protocols that limit
23 the use of opioids in the perioperative setting and
24 upon discharge from such setting.

1 (b) DATA COLLECTION ON PERIOPERATIVE OPIOID
2 USE.—Not later than 1 year after the date of the enact-
3 ment of this Act, the Secretary of Health and Human
4 Services shall submit to Congress a report that contains
5 the following:

6 (1) The diagnosis-related group codes identified
7 by the Secretary as having the highest volume of
8 surgeries.

9 (2) With respect to each of such diagnosis-re-
10 lated group codes so identified, a determination by
11 the Secretary of the data that is both available and
12 reported on opioid use following such surgeries, such
13 as with respect to—

14 (A) surgical volumes, practices, and opioid
15 prescribing patterns;

16 (B) opioid consumption, including—

17 (i) perioperative days of therapy;

18 (ii) average daily dose at the hospital,
19 including dosage greater than 90 milligram
20 morphine equivalent;

21 (iii) post-discharge prescriptions and
22 other combination drugs that are used be-
23 fore intervention and after intervention;

24 (iv) quantity and duration of opioid
25 prescription at discharge; and

1 (v) quantity consumed and number of
2 refills;

3 (C) regional anesthesia and analgesia prac-
4 tices, including pre-surgical and post-surgical
5 injections;

6 (D) naloxone reversal;

7 (E) post-operative respiratory failure;

8 (F) information about storage and dis-
9 posal; and

10 (G) such other information as the Sec-
11 retary may specify.

12 (3) Recommendations for improving data collec-
13 tion on perioperative opioid use, including an anal-
14 ysis to identify and reduce barriers to collecting, re-
15 porting, and analyzing the data described in para-
16 graph (2), including barriers related to technological
17 availability.

18 **SEC. 6095. REQUIRING THE POSTING AND PERIODIC UP-**
19 **DATE OF OPIOID PRESCRIBING GUIDANCE**
20 **FOR MEDICARE BENEFICIARIES.**

21 (a) IN GENERAL.—Not later than 180 days after the
22 date of the enactment of this Act, the Secretary of Health
23 and Human Services (in this section referred to as the
24 “Secretary”) shall post on the public website of the Cen-
25 ters for Medicare & Medicaid Services all guidance pub-

1 lished by the Department of Health and Human Services
2 on or after January 1, 2016, relating to the prescribing
3 of opioids and applicable to opioid prescriptions for indi-
4 viduals entitled to benefits under part A of title XVIII
5 of the Social Security Act (42 U.S.C. 1395c et seq.) or
6 enrolled under part B of such title of such Act (42 U.S.C.
7 1395j et seq.).

8 (b) UPDATE OF GUIDANCE.—

9 (1) PERIODIC UPDATE.—The Secretary shall, in
10 consultation with the entities specified in paragraph
11 (2), periodically (as determined appropriate by the
12 Secretary) update guidance described in subsection
13 (a) and revise the posting of such guidance on the
14 website described in such subsection.

15 (2) CONSULTATION.—The entities specified in
16 this paragraph are the following:

17 (A) Medical professional organizations.

18 (B) Providers and suppliers of services (as
19 such terms are defined in section 1861 of the
20 Social Security Act (42 U.S.C. 1395x)).

21 (C) Health care consumers or groups rep-
22 resenting such consumers.

23 (D) Other entities determined appropriate
24 by the Secretary.

1 **Subtitle K—Providing Reliable Op-**
2 **tions for Patients and Edu-**
3 **catinal Resources**

4 **SEC. 6101. SHORT TITLE.**

5 This subtitle may be cited as the “Providing Reliable
6 Options for Patients and Educational Resources Act of
7 2018” or the “PROPER Act of 2018”.

8 **SEC. 6102. REQUIRING MEDICARE ADVANTAGE PLANS AND**
9 **PART D PRESCRIPTION DRUG PLANS TO IN-**
10 **CLUDE INFORMATION ON RISKS ASSOCIATED**
11 **WITH OPIOIDS AND COVERAGE OF NON-**
12 **PHARMACOLOGICAL THERAPIES AND**
13 **NONOPIOID MEDICATIONS OR DEVICES USED**
14 **TO TREAT PAIN.**

15 Section 1860D–4(a)(1) of the Social Security Act (42
16 U.S.C. 1395w–104(a)(1)) is amended—

17 (1) in subparagraph (A), by inserting “, subject
18 to subparagraph (C),” before “including”;

19 (2) in subparagraph (B), by adding at the end
20 the following new clause:

21 “(vi) For plan year 2021 and each
22 subsequent plan year, subject to subpara-
23 graph (C), with respect to the treatment of
24 pain—

1 “(I) the risks associated with
2 prolonged opioid use; and

3 “(II) coverage of nonpharma-
4 cological therapies, devices, and
5 nonopioid medications—

6 “(aa) in the case of an MA-
7 PD plan under part C, under
8 such plan; and

9 “(bb) in the case of a pre-
10 scription drug plan, under such
11 plan and under parts A and B.”;
12 and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(C) TARGETED PROVISION OF INFORMA-
16 TION.—A PDP sponsor of a prescription drug
17 plan may, in lieu of disclosing the information
18 described in subparagraph (B)(vi) to each en-
19 rollee under the plan, disclose such information
20 through mail or electronic communications to a
21 subset of enrollees under the plan, such as en-
22 rollees who have been prescribed an opioid in
23 the previous 2-year period.”.

1 **SEC. 6103. REQUIRING MEDICARE ADVANTAGE PLANS AND**
2 **PRESCRIPTION DRUG PLANS TO PROVIDE IN-**
3 **FORMATION ON THE SAFE DISPOSAL OF PRE-**
4 **SCRIPTION DRUGS.**

5 (a) **MEDICARE ADVANTAGE.**—Section 1852 of the
6 Social Security Act (42 U.S.C. 1395w–22) is amended by
7 adding at the end the following new subsection:

8 “(n) **PROVISION OF INFORMATION RELATING TO THE**
9 **SAFE DISPOSAL OF CERTAIN PRESCRIPTION DRUGS.**—

10 “(1) **IN GENERAL.**—In the case of an individual
11 enrolled under an MA or MA–PD plan who is fur-
12 nished an in-home health risk assessment on or after
13 January 1, 2021, such plan shall ensure that such
14 assessment includes information on the safe disposal
15 of prescription drugs that are controlled substances
16 that meets the criteria established under paragraph
17 (2). Such information shall include information on
18 drug takeback programs that meet such require-
19 ments determined appropriate by the Secretary and
20 information on in-home disposal.

21 “(2) **CRITERIA.**—The Secretary shall, through
22 rulemaking, establish criteria the Secretary deter-
23 mines appropriate with respect to information pro-
24 vided to an individual to ensure that such informa-
25 tion sufficiently educates such individual on the safe

1 disposal of prescription drugs that are controlled
2 substances.”.

3 (b) PRESCRIPTION DRUG PLANS.—Section 1860D–
4 4(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–
5 104(c)(2)(B)) is amended—

6 (1) by striking “may include elements that pro-
7 mote”;

8 (2) by redesignating clauses (i) through (iii) as
9 subclauses (I) through (III) and adjusting the mar-
10 gins accordingly;

11 (3) by inserting before subclause (I), as so re-
12 designated, the following new clause:

13 “(i) may include elements that pro-
14 mote—”;

15 (4) in subclause (III), as so redesignated, by
16 striking the period at the end and inserting “; and”;
17 and

18 (5) by adding at the end the following new
19 clause:

20 “(ii) with respect to plan years begin-
21 ning on or after January 1, 2021, shall
22 provide for—

23 “(I) the provision of information
24 to the enrollee on the safe disposal of
25 prescription drugs that are controlled

1 substances that meets the criteria es-
2 tablished under section 1852(n)(2),
3 including information on drug
4 takeback programs that meet such re-
5 quirements determined appropriate by
6 the Secretary and information on in-
7 home disposal; and

8 “(II) cost-effective means by
9 which an enrollee may so safely dis-
10 pose of such drugs.”.

11 **SEC. 6104. REVISING MEASURES USED UNDER THE HOS-**
12 **PITAL CONSUMER ASSESSMENT OF**
13 **HEALTHCARE PROVIDERS AND SYSTEMS**
14 **SURVEY RELATING TO PAIN MANAGEMENT.**

15 (a) RESTRICTION ON THE USE OF PAIN QUESTIONS
16 IN HCAHPS.—Section 1886(b)(3)(B)(viii) of the Social
17 Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amend-
18 ed by adding at the end the following new subclause:

19 “(XII)(aa) With respect to a Hospital Consumer As-
20 sessment of Healthcare Providers and Systems survey (or
21 a successor survey) conducted on or after January 1,
22 2020, such survey may not include questions about com-
23 munication by hospital staff with an individual about such
24 individual’s pain unless such questions take into account,
25 as applicable, whether an individual experiencing pain was

1 informed about risks associated with the use of opioids
2 and about non-opioid alternatives for the treatment of
3 pain.

4 “(bb) The Secretary shall not include on the Hospital
5 Compare internet website any measures based on the
6 questions appearing on the Hospital Consumer Assess-
7 ment of Healthcare Providers and Systems survey in 2018
8 or 2019 about communication by hospital staff with an
9 individual about such individual’s pain.”.

10 (b) RESTRICTION ON USE OF 2018 AND 2019 PAIN
11 QUESTIONS IN THE HOSPITAL VALUE-BASED PUR-
12 CHASING PROGRAM.—Section 1886(o)(2)(B) of the Social
13 Security Act (42 U.S.C. 1395ww(o)(2)(B)) is amended by
14 adding at the end the following new clause:

15 “(iii) HCAHPS PAIN QUESTIONS.—
16 The Secretary may not include under sub-
17 paragraph (A) a measure that is based on
18 the questions appearing on the Hospital
19 Consumer Assessment of Healthcare Pro-
20 viders and Systems survey in 2018 or
21 2019 about communication by hospital
22 staff with an individual about the individ-
23 ual’s pain.”.

1 **Subtitle L—Fighting the Opioid**
2 **Epidemic With Sunshine**

3 **SEC. 6111. FIGHTING THE OPIOID EPIDEMIC WITH SUN-**
4 **SHINE.**

5 (a) INCLUSION OF INFORMATION REGARDING PAY-
6 MENTS TO ADDITIONAL PRACTITIONERS.—

7 (1) IN GENERAL.—Section 1128G(e)(6) of the
8 Social Security Act (42 U.S.C. 1320a–7h(e)(6)) is
9 amended—

10 (A) in subparagraph (A), by adding at the
11 end the following new clauses:

12 “(iii) A physician assistant, nurse
13 practitioner, or clinical nurse specialist (as
14 such terms are defined in section
15 1861(aa)(5)).

16 “(iv) A certified registered nurse an-
17 esthetist (as defined in section
18 1861(bb)(2)).

19 “(v) A certified nurse-midwife (as de-
20 fined in section 1861(gg)(2)).”; and

21 (B) in subparagraph (B), by inserting “,
22 physician assistant, nurse practitioner, clinical
23 nurse specialist, certified nurse anesthetist, or
24 certified nurse-midwife” after “physician”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply with respect to infor-
3 mation required to be submitted under section
4 1128G of the Social Security Act (42 U.S.C. 1320a-
5 7h) on or after January 1, 2022.

6 (b) SUNSET OF EXCLUSION OF NATIONAL PROVIDER
7 IDENTIFIER OF COVERED RECIPIENT IN INFORMATION
8 MADE PUBLICLY AVAILABLE.—Section
9 1128G(e)(1)(C)(viii) of the Social Security Act (42 U.S.C.
10 1320a-7h(e)(1)(C)(viii)) is amended by striking “does not
11 contain” and inserting “in the case of information made
12 available under this subparagraph prior to January 1,
13 2022, does not contain”.

14 (c) ADMINISTRATION.—Chapter 35 of title 44,
15 United States Code, shall not apply to this section or the
16 amendments made by this section.

17 **TITLE VII—PUBLIC HEALTH** 18 **PROVISIONS**

19 **Subtitle A—Awareness and** 20 **Training**

21 **SEC. 7001. REPORT ON EFFECTS ON PUBLIC HEALTH OF** 22 **SYNTHETIC DRUG USE.**

23 (a) IN GENERAL.—Not later than 3 years after the
24 date of the enactment of this Act, the Secretary of Health
25 and Human Services, in coordination with the Surgeon

1 General of the Public Health Service, shall submit to the
2 Committee on Energy and Commerce of the House of
3 Representatives and the Committee on Health, Education,
4 Labor, and Pensions of the Senate a report on the health
5 effects of new psychoactive substances, including synthetic
6 drugs, used by adolescents and young adults.

7 (b) NEW PSYCHOACTIVE SUBSTANCE DEFINED.—
8 For purposes of subsection (a), the term “new
9 psychoactive substance” means a controlled substance
10 analogue (as defined in section 102(32) of the Controlled
11 Substances Act (21 U.S.C. 802(32)).

12 **SEC. 7002. FIRST RESPONDER TRAINING.**

13 Section 546 of the Public Health Service Act (42
14 U.S.C. 290ee–1) is amended—

15 (1) in subsection (c)—

16 (A) in paragraph (2), by striking “and” at
17 the end;

18 (B) in paragraph (3), by striking the pe-
19 riod and inserting “; and”; and

20 (C) by adding at the end the following:

21 “(4) train and provide resources for first re-
22 sponders and members of other key community sec-
23 tors on safety around fentanyl, carfentanil, and
24 other dangerous licit and illicit drugs to protect

1 themselves from exposure to such drugs and respond
2 appropriately when exposure occurs.”;

3 (2) in subsection (d), by striking “and mecha-
4 nisms for referral to appropriate treatment for an
5 entity receiving a grant under this section” and in-
6 sserting “mechanisms for referral to appropriate
7 treatment, and safety around fentanyl, carfentanil,
8 and other dangerous licit and illicit drugs”;

9 (3) in subsection (f)—

10 (A) in paragraph (3), by striking “and” at
11 the end;

12 (B) in paragraph (4), by striking the pe-
13 riod and inserting “; and”; and

14 (C) by adding at the end the following:

15 “(5) the number of first responders and mem-
16 bers of other key community sectors trained on safe-
17 ty around fentanyl, carfentanil, and other dangerous
18 licit and illicit drugs.”;

19 (4) by redesignating subsection (g) as sub-
20 section (h);

21 (5) by inserting after subsection (f) the fol-
22 lowing:

23 “(g) OTHER KEY COMMUNITY SECTORS.—In this
24 section, the term ‘other key community sectors’ includes
25 substance use disorder treatment providers, emergency

1 medical services agencies, agencies and organizations
2 working with prison and jail populations and offender re-
3 entry programs, health care providers, harm reduction
4 groups, pharmacies, community health centers, tribal
5 health facilities, and mental health providers.”; and

6 (6) in subsection (h), as so redesignated, by
7 striking “\$12,000,000 for each of fiscal years 2017
8 through 2021” and inserting “\$36,000,000 for each
9 of fiscal years 2019 through 2023”.

10 **Subtitle B—Pilot Program for Pub-**
11 **lic Health Laboratories To De-**
12 **tect Fentanyl and Other Syn-**
13 **thetic Opioids**

14 **SEC. 7011. PILOT PROGRAM FOR PUBLIC HEALTH LABORA-**
15 **TORIES TO DETECT FENTANYL AND OTHER**
16 **SYNTHETIC OPIOIDS.**

17 (a) GRANTS.—The Secretary of Health and Human
18 Services (referred to in this section as the “Secretary”)
19 shall award grants to, or enter into cooperative agree-
20 ments with, Federal, State, and local agencies to improve
21 coordination between public health laboratories and lab-
22 oratories operated by law enforcement agencies, such as
23 Customs and Border Protection and the Drug Enforce-
24 ment Administration, to improve detection of synthetic

1 opioids, including fentanyl and its analogues, as described
2 in subsection (b).

3 (b) DETECTION ACTIVITIES.—The Secretary, in con-
4 sultation with the Director of the National Institute of
5 Standards and Technology, the Director of the Centers for
6 Disease Control and Prevention, the Attorney General of
7 the United States, and the Administrator of the Drug En-
8 forcement Administration, shall, for purposes of this sec-
9 tion, develop or identify—

10 (1) best practices for safely handling and test-
11 ing synthetic opioids, including fentanyl and its ana-
12 logues, including with respect to reference materials,
13 instrument calibration, and quality control protocols;

14 (2) reference materials and quality control
15 standards related to synthetic opioids, including
16 fentanyl and its analogues, to enhance—

17 (A) clinical diagnostics;

18 (B) postmortem data collection; and

19 (C) portable testing equipment utilized by
20 law enforcement and public health officials; and

21 (3) procedures for the identification of new and
22 emerging synthetic opioid formulations and proce-
23 dures for reporting those findings to appropriate law
24 enforcement agencies and Federal, State, and local

1 public health laboratories and health departments,
2 as appropriate.

3 (c) LABORATORIES.—The Secretary shall require re-
4 cipients of grants or cooperative agreements under sub-
5 section (a) to—

6 (1) follow the best practices established under
7 subsection (b) and have the appropriate capabilities
8 to provide laboratory testing of controlled sub-
9 stances, such as synthetic fentanyl, and biospeci-
10 mens for the purposes of aggregating and reporting
11 public health information to Federal, State, and
12 local public health officials, laboratories, and other
13 entities the Secretary deems appropriate;

14 (2) work with law enforcement agencies and
15 public health authorities, as practicable;

16 (3) provide early warning information to Fed-
17 eral, State, and local law enforcement agencies and
18 public health authorities regarding trends or other
19 data related to the supply of synthetic opioids, in-
20 cluding fentanyl and its analogues;

21 (4) provide biosurveillance capabilities with re-
22 spect to identifying trends in adverse health out-
23 comes associated with non-fatal exposures; and

24 (5) provide diagnostic testing, as appropriate
25 and practicable, for non-fatal exposures of emer-

1 agency personnel, first responders, and other individ-
2 uals.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there is authorized to be appropriated
5 \$15,000,000 for each of fiscal years 2019 through 2023.

6 **Subtitle C—Indexing Narcotics,**
7 **Fentanyl, and Opioids**

8 **SEC. 7021. ESTABLISHMENT OF SUBSTANCE USE DISORDER**
9 **INFORMATION DASHBOARD.**

10 Title XVII of the Public Health Service Act (42
11 U.S.C. 300u et seq.) is amended by adding at the end
12 the following new section:

13 **“SEC. 1711. ESTABLISHMENT OF SUBSTANCE USE DIS-**
14 **ORDER INFORMATION DASHBOARD.**

15 “(a) IN GENERAL.—Not later than 6 months after
16 the date of the enactment of this section, the Secretary
17 of Health and Human Services shall, in consultation with
18 the Director of National Drug Control Policy, establish
19 and periodically update, on the Internet website of the De-
20 partment of Health and Human Services, a public infor-
21 mation dashboard that—

22 “(1) provides links to information on programs
23 within the Department of Health and Human Serv-
24 ices related to the reduction of opioid and other sub-
25 stance use disorders;

1 “(2) provides access, to the extent practicable
2 and appropriate, to publicly available data, which
3 may include data from agencies within the Depart-
4 ment of Health and Human Services and—

5 “(A) other Federal agencies;

6 “(B) State, local, and Tribal governments;

7 “(C) nonprofit organizations;

8 “(D) law enforcement;

9 “(E) medical experts;

10 “(F) public health educators; and

11 “(G) research institutions regarding pre-
12 vention, treatment, recovery, and other services
13 for opioid and other substance use disorders;

14 “(3) provides data on substance use disorder
15 prevention and treatment strategies in different re-
16 gions of and populations in the United States;

17 “(4) identifies information on alternatives to
18 controlled substances for pain management, such as
19 approaches studied by the National Institutes of
20 Health Pain Consortium, the National Center for
21 Complimentary and Integrative Health, and other
22 institutes and centers at the National Institutes of
23 Health, as appropriate; and

1 (B) The Attorney General of the United
2 States.

3 (C) The Secretary of Labor.

4 (D) The Secretary of Housing and Urban
5 Development.

6 (E) The Secretary of Education.

7 (F) The Secretary of Veterans Affairs.

8 (G) The Commissioner of Social Security.

9 (H) The Assistant Secretary for Mental
10 Health and Substance Use.

11 (I) The Director of National Drug Control
12 Policy.

13 (J) Representatives of other Federal agen-
14 cies that support or conduct activities or pro-
15 grams related to substance use disorders, as de-
16 termined appropriate by the Secretary.

17 (2) NON-FEDERAL MEMBERS.—The Committee
18 shall include a minimum of 15 non-Federal members
19 appointed by the Secretary, of which—

20 (A) at least two such members shall be an
21 individual who has received treatment for a di-
22 agnosis of a substance use disorder;

23 (B) at least two such members shall be a
24 director of a State substance abuse agency;

1 (C) at least two such members shall be a
2 representative of a leading research, advocacy,
3 or service organization for adults with sub-
4 stance use disorder;

5 (D) at least two such members shall—

6 (i) be a physician, licensed mental
7 health professional, advance practice reg-
8 istered nurse, or physician assistant; and

9 (ii) have experience in treating indi-
10 viduals with substance use disorders;

11 (E) at least one such member shall be a
12 substance use disorder treatment professional
13 who provides treatment services at a certified
14 opioid treatment program;

15 (F) at least one such member shall be a
16 substance use disorder treatment professional
17 who has research or clinical experience in work-
18 ing with racial and ethnic minority populations;

19 (G) at least one such member shall be a
20 substance use disorder treatment professional
21 who has research or clinical mental health expe-
22 rience in working with medically underserved
23 populations;

1 (H) at least one such member shall be a
2 State-certified substance use disorder peer sup-
3 port specialist;

4 (I) at least one such member shall be a
5 drug court judge or a judge with experience in
6 adjudicating cases related to substance use dis-
7 order;

8 (J) at least one such member shall be a
9 public safety officer with extensive experience in
10 interacting with adults with a substance use
11 disorder; and

12 (K) at least one such member shall be an
13 individual with experience providing services for
14 homeless individuals with a substance use dis-
15 order.

16 (c) TERMS.—

17 (1) IN GENERAL.—A member of the Committee
18 appointed under subsection (b)(2) shall be appointed
19 for a term of 3 years and may be reappointed for
20 one or more 3-year terms.

21 (2) VACANCIES.—A vacancy on the Committee
22 shall be filled in the same manner in which the origi-
23 nal appointment was made. Any individual appointed
24 to fill a vacancy for an unexpired term shall be ap-
25 pointed for the remainder of such term and may

1 serve after the expiration of such term until a suc-
2 cessor has been appointed.

3 (d) MEETINGS.—The Committee shall meet not fewer
4 than two times each year.

5 (e) DUTIES.—The Committee shall—

6 (1) identify areas for improved coordination of
7 activities, if any, related to substance use disorders,
8 including research, services, supports, and preven-
9 tion activities across all relevant Federal agencies;

10 (2) identify and provide to the Secretary rec-
11 ommendations for improving Federal programs for
12 the prevention and treatment of, and recovery from,
13 substance use disorders, including by expanding ac-
14 cess to prevention, treatment, and recovery services;

15 (3) analyze substance use disorder prevention
16 and treatment strategies in different regions of and
17 populations in the United States and evaluate the
18 extent to which Federal substance use disorder pre-
19 vention and treatment strategies are aligned with
20 State and local substance use disorder prevention
21 and treatment strategies;

22 (4) make recommendations to the Secretary re-
23 garding any appropriate changes with respect to the
24 activities and strategies described in paragraphs (1)
25 through (3);

1 (5) make recommendations to the Secretary re-
2 garding public participation in decisions relating to
3 substance use disorders and the process by which
4 public feedback can be better integrated into such
5 decisions; and

6 (6) make recommendations to ensure that sub-
7 stance use disorder research, services, supports, and
8 prevention activities of the Department of Health
9 and Human Services and other Federal agencies are
10 not unnecessarily duplicative.

11 (f) ANNUAL REPORT.—Not later than 1 year after
12 the date of the enactment of this Act, and annually there-
13 after for the life of the Committee, the Committee shall
14 publish on the Internet website of the Department of
15 Health and Human Services, which may include the public
16 information dashboard established under section 1711 of
17 the Public Health Service Act, as added by section 7021,
18 a report summarizing the activities carried out by the
19 Committee pursuant to subsection (e), including any find-
20 ings resulting from such activities.

21 (g) WORKING GROUPS.—The Committee may estab-
22 lish working groups for purposes of carrying out the duties
23 described in subsection (e). Any such working group shall
24 be composed of members of the Committee (or the des-
25 ignees of such members) and may hold such meetings as

1 are necessary to enable the working group to carry out
2 the duties delegated to the working group.

3 (h) FEDERAL ADVISORY COMMITTEE ACT.—The
4 Federal Advisory Committee Act (5 U.S.C. App.) shall
5 apply to the Committee only to the extent that the provi-
6 sions of such Act do not conflict with the requirements
7 of this section.

8 (i) SUNSET.—The Committee shall terminate on the
9 date that is 6 years after the date on which the Committee
10 is established under subsection (a).

11 **SEC. 7023. NATIONAL MILESTONES TO MEASURE SUCCESS**
12 **IN CURTAILING THE OPIOID CRISIS.**

13 (a) IN GENERAL.—Not later than 180 days after the
14 date of enactment of this Act, the Secretary of Health and
15 Human Services (referred to in this section as the “Sec-
16 retary”), in coordination with the Administrator of the
17 Drug Enforcement Administration and the Director of the
18 Office of National Drug Control Policy, shall develop or
19 identify existing national indicators (referred to in this
20 section as the “national milestones”) to measure success
21 in curtailing the opioid crisis, with the goal of significantly
22 reversing the incidence and prevalence of opioid misuse
23 and abuse, and opioid-related morbidity and mortality in
24 the United States within 5 years of such date of enact-
25 ment.

1 (b) NATIONAL MILESTONES TO END THE OPIOID
2 CRISIS.—The national milestones under subsection (a)
3 shall include the following:

4 (1) Not fewer than 10 indicators or metrics to
5 accurately and expediently measure progress in
6 meeting the goal described in subsection (a), which
7 shall, as appropriate, include, indicators or metrics
8 related to—

9 (A) the number of fatal and non-fatal
10 opioid overdoses;

11 (B) the number of emergency room visits
12 related to opioid misuse and abuse;

13 (C) the number of individuals in sustained
14 recovery from opioid use disorder;

15 (D) the number of infections associated
16 with illicit drug use, such as HIV, viral hepa-
17 titis, and infective endocarditis, and available
18 capacity for treating such infections;

19 (E) the number of providers prescribing
20 medication-assisted treatment for opioid use
21 disorders, including in primary care settings,
22 community health centers, jails, and prisons;

23 (F) the number of individuals receiving
24 treatment for opioid use disorder; and

1 (G) additional indicators or metrics, as ap-
2 propriate, such as metrics pertaining to specific
3 populations, including women and children,
4 American Indians and Alaskan Natives, individ-
5 uals living in rural and non-urban areas, and
6 justice-involved populations, that would further
7 clarify the progress made in addressing the
8 opioid crisis.

9 (2) A reasonable goal, such as a percentage de-
10 crease or other specified metric, that signifies
11 progress in meeting the goal described in subsection
12 (a), and annual targets to help achieve that goal.

13 (c) CONSIDERATION OF OTHER SUBSTANCE USE
14 DISORDERS.—In developing the national milestones under
15 subsection (b), the Secretary shall, as appropriate, con-
16 sider other substance use disorders in addition to opioid
17 use disorder.

18 (d) EXTENSION OF PERIOD.—If the Secretary deter-
19 mines that the goal described in subsection (a) will not
20 be achieved with respect to any indicator or metric estab-
21 lished under subsection (b)(2) within 5 years of the date
22 of enactment of this Act, the Secretary may extend the
23 timeline for meeting such goal with respect to that indi-
24 cator or metric. The Secretary shall include with any such
25 extension a rationale for why additional time is needed and

1 information on whether significant changes are needed in
2 order to achieve such goal with respect to the indicator
3 or metric.

4 (e) ANNUAL STATUS UPDATE.—Not later than one
5 year after the date of enactment of this Act, the Secretary
6 shall make available on the Internet website of the Depart-
7 ment of Health and Human Services, and submit to the
8 Committee on Health, Education, Labor, and Pensions of
9 the Senate and the Committee on Energy and Commerce
10 of the House of Representatives, an update on the
11 progress, including expected progress in the subsequent
12 year, in achieving the goals detailed in the national mile-
13 stones. Each such update shall include the progress made
14 in the first year or since the previous report, as applicable,
15 in meeting each indicator or metric in the national mile-
16 stones.

17 **SEC. 7024. STUDY ON PRESCRIBING LIMITS.**

18 Not later than 2 years after the date of enactment
19 of this Act, the Secretary of Health and Human Services,
20 in consultation with the Attorney General of the United
21 States, shall submit to the Committee on Health, Edu-
22 cation, Labor, and Pensions of the Senate and the Com-
23 mittee on Energy and Commerce of the House of Rep-
24 resentatives a report on the impact of Federal and State

1 laws and regulations that limit the length, quantity, or
2 dosage of opioid prescriptions. Such report shall address—

3 (1) the impact of such limits on—

4 (A) the incidence and prevalence of over-
5 dose related to prescription opioids;

6 (B) the incidence and prevalence of over-
7 dose related to illicit opioids;

8 (C) the prevalence of opioid use disorders;

9 (D) medically appropriate use of, and ac-
10 cess to, opioids, including any impact on travel
11 expenses and pain management outcomes for
12 patients, whether such limits are associated
13 with significantly higher rates of negative
14 health outcomes, including suicide, and whether
15 the impact of such limits differs based on the
16 clinical indication for which opioids are pre-
17 scribed;

18 (2) whether such limits lead to a significant in-
19 crease in burden for prescribers of opioids or pre-
20 scribers of treatments for opioid use disorder, in-
21 cluding any impact on patient access to treatment,
22 and whether any such burden is mitigated by any
23 factors such as electronic prescribing or telemedi-
24 cine; and

1 (3) the impact of such limits on diversion or
2 misuse of any controlled substance in schedule II,
3 III, or IV of section 202(c) of the Controlled Sub-
4 stances Act (21 U.S.C. 812(c)).

5 **Subtitle D—Ensuring Access to**
6 **Quality Sober Living**

7 **SEC. 7031. NATIONAL RECOVERY HOUSING BEST PRAC-**
8 **TICES.**

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

12 **“SEC. 550. NATIONAL RECOVERY HOUSING BEST PRAC-**
13 **TICES.**

14 “(a) BEST PRACTICES FOR OPERATING RECOVERY
15 HOUSING.—

16 “(1) IN GENERAL.—The Secretary, in consulta-
17 tion with the individuals and entities specified in
18 paragraph (2), shall identify or facilitate the devel-
19 opment of best practices, which may include model
20 laws for implementing suggested minimum stand-
21 ards, for operating recovery housing.

22 “(2) CONSULTATION.—In carrying out the ac-
23 tivities described in paragraph (1), the Secretary
24 shall consult with, as appropriate—

1 “(A) relevant divisions of the Department
2 of Health and Human Services, including the
3 Substance Abuse and Mental Health Services
4 Administration, the Office of Inspector General,
5 the Indian Health Service, and the Centers for
6 Medicare & Medicaid Services;

7 “(B) the Secretary of Housing and Urban
8 Development;

9 “(C) directors or commissioners, as appli-
10 cable, of State health departments, tribal health
11 departments, State Medicaid programs, and
12 State insurance agencies;

13 “(D) representatives of health insurance
14 issuers;

15 “(E) national accrediting entities and rep-
16 utable providers of, and analysts of, recovery
17 housing services, including Indian tribes, tribal
18 organizations, and tribally designated housing
19 entities that provide recovery housing services,
20 as applicable;

21 “(F) individuals with a history of sub-
22 stance use disorder; and

23 “(G) other stakeholders identified by the
24 Secretary.

1 “(b) IDENTIFICATION OF FRAUDULENT RECOVERY
2 HOUSING OPERATORS.—

3 “(1) IN GENERAL.—The Secretary, in consulta-
4 tion with the individuals and entities described in
5 paragraph (2), shall identify or facilitate the devel-
6 opment of common indicators that could be used to
7 identify potentially fraudulent recovery housing oper-
8 ators.

9 “(2) CONSULTATION.—In carrying out the ac-
10 tivities described in paragraph (1), the Secretary
11 shall consult with, as appropriate, the individuals
12 and entities specified in subsection (a)(2) and the
13 Attorney General of the United States.

14 “(3) REQUIREMENTS.—

15 “(A) PRACTICES FOR IDENTIFICATION AND
16 REPORTING.—In carrying out the activities de-
17 scribed in paragraph (1), the Secretary shall
18 consider how law enforcement, public and pri-
19 vate payers, and the public can best identify
20 and report fraudulent recovery housing opera-
21 tors.

22 “(B) FACTORS TO BE CONSIDERED.—In
23 carrying out the activities described in para-
24 graph (1), the Secretary shall identify or de-

1 velop indicators, which may include indicators
2 related to—

3 “(i) unusual billing practices;

4 “(ii) average lengths of stays;

5 “(iii) excessive levels of drug testing
6 (in terms of cost or frequency); and

7 “(iv) unusually high levels of recidi-
8 vism.

9 “(c) DISSEMINATION.—The Secretary shall, as ap-
10 propriate, disseminate the best practices identified or de-
11 veloped under subsection (a) and the common indicators
12 identified or developed under subsection (b) to—

13 “(1) State agencies, which may include the pro-
14 vision of technical assistance to State agencies seek-
15 ing to adopt or implement such best practices;

16 “(2) Indian tribes, tribal organizations, and
17 tribally designated housing entities;

18 “(3) the Attorney General of the United States;

19 “(4) the Secretary of Labor;

20 “(5) the Secretary of Housing and Urban De-
21 velopment;

22 “(6) State and local law enforcement agencies;

23 “(7) health insurance issuers;

24 “(8) recovery housing entities; and

25 “(9) the public.

1 “(d) REQUIREMENTS.—In carrying out the activities
2 described in subsections (a) and (b), the Secretary, in con-
3 sultation with appropriate individuals and entities de-
4 scribed in subsections (a)(2) and (b)(2), shall consider
5 how recovery housing is able to support recovery and pre-
6 vent relapse, recidivism, or overdose (including overdose
7 death), including by improving access and adherence to
8 treatment, including medication-assisted treatment.

9 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
10 tion shall be construed to provide the Secretary with the
11 authority to require States to adhere to minimum stand-
12 ards in the State oversight of recovery housing.

13 “(f) DEFINITIONS.—In this section:

14 “(1) The term ‘recovery housing’ means a
15 shared living environment free from alcohol and il-
16 licit drug use and centered on peer support and con-
17 nection to services that promote sustained recovery
18 from substance use disorders.

19 “(2) The terms ‘Indian tribe’ and ‘tribal organi-
20 zation’ have the meanings given those terms in sec-
21 tion 4 of the Indian Self-Determination and Edu-
22 cation Assistance Act (25 U.S.C. 5304).

23 “(3) The term ‘tribally designated housing enti-
24 ty’ has the meaning given that term in section 4 of

1 the Native American Housing Assistance and Self-
2 Determination Act of 1996 (25 U.S.C. 4103).

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there is authorized to be appro-
5 priated \$3,000,000 for the period of fiscal years 2019
6 through 2021.”.

7 **Subtitle E—Advancing Cutting** 8 **Edge Research**

9 **SEC. 7041. UNIQUE RESEARCH INITIATIVES.**

10 Section 402(n)(1) of the Public Health Service Act
11 (42 U.S.C. 282(n)(1)) is amended—

- 12 (1) in subparagraph (A), by striking “or”;
13 (2) in subparagraph (B), by striking the period
14 and inserting “; or”; and
15 (3) by adding at the end the following:

16 “(C) high impact cutting-edge research
17 that fosters scientific creativity and increases
18 fundamental biological understanding leading to
19 the prevention, diagnosis, or treatment of dis-
20 eases and disorders, or research urgently re-
21 quired to respond to a public health threat.”.

22 **SEC. 7042. PAIN RESEARCH.**

23 Section 409J(b) of the Public Health Service Act (42
24 U.S.C. 284q(b)) is amended—

- 25 (1) in paragraph (5)—

1 (A) in subparagraph (A), by striking “and
2 treatment of pain and diseases and disorders
3 associated with pain” and inserting “treatment,
4 and management of pain and diseases and dis-
5 orders associated with pain, including informa-
6 tion on best practices for the utilization of non-
7 pharmacologic treatments, non-addictive med-
8 ical products, and other drugs or devices ap-
9 proved or cleared by the Food and Drug Ad-
10 ministration”;

11 (B) in subparagraph (B), by striking “on
12 the symptoms and causes of pain;” and insert-
13 ing the following: “on—

14 “(i) the symptoms and causes of pain,
15 including the identification of relevant bio-
16 markers and screening models and the epi-
17 demiology of acute and chronic pain;

18 “(ii) the diagnosis, prevention, treat-
19 ment, and management of acute and
20 chronic pain, including with respect to
21 non-pharmacologic treatments, non-addict-
22 ive medical products, and other drugs or
23 devices approved or cleared by the Food
24 and Drug Administration; and

1 “(iii) risk factors for, and early warn-
2 ing signs of, substance use disorders in
3 populations with acute and chronic pain;
4 and”; and

5 (C) by striking subparagraphs (C) through
6 (E) and inserting the following:

7 “(C) make recommendations to the Direc-
8 tor of NIH—

9 “(i) to ensure that the activities of the
10 National Institutes of Health and other
11 Federal agencies are free of unnecessary
12 duplication of effort;

13 “(ii) on how best to disseminate infor-
14 mation on pain care and epidemiological
15 data related to acute and chronic pain; and

16 “(iii) on how to expand partnerships
17 between public entities and private entities
18 to expand collaborative, cross-cutting re-
19 search.”;

20 (2) by redesignating paragraph (6) as para-
21 graph (7); and

22 (3) by inserting after paragraph (5) the fol-
23 lowing:

24 “(6) REPORT.—The Secretary shall ensure that
25 recommendations and actions taken by the Director

1 with respect to the topics discussed at the meetings
2 described in paragraph (4) are included in appro-
3 priate reports to Congress.”.

4 **Subtitle F—Jessie’s Law**

5 **SEC. 7051. INCLUSION OF OPIOID ADDICTION HISTORY IN** 6 **PATIENT RECORDS.**

7 (a) BEST PRACTICES.—

8 (1) IN GENERAL.—Not later than 1 year after
9 the date of enactment of this Act, the Secretary of
10 Health and Human Services (in this section referred
11 to as the “Secretary”), in consultation with appro-
12 priate stakeholders, including a patient with a his-
13 tory of opioid use disorder, an expert in electronic
14 health records, an expert in the confidentiality of pa-
15 tient health information and records, and a health
16 care provider, shall identify or facilitate the develop-
17 ment of best practices regarding—

18 (A) the circumstances under which infor-
19 mation that a patient has provided to a health
20 care provider regarding such patient’s history of
21 opioid use disorder should, only at the patient’s
22 request, be prominently displayed in the med-
23 ical records (including electronic health records)
24 of such patient;

1 (B) what constitutes the patient's request
2 for the purpose described in subparagraph (A);
3 and

4 (C) the process and methods by which the
5 information should be so displayed.

6 (2) DISSEMINATION.—The Secretary shall dis-
7 seminate the best practices developed under para-
8 graph (1) to health care providers and State agen-
9 cies.

10 (b) REQUIREMENTS.—In identifying or facilitating
11 the development of best practices under subsection (a), as
12 applicable, the Secretary, in consultation with appropriate
13 stakeholders, shall consider the following:

14 (1) The potential for addiction relapse or over-
15 dose, including overdose death, when opioid medica-
16 tions are prescribed to a patient recovering from
17 opioid use disorder.

18 (2) The benefits of displaying information
19 about a patient's opioid use disorder history in a
20 manner similar to other potentially lethal medical
21 concerns, including drug allergies and contraindica-
22 tions.

23 (3) The importance of prominently displaying
24 information about a patient's opioid use disorder
25 when a physician or medical professional is pre-

1 scribing medication, including methods for avoiding
2 alert fatigue in providers.

3 (4) The importance of a variety of appropriate
4 medical professionals, including physicians, nurses,
5 and pharmacists, having access to information de-
6 scribed in this section when prescribing or dis-
7 pensing opioid medication, consistent with Federal
8 and State laws and regulations.

9 (5) The importance of protecting patient pri-
10 vacy, including the requirements related to consent
11 for disclosure of substance use disorder information
12 under all applicable laws and regulations.

13 (6) All applicable Federal and State laws and
14 regulations.

15 **SEC. 7052. COMMUNICATION WITH FAMILIES DURING**
16 **EMERGENCIES.**

17 (a) PROMOTING AWARENESS OF AUTHORIZED DIS-
18 CLOSURES DURING EMERGENCIES.—The Secretary of
19 Health and Human Services shall annually notify health
20 care providers regarding permitted disclosures under Fed-
21 eral health care privacy law during emergencies, including
22 overdoses, of certain health information to families, care-
23 givers, and health care providers.

24 (b) USE OF MATERIAL.—For the purposes of car-
25 rying out subsection (a), the Secretary of Health and

1 Human Services may use material produced under section
2 7053 of this Act or section 11004 of the 21st Century
3 Cures Act (42 U.S.C. 1320d–2 note).

4 **SEC. 7053. DEVELOPMENT AND DISSEMINATION OF MODEL**
5 **TRAINING PROGRAMS FOR SUBSTANCE USE**
6 **DISORDER PATIENT RECORDS.**

7 (a) INITIAL PROGRAMS AND MATERIALS.—Not later
8 than 1 year after the date of the enactment of this Act,
9 the Secretary of Health and Human Services (in this sec-
10 tion referred to as the “Secretary”), in consultation with
11 appropriate experts, shall identify the following model pro-
12 grams and materials (or if no such programs or materials
13 exist, recognize private or public entities to develop and
14 disseminate such programs and materials):

15 (1) Model programs and materials for training
16 health care providers (including physicians, emer-
17 gency medical personnel, psychiatrists, psychologists,
18 counselors, therapists, nurse practitioners, physician
19 assistants, behavioral health facilities and clinics,
20 care managers, and hospitals, including individuals
21 such as general counsels or regulatory compliance
22 staff who are responsible for establishing provider
23 privacy policies) concerning the permitted uses and
24 disclosures, consistent with the standards and regu-
25 lations governing the privacy and security of sub-

1 stance use disorder patient records promulgated by
2 the Secretary under section 543 of the Public
3 Health Service Act (42 U.S.C. 290dd–2) for the
4 confidentiality of patient records.

5 (2) Model programs and materials for training
6 patients and their families regarding their rights to
7 protect and obtain information under the standards
8 and regulations described in paragraph (1).

9 (b) REQUIREMENTS.—The model programs and ma-
10 terials described in paragraphs (1) and (2) of subsection
11 (a) shall address circumstances under which disclosure of
12 substance use disorder patient records is needed to—

13 (1) facilitate communication between substance
14 use disorder treatment providers and other health
15 care providers to promote and provide the best pos-
16 sible integrated care;

17 (2) avoid inappropriate prescribing that can
18 lead to dangerous drug interactions, overdose, or re-
19 lapse; and

20 (3) notify and involve families and caregivers
21 when individuals experience an overdose.

22 (c) PERIODIC UPDATES.—The Secretary shall—

23 (1) periodically review and update the model
24 program and materials identified or developed under
25 subsection (a); and

1 (2) disseminate such updated programs and
2 materials to the individuals described in subsection
3 (a)(1).

4 (d) INPUT OF CERTAIN ENTITIES.—In identifying,
5 reviewing, or updating the model programs and materials
6 under this section, the Secretary shall solicit the input of
7 relevant stakeholders.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section—

10 (1) \$4,000,000 for fiscal year 2019;

11 (2) \$2,000,000 for each of fiscal years 2020
12 and 2021; and

13 (3) \$1,000,000 for each of fiscal years 2022
14 and 2023.

15 **Subtitle G—Protecting Pregnant** 16 **Women and Infants**

17 **SEC. 7061. REPORT ON ADDRESSING MATERNAL AND IN-** 18 **FANT HEALTH IN THE OPIOID CRISIS.**

19 (a) IN GENERAL.—Not later than 18 months after
20 the date of the enactment of this Act, the Secretary of
21 Health and Human Services, in coordination with the Cen-
22 ters for Disease Control and Prevention, the National In-
23 stitutes of Health, the Indian Health Service, and the
24 Substance Abuse and Mental Health Services Administra-
25 tion, shall develop and submit to the Committee on

1 Health, Education, Labor, and Pensions of the Senate and
2 the Committee on Energy and Commerce of the House
3 of Representatives a report that includes—

4 (1) information on opioid, non-opioid, and non-
5 pharmacologic pain management practices during
6 pregnancy and after pregnancy;

7 (2) recommendations for increasing public
8 awareness and education about substance use dis-
9 orders, including opioid use disorders, during and
10 after pregnancy, including available treatment re-
11 sources in urban and rural areas;

12 (3) recommendations to prevent, identify, and
13 reduce substance use disorders, including opioid use
14 disorders, during pregnancy to improve care for
15 pregnant women with substance use disorders and
16 their infants; and

17 (4) an identification of areas in need of further
18 research with respect to acute and chronic pain
19 management during and after pregnancy.

20 (b) NO ADDITIONAL FUNDS.—No additional funds
21 are authorized to be appropriated for purposes of carrying
22 out subsection (a).

23 **SEC. 7062. PROTECTING MOMS AND INFANTS.**

24 (a) REPORT.—

1 (1) IN GENERAL.—Not later than 60 days after
2 the date of enactment of this Act, the Secretary of
3 Health and Human Services (referred to in this sec-
4 tion as the “Secretary”) shall submit to the Com-
5 mittee on Health, Education, Labor, and Pensions
6 of the Senate and the Committee on Energy and
7 Commerce of the House of Representatives, and
8 make available to the public on the Internet website
9 of the Department of Health and Human Services,
10 a report regarding the implementation of the rec-
11 ommendations in the strategy relating to prenatal
12 opioid use, including neonatal abstinence syndrome,
13 developed pursuant to section 2 of the Protecting
14 Our Infants Act of 2015 (Public Law 114–91). Such
15 report shall include—

16 (A) an update on the implementation of
17 the recommendations in the strategy, including
18 information regarding the agencies involved in
19 the implementation; and

20 (B) information on additional funding or
21 authority the Secretary requires, if any, to im-
22 plement the strategy, which may include au-
23 thorities needed to coordinate implementation
24 of such strategy across the Department of
25 Health and Human Services.

1 (2) PERIODIC UPDATES.—The Secretary shall
2 periodically update the report under paragraph (1).

3 (b) RESIDENTIAL TREATMENT PROGRAMS FOR
4 PREGNANT AND POSTPARTUM WOMEN.—Section 508(s)
5 of the Public Health Service Act (42 U.S.C. 290bb–1(s))
6 is amended by striking “\$16,900,000 for each of fiscal
7 years 2017 through 2021” and inserting “\$29,931,000 for
8 each of fiscal years 2019 through 2023”.

9 **SEC. 7063. EARLY INTERVENTIONS FOR PREGNANT WOMEN**
10 **AND INFANTS.**

11 (a) DEVELOPMENT OF EDUCATIONAL MATERIALS BY
12 CENTER FOR SUBSTANCE ABUSE PREVENTION.—Section
13 515(b) of the Public Health Service Act (42 U.S.C.
14 290bb–21(b)) is amended—

15 (1) in paragraph (13), by striking “and” at the
16 end;

17 (2) in paragraph (14), by striking the period at
18 the end and inserting “; and”; and

19 (3) by adding at the end the following:

20 “(15) in consultation with relevant stakeholders
21 and in collaboration with the Director of the Centers
22 for Disease Control and Prevention, develop edu-
23 cational materials for clinicians to use with pregnant
24 women for shared decision making regarding pain

1 management and the prevention of substance use
2 disorders during pregnancy.”.

3 (b) GUIDELINES AND RECOMMENDATIONS BY CEN-
4 TER FOR SUBSTANCE ABUSE TREATMENT.—Section
5 507(b) of the Public Health Service Act (42 U.S.C.
6 290bb(b)) is amended—

7 (1) in paragraph (13), by striking “and” at the
8 end;

9 (2) in paragraph (14), by striking the period at
10 the end and inserting a semicolon; and

11 (3) by adding at the end the following:

12 “(15) in cooperation with the Secretary, imple-
13 ment and disseminate, as appropriate, the rec-
14 ommendations in the report entitled ‘Protecting Our
15 Infants Act: Final Strategy’ issued by the Depart-
16 ment of Health and Human Services in 2017; and”.

17 (c) SUPPORT OF PARTNERSHIPS BY CENTER FOR
18 SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the
19 Public Health Service Act (42 U.S.C. 290bb(b)), as
20 amended by subsection (b), is further amended by adding
21 at the end the following:

22 “(16) in cooperation with relevant stakeholders,
23 and through public-private partnerships, encourage
24 education about substance use disorders for preg-

1 nant women and health care providers who treat
2 pregnant women and babies.”.

3 **SEC. 7064. PRENATAL AND POSTNATAL HEALTH.**

4 Section 317L of the Public Health Service Act (42
5 U.S.C. 247b–13) is amended—

6 (1) in subsection (a)—

7 (A) by amending paragraph (1) to read as
8 follows:

9 “(1) to collect, analyze, and make available data
10 on prenatal smoking and alcohol and other sub-
11 stance abuse and misuse, including—

12 “(A) data on—

13 “(i) the incidence, prevalence, and im-
14 plications of such activities; and

15 “(ii) the incidence and prevalence of
16 implications and outcomes, including neo-
17 natal abstinence syndrome and other ma-
18 ternal and child health outcomes associated
19 with such activities; and

20 “(B) additional information or data, as ap-
21 propriate, on family health history, medication
22 exposures during pregnancy, demographic infor-
23 mation, such as race, ethnicity, geographic loca-
24 tion, and family history, and other relevant in-
25 formation, to inform such analysis;”;

1 (B) in paragraph (2)—

2 (i) by striking “prevention of” and in-
3 sserting “prevention and long-term out-
4 comes associated with”; and

5 (ii) by striking “illegal drug use” and
6 inserting “other substance abuse and mis-
7 use”;

8 (C) in paragraph (3), by striking “and ces-
9 sation programs; and” and inserting “, treat-
10 ment, and cessation programs;”;

11 (D) in paragraph (4), by striking “illegal
12 drug use.” and inserting “other substance
13 abuse and misuse; and”; and

14 (E) by adding at the end the following:

15 “(5) to issue public reports on the analysis of
16 data described in paragraph (1), including analysis
17 of—

18 “(A) long-term outcomes of children af-
19 fected by neonatal abstinence syndrome;

20 “(B) health outcomes associated with pre-
21 natal smoking, alcohol, and substance abuse
22 and misuse; and

23 “(C) relevant studies, evaluations, or infor-
24 mation the Secretary determines to be appro-
25 priate.”;

1 (2) in subsection (b), by inserting “tribal enti-
2 ties,” after “local governments,”;

3 (3) by redesignating subsection (c) as sub-
4 section (d);

5 (4) by inserting after subsection (b) the fol-
6 lowing:

7 “(c) COORDINATING ACTIVITIES.—To carry out this
8 section, the Secretary may—

9 “(1) provide technical and consultative assist-
10 ance to entities receiving grants under subsection
11 (b);

12 “(2) ensure a pathway for data sharing between
13 States, tribal entities, and the Centers for Disease
14 Control and Prevention;

15 “(3) ensure data collection under this section is
16 consistent with applicable State, Federal, and Tribal
17 privacy laws; and

18 “(4) coordinate with the National Coordinator
19 for Health Information Technology, as appropriate,
20 to assist States and Tribes in implementing systems
21 that use standards recognized by such National Co-
22 ordinator, as such recognized standards are avail-
23 able, in order to facilitate interoperability between
24 such systems and health information technology sys-

1 tems, including certified health information tech-
2 nology.”; and

3 (5) in subsection (d), as so redesignated, by
4 striking “2001 through 2005” and inserting “2019
5 through 2023”.

6 **SEC. 7065. PLANS OF SAFE CARE.**

7 (a) IN GENERAL.—Section 105(a) of the Child Abuse
8 Prevention and Treatment Act (42 U.S.C. 5106(a)) is
9 amended by adding at the end the following:

10 “(7) GRANTS TO STATES TO IMPROVE AND CO-
11 ORDINATE THEIR RESPONSE TO ENSURE THE SAFE-
12 TY, PERMANENCY, AND WELL-BEING OF INFANTS
13 AFFECTED BY SUBSTANCE USE.—

14 “(A) PROGRAM AUTHORIZED.—The Sec-
15 retary is authorized to make grants to States
16 for the purpose of assisting child welfare agen-
17 cies, social services agencies, substance use dis-
18 order treatment agencies, hospitals with labor
19 and delivery units, medical staff, public health
20 and mental health agencies, and maternal and
21 child health agencies to facilitate collaboration
22 in developing, updating, implementing, and
23 monitoring plans of safe care described in sec-
24 tion 106(b)(2)(B)(iii). Section 112(a)(2) shall

1 not apply to the program authorized under this
2 paragraph.

3 “(B) DISTRIBUTION OF FUNDS.—

4 “(i) RESERVATIONS.—Of the amounts
5 made available to carry out subparagraph
6 (A), the Secretary shall reserve—

7 “(I) no more than 3 percent for
8 the purposes described in subpara-
9 graph (G); and

10 “(II) up to 3 percent for grants
11 to Indian Tribes and tribal organiza-
12 tions to address the needs of infants
13 born with, and identified as being af-
14 fected by, substance abuse or with-
15 drawal symptoms resulting from pre-
16 natal drug exposure or a fetal alcohol
17 spectrum disorder and their families
18 or caregivers, which to the extent
19 practicable, shall be consistent with
20 the uses of funds described under sub-
21 paragraph (D).

22 “(ii) ALLOTMENTS TO STATES AND
23 TERRITORIES.—The Secretary shall allot
24 the amount made available to carry out
25 subparagraph (A) that remains after appli-

1 cation of clause (i) to each State that ap-
2 plies for such a grant, in an amount equal
3 to the sum of—

4 “(I) \$500,000; and

5 “(II) an amount that bears the
6 same relationship to any funds made
7 available to carry out subparagraph
8 (A) and remaining after application of
9 clause (i), as the number of live births
10 in the State in the previous calendar
11 year bears to the number of live births
12 in all States in such year.

13 “(iii) RATABLE REDUCTION.—If the
14 amount made available to carry out sub-
15 paragraph (A) is insufficient to satisfy the
16 requirements of clause (ii), the Secretary
17 shall ratably reduce each allotment to a
18 State.

19 “(C) APPLICATION.—A State desiring a
20 grant under this paragraph shall submit an ap-
21 plication to the Secretary at such time and in
22 such manner as the Secretary may require.
23 Such application shall include—

24 “(i) a description of—

1 “(I) the impact of substance use
2 disorder in such State, including with
3 respect to the substance or class of
4 substances with the highest incidence
5 of abuse in the previous year in such
6 State, including—

7 “(aa) the prevalence of sub-
8 stance use disorder in such State;

9 “(bb) the aggregate rate of
10 births in the State of infants af-
11 fected by substance abuse or
12 withdrawal symptoms or a fetal
13 alcohol spectrum disorder (as de-
14 termined by hospitals, insurance
15 claims, claims submitted to the
16 State Medicaid program, or other
17 records), if available and to the
18 extent practicable; and

19 “(cc) the number of infants
20 identified, for whom a plan of
21 safe care was developed, and for
22 whom a referral was made for
23 appropriate services, as reported
24 under section 106(d)(18);

1 “(II) the challenges the State
2 faces in developing, implementing, and
3 monitoring plans of safe care in ac-
4 cordance with section
5 106(b)(2)(B)(iii);

6 “(III) the State’s lead agency for
7 the grant program and how that agen-
8 cy will coordinate with relevant State
9 entities and programs, including the
10 child welfare agency, the substance
11 use disorder treatment agency, hos-
12 pitals with labor and delivery units,
13 health care providers, the public
14 health and mental health agencies,
15 programs funded by the Substance
16 Abuse and Mental Health Services
17 Administration that provide substance
18 use disorder treatment for women, the
19 State Medicaid program, the State
20 agency administering the block grant
21 program under title V of the Social
22 Security Act (42 U.S.C. 701 et seq.),
23 the State agency administering the
24 programs funded under part C of the
25 Individuals with Disabilities Edu-

1 cation Act (20 U.S.C. 1431 et seq.),
2 the maternal, infant, and early child-
3 hood home visiting program under
4 section 511 of the Social Security Act
5 (42 U.S.C. 711), the State judicial
6 system, and other agencies, as deter-
7 mined by the Secretary, and Indian
8 Tribes and tribal organizations, as ap-
9 propriate, to implement the activities
10 under this paragraph;

11 “(IV) how the State will monitor
12 local development and implementation
13 of plans of safe care, in accordance
14 with section 106(b)(2)(B)(iii)(II), in-
15 cluding how the State will monitor to
16 ensure plans of safe care address dif-
17 ferences between substance use dis-
18 order and medically supervised sub-
19 stance use, including for the treat-
20 ment of a substance use disorder;

21 “(V) if applicable, how the State
22 plans to utilize funding authorized
23 under part E of title IV of the Social
24 Security Act (42 U.S.C. 670 et seq.)
25 to assist in carrying out any plan of

1 safe care, including such funding au-
2 thORIZED under section 471(e) of such
3 Act (as in effect on October 1, 2018)
4 for mental health and substance abuse
5 prevention and treatment services and
6 in-home parent skill-based programs
7 and funding authorized under such
8 section 472(j) (as in effect on October
9 1, 2018) for children with a parent in
10 a licensed residential family-based
11 treatment facility for substance abuse;
12 and

13 “(VI) an assessment of the treat-
14 ment and other services and programs
15 available in the State to effectively
16 carry out any plan of safe care devel-
17 oped, including identification of need-
18 ed treatment, and other services and
19 programs to ensure the well-being of
20 young children and their families af-
21 fected by substance use disorder, such
22 as programs carried out under part C
23 of the Individuals with Disabilities
24 Education Act (20 U.S.C. 1431 et
25 seq.) and comprehensive early child-

1 hood development services and pro-
2 grams such as Head Start programs;

3 “(ii) a description of how the State
4 plans to use funds for activities described
5 in subparagraph (D) for the purposes of
6 ensuring State compliance with require-
7 ments under clauses (ii) and (iii) of section
8 106(b)(2)(B); and

9 “(iii) an assurance that the State will
10 comply with requirements to refer a child
11 identified as substance-exposed to early
12 intervention services as required pursuant
13 to a grant under part C of the Individuals
14 with Disabilities Education Act (20 U.S.C.
15 1431 et seq.).

16 “(D) USES OF FUNDS.—Funds awarded to
17 a State under this paragraph may be used for
18 the following activities, which may be carried
19 out by the State directly, or through grants or
20 subgrants, contracts, or cooperative agreements:

21 “(i) Improving State and local sys-
22 tems with respect to the development and
23 implementation of plans of safe care,
24 which—

1 “(I) shall include parent and
2 caregiver engagement, as required
3 under section 106(b)(2)(B)(iii)(I), re-
4 garding available treatment and serv-
5 ice options, which may include re-
6 sources available for pregnant,
7 perinatal, and postnatal women; and

8 “(II) may include activities such
9 as—

10 “(aa) developing policies,
11 procedures, or protocols for the
12 administration or development of
13 evidence-based and validated
14 screening tools for infants who
15 may be affected by substance use
16 withdrawal symptoms or a fetal
17 alcohol spectrum disorder and
18 pregnant, perinatal, and post-
19 natal women whose infants may
20 be affected by substance use
21 withdrawal symptoms or a fetal
22 alcohol spectrum disorder;

23 “(bb) improving assessments
24 used to determine the needs of
25 the infant and family;

1 “(cc) improving ongoing
2 case management services;

3 “(dd) improving access to
4 treatment services, which may be
5 prior to the pregnant woman’s
6 delivery date; and

7 “(ee) keeping families safely
8 together when it is in the best in-
9 terest of the child.

10 “(ii) Developing policies, procedures,
11 or protocols in consultation and coordina-
12 tion with health professionals, public and
13 private health facilities, and substance use
14 disorder treatment agencies to ensure
15 that—

16 “(I) appropriate notification to
17 child protective services is made in a
18 timely manner, as required under sec-
19 tion 106(b)(2)(B)(ii);

20 “(II) a plan of safe care is in
21 place, in accordance with section
22 106(b)(2)(B)(iii), before the infant is
23 discharged from the birth or health
24 care facility; and

1 “(III) such health and related
2 agency professionals are trained on
3 how to follow such protocols and are
4 aware of the supports that may be
5 provided under a plan of safe care.

6 “(iii) Training health professionals
7 and health system leaders, child welfare
8 workers, substance use disorder treatment
9 agencies, and other related professionals
10 such as home visiting agency staff and law
11 enforcement in relevant topics including—

12 “(I) State mandatory reporting
13 laws established under section
14 106(b)(2)(B)(i) and the referral and
15 process requirements for notification
16 to child protective services when child
17 abuse or neglect reporting is not man-
18 dated;

19 “(II) the co-occurrence of preg-
20 nancy and substance use disorder, and
21 implications of prenatal exposure;

22 “(III) the clinical guidance about
23 treating substance use disorder in
24 pregnant and postpartum women;

1 106(b)(2) and clause (ii) of this subpara-
2 graph, in areas which may include—

3 “(I) developing a comprehensive,
4 multi-disciplinary assessment and
5 intervention process for infants, preg-
6 nant women, and their families who
7 are affected by substance use dis-
8 order, withdrawal symptoms, or a
9 fetal alcohol spectrum disorder, that
10 includes meaningful engagement with
11 and takes into account the unique
12 needs of each family and addresses
13 differences between medically super-
14 vised substance use, including for the
15 treatment of substance use disorder,
16 and substance use disorder;

17 “(II) ensuring that treatment ap-
18 proaches for serving infants, pregnant
19 women, and perinatal and postnatal
20 women whose infants may be affected
21 by substance use, withdrawal symp-
22 toms, or a fetal alcohol spectrum dis-
23 order, are designed to, where appro-
24 priate, keep infants with their moth-

1 ers during both inpatient and out-
2 patient treatment; and

3 “**(III)** increasing access to all evi-
4 dence-based medication-assisted treat-
5 ment approved by the Food and Drug
6 Administration, behavioral therapy,
7 and counseling services for the treat-
8 ment of substance use disorders, as
9 appropriate.

10 “(v) Developing and updating systems
11 of technology for improved data collection
12 and monitoring under section
13 106(b)(2)(B)(iii), including existing elec-
14 tronic medical records, to measure the out-
15 comes achieved through the plans of safe
16 care, including monitoring systems to meet
17 the requirements of this Act and submis-
18 sion of performance measures.

19 “(E) **REPORTING.**—Each State that re-
20 ceives funds under this paragraph, for each
21 year such funds are received, shall submit a re-
22 port to the Secretary, disaggregated by geo-
23 graphic location, economic status, and major
24 racial and ethnic groups, except that such
25 disaggregation shall not be required if the re-

1 sults would reveal personally identifiable infor-
2 mation on, with respect to infants identified
3 under section 106(b)(2)(B)(ii)—

4 “(i) the number who experienced re-
5 moval associated with parental substance
6 use;

7 “(ii) the number who experienced re-
8 moval and subsequently are reunified with
9 parents, and the length of time between
10 such removal and reunification;

11 “(iii) the number who are referred to
12 community providers without a child pro-
13 tection case;

14 “(iv) the number who receive services
15 while in the care of their birth parents;

16 “(v) the number who receive post-re-
17 unification services within 1 year after a
18 reunification has occurred; and

19 “(vi) the number who experienced a
20 return to out-of-home care within 1 year
21 after reunification.

22 “(F) SECRETARY’S REPORT TO CON-
23 GRESS.—The Secretary shall submit an annual
24 report to the Committee on Health, Education,
25 Labor, and Pensions and the Committee on Ap-

1 appropriations of the Senate and the Committee
2 on Education and the Workforce and the Com-
3 mittee on Appropriations of the House of Rep-
4 resentatives that includes the information de-
5 scribed in subparagraph (E) and recommenda-
6 tions or observations on the challenges, suc-
7 cesses, and lessons derived from implementation
8 of the grant program.

9 “(G) ASSISTING STATES’ IMPLEMENTA-
10 TION.—The Secretary shall use the amount re-
11 served under subparagraph (B)(i)(I) to provide
12 written guidance and technical assistance to
13 support States in complying with and imple-
14 menting this paragraph, which shall include—

15 “(i) technical assistance, including
16 programs of in-depth technical assistance,
17 to additional States, territories, and Indian
18 Tribes and tribal organizations in accord-
19 ance with the substance-exposed infant ini-
20 tiative developed by the National Center on
21 Substance Abuse and Child Welfare;

22 “(ii) guidance on the requirements of
23 this Act with respect to infants born with
24 and identified as being affected by sub-
25 stance use or withdrawal symptoms or

1 fetal alcohol spectrum disorder, as de-
2 scribed in clauses (ii) and (iii) of section
3 106(b)(2)(B), including by—

4 “(I) enhancing States’ under-
5 standing of requirements and flexibili-
6 ties under the law, including by clari-
7 fying key terms;

8 “(II) addressing state-identified
9 challenges with developing, imple-
10 menting, and monitoring plans of safe
11 care, including those reported under
12 subparagraph (C)(i)(II);

13 “(III) disseminating best prac-
14 tices on implementation of plans of
15 safe care, on such topics as differen-
16 tial response, collaboration and coordi-
17 nation, and identification and delivery
18 of services for different populations,
19 while recognizing needs of different
20 populations and varying community
21 approaches across States; and

22 “(IV) helping States improve the
23 long-term safety and well-being of
24 young children and their families;

1 **“PART F—SUBSTANCE USE DISORDER**
2 **TREATMENT WORKFORCE**
3 **“SEC. 781. LOAN REPAYMENT PROGRAM FOR SUBSTANCE**
4 **USE DISORDER TREATMENT WORKFORCE.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Administrator of the Health Resources and Services
7 Administration, shall carry out a program under which—

8 “(1) the Secretary enters into agreements with
9 individuals to make payments in accordance with
10 subsection (b) on the principal of and interest on
11 any eligible loan; and

12 “(2) the individuals each agree to the require-
13 ments of service in substance use disorder treatment
14 employment, as described in subsection (d).

15 “(b) PAYMENTS.—For each year of obligated service
16 by an individual pursuant to an agreement under sub-
17 section (a), the Secretary shall make a payment to such
18 individual as follows:

19 “(1) SERVICE IN A SHORTAGE AREA.—The Sec-
20 retary shall pay—

21 “(A) for each year of obligated service by
22 an individual pursuant to an agreement under
23 subsection (a), $\frac{1}{6}$ of the principal of and inter-
24 est on each eligible loan of the individual which
25 is outstanding on the date the individual began
26 service pursuant to the agreement; and

1 “(B) for completion of the sixth and final
2 year of such service, the remainder of such
3 principal and interest.

4 “(2) MAXIMUM AMOUNT.—The total amount of
5 payments under this section to any individual shall
6 not exceed \$250,000.

7 “(c) ELIGIBLE LOANS.—The loans eligible for repay-
8 ment under this section are each of the following:

9 “(1) Any loan for education or training for a
10 substance use disorder treatment employment.

11 “(2) Any loan under part E of title VIII (relat-
12 ing to nursing student loans).

13 “(3) Any Federal Direct Stafford Loan, Fed-
14 eral Direct PLUS Loan, Federal Direct Unsub-
15 sidized Stafford Loan, or Federal Direct Consolida-
16 tion Loan (as such terms are used in section 455 of
17 the Higher Education Act of 1965).

18 “(4) Any Federal Perkins Loan under part E
19 of title I of the Higher Education Act of 1965.

20 “(5) Any other Federal loan as determined ap-
21 propriate by the Secretary.

22 “(d) REQUIREMENTS OF SERVICE.—Any individual
23 receiving payments under this program as required by an
24 agreement under subsection (a) shall agree to an annual
25 commitment to full-time employment, with no more than

1 1 year passing between any 2 years of covered employ-
2 ment, in substance use disorder treatment employment in
3 the United States in—

4 “(1) a Mental Health Professional Shortage
5 Area, as designated under section 332; or

6 “(2) a county (or a municipality, if not con-
7 tained within any county) where the mean drug
8 overdose death rate per 100,000 people over the past
9 3 years for which official data is available from the
10 State, is higher than the most recent available na-
11 tional average overdose death rate per 100,000 peo-
12 ple, as reported by the Centers for Disease Control
13 and Prevention.

14 “(e) INELIGIBILITY FOR DOUBLE BENEFITS.—No
15 borrower may, for the same service, receive a reduction
16 of loan obligations or a loan repayment under both—

17 “(1) this section; and

18 “(2) any Federally supported loan forgiveness
19 program, including under section 338B, 338I, or
20 846 of this Act, or section 428J, 428L, 455(m), or
21 460 of the Higher Education Act of 1965.

22 “(f) BREACH.—

23 “(1) LIQUIDATED DAMAGES FORMULA.—The
24 Secretary may establish a liquidated damages for-

1 mula to be used in the event of a breach of an
2 agreement entered into under subsection (a).

3 “(2) LIMITATION.—The failure by an individual
4 to complete the full period of service obligated pur-
5 suant to such an agreement, taken alone, shall not
6 constitute a breach of the agreement, so long as the
7 individual completed in good faith the years of serv-
8 ice for which payments were made to the individual
9 under this section.

10 “(g) ADDITIONAL CRITERIA.—The Secretary—

11 “(1) may establish such criteria and rules to
12 carry out this section as the Secretary determines
13 are needed and in addition to the criteria and rules
14 specified in this section; and

15 “(2) shall give notice to the committees speci-
16 fied in subsection (h) of any criteria and rules so es-
17 tablished.

18 “(h) REPORT TO CONGRESS.—Not later than 5 years
19 after the date of enactment of this section, and every other
20 year thereafter, the Secretary shall prepare and submit
21 to the Committee on Energy and Commerce of the House
22 of Representatives and the Committee on Health, Edu-
23 cation, Labor, and Pensions of the Senate a report on—

1 “(1) the number and location of borrowers who
2 have qualified for loan repayments under this sec-
3 tion; and

4 “(2) the impact of this section on the avail-
5 ability of substance use disorder treatment employ-
6 ees nationally and in shortage areas and counties de-
7 scribed in subsection (d).

8 “(i) DEFINITION.—In this section:

9 “(1) The terms ‘Indian tribe’ and ‘tribal organi-
10 zation’ have the meanings given those terms in sec-
11 tion 4 of the Indian Self-Determination and Edu-
12 cation Assistance Act.

13 “(2) The term ‘municipality’ means a city,
14 town, or other public body created by or pursuant to
15 State law, or an Indian tribe.

16 “(3) The term ‘substance use disorder treat-
17 ment employment’ means full-time employment (in-
18 cluding a fellowship)—

19 “(A) where the primary intent and func-
20 tion of the position is the direct treatment or
21 recovery support of patients with or in recovery
22 from a substance use disorder, including mas-
23 ter’s level social workers, psychologists, coun-
24 selors, marriage and family therapists, psy-
25 chiatric mental health practitioners, occupa-

1 tional therapists, psychology doctoral interns,
2 and behavioral health paraprofessionals and
3 physicians, physician assistants, and nurses,
4 who are licensed or certified in accordance with
5 applicable State and Federal laws; and

6 “(B) which is located at a substance use
7 disorder treatment program, private physician
8 practice, hospital or health system-affiliated in-
9 patient treatment center or outpatient clinic
10 (including an academic medical center-affiliated
11 treatment program), correctional facility or pro-
12 gram, youth detention center or program, inpa-
13 tient psychiatric facility, crisis stabilization
14 unit, community health center, community men-
15 tal health or other specialty community behav-
16 ioral health center, recovery center, school, com-
17 munity-based organization, telehealth platform,
18 migrant health center, health program or facil-
19 ity operated by an Indian tribe or tribal organi-
20 zation, Federal medical facility, or any other fa-
21 cility as determined appropriate for purposes of
22 this section by the Secretary.

23 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section
25 \$25,000,000 for each of fiscal years 2019 through 2023.”.

1 **SEC. 7072. CLARIFICATION REGARDING SERVICE IN**
2 **SCHOOLS AND OTHER COMMUNITY-BASED**
3 **SETTINGS.**

4 Subpart III of part D of title III of the Public Health
5 Service Act (42 U.S.C. 254*l* et seq.) is amended by adding
6 at the end the following:

7 **“SEC. 338N. CLARIFICATION REGARDING SERVICE IN**
8 **SCHOOLS AND OTHER COMMUNITY-BASED**
9 **SETTINGS.**

10 “(a) SCHOOLS AND COMMUNITY-BASED SETTINGS.—
11 An entity to which a participant in the Scholarship Pro-
12 gram or the Loan Repayment Program (referred to in this
13 section as a ‘participant’) is assigned under section 333
14 may direct such participant to provide service as a behav-
15 ioral or mental health professional at a school or other
16 community-based setting located in a health professional
17 shortage area.

18 “(b) OBLIGATED SERVICE.—

19 “(1) IN GENERAL.—Any service described in
20 subsection (a) that a participant provides may count
21 towards such participant’s completion of any obli-
22 gated service requirements under the Scholarship
23 Program or the Loan Repayment Program, subject
24 to any limitation imposed under paragraph (2).

25 “(2) LIMITATION.—The Secretary may impose
26 a limitation on the number of hours of service de-

1 scribed in subsection (a) that a participant may
2 credit towards completing obligated service require-
3 ments, provided that the limitation allows a member
4 to credit service described in subsection (a) for not
5 less than 50 percent of the total hours required to
6 complete such obligated service requirements.

7 “(c) **RULE OF CONSTRUCTION.**—The authorization
8 under subsection (a) shall be notwithstanding any other
9 provision of this subpart or subpart II.”.

10 **SEC. 7073. PROGRAMS FOR HEALTH CARE WORKFORCE.**

11 (a) **PROGRAM FOR EDUCATION AND TRAINING IN**
12 **PAIN CARE.**—Section 759 of the Public Health Service
13 Act (42 U.S.C. 294i) is amended—

14 (1) in subsection (a), by striking “hospices, and
15 other public and private entities” and inserting
16 “hospices, tribal health programs (as defined in sec-
17 tion 4 of the Indian Health Care Improvement Act),
18 and other public and nonprofit private entities”;

19 (2) in subsection (b)—

20 (A) in the matter preceding paragraph (1),
21 by striking “award may be made under sub-
22 section (a) only if the applicant for the award
23 agrees that the program carried out with the
24 award will include” and inserting “entity receiv-
25 ing an award under this section shall develop a

1 comprehensive education and training plan that
2 includes”;

3 (B) in paragraph (1)—

4 (i) by inserting “preventing,” after
5 “diagnosing,”; and

6 (ii) by inserting “non-addictive med-
7 ical products and non-pharmacologic treat-
8 ments and” after “including”;

9 (C) in paragraph (2)—

10 (i) by inserting “Federal, State, and
11 local” after “applicable”; and

12 (ii) by striking “the degree to which”
13 and all that follows through “effective pain
14 care” and inserting “opioids”;

15 (D) in paragraph (3), by inserting “, inte-
16 grated, evidence-based pain management, and,
17 as appropriate, non-pharmacotherapy” before
18 the semicolon;

19 (E) in paragraph (4), by striking “; and”
20 and inserting “;”;

21 (F) by striking paragraph (5) and insert-
22 ing the following:

23 “(5) recent findings, developments, and ad-
24 vancements in pain care research and the provision
25 of pain care, which may include non-addictive med-

1 ical products and non-pharmacologic treatments in-
2 tended to treat pain; and

3 “(6) the dangers of opioid abuse and misuse,
4 detection of early warning signs of opioid use dis-
5 orders (which may include best practices related to
6 screening for opioid use disorders, training on
7 screening, brief intervention, and referral to treat-
8 ment), and safe disposal options for prescription
9 medications (including such options provided by law
10 enforcement or other innovative deactivation mecha-
11 nisms).”;

12 (3) in subsection (d), by inserting “prevention,”
13 after “diagnosis,”; and

14 (4) in subsection (e), by striking “2010 through
15 2012” and inserting “2019 through 2023”.

16 (b) MENTAL AND BEHAVIORAL HEALTH EDUCATION
17 AND TRAINING PROGRAM.—Section 756 of the Public
18 Health Service Act (42 U.S.C. 294e–1) is amended—

19 (1) in subsection (a)—

20 (A) in paragraph (1), by inserting “, trau-
21 ma,” after “focus on child and adolescent men-
22 tal health”; and

23 (B) in paragraphs (2) and (3), by inserting
24 “trauma-informed care and” before “substance

1 use disorder prevention and treatment serv-
2 ices”; and

3 (2) in subsection (f), by striking “2018 through
4 2022” and inserting “2019 through 2023”.

5 **Subtitle I—Preventing Overdoses**
6 **While in Emergency Rooms**

7 **SEC. 7081. PROGRAM TO SUPPORT COORDINATION AND**
8 **CONTINUATION OF CARE FOR DRUG OVER-**
9 **DOSE PATIENTS.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services (referred to in this section as the “Sec-
12 retary”) shall identify or facilitate the development of best
13 practices for—

14 (1) emergency treatment of known or suspected
15 drug overdose;

16 (2) the use of recovery coaches, as appropriate,
17 to encourage individuals who experience a non-fatal
18 overdose to seek treatment for substance use dis-
19 order and to support coordination and continuation
20 of care;

21 (3) coordination and continuation of care and
22 treatment, including, as appropriate, through refer-
23 rals, of individuals after a drug overdose; and

24 (4) the provision or prescribing of overdose re-
25 versal medication, as appropriate.

1 (b) GRANT ESTABLISHMENT AND PARTICIPATION.—

2 (1) IN GENERAL.—The Secretary shall award
3 grants on a competitive basis to eligible entities to
4 support implementation of voluntary programs for
5 care and treatment of individuals after a drug over-
6 dose, as appropriate, which may include implementa-
7 tion of the best practices described in subsection (a).

8 (2) ELIGIBLE ENTITY.—In this section, the
9 term “eligible entity” means—

10 (A) a State substance abuse agency;

11 (B) an Indian Tribe or tribal organization;

12 or

13 (C) an entity that offers treatment or
14 other services for individuals in response to, or
15 following, drug overdoses or a drug overdose,
16 such as an emergency department, in consulta-
17 tion with a State substance abuse agency.

18 (3) APPLICATION.—An eligible entity desiring a
19 grant under this section shall submit an application
20 to the Secretary, at such time and in such manner
21 as the Secretary may require, that includes—

22 (A) evidence that such eligible entity car-
23 ries out, or is capable of contracting and coordi-
24 nating with other community entities to carry
25 out, the activities described in paragraph (4);

1 (B) evidence that such eligible entity will
2 work with a recovery community organization to
3 recruit, train, hire, mentor, and supervise recov-
4 ery coaches and fulfill the requirements de-
5 scribed in paragraph (4)(A); and

6 (C) such additional information as the Sec-
7 retary may require.

8 (4) USE OF GRANT FUNDS.—An eligible entity
9 awarded a grant under this section shall use such
10 grant funds to—

11 (A) hire or utilize recovery coaches to help
12 support recovery, including by—

13 (i) connecting patients to a continuum
14 of care services, such as—

15 (I) treatment and recovery sup-
16 port programs;

17 (II) programs that provide non-
18 clinical recovery support services;

19 (III) peer support networks;

20 (IV) recovery community organi-
21 zations;

22 (V) health care providers, includ-
23 ing physicians and other providers of
24 behavioral health and primary care;

1 (VI) education and training pro-
2 viders;

3 (VII) employers;

4 (VIII) housing services; and

5 (IX) child welfare agencies;

6 (ii) providing education on overdose
7 prevention and overdose reversal to pa-
8 tients and families, as appropriate;

9 (iii) providing follow-up services for
10 patients after an overdose to ensure con-
11 tinued recovery and connection to support
12 services;

13 (iv) collecting and evaluating outcome
14 data for patients receiving recovery coach-
15 ing services; and

16 (v) providing other services the Sec-
17 retary determines necessary to help ensure
18 continued connection with recovery support
19 services, including culturally appropriate
20 services, as applicable;

21 (B) establish policies and procedures, pur-
22 suant to Federal and State law, that address
23 the provision of overdose reversal medication,
24 the administration of all drugs or devices ap-
25 proved or cleared under the Federal Food,

1 Drug, and Cosmetic Act (21 U.S.C. 301 et
2 seq.) and all biological products licensed under
3 section 351 of the Public Health Service Act
4 (42 U.S.C. 262) to treat substance use dis-
5 order, and subsequent continuation of, or refer-
6 ral to, evidence-based treatment for patients
7 with a substance use disorder who have experi-
8 enced a non-fatal drug overdose, in order to
9 support long-term treatment, prevent relapse,
10 and reduce recidivism and future overdose; and

11 (C) establish integrated models of care for
12 individuals who have experienced a non-fatal
13 drug overdose which may include patient as-
14 sessment, follow up, and transportation to and
15 from treatment facilities.

16 (5) ADDITIONAL PERMISSIBLE USES.—In addi-
17 tion to the uses described in paragraph (4), a grant
18 awarded under this section may be used, directly or
19 through contractual arrangements, to provide—

20 (A) all drugs or devices approved or
21 cleared under the Federal Food, Drug, and
22 Cosmetic Act (21 U.S.C. 301 et seq.) and all
23 biological products licensed under section 351
24 of the Public Health Service Act (42 U.S.C.

1 262) to treat substance use disorders or reverse
2 overdose, pursuant to Federal and State law;

3 (B) withdrawal and detoxification services
4 that include patient evaluation, stabilization,
5 and preparation for treatment of substance use
6 disorder, including treatment described in sub-
7 paragraph (A), as appropriate; or

8 (C) mental health services provided by a
9 certified professional who is licensed and quali-
10 fied by education, training, or experience to as-
11 sess the psychosocial background of patients, to
12 contribute to the appropriate treatment plan for
13 patients with substance use disorder, and to
14 monitor patient progress.

15 (6) PREFERENCE.—In awarding grants under
16 this section, the Secretary shall give preference to el-
17 igible entities that meet any or all of the following
18 criteria:

19 (A) The eligible entity is a critical access
20 hospital (as defined in section 1861(mm)(1) of
21 the Social Security Act (42 U.S.C.
22 1395x(mm)(1))), a low volume hospital (as de-
23 fined in section 1886(d)(12)(C)(i) of such Act
24 (42 U.S.C. 1395ww(d)(12)(C)(i))), a sole com-
25 munity hospital (as defined in section

1 1886(d)(5)(D)(iii) of such Act (42 U.S.C.
2 1395ww(d)(5)(D)(iii)), or a hospital that re-
3 ceives disproportionate share hospital payments
4 under section 1886(d)(5)(F) of the Social Secu-
5 rity Act (42 U.S.C. 1395ww(d)(5)(F)).

6 (B) The eligible entity is located in a State
7 with an age-adjusted rate of drug overdose
8 deaths that is above the national overdose mor-
9 tality rate, as determined by the Director of the
10 Centers for Disease Control and Prevention, or
11 under the jurisdiction of an Indian Tribe with
12 an age-adjusted rate of drug overdose deaths
13 that is above the national overdose mortality
14 rate, as determined through appropriate mecha-
15 nisms as determined by the Secretary in con-
16 sultation with Indian Tribes.

17 (C) The eligible entity demonstrates that
18 recovery coaches will be placed in both health
19 care settings and community settings.

20 (7) PERIOD OF GRANT.—A grant awarded to an
21 eligible entity under this section shall be for a period
22 of not more than 5 years.

23 (c) DEFINITIONS.—In this section:

24 (1) INDIAN TRIBE; TRIBAL ORGANIZATION.—
25 The terms “Indian Tribe” and “tribal organization”

1 have the meanings given the terms “Indian tribe”
2 and “tribal organization” in section 4 of the Indian
3 Self-Determination and Education Assistance Act
4 (25 U.S.C. 5304).

5 (2) RECOVERY COACH.—the term “recovery
6 coach” means an individual—

7 (A) with knowledge of, or experience with,
8 recovery from a substance use disorder; and

9 (B) who has completed training from, and
10 is determined to be in good standing by, a re-
11 covery services organization capable of con-
12 ducting such training and making such deter-
13 mination.

14 (3) RECOVERY COMMUNITY ORGANIZATION.—
15 The term “recovery community organization” has
16 the meaning given such term in section 547(a) of
17 the Public Health Service Act (42 U.S.C. 290ee-
18 2(a)).

19 (d) REPORTING REQUIREMENTS.—

20 (1) REPORTS BY GRANTEEES.—Each eligible en-
21 tity awarded a grant under this section shall submit
22 to the Secretary an annual report for each year for
23 which the entity has received such grant that in-
24 cludes information on—

1 (A) the number of individuals treated by
2 the entity for non-fatal overdoses, including the
3 number of non-fatal overdoses where overdose
4 reversal medication was administered;

5 (B) the number of individuals administered
6 medication-assisted treatment by the entity;

7 (C) the number of individuals referred by
8 the entity to other treatment facilities after a
9 non-fatal overdose, the types of such other fa-
10 cilities, and the number of such individuals ad-
11 mitted to such other facilities pursuant to such
12 referrals; and

13 (D) the frequency and number of patients
14 with reoccurrences, including readmissions for
15 non-fatal overdoses and evidence of relapse re-
16 lated to substance use disorder.

17 (2) REPORT BY SECRETARY.—Not later than 5
18 years after the date of enactment of this Act, the
19 Secretary shall submit to Congress a report that in-
20 cludes an evaluation of the effectiveness of the grant
21 program carried out under this section with respect
22 to long term health outcomes of the population of in-
23 dividuals who have experienced a drug overdose, the
24 percentage of patients treated or referred to treat-
25 ment by grantees, and the frequency and number of

1 patients who experienced relapse, were readmitted
2 for treatment, or experienced another overdose.

3 (e) PRIVACY.—The requirements of this section, in-
4 cluding with respect to data reporting and program over-
5 sight, shall be subject to all applicable Federal and State
6 privacy laws.

7 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
8 authorized to be appropriated to carry out this section
9 \$10,000,000 for each of fiscal years 2019 through 2023.

10 **Subtitle J—Alternatives to Opioids** 11 **in the Emergency Department**

12 **SEC. 7091. EMERGENCY DEPARTMENT ALTERNATIVES TO** 13 **OPIOIDS DEMONSTRATION PROGRAM.**

14 (a) DEMONSTRATION PROGRAM GRANTS.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services (in this section referred to as the
17 “Secretary”) shall carry out a demonstration pro-
18 gram for purposes of awarding grants to hospitals
19 and emergency departments, including freestanding
20 emergency departments, to develop, implement, en-
21 hance, or study alternatives to opioids for pain man-
22 agement in such settings.

23 (2) ELIGIBILITY.—To be eligible to receive a
24 grant under paragraph (1), a hospital or emergency
25 department shall submit an application to the Sec-

1 retary at such time, in such manner, and containing
2 such information as the Secretary may require.

3 (3) GEOGRAPHIC DISTRIBUTION.—In awarding
4 grants under this section, the Secretary shall seek to
5 ensure geographical distribution among grant recipi-
6 ents.

7 (4) USE OF FUNDS.—Grants under paragraph
8 (1) shall be used to—

9 (A) target treatment approaches for pain-
10 ful conditions frequently treated in such set-
11 tings;

12 (B) train providers and other hospital per-
13 sonnel on protocols or best practices related to
14 the use and prescription of opioids and alter-
15 natives to opioids for pain management in the
16 emergency department; and

17 (C) develop or continue strategies to pro-
18 vide alternatives to opioids, as appropriate.

19 (b) ADDITIONAL DEMONSTRATION PROGRAM.—The
20 Secretary may carry out a demonstration program similar
21 to the program under subsection (a) for other acute care
22 settings.

23 (c) CONSULTATION.—The Secretary shall implement
24 a process for recipients of grants under subsection (a) or
25 (b) to share evidence-based and best practices and pro-

1 mote consultation with persons having robust knowledge,
2 including emergency departments and physicians that
3 have successfully implemented programs that use alter-
4 natives to opioids for pain management, as appropriate,
5 such as approaches studied through the National Center
6 for Complimentary and Integrative Health or other insti-
7 tutes and centers at the National Institutes of Health, as
8 appropriate. The Secretary shall offer to each recipient of
9 a grant under subsection (a) or (b) technical assistance
10 as necessary.

11 (d) TECHNICAL ASSISTANCE.—The Secretary shall
12 identify or facilitate the development of best practices on
13 alternatives to opioids for pain management and provide
14 technical assistance to hospitals and other acute care set-
15 tings on alternatives to opioids for pain management. The
16 technical assistance provided shall be for the purpose of—

17 (1) utilizing information from recipients of a
18 grant under subsection (a) or (b) that have success-
19 fully implemented alternatives to opioids programs;

20 (2) identifying or facilitating the development of
21 best practices on the use of alternatives to opioids,
22 which may include pain-management strategies that
23 involve non-addictive medical products, non-pharma-
24 cologic treatments, and technologies or techniques to
25 identify patients at risk for opioid use disorder;

1 (3) identifying or facilitating the development of
2 best practices on the use of alternatives to opioids
3 that target common painful conditions and include
4 certain patient populations, such as geriatric pa-
5 tients, pregnant women, and children; and

6 (4) disseminating information on the use of al-
7 ternatives to opioids to providers in acute care set-
8 tings, which may include emergency departments,
9 outpatient clinics, critical access hospitals, Federally
10 qualified health centers, Indian Health Service
11 health facilities, and tribal hospitals.

12 (e) REPORT TO THE SECRETARY.—Each recipient of
13 a grant under this section shall submit to the Secretary
14 (during the period of such grant) annual reports on the
15 progress of the program funded through the grant. These
16 reports shall include, in accordance with all applicable
17 State and Federal privacy laws—

18 (1) a description of and specific information
19 about the opioid alternative pain management pro-
20 grams, including the demographic characteristics of
21 patients who were treated with an alternative pain
22 management protocol, implemented in hospitals,
23 emergency departments, and other acute care set-
24 tings;

1 (2) data on the opioid alternative pain manage-
2 ment strategies used, including the number of opioid
3 prescriptions written—

4 (A) during a baseline period before the
5 program began; or

6 (B) at various stages of the program; and

7 (3) data on patients who were eventually pre-
8 scribed opioids after alternative pain management
9 protocols and treatments were utilized; and

10 (4) any other information the Secretary deter-
11 mines appropriate.

12 (f) REPORT TO CONGRESS.—Not later than 1 year
13 after completion of the demonstration program under this
14 section, the Secretary shall submit a report to the Con-
15 gress on the results of the demonstration program and in-
16 clude in the report—

17 (1) the number of applications received and the
18 number funded;

19 (2) a summary of the reports described in sub-
20 section (e), including data that allows for compari-
21 son of programs; and

22 (3) recommendations for broader implementa-
23 tion of pain management strategies that encourage
24 the use of alternatives to opioids in hospitals, emer-
25 gency departments, or other acute care settings.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there is authorized to be appropriated
3 \$10,000,000 for each of fiscal years 2019 through 2021.

4 **Subtitle K—Treatment, Education,**
5 **and Community Help To Com-**
6 **bat Addiction**

7 **SEC. 7101. ESTABLISHMENT OF REGIONAL CENTERS OF EX-**
8 **CELLENCE IN SUBSTANCE USE DISORDER**
9 **EDUCATION.**

10 Part D of title V of the Public Health Service Act,
11 as amended by section 7031, is further amended by adding
12 at the end the following new section:

13 **“SEC. 551. REGIONAL CENTERS OF EXCELLENCE IN SUB-**
14 **STANCE USE DISORDER EDUCATION.**

15 “(a) IN GENERAL.—The Secretary, in consultation
16 with appropriate agencies, shall award cooperative agree-
17 ments to eligible entities for the designation of such enti-
18 ties as Regional Centers of Excellence in Substance Use
19 Disorder Education for purposes of improving health pro-
20 fessional training resources with respect to substance use
21 disorder prevention, treatment, and recovery.

22 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
23 ative agreement under subsection (a), an entity shall—

1 “(1) be an accredited entity that offers edu-
2 cation to students in various health professions,
3 which may include—

4 “(A) a teaching hospital;

5 “(B) a medical school;

6 “(C) a certified behavioral health clinic; or

7 “(D) any other health professions school,
8 school of public health, or Cooperative Exten-
9 sion Program at institutions of higher edu-
10 cation, as defined in section 101 of the Higher
11 Education Act of 1965, engaged in the preven-
12 tion, treatment, or recovery of substance use
13 disorders;

14 “(2) demonstrate community engagement and
15 partnerships with community stakeholders, including
16 entities that train health professionals, mental
17 health counselors, social workers, peer recovery spe-
18 cialists, substance use treatment programs, commu-
19 nity health centers, physician offices, certified behav-
20 ioral health clinics, research institutions, and law en-
21 forcement; and

22 “(3) submit to the Secretary an application
23 containing such information, at such time, and in
24 such manner, as the Secretary may require.

1 “(c) ACTIVITIES.—An entity receiving an award
2 under this section shall develop, evaluate, and distribute
3 evidence-based resources regarding the prevention and
4 treatment of, and recovery from, substance use disorders.
5 Such resources may include information on—

6 “(1) the neurology and pathology of substance
7 use disorders;

8 “(2) advancements in the treatment of sub-
9 stance use disorders;

10 “(3) techniques and best practices to support
11 recovery from substance use disorders;

12 “(4) strategies for the prevention and treatment
13 of, and recovery from substance use disorders across
14 patient populations; and

15 “(5) other topic areas that are relevant to the
16 objectives described in subsection (a).

17 “(d) GEOGRAPHIC DISTRIBUTION.—In awarding co-
18 operative agreements under subsection (a), the Secretary
19 shall take into account regional differences among eligible
20 entities and shall make an effort to ensure geographic dis-
21 tribution.

22 “(e) EVALUATION.—The Secretary shall evaluate
23 each project carried out by an entity receiving an award
24 under this section and shall disseminate the findings with

1 respect to each such evaluation to appropriate public and
2 private entities.

3 “(f) FUNDING.—There is authorized to be appro-
4 priated to carry out this section, \$4,000,000 for each of
5 fiscal years 2019 through 2023.”.

6 **SEC. 7102. YOUTH PREVENTION AND RECOVERY.**

7 (a) SUBSTANCE ABUSE TREATMENT SERVICES FOR
8 CHILDREN, ADOLESCENTS, AND YOUNG ADULTS.—Sec-
9 tion 514 of the Public Health Service Act (42 U.S.C.
10 290bb–7) is amended—

11 (1) in the section heading, by striking “**CHIL-**
12 **DREN AND ADOLESCENTS**” and inserting “**CHIL-**
13 **DREN, ADOLESCENTS, AND YOUNG ADULTS**”;

14 (2) in subsection (a)(2), by striking “children,
15 including” and inserting “children, adolescents, and
16 young adults, including”; and

17 (3) by striking “children and adolescents” each
18 place it appears and inserting “children, adolescents,
19 and young adults”.

20 (b) RESOURCE CENTER.—The Secretary of Health
21 and Human Services (referred to in this section as the
22 “Secretary”, except as otherwise provided), in consultation
23 with the Secretary of Education and other heads of agen-
24 cies, including the Assistant Secretary for Mental Health
25 and Substance Use and the Administrator of the Health

1 Resources and Services Administration, as appropriate,
2 shall establish a resource center to provide technical sup-
3 port to recipients of grants under subsection (c).

4 (c) YOUTH PREVENTION AND RECOVERY INITIA-
5 TIVE.—

6 (1) IN GENERAL.—The Secretary, in consulta-
7 tion with the Secretary of Education, shall admin-
8 ister a program to provide support for communities
9 to support the prevention of, treatment of, and re-
10 covery from, substance use disorders for children,
11 adolescents, and young adults.

12 (2) DEFINITIONS.—In this subsection:

13 (A) ELIGIBLE ENTITY.—The term “eligible
14 entity” means—

15 (i) a local educational agency that is
16 seeking to establish or expand substance
17 use prevention or recovery support services
18 at one or more high schools;

19 (ii) a State educational agency;

20 (iii) an institution of higher education
21 (or consortia of such institutions), which
22 may include a recovery program at an in-
23 stitution of higher education;

24 (iv) a local board or one-stop oper-
25 ator;

1 (v) a nonprofit organization with ap-
2 propriate expertise in providing services or
3 programs for children, adolescents, or
4 young adults, excluding a school;

5 (vi) a State, political subdivision of a
6 State, Indian tribe, or tribal organization;
7 or

8 (vii) a high school or dormitory serv-
9 ing high school students that receives
10 funding from the Bureau of Indian Edu-
11 cation.

12 (B) FOSTER CARE.—The term “foster
13 care” has the meaning given such term in sec-
14 tion 1355.20(a) of title 45, Code of Federal
15 Regulations (or any successor regulations).

16 (C) HIGH SCHOOL.—The term “high
17 school” has the meaning given such term in
18 section 8101 of the Elementary and Secondary
19 Education Act of 1965 (20 U.S.C. 7801).

20 (D) HOMELESS YOUTH.—The term “home-
21 less youth” has the meaning given the term
22 “homeless children or youths” in section 725 of
23 the McKinney-Vento Homeless Assistance Act
24 (42 U.S.C. 11434a).

1 (E) INDIAN TRIBE; TRIBAL ORGANIZA-
2 TION.—The terms “Indian tribe” and “tribal
3 organization” have the meanings given such
4 terms in section 4 of the Indian Self-Deter-
5 mination and Education Assistance Act (25
6 U.S.C. 5304).

7 (F) INSTITUTION OF HIGHER EDU-
8 CATION.—The term “institution of higher edu-
9 cation” has the meaning given such term in
10 section 101 of the Higher Education Act of
11 1965 (20 U.S.C. 1001) and includes a “post-
12 secondary vocational institution” as defined in
13 section 102(c) of such Act (20 U.S.C. 1002(c)).

14 (G) LOCAL EDUCATIONAL AGENCY.—The
15 term “local educational agency” has the mean-
16 ing given such term in section 8101 of the Ele-
17 mentary and Secondary Education Act of 1965
18 (20 U.S.C. 7801).

19 (H) LOCAL BOARD; ONE-STOP OPER-
20 ATOR.—The terms “local board” and “one-stop
21 operator” have the meanings given such terms
22 in section 3 of the Workforce Innovation and
23 Opportunity Act (29 U.S.C. 3102).

24 (I) OUT-OF-SCHOOL YOUTH.—The term
25 “out-of-school youth” has the meaning given

1 such term in section 129(a)(1)(B) of the Work-
2 force Innovation and Opportunity Act (29
3 U.S.C. 3164(a)(1)(B)).

4 (J) RECOVERY PROGRAM.—The term “re-
5 covery program” means a program—

6 (i) to help children, adolescents, or
7 young adults who are recovering from sub-
8 stance use disorders to initiate, stabilize,
9 and maintain healthy and productive lives
10 in the community; and

11 (ii) that includes peer-to-peer support
12 delivered by individuals with lived experi-
13 ence in recovery, and communal activities
14 to build recovery skills and supportive so-
15 cial networks.

16 (K) STATE EDUCATIONAL AGENCY.—The
17 term “State educational agency” has the mean-
18 ing given such term in section 8101 of the Ele-
19 mentary and Secondary Education Act (20
20 U.S.C. 7801).

21 (3) BEST PRACTICES.—The Secretary, in con-
22 sultation with the Secretary of Education, shall—

23 (A) identify or facilitate the development of
24 evidence-based best practices for prevention of
25 substance misuse and abuse by children, adoles-

1 cents, and young adults, including for specific
2 populations such as youth in foster care, home-
3 less youth, out-of-school youth, and youth who
4 are at risk of or have experienced trafficking
5 that address—

6 (i) primary prevention;

7 (ii) appropriate recovery support serv-
8 ices;

9 (iii) appropriate use of medication-as-
10 sisted treatment for such individuals, if ap-
11 plicable, and ways of overcoming barriers
12 to the use of medication-assisted treatment
13 in such population; and

14 (iv) efficient and effective communica-
15 tion, which may include the use of social
16 media, to maximize outreach efforts;

17 (B) disseminate such best practices to
18 State educational agencies, local educational
19 agencies, schools and dormitories funded by the
20 Bureau of Indian Education, institutions of
21 higher education, recovery programs at institu-
22 tions of higher education, local boards, one-stop
23 operators, family and youth homeless providers,
24 and nonprofit organizations, as appropriate;

1 (C) conduct a rigorous evaluation of each
2 grant funded under this subsection, particularly
3 its impact on the indicators described in para-
4 graph (7)(B); and

5 (D) provide technical assistance for grant-
6 ees under this subsection.

7 (4) GRANTS AUTHORIZED.—The Secretary, in
8 consultation with the Secretary of Education, shall
9 award 3-year grants, on a competitive basis, to eligi-
10 ble entities to enable such entities, in coordination
11 with Indian tribes, if applicable, and State agencies
12 responsible for carrying out substance use disorder
13 prevention and treatment programs, to carry out evi-
14 dence-based programs for—

15 (A) prevention of substance misuse and
16 abuse by children, adolescents, and young
17 adults, which may include primary prevention;

18 (B) recovery support services for children,
19 adolescents, and young adults, which may in-
20 clude counseling, job training, linkages to com-
21 munity-based services, family support groups,
22 peer mentoring, and recovery coaching; or

23 (C) treatment or referrals for treatment of
24 substance use disorders, which may include the

1 use of medication-assisted treatment, as appro-
2 priate.

3 (5) SPECIAL CONSIDERATION.—In awarding
4 grants under this subsection, the Secretary shall give
5 special consideration to the unique needs of tribal,
6 urban, suburban, and rural populations.

7 (6) APPLICATION.—To be eligible for a grant
8 under this subsection, an entity shall submit to the
9 Secretary an application at such time, in such man-
10 ner, and containing such information as the Sec-
11 retary may require. Such application shall include—

12 (A) a description of—

13 (i) the impact of substance use dis-
14 orders in the population that will be served
15 by the grant program;

16 (ii) how the eligible entity has solie-
17 ited input from relevant stakeholders,
18 which may include faculty, teachers, staff,
19 families, students, and experts in sub-
20 stance use disorder prevention, treatment,
21 and recovery in developing such applica-
22 tion;

23 (iii) the goals of the proposed project,
24 including the intended outcomes;

1 (iv) how the eligible entity plans to
2 use grant funds for evidence-based activi-
3 ties, in accordance with this subsection to
4 prevent, provide recovery support for, or
5 treat substance use disorders amongst
6 such individuals, or a combination of such
7 activities; and

8 (v) how the eligible entity will collabo-
9 rate with relevant partners, which may in-
10 clude State educational agencies, local edu-
11 cational agencies, institutions of higher
12 education, juvenile justice agencies, preven-
13 tion and recovery support providers, local
14 service providers, including substance use
15 disorder treatment programs, providers of
16 mental health services, youth serving orga-
17 nizations, family and youth homeless pro-
18 viders, child welfare agencies, and primary
19 care providers, in carrying out the grant
20 program; and

21 (B) an assurance that the eligible entity
22 will participate in the evaluation described in
23 paragraph (3)(C).

24 (7) REPORTS TO THE SECRETARY.—Each eligi-
25 ble entity awarded a grant under this subsection

1 shall submit to the Secretary a report at such time
2 and in such manner as the Secretary may require.

3 Such report shall include—

4 (A) a description of how the eligible entity
5 used grant funds, in accordance with this sub-
6 section, including the number of children, ado-
7 lescents, and young adults reached through pro-
8 gramming; and

9 (B) a description, including relevant data,
10 of how the grant program has made an impact
11 on the intended outcomes described in para-
12 graph (6)(A)(iii), including—

13 (i) indicators of student success,
14 which, if the eligible entity is an edu-
15 cational institution, shall include student
16 well-being and academic achievement;

17 (ii) substance use disorders amongst
18 children, adolescents, and young adults, in-
19 cluding the number of overdoses and
20 deaths amongst children, adolescents, and
21 young adults served by the grant during
22 the grant period; and

23 (iii) other indicators, as the Secretary
24 determines appropriate.

1 (8) REPORT TO CONGRESS.—The Secretary
2 shall, not later than October 1, 2022, submit a re-
3 port to the Committee on Health, Education, Labor,
4 and Pensions of the Senate and the Committee on
5 Energy and Commerce and the Committee on Edu-
6 cation and the Workforce of the House of Rep-
7 resentatives a report summarizing the effectiveness
8 of the grant program under this subsection, based
9 on the information submitted in reports required
10 under paragraph (7).

11 (9) AUTHORIZATION OF APPROPRIATIONS.—
12 There is authorized to be appropriated \$10,000,000
13 to carry out this subsection for each of fiscal years
14 2019 through 2023.

15 **Subtitle L—Information From Na-**
16 **tional Mental Health and Sub-**
17 **stance Use Policy Laboratory**

18 **SEC. 7111. INFORMATION FROM NATIONAL MENTAL**
19 **HEALTH AND SUBSTANCE USE POLICY LAB-**
20 **ORATORY.**

21 Section 501A(b) of the Public Health Service Act (42
22 U.S.C. 290aa–0(b)) is amended—

23 (1) in paragraph (5)(C), by striking “; and” at
24 the end and inserting a semicolon;

1 (2) by redesignating paragraph (6) as para-
2 graph (7); and

3 (3) by inserting after paragraph (5) the fol-
4 lowing:

5 “(6) issue and periodically update information
6 for entities applying for grants or cooperative agree-
7 ments from the Substance Abuse and Mental Health
8 Services Administration in order to—

9 “(A) encourage the implementation and
10 replication of evidence-based practices; and

11 “(B) provide technical assistance to appli-
12 cants for funding, including with respect to jus-
13 tifications for such programs and activities;
14 and”.

15 **Subtitle M—Comprehensive Opioid**
16 **Recovery Centers**

17 **SEC. 7121. COMPREHENSIVE OPIOID RECOVERY CENTERS.**

18 (a) IN GENERAL.—Part D of title V of the Public
19 Health Service Act (42 U.S.C. 290dd et seq.), as amended
20 by sections 7031 and 7101, is further amended by adding
21 at the end the following new section:

22 **“SEC. 552. COMPREHENSIVE OPIOID RECOVERY CENTERS.**

23 “(a) IN GENERAL.—The Secretary shall award
24 grants on a competitive basis to eligible entities to estab-
25 lish or operate a comprehensive opioid recovery center (re-

1 ferred to in this section as a ‘Center’). A Center may be
2 a single entity or an integrated delivery network.

3 “(b) GRANT PERIOD.—

4 “(1) IN GENERAL.—A grant awarded under
5 subsection (a) shall be for a period of not less than
6 3 years and not more than 5 years.

7 “(2) RENEWAL.—A grant awarded under sub-
8 section (a) may be renewed, on a competitive basis,
9 for additional periods of time, as determined by the
10 Secretary. In determining whether to renew a grant
11 under this paragraph, the Secretary shall consider
12 the data submitted under subsection (h).

13 “(c) MINIMUM NUMBER OF CENTERS.—The Sec-
14 retary shall allocate the amounts made available under
15 subsection (j) such that not fewer than 10 grants may be
16 awarded. Not more than one grant shall be made to enti-
17 ties in a single State for any one period.

18 “(d) APPLICATION.—

19 “(1) ELIGIBLE ENTITY.—An entity is eligible
20 for a grant under this section if the entity offers
21 treatment and other services for individuals with a
22 substance use disorder.

23 “(2) SUBMISSION OF APPLICATION.—In order
24 to be eligible for a grant under subsection (a), an
25 entity shall submit an application to the Secretary at

1 such time and in such manner as the Secretary may
2 require. Such application shall include—

3 “(A) evidence that such entity carries out,
4 or is capable of coordinating with other entities
5 to carry out, the activities described in sub-
6 section (g); and

7 “(B) such other information as the Sec-
8 retary may require.

9 “(e) PRIORITY.—In awarding grants under sub-
10 section (a), the Secretary shall give priority to eligible enti-
11 ties—

12 “(1) located in a State with an age-adjusted
13 rate of drug overdose deaths that is above the na-
14 tional overdose mortality rate, as determined by the
15 Director of the Centers for Disease Control and Pre-
16 vention; or

17 “(2) serving an Indian Tribe (as defined in sec-
18 tion 4 of the Indian Self-Determination and Edu-
19 cation Assistance Act) with an age-adjusted rate of
20 drug overdose deaths that is above the national over-
21 dose mortality rate, as determined through appro-
22 priate mechanisms determined by the Secretary in
23 consultation with Indian Tribes.

24 “(f) PREFERENCE.—In awarding grants under sub-
25 section (a), the Secretary may give preference to eligible

1 entities utilizing technology-enabled collaborative learning
2 and capacity building models, including such models as de-
3 fined in section 2 of the Expanding Capacity for Health
4 Outcomes Act (Public Law 114–270; 130 Stat. 1395), to
5 conduct the activities described in this section.

6 “(g) CENTER ACTIVITIES.—Each Center shall, at a
7 minimum, carry out the following activities directly,
8 through referral, or through contractual arrangements,
9 which may include carrying out such activities through
10 technology-enabled collaborative learning and capacity
11 building models described in subsection (f):

12 “(1) TREATMENT AND RECOVERY SERVICES.—

13 Each Center shall—

14 “(A) Ensure that intake, evaluations, and
15 periodic patient assessments meet the individ-
16 ualized clinical needs of patients, including by
17 reviewing patient placement in treatment set-
18 tings to support meaningful recovery.

19 “(B) Provide the full continuum of treat-
20 ment services, including—

21 “(i) all drugs and devices approved or
22 cleared under the Federal Food, Drug, and
23 Cosmetic Act and all biological products li-
24 censed under section 351 of this Act to
25 treat substance use disorders or reverse

1 overdoses, pursuant to Federal and State
2 law;

3 “(ii) medically supervised withdrawal
4 management, that includes patient evalua-
5 tion, stabilization, and readiness for and
6 entry into treatment;

7 “(iii) counseling provided by a pro-
8 gram counselor or other certified profes-
9 sional who is licensed and qualified by edu-
10 cation, training, or experience to assess the
11 psychological and sociological background
12 of patients, to contribute to the appro-
13 priate treatment plan for the patient, and
14 to monitor patient progress;

15 “(iv) treatment, as appropriate, for
16 patients with co-occurring substance use
17 and mental disorders;

18 “(v) testing, as appropriate, for infec-
19 tions commonly associated with illicit drug
20 use;

21 “(vi) residential rehabilitation, and
22 outpatient and intensive outpatient pro-
23 grams;

24 “(vii) recovery housing;

1 “(viii) community-based and peer re-
2 covery support services;

3 “(ix) job training, job placement as-
4 sistance, and continuing education assist-
5 ance to support reintegration into the
6 workforce; and

7 “(x) other best practices to provide
8 the full continuum of treatment and serv-
9 ices, as determined by the Secretary.

10 “(C) Ensure that all programs covered by
11 the Center include medication-assisted treat-
12 ment, as appropriate, and do not exclude indi-
13 viduals receiving medication-assisted treatment
14 from any service.

15 “(D) Periodically conduct patient assess-
16 ments to support sustained and clinically sig-
17 nificant recovery, as defined by the Assistant
18 Secretary for Mental Health and Substance
19 Use.

20 “(E) Provide onsite access to medication,
21 as appropriate, and toxicology services; for pur-
22 poses of carrying out this section.

23 “(F) Operate a secure, confidential, and
24 interoperable electronic health information sys-
25 tem.

1 “(G) Offer family support services such as
2 child care, family counseling, and parenting
3 interventions to help stabilize families impacted
4 by substance use disorder, as appropriate.

5 “(2) OUTREACH.—Each Center shall carry out
6 outreach activities regarding the services offered
7 through the Centers, which may include—

8 “(A) training and supervising outreach
9 staff, as appropriate, to work with State and
10 local health departments, health care providers,
11 the Indian Health Service, State and local edu-
12 cational agencies, schools funded by the Indian
13 Bureau of Education, institutions of higher
14 education, State and local workforce develop-
15 ment boards, State and local community action
16 agencies, public safety officials, first respond-
17 ers, Indian Tribes, child welfare agencies, as
18 appropriate, and other community partners and
19 the public, including patients, to identify and
20 respond to community needs;

21 “(B) ensuring that the entities described in
22 subparagraph (A) are aware of the services of
23 the Center; and

24 “(C) disseminating and making publicly
25 available, including through the internet, evi-

1 dence-based resources that educate profes-
2 sionals and the public on opioid use disorder
3 and other substance use disorders, including co-
4 occurring substance use and mental disorders.

5 “(h) DATA REPORTING AND PROGRAM OVER-
6 SIGHT.—With respect to a grant awarded under sub-
7 section (a), not later than 90 days after the end of the
8 first year of the grant period, and annually thereafter for
9 the duration of the grant period (including the duration
10 of any renewal period for such grant), the entity shall sub-
11 mit data, as appropriate, to the Secretary regarding—

12 “(1) the programs and activities funded by the
13 grant;

14 “(2) health outcomes of the population of indi-
15 viduals with a substance use disorder who received
16 services from the Center, evaluated by an inde-
17 pendent program evaluator through the use of out-
18 comes measures, as determined by the Secretary;

19 “(3) the retention rate of program participants;
20 and

21 “(4) any other information that the Secretary
22 may require for the purpose of—ensuring that the
23 Center is complying with all the requirements of the
24 grant, including providing the full continuum of
25 services described in subsection (g)(1)(B).

1 “(i) PRIVACY.—The provisions of this section, includ-
2 ing with respect to data reporting and program oversight,
3 shall be subject to all applicable Federal and State privacy
4 laws.

5 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
6 is authorized to be appropriated \$10,000,000 for each of
7 fiscal years 2019 through 2023 for purposes of carrying
8 out this section.”.

9 (b) REPORTS TO CONGRESS.—

10 (1) PRELIMINARY REPORT.—Not later than 3
11 years after the date of the enactment of this Act, the
12 Secretary of Health and Human Services shall sub-
13 mit to Congress a preliminary report that analyzes
14 data submitted under section 552(h) of the Public
15 Health Service Act, as added by subsection (a).

16 (2) FINAL REPORT.—Not later than 2 years
17 after submitting the preliminary report required
18 under paragraph (1), the Secretary of Health and
19 Human Services shall submit to Congress a final re-
20 port that includes—

21 (A) an evaluation of the effectiveness of
22 the comprehensive services provided by the Cen-
23 ters established or operated pursuant to section
24 552 of the Public Health Service Act, as added
25 by subsection (a), with respect to health out-

1 comes of the population of individuals with sub-
2 stance use disorder who receive services from
3 the Center, which shall include an evaluation of
4 the effectiveness of services for treatment and
5 recovery support and to reduce relapse, recidi-
6 vism, and overdose; and

7 (B) recommendations, as appropriate, re-
8 garding ways to improve Federal programs re-
9 lated to substance use disorders, which may in-
10 clude dissemination of best practices for the
11 treatment of substance use disorders to health
12 care professionals.

13 **Subtitle N—Trauma-Informed Care**

14 **SEC. 7131. CDC SURVEILLANCE AND DATA COLLECTION** 15 **FOR CHILD, YOUTH, AND ADULT TRAUMA.**

16 (a) DATA COLLECTION.—The Director of the Centers
17 for Disease Control and Prevention (referred to in this
18 section as the “Director”) may, in cooperation with the
19 States, collect and report data on adverse childhood expe-
20 riences through the Behavioral Risk Factor Surveillance
21 System, the Youth Risk Behavior Surveillance System,
22 and other relevant public health surveys or questionnaires.

23 (b) TIMING.—The collection of data under subsection
24 (a) may occur biennially.

1 (c) DATA FROM RURAL AREAS.—The Director shall
2 encourage each State that participates in collecting and
3 reporting data under subsection (a) to collect and report
4 data from rural areas within such State, in order to gen-
5 erate a statistically reliable representation of such areas.

6 (d) DATA FROM TRIBAL AREAS.—The Director may,
7 in cooperation with Indian Tribes (as defined in section
8 4 of the Indian Self-Determination and Education Assist-
9 ance Act) and pursuant to a written request from an In-
10 dian Tribe, provide technical assistance to such Indian
11 Tribe to collect and report data on adverse childhood expe-
12 riences through the Behavioral Risk Factor Surveillance
13 System, the Youth Risk Behavior Surveillance System, or
14 another relevant public health survey or questionnaire.

15 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there is authorized to be appropriated
17 \$2,000,000 for each of fiscal years 2019 through 2023.

18 **SEC. 7132. TASK FORCE TO DEVELOP BEST PRACTICES FOR**
19 **TRAUMA-INFORMED IDENTIFICATION, RE-**
20 **FERRAL, AND SUPPORT.**

21 (a) ESTABLISHMENT.—There is established a task
22 force, to be known as the Interagency Task Force on
23 Trauma-Informed Care (in this section referred to as the
24 “task force”) that shall identify, evaluate, and make rec-
25 ommendations regarding—

1 (1) best practices with respect to children and
2 youth, and their families as appropriate, who have
3 experienced or are at risk of experiencing trauma;
4 and

5 (2) ways in which Federal agencies can better
6 coordinate to improve the Federal response to fami-
7 lies impacted by substance use disorders and other
8 forms of trauma.

9 (b) MEMBERSHIP.—

10 (1) COMPOSITION.—The task force shall be
11 composed of the heads of the following Federal de-
12 partments and agencies, or their designees:

13 (A) The Centers for Medicare & Medicaid
14 Services.

15 (B) The Substance Abuse and Mental
16 Health Services Administration.

17 (C) The Agency for Healthcare Research
18 and Quality.

19 (D) The Centers for Disease Control and
20 Prevention.

21 (E) The Indian Health Service.

22 (F) The Department of Veterans Affairs.

23 (G) The National Institutes of Health.

24 (H) The Food and Drug Administration.

1 (I) The Health Resources and Services Ad-
2 ministration.

3 (J) The Department of Defense.

4 (K) The Office of Minority Health of the
5 Department of Health and Human Services.

6 (L) The Administration for Children and
7 Families.

8 (M) The Office of the Assistant Secretary
9 for Planning and Evaluation of the Department
10 of Health and Human Services.

11 (N) The Office for Civil Rights of the De-
12 partment of Health and Human Services.

13 (O) The Office of Juvenile Justice and De-
14 linquency Prevention of the Department of Jus-
15 tice.

16 (P) The Office of Community Oriented Po-
17 licing Services of the Department of Justice.

18 (Q) The Office on Violence Against
19 Women of the Department of Justice.

20 (R) The National Center for Education
21 Evaluation and Regional Assistance of the De-
22 partment of Education.

23 (S) The National Center for Special Edu-
24 cation Research of the Institute of Education
25 Science.

1 (T) The Office of Elementary and Sec-
2 ondary Education of the Department of Edu-
3 cation.

4 (U) The Office for Civil Rights of the De-
5 partment of Education.

6 (V) The Office of Special Education and
7 Rehabilitative Services of the Department of
8 Education.

9 (W) The Bureau of Indian Affairs of the
10 Department of the Interior.

11 (X) The Veterans Health Administration
12 of the Department of Veterans Affairs.

13 (Y) The Office of Special Needs Assistance
14 Programs of the Department of Housing and
15 Urban Development.

16 (Z) The Office of Head Start of the Ad-
17 ministration for Children and Families.

18 (AA) The Children's Bureau of the Admin-
19 istration for Children and Families.

20 (BB) The Bureau of Indian Education of
21 the Department of the Interior.

22 (CC) Such other Federal agencies as the
23 Secretaries determine to be appropriate.

24 (2) DATE OF APPOINTMENTS.—The heads of
25 Federal departments and agencies shall appoint the

1 corresponding members of the task force not later
2 than 60 days after the date of enactment of this
3 Act.

4 (3) CHAIRPERSON.—The task force shall be
5 chaired by the Assistant Secretary for Mental
6 Health and Substance Use, or the Assistant Sec-
7 retary's designee.

8 (c) TASK FORCE DUTIES.—The task force shall—

9 (1) solicit input from stakeholders, including
10 frontline service providers, educators, mental health
11 professionals, researchers, experts in infant, child,
12 and youth trauma, child welfare professionals, and
13 the public, in order to inform the activities under
14 paragraph (2); and

15 (2) identify, evaluate, make recommendations,
16 and update such recommendations not less than an-
17 nually, to the general public, the Secretary of Edu-
18 cation, the Secretary of Health and Human Services,
19 the Secretary of Labor, the Secretary of the Inte-
20 rior, the Attorney General, and other relevant cabi-
21 net Secretaries, and Congress regarding—

22 (A) a set of evidence-based, evidence-in-
23 formed, and promising best practices with re-
24 spect to—

1 (i) prevention strategies for individ-
2 uals at risk of experiencing or being ex-
3 posed to trauma, including trauma as a re-
4 sult of exposure to substance use;

5 (ii) the identification of infants, chil-
6 dren and youth, and their families as ap-
7 propriate, who have experienced or are at
8 risk of experiencing trauma;

9 (iii) the expeditious referral to and
10 implementation of trauma-informed prac-
11 tices and supports that prevent and miti-
12 gate the effects of trauma, which may in-
13 clude whole-family and multi-generational
14 approaches; and

15 (iv) community based or multi-
16 generational practices that support chil-
17 dren and their families;

18 (B) a national strategy on how the task
19 force and member agencies will collaborate,
20 prioritize options for, and implement a coordi-
21 nated approach, which may include—

22 (i) data sharing;

23 (ii) providing support to infants, chil-
24 dren, and youth, and their families as ap-

1 appropriate, who have experienced or are at
2 risk of experiencing trauma;

3 (iii) identifying options for coordi-
4 nating existing grants that support infants,
5 children, and youth, and their families as
6 appropriate, who have experienced, or are
7 at risk of experiencing, exposure to sub-
8 stance use or other trauma, including trau-
9 ma related to substance use; and

10 (iv) other ways to improve coordina-
11 tion, planning, and communication within
12 and across Federal agencies, offices, and
13 programs, to better serve children and
14 families impacted by substance use dis-
15 orders; and

16 (C) existing Federal authorities at the De-
17 partment of Education, Department of Health
18 and Human Services, Department of Justice,
19 Department of Labor, Department of the Inte-
20 rior, and other relevant agencies, and specific
21 Federal grant programs to disseminate best
22 practices on, provide training in, or deliver serv-
23 ices through, trauma-informed practices, and
24 disseminate such information—

1 (i) in writing to relevant program of-
2 fices at such agencies to encourage grant
3 applicants in writing to use such funds,
4 where appropriate, for trauma-informed
5 practices; and

6 (ii) to the general public through the
7 internet website of the task force.

8 (d) BEST PRACTICES.—In identifying, evaluating,
9 and recommending the set of best practices under sub-
10 section (c), the task force shall—

11 (1) include guidelines for providing professional
12 development and education for front-line services
13 providers, including school personnel, early childhood
14 education program providers, providers from child-
15 or youth-serving organizations, housing and home-
16 less providers, primary and behavioral health care
17 providers, child welfare and social services providers,
18 juvenile and family court personnel, health care pro-
19 viders, individuals who are mandatory reporters of
20 child abuse or neglect, trained nonclinical providers
21 (including peer mentors and clergy), and first re-
22 sponders, in—

23 (A) understanding and identifying early
24 signs and risk factors of trauma in infants,
25 children, and youth, and their families as ap-

1 appropriate, including through screening processes
2 and services;

3 (B) providing practices to prevent and
4 mitigate the impact of trauma, including by fos-
5 tering safe and stable environments and rela-
6 tionships; and

7 (C) developing and implementing policies,
8 procedures, or systems that—

9 (i) are designed to quickly refer in-
10 fants, children, youth, and their families as
11 appropriate, who have experienced or are
12 at risk of experiencing trauma to the ap-
13 propriate trauma-informed screening and
14 support and age-appropriate treatment,
15 and to ensure such infants, children,
16 youth, and family members receive such
17 support;

18 (ii) utilize and develop partnerships
19 with early childhood education programs,
20 local social services organizations, such as
21 organizations serving youth, and clinical
22 mental health or other health care pro-
23 viders with expertise in providing support
24 services and age-appropriate trauma-in-
25 formed and evidence-based treatment

1 aimed at preventing or mitigating the ef-
2 fects of trauma;

3 (iii) educate children and youth to—

4 (I) understand and identify the
5 signs, effects, or symptoms of trauma;
6 and

7 (II) build the resilience and cop-
8 ing skills to mitigate the effects of ex-
9 perience trauma;

10 (iv) promote and support multi-
11 generational practices that assist parents,
12 foster parents, and kinship and other care-
13 givers in accessing resources related to,
14 and developing environments conducive to,
15 the prevention and mitigation of trauma;
16 and

17 (v) collect and utilize data from
18 screenings, referrals, or the provision of
19 services and supports to evaluate outcomes
20 and improve processes for trauma-informed
21 services and supports that are culturally
22 sensitive, linguistically appropriate, and
23 specific to age ranges and sex, as applica-
24 ble;

1 (2) recommend best practices that are designed
2 to avoid unwarranted custody loss or criminal pen-
3 alties for parents or guardians in connection with in-
4 fants, children, and youth who have experienced or
5 are at risk of experiencing trauma; and

6 (3) recommend opportunities for local- and
7 State-level partnerships that—

8 (A) are designed to quickly identify and
9 refer children and families, as appropriate, who
10 have experienced or are at risk of experiencing
11 exposure to trauma, including related to sub-
12 stance use;

13 (B) utilize and develop partnerships with
14 early childhood education programs, local social
15 services organizations, and health care services
16 aimed at preventing or mitigating the effects of
17 exposure to trauma, including related to sub-
18 stance use;

19 (C) offer community-based prevention ac-
20 tivities, including educating families and chil-
21 dren on the effects of exposure to trauma, such
22 as trauma related to substance use, and how to
23 build resilience and coping skills to mitigate
24 those effects;

1 (D) in accordance with Federal privacy
2 protections, utilize non-personally-identifiable
3 data from screenings, referrals, or the provision
4 of services and supports to evaluate and im-
5 prove processes addressing exposure to trauma,
6 including related to substance use; and

7 (E) are designed to prevent separation and
8 support reunification of families if in the best
9 interest of the child.

10 (e) OPERATING PLAN.—Not later than 120 days
11 after the date of enactment of this Act, the task force shall
12 hold the first meeting. Not later than 2 years after such
13 date of enactment, the task force shall submit to the Sec-
14 retary of Education, Secretary of Health and Human
15 Services, Secretary of Labor, Secretary of the Interior, the
16 Attorney General, and Congress an operating plan for car-
17 rying out the activities of the task force described in sub-
18 section (c)(2). Such operating plan shall include—

19 (1) a list of specific activities that the task
20 force plans to carry out for purposes of carrying out
21 duties described in subsection (c)(2), which may in-
22 clude public engagement;

23 (2) a plan for carrying out the activities under
24 subsection (c)(2);

1 (3) a list of members of the task force and
2 other individuals who are not members of the task
3 force that may be consulted to carry out such activi-
4 ties;

5 (4) an explanation of Federal agency involve-
6 ment and coordination needed to carry out such ac-
7 tivities, including any statutory or regulatory bar-
8 riers to such coordination;

9 (5) a budget for carrying out such activities;

10 (6) a proposed timeline for implementing rec-
11 ommendations and efforts identified under sub-
12 section (c); and

13 (7) other information that the task force deter-
14 mines appropriate as related to its duties.

15 (f) FINAL REPORT.—Not later than 3 years after the
16 date of the first meeting of the task force, the task force
17 shall submit to the general public, Secretary of Education,
18 Secretary of Health and Human Services, Secretary of
19 Labor, Secretary of the Interior, the Attorney General,
20 other relevant cabinet Secretaries, the Committee on En-
21 ergy and Commerce and the Committee on Education and
22 the Workforce of the House of Representatives and the
23 Committee on Health, Education, Labor, and Pensions of
24 the Senate, and Congress, a final report containing all of
25 the findings and recommendations required under this sec-

1 tion, and shall make such report available online in an
2 accessible format.

3 (g) ADDITIONAL REPORTS.—In addition to the final
4 report under subsection (f). the task force shall submit—

5 (1) a report to Congress identifying any rec-
6 ommendations identified under subsection (c) that
7 require additional legislative authority to implement;
8 and

9 (2) a report to the Governors describing the op-
10 portunities for local- and State-level partnerships,
11 professional development, or best practices rec-
12 ommended under subsection (d)(3).

13 (h) DEFINITIONS.—In this section—

14 (1) the term “early childhood education pro-
15 gram” has the meaning given such term in section
16 103 of the Higher Education Act of 1965 (20
17 U.S.C. 1003);

18 (2) The term “Governor” means the chief exec-
19 utive officer of a State; and

20 (3) the term “State” means each of the several
21 States, the District of Columbia, the Commonwealth
22 of Puerto Rico, the Virgin Islands, Guam, American
23 Samoa, and the Commonwealth of the Northern
24 Mariana Islands.

1 (i) SUNSET.—The task force shall sunset on the date
2 that is 60 days after the submission of the final report
3 under subsection (f), but not later than September 30,
4 2023.

5 **SEC. 7133. NATIONAL CHILD TRAUMATIC STRESS INITIA-**
6 **TIVE.**

7 Section 582(j) of the Public Health Service Act (42
8 U.S.C. 290hh–1(j)) (relating to grants to address the
9 problems of persons who experience violence-related
10 stress) is amended by striking “\$46,887,000 for each of
11 fiscal years 2018 through 2022” and inserting
12 “\$63,887,000 for each of fiscal years 2019 through
13 2023”.

14 **SEC. 7134. GRANTS TO IMPROVE TRAUMA SUPPORT SERV-**
15 **ICES AND MENTAL HEALTH CARE FOR CHIL-**
16 **DREN AND YOUTH IN EDUCATIONAL SET-**
17 **TINGS.**

18 (a) GRANTS, CONTRACTS, AND COOPERATIVE
19 AGREEMENTS AUTHORIZED.—The Secretary, in coordina-
20 tion with the Assistant Secretary for Mental Health and
21 Substance Use, is authorized to award grants to, or enter
22 into contracts or cooperative agreements with, State edu-
23 cational agencies, local educational agencies, Indian Tribes
24 (as defined in section 4 of the Indian Self-Determination
25 and Education Assistance Act) or their tribal educational

1 agencies, a school operated by the Bureau of Indian Edu-
2 cation, a Regional Corporation, or a Native Hawaiian edu-
3 cational organization, for the purpose of increasing stu-
4 dent access to evidence-based trauma support services and
5 mental health care by developing innovative initiatives, ac-
6 tivities, or programs to link local school systems with local
7 trauma-informed support and mental health systems, in-
8 cluding those under the Indian Health Service.

9 (b) DURATION.—With respect to a grant, contract,
10 or cooperative agreement awarded or entered into under
11 this section, the period during which payments under such
12 grant, contract or agreement are made to the recipient
13 may not exceed 4 years.

14 (c) USE OF FUNDS.—An entity that receives a grant,
15 contract, or cooperative agreement under this section shall
16 use amounts made available through such grant, contract,
17 or cooperative agreement for evidence-based activities,
18 which shall include any of the following:

19 (1) Collaborative efforts between school-based
20 service systems and trauma-informed support and
21 mental health service systems to provide, develop, or
22 improve prevention, screening, referral, and treat-
23 ment and support services to students, such as pro-
24 viding trauma screenings to identify students in
25 need of specialized support.

1 (2) To implement schoolwide positive behavioral
2 interventions and supports, or other trauma-in-
3 formed models of support.

4 (3) To provide professional development to
5 teachers, teacher assistants, school leaders, special-
6 ized instructional support personnel, and mental
7 health professionals that—

8 (A) fosters safe and stable learning envi-
9 ronments that prevent and mitigate the effects
10 of trauma, including through social and emo-
11 tional learning;

12 (B) improves school capacity to identify,
13 refer, and provide services to students in need
14 of trauma support or behavioral health services;
15 or

16 (C) reflects the best practices for trauma-
17 informed identification, referral, and support
18 developed by the Task Force under section
19 7132.

20 (4) Services at a full-service community school
21 that focuses on trauma-informed supports, which
22 may include a full-time site coordinator, or other ac-
23 tivities consistent with section 4625 of the Elemen-
24 tary and Secondary Education Act of 1965 (20
25 U.S.C. 7275).

1 (5) Engaging families and communities in ef-
2 forts to increase awareness of child and youth trau-
3 ma, which may include sharing best practices with
4 law enforcement regarding trauma-informed care
5 and working with mental health professionals to pro-
6 vide interventions, as well as longer term coordi-
7 nated care within the community for children and
8 youth who have experienced trauma and their fami-
9 lies.

10 (6) To provide technical assistance to school
11 systems and mental health agencies.

12 (7) To evaluate the effectiveness of the program
13 carried out under this section in increasing student
14 access to evidence-based trauma support services
15 and mental health care.

16 (8) To establish partnerships with or provide
17 subgrants to Head Start agencies (including Early
18 Head Start agencies), public and private preschool
19 programs, child care programs (including home-
20 based providers), or other entities described in sub-
21 section (a), to include such entities described in this
22 paragraph in the evidence-based trauma initiatives,
23 activities, support services, and mental health sys-
24 tems established under this section in order to pro-
25 vide, develop, or improve prevention, screening, re-

1 ferral, and treatment and support services to young
2 children and their families.

3 (d) APPLICATIONS.—To be eligible to receive a grant,
4 contract, or cooperative agreement under this section, an
5 entity described in subsection (a) shall submit an applica-
6 tion to the Secretary at such time, in such manner, and
7 containing such information as the Secretary may reason-
8 ably require, which shall include the following:

9 (1) A description of the innovative initiatives,
10 activities, or programs to be funded under the grant,
11 contract, or cooperative agreement, including how
12 such program will increase access to evidence-based
13 trauma support services and mental health care for
14 students, and, as applicable, the families of such stu-
15 dents.

16 (2) A description of how the program will pro-
17 vide linguistically appropriate and culturally com-
18 petent services.

19 (3) A description of how the program will sup-
20 port students and the school in improving the school
21 climate in order to support an environment condu-
22 cive to learning.

23 (4) An assurance that—

1 (A) persons providing services under the
2 grant, contract, or cooperative agreement are
3 adequately trained to provide such services; and

4 (B) teachers, school leaders, administra-
5 tors, specialized instructional support personnel,
6 representatives of local Indian Tribes or tribal
7 organizations as appropriate, other school per-
8 sonnel, and parents or guardians of students
9 participating in services under this section will
10 be engaged and involved in the design and im-
11 plementation of the services.

12 (5) A description of how the applicant will sup-
13 port and integrate existing school-based services
14 with the program in order to provide mental health
15 services for students, as appropriate.

16 (6) A description of the entities in the commu-
17 nity with which the applicant will partner or to
18 which the applicant will provide subgrants in accord-
19 ance with subsection (c)(8).

20 (e) INTERAGENCY AGREEMENTS.—

21 (1) LOCAL INTERAGENCY AGREEMENTS.—To
22 ensure the provision of the services described in sub-
23 section (c), a recipient of a grant, contract, or coop-
24 erative agreement under this section, or their des-
25 ignee, shall establish a local interagency agreement

1 among local educational agencies, agencies respon-
2 sible for early childhood education programs, Head
3 Start agencies (including Early Head Start agen-
4 cies), juvenile justice authorities, mental health
5 agencies, child welfare agencies, and other relevant
6 agencies, authorities, or entities in the community
7 that will be involved in the provision of such serv-
8 ices.

9 (2) CONTENTS.—In ensuring the provision of
10 the services described in subsection (c), the local
11 interagency agreement shall specify with respect to
12 each agency, authority, or entity that is a party to
13 such agreement—

14 (A) the financial responsibility for the serv-
15 ices;

16 (B) the conditions and terms of responsi-
17 bility for the services, including quality, ac-
18 countability, and coordination of the services;
19 and

20 (C) the conditions and terms of reimburse-
21 ment among such agencies, authorities, or enti-
22 ties, including procedures for dispute resolution.

23 (f) EVALUATION.—The Secretary shall reserve not
24 more than 3 percent of the funds made available under
25 subsection (l) for each fiscal year to—

1 (1) conduct a rigorous, independent evaluation
2 of the activities funded under this section; and

3 (2) disseminate and promote the utilization of
4 evidence-based practices regarding trauma support
5 services and mental health care.

6 (g) DISTRIBUTION OF AWARDS.—The Secretary shall
7 ensure that grants, contracts, and cooperative agreements
8 awarded or entered into under this section are equitably
9 distributed among the geographical regions of the United
10 States and among tribal, urban, suburban, and rural pop-
11 ulations.

12 (h) RULE OF CONSTRUCTION.—Nothing in this sec-
13 tion shall be construed—

14 (1) to prohibit an entity involved with a pro-
15 gram carried out under this section from reporting
16 a crime that is committed by a student to appro-
17 priate authorities; or

18 (2) to prevent Federal, State, and tribal law en-
19 forcement and judicial authorities from exercising
20 their responsibilities with regard to the application
21 of Federal, tribal, and State law to crimes com-
22 mitted by a student.

23 (i) SUPPLEMENT, NOT SUPPLANT.—Any services
24 provided through programs carried out under this section
25 shall supplement, and not supplant, existing mental health

1 services, including any special education and related serv-
2 ices provided under the Individuals with Disabilities Edu-
3 cation Act (20 U.S.C. 1400 et seq.).

4 (j) CONSULTATION WITH INDIAN TRIBES.—In car-
5 rying out subsection (a), the Secretary shall, in a timely
6 manner, meaningfully consult with Indian Tribes and their
7 representatives to ensure notice of eligibility.

8 (k) DEFINITIONS.—In this section:

9 (1) ELEMENTARY SCHOOL.—The term “elemen-
10 tary school” has the meaning given such term in
11 section 8101 of the Elementary and Secondary Edu-
12 cation Act of 1965 (20 U.S.C. 7801).

13 (2) EVIDENCE-BASED.—The term “evidence-
14 based” has the meaning given such term in section
15 8101(21)(A)(i) of the Elementary and Secondary
16 Education Act of 1965 (20 U.S.C. 7801(21)(A)(i)).

17 (3) NATIVE HAWAIIAN EDUCATIONAL ORGANI-
18 ZATION.—The term “Native Hawaiian educational
19 organization” has the meaning given such term in
20 section 6207 of the Elementary and Secondary Edu-
21 cation Act of 1965 (20 U.S.C. 7517).

22 (4) LOCAL EDUCATIONAL AGENCY.—The term
23 “local educational agency” has the meaning given
24 such term in section 8101 of the Elementary and
25 Secondary Education Act of 1965 (20 U.S.C. 7801).

1 (5) REGIONAL CORPORATION.—The term “Re-
2 gional Corporation” has the meaning given the term
3 in section 3 of the Alaska Native Claims Settlement
4 Act (43 U.S.C. 1602)).

5 (6) SCHOOL.—The term “school” means a pub-
6 lic elementary school or public secondary school.

7 (7) SCHOOL LEADER.—The term “school lead-
8 er” has the meaning given such term in section
9 8101 of the Elementary and Secondary Education
10 Act of 1965 (20 U.S.C. 7801).

11 (8) SECONDARY SCHOOL.—The term “sec-
12 ondary school” has the meaning given such term in
13 section 8101 of the Elementary and Secondary Edu-
14 cation Act of 1965 (20 U.S.C. 7801).

15 (9) SECRETARY.—The term “Secretary” means
16 the Secretary of Education.

17 (10) SPECIALIZED INSTRUCTIONAL SUPPORT
18 PERSONNEL.—The term “specialized instructional
19 support personnel” has the meaning given such term
20 in section 8101 of the Elementary and Secondary
21 Education Act of 1965 (20 U.S.C. 7801).

22 (11) STATE EDUCATIONAL AGENCY.—The term
23 “State educational agency” has the meaning given
24 such term in section 8101 of the Elementary and
25 Secondary Education Act of 1965 (20 U.S.C. 7801).

1 (l) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated to carry out this section,
3 \$50,000,000 for each of fiscal years 2019 through 2023.

4 **SEC. 7135. RECOGNIZING EARLY CHILDHOOD TRAUMA RE-**
5 **LATED TO SUBSTANCE ABUSE.**

6 (a) DISSEMINATION OF INFORMATION.—The Sec-
7 retary of Health and Human Services shall disseminate
8 information, resources, and, if requested, technical assist-
9 ance to early childhood care and education providers and
10 professionals working with young children on—

11 (1) ways to properly recognize children who
12 may be impacted by trauma, including trauma re-
13 lated to substance use by a family member or other
14 adult; and

15 (2) how to respond appropriately in order to
16 provide for the safety and well-being of young chil-
17 dren and their families.

18 (b) GOALS.—The information, resources, and tech-
19 nical assistance provided under subsection (a) shall—

20 (1) educate early childhood care and education
21 providers and professionals working with young chil-
22 dren on understanding and identifying the early
23 signs and risk factors of children who might be im-
24 pacted by trauma, including trauma due to exposure
25 to substance use;

1 (2) suggest age-appropriate communication
2 tools, procedures, and practices for trauma-informed
3 care, including ways to prevent or mitigate the ef-
4 fects of trauma;

5 (3) provide options for responding to children
6 impacted by trauma, including due to exposure to
7 substance use, that consider the needs of the child
8 and family, including recommending resources and
9 referrals for evidence-based services to support such
10 family; and

11 (4) promote whole-family and multi-
12 generational approaches to keep families safely to-
13 gether when it is in the best interest of the child.

14 (c) COORDINATION.—The Secretary of Health and
15 Human Services shall coordinate with the task force to
16 develop best practices for trauma-informed identification,
17 referral, and support authorized under section 7132 in dis-
18 seminating the information, resources, and technical as-
19 sistance described under subsection (b).

20 (d) RULE OF CONSTRUCTION.—Such information, re-
21 sources, and if applicable, technical assistance, shall not
22 be construed to amend the requirements under—

23 (1) the Child Care and Development Block
24 Grant Act of 1990 (42 U.S.C. 9858 et seq.);

1 (2) the Head Start Act (42 U.S.C. 9831 et
2 seq.); or

3 (3) the Individuals with Disabilities Education
4 Act (20 U.S.C. 1400 et seq.).

5 **Subtitle O—Eliminating Opioid** 6 **Related Infectious Diseases**

7 **SEC. 7141. REAUTHORIZATION AND EXPANSION OF PRO-** 8 **GRAM OF SURVEILLANCE AND EDUCATION** 9 **REGARDING INFECTIONS ASSOCIATED WITH** 10 **ILLICIT DRUG USE AND OTHER RISK FAC-** 11 **TORS.**

12 Section 317N of the Public Health Service Act (42
13 U.S.C. 247b–15) is amended to read as follows:

14 **“SEC. 317N. SURVEILLANCE AND EDUCATION REGARDING** 15 **INFECTIONS ASSOCIATED WITH ILLICIT** 16 **DRUG USE AND OTHER RISK FACTORS.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Director of the Centers for Disease Control and Pre-
19 vention, may (directly or through grants to public and
20 nonprofit private entities) provide for programs for the fol-
21 lowing:

22 “(1) To cooperate with States and Indian tribes
23 in implementing or maintaining a national system to
24 determine the incidence of infections commonly asso-
25 ciated with illicit drug use, such as viral hepatitis,

1 human immunodeficiency virus, and infective endo-
2 carditis, and to assist the States in determining the
3 prevalence of such infections, which may include the
4 reporting of cases of such infections.

5 “(2) To identify, counsel, and offer testing to
6 individuals who are at risk of infections described in
7 paragraph (1) resulting from illicit drug use, receiv-
8 ing blood transfusions prior to July 1992, or other
9 risk factors.

10 “(3) To provide appropriate referrals for coun-
11 seling, testing, and medical treatment of individuals
12 identified under paragraph (2) and to ensure, to the
13 extent practicable, the provision of appropriate fol-
14 low-up services.

15 “(4) To develop and disseminate public infor-
16 mation and education programs for the detection
17 and control of infections described in paragraph (1),
18 with priority given to high-risk populations as deter-
19 mined by the Secretary.

20 “(5) To improve the education, training, and
21 skills of health professionals in the detection and
22 control of infections described in paragraph (1), in-
23 cluding to improve coordination of treatment of sub-
24 stance use disorders and infectious diseases, with
25 priority given to substance use disorder treatment

1 providers, pediatricians and other primary care pro-
2 viders, obstetrician-gynecologists, and infectious dis-
3 ease clinicians, including HIV clinicians.

4 “(b) LABORATORY PROCEDURES.—The Secretary
5 may (directly or through grants to public and nonprofit
6 private entities) carry out programs to provide for im-
7 provements in the quality of clinical-laboratory procedures
8 regarding infections described in subsection (a)(1).

9 “(c) DEFINITION.—In this section, the term ‘Indian
10 tribe’ has the meaning given that term in section 4 of the
11 Indian Self-Determination and Education Assistance Act.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—For the
13 purpose of carrying out this section, there are authorized
14 to be appropriated \$40,000,000 for each of the fiscal years
15 2019 through 2023.”.

16 **Subtitle P—Peer Support** 17 **Communities of Recovery**

18 **SEC. 7151. BUILDING COMMUNITIES OF RECOVERY.**

19 Section 547 of the Public Health Service Act (42
20 U.S.C. 290ee–2) is amended to read as follows:

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

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

1 “(1) mobilizes resources within and outside of
2 the recovery community, which may include through
3 a peer support network, to increase the prevalence
4 and quality of long-term recovery from substance
5 use disorders; and

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

9 “(b) GRANTS AUTHORIZED.—The Secretary shall
10 award grants to recovery community organizations to en-
11 able such organizations to develop, expand, and enhance
12 recovery services.

13 “(c) FEDERAL SHARE.—The Federal share of the
14 costs of a program funded by a grant under this section
15 may not exceed 85 percent.

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

18 “(1) shall be used to develop, expand, and en-
19 hance community and statewide recovery support
20 services; and

21 “(2) may be used to—

22 “(A) build connections between recovery
23 networks, including between recovery commu-
24 nity organizations and peer support networks,

1 and with other recovery support services, in-
2 cluding—

3 “(i) behavioral health providers;

4 “(ii) primary care providers and phy-
5 sicians;

6 “(iii) educational and vocational
7 schools;

8 “(iv) employers;

9 “(v) housing services;

10 “(vi) child welfare agencies; and

11 “(vii) other recovery support services
12 that facilitate recovery from substance use
13 disorders, including non-clinical community
14 services;

15 “(B) reduce stigma associated with sub-
16 stance use disorders; and

17 “(C) conduct outreach on issues relating to
18 substance use disorders and recovery, includ-
19 ing—

20 “(i) identifying the signs of substance
21 use disorder;

22 “(ii) the resources available to individ-
23 uals with substance use disorder and to
24 families of an individual with a substance
25 use disorder, including programs that men-

1 tor and provide support services to chil-
2 dren;

3 “(iii) the resources available to help
4 support individuals in recovery; and

5 “(iv) related medical outcomes of sub-
6 stance use disorders, the potential of ac-
7 quiring an infection commonly associated
8 with illicit drug use, and neonatal absti-
9 nence syndrome among infants exposed to
10 opioids during pregnancy.

11 “(e) SPECIAL CONSIDERATION.—In carrying out this
12 section, the Secretary shall give special consideration to
13 the unique needs of rural areas, including areas with an
14 age-adjusted rate of drug overdose deaths that is above
15 the national average and areas with a shortage of preven-
16 tion and treatment services.

17 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section
19 \$5,000,000 for each of fiscal years 2019 through 2023.”.

20 **SEC. 7152. PEER SUPPORT TECHNICAL ASSISTANCE CEN-**
21 **TER.**

22 Title V of the Public Health Service Act (42 U.S.C.
23 290dd et seq.) is amended by inserting after section 547
24 the following:

1 **“SEC. 547A. PEER SUPPORT TECHNICAL ASSISTANCE CEN-**
2 **TER.**

3 “(a) ESTABLISHMENT.—The Secretary, acting
4 through the Assistant Secretary, shall establish or operate
5 a National Peer-Run Training and Technical Assistance
6 Center for Addiction Recovery Support (referred to in this
7 section as the ‘Center’).

8 “(b) FUNCTIONS.—The Center established under
9 subsection (a) shall provide technical assistance and sup-
10 port to recovery community organizations and peer sup-
11 port networks, including such assistance and support re-
12 lated to—

13 “(1) training on identifying—

14 “(A) signs of substance use disorder;

15 “(B) resources to assist individuals with a
16 substance use disorder, or resources for families
17 of an individual with a substance use disorder;
18 and

19 “(C) best practices for the delivery of re-
20 covery support services;

21 “(2) the provision of translation services, inter-
22 pretation, or other such services for clients with lim-
23 ited English speaking proficiency;

24 “(3) data collection to support research, includ-
25 ing for translational research;

26 “(4) capacity building; and

1 “(5) evaluation and improvement, as necessary,
2 of the effectiveness of such services provided by re-
3 covery community organizations.

4 “(c) BEST PRACTICES.—The Center established
5 under subsection (a) shall periodically issue best practices
6 for use by recovery community organizations and peer
7 support networks.

8 “(d) RECOVERY COMMUNITY ORGANIZATION.—In
9 this section, the term ‘recovery community organization’
10 has the meaning given such term in section 547.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section
13 \$1,000,000 for each of fiscal years 2019 through 2023.”.

14 **Subtitle Q—Creating Opportunities**
15 **That Necessitate New and En-**
16 **hanced Connections That Im-**
17 **prove Opioid Navigation Strate-**
18 **gies**

19 **SEC. 7161. PREVENTING OVERDOSES OF CONTROLLED SUB-**
20 **STANCES.**

21 “(a) IN GENERAL.—Part J of title III of the Public
22 Health Service Act (42 U.S.C. 280b et seq.) is amended
23 by inserting after section 392 (42 U.S.C. 280b–1) the fol-
24 lowing:

1 **“SEC. 392A. PREVENTING OVERDOSES OF CONTROLLED**
2 **SUBSTANCES.**

3 “(a) EVIDENCE-BASED PREVENTION GRANTS.—

4 “(1) IN GENERAL.—The Director of the Cen-
5 ters for Disease Control and Prevention may—

6 “(A) to the extent practicable, carry out
7 and expand any evidence-based prevention ac-
8 tivities described in paragraph (2);

9 “(B) provide training and technical assist-
10 ance to States, localities, and Indian tribes for
11 purposes of carrying out such activity; and

12 “(C) award grants to States, localities, and
13 Indian tribes for purposes of carrying out such
14 activity.

15 “(2) EVIDENCE-BASED PREVENTION ACTIVI-
16 TIES.—An evidence-based prevention activity de-
17 scribed in this paragraph is any of the following ac-
18 tivities:

19 “(A) Improving the efficiency and use of a
20 new or currently operating prescription drug
21 monitoring program, including by—

22 “(i) encouraging all authorized users
23 (as specified by the State or other entity)
24 to register with and use the program;

25 “(ii) enabling such users to access any
26 updates to information collected by the

1 program in as close to real-time as possible;
2

3 “(iii) improving the ease of use of
4 such program;

5 “(iv) providing for a mechanism for
6 the program to notify authorized users of
7 any potential misuse or abuse of controlled
8 substances and any detection of inappropriate
9 prescribing or dispensing practices
10 relating to such substances;

11 “(v) encouraging the analysis of pre-
12 scription drug monitoring data for pur-
13 poses of providing de-identified, aggregate
14 reports based on such analysis to State
15 public health agencies, State substance
16 abuse agencies, State licensing boards, and
17 other appropriate State agencies, as per-
18 mitted under applicable Federal and State
19 law and the policies of the prescription
20 drug monitoring program and not con-
21 taining any protected health information,
22 to prevent inappropriate prescribing, drug
23 diversion, or abuse and misuse of con-
24 trolled substances, and to facilitate better
25 coordination among agencies;

1 “(vi) enhancing interoperability be-
2 tween the program and any health infor-
3 mation technology (including certified
4 health information technology), including
5 by integrating program data into such
6 technology;

7 “(vii) updating program capabilities to
8 respond to technological innovation for
9 purposes of appropriately addressing the
10 occurrence and evolution of controlled sub-
11 stance overdoses;

12 “(viii) facilitating and encouraging
13 data exchange between the program and
14 the prescription drug monitoring programs
15 of other States;

16 “(ix) enhancing data collection and
17 quality, including improving patient match-
18 ing and proactively monitoring data qual-
19 ity;

20 “(x) providing prescriber and dis-
21 penser practice tools, including prescriber
22 practice insight reports for practitioners to
23 review their prescribing patterns in com-
24 parison to such patterns of other practi-
25 tioners in the specialty; and

1 “(xi) meeting the purpose of the pro-
2 gram established under section 3990, as
3 described in section 3990(a).

4 “(B) Promoting community or health sys-
5 tem interventions.

6 “(C) Evaluating interventions to prevent
7 controlled substance overdoses.

8 “(D) Implementing projects to advance an
9 innovative prevention approach with respect to
10 new and emerging public health crises and op-
11 portunities to address such crises, such as en-
12 hancing public education and awareness on the
13 risks associated with opioids.

14 “(3) ADDITIONAL GRANTS.—The Director may
15 award grants to States, localities, and Indian
16 Tribes—

17 “(A) to carry out innovative projects for
18 grantees to rapidly respond to controlled sub-
19 stance misuse, abuse, and overdoses, including
20 changes in patterns of controlled substance use;
21 and

22 “(B) for any other evidence-based activity
23 for preventing controlled substance misuse,
24 abuse, and overdoses as the Director determines
25 appropriate.

1 “(4) RESEARCH.—The Director, in coordination
2 with the Assistant Secretary for Mental Health and
3 Substance Use and the National Mental Health and
4 Substance Use Policy Laboratory established under
5 section 501A, as appropriate and applicable, may
6 conduct studies and evaluations to address substance
7 use disorders, including preventing substance use
8 disorders or other related topics the Director deter-
9 mines appropriate.

10 “(b) ENHANCED CONTROLLED SUBSTANCE OVER-
11 DOSE DATA COLLECTION, ANALYSIS, AND DISSEMINA-
12 TION GRANTS.—

13 “(1) IN GENERAL.—The Director of the Cen-
14 ters for Disease Control and Prevention may—

15 “(A) to the extent practicable, carry out
16 any controlled substance overdose data collec-
17 tion activities described in paragraph (2);

18 “(B) provide training and technical assist-
19 ance to States, localities, and Indian tribes for
20 purposes of carrying out such activity;

21 “(C) award grants to States, localities, and
22 Indian tribes for purposes of carrying out such
23 activity; and

24 “(D) coordinate with the Assistant Sec-
25 retary for Mental Health and Substance Use to

1 collect data pursuant to section 505(d)(1)(A)
2 (relating to the number of individuals admitted
3 to emergency departments as a result of the
4 abuse of alcohol or other drugs).

5 “(2) CONTROLLED SUBSTANCE OVERDOSE
6 DATA COLLECTION AND ANALYSIS ACTIVITIES.—A
7 controlled substance overdose data collection, anal-
8 ysis, and dissemination activity described in this
9 paragraph is any of the following activities:

10 “(A) Improving the timeliness of reporting
11 data to the public, including data on fatal and
12 nonfatal overdoses of controlled substances.

13 “(B) Enhancing the comprehensiveness of
14 controlled substance overdose data by collecting
15 information on such overdoses from appropriate
16 sources such as toxicology reports, autopsy re-
17 ports, death scene investigations, and emer-
18 gency departments.

19 “(C) Modernizing the system for coding
20 causes of death related to controlled substance
21 overdoses to use an electronic-based system.

22 “(D) Using data to help identify risk fac-
23 tors associated with controlled substance
24 overdoses.

1 “(E) Supporting entities involved in pro-
2 viding information on controlled substance
3 overdoses, such as coroners, medical examiners,
4 and public health laboratories to improve accu-
5 rate testing and standardized reporting of
6 causes and contributing factors to controlled
7 substances overdoses and analysis of various
8 opioid analogues to controlled substance
9 overdoses.

10 “(F) Working to enable and encourage the
11 access, exchange, and use of information re-
12 garding controlled substance overdoses among
13 data sources and entities.

14 “(c) DEFINITIONS.—In this section:

15 “(1) CONTROLLED SUBSTANCE.—The term
16 ‘controlled substance’ has the meaning given that
17 term in section 102 of the Controlled Substances
18 Act.

19 “(2) INDIAN TRIBE.—The term ‘Indian tribe’
20 has the meaning given that term in section 4 of the
21 Indian Self-Determination and Education Assistance
22 Act.

23 “(d) AUTHORIZATION OF APPROPRIATIONS.—For
24 purposes of carrying out this section, section 3990 of this
25 Act, and section 102 of the Comprehensive Addiction and

1 Recovery Act of 2016 (Public Law 114–198), there is au-
2 thorized to be appropriated \$496,000,000 for each of fis-
3 cal years 2019 through 2023.”.

4 (b) EDUCATION AND AWARENESS.—Section 102 of
5 the Comprehensive Addiction and Recovery Act of 2016
6 (Public Law 114–198) is amended—

7 (1) by amending subsection (a) to read as fol-
8 lows:

9 “(a) IN GENERAL.—The Secretary of Health and
10 Human Services, acting through the Director of the Cen-
11 ters for Disease Control and Prevention and in coordina-
12 tion with the heads of other departments and agencies,
13 shall advance education and awareness regarding the risks
14 related to misuse and abuse of opioids, as appropriate,
15 which may include developing or improving existing pro-
16 grams, conducting activities, and awarding grants that ad-
17 vance the education and awareness of—

18 “(1) the public, including patients and con-
19 sumers—

20 “(A) generally; and

21 “(B) regarding such risks related to un-
22 used opioids and the dispensing options under
23 section 309(f) of the Controlled Substances Act,
24 as applicable; and

25 “(2) providers, which may include—

1 “(A) providing for continuing education on
2 appropriate prescribing practices;

3 “(B) education related to applicable State
4 or local prescriber limit laws, information on
5 the use of non-addictive alternatives for pain
6 management, and the use of overdose reversal
7 drugs, as appropriate;

8 “(C) disseminating and improving the use
9 of evidence-based opioid prescribing guidelines
10 across relevant health care settings, as appro-
11 priate, and updating guidelines as necessary;

12 “(D) implementing strategies, such as best
13 practices, to encourage and facilitate the use of
14 prescriber guidelines, in accordance with State
15 and local law;

16 “(E) disseminating information to pro-
17 viders about prescribing options for controlled
18 substances, including such options under sec-
19 tion 309(f) of the Controlled Substances Act, as
20 applicable; and

21 “(F) disseminating information, as appro-
22 priate, on the National Pain Strategy developed
23 by or in consultation with the Assistant Sec-
24 retary for Health; and

25 “(3) other appropriate entities.”; and

1 (2) in subsection (b)—

2 (A) by striking “opioid abuse” each place
3 such term appears and inserting “opioid misuse
4 and abuse”; and

5 (B) in paragraph (2), by striking “safe dis-
6 posal of prescription medications and other”
7 and inserting “non-addictive treatment options,
8 safe disposal options for prescription medica-
9 tions, and other applicable”.

10 **SEC. 7162. PRESCRIPTION DRUG MONITORING PROGRAM.**

11 Section 3990 of the Public Health Service Act (42
12 U.S.C. 280g–3) is amended to read as follows:

13 **“SEC. 3990. PRESCRIPTION DRUG MONITORING PROGRAM.**

14 **“(a) PROGRAM.—**

15 **“(1) IN GENERAL.—**Each fiscal year, the Sec-
16 retary, acting through the Director of the Centers
17 for Disease Control and Prevention, in coordination
18 with the heads of other departments and agencies as
19 appropriate, shall support States or localities for the
20 purpose of improving the efficiency and use of
21 PDMPs, including—

22 **“(A)** establishment and implementation of
23 a PDMP;

24 **“(B)** maintenance of a PDMP;

25 **“(C)** improvements to a PDMP by—

1 “(i) enhancing functional components
2 to work toward—

3 “(I) universal use of PDMPs
4 among providers and their delegates,
5 to the extent that State laws allow;

6 “(II) more timely inclusion of
7 data within a PDMP;

8 “(III) active management of the
9 PDMP, in part by sending proactive
10 or unsolicited reports to providers to
11 inform prescribing; and

12 “(IV) ensuring the highest level
13 of ease in use of and access to
14 PDMPs by providers and their dele-
15 gates, to the extent that State laws
16 allow;

17 “(ii) in consultation with the Office of
18 the National Coordinator for Health Infor-
19 mation Technology, improving the intra-
20 state interoperability of PDMPs by—

21 “(I) making PDMPs more ac-
22 tionable by integrating PDMPs within
23 electronic health records and health
24 information technology infrastructure;
25 and

1 “(II) linking PDMP data to
2 other data systems within the State,
3 including—

4 “(aa) the data of pharmacy
5 benefit managers, medical exam-
6 iners and coroners, and the
7 State’s Medicaid program;

8 “(bb) worker’s compensation
9 data; and

10 “(cc) prescribing data of
11 providers of the Department of
12 Veterans Affairs and the Indian
13 Health Service within the State;

14 “(iii) in consultation with the Office
15 of the National Coordinator for Health In-
16 formation Technology, improving the inter-
17 state interoperability of PDMPs through—

18 “(I) sharing of dispensing data in
19 near-real time across State lines; and

20 “(II) integration of automated
21 queries for multistate PDMP data
22 and analytics into clinical workflow to
23 improve the use of such data and ana-
24 lytics by practitioners and dispensers;
25 or

1 “(iv) improving the ability to include
2 treatment availability resources and refer-
3 ral capabilities within the PDMP.

4 “(2) LEGISLATION.—As a condition on the re-
5 ceipt of support under this section, the Secretary
6 shall require a State or locality to demonstrate that
7 it has enacted legislation or regulations—

8 “(A) to provide for the implementation of
9 the PDMP; and

10 “(B) to permit the imposition of appro-
11 priate penalties for the unauthorized use and
12 disclosure of information maintained by the
13 PDMP.

14 “(b) PDMP STRATEGIES.—The Secretary shall en-
15 courage a State or locality, in establishing, improving, or
16 maintaining a PDMP, to implement strategies that im-
17 prove—

18 “(1) the reporting of dispensing in the State or
19 locality of a controlled substance to an ultimate user
20 so the reporting occurs not later than 24 hours after
21 the dispensing event;

22 “(2) the consultation of the PDMP by each pre-
23 scribing practitioner, or their designee, in the State
24 or locality before initiating treatment with a con-
25 trolled substance, or any substance as required by

1 the State to be reported to the PDMP, and over the
2 course of ongoing treatment for each prescribing
3 event;

4 “(3) the consultation of the PDMP before dis-
5 pensing a controlled substance, or any substance as
6 required by the State to be reported to the PDMP;

7 “(4) the proactive notification to a practitioner
8 when patterns indicative of controlled substance mis-
9 use by a patient, including opioid misuse, are de-
10 tected;

11 “(5) the availability of data in the PDMP to
12 other States, as allowable under State law; and

13 “(6) the availability of nonidentifiable informa-
14 tion to the Centers for Disease Control and Preven-
15 tion for surveillance, epidemiology, statistical re-
16 search, or educational purposes.

17 “(c) DRUG MISUSE AND ABUSE.—In consultation
18 with practitioners, dispensers, and other relevant and in-
19 terested stakeholders, a State receiving support under this
20 section—

21 “(1) shall establish a program to notify practi-
22 tioners and dispensers of information that will help
23 to identify and prevent the unlawful diversion or
24 misuse of controlled substances;

1 “(2) may, to the extent permitted under State
2 law, notify the appropriate authorities responsible
3 for carrying out drug diversion investigations if the
4 State determines that information in the PDMP
5 maintained by the State indicates an unlawful diver-
6 sion or abuse of a controlled substance;

7 “(3) may conduct analyses of controlled sub-
8 stance program data for purposes of providing ap-
9 propriate State agencies with aggregate reports
10 based on such analyses in as close to real-time as
11 practicable, regarding prescription patterns flagged
12 as potentially presenting a risk of misuse, abuse, ad-
13 diction, overdose, and other aggregate information,
14 as appropriate and in compliance with applicable
15 Federal and State laws and provided that such re-
16 ports shall not include protected health information;
17 and

18 “(4) may access information about prescrip-
19 tions, such as claims data, to ensure that such pre-
20 scribing and dispensing history is updated in as
21 close to real-time as practicable, in compliance with
22 applicable Federal and State laws and provided that
23 such information shall not include protected health
24 information.

1 “(d) EVALUATION AND REPORTING.—As a condition
2 on receipt of support under this section, the State shall
3 report on interoperability with PDMPs of other States and
4 Federal agencies, where appropriate, intrastate interoper-
5 ability with health information technology systems such as
6 electronic health records, health information exchanges,
7 and e-prescribing, where appropriate, and whether or not
8 the State provides automatic, up-to-date, or daily informa-
9 tion about a patient when a practitioner (or the designee
10 of a practitioner, where permitted) requests information
11 about such patient.

12 “(e) EVALUATION AND REPORTING.—A State receiv-
13 ing support under this section shall provide the Secretary
14 with aggregate nonidentifiable information, as permitted
15 by State law, to enable the Secretary—

16 “(1) to evaluate the success of the State’s pro-
17 gram in achieving the purpose described in sub-
18 section (a); or

19 “(2) to prepare and submit to the Congress the
20 report required by subsection (i)(2).

21 “(f) EDUCATION AND ACCESS TO THE MONITORING
22 SYSTEM.—A State receiving support under this section
23 shall take steps to—

1 “(1) facilitate prescribers and dispensers, and
2 their delegates, as permitted by State law, to use the
3 PDMP, to the extent practicable; and

4 “(2) educate prescribers and dispensers, and
5 their delegates on the benefits of the use of PDMPs.

6 “(g) ELECTRONIC FORMAT.—The Secretary may
7 issue guidelines specifying a uniform electronic format for
8 the reporting, sharing, and disclosure of information pur-
9 suant to PDMPs. To the extent possible, such guidelines
10 shall be consistent with standards recognized by the Office
11 of the National Coordinator for Health Information Tech-
12 nology.

13 “(h) RULES OF CONSTRUCTION.—

14 “(1) FUNCTIONS OTHERWISE AUTHORIZED BY
15 LAW.—Nothing in this section shall be construed to
16 restrict the ability of any authority, including any
17 local, State, or Federal law enforcement, narcotics
18 control, licensure, disciplinary, or program authority,
19 to perform functions otherwise authorized by law.

20 “(2) ADDITIONAL PRIVACY PROTECTIONS.—
21 Nothing in this section shall be construed as pre-
22 empting any State from imposing any additional pri-
23 vacy protections.

24 “(3) FEDERAL PRIVACY REQUIREMENTS.—
25 Nothing in this section shall be construed to super-

1 sede any Federal privacy or confidentiality require-
2 ment, including the regulations promulgated under
3 section 264(c) of the Health Insurance Portability
4 and Accountability Act of 1996 (Public Law 104–
5 191; 110 Stat. 2033) and section 543 of this Act.

6 “(4) NO FEDERAL PRIVATE CAUSE OF AC-
7 TION.—Nothing in this section shall be construed to
8 create a Federal private cause of action.

9 “(i) PROGRESS REPORT.—Not later than 3 years
10 after the date of enactment of this section, the Secretary
11 shall—

12 “(1) complete a study that—

13 “(A) determines the progress of grantees
14 in establishing and implementing PDMPs con-
15 sistent with this section;

16 “(B) provides an analysis of the extent to
17 which the operation of PDMPs has—

18 “(i) reduced inappropriate use, abuse,
19 diversion of, and overdose with, controlled
20 substances;

21 “(ii) established or strengthened ini-
22 tiatives to ensure linkages to substance use
23 disorder treatment services; or

24 “(iii) affected patient access to appro-
25 priate care in States operating PDMPs;

1 “(C) determine the progress of grantees in
2 achieving interstate interoperability and intra-
3 state interoperability of PDMPs, including an
4 assessment of technical, legal, and financial
5 barriers to such progress and recommendations
6 for addressing these barriers;

7 “(D) determines the progress of grantees
8 in implementing near real-time electronic
9 PDMPs;

10 “(E) provides an analysis of the privacy
11 protections in place for the information re-
12 ported to the PDMP in each State or locality
13 receiving support under this section and any
14 recommendations of the Secretary for additional
15 Federal or State requirements for protection of
16 this information;

17 “(F) determines the progress of States or
18 localities in implementing technological alter-
19 natives to centralized data storage, such as
20 peer-to-peer file sharing or data pointer sys-
21 tems, in PDMPs and the potential for such al-
22 ternatives to enhance the privacy and security
23 of individually identifiable data; and

24 “(G) evaluates the penalties that States or
25 localities have enacted for the unauthorized use

1 and disclosure of information maintained in
2 PDMPs, and the criteria used by the Secretary
3 to determine whether such penalties qualify as
4 appropriate for purposes of subsection (a)(2);
5 and

6 “(2) submit a report to the Congress on the re-
7 sults of the study.

8 “(j) ADVISORY COUNCIL.—

9 “(1) ESTABLISHMENT.—A State or locality
10 may establish an advisory council to assist in the es-
11 tablishment, improvement, or maintenance of a
12 PDMP consistent with this section.

13 “(2) LIMITATION.—A State or locality may not
14 use Federal funds for the operations of an advisory
15 council to assist in the establishment, improvement,
16 or maintenance of a PDMP.

17 “(3) SENSE OF CONGRESS.—It is the sense of
18 the Congress that, in establishing an advisory coun-
19 cil to assist in the establishment, improvement, or
20 maintenance of a PDMP, a State or locality should
21 consult with appropriate professional boards and
22 other interested parties.

23 “(k) DEFINITIONS.—For purposes of this section:

24 “(1) The term ‘controlled substance’ means a
25 controlled substance (as defined in section 102 of

1 the Controlled Substances Act) in schedule II, III,
2 or IV of section 202 of such Act.

3 “(2) The term ‘dispense’ means to deliver a
4 controlled substance to an ultimate user by, or pur-
5 suant to the lawful order of, a practitioner, irrespec-
6 tive of whether the dispenser uses the Internet or
7 other means to effect such delivery.

8 “(3) The term ‘dispenser’ means a physician,
9 pharmacist, or other person that dispenses a con-
10 trolled substance to an ultimate user.

11 “(4) The term ‘interstate interoperability’ with
12 respect to a PDMP means the ability of the PDMP
13 to electronically share reported information with an-
14 other State if the information concerns either the
15 dispensing of a controlled substance to an ultimate
16 user who resides in such other State, or the dis-
17 pensing of a controlled substance prescribed by a
18 practitioner whose principal place of business is lo-
19 cated in such other State.

20 “(5) The term ‘intrastate interoperability’ with
21 respect to a PDMP means the integration of PDMP
22 data within electronic health records and health in-
23 formation technology infrastructure or linking of a
24 PDMP to other data systems within the State, in-
25 cluding the State’s Medicaid program, workers’ com-

1 pensation programs, and medical examiners or coro-
2 ners.

3 “(6) The term ‘nonidentifiable information’
4 means information that does not identify a practi-
5 tioner, dispenser, or an ultimate user and with re-
6 spect to which there is no reasonable basis to believe
7 that the information can be used to identify a practi-
8 tioner, dispenser, or an ultimate user.

9 “(7) The term ‘PDMP’ means a prescription
10 drug monitoring program that is State-controlled.

11 “(8) The term ‘practitioner’ means a physician,
12 dentist, veterinarian, scientific investigator, phar-
13 macy, hospital, or other person licensed, registered,
14 or otherwise permitted, by the United States or the
15 jurisdiction in which the individual practices or does
16 research, to distribute, dispense, conduct research
17 with respect to, administer, or use in teaching or
18 chemical analysis, a controlled substance in the
19 course of professional practice or research.

20 “(9) The term ‘State’ means each of the 50
21 States, the District of Columbia, and any common-
22 wealth or territory of the United States.

23 “(10) The term ‘ultimate user’ means a person
24 who has obtained from a dispenser, and who pos-
25 sesses, a controlled substance for the person’s own

1 use, for the use of a member of the person’s house-
2 hold, or for the use of an animal owned by the per-
3 son or by a member of the person’s household.

4 “(11) The term ‘clinical workflow’ means the
5 integration of automated queries for prescription
6 drug monitoring programs data and analytics into
7 health information technologies such as electronic
8 health record systems, health information exchanges,
9 and/or pharmacy dispensing software systems, thus
10 streamlining provider access through automated que-
11 ries.”.

12 **Subtitle R—Review of Substance**
13 **Use Disorder Treatment Pro-**
14 **viders Receiving Federal Fund-**
15 **ing**

16 **SEC. 7171. REVIEW OF SUBSTANCE USE DISORDER TREAT-**
17 **MENT PROVIDERS RECEIVING FEDERAL**
18 **FUNDING.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services (in this section referred to as the “Sec-
21 retary”) shall conduct a review of entities that receive
22 Federal funding for the provision of substance use dis-
23 order treatment services. The review shall include:

1 (1) The length of time the entity has provided
2 substance use disorder treatment services and the
3 geographic area served by the entity.

4 (2) A detailed analysis of the patient population
5 served by the entity, including but not limited to the
6 number of patients, types of diagnosed substance
7 use disorders and the demographic information of
8 such patients, including sex, race, ethnicity, and so-
9 cioeconomic status.

10 (3) Detailed information on the types of sub-
11 stance use disorders for which the entity has the ex-
12 perience, capability, and capacity to provide such
13 services.

14 (4) An analysis of how the entity handles pa-
15 tients requiring treatment for a substance use dis-
16 order that the organization is not able to treat.

17 (5) An analysis of what is needed in order to
18 improve the entity's ability to meet the addiction
19 treatment needs of the communities served by that
20 entity.

21 (6) Based on the identified needs of the com-
22 munities served, a description of unmet needs and
23 inadequate services and how such needs and services
24 could be better addressed to treat individuals with

1 methamphetamine, cocaine, including crack cocaine,
2 heroin, opioid, and other substance use disorders.

3 (b) REPORT.—Not later than 2 years after the date
4 of the enactment of this Act, the Secretary shall develop
5 and submit to Congress a plan to direct appropriate re-
6 sources to entities that provide substance use disorder
7 treatment services in order to address inadequacies in
8 services or funding identified through the survey described
9 in subsection (a).

10 **Subtitle S—Other Health** 11 **Provisions**

12 **SEC. 7181. STATE RESPONSE TO THE OPIOID ABUSE CRISIS.**

13 (a) IN GENERAL.—Section 1003 of the 21st Century
14 Cures Act (Public Law 114–255) is amended—

15 (1) in subsection (a)—

16 (A) by striking “the authorization of ap-
17 propriations under subsection (b) to carry out
18 the grant program described in subsection (c)”
19 and inserting “subsection (h) to carry out the
20 grant program described in subsection (b)”;
21 and

22 (B) by inserting “and Indian Tribes” after
23 “States”;

24 (2) by striking subsection (b);

1 (3) by redesignating subsections (e) through (e)
2 as subsections (b) through (d), respectively;

3 (4) by redesignating subsection (f) as sub-
4 section (j);

5 (5) in subsection (b), as so redesignated—

6 (A) in paragraph (1)—

7 (i) in the paragraph heading, by in-
8 serting “AND TRIBAL” after “STATE”;

9 (ii) by striking “States for the pur-
10 pose of addressing the opioid abuse crisis
11 within such States” and inserting “States
12 and Indian Tribes for the purpose of ad-
13 dressing the opioid abuse crisis within such
14 States and Indian Tribes”;

15 (iii) by inserting “or Indian Tribes”
16 after “preference to States”; and

17 (iv) by inserting before the period of
18 the second sentence “or other Indian
19 Tribes, as applicable”; and

20 (B) in paragraph (2)—

21 (i) in the matter preceding subpara-
22 graph (A), by striking “to a State”;

23 (ii) in subparagraph (A), by striking
24 “Improving State” and inserting “Estab-
25 lishing or improving”;

1 (iii) in subparagraph (C), by inserting
2 “preventing diversion of controlled sub-
3 stances,” after “treatment programs,”;
4 and

5 (iv) in subparagraph (E), by striking
6 “as the State determines appropriate, re-
7 lated to addressing the opioid abuse crisis
8 within the State” and inserting “as the
9 State or Indian Tribe determines appro-
10 priate, related to addressing the opioid
11 abuse crisis within the State or Indian
12 Tribe, including directing resources in ac-
13 cordance with local needs related to sub-
14 stance use disorders”;

15 (6) in subsection (c), as so redesignated, by
16 striking “subsection (c)” and inserting “subsection
17 (b)”;

18 (7) in subsection (d), as so redesignated—

19 (A) in the matter preceding paragraph (1),
20 by striking “the authorization of appropriations
21 under subsection (b)” and inserting “subsection
22 (h)”;

23 (B) in paragraph (1), by striking “sub-
24 section (c)” and inserting “subsection (b)”;

1 (8) by inserting after subsection (d), as so re-
2 designated, the following:

3 “(e) INDIAN TRIBES.—

4 “(1) DEFINITION.—For purposes of this sec-
5 tion, the term ‘Indian Tribe’ has the meaning given
6 the term ‘Indian tribe’ in section 4 of the Indian
7 Self-Determination and Education Assistance Act
8 (25 U.S.C. 5304).

9 “(2) APPROPRIATE MECHANISMS.—The Sec-
10 retary, in consultation with Indian Tribes, shall
11 identify and establish appropriate mechanisms for
12 Tribes to demonstrate or report the information as
13 required under subsections (b), (c), and (d).

14 “(f) REPORT TO CONGRESS.—Not later than 1 year
15 after the date on which amounts are first awarded after
16 the date of enactment of this subsection, pursuant to sub-
17 section (b), and annually thereafter, the Secretary shall
18 submit to the Committee on Health, Education, Labor,
19 and Pensions of the Senate and the Committee on Energy
20 and Commerce of the House of Representatives a report
21 summarizing the information provided to the Secretary in
22 reports made pursuant to subsection (c), including the
23 purposes for which grant funds are awarded under this
24 section and the activities of such grant recipients.

1 “(g) TECHNICAL ASSISTANCE.—The Secretary, in-
2 cluding through the Tribal Training and Technical Assist-
3 ance Center of the Substance Abuse and Mental Health
4 Services Administration, shall provide State agencies and
5 Indian Tribes, as applicable, with technical assistance con-
6 cerning grant application and submission procedures
7 under this section, award management activities, and en-
8 hancing outreach and direct support to rural and under-
9 served communities and providers in addressing the opioid
10 crisis.

11 “(h) AUTHORIZATION OF APPROPRIATIONS.—For
12 purposes of carrying out the grant program under sub-
13 section (b), there is authorized to be appropriated
14 \$500,000,000 for each of fiscal years 2019 through 2021,
15 to remain available until expended.

16 “(i) SET ASIDE.—Of the amounts made available for
17 each fiscal year to award grants under subsection (b) for
18 a fiscal year, 5 percent of such amount for such fiscal year
19 shall be made available to Indian Tribes, and up to 15
20 percent of such amount for such fiscal year may be set
21 aside for States with the highest age-adjusted rate of drug
22 overdose death based on the ordinal ranking of States ac-
23 cording to the Director of the Centers for Disease Control
24 and Prevention.”.

1 (b) CONFORMING AMENDMENT.—Section 1004(c) of
2 the 21st Century Cures Act (Public Law 114–255) is
3 amended by striking “, the FDA Innovation Account, or
4 the Account For the State Response to the Opioid Abuse
5 Crisis” and inserting “or the FDA Innovation Account”.

6 **SEC. 7182. REPORT ON INVESTIGATIONS REGARDING PAR-**
7 **ITY IN MENTAL HEALTH AND SUBSTANCE**
8 **USE DISORDER BENEFITS.**

9 (a) IN GENERAL.—Section 13003 of the 21st Cen-
10 tury Cures Act (Public Law 114–255) is amended—

11 (1) in subsection (a)—

12 (A) by striking “with findings of any seri-
13 ous violation regarding” and inserting “con-
14 cerning”; and

15 (B) by inserting “and the Committee on
16 Education and the Workforce” after “Energy
17 and Commerce”; and

18 (2) in subsection (b)(1)—

19 (A) by inserting “complaints received and
20 number of” before “closed”; and

21 (B) by inserting before the period “, and,
22 for each such investigation closed, which agency
23 conducted the investigation, whether the health
24 plan that is the subject of the investigation is
25 fully insured or not fully insured and a sum-

1 mary of any coordination between the applicable
2 State regulators and the Department of Labor,
3 the Department of Health and Human Services,
4 or the Department of the Treasury, and ref-
5 erences to any guidance provided by the agen-
6 cies addressing the category of violation com-
7 mitted”.

8 (b) **APPLICABILITY.**—The amendments made by sub-
9 section (a) shall apply with respect to the second annual
10 report required under such section 13003 and each such
11 annual report thereafter.

12 **SEC. 7183. CAREER ACT.**

13 (a) **IN GENERAL.**—The Secretary of Health and
14 Human Services (referred to in this section as the “Sec-
15 retary”), in consultation with the Secretary of Labor, shall
16 continue or establish a program to support individuals in
17 substance use disorder treatment and recovery to live inde-
18 pendently and participate in the workforce.

19 (b) **GRANTS AUTHORIZED.**—In carrying out the ac-
20 tivities under this section, the Secretary shall, on a com-
21 petitive basis, award grants for a period of not more than
22 5 years to entities to enable such entities to carry out evi-
23 dence-based programs to help individuals in substance use
24 disorder treatment and recovery to live independently and
25 participate in the workforce. Such entities shall coordi-

1 nate, as applicable, with Indian tribes or tribal organiza-
2 tions (as applicable), State boards and local boards (as
3 defined in section 3 of the Workforce Innovation and Op-
4 portunity Act (29 U.S.C. 3102), lead State agencies with
5 responsibility for a workforce investment activity (as de-
6 fined in such section 3), and State agencies responsible
7 for carrying out substance use disorder prevention and
8 treatment programs.

9 (c) PRIORITY.—

10 (1) IN GENERAL.—In awarding grants under
11 this section, the Secretary shall give priority based
12 on the State in which the entity is located. Priority
13 shall be given among States according to a formula
14 based on the rates described in paragraph (2) and
15 weighted as described in paragraph (3).

16 (2) RATES.—The rates described in this para-
17 graph are the following:

18 (A) The amount by which the rate of drug
19 overdose deaths in the State, adjusted for age,
20 is above the national overdose mortality rate, as
21 determined by the Director of the Centers for
22 Disease Control and Prevention.

23 (B) The amount by which the rate of un-
24 employment for the State, based on data pro-
25 vided by the Bureau of Labor Statistics for the

1 preceding 5 calendar years for which there is
2 available data, is above the national average.

3 (C) The amount by which rate of labor
4 force participation in the State, based on data
5 provided by the Bureau of Labor Statistics for
6 the preceding 5 calendar years for which there
7 is available data, is below the national average.

8 (3) WEIGHTING.—The rates described in para-
9 graph (2) shall be weighted as follows:

10 (A) The rate described in paragraph
11 (2)(A) shall be weighted 70 percent.

12 (B) The rate described in paragraph
13 (2)(B) shall be weighted 15 percent.

14 (C) The rate described in paragraph (2)(C)
15 shall be weighted 15 percent.

16 (d) PREFERENCE.—In awarding grants under this
17 section, the Secretary shall give preference to entities lo-
18 cated in areas within States with the greatest need, with
19 such need based on the highest mortality rate related to
20 substance use disorder.

21 (e) DEFINITIONS.—In this section:

22 (1) ELIGIBLE ENTITY.—The term “eligible enti-
23 ty” means an entity that offers treatment or recov-
24 ery services for individuals with substance use dis-
25 orders, and partners with one or more local or State

1 stakeholders, which may include local employers,
2 community organizations, the local workforce devel-
3 opment board, local and State governments, and In-
4 dian Tribes or tribal organizations, to support recov-
5 ery, independent living, and participation in the
6 workforce.

7 (2) INDIAN TRIBES; TRIBAL ORGANIZATION.—
8 The terms “Indian Tribe” and “tribal organization”
9 have the meanings given the terms “Indian tribe”
10 and “tribal organization” in section 4 of the Indian
11 Self-Determination and Education Assistance Act
12 (25 U.S.C. 5304).

13 (3) STATE.—The term “State” includes only
14 the several States and the District of Columbia.

15 (f) APPLICATIONS.—An eligible entity shall submit
16 an application at such time and in such manner as the
17 Secretary may require. In submitting an application, the
18 entity shall demonstrate the ability to partner with local
19 stakeholders, which may include local employers, commu-
20 nity stakeholders, the local workforce development board,
21 local and State governments, and Indian Tribes or tribal
22 organizations, as applicable, to—

23 (1) identify gaps in the workforce due to the
24 prevalence of substance use disorders;

1 (2) in coordination with statewide employment
2 and training activities, including coordination and
3 alignment of activities carried out by entities pro-
4 vided grant funds under section 8041, help individ-
5 uals in recovery from a substance use disorder tran-
6 sition into the workforce, including by providing ca-
7 reer services, training services as described in para-
8 graph (2) of section 134(c) of the Workforce Innova-
9 tion and Opportunity Act (29 U.S.C. 3174(c)), and
10 related services described in section 134(a)(3) of
11 such Act (42 U.S.C. 3174(a)); and

12 (3) assist employers with informing their em-
13 ployees of the resources, such as resources related to
14 substance use disorders that are available to their
15 employees.

16 (g) USE OF FUNDS.—An entity receiving a grant
17 under this section shall use the funds to conduct one or
18 more of the following activities:

19 (1) Hire case managers, care coordinators, pro-
20 viders of peer recovery support services, as described
21 in section 547(a) of the Public Health Service Act
22 (42 U.S.C. 290ee–2(a)), or other professionals, as
23 appropriate, to provide services that support treat-
24 ment, recovery, and rehabilitation, and prevent re-

1 lapse, recidivism, and overdose, including by encour-
2 aging—

3 (A) the development and strengthening of
4 daily living skills; and

5 (B) the use of counseling, care coordina-
6 tion, and other services, as appropriate, to sup-
7 port recovery from substance use disorders.

8 (2) Implement or utilize innovative technologies,
9 which may include the use of telemedicine.

10 (3) In coordination with the lead State agency
11 with responsibility for a workforce investment activ-
12 ity or local board described in subsection (b), pro-
13 vide—

14 (A) short-term prevocational training serv-
15 ices; and

16 (B) training services that are directly
17 linked to the employment opportunities in the
18 local area or the planning region.

19 (h) SUPPORT FOR STATE STRATEGY.—An eligible en-
20 tity shall include in its application under subsection (f)
21 information describing how the services and activities pro-
22 posed in such application are aligned with the State, out-
23 lying area, or Tribal strategy, as applicable, for addressing
24 issues described in such application and how such entity

1 will coordinate with existing systems to deliver services as
2 described in such application.

3 (i) DATA REPORTING AND PROGRAM OVERSIGHT.—

4 Each eligible entity awarded a grant under this section
5 shall submit to the Secretary a report at such time and
6 in such manner as the Secretary may require. Such report
7 shall include a description of—

8 (1) the programs and activities funded by the
9 grant;

10 (2) outcomes of the population of individuals
11 with a substance use disorder the grantee served
12 through activities described in subsection (g); and

13 (3) any other information that the Secretary
14 may require for the purpose of ensuring that the
15 grantee is complying with all of the requirements of
16 the grant.

17 (j) REPORTS TO CONGRESS.—

18 (1) PRELIMINARY REPORT.—Not later than 2
19 years after the end of the first year of the grant pe-
20 riod under this section, the Secretary shall submit to
21 Congress a preliminary report that analyzes reports
22 submitted under subsection (i).

23 (2) FINAL REPORT.—Not later than 2 years
24 after submitting the preliminary report required

1 under paragraph (1), the Secretary shall submit to
2 Congress a final report that includes—

3 (A) a description of how the grant funding
4 was used, including the number of individuals
5 who received services under subsection (g)(3)
6 and an evaluation of the effectiveness of the ac-
7 tivities conducted by the grantee with respect to
8 outcomes of the population of individuals with
9 substance use disorder who receive services
10 from the grantee; and

11 (B) recommendations related to best prac-
12 tices for health care professionals to support in-
13 dividuals in substance use disorder treatment or
14 recovery to live independently and participate in
15 the workforce.

16 (k) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated \$5,000,000 for each of fis-
18 cal years 2019 through 2023 for purposes of carrying out
19 this section.

1 **TITLE VIII—MISCELLANEOUS**
2 **Subtitle A—Synthetics Trafficking**
3 **and Overdose Prevention**

4 **SEC. 8001. SHORT TITLE.**

5 This subtitle may be cited as the “Synthetics Traf-
6 ficking and Overdose Prevention Act of 2018” or “STOP
7 Act of 2018”.

8 **SEC. 8002. CUSTOMS FEES.**

9 (a) **IN GENERAL.**—Section 13031(b)(9) of the Con-
10 solidated Omnibus Budget Reconciliation Act of 1985 (19
11 U.S.C. 58c(b)(9)) is amended by adding at the end the
12 following:

13 “(D)(i) With respect to the processing of items
14 that are sent to the United States through the inter-
15 national postal network by ‘Inbound Express Mail
16 service’ or ‘Inbound EMS’ (as that service is de-
17 scribed in the mail classification schedule referred to
18 in section 3631 of title 39, United States Code), the
19 following payments are required:

20 “(I) \$1 per Inbound EMS item.

21 “(II) If an Inbound EMS item is formally
22 entered, the fee provided for under subsection
23 (a)(9), if applicable.

24 “(ii) Notwithstanding section 451 of the Tariff
25 Act of 1930 (19 U.S.C. 1451), the payments re-

1 quired by clause (i), as allocated pursuant to clause
2 (iii)(I), shall be the only payments required for reim-
3 bursement of U.S. Customs and Border Protection
4 for customs services provided in connection with the
5 processing of an Inbound EMS item.

6 “(iii)(I) The payments required by clause (i)(I)
7 shall be allocated as follows:

8 “(aa) 50 percent of the amount of the pay-
9 ments shall be paid on a quarterly basis by the
10 United States Postal Service to the Commis-
11 sioner of U.S. Customs and Border Protection
12 in accordance with regulations prescribed by the
13 Secretary of the Treasury to reimburse U.S.
14 Customs and Border Protection for customs
15 services provided in connection with the proc-
16 essing of Inbound EMS items.

17 “(bb) 50 percent of the amount of the pay-
18 ments shall be retained by the Postal Service to
19 reimburse the Postal Service for services pro-
20 vided in connection with the customs processing
21 of Inbound EMS items.

22 “(II) Payments received by U.S. Customs and
23 Border Protection under subclause (I)(aa) shall, in
24 accordance with section 524 of the Tariff Act of
25 1930 (19 U.S.C. 1524), be deposited in the Customs

1 User Fee Account and used to directly reimburse
2 each appropriation for the amount paid out of that
3 appropriation for the costs incurred in providing
4 services to international mail facilities. Amounts de-
5 posited in accordance with the preceding sentence
6 shall be available until expended for the provision of
7 such services.

8 “(III) Payments retained by the Postal Service
9 under subclause (I)(bb) shall be used to directly re-
10 imburse the Postal Service for the costs incurred in
11 providing services in connection with the customs
12 processing of Inbound EMS items.

13 “(iv) Beginning in fiscal year 2021, the Sec-
14 retary, in consultation with the Postmaster General,
15 may adjust, not more frequently than once each fis-
16 cal year, the amount described in clause (i)(I) to an
17 amount commensurate with the costs of services pro-
18 vided in connection with the customs processing of
19 Inbound EMS items, consistent with the obligations
20 of the United States under international agree-
21 ments.”.

22 (b) CONFORMING AMENDMENTS.—Section 13031(a)
23 of the Consolidated Omnibus Budget Reconciliation Act
24 of 1985 (19 U.S.C. 58c(a)) is amended—

1 (1) in paragraph (6), by inserting “(other than
2 an item subject to a fee under subsection
3 (b)(9)(D))” after “customs officer”; and

4 (2) in paragraph (10)—

5 (A) in subparagraph (C), in the matter
6 preceding clause (i), by inserting “(other than
7 Inbound EMS items described in subsection
8 (b)(9)(D))” after “release”; and

9 (B) in the flush at the end, by inserting
10 “or of Inbound EMS items described in sub-
11 section (b)(9)(D),” after “(C),”.

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall take effect on January 1, 2020.

14 **SEC. 8003. MANDATORY ADVANCE ELECTRONIC INFORMA-**
15 **TION FOR POSTAL SHIPMENTS.**

16 (a) MANDATORY ADVANCE ELECTRONIC INFORMA-
17 TION.—

18 (1) IN GENERAL.—Section 343(a)(3)(K) of the
19 Trade Act of 2002 (Public Law 107–210; 19 U.S.C.
20 2071 note) is amended to read as follows:

21 “(K)(i) The Secretary shall prescribe regu-
22 lations requiring the United States Postal Serv-
23 ice to transmit the information described in
24 paragraphs (1) and (2) to the Commissioner of
25 U.S. Customs and Border Protection for inter-

1 national mail shipments by the Postal Service
2 (including shipments to the Postal Service from
3 foreign postal operators that are transported by
4 private carrier) consistent with the require-
5 ments of this subparagraph.

6 “(ii) In prescribing regulations under
7 clause (i), the Secretary shall impose require-
8 ments for the transmission to the Commissioner
9 of information described in paragraphs (1) and
10 (2) for mail shipments described in clause (i)
11 that are comparable to the requirements for the
12 transmission of such information imposed on
13 similar non-mail shipments of cargo, taking into
14 account the parameters set forth in subpara-
15 graphs (A) through (J).

16 “(iii) The regulations prescribed under
17 clause (i) shall require the transmission of the
18 information described in paragraphs (1) and (2)
19 with respect to a shipment as soon as prac-
20 ticable in relation to the transportation of the
21 shipment, consistent with subparagraph (H).

22 “(iv) Regulations prescribed under clause
23 (i) shall allow for the requirements for the
24 transmission to the Commissioner of informa-
25 tion described in paragraphs (1) and (2) for

1 mail shipments described in clause (i) to be im-
2 plemented in phases, as appropriate, by—

3 “(I) setting incremental targets for in-
4 creasing the percentage of such shipments
5 for which information is required to be
6 transmitted to the Commissioner; and

7 “(II) taking into consideration—

8 “(aa) the risk posed by such
9 shipments;

10 “(bb) the volume of mail shipped
11 to the United States by or through a
12 particular country; and

13 “(cc) the capacities of foreign
14 postal operators to provide that infor-
15 mation to the Postal Service.

16 “(v)(I) Notwithstanding clause (iv), the
17 Postal Service shall, not later than December
18 31, 2018, arrange for the transmission to the
19 Commissioner of the information described in
20 paragraphs (1) and (2) for not less than 70
21 percent of the aggregate number of mail ship-
22 ments, including 100 percent of mail shipments
23 from the People’s Republic of China, described
24 in clause (i).

1 “(II) If the requirements of subclause (I)
2 are not met, the Comptroller General of the
3 United States shall submit to the appropriate
4 congressional committees, not later than June
5 30, 2019, a report—

6 “(aa) assessing the reasons for the
7 failure to meet those requirements; and

8 “(bb) identifying recommendations to
9 improve the collection by the Postal Serv-
10 ice of the information described in para-
11 graphs (1) and (2).

12 “(vi)(I) Notwithstanding clause (iv), the
13 Postal Service shall, not later than December
14 31, 2020, arrange for the transmission to the
15 Commissioner of the information described in
16 paragraphs (1) and (2) for 100 percent of the
17 aggregate number of mail shipments described
18 in clause (i).

19 “(II) The Commissioner, in consultation
20 with the Postmaster General, may determine to
21 exclude a country from the requirement de-
22 scribed in subclause (I) to transmit information
23 for mail shipments described in clause (i) from
24 the country if the Commissioner determines
25 that the country—

1 “(aa) does not have the capacity to
2 collect and transmit such information;

3 “(bb) represents a low risk for mail
4 shipments that violate relevant United
5 States laws and regulations; and

6 “(cc) accounts for low volumes of mail
7 shipments that can be effectively screened
8 for compliance with relevant United States
9 laws and regulations through an alternate
10 means.

11 “(III) The Commissioner shall, at a min-
12 imum on an annual basis, re-evaluate any de-
13 termination made under subclause (II) to ex-
14 clude a country from the requirement described
15 in subclause (I). If, at any time, the Commis-
16 sioner determines that a country no longer
17 meets the requirements under subclause (II),
18 the Commissioner may not further exclude the
19 country from the requirement described in sub-
20 clause (I).

21 “(IV) The Commissioner shall, on an an-
22 nual basis, submit to the appropriate congress-
23 sional committees—

24 “(aa) a list of countries with respect
25 to which the Commissioner has made a de-

1 termination under subclause (II) to exclude
2 the countries from the requirement de-
3 scribed in subclause (I); and

4 “(bb) information used to support
5 such determination with respect to such
6 countries.

7 “(vii)(I) The Postmaster General shall, in
8 consultation with the Commissioner, refuse any
9 shipments received after December 31, 2020,
10 for which the information described in para-
11 graphs (1) and (2) is not transmitted as re-
12 quired under this subparagraph, except as pro-
13 vided in subclause (II).

14 “(II) If remedial action is warranted in
15 lieu of refusal of shipments pursuant to sub-
16 clause (I), the Postmaster General and the
17 Commissioner shall take remedial action with
18 respect to the shipments, including destruction,
19 seizure, controlled delivery or other law enforce-
20 ment initiatives, or correction of the failure to
21 provide the information described in paragraphs
22 (1) and (2) with respect to the shipments.

23 “(viii) Nothing in this subparagraph shall
24 be construed to limit the authority of the Sec-
25 retary to obtain information relating to inter-

1 national mail shipments from private carriers or
2 other appropriate parties.

3 “(ix) In this subparagraph, the term ‘ap-
4 appropriate congressional committees’ means—

5 “(I) the Committee on Finance and
6 the Committee on Homeland Security and
7 Governmental Affairs of the Senate; and

8 “(II) the Committee on Ways and
9 Means, the Committee on Oversight and
10 Government Reform, and the Committee
11 on Homeland Security of the House of
12 Representatives.”.

13 (2) JOINT STRATEGIC PLAN ON MANDATORY
14 ADVANCE INFORMATION.—Not later than 60 days
15 after the date of the enactment of this Act, the Sec-
16 retary of Homeland Security and the Postmaster
17 General shall develop and submit to the appropriate
18 congressional committees a joint strategic plan de-
19 tailing specific performance measures for achiev-
20 ing—

21 (A) the transmission of information as re-
22 quired by section 343(a)(3)(K) of the Trade
23 Act of 2002, as amended by paragraph (1); and

24 (B) the presentation by the Postal Service
25 to U.S. Customs and Border Protection of all

1 “(B) PROVISION OF EQUIPMENT AND
2 TECHNOLOGY.—With respect to the provision of
3 equipment and technology under subparagraph
4 (A), the Secretary may lease, loan, provide, or
5 otherwise assist in the deployment of such
6 equipment and technology under such terms
7 and conditions as the Secretary may prescribe,
8 including nonreimbursable loans or the transfer
9 of ownership of equipment and technology.”.

10 (2) JOINT STRATEGIC PLAN ON CAPACITY
11 BUILDING.—Not later than 1 year after the date of
12 the enactment of this Act, the Secretary of Home-
13 land Security and the Postmaster General shall, in
14 consultation with the Secretary of State, jointly de-
15 velop and submit to the appropriate congressional
16 committees a joint strategic plan—

17 (A) detailing the extent to which U.S. Cus-
18 toms and Border Protection and the United
19 States Postal Service are engaged in capacity
20 building efforts under section 343(a)(5) of the
21 Trade Act of 2002, as added by paragraph (1);

22 (B) describing plans for future capacity
23 building efforts; and

24 (C) assessing how capacity building has in-
25 creased the ability of U.S. Customs and Border

1 Protection and the Postal Service to advance
2 the goals of this subtitle and the amendments
3 made by this subtitle.

4 (c) REPORT AND CONSULTATIONS BY SECRETARY OF
5 HOMELAND SECURITY AND POSTMASTER GENERAL.—

6 (1) REPORT.—Not later than 180 days after
7 the date of the enactment of this Act, and annually
8 thereafter until 3 years after the Postmaster Gen-
9 eral has met the requirement under clause (vi) of
10 subparagraph (K) of section 343(a)(3) of the Trade
11 Act of 2002, as amended by subsection (a)(1), the
12 Secretary of Homeland Security and the Postmaster
13 General shall, in consultation with the Secretary of
14 State, jointly submit to the appropriate congress-
15 sional committees a report on compliance with that
16 subparagraph that includes the following:

17 (A) An assessment of the status of the reg-
18 ulations required to be promulgated under that
19 subparagraph.

20 (B) An update regarding new and existing
21 agreements reached with foreign postal opera-
22 tors for the transmission of the information re-
23 quired by that subparagraph.

24 (C) A summary of deliberations between
25 the United States Postal Service and foreign

1 postal operators with respect to issues relating
2 to the transmission of that information.

3 (D) A summary of the progress made in
4 achieving the transmission of that information
5 for the percentage of shipments required by
6 that subparagraph.

7 (E) An assessment of the quality of that
8 information being received by foreign postal op-
9 erators, as determined by the Secretary of
10 Homeland Security, and actions taken to im-
11 prove the quality of that information.

12 (F) A summary of policies established by
13 the Universal Postal Union that may affect the
14 ability of the Postmaster General to obtain the
15 transmission of that information.

16 (G) A summary of the use of technology to
17 detect illicit synthetic opioids and other illegal
18 substances in international mail parcels and
19 planned acquisitions and advancements in such
20 technology.

21 (H) Such other information as the Sec-
22 retary of Homeland Security and the Post-
23 master General consider appropriate with re-
24 spect to obtaining the transmission of informa-
25 tion required by that subparagraph.

1 (2) CONSULTATIONS.—Not later than 180 days
2 after the date of the enactment of this Act, and
3 every 180 days thereafter until the Postmaster Gen-
4 eral has met the requirement under clause (vi) of
5 section 343(a)(3)(K) of the Trade Act of 2002, as
6 amended by subsection (a)(1), to arrange for the
7 transmission of information with respect to 100 per-
8 cent of the aggregate number of mail shipments de-
9 scribed in clause (i) of that section, the Secretary of
10 Homeland Security and the Postmaster General
11 shall provide briefings to the appropriate congres-
12 sional committees on the progress made in achieving
13 the transmission of that information for that per-
14 centage of shipments.

15 (d) GOVERNMENT ACCOUNTABILITY OFFICE RE-
16 PORT.—Not later than June 30, 2019, the Comptroller
17 General of the United States shall submit to the appro-
18 priate congressional committees a report—

19 (1) assessing the progress of the United States
20 Postal Service in achieving the transmission of the
21 information required by subparagraph (K) of section
22 343(a)(3) of the Trade Act of 2002, as amended by
23 subsection (a)(1), for the percentage of shipments
24 required by that subparagraph;

1 (2) assessing the quality of the information re-
2 ceived from foreign postal operators for targeting
3 purposes;

4 (3) assessing the specific percentage of targeted
5 mail presented by the Postal Service to U.S. Cus-
6 toms and Border Protection for inspection;

7 (4) describing the costs of collecting the infor-
8 mation required by such subparagraph (K) from for-
9 eign postal operators and the costs of implementing
10 the use of that information;

11 (5) assessing the benefits of receiving that in-
12 formation with respect to international mail ship-
13 ments;

14 (6) assessing the feasibility of assessing a cus-
15 toms fee under section 13031(b)(9) of the Consoli-
16 dated Omnibus Budget Reconciliation Act of 1985,
17 as amended by section 8002, on international mail
18 shipments other than Inbound Express Mail service
19 in a manner consistent with the obligations of the
20 United States under international agreements; and

21 (7) identifying recommendations, including rec-
22 ommendations for legislation, to improve the compli-
23 ance of the Postal Service with such subparagraph
24 (K), including an assessment of whether the detec-

1 tion of illicit synthetic opioids in the international
2 mail would be improved by—

3 (A) requiring the Postal Service to serve as
4 the consignee for international mail shipments
5 containing goods; or

6 (B) designating a customs broker to act as
7 an importer of record for international mail
8 shipments containing goods.

9 (e) **TECHNICAL CORRECTION.**—Section 343 of the
10 Trade Act of 2002 (Public Law 107–210; 19 U.S.C. 2071
11 note) is amended in the section heading by striking “**AD-**
12 **VANCED**” and inserting “**ADVANCE**”.

13 (f) **APPROPRIATE CONGRESSIONAL COMMITTEES DE-**
14 **FINED.**—In this section, the term “appropriate congres-
15 sional committees” means—

16 (1) the Committee on Finance and the Com-
17 mittee on Homeland Security and Governmental Af-
18 fairs of the Senate; and

19 (2) the Committee on Ways and Means, the
20 Committee on Oversight and Government Reform,
21 and the Committee on Homeland Security of the
22 House of Representatives.

23 **SEC. 8004. INTERNATIONAL POSTAL AGREEMENTS.**

24 (a) **EXISTING AGREEMENTS.**—

1 (1) IN GENERAL.—In the event that any provi-
2 sion of this subtitle, or any amendment made by this
3 subtitle, is determined to be in violation of obliga-
4 tions of the United States under any postal treaty,
5 convention, or other international agreement related
6 to international postal services, or any amendment
7 to such an agreement, the Secretary of State should
8 negotiate to amend the relevant provisions of the
9 agreement so that the United States is no longer in
10 violation of the agreement.

11 (2) RULE OF CONSTRUCTION.—Nothing in this
12 subsection shall be construed to permit delay in the
13 implementation of this subtitle or any amendment
14 made by this subtitle.

15 (b) FUTURE AGREEMENTS.—

16 (1) CONSULTATIONS.—Before entering into, on
17 or after the date of the enactment of this Act, any
18 postal treaty, convention, or other international
19 agreement related to international postal services, or
20 any amendment to such an agreement, that is re-
21 lated to the ability of the United States to secure
22 the provision of advance electronic information by
23 foreign postal operators, the Secretary of State
24 should consult with the appropriate congressional
25 committees (as defined in section 8003(f)).

1 (2) EXPEDITED NEGOTIATION OF NEW AGREE-
2 MENT.—To the extent that any new postal treaty,
3 convention, or other international agreement related
4 to international postal services would improve the
5 ability of the United States to secure the provision
6 of advance electronic information by foreign postal
7 operators as required by regulations prescribed
8 under section 343(a)(3)(K) of the Trade Act of
9 2002, as amended by section 8003(a)(1), the Sec-
10 retary of State should expeditiously conclude such
11 an agreement.

12 **SEC. 8005. COST RECOUPMENT.**

13 (a) IN GENERAL.—The United States Postal Service
14 shall, to the extent practicable and otherwise recoverable
15 by law, ensure that all costs associated with complying
16 with this subtitle and amendments made by this subtitle
17 are charged directly to foreign shippers or foreign postal
18 operators.

19 (b) COSTS NOT CONSIDERED REVENUE.—The recov-
20 ery of costs under subsection (a) shall not be deemed rev-
21 enue for purposes of subchapter I and II of chapter 36
22 of title 39, United States Code, or regulations prescribed
23 under that chapter.

1 **SEC. 8006. DEVELOPMENT OF TECHNOLOGY TO DETECT IL-**
2 **LICIT NARCOTICS.**

3 (a) IN GENERAL.—The Postmaster General and the
4 Commissioner of U.S. Customs and Border Protection, in
5 coordination with the heads of other agencies as appro-
6 priate, shall collaborate to identify and develop technology
7 for the detection of illicit fentanyl, other synthetic opioids,
8 and other narcotics and psychoactive substances entering
9 the United States by mail.

10 (b) OUTREACH TO PRIVATE SECTOR.—The Post-
11 master General and the Commissioner shall conduct out-
12 reach to private sector entities to gather information re-
13 garding the current state of technology to identify areas
14 for innovation relating to the detection of illicit fentanyl,
15 other synthetic opioids, and other narcotics and
16 psychoactive substances entering the United States.

17 **SEC. 8007. CIVIL PENALTIES FOR POSTAL SHIPMENTS.**

18 Section 436 of the Tariff Act of 1930 (19 U.S.C.
19 1436) is amended by adding at the end the following new
20 subsection:

21 “(e) CIVIL PENALTIES FOR POSTAL SHIPMENTS.—

22 “(1) CIVIL PENALTY.—A civil penalty shall be
23 imposed against the United States Postal Service if
24 the Postal Service accepts a shipment in violation of
25 section 343(a)(3)(K)(vii)(I) of the Trade Act of
26 2002.

1 “(2) MODIFICATION OF CIVIL PENALTY.—

2 “(A) IN GENERAL.—U.S. Customs and
3 Border Protection shall reduce or dismiss a civil
4 penalty imposed pursuant to paragraph (1) if
5 U.S. Customs and Border Protection deter-
6 mines that the United States Postal Service—

7 “(i) has a low error rate in compliance
8 with section 343(a)(3)(K) of the Trade Act
9 of 2002;

10 “(ii) is cooperating with U.S. Customs
11 and Border Protection with respect to the
12 violation of section 343(a)(3)(K)(vii)(I) of
13 the Trade Act of 2002; or

14 “(iii) has taken remedial action to
15 prevent future violations of section
16 343(a)(3)(K)(vii)(I) of the Trade Act of
17 2002.

18 “(B) WRITTEN NOTIFICATION.—U.S. Cus-
19 toms and Border Protection shall issue a writ-
20 ten notification to the Postal Service with re-
21 spect to each exercise of the authority of sub-
22 paragraph (A) to reduce or dismiss a civil pen-
23 alty imposed pursuant to paragraph (1).

1 “(3) ONGOING LACK OF COMPLIANCE.—If U.S.
2 Customs and Border Protection determines that the
3 United States Postal Service—

4 “(A) has repeatedly committed violations
5 of section 343(a)(3)(K)(vii)(I) of the Trade Act
6 of 2002,

7 “(B) has failed to cooperate with U.S.
8 Customs and Border Protection with respect to
9 violations of section 343(a)(3)(K)(vii)(I) of the
10 Trade Act of 2002, and

11 “(C) has an increasing error rate in com-
12 pliance with section 343(a)(3)(K) of the Trade
13 Act of 2002,

14 civil penalties may be imposed against the United
15 States Postal Service until corrective action, satis-
16 factory to U.S. Customs and Border Protection, is
17 taken.”.

18 **SEC. 8008. REPORT ON VIOLATIONS OF ARRIVAL, REPORT-**
19 **ING, ENTRY, AND CLEARANCE REQUIRE-**
20 **MENTS AND FALSITY OR LACK OF MANIFEST.**

21 (a) IN GENERAL.—The Commissioner of U.S. Cus-
22 toms and Border Protection shall submit to the appro-
23 priate congressional committees an annual report that
24 contains the information described in subsection (b) with
25 respect to each violation of section 436 of the Tariff Act

1 of 1930 (19 U.S.C. 1436), as amended by section 8007,
2 and section 584 of such Act (19 U.S.C. 1584) that oc-
3 curred during the previous year.

4 (b) INFORMATION DESCRIBED.—The information de-
5 scribed in this subsection is the following:

6 (1) The name and address of the violator.

7 (2) The specific violation that was committed.

8 (3) The location or port of entry through which
9 the items were transported.

10 (4) An inventory of the items seized, including
11 a description of the items and the quantity seized.

12 (5) The location from which the items origi-
13 nated.

14 (6) The entity responsible for the apprehension
15 or seizure, organized by location or port of entry.

16 (7) The amount of penalties assessed by U.S.
17 Customs and Border Protection, organized by name
18 of the violator and location or port of entry.

19 (8) The amount of penalties that U.S. Customs
20 and Border Protection could have levied, organized
21 by name of the violator and location or port of entry.

22 (9) The rationale for negotiating lower pen-
23 alties, organized by name of the violator and location
24 or port of entry.

1 (c) APPROPRIATE CONGRESSIONAL COMMITTEES DE-
2 FINED.—In this section, the term “appropriate congress-
3 sional committees” means—

4 (1) the Committee on Finance and the Com-
5 mittee on Homeland Security and Governmental Af-
6 fairs of the Senate; and

7 (2) the Committee on Ways and Means, the
8 Committee on Oversight and Government Reform,
9 and the Committee on Homeland Security of the
10 House of Representatives.

11 **SEC. 8009. EFFECTIVE DATE; REGULATIONS.**

12 (a) EFFECTIVE DATE.—This subtitle and the amend-
13 ments made by this subtitle (other than the amendments
14 made by section 8002) shall take effect on the date of the
15 enactment of this Act.

16 (b) REGULATIONS.—Not later than 1 year after the
17 date of the enactment of this Act, such regulations as are
18 necessary to carry out this subtitle and the amendments
19 made by this subtitle shall be prescribed.

20 **Subtitle B—Opioid Addiction**
21 **Recovery Fraud Prevention**

22 **SEC. 8021. SHORT TITLE.**

23 This subtitle may be cited as the “Opioid Addiction
24 Recovery Fraud Prevention Act of 2018”.

1 **SEC. 8022. DEFINITIONS.**

2 For purposes of this subtitle only, and not be con-
3 strued or applied as to challenge or affect the character-
4 ization, definition, or treatment under any other statute,
5 regulation, or rule:

6 (1) **SUBSTANCE USE DISORDER TREATMENT**
7 **PRODUCT.**—The term “substance use disorder treat-
8 ment product” means a product for use or marketed
9 for use in the treatment, cure, or prevention of a
10 substance use disorder, including an opioid use dis-
11 order.

12 (2) **SUBSTANCE USE DISORDER TREATMENT**
13 **SERVICE.**—The term “substance use disorder treat-
14 ment service” means a service that purports to pro-
15 vide referrals to treatment, treatment, or recovery
16 housing for people diagnosed with, having, or pur-
17 porting to have a substance use disorder, including
18 an opioid use disorder.

19 **SEC. 8023. UNFAIR OR DECEPTIVE ACTS OR PRACTICES**
20 **WITH RESPECT TO SUBSTANCE USE DIS-**
21 **ORDER TREATMENT SERVICE AND PROD-**
22 **UCTS.**

23 (a) **UNLAWFUL ACTIVITY.**—It is unlawful to engage
24 in an unfair or deceptive act or practice with respect to
25 any substance use disorder treatment service or substance
26 use disorder treatment product.

1 (b) ENFORCEMENT BY THE FEDERAL TRADE COM-
2 MISSION.—

3 (1) UNFAIR OR DECEPTIVE ACTS OR PRAC-
4 TICES.—A violation of subsection (a) shall be treated
5 as a violation of a rule under section 18 of the Fed-
6 eral Trade Commission Act (15 U.S.C. 57a) regard-
7 ing unfair or deceptive acts or practices.

8 (2) POWERS OF THE FEDERAL TRADE COMMIS-
9 SION.—

10 (A) IN GENERAL.—The Federal Trade
11 Commission shall enforce this section in the
12 same manner, by the same means, and with the
13 same jurisdiction, powers, and duties as though
14 all applicable terms and provisions of the Fed-
15 eral Trade Commission Act (15 U.S.C. 41 et
16 seq.) were incorporated into and made a part of
17 this section.

18 (B) PRIVILEGES AND IMMUNITIES.—Any
19 person who violates subsection (a) shall be sub-
20 ject to the penalties and entitled to the privi-
21 leges and immunities provided in the Federal
22 Trade Commission Act as though all applicable
23 terms and provisions of the Federal Trade
24 Commission Act (15 U.S.C. 41 et seq.) were in-
25 corporated and made part of this section.

1 (c) AUTHORITY PRESERVED.—Nothing in this sub-
2 title shall be construed to limit the authority of the Fed-
3 eral Trade Commission or the Food and Drug Administra-
4 tion under any other provision of law.

5 **Subtitle C—Addressing Economic**
6 **and Workforce Impacts of the**
7 **Opioid Crisis**

8 **SEC. 8041. ADDRESSING ECONOMIC AND WORKFORCE IM-**
9 **PACTS OF THE OPIOID CRISIS.**

10 (a) DEFINITIONS.—Except as otherwise expressly
11 provided, in this section:

12 (1) WIOA DEFINITIONS.—The terms “core pro-
13 gram”, “individual with a barrier to employment”,
14 “local area”, “local board”, “one-stop operator”,
15 “outlying area”, “State”, “State board”, and “sup-
16 portive services” have the meanings given the terms
17 in section 3 of the Workforce Innovation and Oppor-
18 tunity Act (29 U.S.C. 3102).

19 (2) EDUCATION PROVIDER.—The term “edu-
20 cation provider” means—

21 (A) an institution of higher education, as
22 defined in section 101 of the Higher Education
23 Act of 1965 (20 U.S.C. 1001); or

1 (B) a postsecondary vocational institution,
2 as defined in section 102(e) of such Act (20
3 U.S.C. 1002(e)).

4 (3) ELIGIBLE ENTITY.—The term “eligible enti-
5 ty” means—

6 (A) a State workforce agency;

7 (B) an outlying area; or

8 (C) a Tribal entity.

9 (4) PARTICIPATING PARTNERSHIP.—The term
10 “participating partnership” means a partnership—

11 (A) evidenced by a written contract or
12 agreement; and

13 (B) including, as members of the partner-
14 ship, a local board receiving a subgrant under
15 subsection (d) and 1 or more of the following:

16 (i) The eligible entity.

17 (ii) A treatment provider.

18 (iii) An employer or industry organi-
19 zation.

20 (iv) An education provider.

21 (v) A legal service or law enforcement
22 organization.

23 (vi) A faith-based or community-based
24 organization.

1 (vii) Other State or local agencies, in-
2 cluding counties or local governments.

3 (viii) Other organizations, as deter-
4 mined to be necessary by the local board.

5 (ix) Indian Tribes or tribal organiza-
6 tions.

7 (5) PROGRAM PARTICIPANT.—The term “pro-
8 gram participant” means an individual who—

9 (A) is a member of a population of workers
10 described in subsection (e)(2) that is served by
11 a participating partnership through the pilot
12 program under this section; and

13 (B) enrolls with the applicable partici-
14 pating partnership to receive any of the services
15 described in subsection (e)(3).

16 (6) PROVIDER OF PEER RECOVERY SUPPORT
17 SERVICES.—The term “provider of peer recovery
18 support services” means a provider that delivers
19 peer recovery support services through an organiza-
20 tion described in section 547(a) of the Public Health
21 Service Act (42 U.S.C. 290ee–2(a)).

22 (7) SECRETARY.—The term “Secretary” means
23 the Secretary of Labor.

24 (8) STATE WORKFORCE AGENCY.—The term
25 “State workforce agency” means the lead State

1 agency with responsibility for the administration of
2 a program under chapter 2 or 3 of subtitle B of title
3 I of the Workforce Innovation and Opportunity Act
4 (29 U.S.C. 3161 et seq., 3171 et seq.).

5 (9) SUBSTANCE USE DISORDER.—The term
6 “substance use disorder” has the meaning given
7 such term by the Assistant Secretary for Mental
8 Health and Substance Use.

9 (10) TREATMENT PROVIDER.—The term “treat-
10 ment provider”—

11 (A) means a health care provider that—

12 (i) offers services for treating sub-
13 stance use disorders and is licensed in ac-
14 cordance with applicable State law to pro-
15 vide such services; and

16 (ii) accepts health insurance for such
17 services, including coverage under title
18 XIX of the Social Security Act (42 U.S.C.
19 1396 et seq.); and

20 (B) may include—

21 (i) a nonprofit provider of peer recov-
22 ery support services;

23 (ii) a community health care provider;

1 (iii) a Federally qualified health cen-
2 ter (as defined in section 1861(aa) of the
3 Social Security Act (42 U.S.C. 1395x));

4 (iv) an Indian health program (as de-
5 fined in section 3 of the Indian Health
6 Care Improvement Act (25 U.S.C. 1603)),
7 including an Indian health program that
8 serves an urban center (as defined in such
9 section); and

10 (v) a Native Hawaiian health center
11 (as defined in section 12 of the Native Ha-
12 waiian Health Care Improvement Act (42
13 U.S.C. 11711)).

14 (11) TRIBAL ENTITY.—The term “Tribal enti-
15 ty” includes any Indian Tribe, tribal organization,
16 Indian-controlled organization serving Indians, Na-
17 tive Hawaiian organization, or Alaska Native entity,
18 as such terms are defined or used in section 166 of
19 the Workforce Innovation and Opportunity Act (29
20 U.S.C. 3221).

21 (b) PILOT PROGRAM AND GRANTS AUTHORIZED.—

22 (1) IN GENERAL.—The Secretary, in consulta-
23 tion with the Secretary of Health and Human Serv-
24 ices, shall carry out a pilot program to address eco-
25 nomic and workforce impacts associated with a high

1 rate of a substance use disorder. In carrying out the
2 pilot program, the Secretary shall make grants, on
3 a competitive basis, to eligible entities to enable such
4 entities to make subgrants to local boards to address
5 the economic and workforce impacts associated with
6 a high rate of a substance use disorder.

7 (2) GRANT AMOUNTS.—The Secretary shall
8 make each such grant in an amount that is not less
9 than \$500,000, and not more than \$5,000,000, for
10 a fiscal year.

11 (c) GRANT APPLICATIONS.—

12 (1) IN GENERAL.—An eligible entity applying
13 for a grant under this section shall submit an appli-
14 cation to the Secretary at such time and in such
15 form and manner as the Secretary may reasonably
16 require, including the information described in this
17 subsection.

18 (2) SIGNIFICANT IMPACT ON COMMUNITY BY
19 OPIOID AND SUBSTANCE USE DISORDER-RELATED
20 PROBLEMS.—

21 (A) DEMONSTRATION.—An eligible entity
22 shall include in the application—

23 (i) information that demonstrates sig-
24 nificant impact on the community by prob-

1 lems related to opioid abuse or another
2 substance use disorder, by—

3 (I) identifying the counties, com-
4 munities, regions, or local areas that
5 have been significantly impacted and
6 will be served through the grant (each
7 referred to in this section as a “serv-
8 ice area”); and

9 (II) demonstrating for each such
10 service area, an increase equal to or
11 greater than the national increase in
12 such problems, between—

13 (aa) 1999; and

14 (bb) 2016 or the latest year
15 for which data are available; and

16 (ii) a description of how the eligible
17 entity will prioritize support for signifi-
18 cantly impacted service areas described in
19 clause (i)(I).

20 (B) INFORMATION.—To meet the require-
21 ments described in subparagraph (A)(i)(II), the
22 eligible entity may use information including
23 data on—

1 (i) the incidence or prevalence of
2 opioid abuse and other substance use dis-
3 orders;

4 (ii) the age-adjusted rate of drug
5 overdose deaths, as determined by the Di-
6 rector of the Centers for Disease Control
7 and Prevention;

8 (iii) the rate of non-fatal hospitaliza-
9 tions related to opioid abuse or other sub-
10 stance use disorders;

11 (iv) the number of arrests or convic-
12 tions, or a relevant law enforcement sta-
13 tistic, that reasonably shows an increase in
14 opioid abuse or another substance use dis-
15 order; or

16 (v) in the case of an eligible entity de-
17 scribed in subsection (a)(3)(C), other alter-
18 native relevant data as determined appro-
19 priate by the Secretary.

20 (C) SUPPORT FOR STATE STRATEGY.—The
21 eligible entity may include in the application in-
22 formation describing how the proposed services
23 and activities are aligned with the State, out-
24 lying area, or Tribal strategy, as applicable, for
25 addressing problems described in subparagraph

1 (A) in specific service areas or across the State,
2 outlying area, or Tribal land.

3 (3) ECONOMIC AND EMPLOYMENT CONDITIONS
4 DEMONSTRATE ADDITIONAL FEDERAL SUPPORT
5 NEEDED.—

6 (A) DEMONSTRATION.—An eligible entity
7 shall include in the application information that
8 demonstrates that a high rate of a substance
9 use disorder has caused, or is coincident to—

10 (i) an economic or employment down-
11 turn in the service area; or

12 (ii) persistent economically depressed
13 conditions in such service area.

14 (B) INFORMATION.—To meet the require-
15 ments of subparagraph (A), an eligible entity
16 may use information including—

17 (i) documentation of any layoff, an-
18 nounced future layoff, legacy industry de-
19 cline, decrease in an employment or labor
20 market participation rate, or economic im-
21 pact, whether or not the result described in
22 this clause is overtly related to a high rate
23 of a substance use disorder;

24 (ii) documentation showing decreased
25 economic activity related to, caused by, or

1 contributing to a high rate of a substance
2 use disorder, including a description of
3 how the service area has been impacted, or
4 will be impacted, by such a decrease;

5 (iii) information on economic indica-
6 tors, labor market analyses, information
7 from public announcements, and demo-
8 graphic and industry data;

9 (iv) information on rapid response ac-
10 tivities (as defined in section 3 of the
11 Workforce Innovation and Opportunity Act
12 (29 U.S.C. 3102)) that have been or will
13 be conducted, including demographic data
14 gathered by employer or worker surveys or
15 through other methods;

16 (v) data or documentation, beyond an-
17 ecdotal evidence, showing that employers
18 face challenges filling job vacancies due to
19 a lack of skilled workers able to pass a
20 drug test; or

21 (vi) any additional relevant data or in-
22 formation on the economy, workforce, or
23 another aspect of the service area to sup-
24 port the application.

1 (d) SUBGRANT AUTHORIZATION AND APPLICATION
2 PROCESS.—

3 (1) SUBGRANTS AUTHORIZED.—

4 (A) IN GENERAL.—An eligible entity re-
5 ceiving a grant under subsection (b)—

6 (i) may use not more than 5 percent
7 of the grant funds for the administrative
8 costs of carrying out the grant;

9 (ii) in the case of an eligible entity de-
10 scribed in subparagraph (A) or (B) of sub-
11 section (a)(3), shall use the remaining
12 grant funds to make subgrants to local en-
13 tities in the service area to carry out the
14 services and activities described in sub-
15 section (e); and

16 (iii) in the case of an eligible entity
17 described in subsection (a)(3)(C), shall use
18 the remaining grant funds to carry out the
19 services and activities described in sub-
20 section (e).

21 (B) EQUITABLE DISTRIBUTION.—In mak-
22 ing subgrants under this subsection, an eligible
23 entity shall ensure, to the extent practicable,
24 the equitable distribution of subgrants, based
25 on—

1 (i) geography (such as urban and
2 rural distribution); and

3 (ii) significantly impacted service
4 areas as described in subsection (c)(2).

5 (C) TIMING OF SUBGRANT FUNDS DIS-
6 TRIBUTION.—An eligible entity making sub-
7 grants under this subsection shall disburse
8 subgrant funds to a local board receiving a
9 subgrant from the eligible entity by the later
10 of—

11 (i) the date that is 90 days after the
12 date on which the Secretary makes the
13 funds available to the eligible entity; or

14 (ii) the date that is 15 days after the
15 date that the eligible entity makes the
16 subgrant under subparagraph (A)(ii).

17 (2) SUBGRANT APPLICATION.—

18 (A) IN GENERAL.—A local board desiring
19 to receive a subgrant under this subsection
20 from an eligible entity shall submit an applica-
21 tion at such time and in such manner as the el-
22 igible entity may reasonably require, including
23 the information described in this paragraph.

24 (B) CONTENTS.—Each application de-
25 scribed in subparagraph (A) shall include—

1 (i) an analysis of the estimated per-
2 formance of the local board in carrying out
3 the proposed services and activities under
4 the subgrant—

5 (I) based on—

6 (aa) primary indicators of
7 performance described in section
8 116(c)(1)(A)(i) of the Workforce
9 Innovation and Opportunity Act
10 (29 U.S.C. 3141(c)(1)(A)(i), to
11 assess estimated effectiveness of
12 the proposed services and activi-
13 ties, including the estimated
14 number of individuals with a sub-
15 stance use disorder who may be
16 served by the proposed services
17 and activities;

18 (bb) the record of the local
19 board in serving individuals with
20 a barrier to employment; and

21 (cc) the ability of the local
22 board to establish a participating
23 partnership; and

24 (II) which may include or uti-
25 lize—

1 (aa) data from the National
2 Center for Health Statistics of
3 the Centers for Disease Control
4 and Prevention;

5 (bb) data from the Center
6 for Behavioral Health Statistics
7 and Quality of the Substance
8 Abuse and Mental Health Serv-
9 ices Administration;

10 (cc) State vital statistics;

11 (dd) municipal police depart-
12 ment records;

13 (ee) reports from local coro-
14 ners; or

15 (ff) other relevant data; and

16 (ii) in the case of a local board pro-
17 posing to serve a population described in
18 subsection (e)(2)(B), a demonstration of
19 the workforce shortage in the professional
20 area to be addressed under the subgrant
21 (which may include substance use disorder
22 treatment and related services, non-addict-
23 ive pain therapy and pain management
24 services, mental health care treatment
25 services, emergency response services, or

1 mental health care), which shall include in-
2 formation that can demonstrate such a
3 shortage, such as—

4 (I) the distance between—

5 (aa) communities affected by
6 opioid abuse or another sub-
7 stance use disorder; and

8 (bb) facilities or profes-
9 sionals offering services in the
10 professional area; or

11 (II) the maximum capacity of fa-
12 cilities or professionals to serve indi-
13 viduals in an affected community, or
14 increases in arrests related to opioid
15 or another substance use disorder,
16 overdose deaths, or nonfatal overdose
17 emergencies in the community.

18 (e) SUBGRANT SERVICES AND ACTIVITIES.—

19 (1) IN GENERAL.—Each local board that re-
20 ceives a subgrant under subsection (d) shall carry
21 out the services and activities described in this sub-
22 section through a participating partnership.

23 (2) SELECTION OF POPULATION TO BE
24 SERVED.—A participating partnership shall elect to

1 provide services and activities under the subgrant to
2 one or both of the following populations of workers:

3 (A) Workers, including dislocated workers,
4 individuals with barriers to employment, new
5 entrants in the workforce, or incumbent work-
6 ers (employed or underemployed), each of
7 whom—

8 (i) is directly or indirectly affected by
9 a high rate of a substance use disorder;
10 and

11 (ii) voluntarily confirms that the
12 worker, or a friend or family member of
13 the worker, has a history of opioid abuse
14 or another substance use disorder.

15 (B) Workers, including dislocated workers,
16 individuals with barriers to employment, new
17 entrants in the workforce, or incumbent work-
18 ers (employed or underemployed), who—

19 (i) seek to transition to professions
20 that support individuals with a substance
21 use disorder or at risk for developing such
22 disorder, such as professions that pro-
23 vide—

24 (I) substance use disorder treat-
25 ment and related services;

1 (II) services offered through pro-
2 viders of peer recovery support serv-
3 ices;

4 (III) non-addictive pain therapy
5 and pain management services;

6 (IV) emergency response services;

7 or

8 (V) mental health care; and

9 (ii) need new or upgraded skills to
10 better serve such a population of strug-
11 gling or at-risk individuals.

12 (3) SERVICES AND ACTIVITIES.—Each partici-
13 pating partnership shall use funds available through
14 a subgrant under this subsection to carry out 1 or
15 more of the following:

16 (A) ENGAGING EMPLOYERS.—Engaging
17 with employers to—

18 (i) learn about the skill and hiring re-
19 quirements of employers;

20 (ii) learn about the support needed by
21 employers to hire and retain program par-
22 ticipants, and other individuals with a sub-
23 stance use disorder, and the support need-
24 ed by such employers to obtain their com-
25 mitment to testing creative solutions to

1 employing program participants and such
2 individuals;

3 (iii) connect employers and workers to
4 on-the-job or customized training programs
5 before or after layoff to help facilitate re-
6 employment;

7 (iv) connect employers with an edu-
8 cation provider to develop classroom in-
9 struction to complement on-the-job learn-
10 ing for program participants and such in-
11 dividuals;

12 (v) help employers develop the cur-
13 riculum design of a work-based learning
14 program for program participants and
15 such individuals;

16 (vi) help employers employ program
17 participants or such individuals engaging
18 in a work-based learning program for a
19 transitional period before hiring such a
20 program participant or individual for full-
21 time employment of not less than 30 hours
22 a week; or

23 (vii) connect employers to program
24 participants receiving concurrent out-
25 patient treatment and job training services.

1 (B) SCREENING SERVICES.—Providing
2 screening services, which may include—

3 (i) using an evidence-based screening
4 method to screen each individual seeking
5 participation in the pilot program to deter-
6 mine whether the individual has a sub-
7 stance use disorder;

8 (ii) conducting an assessment of each
9 such individual to determine the services
10 needed for such individual to obtain or re-
11 tain employment, including an assessment
12 of strengths and general work readiness; or

13 (iii) accepting walk-ins or referrals
14 from employers, labor organizations, or
15 other entities recommending individuals to
16 participate in such program.

17 (C) INDIVIDUAL TREATMENT AND EM-
18 PLOYMENT PLAN.—Developing an individual
19 treatment and employment plan for each pro-
20 gram participant—

21 (i) in coordination, as appropriate,
22 with other programs serving the partici-
23 pant such as the core programs within the
24 workforce development system under the

1 Workforce Innovation and Opportunity Act
2 (29 U.S.C. 3101 et seq.); and

3 (ii) which shall include providing a
4 case manager to work with each partici-
5 pant to develop the plan, which may in-
6 clude—

7 (I) identifying employment and
8 career goals;

9 (II) exploring career pathways
10 that lead to in-demand industries and
11 sectors, as determined by the State
12 board and the head of the State work-
13 force agency or, as applicable, the
14 Tribal entity;

15 (III) setting appropriate achieve-
16 ment objectives to attain the employ-
17 ment and career goals identified
18 under subclause (I); or

19 (IV) developing the appropriate
20 combination of services to enable the
21 participant to achieve the employment
22 and career goals identified under sub-
23 clause (I).

24 (D) OUTPATIENT TREATMENT AND RECOV-
25 ERY CARE.—In the case of a participating part-

1 nership serving program participants described
2 in paragraph (2)(A) with a substance use dis-
3 order, providing individualized and group out-
4 patient treatment and recovery services for such
5 program participants that are offered during
6 the day and evening, and on weekends. Such
7 treatment and recovery services—

8 (i) shall be based on a model that uti-
9 lizes combined behavioral interventions and
10 other evidence-based or evidence-informed
11 interventions; and

12 (ii) may include additional services
13 such as—

14 (I) health, mental health, addic-
15 tion, or other forms of outpatient
16 treatment that may impact a sub-
17 stance use disorder and co-occurring
18 conditions;

19 (II) drug testing for a current
20 substance use disorder prior to enroll-
21 ment in career or training services or
22 prior to employment;

23 (III) linkages to community serv-
24 ices, including services offered by

1 partner organizations designed to sup-
2 port program participants; or

3 (IV) referrals to health care, in-
4 cluding referrals to substance use dis-
5 order treatment and mental health
6 services.

7 (E) SUPPORTIVE SERVICES.—Providing
8 supportive services, which shall include services
9 such as—

10 (i) coordinated wraparound services to
11 provide maximum support for program
12 participants to assist the program partici-
13 pants in maintaining employment and re-
14 covery for not less than 12 months, as ap-
15 propriate;

16 (ii) assistance in establishing eligi-
17 bility for assistance under Federal, State,
18 Tribal, and local programs providing
19 health services, mental health services, vo-
20 cational services, housing services, trans-
21 portation services, social services, or serv-
22 ices through early childhood education pro-
23 grams (as defined in section 103 of the
24 Higher Education Act of 1965 (20 U.S.C.
25 1003));

1 sonal maintenance skills, and profes-
2 sional conduct;

3 (IV) in-depth interviewing and
4 evaluation to identify employment bar-
5 riers and to develop individual em-
6 ployment plans;

7 (V) career planning that in-
8 cludes—

9 (aa) career pathways leading
10 to in-demand, high-wage jobs;
11 and

12 (bb) job coaching, job
13 matching, and job placement
14 services;

15 (VI) provision of payments and
16 fees for employment and training-re-
17 lated applications, tests, and certifi-
18 cations; or

19 (VII) any other appropriate ca-
20 reer service or training service de-
21 scribed in section 134(c) of the Work-
22 force Innovation and Opportunity Act
23 (29 U.S.C. 3174(c)).

24 (ii) Services provided to program par-
25 ticipants during their first 6 months of

1 employment to ensure job retention, which
2 may include—

3 (I) case management and support
4 services, including a continuation of
5 the services described in clause (i);

6 (II) a continuation of skills train-
7 ing, and career and technical edu-
8 cation, described in clause (i) that is
9 conducted in collaboration with the
10 employers of such participants;

11 (III) mentorship services and job
12 retention support for such partici-
13 pants; or

14 (IV) targeted training for man-
15 agers and workers working with such
16 participants (such as mentors), and
17 human resource representatives in the
18 business in which such participants
19 are employed.

20 (iii) Services to assist program partici-
21 pants in maintaining employment for not
22 less than 12 months, as appropriate.

23 (G) PROVEN AND PROMISING PRAC-
24 TICES.—Leading efforts in the service area to
25 identify and promote proven and promising

1 strategies and initiatives for meeting the needs
2 of employers and program participants.

3 (4) LIMITATIONS.—A participating partnership
4 may not use—

5 (A) more than 10 percent of the funds re-
6 ceived under a subgrant under subsection (d)
7 for the administrative costs of the partnership;

8 (B) more than 10 percent of the funds re-
9 ceived under such subgrant for the provision of
10 treatment and recovery services, as described in
11 paragraph (3)(D); and

12 (C) more than 10 percent of the funds re-
13 ceived under such subgrant for the provision of
14 supportive services described in paragraph
15 (3)(E) to program participants.

16 (f) PERFORMANCE ACCOUNTABILITY.—

17 (1) REPORTS.—The Secretary shall establish
18 quarterly reporting requirements for recipients of
19 grants and subgrants under this section that, to the
20 extent practicable, are based on the performance ac-
21 countability system under section 116 of the Work-
22 force Innovation and Opportunity Act (29 U.S.C.
23 3141) and, in the case of a grant awarded to an eli-
24 gible entity described in subsection (a)(3)(C), section
25 166(h) of such Act (29 U.S.C. 3221(h)), including

1 the indicators described in subsection (c)(1)(A)(i) of
2 such section 116 and the requirements for local area
3 performance reports under subsection (d) of such
4 section 116.

5 (2) EVALUATIONS.—

6 (A) AUTHORITY TO ENTER INTO AGREE-
7 MENTS.—The Secretary shall ensure that an
8 independent evaluation is conducted on the pilot
9 program carried out under this section to deter-
10 mine the impact of the program on employment
11 of individuals with substance use disorders. The
12 Secretary shall enter into an agreement with el-
13 igible entities receiving grants under this sec-
14 tion to pay for all or part of such evaluation.

15 (B) METHODOLOGIES TO BE USED.—The
16 independent evaluation required under this
17 paragraph shall use experimental designs using
18 random assignment or, when random assign-
19 ment is not feasible, other reliable, evidence-
20 based research methodologies that allow for the
21 strongest possible causal inferences.

22 (g) FUNDING.—

23 (1) COVERED FISCAL YEAR.—In this sub-
24 section, the term “covered fiscal year” means any of
25 fiscal years 2019 through 2023.

1 (2) USING FUNDING FOR NATIONAL DIS-
2 LOCATED WORKER GRANTS.—Subject to paragraph
3 (4) and notwithstanding section 132(a)(2)(A) and
4 subtitle D of the Workforce Innovation and Oppor-
5 tunity Act (29 U.S.C. 3172(a)(2)(A), 3221 et seq.),
6 the Secretary may use, to carry out the pilot pro-
7 gram under this section for a covered fiscal year—

8 (A) funds made available to carry out sec-
9 tion 170 of such Act (29 U.S.C. 3225) for that
10 fiscal year;

11 (B) funds made available to carry out sec-
12 tion 170 of such Act that remain available for
13 that fiscal year; and

14 (C) funds that remain available under sec-
15 tion 172(f) of such Act (29 U.S.C. 3227(f)).

16 (3) AVAILABILITY OF FUNDS.—Funds appro-
17 priated under section 136(c) of such Act (29 U.S.C.
18 3181(c)) and made available to carry out section
19 170 of such Act for a fiscal year shall remain avail-
20 able for use under paragraph (2) for a subsequent
21 fiscal year until expended.

22 (4) LIMITATION.—The Secretary may not use
23 more than \$100,000,000 of the funds described in
24 paragraph (2) for any covered fiscal year under this
25 section.

1 **Subtitle D—Peer Support Coun-**
2 **seling Program for Women Vet-**
3 **erans**

4 **SEC. 8051. PEER SUPPORT COUNSELING PROGRAM FOR**
5 **WOMEN VETERANS.**

6 (a) IN GENERAL.—Section 1720F(j) of title 38,
7 United States Code, is amended by adding at the end the
8 following new paragraph:

9 “(4)(A) As part of the counseling program under this
10 subsection, the Secretary shall emphasize appointing peer
11 support counselors for women veterans. To the degree
12 practicable, the Secretary shall seek to recruit women peer
13 support counselors with expertise in—

14 “(i) female gender-specific issues and services;

15 “(ii) the provision of information about services
16 and benefits provided under laws administered by
17 the Secretary; or

18 “(iii) employment mentoring.

19 “(B) To the degree practicable, the Secretary shall
20 emphasize facilitating peer support counseling for women
21 veterans who are eligible for counseling and services under
22 section 1720D of this title, have post-traumatic stress dis-
23 order or suffer from another mental health condition, are
24 homeless or at risk of becoming homeless, or are otherwise

1 at increased risk of suicide, as determined by the Sec-
2 retary.

3 “(C) The Secretary shall conduct outreach to inform
4 women veterans about the program and the assistance
5 available under this paragraph.

6 “(D) In carrying out this paragraph, the Secretary
7 shall coordinate with such community organizations, State
8 and local governments, institutions of higher education,
9 chambers of commerce, local business organizations, orga-
10 nizations that provide legal assistance, and other organiza-
11 tions as the Secretary considers appropriate.

12 “(E) In carrying out this paragraph, the Secretary
13 shall provide adequate training for peer support coun-
14 selors, including training carried out under the national
15 program of training required by section 304(c) of the
16 Caregivers and Veterans Omnibus Health Services Act of
17 2010 (38 U.S.C. 1712A note).”.

18 (b) FUNDING.—The Secretary of Veterans Affairs
19 shall carry out paragraph (4) of section 1720F(j) of title
20 38, United States Code, as added by subsection (a), using
21 funds otherwise made available to the Secretary. No addi-
22 tional funds are authorized to be appropriated by reason
23 of such paragraph.

24 (c) REPORT TO CONGRESS.—Not later than 2 years
25 after the date of the enactment of this Act, the Secretary

1 projects and activities to address drug abuse, including
2 opioid abuse, in the region, including projects and activi-
3 ties—

4 “(1) to facilitate the sharing of best practices
5 among States, counties, and other experts in the re-
6 gion with respect to reducing such abuse;

7 “(2) to initiate or expand programs designed to
8 eliminate or reduce the harm to the workforce and
9 economic growth of the region that results from such
10 abuse;

11 “(3) to attract and retain relevant health care
12 services, businesses, and workers; and

13 “(4) to develop relevant infrastructure, includ-
14 ing broadband infrastructure that supports the use
15 of telemedicine.

16 “(b) LIMITATION ON AVAILABLE AMOUNTS.—Of the
17 cost of any activity eligible for a grant under this sec-
18 tion—

19 “(1) not more than 50 percent may be provided
20 from amounts appropriated to carry out this section;
21 and

22 “(2) notwithstanding paragraph (1)—

23 “(A) in the case of a project to be carried
24 out in a county for which a distressed county
25 designation is in effect under section 14526,

1 not more than 80 percent may be provided from
2 amounts appropriated to carry out this section;
3 and

4 “(B) in the case of a project to be carried
5 out in a county for which an at-risk designation
6 is in effect under section 14526, not more than
7 70 percent may be provided from amounts ap-
8 propriated to carry out this section.

9 “(c) SOURCES OF ASSISTANCE.—Subject to sub-
10 section (b), a grant provided under this section may be
11 provided from amounts made available to carry out this
12 section in combination with amounts made available—

13 “(1) under any other Federal program (subject
14 to the availability of subsequent appropriations); or

15 “(2) from any other source.

16 “(d) FEDERAL SHARE.—Notwithstanding any provi-
17 sion of law limiting the Federal share under any other
18 Federal program, amounts made available to carry out
19 this section may be used to increase that Federal share,
20 as the Appalachian Regional Commission determines to be
21 appropriate.”.

22 (b) CLERICAL AMENDMENT.—The analysis for chap-
23 ter 145 of title 40, United States Code, is amended by
24 inserting after the item relating to section 14509 the fol-
25 lowing:

“14510. Drug abuse mitigation initiative.”.

1 **Subtitle F—Pilot Program to Help**
2 **Individuals in Recovery From a**
3 **Substance Use Disorder Become**
4 **Stably Housed**

5 **SEC. 8071. PILOT PROGRAM TO HELP INDIVIDUALS IN RE-**
6 **COVERY FROM A SUBSTANCE USE DISORDER**
7 **BECOME STABLY HOUSED.**

8 (a) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated under this section such
10 sums as may be necessary for each of fiscal years 2019
11 through 2023 for assistance to States to provide individ-
12 uals in recovery from a substance use disorder stable, tem-
13 porary housing for a period of not more than 2 years or
14 until the individual secures permanent housing, whichever
15 is earlier.

16 (b) ALLOCATION OF APPROPRIATED AMOUNTS.—

17 (1) IN GENERAL.—The amounts appropriated
18 or otherwise made available to States under this sec-
19 tion shall be allocated based on a funding formula
20 established by the Secretary of Housing and Urban
21 Development (referred to in this section as the “Sec-
22 retary”) not later than 60 days after the date of en-
23 actment of this Act.

24 (2) CRITERIA.—

1 (A) IN GENERAL.—The funding formula
2 required under paragraph (1) shall ensure that
3 any amounts appropriated or otherwise made
4 available under this section are allocated to
5 States with an age-adjusted rate of drug over-
6 dose deaths that is above the national overdose
7 mortality rate, according to the Centers for Dis-
8 ease Control and Prevention.

9 (B) PRIORITY.—

10 (i) IN GENERAL.—Among such States,
11 priority shall be given to States with the
12 greatest need, as such need is determined
13 by the Secretary based on the following
14 factors, and weighting such factors as de-
15 scribed in clause (ii):

16 (I) The highest average rates of
17 unemployment based on data provided
18 by the Bureau of Labor Statistics for
19 calendar years 2013 through 2017.

20 (II) The lowest average labor
21 force participation rates based on data
22 provided by the Bureau of Labor Sta-
23 tistics for calendar years 2013
24 through 2017.

1 (III) The highest age-adjusted
2 rates of drug overdose deaths based
3 on data from the Centers for Disease
4 Control and Prevention.

5 (ii) WEIGHTING.—The factors de-
6 scribed in clause (i) shall be weighted as
7 follows:

8 (I) The rate described in clause
9 (i)(I) shall be weighted at 15 percent.

10 (II) The rate described in clause
11 (i)(II) shall be weighted at 15 percent.

12 (III) The rate described in clause
13 (i)(III) shall be weighted at 70 per-
14 cent.

15 (3) DISTRIBUTION.—Amounts appropriated or
16 otherwise made available under this section shall be
17 distributed according to the funding formula estab-
18 lished by the Secretary under paragraph (1) not
19 later than 30 days after the establishment of such
20 formula.

21 (c) USE OF FUNDS.—

22 (1) IN GENERAL.—Any State that receives
23 amounts pursuant to this section shall expend at
24 least 30 percent of such funds within one year of the

1 date funds become available to the grantee for obli-
2 gation.

3 (2) PRIORITY.—Any State that receives
4 amounts pursuant to this section shall distribute
5 such amounts giving priority to entities with the
6 greatest need and ability to deliver effective assist-
7 ance in a timely manner.

8 (3) ADMINISTRATIVE COSTS.—Any State that
9 receives amounts pursuant to this section may use
10 up to 5 percent of any grant for administrative
11 costs.

12 (d) RULES OF CONSTRUCTION.—

13 (1) IN GENERAL.—Except as otherwise pro-
14 vided by this section, amounts appropriated, or
15 amounts otherwise made available to States under
16 this section shall be treated as though such funds
17 were community development block grant funds
18 under title I of the Housing and Community Devel-
19 opment Act of 1974 (42 U.S.C. 5301 et seq.).

20 (2) NO MATCH.—No matching funds shall be
21 required in order for a State to receive any amounts
22 under this section.

23 (e) AUTHORITY TO WAIVE OR SPECIFY ALTER-
24 NATIVE REQUIREMENTS.—

1 (1) IN GENERAL.—In administering any
2 amounts appropriated or otherwise made available
3 under this section, the Secretary may waive or speci-
4 fy alternative requirements to any provision under
5 title I of the Housing and Community Development
6 Act of 1974 (42 U.S.C. 5301 et seq.) except for re-
7 quirements related to fair housing, nondiscrimina-
8 tion, labor standards, the environment, and require-
9 ments that activities benefit persons of low- and
10 moderate-income, upon a finding that such a waiver
11 is necessary to expedite or facilitate the use of such
12 funds.

13 (2) NOTICE OF INTENT.—The Secretary shall
14 provide written notice of its intent to exercise the
15 authority to specify alternative requirements under
16 paragraph (1) to the Committee on Banking, Hous-
17 ing, and Urban Affairs of the Senate and the Com-
18 mittee on Financial Services of the House of Rep-
19 resentatives not later than 15 business days before
20 such exercise of authority occurs.

21 (3) NOTICE TO THE PUBLIC.—The Secretary
22 shall provide written notice of its intent to exercise
23 the authority to specify alternative requirements
24 under paragraph (1) to the public via notice, on the
25 internet website of the Department of Housing and

1 Urban Development, and by other appropriate
2 means, not later than 15 business days before such
3 exercise of authority occurs.

4 (f) TECHNICAL ASSISTANCE.—For the 2-year period
5 following the date of enactment of this Act, the Secretary
6 may use not more than 2 percent of the funds made avail-
7 able under this section for technical assistance to grantees.

8 (g) STATE.—For purposes of this section the term
9 “State” includes any State as defined in section 102 of
10 the Housing and Community Development Act of 1974
11 (42 U.S.C. 5302) and the District of Columbia.

12 **Subtitle G—Human Services**

13 **SEC. 8081. SUPPORTING FAMILY-FOCUSED RESIDENTIAL** 14 **TREATMENT.**

15 (a) DEFINITIONS.—In this section:

16 (1) FAMILY-FOCUSED RESIDENTIAL TREAT-
17 MENT PROGRAM.—The term “family-focused resi-
18 dential treatment program” means a trauma-in-
19 formed residential program primarily for substance
20 use disorder treatment for pregnant and postpartum
21 women and parents and guardians that allows chil-
22 dren to reside with such women or their parents or
23 guardians during treatment to the extent appro-
24 priate and applicable.

1 (2) MEDICAID PROGRAM.—The term “Medicaid
2 program” means the program established under title
3 XIX of the Social Security Act (42 U.S.C. 1396 et
4 seq.).

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

7 (4) TITLE IV–E PROGRAM.—The term “title
8 IV–E program” means the program for foster care,
9 prevention, and permanency established under part
10 E of title IV of the Social Security Act (42 U.S.C.
11 670 et seq.).

12 (b) GUIDANCE ON FAMILY-FOCUSED RESIDENTIAL
13 TREATMENT PROGRAMS.—

14 (1) IN GENERAL.—Not later than 180 days
15 after the date of enactment of this Act, the Sec-
16 retary, in consultation with divisions of the Depart-
17 ment of Health and Human Services administering
18 substance use disorder or child welfare programs,
19 shall develop and issue guidance to States identi-
20 fying opportunities to support family-focused resi-
21 dential treatment programs for the provision of sub-
22 stance use disorder treatment. Before issuing such
23 guidance, the Secretary shall solicit input from rep-
24 resentatives of States, health care providers with ex-
25 pertise in addiction medicine, obstetrics and gyne-

1 cology, neonatology, child trauma, and child develop-
2 ment, health plans, recipients of family-focused
3 treatment services, and other relevant stakeholders.

4 (2) ADDITIONAL REQUIREMENTS.—The guid-
5 ance required under paragraph (1) shall include de-
6 scriptions of the following:

7 (A) Existing opportunities and flexibilities
8 under the Medicaid program, including under
9 waivers authorized under section 1115 or 1915
10 of the Social Security Act (42 U.S.C. 1315,
11 1396n), for States to receive Federal Medicaid
12 funding for the provision of substance use dis-
13 order treatment for pregnant and postpartum
14 women and parents and guardians and, to the
15 extent applicable, their children, in family-fo-
16 cused residential treatment programs.

17 (B) How States can employ and coordinate
18 funding provided under the Medicaid program,
19 the title IV-E program, and other programs ad-
20 ministered by the Secretary to support the pro-
21 vision of treatment and services provided by a
22 family-focused residential treatment facility
23 such as substance use disorder treatment and
24 services, including medication-assisted treat-
25 ment, family, group, and individual counseling,

1 case management, parenting education and
2 skills development, the provision, assessment, or
3 coordination of care and services for children,
4 including necessary assessments and appro-
5 priate interventions, non-emergency transpor-
6 tation for necessary care provided at or away
7 from a program site, transitional services and
8 supports for families leaving treatment, and
9 other services.

10 (C) How States can employ and coordinate
11 funding provided under the Medicaid program
12 and the title IV–E program (including as
13 amended by the Family First Prevention Serv-
14 ices Act enacted under title VII of division E of
15 Public Law 115–123, and particularly with re-
16 spect to the authority under subsections
17 (a)(2)(C) and (j) of section 472 and section
18 474(a)(1) of the Social Security Act (42 U.S.C.
19 672, 674(a)(1)) (as amended by section 50712
20 of Public Law 115–123) to provide foster care
21 maintenance payments for a child placed with a
22 parent who is receiving treatment in a licensed
23 residential family-based treatment facility for a
24 substance use disorder) to support placing chil-

1 dren with their parents in family-focused resi-
2 dential treatment programs.

3 **SEC. 8082. IMPROVING RECOVERY AND REUNIFYING FAMI-**
4 **LIES.**

5 (a) FAMILY RECOVERY AND REUNIFICATION PRO-
6 GRAM REPLICATION PROJECT.—Section 435 of the Social
7 Security Act (42 U.S.C. 629e) is amended by adding at
8 the end the following:

9 “(e) FAMILY RECOVERY AND REUNIFICATION PRO-
10 GRAM REPLICATION PROJECT.—

11 “(1) PURPOSE.—The purpose of this subsection
12 is to provide resources to the Secretary to support
13 the conduct and evaluation of a family recovery and
14 reunification program replication project (referred to
15 in this subsection as the ‘project’) and to determine
16 the extent to which such programs may be appro-
17 priate for use at different intervention points (such
18 as when a child is at risk of entering foster care or
19 when a child is living with a guardian while a parent
20 is in treatment). The family recovery and reunifica-
21 tion program conducted under the project shall use
22 a recovery coach model that is designed to help re-
23 unify families and protect children by working with
24 parents or guardians with a substance use disorder
25 who have temporarily lost custody of their children.

1 “(2) PROGRAM COMPONENTS.—The family re-
2 covery and reunification program conducted under
3 the project shall adhere closely to the elements and
4 protocol determined to be most effective in other re-
5 covery coaching programs that have been rigorously
6 evaluated and shown to increase family reunification
7 and protect children and, consistent with such ele-
8 ments and protocol, shall provide such items and
9 services as—

10 “(A) assessments to evaluate the needs of
11 the parent or guardian;

12 “(B) assistance in receiving the appro-
13 priate benefits to aid the parent or guardian in
14 recovery;

15 “(C) services to assist the parent or guard-
16 ian in prioritizing issues identified in assess-
17 ments, establishing goals for resolving such
18 issues that are consistent with the goals of the
19 treatment provider, child welfare agency,
20 courts, and other agencies involved with the
21 parent or guardian or their children, and mak-
22 ing a coordinated plan for achieving such goals;

23 “(D) home visiting services coordinated
24 with the child welfare agency and treatment

1 provider involved with the parent or guardian
2 or their children;

3 “(E) case management services to remove
4 barriers for the parent or guardian to partici-
5 pate and continue in treatment, as well as to
6 re-engage a parent or guardian who is not par-
7 ticipating or progressing in treatment;

8 “(F) access to services needed to monitor
9 the parent’s or guardian’s compliance with pro-
10 gram requirements;

11 “(G) frequent reporting between the treat-
12 ment provider, child welfare agency, courts, and
13 other agencies involved with the parent or
14 guardian or their children to ensure appropriate
15 information on the parent’s or guardian’s sta-
16 tus is available to inform decision-making; and

17 “(H) assessments and recommendations
18 provided by a recovery coach to the child wel-
19 fare caseworker responsible for documenting the
20 parent’s or guardian’s progress in treatment
21 and recovery as well as the status of other
22 areas identified in the treatment plan for the
23 parent or guardian, including a recommenda-
24 tion regarding the expected safety of the child
25 if the child is returned to the custody of the

1 parent or guardian that can be used by the
2 caseworker and a court to make permanency
3 decisions regarding the child.

4 “(3) RESPONSIBILITIES OF THE SECRETARY.—

5 “(A) IN GENERAL.—The Secretary shall,
6 through a grant or contract with 1 or more en-
7 tities, conduct and evaluate the family recovery
8 and reunification program under the project.

9 “(B) REQUIREMENTS.—In identifying 1 or
10 more entities to conduct the evaluation of the
11 family recovery and reunification program, the
12 Secretary shall—

13 “(i) determine that the area or areas
14 in which the program will be conducted
15 have sufficient substance use disorder
16 treatment providers and other resources
17 (other than those provided with funds
18 made available to carry out the project) to
19 successfully conduct the program;

20 “(ii) determine that the area or areas
21 in which the program will be conducted
22 have enough potential program partici-
23 pants, and will serve a sufficient number of
24 parents or guardians and their children, so
25 as to allow for the formation of a control

1 group, evaluation results to be adequately
2 powered, and preliminary results of the
3 evaluation to be available within 4 years of
4 the program's implementation;

5 “(iii) provide the entity or entities
6 with technical assistance for the program
7 design, including by working with 1 or
8 more entities that are or have been in-
9 volved in recovery coaching programs that
10 have been rigorously evaluated and shown
11 to increase family reunification and protect
12 children so as to make sure the program
13 conducted under the project adheres closely
14 to the elements and protocol determined to
15 be most effective in such other recovery
16 coaching programs;

17 “(iv) assist the entity or entities in se-
18 curing adequate coaching, treatment, child
19 welfare, court, and other resources needed
20 to successfully conduct the family recovery
21 and reunification program under the
22 project; and

23 “(v) ensure the entity or entities will
24 be able to monitor the impacts of the pro-
25 gram in the area or areas in which it is

1 conducted for at least 5 years after parents
2 or guardians and their children are ran-
3 domly assigned to participate in the pro-
4 gram or to be part of the program’s con-
5 trol group.

6 “(4) EVALUATION REQUIREMENTS.—

7 “(A) IN GENERAL.—The Secretary, in con-
8 sultation with the entity or entities conducting
9 the family recovery and reunification program
10 under the project, shall conduct an evaluation
11 to determine whether the program has been im-
12 plemented effectively and resulted in improve-
13 ments for children and families. The evaluation
14 shall have 3 components: a pilot phase, an im-
15 pact study, and an implementation study.

16 “(B) PILOT PHASE.—The pilot phase com-
17 ponent of the evaluation shall consist of the
18 Secretary providing technical assistance to the
19 entity or entities conducting the family recovery
20 and reunification program under the project to
21 ensure—

22 “(i) the program’s implementation ad-
23 heres closely to the elements and protocol
24 determined to be most effective in other re-
25 covery coaching programs that have been

1 rigorously evaluated and shown to increase
2 family reunification and protect children;
3 and

4 “(ii) random assignment of parents or
5 guardians and their children to be partici-
6 pants in the program or to be part of the
7 program’s control group is being carried
8 out.

9 “(C) IMPACT STUDY.—The impact study
10 component of the evaluation shall determine the
11 impacts of the family recovery and reunification
12 program conducted under the project on the
13 parents and guardians and their children par-
14 ticipating in the program. The impact study
15 component shall—

16 “(i) be conducted using an experi-
17 mental design that uses a random assign-
18 ment research methodology;

19 “(ii) consistent with previous studies
20 of other recovery coaching programs that
21 have been rigorously evaluated and shown
22 to increase family reunification and protect
23 children, measure outcomes for parents
24 and guardians and their children over mul-

1 tiple time periods, including for a period of
2 5 years; and

3 “(iii) include measurements of family
4 stability and parent, guardian, and child
5 safety for program participants and the
6 program control group that are consistent
7 with measurements of such factors for par-
8 ticipants and control groups from previous
9 studies of other recovery coaching pro-
10 grams so as to allow results of the impact
11 study to be compared with the results of
12 such prior studies, including with respect
13 to comparisons between program partici-
14 pants and the program control group re-
15 garding—

16 “(I) safe family reunification;

17 “(II) time to reunification;

18 “(III) permanency (such as
19 through measures of reunification,
20 adoption, or placement with guard-
21 ians);

22 “(IV) safety (such as through
23 measures of subsequent maltreat-
24 ment);

1 “(V) parental or guardian treat-
2 ment persistence and engagement;

3 “(VI) parental or guardian sub-
4 stance use;

5 “(VII) juvenile delinquency;

6 “(VIII) cost; and

7 “(IX) other measurements
8 agreed upon by the Secretary and the
9 entity or entities operating the family
10 recovery and reunification program
11 under the project.

12 “(D) IMPLEMENTATION STUDY.—The im-
13 plementation study component of the evaluation
14 shall be conducted concurrently with the con-
15 duct of the impact study component and shall
16 include, in addition to such other information
17 as the Secretary may determine, descriptions
18 and analyses of—

19 “(i) the adherence of the family recov-
20 ery and reunification program conducted
21 under the project to other recovery coach-
22 ing programs that have been rigorously
23 evaluated and shown to increase family re-
24 unification and protect children; and

1 “(ii) the difference in services received
2 or proposed to be received by the program
3 participants and the program control
4 group.

5 “(E) REPORT.—The Secretary shall pub-
6 lish on an internet website maintained by the
7 Secretary the following information:

8 “(i) A report on the pilot phase com-
9 ponent of the evaluation.

10 “(ii) A report on the impact study
11 component of the evaluation.

12 “(iii) A report on the implementation
13 study component of the evaluation.

14 “(iv) A report that includes—

15 “(I) analyses of the extent to
16 which the program has resulted in in-
17 creased reunifications, increased per-
18 manency, case closures, net savings to
19 the State or States involved (taking
20 into account both costs borne by
21 States and the Federal government),
22 or other outcomes, or if the program
23 did not produce such outcomes, an
24 analysis of why the replication of the
25 program did not yield such results;

1 “(II) if, based on such analyses,
2 the Secretary determines the program
3 should be replicated, a replication
4 plan; and

5 “(III) such recommendations for
6 legislation and administrative action
7 as the Secretary determines appro-
8 priate.

9 “(5) APPROPRIATION.—In addition to any
10 amounts otherwise made available to carry out this
11 subpart, out of any money in the Treasury of the
12 United States not otherwise appropriated, there are
13 appropriated \$15,000,000 for fiscal year 2019 to
14 carry out the project, which shall remain available
15 through fiscal year 2026.”.

16 (b) CLARIFICATION OF PAYER OF LAST RESORT AP-
17 PLICATION TO CHILD WELFARE PREVENTION AND FAM-
18 ILY SERVICES.—Section 471(e)(10) of the Social Security
19 Act (42 U.S.C. 671(e)(10)), as added by section
20 50711(a)(2) of division E of Public Law 115–123, is
21 amended—

22 (1) in subparagraph (A), by inserting “, nor
23 shall the provision of such services or programs be
24 construed to permit the State to reduce medical or

1 other assistance available to a recipient of such serv-
2 ices or programs” after “under this Act”; and

3 (2) by adding at the end the following:

4 “(C) PAYER OF LAST RESORT.—In car-
5 rying out its responsibilities to ensure access to
6 services or programs under this subsection, the
7 State agency shall not be considered to be a le-
8 gally liable third party for purposes of satis-
9 fying a financial commitment for the cost of
10 providing such services or programs with re-
11 spect to any individual for whom such cost
12 would have been paid for from another public
13 or private source but for the enactment of this
14 subsection (except that whenever considered
15 necessary to prevent a delay in the receipt of
16 appropriate early intervention services by a
17 child or family in a timely fashion, funds pro-
18 vided under section 474(a)(6) may be used to
19 pay the provider of services or programs pend-
20 ing reimbursement from the public or private
21 source that has ultimate responsibility for the
22 payment).”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 subsection (b) shall take effect as if included in section
25 50711 of division E of Public Law 115–123.

1 **SEC. 8083. BUILDING CAPACITY FOR FAMILY-FOCUSED RES-**
2 **IDENTIAL TREATMENT.**

3 (a) DEFINITIONS.—In this section:

4 (1) ELIGIBLE ENTITY.—The term “eligible enti-
5 ty” means a State, county, local, or tribal health or
6 child welfare agency, a private nonprofit organiza-
7 tion, a research organization, a treatment service
8 provider, an institution of higher education (as de-
9 fined under section 101 of the Higher Education Act
10 of 1965 (20 U.S.C. 1001)), or another entity speci-
11 fied by the Secretary.

12 (2) FAMILY-FOCUSED RESIDENTIAL TREAT-
13 MENT PROGRAM.—The term “family-focused resi-
14 dential treatment program” means a trauma-in-
15 formed residential program primarily for substance
16 use disorder treatment for pregnant and postpartum
17 women and parents and guardians that allows chil-
18 dren to reside with such women or their parents or
19 guardians during treatment to the extent appro-
20 priate and applicable.

21 (3) SECRETARY.—The term “Secretary” means
22 the Secretary of Health and Human Services.

23 (b) SUPPORT FOR THE DEVELOPMENT OF EVI-
24 DENCE-BASED FAMILY-FOCUSED RESIDENTIAL TREAT-
25 MENT PROGRAMS.—

1 (1) AUTHORITY TO AWARD GRANTS.—The Sec-
2 retary shall award grants to eligible entities for pur-
3 poses of developing, enhancing, or evaluating family-
4 focused residential treatment programs to increase
5 the availability of such programs that meet the re-
6 quirements for promising, supported, or well-sup-
7 ported practices specified in section 471(e)(4)(C) of
8 the Social Security Act (42 U.S.C. 671(e)(4)(C))
9 (as added by the Family First Prevention Services
10 Act enacted under title VII of division E of Public
11 Law 115–123).

12 (2) EVALUATION REQUIREMENT.—The Sec-
13 retary shall require any evaluation of a family-fo-
14 cused residential treatment program by an eligible
15 entity that uses funds awarded under this section for
16 all or part of the costs of the evaluation be designed
17 to assist in the determination of whether the pro-
18 gram may qualify as a promising, supported, or well-
19 supported practice in accordance with the require-
20 ments of such section 471(e)(4)(C).

21 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to the Secretary to carry
23 out this section, \$20,000,000 for fiscal year 2019, which
24 shall remain available through fiscal year 2023.

1 **Subtitle H—Reauthorizing and Ex-**
2 **tending Grants for Recovery**
3 **From Opioid Use Programs**

4 **SEC. 8091. SHORT TITLE.**

5 This subtitle may be cited as the “Reauthorizing and
6 Extending Grants for Recovery from Opioid Use Pro-
7 grams Act of 2018” or the “REGROUP Act of 2018”.

8 **SEC. 8092. REAUTHORIZATION OF THE COMPREHENSIVE**
9 **OPIOID ABUSE GRANT PROGRAM.**

10 Section 1001(a)(27) of the Omnibus Crime Control
11 and Safe Streets Act of 1968 (34 U.S.C. 10261(a)(27))
12 is amended by striking “through 2021” and inserting
13 “and 2018, and \$330,000,000 for each of fiscal years
14 2019 through 2023”.

15 **Subtitle I—Fighting Opioid Abuse**
16 **in Transportation**

17 **SEC. 8101. SHORT TITLE.**

18 This subtitle may be cited as the “Fighting Opioid
19 Abuse in Transportation Act”.

20 **SEC. 8102. ALCOHOL AND CONTROLLED SUBSTANCE TEST-**
21 **ING OF MECHANICAL EMPLOYEES.**

22 (a) IN GENERAL.—Not later than 2 years after the
23 date of enactment of this Act, the Secretary of Transpor-
24 tation shall publish a rule in the Federal Register revising
25 the regulations promulgated under section 20140 of title

1 49, United States Code, to cover all employees of railroad
2 carriers who perform mechanical activities.

3 (b) DEFINITION OF MECHANICAL ACTIVITIES.—For
4 the purposes of the rule under subsection (a), the Sec-
5 retary shall define the term “mechanical activities” by reg-
6 ulation.

7 **SEC. 8103. DEPARTMENT OF TRANSPORTATION PUBLIC**
8 **DRUG AND ALCOHOL TESTING DATABASE.**

9 (a) IN GENERAL.—Subject to subsection (c), the Sec-
10 retary of Transportation shall—

11 (1) not later than March 31, 2019, establish
12 and make publicly available on its website a data-
13 base of the drug and alcohol testing data reported
14 by employers for each mode of transportation; and

15 (2) update the database annually.

16 (b) CONTENTS.—The database under subsection (a)
17 shall include, for each mode of transportation—

18 (1) the total number of drug and alcohol tests
19 by type of substance tested;

20 (2) the drug and alcohol test results by type of
21 substance tested;

22 (3) the reason for the drug or alcohol test, such
23 as pre-employment, random, post-accident, reason-
24 able suspicion or cause, return-to-duty, or follow-up,
25 by type of substance tested; and

1 (2) submit to the Committee on Commerce,
2 Science, and Transportation of the Senate and the
3 Committee on Transportation and Infrastructure of
4 the House of Representatives a report on the review,
5 including recommendations under subsection (c).

6 (b) CONTENTS.—The report under subsection (a)
7 shall include—

8 (1) a description of the process the Department
9 of Transportation uses to collect and record drug
10 and alcohol testing data submitted by employers for
11 each mode of transportation;

12 (2) an assessment of whether and, if so, how
13 the Department of Transportation uses the data de-
14 scribed in paragraph (1) in carrying out its respon-
15 sibilities; and

16 (3) an assessment of the Department of Trans-
17 portation public drug and alcohol testing database
18 under section 8103.

19 (c) RECOMMENDATIONS.—The report under sub-
20 section (a) may include recommendations regarding—

21 (1) how the Department of Transportation can
22 best use the data described in subsection (b)(1);

23 (2) any improvements that could be made to
24 the process described in subsection (b)(1);

1 (3) whether and, if so, how the Department of
2 Transportation public drug and alcohol testing data-
3 base under section 8103 could be made more effec-
4 tive; and

5 (4) such other recommendations as the Comp-
6 troller General considers appropriate.

7 **SEC. 8105. TRANSPORTATION WORKPLACE DRUG AND AL-**
8 **COHOL TESTING PROGRAM; ADDITION OF**
9 **FENTANYL AND OTHER SUBSTANCES.**

10 (a) MANDATORY GUIDELINES FOR FEDERAL WORK-
11 PLACE DRUG TESTING PROGRAMS.—

12 (1) IN GENERAL.—Not later than 180 days
13 after the date of enactment of this Act, the Sec-
14 retary of Health and Human Services shall—

15 (A) determine whether a revision of the
16 Mandatory Guidelines for Federal Workplace
17 Drug Testing Programs to expand the opiate
18 category on the list of authorized substance
19 testing to include fentanyl is justified, based on
20 the reliability and cost-effectiveness of available
21 testing; and

22 (B) consider whether to include with the
23 determination under subparagraph (A) a sepa-
24 rate determination on whether a revision of the
25 Mandatory Guidelines for Federal Workplace

1 Drug Testing Programs to expand the list of
2 substances authorized for testing to include any
3 other drugs or other substances listed in sched-
4 ule I and II of section 202 of the Controlled
5 Substances Act (21 U.S.C. 812) is justified
6 based on the criteria described in subparagraph
7 (A).

8 (2) REVISION OF GUIDELINES.—If an expan-
9 sion of the substance list is determined to be justi-
10 fied under paragraph (1), the Secretary of Health
11 and Human Services shall—

12 (A) notify the Committee on Commerce,
13 Science, and Transportation of the Senate and
14 the Committee on Transportation and Infra-
15 structure of the House of Representatives of
16 the determination; and

17 (B) publish in the Federal Register, not
18 later than 18 months after the date of the de-
19 termination under that paragraph, a final no-
20 tice of the revision of the Mandatory Guidelines
21 for Federal Workplace Drug Testing Programs
22 to expand the list of substances authorized to
23 be tested to include the substance or substances
24 determined to be justified for inclusion.

1 (3) REPORT.—If an expansion of the substance
2 list is determined not to be justified under para-
3 graph (1), the Secretary of Health and Human
4 Services shall submit to the Committee on Com-
5 merce, Science, and Transportation of the Senate
6 and the Committee on Transportation and Infra-
7 structure of the House of Representatives a report
8 explaining, in detail, the reasons the expansion of
9 the list of authorized substances is not justified.

10 (b) DEPARTMENT OF TRANSPORTATION DRUG-TEST-
11 ING PANEL.—If an expansion is determined to be justified
12 under subsection (a)(1), the Secretary of Transportation
13 shall publish in the Federal Register, not later than 18
14 months after the date the final notice is published under
15 subsection (a)(2), a final rule revising part 40 of title 49,
16 Code of Federal Regulations, to include such substances
17 in the Department of Transportation’s drug-testing panel,
18 consistent with the Mandatory Guidelines for Federal
19 Workplace Drug Testing Programs as revised by the Sec-
20 retary of Health and Human Services under subsection
21 (a).

22 (c) SAVINGS PROVISION.—Nothing in this section
23 may be construed as—

24 (1) delaying the publication of the notices de-
25 scribed in sections 8106 and 8107 of this Act until

1 the Secretary of Health and Human Services makes
2 a determination or publishes a notice under this sec-
3 tion; or

4 (2) limiting or otherwise affecting any authority
5 of the Secretary of Health and Human Services or
6 the Secretary of Transportation to expand the list of
7 authorized substance testing to include an additional
8 substance.

9 **SEC. 8106. STATUS REPORTS ON HAIR TESTING GUIDE-**
10 **LINES.**

11 (a) IN GENERAL.—Not later than 60 days after the
12 date of enactment of this Act, and annually thereafter
13 until the date that the Secretary of Health and Human
14 Services publishes in the Federal Register a final notice
15 of scientific and technical guidelines for hair testing in ac-
16 cordance with section 5402(b) of the Fixing America’s
17 Surface Transportation Act (Public Law 114-94; 129
18 Stat. 1312), the Secretary of Health and Human Services
19 shall submit to the Committee on Commerce, Science, and
20 Transportation of the Senate and the Committee on
21 Transportation and Infrastructure of the House of Rep-
22 resentatives a report on—

23 (1) the status of the hair testing guidelines;

24 (2) an explanation for why the hair testing
25 guidelines have not been issued; and

1 (3) an estimated date of completion of the hair
2 testing guidelines.

3 (b) REQUIREMENT.—To the extent practicable and
4 consistent with the objective of the hair testing described
5 in subsection (a) to detect illegal or unauthorized use of
6 substances by the individual being tested, the final notice
7 of scientific and technical guidelines under that sub-
8 section, as determined by the Secretary of Health and
9 Human Services, shall eliminate the risk of positive test
10 results, of the individual being tested, caused solely by the
11 drug use of others and not caused by the drug use of the
12 individual being tested.

13 **SEC. 8107. MANDATORY GUIDELINES FOR FEDERAL WORK-**
14 **PLACE DRUG TESTING PROGRAMS USING**
15 **ORAL FLUID.**

16 (a) DEADLINE.—Not later than December 31, 2018,
17 the Secretary of Health and Human Services shall publish
18 in the Federal Register a final notice of the Mandatory
19 Guidelines for Federal Workplace Drug Testing Programs
20 using Oral Fluid, based on the notice of proposed manda-
21 tory guidelines published in the Federal Register on May
22 15, 2015 (94 FR 28054).

23 (b) REQUIREMENT.—To the extent practicable and
24 consistent with the objective of the testing described in
25 subsection (a) to detect illegal or unauthorized use of sub-

1 stances by the individual being tested, the final notice of
2 scientific and technical guidelines under that subsection,
3 as determined by the Secretary of Health and Human
4 Services, shall eliminate the risk of positive test results,
5 of the individual being tested, caused solely by the drug
6 use of others and not caused by the drug use of the indi-
7 vidual being tested.

8 (c) **RULE OF CONSTRUCTION.**—Nothing in this sec-
9 tion may be construed as requiring the Secretary of
10 Health and Human Services to reissue a notice of pro-
11 posed mandatory guidelines to carry out subsection (a).

12 **SEC. 8108. ELECTRONIC RECORDKEEPING.**

13 (a) **DEADLINE.**—Not later than 1 year after the date
14 of enactment of this Act, the Secretary of Health and
15 Human Services shall—

16 (1) ensure that each certified laboratory that
17 requests approval for the use of completely paperless
18 electronic Federal Drug Testing Custody and Con-
19 trol Forms from the National Laboratory Certifi-
20 cation Program’s Electronic Custody and Control
21 Form systems receives approval for those completely
22 paperless electronic forms instead of forms that in-
23 clude any combination of electronic traditional hand-
24 written signatures executed on paper forms; and

1 (2) establish a deadline for a certified labora-
2 tory to request approval under paragraph (1).

3 (b) SAVINGS CLAUSE.—Nothing in this section may
4 be construed as limiting or otherwise affecting any author-
5 ity of the Secretary of Health and Human Services to
6 grant approval to a certified laboratory for use of com-
7 pletely paperless electronic Federal Drug Testing Custody
8 and Control Forms, including to grant approval outside
9 of the process under subsection (a).

10 (c) ELECTRONIC SIGNATURES.—Not later than 18
11 months after the date of the deadline under subsection
12 (a)(2), the Secretary of Transportation shall issue a final
13 rule revising part 40 of title 49, Code of Federal Regula-
14 tions, to authorize, to the extent practicable, the use of
15 electronic signatures or digital signatures executed to elec-
16 tronic forms instead of traditional handwritten signatures
17 executed on paper forms.

18 **SEC. 8109. STATUS REPORTS ON COMMERCIAL DRIVER'S LI-**
19 **CENSE DRUG AND ALCOHOL CLEARING-**
20 **HOUSE.**

21 (a) IN GENERAL.—Not later than 60 days after the
22 date of enactment of this Act, and annually thereafter
23 until the compliance date, the Administrator of the Fed-
24 eral Motor Carrier Safety Administration shall submit to
25 the Committee on Commerce, Science, and Transportation

1 of the Senate and the Committee on Transportation and
2 Infrastructure of the House of Representatives a status
3 report on implementation of the final rule for the Com-
4 mercial Driver’s License Drug and Alcohol Clearinghouse
5 (81 FR 87686), including—

6 (1) an updated schedule, including benchmarks,
7 for implementing the final rule as soon as prac-
8 ticable, but not later than the compliance date; and

9 (2) a description of each action the Federal
10 Motor Carrier Safety Administration is taking to im-
11 plement the final rule before the compliance date.

12 (b) DEFINITION OF COMPLIANCE DATE.—In this sec-
13 tion, the term “compliance date” means the earlier of—

14 (1) January 6, 2020; or

15 (2) the date that the national clearinghouse re-
16 quired under section 31306a of title 49, United
17 States Code, is operational.

18 **Subtitle J—Eliminating Kickbacks** 19 **in Recovery**

20 **SEC. 8121. SHORT TITLE.**

21 This subtitle may be cited as the “Eliminating Kick-
22 backs in Recovery Act of 2018”.

1 **SEC. 8122. CRIMINAL PENALTIES.**

2 (a) IN GENERAL.—Chapter 11 of title 18, United
3 States Code, is amended by inserting after section 219 the
4 following:

5 **“§ 220. Illegal remunerations for referrals to recovery**
6 **homes, clinical treatment facilities, and**
7 **laboratories**

8 “(a) OFFENSE.—Except as provided in subsection
9 (b), whoever, with respect to services covered by a health
10 care benefit program, in or affecting interstate or foreign
11 commerce, knowingly and willfully—

12 “(1) solicits or receives any remuneration (in-
13 cluding any kickback, bribe, or rebate) directly or in-
14 directly, overtly or covertly, in cash or in kind, in re-
15 turn for referring a patient or patronage to a recov-
16 ery home, clinical treatment facility, or laboratory;
17 or

18 “(2) pays or offers any remuneration (including
19 any kickback, bribe, or rebate) directly or indirectly,
20 overtly or covertly, in cash or in kind—

21 “(A) to induce a referral of an individual
22 to a recovery home, clinical treatment facility,
23 or laboratory; or

24 “(B) in exchange for an individual using
25 the services of that recovery home, clinical
26 treatment facility, or laboratory,

1 shall be fined not more than \$200,000, imprisoned not
2 more than 10 years, or both, for each occurrence.

3 “(b) APPLICABILITY.—Subsection (a) shall not apply
4 to—

5 “(1) a discount or other reduction in price ob-
6 tained by a provider of services or other entity under
7 a health care benefit program if the reduction in
8 price is properly disclosed and appropriately re-
9 flected in the costs claimed or charges made by the
10 provider or entity;

11 “(2) a payment made by an employer to an em-
12 ployee or independent contractor (who has a bona
13 fide employment or contractual relationship with
14 such employer) for employment, if the employee’s
15 payment is not determined by or does not vary by—

16 “(A) the number of individuals referred to
17 a particular recovery home, clinical treatment
18 facility, or laboratory;

19 “(B) the number of tests or procedures
20 performed; or

21 “(C) the amount billed to or received from,
22 in part or in whole, the health care benefit pro-
23 gram from the individuals referred to a par-
24 ticular recovery home, clinical treatment facil-
25 ity, or laboratory;

1 “(3) a discount in the price of an applicable
2 drug of a manufacturer that is furnished to an ap-
3 plicable beneficiary under the Medicare coverage gap
4 discount program under section 1860D–14A(g) of
5 the Social Security Act (42 U.S.C. 1395w–114a(g));

6 “(4) a payment made by a principal to an agent
7 as compensation for the services of the agent under
8 a personal services and management contract that
9 meets the requirements of section 1001.952(d) of
10 title 42, Code of Federal Regulations, as in effect on
11 the date of enactment of this section;

12 “(5) a waiver or discount (as defined in section
13 1001.952(h)(5) of title 42, Code of Federal Regula-
14 tions, or any successor regulation) of any coinsur-
15 ance or copayment by a health care benefit program
16 if—

17 “(A) the waiver or discount is not routinely
18 provided; and

19 “(B) the waiver or discount is provided in
20 good faith;

21 “(6) a remuneration described in section
22 1128B(b)(3)(I) of the Social Security Act (42
23 U.S.C. 1320a–7b(b)(3)(I));

24 “(7) a remuneration made pursuant to an alter-
25 native payment model (as defined in section

1 1833(z)(3)(C) of the Social Security Act) or pursu-
2 ant to a payment arrangement used by a State,
3 health insurance issuer, or group health plan if the
4 Secretary of Health and Human Services has deter-
5 mined that such arrangement is necessary for care
6 coordination or value-based care; or

7 “(8) any other payment, remuneration, dis-
8 count, or reduction as determined by the Attorney
9 General, in consultation with the Secretary of
10 Health and Human Services, by regulation.

11 “(c) REGULATIONS.—The Attorney General, in con-
12 sultation with the Secretary of Health and Human Serv-
13 ices, may promulgate regulations to clarify the exceptions
14 described in subsection (b).

15 “(d) RULE OF CONSTRUCTION.—Nothing in sub-
16 section (a) should be interpreted to supersede or preempt
17 other applicable Federal or State law including, but not
18 limited to, section 1128B of the Social Security Act (42
19 U.S.C. 1320a–7b).

20 “(e) DEFINITIONS.—In this section—

21 “(1) the terms ‘applicable beneficiary’ and ‘ap-
22 plicable drug’ have the meanings given those terms
23 in section 1860D–14A(g) of the Social Security Act
24 (42 U.S.C. 1395w–114a(g));

1 **Subtitle K—Substance Abuse**
2 **Prevention**

3 **SEC. 8201. SHORT TITLE.**

4 This subtitle may be cited as the “Substance Abuse
5 Prevention Act of 2018”.

6 **SEC. 8202. REAUTHORIZATION OF THE OFFICE OF NA-**
7 **TIONAL DRUG CONTROL POLICY.**

8 (a) OFFICE OF NATIONAL DRUG CONTROL POLICY
9 REAUTHORIZATION ACT OF 1998.—

10 (1) IN GENERAL.—The Office of National Drug
11 Control Policy Reauthorization Act of 1998 (21
12 U.S.C. 1701 et seq.), as in effect on September 29,
13 2003, and as amended by the laws described in
14 paragraph (2), is revived and restored.

15 (2) LAWS DESCRIBED.—The laws described in
16 this paragraph are:

17 (A) The Office of National Drug Control
18 Policy Reauthorization Act of 2006 (Public
19 Law 109–469; 120 Stat. 3502).

20 (B) The Presidential Appointment Effi-
21 ciency and Streamlining Act of 2011 (Public
22 Law 112–166; 126 Stat. 1283).

23 (b) REAUTHORIZATION.—

24 (1) IN GENERAL.—Section 714 of the Office of
25 National Drug Control Policy Reauthorization Act of

1 1998 (21 U.S.C. 1711) is amended by striking
2 “such sums as may be necessary for each of fiscal
3 years 2006 through 2010” and inserting
4 “\$18,400,000 for each of fiscal years 2018 through
5 2023”.

6 (2) REPEAL OF TERMINATION.—The Office of
7 National Drug Control Policy Reauthorization Act of
8 1998 (21 U.S.C. 1701 et seq.) is amended by strik-
9 ing section 715 (21 U.S.C. 1712).

10 **SEC. 8203. REAUTHORIZATION OF THE DRUG-FREE COMMU-**
11 **NITIES PROGRAM.**

12 (a) REVIVAL OF NATIONAL NARCOTICS LEADERSHIP
13 ACT OF 1988.—

14 (1) IN GENERAL.—Chapter 2 of the National
15 Narcotics Leadership Act of 1988 (21 U.S.C. 1521
16 et seq.), except for subchapter II (21 U.S.C. 1541
17 et seq.), as in effect on September 29, 1997, and as
18 amended by the laws described in paragraph (2), is
19 revived and restored.

20 (2) LAWS DESCRIBED.—The laws described in
21 this paragraph are:

22 (A) Public Law 107–82 (115 Stat. 814).

23 (B) The Office of National Drug Control
24 Policy Reauthorization Act of 2006 (Public

1 Law 109–469: 120 Stat. 3502), as amended by
2 paragraph (4).

3 (3) AMENDMENT TO TERMINATION PROVI-
4 SION.—Section 1009 of the National Narcotics
5 Leadership Act of 1988 (21 U.S.C. 1056) is amend-
6 ed by inserting “and sections 1021 through 1035”
7 after “section 1007”.

8 (4) TECHNICAL CORRECTION.—

9 (A) IN GENERAL.—Title VIII of the Office
10 of National Drug Control Policy Reauthoriza-
11 tion Act of 2006 (Public Law 109–469; 120
12 Stat. 3535) is amended by striking “Drug-Free
13 Communities Act of 1997” each place it ap-
14 pears and inserting “National Narcotics Lead-
15 ership Act of 1988”.

16 (B) EFFECTIVE DATE.—The amendments
17 made by subparagraph (A) shall take effect as
18 though enacted as part of the Office of Na-
19 tional Drug Control Policy Reauthorization Act
20 of 2006 (Public Law 109–469; 120 Stat.
21 3502).

22 (b) AMENDMENT TO NATIONAL NARCOTICS LEADER-
23 SHIP ACT OF 1988.—Chapter 2 of subtitle A of title I
24 of the National Narcotics Leadership Act of 1988 (21
25 U.S.C. 1521 et seq.) is amended—

1 (1) in section 1022 (21 U.S.C. 1522), by strik-
2 ing “substance abuse” each place it appears and in-
3 serting “substance use and misuse”;

4 (2) in section 1023 (21 U.S.C. 1523), by strik-
5 ing paragraph (9) and inserting the following:

6 “(9) SUBSTANCE USE AND MISUSE.—The term
7 ‘substance use and misuse’ means—

8 “(A) the illegal use or misuse of drugs, in-
9 cluding substances for which a listing is effect
10 under any of schedules I through V under sec-
11 tion 202 of the Controlled Substances Act (21
12 U.S.C. 812);

13 “(B) the misuse of inhalants or over-the-
14 counter drugs; or

15 “(C) the use of alcohol, tobacco, or other
16 related product as such use is prohibited by
17 State or local law.”;

18 (3) in section 1024 (21 U.S.C. 1524), by strik-
19 ing subsections (a) and (b) and inserting the fol-
20 lowing:

21 “(a) IN GENERAL.—There is authorized to be appro-
22 priated to the Office of National Drug Control Policy to
23 carry out this chapter \$99,000,000 for each of fiscal years
24 2018 through 2023.

1 “(b) ADMINISTRATIVE COSTS.—Not more than 8
2 percent of the funds appropriated to carry out this chapter
3 may be used by the Office of National Drug Control Policy
4 to pay administrative costs associated with the responsibil-
5 ities of the Office under this chapter.”;

6 (4) in subchapter I (21 U.S.C. 1531 et seq.)—

7 (A) by striking “substance abuse” each
8 place it appears and inserting “substance use
9 and misuse”; and

10 (B) in section 1032(b)(1)(A) (21 U.S.C.
11 1532(b)(1)(A)), by striking clause (iii) and in-
12 serting the following:

13 “(iii) RENEWAL GRANTS.—Subject to
14 clause (iv), the Administrator may award a
15 renewal grant to a grant recipient under
16 this subparagraph for each fiscal year of
17 the 4-fiscal-year period following the first
18 fiscal year for which the initial additional
19 grant is awarded in an amount not to ex-
20 ceed the following:

21 “(I) For the first and second fis-
22 cal years of the 4-fiscal-year period,
23 the amount of the non-Federal funds,
24 including in-kind contributions, raised
25 by the coalition for the applicable fis-

1 cal year is not less than 125 percent
2 of the amount awarded.

3 “(II) For the third and fourth
4 fiscal years of the 4-fiscal-year period,
5 the amount of the non-Federal funds,
6 including in-kind contributions, raised
7 by the coalition for the applicable fis-
8 cal year is not less than 150 percent
9 of the amount awarded.”; and

10 (5) by striking subchapter II (21 U.S.C. 1541
11 et seq.).

12 **SEC. 8204. REAUTHORIZATION OF THE NATIONAL COMMU-
13 NITY ANTI-DRUG COALITION INSTITUTE.**

14 Section 4 of Public Law 107–82 (21 U.S.C. 1521
15 note) is amended to read as follows:

16 **“SEC. 4. AUTHORIZATION FOR NATIONAL COMMUNITY
17 ANTIDRUG COALITION INSTITUTE.**

18 “(a) IN GENERAL.—The Director shall, using
19 amounts authorized to be appropriated by subsection (d),
20 make a competitive grant to provide for the continuation
21 of the National Community Anti-drug Coalition Institute.

22 “(b) ELIGIBLE ORGANIZATIONS.—An organization
23 eligible for the grant under subsection (a) is any national
24 nonprofit organization that represents, provides technical
25 assistance and training to, and has special expertise and

1 broad, national-level experience in community antidrug
2 coalitions under this subchapter.

3 “(c) USE OF GRANT AMOUNT.—The organization
4 that receives the grant under subsection (a) shall continue
5 a National Community Anti-Drug Coalition Institute to—

6 “(1) provide education, training, and technical
7 assistance for coalition leaders and community
8 teams, with emphasis on the development of coali-
9 tions serving economically disadvantaged areas;

10 “(2) develop and disseminate evaluation tools,
11 mechanisms, and measures to better assess and doc-
12 ument coalition performance measures and out-
13 comes; and

14 “(3) bridge the gap between research and prac-
15 tice by translating knowledge from research into
16 practical information.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—The
18 Director shall, using amounts authorized to be appro-
19 priated by section 1032 of the National Narcotics Leader-
20 ship Act of 1988 (15 U.S.C. 1532), make a grant of \$2
21 million under subsection (a), for each of the fiscal years
22 2018 through 2023.”.

1 **SEC. 8205. REAUTHORIZATION OF THE HIGH-INTENSITY**
2 **DRUG TRAFFICKING AREA PROGRAM.**

3 Section 707 of the Office of National Drug Control
4 Policy Reauthorization Act of 1998 (21 U.S.C. 1706) is
5 amended—

6 (1) in subsection (f), by striking “no Federal”
7 and all that follows through “programs.” and insert-
8 ing the following: “not more than a total of 5 per-
9 cent of Federal funds appropriated for the Program
10 are expended for substance use disorder treatment
11 programs and drug prevention programs.”;

12 (2) in subsection (p)—

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

15 (B) in paragraph (5), by striking the pe-
16 riod at the end and inserting “; and”; and

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

18 “(6) \$280,000,000 for each of fiscal years 2018
19 through 2023.”; and

20 (3) in subsection (q)—

21 (A) by striking paragraph (2) and insert-
22 ing the following:

23 “(2) **REQUIRED USES.**—The funds used under
24 paragraph (1) shall be used to ensure the safety of
25 neighborhoods and the protection of communities,
26 including the prevention of the intimidation of wit-

1 nesses of illegal drug distribution and related activi-
2 ties and the establishment of, or support for, pro-
3 grams that provide protection or assistance to wit-
4 nesses in court proceedings.”; and

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

6 “(3) BEST PRACTICE MODELS.—The Director
7 shall work with HIDTAs to develop and maintain
8 best practice models to assist State, local, and Tribal
9 governments in addressing witness safety, relocation,
10 financial and housing assistance, or any other serv-
11 ices related to witness protection or assistance in
12 cases of illegal drug distribution and related activi-
13 ties. The Director shall ensure dissemination of the
14 best practice models to each HIDTA.”.

15 **SEC. 8206. REAUTHORIZATION OF DRUG COURT PROGRAM.**

16 Section 1001(a)(25)(A) of title I of the Omnibus
17 Crime Control and Safe Streets Act of 1968 (34 U.S.C.
18 10261(a)(25)(A)) is amended by striking “Except as pro-
19 vided” and all that follows and inserting the following:
20 “Except as provided in subparagraph (C), there is author-
21 ized to be appropriated to carry out part EE \$75,000,000
22 for each of fiscal years 2018 through 2023.”.

1 **SEC. 8207. DRUG COURT TRAINING AND TECHNICAL AS-**
2 **SISTANCE.**

3 Section 705 of the Office of National Drug Control
4 Policy Reauthorization Act of 1998 (21 U.S.C. 1704) is
5 amended by adding at the end the following:

6 “(e) DRUG COURT TRAINING AND TECHNICAL AS-
7 SISTANCE PROGRAM.—

8 “(1) GRANTS AUTHORIZED.—The Director may
9 make a grant to a nonprofit organization for the
10 purpose of providing training and technical assist-
11 ance to drug courts.

12 “(2) AUTHORIZATION OF APPROPRIATIONS.—
13 There is authorized to be appropriated to carry out
14 this subsection \$2,000,000 for each of fiscal years
15 2018 through 2023.”.

16 **SEC. 8208. DRUG OVERDOSE RESPONSE STRATEGY.**

17 Section 707 of the Office of National Drug Control
18 Policy Reauthorization Act of 1998 (21 U.S.C. 1706) is
19 amended by adding at the end the following:

20 “(r) DRUG OVERDOSE RESPONSE STRATEGY IMPLE-
21 MENTATION.—The Director may use funds appropriated
22 to carry out this section to implement a drug overdose re-
23 sponse strategy in high intensity drug trafficking areas on
24 a nationwide basis by—

25 “(1) coordinating multi-disciplinary efforts to
26 prevent, reduce, and respond to drug overdoses, in-

1 including the uniform reporting of fatal and non-fatal
2 overdoses to public health and safety officials;

3 “(2) increasing data sharing among public safe-
4 ty and public health officials concerning drug-related
5 abuse trends, including new psychoactive substances,
6 and related crime; and

7 “(3) enabling collaborative deployment of pre-
8 vention, intervention, and enforcement resources to
9 address substance use addiction and narcotics traf-
10 ficking.”.

11 **SEC. 8209. PROTECTING LAW ENFORCEMENT OFFICERS**
12 **FROM ACCIDENTAL EXPOSURE.**

13 Section 707 of the Office of National Drug Control
14 Policy Reauthorization Act of 1998 (21 U.S.C. 1706), as
15 amended by section 8208, is amended by adding at the
16 end the following:

17 “(s) SUPPLEMENTAL GRANTS.—The Director is au-
18 thorized to use not more than \$10,000,000 of the amounts
19 otherwise appropriated to carry out this section to provide
20 supplemental competitive grants to high intensity drug
21 trafficking areas that have experienced high seizures of
22 fentanyl and new psychoactive substances for the purposes
23 of—

24 “(1) purchasing portable equipment to test for
25 fentanyl and other substances;

1 “(2) training law enforcement officers and
2 other first responders on best practices for handling
3 fentanyl and other substances; and

4 “(3) purchasing protective equipment, including
5 overdose reversal drugs.”.

6 **SEC. 8210. COPS ANTI-METH PROGRAM.**

7 Section 1701 of title I of the Omnibus Crime Control
8 and Safe Streets Act of 1968 (34 U.S.C. 10381) is amend-
9 ed—

10 (1) by redesignating subsection (k) as sub-
11 section (l); and

12 (2) by inserting after subsection (j) the fol-
13 lowing:

14 “(k) COPS ANTI-METH PROGRAM.—The Attorney
15 General shall use amounts otherwise appropriated to carry
16 out this section to make competitive grants, in amounts
17 of not less than \$1,000,000 for a fiscal year, to State law
18 enforcement agencies with high seizures of precursor
19 chemicals, finished methamphetamine, laboratories, and
20 laboratory dump seizures for the purpose of locating or
21 investigating illicit activities, such as precursor diversion,
22 laboratories, or methamphetamine traffickers.”.

1 **SEC. 8211. COPS ANTI-HEROIN TASK FORCE PROGRAM.**

2 Section 1701 of title I of the Omnibus Crime Control
3 and Safe Streets Act of 1968 (34 U.S.C. 10381) is amend-
4 ed—

5 (1) by redesignating subsection (l), as so redес-
6 igned by section 8210, as subsection (m); and

7 (2) by inserting after subsection (k), as added
8 by section 8210, the following:

9 “(l) COPS ANTI-HEROIN TASK FORCE PROGRAM.—
10 The Attorney General shall use amounts otherwise appro-
11 priated to carry out this section, or other amounts as ap-
12 propriated, to make competitive grants to State law en-
13 forcement agencies in States with high per capita rates
14 of primary treatment admissions, for the purpose of locat-
15 ing or investigating illicit activities, through Statewide col-
16 laboration, relating to the distribution of heroin, fentanyl,
17 or carfentanil or relating to the unlawful distribution of
18 prescription opioids.”.

19 **SEC. 8212. COMPREHENSIVE ADDICTION AND RECOVERY**
20 **ACT EDUCATION AND AWARENESS.**

21 Title VII of the Comprehensive Addiction and Recov-
22 ery Act of 2016 (Public Law 114–198; 130 Stat. 735)
23 is amended by adding at the end the following:

1 **“SEC. 709. SERVICES FOR FAMILIES AND PATIENTS IN CRI-**
2 **SIS.**

3 “(a) IN GENERAL.—The Secretary of Health and
4 Human Services may make grants to entities that focus
5 on addiction and substance use disorders and specialize
6 in family and patient services, advocacy for patients and
7 families, and educational information.

8 “(b) ALLOWABLE USES.—A grant awarded under
9 this section may be used for nonprofit national, State, or
10 local organizations that engage in the following activities:

11 “(1) Expansion of resource center services with
12 professional, clinical staff that provide, for families
13 and individuals impacted by a substance use dis-
14 order, support, access to treatment resources, brief
15 assessments, medication and overdose prevention
16 education, compassionate listening services, recovery
17 support or peer specialists, bereavement and grief
18 support, and case management.

19 “(2) Continued development of health informa-
20 tion technology systems that leverage new and up-
21 coming technology and techniques for prevention,
22 intervention, and filling resource gaps in commu-
23 nities that are underserved.

24 “(3) Enhancement and operation of treatment
25 and recovery resources, easy-to-read scientific and
26 evidence-based education on addiction and substance

1 use disorders, and other informational tools for fam-
2 ilies and individuals impacted by a substance use
3 disorder and community stakeholders, such as law
4 enforcement agencies.

5 “(4) Provision of training and technical assist-
6 ance to State and local governments, law enforce-
7 ment agencies, health care systems, research institu-
8 tions, and other stakeholders.

9 “(5) Expanding upon and implementing edu-
10 cational information using evidence-based informa-
11 tion on substance use disorders.

12 “(6) Expansion of training of community stake-
13 holders, law enforcement officers, and families
14 across a broad-range of addiction, health, and re-
15 lated topics on substance use disorders, local issues
16 and community-specific issues related to the drug
17 epidemic.

18 “(7) Program evaluation.”.

19 **SEC. 8213. REIMBURSEMENT OF SUBSTANCE USE DIS-**
20 **ORDER TREATMENT PROFESSIONALS.**

21 Not later than January 1, 2020, the Comptroller
22 General of the United States shall submit to Congress a
23 report examining how substance use disorder services are
24 reimbursed.

1 **SEC. 8214. SOBRIETY TREATMENT AND RECOVERY TEAMS**

2 **(START).**

3 Title V of the Public Health Service Act (42 U.S.C.
4 290dd et seq.) is amended by adding at the end the fol-
5 lowing:

6 **“SEC. 550. SOBRIETY TREATMENT AND RECOVERY TEAMS.**

7 “(a) IN GENERAL.—The Secretary may make grants
8 to States, units of local government, or tribal governments
9 to establish or expand Sobriety Treatment And Recovery
10 Team (referred to in this section as ‘START’) or other
11 similar programs to determine the effectiveness of pairing
12 social workers or mentors with families that are struggling
13 with a substance use disorder and child abuse or neglect
14 in order to help provide peer support, intensive treatment,
15 and child welfare services to such families.

16 “(b) ALLOWABLE USES.—A grant awarded under
17 this section may be used for one or more of the following
18 activities:

19 “(1) Training eligible staff, including social
20 workers, social services coordinators, child welfare
21 specialists, substance use disorder treatment profes-
22 sionals, and mentors.

23 “(2) Expanding access to substance use dis-
24 order treatment services and drug testing.

25 “(3) Enhancing data sharing with law enforce-
26 ment agencies, child welfare agencies, substance use

1 disorder treatment providers, judges, and court per-
2 sonnel.

3 “(4) Program evaluation and technical assist-
4 ance.

5 “(c) PROGRAM REQUIREMENTS.—A State, unit of
6 local government, or tribal government receiving a grant
7 under this section shall—

8 “(1) serve only families for which—

9 “(A) there is an open record with the child
10 welfare agency; and

11 “(B) substance use disorder was a reason
12 for the record or finding described in paragraph
13 (1); and

14 “(2) coordinate any grants awarded under this
15 section with any grant awarded under section 437(f)
16 of the Social Security Act focused on improving out-
17 comes for children affected by substance abuse.

18 “(d) TECHNICAL ASSISTANCE.—The Secretary may
19 reserve not more than 5 percent of funds provided under
20 this section to provide technical assistance on the estab-
21 lishment or expansion of programs funded under this sec-
22 tion from the National Center on Substance Abuse and
23 Child Welfare.”.

1 **SEC. 8215. PROVIDER EDUCATION.**

2 Not later than 60 days after the date of enactment
3 of this Act, the Attorney General, in consultation with the
4 Secretary of Health and Human Services, shall complete
5 the plan related to medical registration coordination re-
6 quired by Senate Report 114–239, which accompanied the
7 Veterans Care Financial Protection Act of 2017 (Public
8 Law 115–131; 132 Stat. 334).

9 **SEC. 8216. DEFINITIONS.**

10 Section 702 of the Office of National Drug Control
11 Policy Reauthorization Act of 1998 (21 U.S.C. 1701) is
12 amended—

13 (1) by striking paragraphs (5), (12), and (13);

14 (2) by redesignating paragraph (11) as para-
15 graph (17);

16 (3) by redesignating paragraphs (9) and (10)
17 as paragraphs (14) and (15), respectively;

18 (4) by redesignating paragraphs (6), (7), and
19 (8) as paragraphs (10), (11), and (12), respectively;

20 (5) by redesignating paragraphs (1), (2), (3),
21 and (4) as paragraphs (3), (4), (5), and (6), respec-
22 tively;

23 (6) by inserting before paragraph (3), as so re-
24 designated, the following:

1 “(1) AGENCY.—The term ‘agency’ has the
2 meaning given the term ‘executive agency’ in section
3 102 of title 31, United States Code.

4 “(2) APPROPRIATE CONGRESSIONAL COMMIT-
5 TEES.—

6 “(A) IN GENERAL.—The term ‘appropriate
7 congressional committees’ means—

8 “(i) the Committee on the Judiciary,
9 the Committee on Appropriations, and the
10 Committee on Health, Education, Labor,
11 and Pensions of the Senate; and

12 “(ii) the Committee on Oversight and
13 Government Reform, the Committee on the
14 Judiciary, the Committee on Energy and
15 Commerce, and the Committee on Appro-
16 priations of the House of Representatives.

17 “(B) SUBMISSION TO CONGRESS.—Any
18 submission to Congress shall mean submission
19 to the appropriate congressional committees.”;

20 (7) by amending paragraph (3), as so redesign-
21 nated, to read as follows:

22 “(3) DEMAND REDUCTION.—The term ‘demand
23 reduction’ means any activity conducted by a Na-
24 tional Drug Control Program Agency, other than an
25 enforcement activity, that is intended to reduce or

1 prevent the use of drugs or support, expand, or pro-
2 vide treatment and recovery efforts, including—

3 “(A) education about the dangers of illicit
4 drug use;

5 “(B) services, programs, or strategies to
6 prevent substance use disorder, including evi-
7 dence-based education campaigns, community-
8 based prevention programs, collection and dis-
9 posal of unused prescription drugs, and services
10 to at-risk populations to prevent or delay initial
11 use of an illicit drug;

12 “(C) substance use disorder treatment;

13 “(D) support for long-term recovery from
14 substance use disorders;

15 “(E) drug-free workplace programs;

16 “(F) drug testing, including the testing of
17 employees;

18 “(G) interventions for illicit drug use and
19 dependence;

20 “(H) expanding availability of access to
21 health care services for the treatment of sub-
22 stance use disorders;

23 “(I) international drug control coordina-
24 tion and cooperation with respect to activities
25 described in this paragraph;

1 “(J) pre- and post-arrest criminal justice
2 interventions such as diversion programs, drug
3 courts, and the provision of evidence-based
4 treatment to individuals with substance use dis-
5 orders who are arrested or under some form of
6 criminal justice supervision, including medica-
7 tion assisted treatment;

8 “(K) other coordinated and joint initiatives
9 among Federal, State, local, and Tribal agen-
10 cies to promote comprehensive drug control
11 strategies designed to reduce the demand for,
12 and the availability of, illegal drugs;

13 “(L) international illicit drug use edu-
14 cation, prevention, treatment, recovery, re-
15 search, rehabilitation activities, and interven-
16 tions for illicit drug use and dependence; and

17 “(M) research related to illicit drug use
18 and any of the activities described in this para-
19 graph.”;

20 (8) by inserting after paragraph (6), as so re-
21 designated, the following:

22 “(7) EMERGING DRUG THREAT.—The term
23 ‘emerging drug threat’ means the occurrence of a
24 new and growing trend in the use of an illicit drug

1 or class of drugs, including rapid expansion in the
2 supply of or demand for such drug.

3 “(8) ILLICIT DRUG USE; ILLICIT DRUGS; ILLE-
4 GAL DRUGS.—The terms ‘illicit drug use’, ‘illicit
5 drugs’, and ‘illegal drugs’ include the illegal or illicit
6 use of prescription drugs.

7 “(9) LAW ENFORCEMENT.—The term ‘law en-
8 forcement’ or ‘drug law enforcement’ means all ef-
9 forts by a Federal, State, local, or Tribal govern-
10 ment agency to enforce the drug laws of the United
11 States or any State, including investigation, arrest,
12 prosecution, and incarceration or other punishments
13 or penalties.”;

14 (9) by amending paragraph (11), as so redesign-
15 nated, to read as follows:

16 “(11) NATIONAL DRUG CONTROL PROGRAM
17 AGENCY.—The term ‘National Drug Control Pro-
18 gram Agency’ means any agency (or bureau, office,
19 independent agency, board, division, commission,
20 subdivision, unit, or other component thereof) that is
21 responsible for implementing any aspect of the Na-
22 tional Drug Control Strategy, including any agency
23 that receives Federal funds to implement any aspect
24 of the National Drug Control Strategy, but does not
25 include any agency that receives funds for drug con-

1 trol activity solely under the National Intelligence
2 Program or the Joint Military Intelligence Pro-
3 gram.”;

4 (10) in paragraph (12), as so redesignated—

5 (A) by inserting “or ‘Strategy’” before
6 “means”; and

7 (B) by inserting “, including any report,
8 plan, or strategy required to be incorporated
9 into or issued concurrently with such strategy”
10 before the period at the end;

11 (11) by inserting after paragraph (12), as so
12 redesignated, the following:

13 “(13) NONPROFIT ORGANIZATION.—The term
14 ‘nonprofit organization’ means an organization that
15 is described in section 501(c)(3) of the Internal Rev-
16 enue Code of 1986 and exempt from tax under sec-
17 tion 501(a) of such Code.”;

18 (12) in paragraph (14), as so redesignated, by
19 striking “Unless the context clearly indicates other-
20 wise, the” and inserting “The”;

21 (13) by inserting after paragraph (15), as so
22 redesignated, the following:

23 “(16) SUBSTANCE USE DISORDER TREAT-
24 MENT.—The term ‘substance use disorder treat-
25 ment’ means an evidence-based, professionally di-

1 rected, deliberate, and planned regimen including
2 evaluation, observation, medical monitoring, and re-
3 habilitative services and interventions such as
4 pharmacotherapy, behavioral therapy, and individual
5 and group counseling, on an inpatient or outpatient
6 basis, to help patients with substance use disorder
7 reach recovery.”; and

8 (14) in paragraph (17), as so redesignated—

9 (A) by redesignating subparagraphs (B),
10 (C), (D), and (E), as subparagraphs (C), (D),
11 (E), and (F), respectively;

12 (B) by inserting after subparagraph (A)
13 the following:

14 “(B) domestic law enforcement;”;

15 (C) in subparagraph (E), as so redesign-
16 ated, by striking “and” at the end;

17 (D) in subparagraph (F), as so redesign-
18 ated, by striking the period at the end and in-
19 serting a semicolon; and

20 (E) by adding at the end the following:

21 “(G) activities to prevent the diversion of
22 drugs for their illicit use; and

23 “(H) research related to any of the activi-
24 ties described in this paragraph.”.

1 **SEC. 8217. AMENDMENTS TO ADMINISTRATION OF THE OF-**
2 **FICE.**

3 (a) RESPONSIBILITIES OF OFFICE.—Section 703(a)
4 of the Office of National Drug Control Policy Reauthor-
5 ization Act of 1998 (21 U.S.C. 1702(a)) is amended—

6 (1) by striking paragraph (1) and inserting the
7 following:

8 “(1) lead the national drug control effort, in-
9 cluding coordinating with the National Drug Control
10 Program Agencies;”;

11 (2) in paragraph (2), by inserting before the
12 semicolon the following: “, including the National
13 Drug Control Strategy”;

14 (3) in paragraph (3), by striking “and” at the
15 end; and

16 (4) by striking paragraph (4) and all that fol-
17 lows through “the National Academy of Sciences.”
18 and inserting the following:

19 “(4) evaluate the effectiveness of national drug
20 control policy efforts, including the National Drug
21 Control Program Agencies’ program, by developing
22 and applying specific goals and performance meas-
23 urements and monitoring the agencies’ program-level
24 spending;

25 “(5) identify and respond to emerging drug
26 threats related to illicit drug use;

1 “(6) administer the Drug-Free Communities
2 Program, the High-Intensity Drug Trafficking Areas
3 Program, and other grant programs directly author-
4 ized to be administered by the Office in furtherance
5 of the National Drug Control Strategy; and

6 “(7) facilitate broad-scale information sharing
7 and data standardization among Federal, State, and
8 local entities to support the national drug control ef-
9 forts.”.

10 (b) ETHICS GUIDELINES.—Section 703(d) of the Of-
11 fice of National Drug Control Policy Reauthorization Act
12 of 1998 (21 U.S.C. 1702(d)) is amended by adding at the
13 end the following:

14 “(4) ETHICS GUIDELINES.—The Director shall
15 establish written guidelines setting forth the criteria
16 to be used in determining whether a gift or donation
17 should be declined under this subsection because the
18 acceptance of the gift or donation would—

19 “(A) reflect unfavorably upon the ability of
20 the Director or the Office, or any employee of
21 the Office, to carry out responsibilities or offi-
22 cial duties under this chapter in a fair and ob-
23 jective manner; or

24 “(B) compromise the integrity or the ap-
25 pearance of integrity of programs or services

1 provided under this chapter or of any official
2 involved in those programs or services.

3 “(5) REGISTRY OF GIFTS.—The Director shall
4 maintain a list of—

5 “(A) the source and amount of each gift or
6 donation accepted by the Office; and

7 “(B) the source and amount of each gift or
8 donation accepted by a contractor to be used in
9 its performance of a contract for the Office.

10 “(6) REPORT TO CONGRESS.—The Director
11 shall include in the annual assessment under section
12 706(g) a copy of the registry maintained under
13 paragraph (5).”.

14 (c) APPOINTMENT OF DIRECTOR AND DEPUTY DI-
15 RECTOR.—Section 704(a) of the Office of National Drug
16 Control Policy Reauthorization Act of 1998 (21 U.S.C.
17 1703(a)) is amended—

18 (1) in paragraph (1), by striking subparagraphs
19 (A), (B), and (C), and inserting the following:

20 “(A) DIRECTOR.—

21 “(i) IN GENERAL.—There shall be at
22 the head of the Office a Director who shall
23 hold the same rank and status as the head
24 of an executive department listed in section
25 101 of title 5, United States Code.

1 “(ii) APPOINTMENT.—The Director
2 shall be appointed by the President, by and
3 with the advice and consent of the Senate,
4 and shall serve at the pleasure of the
5 President.

6 “(B) DEPUTY DIRECTOR.—There shall be
7 a Deputy Director who shall report directly to
8 the Director, and who shall be appointed by the
9 President, and shall serve at the pleasure of the
10 President.

11 “(C) COORDINATORS.—The following coor-
12 dinators shall be appointed by the Director:

13 “(i) Performance Budget Coordinator,
14 as described in section 704(c)(4).

15 “(ii) Interdiction Coordinator, as de-
16 scribed in section 711.

17 “(iii) Emerging and Continuing
18 Threats Coordinator, as described in sec-
19 tion 709.

20 “(iv) State, Local, and Tribal Affairs
21 Coordinator, to carry out the activities de-
22 scribed in section 704(j).

23 “(v) Demand Reduction Coordinator,
24 as described in subparagraph (D).

1 “(D) DEMAND REDUCTION COORDI-
2 NATOR.—The Director shall designate or ap-
3 point a United States Demand Reduction Coor-
4 dinator to be responsible for the activities de-
5 scribed in section 702(3). The Director shall de-
6 termine whether the coordinator position is a
7 noncareer appointee in the Senior Executive
8 Service or a career appointee in a position at
9 level 15 of the General Schedule (or equiva-
10 lent).”;

11 (2) in paragraph (5), by striking “such official”
12 and inserting “such officer or employee”; and

13 (3) by adding at the end the following:

14 “(6) PROHIBITION ON THE USE OF FUNDS FOR
15 BALLOT INITIATIVES.—No funds authorized under
16 this title may be obligated for the purpose of ex-
17 pressly advocating the passage or defeat of a State
18 or local ballot initiative.”.

19 (d) CONSULTATION.—Section 704(b) of the Office of
20 National Drug Control Policy Reauthorization Act of 1998
21 (21 U.S.C. 1703(b)) is amended—

22 (1) in paragraph (19), by striking “; and” and
23 inserting a semicolon;

24 (2) in paragraph (20), by striking the period at
25 the end and inserting “; and”; and

1 (3) by adding at the end the following:

2 “(21) in order to formulate the national drug
3 control policies, goals, objectives, and priorities—

4 “(A) shall consult with and assist—

5 “(i) State and local governments;

6 “(ii) National Drug Control Program
7 Agencies;

8 “(iii) each committee, working group,
9 council, or other entity established under
10 this chapter, as appropriate;

11 “(iv) the public;

12 “(v) appropriate congressional com-
13 mittees; and

14 “(vi) any other person in the discre-
15 tion of the Director; and

16 “(B) may—

17 “(i) establish advisory councils;

18 “(ii) acquire data from agencies; and

19 “(iii) request data from any other en-
20 tity.”.

21 (e) NATIONAL DRUG CONTROL PROGRAM BUDG-
22 ET.—Section 704(c) of the Office of National Drug Con-
23 trol Policy Reauthorization Act of 1998 (21 U.S.C.
24 1703(c)) is amended—

25 (1) in paragraph (2)—

1 (A) in subparagraph (A), by striking
2 “paragraph (1)(C);” and inserting the fol-
3 lowing: “paragraph (1)(C) and include—

4 “(i) the funding level for each Na-
5 tional Drug Control Program agency; and

6 “(ii) alternative funding structures
7 that could improve progress on achieving
8 the goals fo the National Drug Control
9 Strategy; and”;

10 (B) in subparagraph (B), strike “the
11 President; and” and inserting “the President
12 and Congress.”; and

13 (C) by striking subparagraph (C);

14 (2) in paragraph (3)(E), by striking clause (ii)
15 and inserting the following:

16 “(ii) CERTIFICATION.—The Director
17 shall—

18 “(I) review each budget submis-
19 sion submitted under subparagraph
20 (A);

21 “(II) based on the review under
22 clause (i), make a determination as to
23 whether the budget submission of a
24 National Drug Control Program agen-
25 cy includes the funding levels and ini-

1 tiatives described in subparagraph
2 (B); and

3 “(III) submit to the appropriate
4 congressional committees—

5 “(aa) a written statement
6 that either—

7 “(AA) certifies that the
8 budget submission includes
9 sufficient funding; or

10 “(BB) decertifies the
11 budget submission as not in-
12 cluding sufficient funding;

13 “(bb) a copy of the descrip-
14 tion made under subparagraph
15 (B); and

16 “(cc) the budget rec-
17 ommendations made under sub-
18 section (b)(8).”; and

19 (3) by adding at the end the following:

20 “(5) PERFORMANCE-BUDGET COORDINATOR.—

21 “(A) DESIGNATION.—The Director shall
22 designate or appoint a United States Perform-
23 ance-Budget Coordinator to—

24 “(i) ensure the Director has sufficient
25 information necessary to analyze the per-

1 performance of each National Drug Control
2 Program Agency, the impact Federal fund-
3 ing has had on the goals in the Strategy,
4 and the likely contributions to the goals of
5 the Strategy based on funding levels of
6 each National Drug Control Program
7 Agency, to make an independent assess-
8 ment of the budget request of each agency
9 under this subsection;

10 “(ii) advise the Director on agency
11 budgets, performance measures and tar-
12 gets, and additional data and research
13 needed to make informed policy decisions
14 under this section and section 706; and

15 “(iii) other duties as may be deter-
16 mined by the Director with respect to
17 measuring or assessing performance or
18 agency budgets.

19 “(B) DETERMINATION OF POSITION.—The
20 Director shall determine whether the coordi-
21 nator position is a noncareer appointee in the
22 Senior Executive Service or a career appointee
23 in a position at level 15 of the General Schedule
24 (or equivalent).

1 “(6) BUDGET ESTIMATE OR REQUEST SUBMIS-
2 SION TO CONGRESS.—Whenever the Director sub-
3 mits any budget estimate or request to the President
4 or the Office of Management and Budget, the Direc-
5 tor shall concurrently transmit to the appropriate
6 congressional committees a detailed statement of the
7 budgetary needs of the Office to execute its mission
8 based on the good-faith assessment of the Direc-
9 tor.”.

10 (f) POWERS AND RESPONSIBILITIES OF THE DIREC-
11 TOR.—Section 704 of the Office of National Drug Control
12 Policy Reauthorization Act of 1998 (21 U.S.C. 1703) is
13 amended—

14 (1) in subsection (d)(8)—

15 (A) in subparagraph (D), by striking
16 “and” at the end;

17 (B) in subparagraph (E)—

18 (i) in clause (i)—

19 (I) by striking “Congress, includ-
20 ing to the Committees on Appropria-
21 tions of the Senate and the House of
22 Representatives, the authorizing com-
23 mittees for the Office,” and inserting
24 “the appropriate congressional com-
25 mittees”; and

1 (II) by striking “or agencies”;

2 (ii) in clause (ii)—

3 (I) by striking “Congress” and
4 inserting “the appropriate congress-
5 sional committees”; and

6 (II) by adding “and” at the end;

7 and

8 (iii) by adding at the end the fol-
9 lowing:

10 “(iii) funds may only be used for—

11 “(I) expansion of demand reduc-
12 tion activities;

13 “(II) interdiction of illicit drugs
14 on the high seas, in United States ter-
15 ritorial waters, and at United States
16 ports of entry by officers and employ-
17 ees of National Drug Control Pro-
18 gram Agencies and domestic and for-
19 eign law enforcement officers;

20 “(III) accurate assessment and
21 monitoring of international drug pro-
22 duction and interdiction programs and
23 policies;

24 “(IV) activities to facilitate and
25 enhance the sharing of domestic and

1 foreign intelligence information among
2 National Drug Control Program
3 Agencies related to the production
4 and trafficking of drugs in the United
5 States and foreign countries; and

6 “(V) research related to any of
7 these activities.”;

8 (2) in subsection (e)(2)(A), by striking “Not-
9 withstanding any other provision of law” and insert-
10 ing “Subject to the availability of appropriations”;
11 and

12 (3) by adding at the end the following:

13 “(i) MODEL ACTS PROGRAM.—

14 “(1) IN GENERAL.—The Director shall provide
15 for or shall enter into an agreement with a nonprofit
16 organization to—

17 “(A) advise States on establishing laws
18 and policies to address illicit drug use issues;
19 and

20 “(B) revise such model State drug laws
21 and draft supplementary model State laws to
22 take into consideration changes in illicit drug
23 use issues in the State involved.

24 “(2) AUTHORIZATION OF APPROPRIATIONS.—

25 There is authorized to be appropriated to carry out

1 this subsection \$1,250,000 for each of fiscal years
2 2018 through 2023.

3 “(j) STATE, LOCAL, AND TRIBAL AFFAIRS COORDI-
4 NATOR.—The Director shall designate or appoint a United
5 States State, Local, and Tribal Affairs Coordinator to per-
6 form the duties of the Office outlined in this section and
7 706 and such other duties as may be determined by the
8 Director with respect to coordination of drug control ef-
9 forts between agencies and State, local, and Tribal govern-
10 ments. The Director shall determine whether the coordi-
11 nator position is a noncareer appointee in the Senior Exec-
12 utive Service or a career appointee in a position at level
13 15 of the General Schedule (or equivalent).

14 “(k) HARM REDUCTION PROGRAMS .—When devel-
15 oping the national drug control policy, any policy of the
16 Director, including policies relating to syringe exchange
17 programs for intravenous drug users, shall be based on
18 the best available medical and scientific evidence regarding
19 the effectiveness of such policy in promoting individual
20 health and preventing the spread of infectious disease and
21 the impact of such policy on drug addiction and use. In
22 making any policy relating to harm reduction programs,
23 the Director shall consult with the National Institutes of
24 Health and the National Academy of Sciences.”.

1 (g) ACCOUNTING OF FUNDS EXPENDED.—Section
2 705 of the Office of National Drug Control Policy Reau-
3 thorization Act of 1998 (21 U.S.C. 1704(d)), as amended
4 by section 8207 is further amended—

5 (1) by amending subsection (d) to read as fol-
6 lows:

7 “(d) ACCOUNTING OF FUNDS EXPENDED.—

8 “(1) IN GENERAL.—Not later than February 1
9 of each year, in accordance with guidance issued by
10 the Director, the head of each National Drug Con-
11 trol Program Agency shall submit to the Director a
12 detailed accounting of all funds expended by the
13 agency for National Drug Control Program activities
14 during the previous fiscal year and shall ensure such
15 detailed accounting is authenticated for the previous
16 fiscal year by the Inspector General for such agency
17 prior to the submission to the Director as frequently
18 as determined by the Inspector General but not less
19 frequently that every 3 years.

20 “(2) SUBMISSION TO CONGRESS.—The Director
21 shall submit to Congress not later than April 1 of
22 each year the information submitted to the Director
23 under paragraph (1).”; and

24 (2) by adding at the end the following:

1 “(f) TRACKING SYSTEM FOR FEDERALLY FUNDED
2 GRANT PROGRAMS.—

3 “(1) ESTABLISHMENT.—The Director, or the
4 head of an agency designated by the Director, in co-
5 ordination with the Secretary of Health and Human
6 Services, shall track federally-funded grant programs
7 to—

8 “(A) ensure the public has electronic ac-
9 cess to information identifying:

10 “(i) all drug control grants and perti-
11 nent identifying information for each
12 grant;

13 “(ii) any available performance
14 metrics, evaluations, or other information
15 indicating the effectiveness of such pro-
16 grams;

17 “(B) facilitate efforts to identify duplica-
18 tion, overlap, or gaps in funding to provide in-
19 creased accountability of Federally-funded
20 grants for substance use disorder treatment,
21 prevention, and enforcement; and

22 “(C) identify barriers in the grant applica-
23 tion process impediments that applicants cur-
24 rently have in the grant application process
25 with applicable agencies.

1 “(2) NATIONAL DRUG CONTROL AGENCIES.—
2 The head of each National Drug Control Program
3 Agency shall provide to the Director a complete list
4 of all drug control program grant programs and any
5 other relevant information for inclusion in the sys-
6 tem developed under paragraph (1) and annually up-
7 date such list.

8 “(3) UPDATING EXISTING SYSTEMS.—The Di-
9 rector may meet the requirements of this subsection
10 by utilizing, updating, or improving existing Federal
11 information systems to ensure they meet the require-
12 ments of this subsection.

13 “(4) REPORT.—Not later than 3 years after the
14 date of enactment of this subsection, the Comp-
15 troller General of the United States shall submit to
16 Congress a report examining implementation of this
17 subsection.”.

18 (h) TECHNICAL AND CONFORMING AMENDMENT.—
19 Section 1105 of the Office of National Drug Control Pol-
20 icy Reauthorization Act of 2006 (21 U.S.C. 1701 note)
21 is repealed.

1 **SEC. 8218. EMERGING THREATS COMMITTEE, PLAN, AND**
2 **MEDIA CAMPAIGN.**

3 (a) IN GENERAL.—Section 709 of the Office of Na-
4 tional Drug Control Policy Reauthorization Act of 1998
5 (21 U.S.C. 1708) is amended to read as follows:

6 **“SEC. 709. EMERGING THREATS COMMITTEE, PLAN, AND**
7 **MEDIA CAMPAIGN.**

8 “(a) EMERGING THREATS COORDINATOR.—The Di-
9 rector shall designate or appoint a United States Emerg-
10 ing and Continuing Threats Coordinator to perform the
11 duties of that position described in this section and such
12 other duties as may be determined by the Director. The
13 Director shall determine whether the coordinator position
14 is a noncareer appointee in the Senior Executive Service
15 or a career appointee in a position at level 15 of the Gen-
16 eral Schedule (or equivalent).

17 “(b) EMERGING THREATS COMMITTEE.—

18 “(1) IN GENERAL.—The Emerging Threats
19 Committee shall—

20 “(A) monitor evolving and emerging drug
21 threats in the United States;

22 “(B) identify and discuss evolving and
23 emerging drug trends in the United States
24 using the criteria required to be established
25 under paragraph (6);

1 “(C) assist in the formulation of and over-
2 see implementation of any plan described in
3 subsection (d);

4 “(D) provide such other advice to the Co-
5 ordinator and Director concerning strategy and
6 policies for emerging drug threats and trends as
7 the Committee determines to be appropriate;
8 and

9 “(E) disseminate and facilitate the sharing
10 with Federal, State, local, and Tribal officials
11 and other entities as determined by the Direc-
12 tor of pertinent information and data relating
13 to—

14 “(i) recent trends in drug supply and
15 demand;

16 “(ii) fatal and nonfatal overdoses;

17 “(iii) demand for and availability of
18 evidence-based substance use disorder
19 treatment, including the extent of the
20 unmet treatment need, and treatment ad-
21 mission trends;

22 “(iv) recent trends in drug interdic-
23 tion, supply, and demand from State, local,
24 and Tribal law enforcement agencies; and

1 “(v) other subject matter as deter-
2 mined necessary by the Director.

3 “(2) CHAIRPERSON.—The Director shall des-
4 ignate one of the members of the Emerging Threats
5 Committee to serve as Chairperson.

6 “(3) MEMBERS.—The Director shall appoint
7 other members of the Committee, which shall in-
8 clude—

9 “(A) representatives from National Drug
10 Control Program Agencies or other agencies;

11 “(B) representatives from State, local, and
12 Tribal governments; and

13 “(C) representatives from other entities as
14 designated by the Director.

15 “(4) MEETINGS.—The members of the Emerg-
16 ing Threats Committee shall meet, in person and not
17 through any delegate or representative, not less fre-
18 quently than once per calendar year, before June 1.
19 At the call of the Director or the Chairperson, the
20 Emerging Threats Committee may hold additional
21 meetings as the members may choose.

22 “(5) CONTRACT, AGREEMENT, AND OTHER AU-
23 THORITY.—The Director may award contracts, enter
24 into interagency agreements, manage individual
25 projects, and conduct other activities in support of

1 the identification of emerging drug threats and in
2 support of the development, implementation, and as-
3 sessment of any Emerging Threat Response Plan.

4 “(6) CRITERIA TO IDENTIFY EMERGING DRUG
5 THREATS.—Not later than 180 days after the date
6 on which the Committee first meets, the Committee
7 shall develop and recommend to the Director criteria
8 to be used to identify an emerging drug threat or
9 the termination of an emerging drug threat designa-
10 tion based on information gathered by the Com-
11 mittee, statistical data, and other evidence.

12 “(c) DESIGNATION.—

13 “(1) IN GENERAL.—The Director, in consulta-
14 tion with the Coordinator, the Committee, and the
15 head of each National Drug Control Program Agen-
16 cy, may designate an emerging drug threat in the
17 United States.

18 “(2) STANDARDS FOR DESIGNATION.—The Di-
19 rector, in consultation with the Coordinator, shall
20 promulgate and make publicly available standards by
21 which a designation under paragraph (1) and the
22 termination of such designation may be made. In de-
23 veloping such standards, the Director shall consider
24 the recommendations of the committee and other
25 criteria the Director considers to be appropriate.

1 “(3) PUBLIC STATEMENT REQUIRED.—The Di-
2 rector shall publish a public written statement on
3 the portal of the Office explaining the designation of
4 an emerging drug threat or the termination of such
5 designation and shall notify the appropriate congres-
6 sional committees of the availability of such state-
7 ment when a designation or termination of such des-
8 ignation has been made.

9 “(d) PLAN.—

10 “(1) PUBLIC AVAILABILITY OF PLAN.—Not
11 later than 90 days after making a designation under
12 subsection (c), the Director shall publish and make
13 publicly available an Emerging Threat Response
14 Plan and notify the President and the appropriate
15 congressional committees of such plan’s availability.

16 “(2) TIMING.—Concurrently with the annual
17 submissions under section 706(g), the Director shall
18 update the plan and report on implementation of the
19 plan, until the Director issues the public statement
20 required under subsection (c)(3) to terminate the
21 emerging drug threat designation.

22 “(3) CONTENTS OF AN EMERGING THREAT RE-
23 SPONSE PLAN.—The Director shall include in the
24 plan required under this subsection—

1 “(A) a comprehensive strategic assessment
2 of the emerging drug threat, including the cur-
3 rent availability of, demand for, and effective-
4 ness of evidence-based prevention, treatment,
5 and enforcement programs and efforts to re-
6 spond to the emerging drug threat;

7 “(B) comprehensive, research-based, short-
8 and long-term, quantifiable goals for addressing
9 the emerging drug threat, including for reduc-
10 ing the supply of the drug designated as the
11 emerging drug threat and for expanding the
12 availability and effectiveness of evidence-based
13 substance use disorder treatment and preven-
14 tion programs to reduce the demand for the
15 emerging drug threat;

16 “(C) performance measures pertaining to
17 the plan’s goals, including quantifiable and
18 measurable objectives and specific targets;

19 “(D) the level of funding needed to imple-
20 ment the plan, including whether funding is
21 available to be reprogrammed or transferred to
22 support implementation of the plan or whether
23 additional appropriations are necessary to im-
24 plement the plan;

1 “(E) an implementation strategy for the
2 media campaign under subsection (f), including
3 goals as described under subparagraph (B) of
4 this paragraph and performance measures, ob-
5 jectives, and targets, as described under sub-
6 paragraph (C) of this paragraph; and

7 “(F) any other information necessary to
8 inform the public of the status, progress, or re-
9 sponse of an emerging drug threat.

10 “(4) IMPLEMENTATION.—

11 “(A) IN GENERAL.—Not later than 120
12 days after the date on which a designation is
13 made under subsection (c), the Director, in con-
14 sultation with the President, the appropriate
15 congressional committees, and the head of each
16 National Drug Control Program Agency, shall
17 issue guidance on implementation of the plan
18 described in this subsection to the National
19 Drug Control Program Agencies and any other
20 relevant agency determined to be necessary by
21 the Director.

22 “(B) COORDINATOR’S RESPONSIBIL-
23 ITIES.—The Coordinator shall—

24 “(i) direct the implementation of the
25 plan among the agencies identified in the

1 plan, State, local, and Tribal governments,
2 and other relevant entities;

3 “(ii) facilitate information-sharing be-
4 tween agencies identified in the plan,
5 State, local, and Tribal governments, and
6 other relevant entities; and

7 “(iii) monitor implementation of the
8 plan by coordinating the development and
9 implementation of collection and reporting
10 systems to support performance measure-
11 ment and adherence to the plan by agen-
12 cies identified in plan, where appropriate.

13 “(C) REPORTING.—Not later than 180
14 days after the date on which a designation is
15 made under subsection (c) and in accordance
16 with subparagraph (A), the head of each agency
17 identified in the plan shall submit to the Coor-
18 dinator a report on implementation of the plan.

19 “(e) EVALUATION OF MEDIA CAMPAIGN.—Upon des-
20 ignation of an emerging drug threat, the Director shall
21 evaluate whether a media campaign would be appropriate
22 to address that threat.

23 “(f) NATIONAL ANTI-DRUG MEDIA CAMPAIGN.—

24 “(1) IN GENERAL.—The Director shall, to the
25 extent feasible and appropriate, conduct a national

1 anti-drug media campaign (referred to in this sub-
2 title as the ‘national media campaign’) in accordance
3 with this subsection for the purposes of—

4 “(A) preventing substance abuse among
5 people in the United States;

6 “(B) educating the public about the dan-
7 gers and negative consequences of substance
8 use and abuse, including patient and family
9 education about the characteristics and hazards
10 of substance abuse and methods to safeguard
11 against substance use, to include the safe dis-
12 posal of prescription medications;

13 “(C) supporting evidence-based prevention
14 programs targeting the attitudes, perception,
15 and beliefs of persons concerning substance use
16 and intentions to initiate or continue such use;

17 “(D) encouraging individuals affected by
18 substance use disorders to seek treatment and
19 providing such individuals with information
20 on—

21 “(i) how to recognize addiction issues;

22 “(ii) what forms of evidence-based
23 treatment options are available; and

24 “(iii) how to access such treatment;

1 “(E) combating the stigma of addiction
2 and substance use disorders, including the stig-
3 ma of treating such disorders with medication-
4 assisted treatment therapies; and

5 “(F) informing the public about the dan-
6 gers of any drug identified by the Director as
7 an emerging drug threat as appropriate.

8 “(2) USE OF FUNDS.—

9 “(A) IN GENERAL.—Amounts made avail-
10 able to carry out this subsection for the na-
11 tional media campaign may only be used for the
12 following:

13 “(i) The purchase of media time and
14 space, including the strategic planning for,
15 tracking, and accounting of, such pur-
16 chases.

17 “(ii) Creative and talent costs, con-
18 sistent with subparagraph (B)(i).

19 “(iii) Advertising production costs,
20 which may include television, radio, inter-
21 net, social media, and other commercial
22 marketing venues.

23 “(iv) Testing and evaluation of adver-
24 tising.

1 “(v) Evaluation of the effectiveness of
2 the national media campaign.

3 “(vi) Costs of contracts to carry out
4 activities authorized by this subsection.

5 “(vii) Partnerships with professional
6 and civic groups, community-based organi-
7 zations, including faith-based organiza-
8 tions, and government organizations re-
9 lated to the national media campaign.

10 “(viii) Entertainment industry out-
11 reach, interactive outreach, media projects
12 and activities, public information, news
13 media outreach, and corporate sponsorship
14 and participation.

15 “(ix) Operational and management
16 expenses.

17 “(B) SPECIFIC REQUIREMENTS.—

18 “(i) CREATIVE SERVICES.—In using
19 amounts for creative and talent costs
20 under subparagraph (A)(ii), the Director
21 shall use creative services donated at no
22 cost to the Government wherever feasible
23 and may only procure creative services for
24 advertising—

1 “(I) responding to high-priority
2 or emergent campaign needs that can-
3 not timely be obtained at no cost; or

4 “(II) intended to reach a minor-
5 ity, ethnic, or other special audience
6 that cannot reasonably be obtained at
7 no cost.

8 “(ii) TESTING AND EVALUATION OF
9 ADVERTISING.—In using amounts for test-
10 ing and evaluation of advertising under
11 subparagraph (A)(iv), the Director shall
12 test all advertisements prior to use in the
13 national media campaign to ensure that
14 the advertisements are effective with the
15 target audience and meet industry-accept-
16 ed standards. The Director may waive this
17 requirement for advertisements using no
18 more than 10 percent of the purchase of
19 advertising time purchased under this sub-
20 section in a fiscal year and no more than
21 10 percent of the advertising space pur-
22 chased under this subsection in a fiscal
23 year, if the advertisements respond to
24 emergent and time-sensitive campaign
25 needs or the advertisements will not be

1 widely utilized in the national media cam-
2 paign.

3 “(iii) CONSULTATION.—For the plan-
4 ning of the campaign under paragraph (1),
5 the Director may consult with—

6 “(I) the head of any appropriate
7 National Drug Control Program
8 Agency;

9 “(II) experts on the designated
10 drug;

11 “(III) State, local, and Tribal
12 government officials and relevant
13 agencies;

14 “(IV) communications profes-
15 sionals;

16 “(V) the public; and

17 “(VI) appropriate congressional
18 committees.

19 “(iv) EVALUATION OF EFFECTIVE-
20 NESS OF NATIONAL MEDIA CAMPAIGN.—In
21 using amounts for the evaluation of the ef-
22 fectiveness of the national media campaign
23 under subparagraph (A)(v), the Director
24 shall—

1 “(I) designate an independent
2 entity to evaluate by April 20 of each
3 year the effectiveness of the national
4 media campaign based on data
5 from—

6 “(aa) the Monitoring the
7 Future Study published by the
8 Department of Health and
9 Human Services;

10 “(bb) the National Survey
11 on Drug Use and Health; and

12 “(cc) other relevant studies
13 or publications, as determined by
14 the Director, including tracking
15 and evaluation data collected ac-
16 cording to marketing and adver-
17 tising industry standards; and

18 “(II) ensure that the effective-
19 ness of the national media campaign
20 is evaluated in a manner that enables
21 consideration of whether the national
22 media campaign has contributed to
23 changes in attitude or behaviors
24 among the target audience with re-
25 spect to substance use and such other

1 measures of evaluation as the Director
2 determines are appropriate.

3 “(3) ADVERTISING.—In carrying out this sub-
4 section, the Director shall ensure that sufficient
5 funds are allocated to meet the stated goals of the
6 national media campaign.

7 “(4) RESPONSIBILITIES AND FUNCTIONS
8 UNDER THE PROGRAM.—

9 “(A) IN GENERAL.—The Director shall de-
10 termine the overall purposes and strategy of the
11 national media campaign.

12 “(B) DIRECTOR.—

13 “(i) IN GENERAL.—The Director shall
14 approve—

15 “(I) the strategy of the national
16 media campaign;

17 “(II) all advertising and pro-
18 motional material used in the national
19 media campaign; and

20 “(III) the plan for the purchase
21 of advertising time and space for the
22 national media campaign.

23 “(ii) IMPLEMENTATION.—The Direc-
24 tor shall be responsible for implementing a
25 focused national media campaign to meet

1 the purposes set forth in paragraph (1)
2 and shall ensure—

3 “(I) information disseminated
4 through the campaign is accurate and
5 scientifically valid; and

6 “(II) the campaign is designed
7 using strategies demonstrated to be
8 the most effective at achieving the
9 goals and requirements of paragraph
10 (1), which may include—

11 “(aa) a media campaign, as
12 described in paragraph (2);

13 “(bb) local, regional, or pop-
14 ulation specific messaging;

15 “(cc) the development of
16 websites to publicize and dissemi-
17 nate information;

18 “(dd) conducting outreach
19 and providing educational re-
20 sources for parents;

21 “(ee) collaborating with law
22 enforcement agencies; and

23 “(ff) providing support for
24 school-based public health edu-
25 cation classes to improve teen

1 knowledge about the effects of
2 substance use.

3 “(5) PROHIBITIONS.—None of the amounts
4 made available under paragraph (2) may be obli-
5 gated or expended for any of the following:

6 “(A) To supplant current anti-drug com-
7 munity-based coalitions.

8 “(B) To supplant pro bono public service
9 time donated by national and local broadcasting
10 networks for other public service campaigns.

11 “(C) For partisan political purposes, or to
12 express advocacy in support of or to defeat any
13 clearly identified candidate, clearly identified
14 ballot initiative, or clearly identified legislative
15 or regulatory proposal.

16 “(D) To fund advertising that features any
17 elected officials, persons seeking elected office,
18 cabinet level officials, or other Federal officials
19 employed pursuant to section 213 of Schedule
20 C of title 5, Code of Federal Regulations.

21 “(E) To fund advertising that does not
22 contain a primary message intended to reduce
23 or prevent substance use.

24 “(F) To fund advertising containing a pri-
25 mary message intended to promote support for

1 the national media campaign or private sector
2 contributions to the national media campaign.

3 “(6) MATCHING REQUIREMENT.—

4 “(A) IN GENERAL.—Amounts made avail-
5 able under paragraph (2) for media time and
6 space shall be matched by an equal amount of
7 non-Federal funds for the national media cam-
8 paign, or be matched with in-kind contributions
9 of the same value.

10 “(B) NO-COST MATCH ADVERTISING DI-
11 RECT RELATIONSHIP REQUIREMENT.—The Di-
12 rector shall ensure that not less than 85 per-
13 cent of no-cost match advertising directly re-
14 lates to substance abuse prevention consistent
15 with the specific purposes of the national media
16 campaign.

17 “(C) NO-COST MATCH ADVERTISING NOT
18 DIRECTLY RELATED.—The Director shall en-
19 sure that no-cost match advertising that does
20 not directly relate to substance abuse preven-
21 tion consistent with the purposes of the na-
22 tional media campaign includes a clear anti-
23 drug message. Such message is not required to
24 be the primary message of the match adver-
25 tising.

1 “(7) FINANCIAL AND PERFORMANCE ACCOUNT-
2 ABILITY.—The Director shall cause to be per-
3 formed—

4 “(A) audits and reviews of costs of the na-
5 tional media campaign pursuant to section
6 4706 of title 41, United States Code; and

7 “(B) an audit to determine whether the
8 costs of the national media campaign are allow-
9 able under chapter 43 of title 41, United States
10 Code.

11 “(8) REPORT TO CONGRESS.—The Director
12 shall submit on an annual basis a report to Congress
13 that describes—

14 “(A) the strategy of the national media
15 campaign and whether specific objectives of the
16 national media campaign were accomplished;

17 “(B) steps taken to ensure that the na-
18 tional media campaign operates in an effective
19 and efficient manner consistent with the overall
20 strategy and focus of the national media cam-
21 paign;

22 “(C) plans to purchase advertising time
23 and space;

24 “(D) policies and practices implemented to
25 ensure that Federal funds are used responsibly

1 to purchase advertising time and space and
2 eliminate the potential for waste, fraud, and
3 abuse;

4 “(E) all contracts entered into with a cor-
5 poration, partnership, or individual working on
6 behalf of the national media campaign;

7 “(F) the results of any financial audit of
8 the national media campaign;

9 “(G) a description of any evidence used to
10 develop the national media campaign;

11 “(H) specific policies and steps imple-
12 mented to ensure compliance with this section;

13 “(I) a detailed accounting of the amount of
14 funds obligated during the previous fiscal year
15 for carrying out the national media campaign,
16 including each recipient of funds, the purpose
17 of each expenditure, the amount of each ex-
18 penditure, any available outcome information,
19 and any other information necessary to provide
20 a complete accounting of the funds expended;
21 and

22 “(J) a review and evaluation of the effec-
23 tiveness of the national media campaign strat-
24 egy for the past year.

1 “(9) REQUIRED NOTICE FOR COMMUNICATION
2 FROM THE OFFICE.—Any communication, including
3 an advertisement, paid for or otherwise disseminated
4 by the Office directly or through a contract awarded
5 by the Office shall include a prominent notice in-
6 forming the audience that the communication was
7 paid for by the Office.

8 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to the Office to carry out
10 this section, \$25,000,000 for each of fiscal years 2018
11 through 2023.”.

12 (b) TECHNICAL AND CONFORMING AMENDMENT.—
13 Subsection (a) of section 203 of the Office of National
14 Drug Control Policy Reauthorization Act of 2006 (21
15 U.S.C. 1708a) is repealed.

16 **SEC. 8219. DRUG INTERDICTION.**

17 (a) REPEAL.—This first section 711 of the Office of
18 National Drug Control Policy Reauthorization Act of 1998
19 (21 U.S.C. 1710) is repealed.

20 (b) AMENDMENTS.—Section 711 of the Office of Na-
21 tional Drug Control Policy Reauthorization Act of 1998
22 (21 U.S.C. 1710), as added by Public Law 109–469 (120
23 Stat. 3507), is amended—

24 (1) in subsection (a)—

25 (A) in paragraph (1)—

1 (i) by striking “The United” and in-
2 serting “The Director shall designate or
3 appoint an appointee in the Senior Execu-
4 tive Service or an appointee in a position
5 at level 15 of the General Schedule (or
6 equivalent) as the United”; and

7 (ii) by striking “shall” and inserting
8 “to”;

9 (B) in paragraph (2)(B)—

10 (i) by striking “March 1” and insert-
11 ing “September 1”; and

12 (ii) by striking “paragraph (3)” and
13 inserting “paragraph (4)”;

14 (C) in paragraph (3)—

15 (i) by striking “also, at his discre-
16 tion,”; and

17 (ii) by striking “the Office of Supply
18 Reduction for that purpose” and inserting
19 “assist in carrying out such responsibil-
20 ities”; and

21 (D) in paragraph (4)—

22 (i) in subparagraph (B), by striking
23 “The United” and inserting “Before sub-
24 mission of the National Drug Control
25 Strategy or annual assessment required

1 under section 706, as applicable, the
2 United”;

3 (ii) by striking subparagraphs (C) and
4 (E);

5 (iii) by redesignating subparagraph
6 (D) as subparagraph (C);

7 (iv) in subparagraph (C), as so reded-
8 igned—

9 (I) in the matter preceding clause

10 (i)—

11 (aa) by striking “March 1”
12 and inserting “September 1”;

13 (bb) by inserting “the Direc-
14 tor, acting through” before “the
15 United States”;

16 (cc) by inserting a comma
17 after “Coordinator”;

18 (dd) by striking “a report on
19 behalf of the Director”; and

20 (ee) by striking “, which
21 shall include” and inserting “a
22 report that”;

23 (II) by redesignating clauses (i),
24 (ii), and (iii) as subclauses (I), (II),

1 and (III), and adjusting the margins
2 accordingly;

3 (III) by inserting before sub-
4 clause (I), as so redesignated, the fol-
5 lowing:

6 “(i) includes—”;

7 (IV) in clause (i), as so redesign-
8 ated—

9 (aa) in subclause (I), as so
10 redesignated, by inserting “, in-
11 cluding information about how
12 each National Drug Control Pro-
13 gram agency conducting drug
14 interdiction activities is engaging
15 with relevant international part-
16 ners” after “Plan”;

17 (bb) in subclause (II), as so
18 redesignated, by striking “, as
19 well as” and inserting “and”;

20 (cc) in subclause III, as so
21 redesignated—

22 (AA) by striking “, as
23 well as” and inserting
24 “and”; and

1 (BB) by striking the
2 period at the end and insert-
3 ing “; and”; and

4 (V) by adding at the end the fol-
5 lowing:

6 “(ii) may include recommendations for
7 changes to existing agency authorities or
8 laws governing interagency relationships.”;
9 and

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

11 “(D) CLASSIFIED ANNEX.—Each report
12 required to be submitted under subparagraph
13 (C) shall be in unclassified form, but may in-
14 clude a classified annex.”;

15 (2) in subsection (b)—

16 (A) in paragraph (1)(B), by inserting “and
17 how to strengthen international partnerships to
18 better achieve the goals of that plan” after
19 “that plan”;

20 (B) in paragraph (2)—

21 (i) in the paragraph heading, by strik-
22 ing “CHAIRMAN” and inserting “CHAIR-
23 PERSON”; and

24 (ii) by striking “chairman” and in-
25 serting “Chairperson”;

1 (C) in paragraph (3)—

2 (i) by striking “prior to March 1” and
3 inserting “before June 1”;

4 (ii) by striking “either” each place it
5 appears;

6 (iii) by striking “current chairman”
7 and inserting “Chairperson”; and

8 (iv) by striking “they” and inserting
9 “the members”; and

10 (D) in paragraph (4)—

11 (i) by striking “chairman” each place
12 it appears and inserting “Chairperson”;

13 (ii) in the first sentence, by striking
14 “a report”;

15 (iii) by inserting “a report” after
16 “committees”; and

17 (iv) by striking the second sentence
18 and inserting the following: “The report
19 required under this paragraph shall be in
20 unclassified form, but may include a classi-
21 fied annex.”; and

22 (3) by adding at the end the following:

23 “(c) INTERNATIONAL COORDINATION.—The Director
24 may facilitate international drug control coordination ef-
25 forts.”.

1 **SEC. 8220. GAO AUDIT.**

2 Not later than 4 years after the date of enactment
3 of this Act, and every 4 years thereafter, the Comptroller
4 General of the United States shall—

5 (1) conduct an audit relating to the programs
6 and operations of—

7 (A) the Office; and

8 (B) certain programs within the Office, in-
9 cluding—

10 (i) the High Intensity Drug Traf-
11 ficking Areas Program;

12 (ii) the Drug-Free Communities Pro-
13 gram; and

14 (iii) the campaign under section
15 709(f) of the Office of National Drug Con-
16 trol Policy Reauthorization Act of 1998
17 (21 U.S.C. 1708(f)); and

18 (2) submit to the Director and the appropriate
19 congressional committees a report containing an
20 evaluation of and recommendations on the—

21 (A) policies and activities of the programs
22 and operations subject to the audit;

23 (B) economy, efficiency, and effectiveness
24 in the administration of the reviewed programs
25 and operations; and

1 (C) policy or management changes needed
2 to prevent and detect fraud and abuse in such
3 programs and operations.

4 **SEC. 8221. NATIONAL DRUG CONTROL STRATEGY.**

5 (a) IN GENERAL.—Section 706 of the Office of Na-
6 tional Drug Control Policy Reauthorization Act of 1998
7 (21 U.S.C. 1705) is amended to read as follows:

8 **“SEC. 706. NATIONAL DRUG CONTROL STRATEGY.**

9 “(a) IN GENERAL.—

10 “(1) STATEMENT OF DRUG POLICY PRIOR-
11 ITIES.—The Director shall release a statement of
12 drug control policy priorities in the calendar year of
13 a Presidential inauguration following the inaugura-
14 tion, but not later than April 1.

15 “(2) NATIONAL DRUG CONTROL STRATEGY
16 SUBMITTED BY THE PRESIDENT.—Not later than
17 the first Monday in February following the year in
18 which the term of the President commences, and
19 every 2 years thereafter, the President shall submit
20 to Congress a National Drug Control Strategy.

21 “(b) DEVELOPMENT OF THE NATIONAL DRUG CON-
22 TROL STRATEGY.—

23 “(1) PROMULGATION.—The Director shall pro-
24 mulgate the National Drug Control Strategy, which
25 shall set forth a comprehensive plan to reduce illicit

1 drug use and the consequences of such illicit drug
2 use in the United States by limiting the availability
3 of and reducing the demand for illegal drugs and
4 promoting prevention, early intervention, treatment,
5 and recovery support for individuals with substance
6 use disorders.

7 “(2) STATE AND LOCAL COMMITMENT.—The
8 Director shall seek the support and commitment of
9 State, local, and Tribal officials in the formulation
10 and implementation of the National Drug Control
11 Strategy.

12 “(3) STRATEGY BASED ON EVIDENCE.—The Di-
13 rector shall ensure the National Drug Control Strat-
14 egy is based on the best available evidence regarding
15 the policies that are most effective in reducing the
16 demand for and supply of illegal drugs.

17 “(4) PROCESS FOR DEVELOPMENT AND SUB-
18 MISSION OF NATIONAL DRUG CONTROL STRATEGY.—
19 In developing and effectively implementing the Na-
20 tional Drug Control Strategy, the Director—

21 “(A) shall consult with—

22 “(i) the heads of the National Drug
23 Control Program Agencies;

24 “(ii) each Coordinator listed in section
25 704;

1 “(iii) the Interdiction Committee and
2 the Emerging Threats Committee;

3 “(iv) the appropriate congressional
4 committees and any other committee of ju-
5 risdiction;

6 “(v) State, local, and Tribal officials;

7 “(vi) private citizens and organiza-
8 tions, including community and faith-based
9 organizations, with experience and exper-
10 tise in demand reduction;

11 “(vii) private citizens and organiza-
12 tions with experience and expertise in sup-
13 ply reduction; and

14 “(viii) appropriate representatives of
15 foreign governments; and

16 “(B) in satisfying the requirements of sub-
17 paragraph (A), shall ensure, to the maximum
18 extent possible, that State, local, and Tribal of-
19 ficials and relevant private organizations com-
20 mit to support and take steps to achieve the
21 goals and objectives of the National Drug Con-
22 trol Strategy.

23 “(c) CONTENTS OF THE NATIONAL DRUG CONTROL
24 STRATEGY.—

1 “(1) IN GENERAL.—The National Drug Control
2 Strategy submitted under subsection (a)(2) shall in-
3 clude the following:

4 “(A) A mission statement detailing the
5 major functions of the National Drug Control
6 Program.

7 “(B) Comprehensive, research-based, long-
8 range, quantifiable goals for reducing illicit
9 drug use, and the consequences of illicit drug
10 use in the United States.

11 “(C) Annual quantifiable and measurable
12 objectives and specific targets to accomplish
13 long-term quantifiable goals that the Director
14 determines may be achieved during each year
15 beginning on the date on which the National
16 Drug Control Strategy is submitted.

17 “(D) A 5-year projection for the National
18 Drug Control Program and budget priorities.

19 “(E) A review of international, State, local,
20 and private sector drug control activities to en-
21 sure that the United States pursues coordinated
22 and effective drug control at all levels of gov-
23 ernment.

1 “(F) A description of how each goal estab-
2 lished under subparagraph (B) will be achieved,
3 including for each goal—

4 “(i) a list of each relevant National
5 Drug Control Program Agency and each
6 such agency’s related programs, activities,
7 and available assets and the role of each
8 such program, activity, and asset in achiev-
9 ing such goal;

10 “(ii) a list of relevant stakeholders
11 and each such stakeholder’s role in achiev-
12 ing such goal;

13 “(iii) an estimate of Federal funding
14 and other resources needed to achieve such
15 goal;

16 “(iv) a list of each existing or new co-
17 ordinating mechanism needed to achieve
18 such goal; and

19 “(v) a description of the Office’s role
20 in facilitating the achievement of such
21 goal.

22 “(G) For each year covered by the Strat-
23 egy, a performance evaluation plan for each
24 goal established under subparagraph (B) for

1 each National Drug Control Program Agency,
2 including—

3 “(i) specific performance measures for
4 each National Drug Control Program
5 Agency;

6 “(ii) annual and, to the extent prac-
7 ticable, quarterly objectives and targets for
8 each performance measure; and

9 “(iii) an estimate of Federal funding
10 and other resources needed to achieve each
11 performance objective and target.

12 “(H) A list identifying existing data
13 sources or a description of data collection need-
14 ed to evaluate performance, including a descrip-
15 tion of how the Director will obtain such data.

16 “(I) A list of any anticipated challenges to
17 achieving the National Drug Control Strategy
18 goals and planned actions to address such chal-
19 lenges.

20 “(J) A description of how each goal estab-
21 lished under subparagraph (B) was determined,
22 including—

23 “(i) a description of each required
24 consultation and a description of how such
25 consultation was incorporated; and

1 “(ii) data, research, or other informa-
2 tion used to inform the determination to
3 establish the goal.

4 “(K) A description of the current preva-
5 lence of illicit drug use in the United States, in-
6 cluding both the availability of illicit drugs and
7 the prevalence of substance use disorders.

8 “(L) Such other statistical data and infor-
9 mation as the Director considers appropriate to
10 demonstrate and assess trends relating to illicit
11 drug use, the effects and consequences of illicit
12 drug use (including the effects on children),
13 supply reduction, demand reduction, drug-re-
14 lated law enforcement, and the implementation
15 of the National Drug Control Strategy.

16 “(M) A systematic plan for increasing data
17 collection to enable real time surveillance of
18 drug control threats, developing analysis and
19 monitoring capabilities, and identifying and ad-
20 dressing policy questions related to the National
21 Drug Control Strategy and Program, which
22 shall include—

23 “(i) a list of policy-relevant questions
24 for which the Director and each National
25 Drug Control Program Agency intends to

1 develop evidence to support the National
2 Drug Control Program and Strategy;

3 “(ii) a list of data the Director and
4 each National Drug Control Program
5 Agency intends to collect, use, or acquire
6 to facilitate the use of evidence in drug
7 control policymaking and monitoring;

8 “(iii) a list of methods and analytical
9 approaches that may be used to develop
10 evidence to support the National Drug
11 Control Program and Strategy and related
12 policy;

13 “(iv) a list of any challenges to devel-
14 oping evidence to support policymaking, in-
15 cluding any barriers to accessing, col-
16 lecting, or using relevant data;

17 “(v) a description of the steps the Di-
18 rector and the head of each National Drug
19 Control Program Agency will take to effec-
20 tuate the plan; and

21 “(vi) any other relevant information
22 as determined by the Director.

23 “(N) A plan to expand treatment of sub-
24 stance use disorders, which shall—

1 “(i) identify unmet needs for treat-
2 ment for substance use disorders and a
3 strategy for closing the gap between avail-
4 able and needed treatment;

5 “(ii) describe the specific roles and re-
6 sponsibilities of the relevant National Drug
7 Control Programs for implementing the
8 plan;

9 “(iii) identify the specific resources re-
10 quired to enable the relevant National
11 Drug Control Agencies to implement that
12 strategy; and

13 “(iv) identify the resources, including
14 private sources, required to eliminate the
15 unmet need for evidence-based substance
16 use disorder treatment.

17 “(2) CONSULTATION.—In developing the plan
18 required under paragraph (1), the Director shall
19 consult with the following:

20 “(A) The public.

21 “(B) Any evaluation or analysis units and
22 personnel of the Office.

23 “(C) Office officials responsible for imple-
24 menting privacy policy.

1 “(D) Office officials responsible for data
2 governance.

3 “(E) The appropriate congressional com-
4 mittees.

5 “(F) Any other individual or entity as de-
6 termined by the Director.

7 “(3) ADDITIONAL STRATEGIES.—

8 “(A) IN GENERAL.—The Director shall in-
9 clude in the National Drug Control Strategy
10 the additional strategies described under this
11 paragraph and shall comply with the following:

12 “(i) Provide a copy of the additional
13 strategies to the appropriate congressional
14 committees and to the Committee on
15 Armed Services and the Committee on
16 Homeland Security of the House of Rep-
17 resentatives, and the Committee on Home-
18 land Security and Governmental Affairs
19 and the Committee on Armed Services of
20 the Senate.

21 “(ii) Issue the additional strategies in
22 consultation with the head of each relevant
23 National Drug Control Program Agency,
24 any relevant official of a State, local, or

1 Tribal government, and the government of
2 other relevant countries.

3 “(iii) Not change any existing agency
4 authority or construe any strategy de-
5 scribed under this paragraph to amend or
6 modify any law governing interagency rela-
7 tionship but may include recommendations
8 about changes to such authority or law.

9 “(iv) Present separately from the rest
10 of any strategy described under this para-
11 graph any information classified under cri-
12 teria established by an Executive order, or
13 whose public disclosure, as determined by
14 the Director or the head of any relevant
15 National Drug Control Program Agency,
16 would be detrimental to the law enforce-
17 ment or national security activities of any
18 Federal, State, local, or Tribal agency.

19 “(B) REQUIREMENT FOR SOUTHWEST
20 BORDER COUNTERNARCOTICS STRATEGY.—

21 “(i) PURPOSES.—The Southwest Bor-
22 der Counternarcotics Strategy shall—

23 “(I) set forth the Government’s
24 strategy for preventing the illegal traf-
25 ficking of drugs across the inter-

1 national border between the United
2 States and Mexico, including through
3 ports of entry and between ports of
4 entry on that border;

5 “(II) state the specific roles and
6 responsibilities of the relevant Na-
7 tional Drug Control Program Agen-
8 cies for implementing that strategy;
9 and

10 “(III) identify the specific re-
11 sources required to enable the relevant
12 National Drug Control Program
13 Agencies to implement that strategy.

14 “(ii) SPECIFIC CONTENT RELATED TO
15 DRUG TUNNELS BETWEEN THE UNITED
16 STATES AND MEXICO.—The Southwest
17 Border Counternarcotics Strategy shall in-
18 clude—

19 “(I) a strategy to end the con-
20 struction and use of tunnels and sub-
21 terranean passages that cross the
22 international border between the
23 United States and Mexico for the pur-
24 pose of illegal trafficking of drugs
25 across such border; and

1 “(II) recommendations for crimi-
2 nal penalties for persons who con-
3 struct or use such a tunnel or sub-
4 terranean passage for such a purpose.

5 “(C) REQUIREMENT FOR NORTHERN BOR-
6 DER COUNTERNARCOTICS STRATEGY.—

7 “(i) PURPOSES.—The Northern Bor-
8 der Counternarcotics Strategy shall—

9 “(I) set forth the strategy of the
10 Federal Government for preventing
11 the illegal trafficking of drugs across
12 the international border between the
13 United States and Canada, including
14 through ports of entry and between
15 ports of entry on the border;

16 “(II) state the specific roles and
17 responsibilities of each relevant Na-
18 tional Drug Control Program Agency
19 for implementing the strategy;

20 “(III) identify the specific re-
21 sources required to enable the relevant
22 National Drug Control Program
23 Agencies to implement the strategy;

1 “(IV) be designed to promote,
2 and not hinder, legitimate trade and
3 travel; and

4 “(V) reflect the unique nature of
5 small communities along the inter-
6 national border between the United
7 States and Canada, ongoing coopera-
8 tion and coordination with Canadian
9 law, enforcement authorities, and
10 variations in the volumes of vehicles
11 and pedestrians crossing through
12 ports of entry along the international
13 border between the United States and
14 Canada.

15 “(ii) SPECIFIC CONTENT RELATED TO
16 CROSS-BORDER INDIAN RESERVATIONS.—
17 The Northern Border Counternarcotics
18 Strategy shall include—

19 “(I) a strategy to end the illegal
20 trafficking of drugs to or through In-
21 dian reservations on or near the inter-
22 national border between the United
23 States and Canada; and

24 “(II) recommendations for addi-
25 tional assistance, if any, needed by

1 Tribal law enforcement agencies relat-
2 ing to the strategy, including an eval-
3 uation of Federal technical and finan-
4 cial assistance, infrastructure capacity
5 building, and interoperability defi-
6 ciencies.

7 “(4) CLASSIFIED INFORMATION.—Any contents
8 of the National Drug Control Strategy that involve
9 information properly classified under criteria estab-
10 lished by an Executive order shall be presented to
11 Congress separately from the rest of the National
12 Drug Control Strategy.

13 “(5) SELECTION OF DATA AND INFORMA-
14 TION.—In selecting data and information for inclu-
15 sion in the Strategy, the Director shall ensure—

16 “(A) the inclusion of data and information
17 that will permit analysis of current trends
18 against previously compiled data and informa-
19 tion where the Director believes such analysis
20 enhances long-term assessment of the National
21 Drug Control Strategy; and

22 “(B) the inclusion of data and information
23 to permit a standardized and uniform assess-
24 ment of the effectiveness of drug treatment pro-
25 grams in the United States.

1 “(d) SUBMISSION OF REVISED STRATEGY.—The
2 President may submit to Congress a revised National
3 Drug Control Strategy that meets the requirements of this
4 section—

5 “(1) at any time, upon a determination of the
6 President, in consultation with the Director, that the
7 National Drug Control Strategy in effect is not suf-
8 ficiently effective; or

9 “(2) if a new President or Director takes office.

10 “(e) FAILURE OF DIRECTOR TO SUBMIT NATIONAL
11 DRUG CONTROL STRATEGY.—If the Director does not
12 submit a National Drug Control Strategy to Congress in
13 accordance with subsection (a)(2), not later than five days
14 after the first Monday in February following the year in
15 which the term of the President commences, the Director
16 shall send a notification to the appropriate congressional
17 committees—

18 “(1) explaining why the Strategy was not sub-
19 mitted; and

20 “(2) specifying the date by which the Strategy
21 will be submitted.

22 “(f) DRUG CONTROL DATA DASHBOARD.—

23 “(1) IN GENERAL.—The Director shall collect
24 and disseminate, as appropriate, such information as
25 the Director determines is appropriate, but not less

1 than the information described in this subsection.
2 The data shall be publicly available in a machine-
3 readable format on the online portal of the Office,
4 and to the extent practicable on the Drug Control
5 Data Dashboard.

6 “(2) ESTABLISHMENT.—The Director shall
7 publish to the online portal of the office in a ma-
8 chine-readable, sortable, and searchable format, or
9 to the extent practicable, establish and maintain a
10 data dashboard on the online portal of the Office to
11 be known as the ‘Drug Control Data Dashboard’. To
12 the extent practicable, when establishing the Drug
13 Control Dashboard, the Director shall ensure the
14 user interface of the dashboard is constructed with
15 modern design standards. To the extent practicable,
16 the data made available on the dashboard shall be
17 publicly available in a machine-readable format and
18 searchable by year, agency, drug, and location.

19 “(3) DATA.—The data included in the Drug
20 Control Data Dashboard shall be updated quarterly
21 to the extent practicable, but not less frequently
22 than annually and shall include, at a minimum, the
23 following:

1 “(A) For each substance identified by the
2 Director as having a significant impact on the
3 prevalence of illicit drug use—

4 “(i) data sufficient to show the quan-
5 tities of such substance available in the
6 United States, including—

7 “(I) the total amount seized and
8 disrupted in the calendar year and
9 each of the previous 3 calendar years,
10 including to the extent practicable the
11 amount seized by State, local, and
12 Tribal governments;

13 “(II) the known and estimated
14 flows into the United States from all
15 sources in the calendar year and each
16 of the previous 3 calendar years;

17 “(III) the total amount of known
18 flows that could not be interdicted or
19 disrupted in the calendar year and
20 each of the previous 3 calendar years;

21 “(IV) the known and estimated
22 levels of domestic production in the
23 calendar year and each of the previous
24 three calendar years, including the
25 levels of domestic production if the

1 drug is a prescription drug, as deter-
2 mined under the Federal Food, Drug,
3 and Cosmetic Act, for which a listing
4 is in effect under section 202 of the
5 Controlled Substances Act (21 U.S.C.
6 812);

7 “(V) the average street price for
8 the calendar year and the highest
9 known street price during the pre-
10 ceding 10-year period; and

11 “(VI) to the extent practicable,
12 related prosecutions by State, local,
13 and Tribal governments;

14 “(ii) data sufficient to show the fre-
15 quency of use of such substance, includ-
16 ing—

17 “(I) use of such substance in the
18 workplace and productivity lost by
19 such use;

20 “(II) use of such substance by
21 arrestees, probationers, and parolees;

22 “(III) crime and criminal activity
23 related to such substance;

1 “(IV) to the extent practicable,
2 related prosecutions by State, local,
3 and Tribal governments;

4 “(B) For the calendar year and each of the
5 previous three years data sufficient to show,
6 disaggregated by State and, to the extent fea-
7 sible, by region within a State, county, or city,
8 the following:

9 “(i) The number of fatal and non-
10 fatal overdoses caused by each drug identi-
11 fied under subparagraph (A)(i).

12 “(ii) The prevalence of substance use
13 disorders.

14 “(iii) The number of individuals who
15 have received substance use disorder treat-
16 ment, including medication assisted treat-
17 ment, for a substance use disorder, includ-
18 ing treatment provided through publicly-fi-
19 nanced health care programs.

20 “(iv) The extent of the unmet need
21 for substance use disorder treatment, in-
22 cluding the unmet need for medication-as-
23 sisted treatment.

24 “(C) Data sufficient to show the extent of
25 prescription drug diversion, trafficking, and

1 misuse in the calendar year and each of the
2 previous 3 calendar years.

3 “(D) Any quantifiable measures the Direc-
4 tor determines to be appropriate to detail
5 progress toward the achievement of the goals of
6 the National Drug Control Strategy.

7 “(g) DEVELOPMENT OF AN ANNUAL NATIONAL
8 DRUG CONTROL ASSESSMENT.—

9 “(1) TIMING.—Not later than the first Monday
10 in February of each year, the Director shall submit
11 to the President, Congress, and the appropriate con-
12 gressional committees, a report assessing the
13 progress of each National Drug Control Program
14 Agency toward achieving each goal, objective, and
15 target contained in the National Drug Control Strat-
16 egy applicable to the prior fiscal year.

17 “(2) PROCESS FOR DEVELOPMENT OF THE AN-
18 NUAL ASSESSMENT.—Not later than November 1 of
19 each year, the head of each National Drug Control
20 Program Agency shall submit, in accordance with
21 guidance issued by the Director, to the Director an
22 evaluation of progress by the agency with respect to
23 the National Drug Control Strategy goals using the
24 performance measures for the agency developed
25 under this title, including progress with respect to—

1 “(A) success in achieving the goals of the
2 National Drug Control Strategy;

3 “(B) success in reducing domestic and for-
4 eign sources of illegal drugs;

5 “(C) success in expanding access to and
6 increasing the effectiveness of substance use
7 disorder treatment;

8 “(D) success in protecting the borders of
9 the United States (and in particular the South-
10 western border of the United States) from pen-
11 etration by illegal narcotics;

12 “(E) success in reducing crime associated
13 with drug use in the United States;

14 “(F) success in reducing the negative
15 health and social consequences of drug use in
16 the United States;

17 “(G) implementation of evidence-based
18 substance use disorder treatment and preven-
19 tion programs in the United States and im-
20 provements in the adequacy and effectiveness of
21 such programs; and

22 “(H) success in increasing the prevention
23 of illicit drug use.

1 “(3) CONTENTS OF THE ANNUAL ASSESS-
2 MENT.—The Director shall include in the annual as-
3 sessment required under paragraph (1)—

4 “(A) a summary of each evaluation re-
5 ceived by the Director under paragraph (2);

6 “(B) a summary of the progress of each
7 National Drug Control Program Agency toward
8 the National Drug Control Strategy goals of the
9 agency using the performance measures for the
10 agency developed under this chapter;

11 “(C) an assessment of the effectiveness of
12 each National Drug Control Program Agency
13 and program in achieving the National Drug
14 Control Strategy for the previous year, includ-
15 ing a specific evaluation of whether the applica-
16 ble goals, measures, objectives, and targets for
17 the previous year were met; and

18 “(D) the assessments required under this
19 subsection shall be based on the Performance
20 Measurement System.”.

21 (b) TECHNICAL AND CONFORMING AMENDMENTS.—

22 (1) Section 704(b) of the Office of National
23 Drug Control Policy Reauthorization Act of 1998
24 (21 U.S.C. 1703(b)) is amended—

1 (A) by striking paragraphs (13) and (17);

2 and

3 (B) in paragraph (14)(A), by striking

4 “paragraph (13)” and inserting “section

5 706(g)(2)”.

6 (2) The Office of National Drug Control Policy

7 Reauthorization Act of 2006 (Public Law 109–469;

8 120 Stat. 3502) is amended by striking sections

9 1110 and 1110A.

10 **SEC. 8222. TECHNICAL AND CONFORMING AMENDMENTS**

11 **TO THE OFFICE OF NATIONAL DRUG CON-**

12 **TROL POLICY REAUTHORIZATION ACT OF**

13 **1998.**

14 The Office of National Drug Control Policy Reau-

15 thorization Act of 1998 (21 U.S.C. 1701 et seq.) is

16 amended—

17 (1) by striking section 703(b) (21 U.S.C.

18 1702(b));

19 (2) in section 704 (21 U.S.C. 1703)—

20 (A) in subsection (c)—

21 (i) in paragraph (3)(C)—

22 (I) in the matter before clause

23 (i), by inserting “requests a level of

24 funding that will not enable achieve-

25 ment of the goals of the National

1 Drug Control Strategy, including”
2 after “request that”;

3 (II) in clause (iii)—

4 (aa) by striking “drug treat-
5 ment” and inserting “substance
6 use disorder prevention and
7 treatment”; and

8 (bb) by striking the semi-
9 colon at the end and inserting “;
10 and”;

11 (III) by striking clauses (iv), (vi),
12 and (vii);

13 (IV) by redesignating clause (v)
14 as clause (iv); and

15 (V) in clause (iv), as so redesi-
16 gnated, by striking the semicolon and
17 inserting a period;

18 (ii) in paragraph (4)(A), by striking
19 “\$1,000,000” and inserting “\$5,000,000
20 or 10 percent of a specific program or ac-
21 count”; and

22 (B) in subsection (f)—

23 (i) by striking the first paragraph (5);

24 and

- 1 (ii) by striking the second paragraph
- 2 (4); and
- 3 (3) by striking section 708 (21 U.S.C. 1707).

