

114TH CONGRESS
2D SESSION

H. R. 4396

To support a comprehensive public health response to the heroin and prescription drug abuse crisis.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 28, 2016

Mr. PALLONE introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To support a comprehensive public health response to the heroin and prescription drug abuse crisis.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Heroin and Prescription Drug Abuse Prevention and Re-
6 duction Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PREVENTION

- Sec. 101. Practitioner education.
 Sec. 102. Co-prescribing opioid overdose reversal drugs grant program.
 Sec. 103. Opioid overdose reversal co-prescribing guidelines.
 Sec. 104. Surveillance capacity building.

TITLE II—CRISIS

- Sec. 201. Grants to support syringe exchange programs.
 Sec. 202. Grant program to reduce drug overdose deaths.

TITLE III—TREATMENT

- Sec. 301. Expansion of patient limits under waiver.
 Sec. 302. Definitions.
 Sec. 303. Evaluation by assistant Secretary for planning and evaluation.
 Sec. 304. Reauthorization of residential treatment programs for pregnant and postpartum women.
 Sec. 305. Pilot program grants for State substance abuse agencies.
 Sec. 306. Evidence-based opioid and heroin treatment and interventions demonstration.
 Sec. 307. Adolescent treatment and recovery services demonstration grant program.
 Sec. 308. Strengthening parity in mental health and substance use disorder benefits.
 Sec. 309. Study on treatment infrastructure.
 Sec. 310. Substance use disorder professional loan repayment program.

TITLE IV—RECOVERY

- Sec. 401. National youth recovery initiative.
 Sec. 402. Grants to enhance and expand recovery support services.

1 **TITLE I—PREVENTION**

2 **SEC. 101. PRACTITIONER EDUCATION.**

3 (a) EDUCATION REQUIREMENTS.—

4 (1) REGISTRATION CONSIDERATION.—Section
 5 303(f) of the Controlled Substances Act (21 U.S.C.
 6 823(f)) is amended by inserting after paragraph (5)
 7 the following:

8 “(6) The applicant’s compliance with the train-
 9 ing requirements described in subsection (g)(3) dur-

1 ing any previous period in which the applicant has
2 been subject to such training requirements.”.

3 (2) TRAINING REQUIREMENTS.—Section 303(g)
4 of the Controlled Substances Act (21 U.S.C. 823(g))
5 is amended by adding at the end the following:

6 “(3)(A) To be registered to prescribe or otherwise
7 dispense opioids for the treatment of pain, or pain man-
8 agement, a practitioner described in paragraph (1) shall
9 comply with the 12-hour training requirement of subpara-
10 graph (B) at least once during each 3-year period.

11 “(B) The training requirement of this subparagraph
12 is that the practitioner has completed not less than 12
13 hours of training (through classroom situations, seminars
14 at professional society meetings, electronic communica-
15 tions, or otherwise) with respect to—

16 “(i) the treatment and management of opioid-
17 dependent patients;

18 “(ii) pain management treatment guidelines;
19 and

20 “(iii) early detection of opioid addiction, includ-
21 ing through such methods as Screening, Brief Inter-
22 vention, and Referral to Treatment (SBIRT),

23 that is provided by the American Society of Addiction
24 Medicine, the American Academy of Addiction Psychiatry,
25 the American Medical Association, the American Osteo-

1 pathic Association, the American Psychiatric Association,
2 the American Academy of Pain Management, the Amer-
3 ican Pain Society, the American Academy of Pain Medi-
4 cine, the American Board of Pain Medicine, the American
5 Society of Interventional Pain Physicians, or any other or-
6 ganization that the Secretary determines is appropriate
7 for purposes of this subparagraph.”.

8 (b) FUNDING.—The Drug Enforcement Administra-
9 tion shall fund the enforcement of the requirements speci-
10 fied in section 303(g)(3) of the Controlled Substances Act
11 (as added by subsection (a)) through the use of a portion
12 of the licensing fees paid by controlled substance pre-
13 scribers under the Controlled Substances Act (21 U.S.C.
14 801 et seq.).

15 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
16 authorized to be appropriated to carry out this section
17 \$1,000,000 for each of fiscal years 2017 through 2021.

18 **SEC. 102. CO-PRESCRIBING OPIOID OVERDOSE REVERSAL**

19 **DRUGS GRANT PROGRAM.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—Not later than six months
22 after the date of the enactment of this Act, the Sec-
23 retary of Health and Human Services shall estab-
24 lish, in accordance with this section, a four-year co-
25 prescribing opioid overdose reversal drugs grant pro-

1 gram (in this title referred to as the “grant pro-
2 gram”) under which the Secretary shall provide not
3 more than a total of 12 grants to eligible entities to
4 carry out the activities described in subsection (c).

5 (2) ELIGIBLE ENTITY.—For purposes of this
6 section, the term “eligible entity” means a federally
7 qualified health center (as defined in section
8 1861(aa) of the Social Security Act (42 U.S.C.
9 1395x(aa))), an opioid treatment program under
10 part 8 of title 42, Code of Federal Regulations, or
11 section 303(g) of the Controlled Substances Act (21
12 U.S.C. 823(g)), a program approved by a State sub-
13 stance abuse agency, or any other entity that the
14 Secretary deems appropriate.

15 (3) CO-PRESCRIBING.—For purposes of this
16 title, the term “co-prescribing” means, with respect
17 to an opioid overdose reversal drug, the practice of
18 prescribing such drug in conjunction with an opioid
19 prescription for patients at an elevated risk of over-
20 dose, or in conjunction with an opioid agonist ap-
21 proved under section 505 of the Federal Food,
22 Drug, and Cosmetic Act (21 U.S.C. 355) for the
23 treatment of opioid abuse disorders, or in other cir-
24 cumstances in which a provider identifies a patient
25 at an elevated risk for an intentional or uninten-

1 tional drug overdose from heroin or prescription
2 opioid therapies. For purposes of the previous sen-
3 tence, a patient may be at an elevated risk of over-
4 dose if the patient meets the criteria under the exist-
5 ing co-prescribing guidelines that the Secretary
6 deems appropriate, such as the criteria provided in
7 the Opioid Overdose Toolkit published by the Sub-
8 stance Abuse and Mental Health Services Adminis-
9 tration.

10 (b) APPLICATION.—To be eligible to receive a grant
11 under this section, an eligible entity shall submit to the
12 Secretary of Health and Human Services, in such form
13 and manner as specified by the Secretary, an application
14 that describes—

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

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

21 (3) how such program will work to try to iden-
22 tify State, local, or private funding to continue the
23 program after expiration of the grant.

1 (c) USE OF FUNDS.—An eligible entity receiving a
2 grant under this section may use the grant for any of the
3 following activities:

4 (1) To establish a program for co-prescribing
5 opioid overdose reversal drugs, such as naloxone.

6 (2) To train and provide resources for health
7 care providers and pharmacists on the co-prescribing
8 of opioid overdose reversal drugs.

9 (3) To establish mechanisms and processes,
10 consistent with applicable Federal and State privacy
11 rules, for tracking patients participating in the pro-
12 gram described in paragraph (1) and the health out-
13 comes of such patients.

14 (4) To purchase opioid overdose reversal drugs
15 for distribution under the program described in
16 paragraph (1).

17 (5) To offset the co-pays and other cost sharing
18 associated with opioid overdose reversal drugs to en-
19 sure that cost is not a limiting factor for eligible pa-
20 tients.

21 (6) To conduct community outreach, in con-
22 junction with community-based organizations, de-
23 signed to raise awareness of co-prescribing practices,
24 and the availability of opioid overdose reversal
25 drugs.

1 (7) To establish protocols to connect patients
2 who have experienced a drug overdose with appro-
3 priate treatment, including medication assisted
4 treatment and appropriate counseling and behavioral
5 therapies.

6 (d) EVALUATIONS BY RECIPIENTS.—As a condition
7 of receipt of a grant under this section, an eligible entity
8 shall, for each year for which the grant is received, submit
9 to the Secretary of Health and Human Services informa-
10 tion on appropriate outcome measures specified by the
11 Secretary to assess the outcomes of the program funded
12 by the grant, including—

13 (1) the number of prescribers trained;

14 (2) the number of prescribers who have co-pre-
15 scribed an opioid overdose reversal drug to at least
16 one patient;

17 (3) the total number of prescriptions written for
18 opioid overdose reversal drugs;

19 (4) the percentage of patients at elevated risk
20 who received a prescription for an opioid overdose
21 reversal drug;

22 (5) the number of patients reporting use of an
23 opioid overdose reversal drug; and

24 (6) any other outcome measures that the Sec-
25 retary deems appropriate.

1 (e) REPORTS BY SECRETARY.—For each year of the
2 grant program under this section, the Secretary of Health
3 and Human Services shall submit to the appropriate com-
4 mittees of the House of Representatives and of the Senate
5 a report aggregating the information received from the
6 grant recipients for such year under subsection (d) and
7 evaluating the outcomes achieved by the programs funded
8 by grants made under this section.

9 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated to carry out this section and
11 section 103 \$4,000,000 for each of fiscal years 2017
12 through 2021.

13 **SEC. 103. OPIOID OVERDOSE REVERSAL CO-PRESCRIBING**
14 **GUIDELINES.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall establish a grant program under
17 which the Secretary shall award grants to eligible State
18 entities to develop opioid overdose reversal co-prescribing
19 guidelines.

20 (b) ELIGIBLE STATE ENTITIES.—For purposes of
21 subsection (a), eligible State entities are State depart-
22 ments of health in conjunction with State medical boards;
23 city, county, and local health departments; and community
24 stakeholder groups involved in reducing opioid overdose
25 deaths.

1 (c) ADMINISTRATIVE PROVISIONS.—

2 (1) GRANT AMOUNTS.—A grant made under
3 this section may not be for more than \$200,000 per
4 grant.

5 (2) PRIORITIZATION.—In awarding grants
6 under this section, the Secretary shall give priority
7 to eligible State entities which propose to base their
8 guidelines on existing guidelines on co-prescribing to
9 speed enactment, including guidelines of—

10 (A) the Department of Veterans Affairs;

11 (B) nationwide medical societies, such as
12 the American Society of Addiction Medicine or
13 the American Medical Association; and

14 (C) the Centers for Disease Control and
15 Prevention.

16 **SEC. 104. SURVEILLANCE CAPACITY BUILDING.**

17 (a) PROGRAM AUTHORIZED.—The Secretary of
18 Health and Human Services, acting through the Director
19 of the Centers for Disease Control and Prevention, shall
20 award cooperative agreements or grants to eligible entities
21 to improve fatal and nonfatal drug overdose surveillance
22 and reporting capabilities, including—

23 (1) providing training to improve identification
24 of drug overdose as the cause of death by coroners
25 and medical examiners;

1 (2) establishing, in cooperation with the Na-
2 tional Poison Data System, coroners, and medical
3 examiners, a comprehensive national program for
4 surveillance of, and reporting to an electronic data-
5 base on, drug overdose deaths in the United States;
6 and

7 (3) establishing, in cooperation with the Na-
8 tional Poison Data System, a comprehensive na-
9 tional program for surveillance of, and reporting to
10 an electronic database on, fatal and nonfatal drug
11 overdose occurrences, including epidemiological and
12 toxicologic analysis and trends.

13 (b) ELIGIBLE ENTITY.—To be eligible to receive a
14 grant or cooperative agreement under this section, an enti-
15 ty shall be—

16 (1) a State, local, or tribal government; or

17 (2) the National Poison Data System working
18 in conjunction with a State, local, or tribal govern-
19 ment.

20 (c) APPLICATION.—

21 (1) IN GENERAL.—An eligible entity desiring a
22 grant or cooperative agreement under this section
23 shall submit to the Secretary an application at such
24 time, in such manner, and containing such informa-
25 tion as the Secretary may require.

1 (2) CONTENTS.—An application described in
2 paragraph (1) shall include—

3 (A) a description of the activities to be
4 funded through the grant or cooperative agree-
5 ment; and

6 (B) evidence that the eligible entity has the
7 capacity to carry out such activities.

8 (d) REPORT.—As a condition of receipt of a grant
9 or cooperative agreement under this section, an eligible en-
10 tity shall agree to prepare and submit, not later than 90
11 days after the end of the grant or cooperative agreement
12 period, a report to the Secretary describing the results of
13 the activities supported through the grant or cooperative
14 agreement.

15 (e) NATIONAL POISON DATA SYSTEM.—In this sec-
16 tion, the term “National Poison Data System” means the
17 system operated by the American Association of Poison
18 Control Centers, in partnership with the Centers for Dis-
19 ease Control and Prevention, for real-time local, State,
20 and national electronic reporting, and the corresponding
21 database network.

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 \$5,000,000 for each of the fiscal years 2017 through
25 2021.

TITLE II—CRISIS

1

2 SEC. 201. GRANTS TO SUPPORT SYRINGE EXCHANGE PRO-
3 GRAMS.

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services may award grants to State, local, and
6 tribal governments and community organizations to sup-
7 port syringe exchange programs.

8 (b) USE OF FUNDS.—Grants under subsection (a)
9 may be used to support carrying out syringe exchange pro-
10 grams, including through—

11 (1) providing outreach, counseling, health edu-
12 cation, case management, syringe disposal, and
13 other services as determined appropriate by the Sec-
14 retary of Health and Human Services; and

15 (2) providing technical assistance, including
16 training and capacity building, to assist the develop-
17 ment and implementation of syringe exchange pro-
18 grams.

19 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated \$15,000,000 for each of fis-
21 cal years 2017 through 2021 to carry out this section, of
22 which—

23 (1) at least 15 percent shall be for syringe ex-
24 change programs that have been in operation for
25 less than 3 years; and

1 (2) CONTENTS.—An application under para-
2 graph (1) shall include—

3 (A) a description of the activities to be
4 funded through the grant or cooperative agree-
5 ment; and

6 (B) evidence that the eligible entity has the
7 capacity to carry out such activities.

8 (d) PRIORITY.—In entering into grants and coopera-
9 tive agreements under subsection (a), the Secretary of
10 Health and Human Services shall give priority to eligible
11 entities that—

12 (1) include a public health agency or commu-
13 nity-based organization; and

14 (2) have expertise in preventing deaths occur-
15 ring from overdoses of drugs in populations at high
16 risk of such deaths.

17 (e) ELIGIBLE ACTIVITIES.—As a condition of receipt
18 of a grant or cooperative agreement under this section,
19 an eligible entity shall agree to use the grant or coopera-
20 tive agreement to do each of the following:

21 (1) Purchase and distribute the drug naloxone
22 or a similarly effective medication.

23 (2) Carry out one or more of the following ac-
24 tivities:

1 (A) Educating prescribers and pharmacists
2 about overdose prevention and naloxone pre-
3 scription, or prescriptions of a similarly effec-
4 tive medication.

5 (B) Training first responders, other indi-
6 viduals in a position to respond to an overdose,
7 and law enforcement and corrections officials on
8 the effective response to individuals who have
9 overdosed on drugs. Training pursuant to this
10 subparagraph may include any activity that is
11 educational, instructional, or consultative in na-
12 ture, and may include volunteer training,
13 awareness building exercises, outreach to indi-
14 viduals who are at-risk of a drug overdose, and
15 distribution of educational materials.

16 (C) Implementing and enhancing programs
17 to provide overdose prevention, recognition,
18 treatment, and response to individuals in need
19 of such services.

20 (D) Educating the public and providing
21 outreach to the public about overdose preven-
22 tion and naloxone prescriptions, or prescriptions
23 of other similarly effective medications.

24 (f) COORDINATING CENTER.—

1 (1) ESTABLISHMENT.—The Secretary of Health
2 and Human Services shall establish and provide for
3 the operation of a coordinating center responsible
4 for—

5 (A) collecting, compiling, and dissemi-
6 nating data on the programs and activities
7 under this section, including tracking and eval-
8 uating the distribution and use of naloxone and
9 other similarly effective medication;

10 (B) evaluating such data and, based on
11 such evaluation, developing best practices for
12 preventing deaths occurring from drug
13 overdoses;

14 (C) making such best practices specific to
15 the type of community involved;

16 (D) coordinating and harmonizing data
17 collection measures;

18 (E) evaluating the effects of the program
19 on overdose rates; and

20 (F) education and outreach to the public
21 about overdose prevention and prescription of
22 naloxone and other similarly effective medica-
23 tion.

24 (2) REPORTS TO CENTER.—As a condition on
25 receipt of a grant or cooperative agreement under

1 this section, an eligible entity shall agree to prepare
2 and submit, not later than 90 days after the end of
3 the award period, a report to such coordinating cen-
4 ter and the Secretary of Health and Human Services
5 describing the results of the activities supported
6 through the grant or cooperative agreement.

7 (g) DURATION.—The period of a grant or cooperative
8 agreement under this section shall be 4 years.

9 (h) DEFINITION.—In this part, the term “drug”—

10 (1) means a drug, as defined in section 201 of
11 the Federal Food, Drug, and Cosmetic Act (21
12 U.S.C. 321); and

13 (2) includes controlled substances, as defined in
14 section 102 of the Controlled Substances Act (21
15 U.S.C. 802).

16 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated \$20,000,000 to carry out
18 this section for each of the fiscal years 2017 through
19 2021.

20 **TITLE III—TREATMENT**

21 **SEC. 301. EXPANSION OF PATIENT LIMITS UNDER WAIVER.**

22 Section 303(g)(2)(B) of the Controlled Substances
23 Act (21 U.S.C. 823(g)(2)(B)) is amended—

24 (1) in clause (i), by striking “physician” and in-
25 serting “practitioner”;

1 (2) in clause (iii)—

2 (A) by striking “30” and inserting “100”;

3 and

4 (B) by striking “, unless, not sooner” and

5 all that follows through the end and inserting a

6 period; and

7 (3) by inserting at the end the following new

8 clause:

9 “(iv) Not earlier than 1 year after the date
10 on which a qualifying practitioner obtained an
11 initial waiver pursuant to clause (iii), the quali-
12 fying practitioner may submit a second notifica-
13 tion to the Secretary of the need and intent of
14 the qualifying practitioner to treat an unlimited
15 number of patients, if the qualifying practi-
16 tioner—

17 “(I)(aa) satisfies the requirements of
18 item (aa), (bb), (cc), or (dd) of subpara-
19 graph (G)(ii)(I); and

20 “(bb) agrees to fully participate in the
21 Prescription Drug Monitoring Program of
22 the State in which the qualifying practi-
23 tioner is licensed, pursuant to applicable
24 State guidelines; or

1 “(II)(aa) satisfies the requirements of
2 item (ee), (ff), or (gg) of subparagraph
3 (G)(ii)(I);

4 “(bb) agrees to fully participate in the
5 Prescription Drug Monitoring Program of
6 the State in which the qualifying practi-
7 tioner is licensed, pursuant to applicable
8 State guidelines;

9 “(cc) practices in a qualified practice
10 setting; and

11 “(dd) has completed not less than 24
12 hours of training (through classroom situa-
13 tions, seminars at professional society
14 meetings, electronic communications, or
15 otherwise) with respect to the treatment
16 and management of opiate-dependent pa-
17 tients for substance use disorders provided
18 by the American Society of Addiction Med-
19 icine, the American Academy of Addiction
20 Psychiatry, the American Medical Associa-
21 tion, the American Osteopathic Associa-
22 tion, the American Psychiatric Association,
23 or any other organization that the Sec-
24 retary determines is appropriate for pur-
25 poses of this subclause.”.

1 **SEC. 302. DEFINITIONS.**

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

4 (1) by striking clause (ii) and inserting the fol-
5 lowing:

6 “(ii) The term ‘qualifying practitioner’
7 means the following:

8 “(I) A physician who is licensed under
9 State law and who meets 1 or more of the
10 following conditions:

11 “(aa) The physician holds a
12 board certification in addiction psychi-
13 atry from the American Board of
14 Medical Specialties.

15 “(bb) The physician holds an ad-
16 diction certification from the Amer-
17 ican Society of Addiction Medicine.

18 “(cc) The physician holds a
19 board certification in addiction medi-
20 cine from the American Osteopathic
21 Association.

22 “(dd) The physician holds a
23 board certification from the American
24 Board of Addiction Medicine.

25 “(ee) The physician has com-
26 pleted not less than 8 hours of train-

1 ing (through classroom situations,
2 seminar at professional society meet-
3 ings, electronic communications, or
4 otherwise) with respect to the treat-
5 ment and management of opiate-de-
6 pendent patients for substance use
7 disorders provided by the American
8 Society of Addiction Medicine, the
9 American Academy of Addiction Psy-
10 chiatry, the American Medical Asso-
11 ciation, the American Osteopathic As-
12 sociation, the American Psychiatric
13 Association, or any other organization
14 that the Secretary determines is ap-
15 propriate for purposes of this sub-
16 clause.

17 “(ff) The physician has partici-
18 pated as an investigator in 1 or more
19 clinical trials leading to the approval
20 of a narcotic drug in schedule III, IV,
21 or V for maintenance or detoxification
22 treatment, as demonstrated by a
23 statement submitted to the Secretary
24 by this sponsor of such approved
25 drug.

1 “(gg) The physician has such
2 other training or experience as the
3 Secretary determines will demonstrate
4 the ability of the physician to treat
5 and manage opiate-dependent pa-
6 tients.

7 “(II) A nurse practitioner or physi-
8 cian assistant who is licensed under State
9 law and meets all of the following condi-
10 tions:

11 “(aa) The nurse practitioner or
12 physician assistant is licensed under
13 State law to prescribe schedule III,
14 IV, or V medications for pain.

15 “(bb) The nurse practitioner or
16 physician assistant satisfies 1 or more
17 of the following:

18 “(AA) Has completed not
19 fewer than 24 hours of training
20 (through classroom situations,
21 seminar at professional society
22 meetings, electronic communica-
23 tions, or otherwise) with respect
24 to the treatment and manage-
25 ment of opiate-dependent pa-

1 tients for substance use disorders
2 provided by the American Society
3 of Addiction Medicine, the Amer-
4 ican Academy of Addiction Psy-
5 chiatry, the American Medical
6 Association, the American Osteo-
7 pathic Association, the American
8 Psychiatric Association, or any
9 other organization that the Sec-
10 retary determines is appropriate
11 for purposes of this subclause.

12 “(BB) Has such other train-
13 ing or experience as the Sec-
14 retary determines will dem-
15 onstrate the ability of the nurse
16 practitioner or physician assist-
17 ant to treat and manage opiate-
18 dependent patients.

19 “(cc) The nurse practitioner or
20 physician assistant practices within
21 the scope of their State license, in-
22 cluding compliance with any super-
23 vision or collaboration requirements
24 under State law.

1 “(dd) The nurse practitioner or
2 physician assistant practice in a quali-
3 fied practice setting.”; and

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

5 “(iii) The term ‘qualified practice setting’
6 means 1 or more of the following treatment set-
7 tings:

8 “(I) A National Committee for Qual-
9 ity Assurance-recognized Patient-Centered
10 Medical Home or Patient-Centered Spe-
11 cialty Practice.

12 “(II) A Centers for Medicaid & Medi-
13 care Services-recognized Accountable Care
14 Organization.

15 “(III) A clinical facility administered
16 by the Department of Veterans Affairs,
17 Department of Defense, or Indian Health
18 Service.

19 “(IV) A Behavioral Health Home ac-
20 credited by the Joint Commission.

21 “(V) A Federally-qualified health cen-
22 ter (as defined in section 1905(l)(2)(B) of
23 the Social Security Act (42 U.S.C.
24 1396d(l)(2)(B))) or a Federally-qualified
25 health center look-alike.

1 “(VI) A Substance Abuse and Mental
2 Health Services-certified Opioid Treatment
3 Program.

4 “(VII) A clinical program of a State
5 or Federal jail, prison, or other facility
6 where individuals are incarcerated.

7 “(VIII) A clinic that demonstrates
8 compliance with the Model Policy on
9 DATA 2000 and Treatment of Opioid Ad-
10 diction in the Medical Office issued by the
11 Federation of State Medical Boards.

12 “(IX) A treatment setting that is part
13 of an Accreditation Council for Graduate
14 Medical Education, American Association
15 of Colleges of Osteopathic Medicine, or
16 American Osteopathic Association-accred-
17 ited residency or fellowship training pro-
18 gram.

19 “(X) Any other practice setting ap-
20 proved by a State regulatory board, State
21 substance abuse agency, or State Medicaid
22 Plan to provide addiction treatment serv-
23 ices.

24 “(XI) Any other practice setting ap-
25 proved by the Secretary.”.

1 **SEC. 303. EVALUATION BY ASSISTANT SECRETARY FOR**
2 **PLANNING AND EVALUATION.**

3 Two years after the date on which the first notifica-
4 tion under clause (iv) of section 303(g)(2)(B) of the Con-
5 trolled Substances Act (21 U.S.C. 823(g)(2)(B)), as added
6 by section 301, is received by the Secretary of Health and
7 Human Services, the Assistant Secretary for Planning and
8 Evaluation shall initiate an evaluation of the effectiveness
9 of the amendments made by sections 301 and 302, which
10 shall include an evaluation of—

11 (1) any changes in the availability and use of
12 medication-assisted treatment for opioid addiction;

13 (2) the quality of medication-assisted treatment
14 programs;

15 (3) the integration of medication-assisted treat-
16 ment with routine healthcare services;

17 (4) diversion of opioid addiction treatment
18 medication;

19 (5) changes in State or local policies and legis-
20 lation relating to opioid addiction treatment;

21 (6) the use of nurse practitioners and physician
22 assistants who prescribe opioid addiction medication;

23 (7) the use of Prescription Drug Monitoring
24 Programs by waived practitioners to maximize safety
25 of patient care and prevent diversion of opioid addic-
26 tion medication;

1 (8) the findings of the Drug Enforcement Ad-
2 ministration inspections of waived practitioners, in-
3 cluding the frequency with which the Drug Enforce-
4 ment Administration finds no documentation of ac-
5 cess to behavioral health services; and

6 (9) the effectiveness of cross-agency collabora-
7 tion between Department of Health and Human
8 Services and the Drug Enforcement Administration
9 for expanding effective opioid addiction treatment.

10 **SEC. 304. REAUTHORIZATION OF RESIDENTIAL TREAT-**
11 **MENT PROGRAMS FOR PREGNANT AND**
12 **POSTPARTUM WOMEN.**

13 Section 508 of the Public Health Service Act (42
14 U.S.C. 290bb-1) is amended—

15 (1) in subsection (p), by inserting “(other than
16 subsection (r))” after “section”; and

17 (2) in subsection (r), by striking “such sums”
18 and all that follows through “2003” and inserting
19 “\$40,000,000 for each of fiscal years 2017 through
20 2021”.

21 **SEC. 305. PILOT PROGRAM GRANTS FOR STATE SUBSTANCE**
22 **ABUSE AGENCIES.**

23 (a) IN GENERAL.—Section 508 of the Public Health
24 Service Act (42 U.S.C. 290bb-1) is amended—

1 (1) by redesignating subsection (r), as amended
2 by section 304, as subsection (s); and

3 (2) by inserting after subsection (q) the fol-
4 lowing new subsection:

5 “(r) PILOT PROGRAM FOR STATE SUBSTANCE
6 ABUSE AGENCIES.—

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

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

18 “(B) help State substance abuse agencies
19 address identified gaps in services furnished to
20 such women along the continuum of care, in-
21 cluding services provided to women in non-resi-
22 dential based settings; and

23 “(C) promote a coordinated, effective, and
24 efficient State system managed by State sub-

1 stance abuse agencies by encouraging new ap-
2 proaches and models of service delivery.

3 “(2) REQUIREMENTS.—In carrying out the
4 pilot program under this subsection, the Director
5 shall—

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

11 “(B) identify, based on such submitted ap-
12 plications, State substance abuse agencies that
13 are eligible for such grants;

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

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

23 “(E) not require that grant recipients
24 under the program make available through use

1 of the grant all services described in subsection
2 (d); and

3 “(F) consider not applying requirements
4 described in paragraphs (1) and (2) of sub-
5 section (f) to applicants, depending on the cir-
6 cumstances of the applicant.

7 “(3) REQUIRED SERVICES.—

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

13 “(i) shall include requirements de-
14 scribed in subsection (c) and be based on
15 the recommendations submitted under sub-
16 paragraph (B); and

17 “(ii) may be selected from among the
18 services described in subsection (d) and in-
19 clude other services as appropriate.

20 “(B) STAKEHOLDER INPUT.—The Director
21 shall convene and solicit recommendations from
22 stakeholders, including State substance abuse
23 agencies, health care providers, persons in re-
24 covery from substance abuse, and other appro-

1 appropriate individuals, for the minimum set of serv-
2 ices described in subparagraph (A).

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

5 “(5) EVALUATION AND REPORT TO CON-
6 GRESS.—The Director of the Center for Behavioral
7 Health Statistics and Quality shall fund an evalua-
8 tion of the pilot program at the conclusion of the
9 first grant cycle funded by the pilot program. The
10 Director of the Center for Behavioral Health Statis-
11 tics and Quality, in coordination with the Director of
12 the Center for Substance Abuse Treatment shall
13 submit to the relevant committees of jurisdiction of
14 the House of Representatives and the Senate a re-
15 port on such evaluation. The report shall include at
16 a minimum outcomes information from the pilot pro-
17 gram, including any resulting reductions in the use
18 of alcohol and other drugs; engagement in treatment
19 services; retention in the appropriate level and dura-
20 tion of services; increased access to the use of medi-
21 cations approved by the Food and Drug Administra-
22 tion for the treatment of substance use disorders in
23 combination with counseling; and other appropriate
24 measures.

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

7 (b) FUNDING.—Subsection (s) of section 508 of the
8 Public Health Service Act (42 U.S.C. 290bb–1), as
9 amended by section 304 and redesignated by subsection
10 (a), is further amended by adding at the end the following
11 new sentence: “Of the amounts made available for a year
12 pursuant to the previous sentence to carry out this section,
13 not more than 25 percent of such amounts shall be made
14 available for such year to carry out subsection (r), other
15 than paragraph (5) of such subsection.”.

16 **SEC. 306. EVIDENCE-BASED OPIOID AND HEROIN TREAT-**
17 **MENT AND INTERVENTIONS DEMONSTRA-**
18 **TION.**

19 Subpart 1 of part B of title V of the Public Health
20 Service Act (42 U.S.C. 290bb et seq.) is amended—

21 (1) by redesignating section 514 (42 U.S.C.
22 290bb–9), as added by section 3632 of the Meth-
23 amphetamine Anti-Proliferation Act of 2000 (Public
24 Law 106–310; 114 Stat. 1236), as section 514B;
25 and

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

2 **“SEC. 514C. EVIDENCE-BASED OPIOID AND HEROIN TREAT-**
3 **MENT AND INTERVENTIONS DEMONSTRA-**
4 **TION.**

5 “(a) GRANTS.—

6 “(1) AUTHORITY TO MAKE GRANTS.—The Di-
7 rector of the Center for Substance Abuse Treatment
8 (referred to in this section as the ‘Director’) shall
9 award grants to State substance abuse agencies,
10 units of local government, nonprofit organizations,
11 and Indian tribes or tribal organizations (as defined
12 in section 4 of the Indian Health Care Improvement
13 Act (25 U.S.C. 1603)) that have a high rate, or
14 have had a rapid increase, in the use of heroin or
15 other opioids, in order to permit such entities to ex-
16 pand activities, including an expansion in the avail-
17 ability of medication assisted treatment, evidence-
18 based counseling, or behavioral therapies with re-
19 spect to the treatment of addiction in the specific
20 geographical areas of such entities where there is a
21 rate or rapid increase in the use of heroin or other
22 opioids.

23 “(2) RECIPIENTS.—The entities receiving
24 grants under paragraph (1) shall be selected by the
25 Director.

1 “(3) NATURE OF ACTIVITIES.—The grant funds
2 awarded under paragraph (1) shall be used for ac-
3 tivities that are based on reliable scientific evidence
4 of efficacy in the treatment of problems related to
5 heroin or other opioids.

6 “(b) GEOGRAPHIC DISTRIBUTION.—The Director
7 shall ensure that grants awarded under subsection (a) are
8 distributed equitably among the various regions of the Na-
9 tion and among rural, urban, and suburban areas that are
10 affected by the use of heroin or other opioids.

11 “(c) ADDITIONAL ACTIVITIES.—The Director shall—

12 “(1) evaluate the activities supported by grants
13 awarded under subsection (a);

14 “(2) disseminate widely such significant infor-
15 mation derived from the evaluation as the Director
16 considers appropriate;

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

21 “(4) fund only those applications that specifi-
22 cally support recovery services as a critical compo-
23 nent of the grant program.

24 “(d) DEFINITION.—The term ‘medication assisted
25 treatment’ means the use, for problems relating to heroin

1 and other opioids, of medications approved by the Food
2 and Drug Administration in combination with counseling
3 and behavioral therapies.

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—

5 “(1) IN GENERAL.—There is authorized to be
6 appropriated to carry out this section \$300,000,000
7 for each of fiscal years 2017 through 2021.

8 “(2) USE OF CERTAIN FUNDS.—Of the funds
9 appropriated to carry out this section in any fiscal
10 year, not more than 5 percent of such funds shall
11 be available to the Director for purposes of carrying
12 out subsection (c).”.

13 **SEC. 307. ADOLESCENT TREATMENT AND RECOVERY SERV-**
14 **ICES DEMONSTRATION GRANT PROGRAM.**

15 Subpart 1 of part B of title V of the Public Health
16 Service Act (42 U.S.C. 290bb et seq.), as amended by sec-
17 tion 306, is further amended by adding at the end the
18 following:

19 **“SEC. 514D. GRANTS TO IMPROVE ACCESS TO TREATMENT**
20 **AND RECOVERY FOR ADOLESCENTS.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Director of the Center for Substance Abuse Treat-
23 ment, shall award grants, contracts, or cooperative agree-
24 ments to eligible State substance abuse agencies and other
25 entities determined appropriate by the Director for the

1 purpose of increasing the capacity of substance use dis-
2 order treatment and recovery services for adolescents.

3 “(b) ELIGIBILITY.—To be eligible to receive a grant,
4 contract, or cooperative agreement under subsection (a)
5 an entity shall—

6 “(1) prepare and submit to the Director an ap-
7 plication at such time, in such manner, and contain
8 such information as the Director may require, in-
9 cluding a plan for the evaluation of any activities
10 carried out with the funds provided under this sec-
11 tion;

12 “(2) ensure that all entities receiving support
13 under the grant, contract, or cooperative agreement
14 comply with all applicable State licensure or certifi-
15 cation requirements regarding the provision of the
16 services involved; and

17 “(3) provide the Director with periodic evalua-
18 tions of the progress of the activities funded under
19 this section and an evaluation at the completion of
20 such activities, as the Director determines to be ap-
21 propriate.

22 “(c) PRIORITY.—In awarding grants, contracts, and
23 cooperative agreements under subsection (a), the Director
24 shall give priority to applicants who propose to fill a dem-

1 onstrated geographic need for adolescent specific residen-
2 tial treatment services.

3 “(d) USE OF FUNDS.—Amounts awarded under
4 grants, contracts, or cooperative agreements under this
5 section may be used to enable health care providers or fa-
6 cilities that provide treatment and recovery assistance for
7 adolescents with a substance use disorder to provide the
8 following services:

9 “(1) Individualized patient centered care that is
10 specific to circumstances of the individual patient.

11 “(2) Clinically appropriate, trauma-informed,
12 gender-specific and age appropriate treatment serv-
13 ices that are based on reliable scientific evidence of
14 efficacy in the treatment of problems related to sub-
15 stance use disorders.

16 “(3) Clinically appropriate care to address
17 treatment for substance use and any co-occurring
18 physical and mental health disorders at the same lo-
19 cation, and through access to primary care services.

20 “(4) Coordination of treatment services with re-
21 covery and other social support, including edu-
22 cational, vocational training, assistance with the ju-
23 venile justice system, child welfare, and mental
24 health agencies.

1 “(5) Aftercare and long-term recovery support,
2 including peer support services.

3 “(e) DURATION OF ASSISTANCE.—Grants, contracts,
4 and cooperative agreements awarded under subsection (a)
5 shall be for a period not to exceed 5 years.

6 “(f) ADDITIONAL ACTIVITIES.—The Director shall—

7 “(1) collect and evaluate the activities carried
8 out with amounts received under subsection (a);

9 “(2) disseminate widely such significant infor-
10 mation derived from the evaluation as the Secretary
11 considers appropriate; and

12 “(3) provide States, Indian tribes and tribal or-
13 ganizations, and providers with technical assistance
14 in connection with the provision of treatment and re-
15 covery services funded through this section to ado-
16 lescents related to the abuse of heroin and other
17 opioids.

18 “(g) AUTHORIZATION OF APPROPRIATIONS.—

19 “(1) IN GENERAL.—There is authorized to be
20 appropriated to carry out this section, \$25,000,000
21 for each of fiscal years 2017 through 2021.

22 “(2) USE OF CERTAIN FUNDS.—Of the funds
23 appropriated to carry out this section in any fiscal
24 year, not more than 5 percent of such funds shall

1 be available to the Director for purposes of carrying
2 out subsection (f).”.

3 **SEC. 308. STRENGTHENING PARITY IN MENTAL HEALTH**
4 **AND SUBSTANCE USE DISORDER BENEFITS.**

5 (a) PUBLIC HEALTH SERVICE ACT.—Section
6 2726(a) of the Public Health Service Act (42 U.S.C.
7 300gg–26(a)) is amended by adding at the end the fol-
8 lowing new paragraphs:

9 “(6) DISCLOSURE AND ENFORCEMENT RE-
10 QUIREMENTS.—

11 “(A) DISCLOSURE REQUIREMENTS.—

12 “(i) REGULATIONS.—Not later than
13 December 31, 2016, the Secretary, in co-
14 operation with the Secretaries of Labor
15 and the Treasury, as appropriate, shall
16 issue additional regulations for carrying
17 out this section, including an explanation
18 of documents that must be disclosed by
19 plans and issuers, the process governing
20 such disclosures by plans and issuers, and
21 analyses that must be conducted by plans
22 and issuers by a group health plan or
23 health insurance issuer offering health in-
24 surance coverage in the group or individual
25 market in order for such plan or issuer to

1 demonstrate compliance with the provisions
2 of this section.

3 “(ii) DISCLOSURE REQUIREMENTS.—
4 Documents required to be disclosed by a
5 group health plan or health insurance
6 issuer offering health insurance coverage in
7 the group or individual market under
8 clause (i) shall include an annual report
9 that details the specific analyses performed
10 to ensure compliance of such plan or cov-
11 erage with the law and regulations. At a
12 minimum, with respect to the application
13 of non-quantitative treatment limitations
14 (in this paragraph referred to as NQTLs)
15 to benefits under the plan or coverage,
16 such report shall—

17 “(I) identify the specific factors
18 the plan or coverage used in per-
19 forming its NQTL analysis;

20 “(II) identify and define the spe-
21 cific evidentiary standards relied on to
22 evaluate the factors;

23 “(III) describe how the evi-
24 dentiary standards are applied to each
25 service category for mental health,

1 substance use disorders, medical bene-
2 fits, and surgical benefits;

3 “(IV) disclose the results of the
4 analyses of the specific evidentiary
5 standards in each service category;
6 and

7 “(V) disclose the specific findings
8 of the plan or coverage in each service
9 category and the conclusions reached
10 with respect to whether the processes,
11 strategies, evidentiary standards, or
12 other factors used in applying the
13 NQTL to mental health or substance
14 use disorder benefits are comparable
15 to, and applied no more stringently
16 than, the processes, strategies, evi-
17 dentiary standards, or other factors
18 used in applying the limitation with
19 respect to medical and surgical bene-
20 fits in the same classification.

21 “(iii) GUIDANCE.—The Secretary, in
22 cooperation with the Secretaries of Labor
23 and the Treasury, as appropriate, shall
24 issue guidance to group health plans and
25 health insurance issuers offering health in-

1 surance coverage in the group or individual
2 markets on how to satisfy the requirements
3 of this section with respect to making in-
4 formation available to current and poten-
5 tial participants and beneficiaries. Such in-
6 formation shall include certificate of cov-
7 erage documents and instruments under
8 which the plan or coverage involved is ad-
9 ministered and operated that specify, in-
10 clude, or refer to procedures, formulas, and
11 methodologies applied to determine a par-
12 ticipant or beneficiary's benefit under the
13 plan or coverage, regardless of whether
14 such information is contained in a docu-
15 ment designated as the 'plan document'.
16 Such guidance shall include a disclosure of
17 how the plan or coverage involved has pro-
18 vided that processes, strategies, evidentiary
19 standards, and other factors used in apply-
20 ing the NQTL to mental health or sub-
21 stance use disorder benefits are com-
22 parable to, and applied no more stringently
23 than, the processes, strategies, evidentiary
24 standards, or other factors used in apply-
25 ing the limitation with respect to medical

1 and surgical benefits in the same classi-
2 fication.

3 “(iv) DEFINITIONS.—In this para-
4 graph and paragraph (7), the terms ‘non-
5 quantitative treatment limitations’, ‘com-
6 parable to’, and ‘applied no more strin-
7 gently than’ have the meanings given such
8 terms in sections 146 and 147 of title 45,
9 Code of Federal Regulations (or any suc-
10 cessor regulation).

11 “(B) ENFORCEMENT.—

12 “(i) PROCESS FOR COMPLAINTS.—The
13 Secretary, in cooperation with the Secre-
14 taries of Labor and the Treasury, as ap-
15 propriate, shall, with respect to group
16 health plans and health insurance issuers
17 offering health insurance coverage in the
18 group or individual market, issue guidance
19 to clarify the process and timeline for cur-
20 rent and potential participants and bene-
21 ficiaries (and authorized representatives
22 and health care providers of such partici-
23 pants and beneficiaries) with respect to
24 such plans and coverage to file formal
25 complaints of such plans or issuers being

1 in violation of this section, including guid-
2 ance, by plan type, on the relevant State,
3 regional, and national offices with which
4 such complaints should be filed.

5 “(ii) AUTHORITY FOR PUBLIC EN-
6 FORCEMENT.—The Secretary, in consulta-
7 tion with the Secretaries of Labor and the
8 Treasury, shall make available to the pub-
9 lic on the Consumer Parity Portal website
10 established under paragraph (7) de-identi-
11 fied information on audits and investiga-
12 tions of group health plans and health in-
13 surance issuers conducted under this sec-
14 tion.

15 “(iii) AUDITS.—

16 “(I) RANDOMIZED AUDITS.—The
17 Secretary in cooperation with the Sec-
18 retaries of Labor and the Treasury, is
19 authorized to conduct randomized au-
20 dits of group health plans and health
21 insurance issuers offering health in-
22 surance coverage in the group or indi-
23 vidual market to determine compli-
24 ance with this section. Such audits
25 shall be conducted on no fewer than

1 twelve plans and issuers per plan
2 year. Information from such audits
3 shall be made plainly available on the
4 Consumer Parity Portal website es-
5 tablished under paragraph (7).

6 “(II) ADDITIONAL AUDITS.—In
7 the case of a group health plan or
8 health insurance issuer offering health
9 insurance coverage in the group or in-
10 dividual market with respect to which
11 any claim has been filed during a plan
12 year, the Secretary may audit the
13 books and records of such plan or
14 issuer to determine compliance with
15 this section. Information detailing the
16 results of the audit shall be made
17 available on the Consumer Parity Por-
18 tal website established under para-
19 graph (7).

20 “(iv) DENIAL RATES.—The Secretary
21 shall collect information on the rates of
22 and reasons for denial by group health
23 plans and health insurance issuers offering
24 health insurance coverage in the group or
25 individual market of claims for outpatient

1 and inpatient mental health and substance
2 use disorder services compared to the rates
3 of and reasons for denial of claims for
4 medical and surgical services. For the first
5 plan year beginning at least two years
6 after the date of the enactment of this
7 paragraph and each subsequent plan year,
8 the Secretary shall submit to the Com-
9 mittee on Energy and Commerce of the
10 House of Representatives and the Com-
11 mittee on Health, Education, Labor, and
12 Pensions of the Senate, and make plainly
13 available on the Consumer Parity Portal
14 website under paragraph (7), the informa-
15 tion collected under the previous sentence
16 with respect to the previous plan year.

17 “(7) CONSUMER PARITY PORTAL WEBSITE.—
18 The Secretary, in consultation with the Secretaries
19 of Labor and the Treasury, shall establish a one-
20 stop Internet website portal for—

21 “(A) submitting complaints and violations
22 relating to this section, section 712 of the Em-
23 ployee Retirement Income Security Act of 1974,
24 and section 9812 of the Internal Revenue Code
25 of 1986; and

1 “(B) for each of such Secretaries to submit
2 information in order to provide such informa-
3 tion to health care consumers pursuant to para-
4 graph (6), section 712(a)(6) of the Employee
5 Retirement Income Security Act of 1974, and
6 section 9812(a)(6) of the Internal Revenue
7 Code of 1986.

8 Such portal shall have the ability to take basic infor-
9 mation related to the complaint, including name,
10 contact information, and brief narrative, and trans-
11 mit such information in a timely fashion to the ap-
12 propriate State or Federal enforcement agency. Once
13 the consumer information is submitted, such portal
14 shall provide the consumer with contact information
15 for the appropriate enforcement agency to follow-up
16 on the complaint.”.

17 (b) EMPLOYEE RETIREMENT INCOME SECURITY ACT
18 OF 1974.—Section 712(a) of the Employee Retirement In-
19 come Security Act of 1974 (29 U.S.C. 1185a(a)) is
20 amended by adding at the end the following new para-
21 graph:

22 “(6) DISCLOSURE AND ENFORCEMENT RE-
23 QUIREMENTS.—

24 “(A) DISCLOSURE REQUIREMENTS.—

1 “(i) REGULATIONS.—Not later than
2 December 31, 2016, the Secretary, in co-
3 operation with the Secretaries of Health
4 and Human Services and the Treasury, as
5 appropriate, shall issue additional regula-
6 tions for carrying out this section, includ-
7 ing an explanation of documents that must
8 be disclosed by plans and issuers, the proc-
9 ess governing such disclosures by plans
10 and issuers, and analyses that must be
11 conducted by plans and issuers by a group
12 health plan (or health insurance coverage
13 offered in connection with such a plan) in
14 order for such plan or issuer to dem-
15 onstrate compliance with the provisions of
16 this section.

17 “(ii) DISCLOSURE REQUIREMENTS.—
18 Documents required to be disclosed by a
19 group health plan (or health insurance cov-
20 erage offered in connection with such a
21 plan) under clause (i) shall include an an-
22 nual report that details the specific anal-
23 yses performed to ensure compliance of
24 such plan or coverage with the law or regu-
25 lations. At a minimum, with respect to the

1 application of non-quantitative treatment
2 limitations (in this paragraph referred to
3 as NQTLs) to benefits under the plan or
4 coverage, such report shall—

5 “(I) identify the specific factors
6 the plan or coverage used in per-
7 forming its NQTL analysis;

8 “(II) identify and define the spe-
9 cific evidentiary standards relied on to
10 evaluate the factors;

11 “(III) describe how the evi-
12 dentiary standards are applied to each
13 service category for mental health,
14 substance use disorders, medical bene-
15 fits, and surgical benefits;

16 “(IV) disclose the results of the
17 analyses of the specific evidentiary
18 standards in each service category;
19 and

20 “(V) disclose the specific findings
21 of the plan or coverage in each service
22 category and the conclusions reached
23 with respect to whether the processes,
24 strategies, evidentiary standards, or
25 other factors used in applying the

1 NQTL to mental health or substance
2 use disorder benefits are comparable
3 to, and applied no more stringently
4 than, the processes, strategies, evi-
5 dentiary standards, or other factors
6 used in applying the limitation with
7 respect to medical and surgical bene-
8 fits in the same classification.

9 “(iii) GUIDANCE.—The Secretary, in
10 cooperation with the Secretaries of Health
11 and Human Services and the Treasury, as
12 appropriate, shall issue guidance to group
13 health plans (and health insurance cov-
14 erage offered in connection with such a
15 plan) on how to satisfy the requirements of
16 this section with respect to making infor-
17 mation available to current and potential
18 participants and beneficiaries. Such infor-
19 mation shall include certificate of coverage
20 documents and instruments under which
21 the plan or coverage involved is adminis-
22 tered and operated that specify, include, or
23 refer to procedures, formulas, and meth-
24 odologies applied to determine a partici-
25 pant or beneficiary’s benefit under the plan

1 or coverage, regardless of whether such in-
2 formation is contained in a document des-
3 ignated as the ‘plan document’. Such guid-
4 ance shall include a disclosure of how the
5 plan or coverage involved has provided that
6 processes, strategies, evidentiary stand-
7 ards, and other factors used in applying
8 the NQTL to mental health or substance
9 use disorder benefits are comparable to,
10 and applied no more stringently than, the
11 processes, strategies, evidentiary stand-
12 ards, or other factors used in applying the
13 limitation with respect to medical and sur-
14 gical benefits in the same classification.

15 “(iv) DEFINITIONS.—In this para-
16 graph, the terms ‘non-quantitative treat-
17 ment limitations’, ‘comparable to’, and ‘ap-
18 plied no more stringently than’ have the
19 meanings given such terms in sections 146
20 and 147 of title 45, Code of Federal Regu-
21 lations (or any successor regulation).

22 “(B) ENFORCEMENT.—

23 “(i) PROCESS FOR COMPLAINTS.—The
24 Secretary, in cooperation with the Secre-
25 taries of Health and Human Services and

1 the Treasury, as appropriate, shall, with
2 respect to group health plans (and health
3 insurance coverage offered in connection
4 with such a plan), issue guidance to clarify
5 the process and timeline for current and
6 potential participants and beneficiaries
7 (and authorized representatives and health
8 care providers of such participants and
9 beneficiaries) with respect to such plans
10 (and coverage) to file formal complaints of
11 such plans (or coverage) being in violation
12 of this section, including guidance, by plan
13 type, on the relevant State, regional, and
14 national offices with which such complaints
15 should be filed.

16 “(ii) AUTHORITY FOR PUBLIC EN-
17 FORCEMENT.—The Secretary, in consulta-
18 tion with the Secretaries of Labor and the
19 Treasury, shall make available to the pub-
20 lic on the Consumer Parity Portal website
21 established under section 2726(a)(7) of the
22 Public Health Service Act de-identified in-
23 formation on audits and investigations of
24 group health plans (and health insurance

1 coverage offered in connection with such a
2 plan) conducted under this section.

3 “(iii) AUDITS.—

4 “(I) RANDOMIZED AUDITS.—The
5 Secretary in cooperation with the Sec-
6 retaries of Health and Human Serv-
7 ices and the Treasury, is authorized
8 to conduct randomized audits of
9 group health plans (and health insur-
10 ance coverage offered in connection
11 with such a plan) to determine com-
12 pliance with this section. Such audits
13 shall be conducted on no fewer than
14 twelve plans and coverage per plan
15 year. Information from such audits
16 shall be made plainly available on the
17 Consumer Parity Portal website es-
18 tablished under section 2726(a)(7) of
19 the Public Health Service Act.

20 “(II) ADDITIONAL AUDITS.—In
21 the case of a group health plan (or
22 health insurance coverage offered in
23 connection with such a plan) with re-
24 spect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan (or coverage) to determine
3 compliance with this section. Informa-
4 tion detailing the results of the audit
5 shall be made available on the Con-
6 sumer Parity Portal website estab-
7 lished under section 2726(a)(7) of the
8 Public Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans (and health insurance coverage of-
13 fered in connection with such a plan) of
14 claims for outpatient and inpatient mental
15 health and substance use disorder services
16 compared to the rates of and reasons for
17 denial of claims for medical and surgical
18 services. For the first plan year beginning
19 at least two years after the date of the en-
20 actment of this paragraph and each subse-
21 quent plan year, the Secretary shall submit
22 to the Committee on Energy and Com-
23 merce of the House of Representatives and
24 the Committee on Health, Education,
25 Labor, and Pensions of the Senate, and

1 make plainly available on the Consumer
2 Parity Portal website under section
3 2726(a)(7) of the Public Health Service
4 Act, the information collected under the
5 previous sentence with respect to the pre-
6 vious plan year.”.

7 (c) INTERNAL REVENUE CODE OF 1986.—Section
8 9812(a) of the Internal Revenue Code of 1986 is amended
9 by adding at the end the following new paragraph:

10 “(6) DISCLOSURE AND ENFORCEMENT RE-
11 QUIREMENTS.—

12 “(A) DISCLOSURE REQUIREMENTS.—

13 “(i) REGULATIONS.—Not later than
14 December 31, 2016, the Secretary, in co-
15 operation with the Secretaries of Health
16 and Human Services and Labor, as appro-
17 priate, shall issue additional regulations for
18 carrying out this section, including an ex-
19 planation of documents that must be dis-
20 closed by plans and issuers, the process
21 governing such disclosures by plans and
22 issuers, and analyses that must be con-
23 ducted by plans and issuers by a group
24 health plan in order for such plan to dem-

1 onstrate compliance with the provisions of
2 this section.

3 “(ii) DISCLOSURE REQUIREMENTS.—
4 Documents required to be disclosed by a
5 group health plan under clause (i) shall in-
6 clude an annual report that details the spe-
7 cific analyses performed to ensure compli-
8 ance of such plan with the law and regula-
9 tions. At a minimum, with respect to the
10 application of non-quantitative treatment
11 limitations (in this paragraph referred to
12 as NQTLs) to benefits under the plan or
13 coverage, such report shall—

14 “(I) identify the specific factors
15 the plan or coverage used in per-
16 forming its NQTL analysis;

17 “(II) identify and define the spe-
18 cific evidentiary standards relied on to
19 evaluate the factors;

20 “(III) describe how the evi-
21 dentiary standards are applied to each
22 service category for mental health,
23 substance use disorders, medical bene-
24 fits, and surgical benefits;

1 “(IV) disclose the results of the
2 analyses of the specific evidentiary
3 standards in each service category;
4 and

5 “(V) disclose the specific findings
6 of the plan in each service category
7 and the conclusions reached with re-
8 spect to whether the processes, strate-
9 gies, evidentiary standards, or other
10 factors used in applying the NQTL to
11 mental health or substance use dis-
12 order benefits are comparable to, and
13 applied no more stringently than, the
14 processes, strategies, evidentiary
15 standards, or other factors used in ap-
16 plying the limitation with respect to
17 medical and surgical benefits in the
18 same classification.

19 “(iii) GUIDANCE.—The Secretary, in
20 cooperation with the Secretaries of Health
21 and Human Services and Labor, as appro-
22 priate, shall issue guidance to group health
23 plans on how to satisfy the requirements of
24 this section with respect to making infor-
25 mation available to current and potential

1 participants and beneficiaries. Such infor-
2 mation shall include certificate of coverage
3 documents and instruments under which
4 the plan involved is administered and oper-
5 ated that specify, include, or refer to pro-
6 cedures, formulas, and methodologies ap-
7 plied to determine a participant or bene-
8 ficiary's benefit under the plan, regardless
9 of whether such information is contained
10 in a document designated as the 'plan doc-
11 ument'. Such guidance shall include a dis-
12 closure of how the plan involved has pro-
13 vided that processes, strategies, evidentiary
14 standards, and other factors used in apply-
15 ing the NQTL to mental health or sub-
16 stance use disorder benefits are com-
17 parable to, and applied no more stringently
18 than, the processes, strategies, evidentiary
19 standards, or other factors used in apply-
20 ing the limitation with respect to medical
21 and surgical benefits in the same classi-
22 fication.

23 “(iv) DEFINITIONS.—In this para-
24 graph, the terms ‘non-quantitative treat-
25 ment limitations’, ‘comparable to’, and ‘ap-

1 plied no more stringently than' have the
2 meanings given such terms in sections 146
3 and 147 of title 45, Code of Federal Regu-
4 lations (or any successor regulation).

5 “(B) ENFORCEMENT.—

6 “(i) PROCESS FOR COMPLAINTS.—The
7 Secretary, in cooperation with the Secre-
8 taries of Health and Human Services and
9 Labor, as appropriate, shall, with respect
10 to group health plans, issue guidance to
11 clarify the process and timeline for current
12 and potential participants and beneficiaries
13 (and authorized representatives and health
14 care providers of such participants and
15 beneficiaries) with respect to such plans
16 (and coverage) to file formal complaints of
17 such plans being in violation of this sec-
18 tion, including guidance, by plan type, on
19 the relevant State, regional, and national
20 offices with which such complaints should
21 be filed.

22 “(ii) AUTHORITY FOR PUBLIC EN-
23 FORCEMENT.—The Secretary, in consulta-
24 tion with the Secretaries of Labor and the
25 Treasury, shall make available to the pub-

1 lic on the Consumer Parity Portal website
2 established under section 2726(a)(7) of the
3 Public Health Service Act de-identified in-
4 formation on audits and investigations of
5 group health plans conducted under this
6 section.

7 “(iii) AUDITS.—

8 “(I) RANDOMIZED AUDITS.—The
9 Secretary in cooperation with the Sec-
10 retaries of Health and Human Serv-
11 ices and Labor, is authorized to con-
12 duct randomized audits of group
13 health plans to determine compliance
14 with this section. Such audits shall be
15 conducted on no fewer than twelve
16 plans per plan year. Information from
17 such audits shall be made plainly
18 available on the Consumer Parity Por-
19 tal website established under section
20 2726(a)(7) of the Public Health Serv-
21 ice Act.

22 “(II) ADDITIONAL AUDITS.—In
23 the case of a group health plan with
24 respect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan to determine compliance
3 with this section. Information detail-
4 ing the results of the audit shall be
5 made available on the Consumer Par-
6 ity Portal website established under
7 section 2726(a)(7) of the Public
8 Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans of claims for outpatient and inpa-
13 tient mental health and substance use dis-
14 order services compared to the rates of and
15 reasons for denial of claims for medical
16 and surgical services. For the first plan
17 year beginning at least two years after the
18 date of the enactment of this paragraph
19 and each subsequent plan year, the Sec-
20 retary shall submit to the Committee on
21 Energy and Commerce of the House of
22 Representatives and the Committee on
23 Health, Education, Labor, and Pensions of
24 the Senate, and make plainly available on
25 the Consumer Parity Portal website under

1 section 2726(a)(7) of the Public Health
2 Service Act, the information collected
3 under the previous sentence with respect to
4 the previous plan year.”.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated \$2,000,000 for each of fis-
7 cal years 2017 through 2021 to carry out this section, in-
8 cluding the amendments made by this section.

9 **SEC. 309. STUDY ON TREATMENT INFRASTRUCTURE.**

10 Not later than 24 months after the date of enactment
11 of this Act, the Comptroller General of the United States
12 shall initiate an evaluation, and submit to Congress a re-
13 port, of the in-patient and outpatient treatment capacity,
14 availability, and needs of the United States, which shall
15 include, to the extent data is available—

16 (1) the capacity of acute residential or inpatient
17 detoxification programs;

18 (2) the capacity of inpatient clinical stabiliza-
19 tion programs, transitional residential support serv-
20 ices, and residential rehabilitation programs;

21 (3) the capacity of demographic specific resi-
22 dential or inpatient treatment programs, such as
23 those designed for pregnant women or adolescents;

24 (4) geographical differences of the availability
25 of residential and outpatient treatment and recovery

1 options for substance use disorders across the con-
2 tinuum of care;

3 (5) the availability of residential and outpatient
4 treatment programs that offer treatment options
5 based on reliable scientific evidence of efficacy for
6 the treatment of substance use disorders, including
7 the use of Food and Drug Administration-approved
8 medicines and evidence-based nonpharmacological
9 therapies;

10 (6) the number of patients in residential and
11 specialty outpatient treatment services for substance
12 use disorders; and

13 (7) an assessment of the need for residential
14 and outpatient treatment for substance use disorders
15 across the continuum of care.

16 **SEC. 310. SUBSTANCE USE DISORDER PROFESSIONAL LOAN**
17 **REPAYMENT PROGRAM.**

18 Subpart 3 of part E of title VII of the Public Health
19 Service Act (42 U.S.C. 295f et seq.) is amended by adding
20 at the end the following:

21 **“SEC. 779. SUBSTANCE USE DISORDER PROFESSIONAL**
22 **LOAN REPAYMENT PROGRAM.**

23 “(a) ESTABLISHMENT.—The Secretary shall estab-
24 lish and carry out a substance use disorder health profes-
25 sional loan repayment program under which qualified

1 health professionals agree to be employed full-time for a
2 specified period (which shall be not less than 2 years) in
3 providing substance use disorder prevention and treatment
4 services.

5 “(b) PROGRAM ADMINISTRATION.—Through the pro-
6 gram established under this section, the Secretary shall
7 enter into contracts with qualified health professionals
8 under which—

9 “(1) a qualified health professional agrees to
10 provide substance use disorder prevention and treat-
11 ment services with respect to an area or population
12 that (as determined by the Secretary)—

13 “(A) has a shortage of such services (as
14 defined by the Secretary); and

15 “(B) has a sufficient population of individ-
16 uals with a substance use disorder to support
17 the provision of such services; and

18 “(2) the Secretary agrees to make payments on
19 the principal and interest of undergraduate, or grad-
20 uate education loans of the qualified health profes-
21 sional—

22 “(A) of not more than \$35,000 for each
23 year of service described in paragraph (1); and

24 “(B) for not more than 3 years.

1 “(c) QUALIFIED HEALTH PROFESSIONAL DE-
 2 FINED.—In this section, the term ‘qualified health profes-
 3 sional’ means an individual who is (or will be upon the
 4 completion of the individual’s graduate education) a psy-
 5 chiatrist, psychologist, nurse practitioner, physician assist-
 6 ant, clinical social worker, substance abuse counselor, or
 7 other substance use disorder health professional.

8 “(d) PRIORITY.—In entering into agreements under
 9 this section, the Secretary shall give priority to applicants
 10 who—

11 “(1) have familiarity with evidence-based meth-
 12 ods and culturally and linguistically competent
 13 health care services; and

14 “(2) demonstrate financial need.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 16 is authorized to be appropriated \$20,000,000 for each of
 17 fiscal years 2017 through 2021 to carry out this section.”.

18 **TITLE IV—RECOVERY**

19 **SEC. 401. NATIONAL YOUTH RECOVERY INITIATIVE.**

20 (a) DEFINITIONS.—In this section:

21 (1) ELIGIBLE ENTITY.—The term “eligible enti-
 22 ty” means—

23 (A) a high school that has been accredited
 24 as a recovery high school by the Association of
 25 Recovery Schools;

1 (B) an accredited high school that is seek-
2 ing to establish or expand recovery support
3 services;

4 (C) an institution of higher education;

5 (D) a recovery program at a nonprofit col-
6 legiate institution; or

7 (E) a nonprofit organization.

8 (2) INSTITUTION OF HIGHER EDUCATION.—The
9 term “institution of higher education” has the
10 meaning given the term in section 101 of the Higher
11 Education Act of 1965 (20 U.S.C. 1001).

12 (3) RECOVERY PROGRAM.—The term “recovery
13 program”—

14 (A) means a program to help individuals
15 who are recovering from substance use dis-
16 orders to initiate, stabilize, and maintain
17 healthy and productive lives in the community;
18 and

19 (B) includes peer-to-peer support and com-
20 munal activities to build recovery skills and
21 supportive social networks.

22 (b) GRANTS AUTHORIZED.—The Secretary of Health
23 and Human Services, acting through the Substance Abuse
24 and Mental Health Services Administration, in consulta-

1 tion with the Secretary of Education, may award grants
2 to eligible entities to enable the entities to—

3 (1) provide substance use recovery support serv-
4 ices to young people in high school and enrolled in
5 institutions of higher education;

6 (2) help build communities of support for young
7 people in recovery through a spectrum of activities
8 such as counseling and healthy and wellness-oriented
9 social activities; and

10 (3) encourage initiatives designed to help young
11 people achieve and sustain recovery from substance
12 use disorders.

13 (c) USE OF FUNDS.—Grants awarded under sub-
14 section (b) may be used for activities to develop, support,
15 and maintain youth recovery support services, including—

16 (1) the development and maintenance of a dedi-
17 cated physical space for recovery programs;

18 (2) dedicated staff for the provision of recovery
19 programs;

20 (3) healthy and wellness-oriented social activi-
21 ties and community engagement;

22 (4) establishment of recovery high schools;

23 (5) coordination of recovery programs with—

24 (A) substance use disorder treatment pro-
25 grams and systems;

1 (B) providers of mental health services;

2 (C) primary care providers;

3 (D) the criminal justice system, including
4 the juvenile justice system;

5 (E) employers;

6 (F) housing services;

7 (G) child welfare services;

8 (H) institutions of secondary higher edu-
9 cation and institutions of higher education; and

10 (I) other programs or services related to
11 the welfare of an individual in recovery from a
12 substance use disorder;

13 (6) the development of peer-to-peer support
14 programs or services; and

15 (7) additional activities that help youths and
16 young adults to achieve recovery from substance use
17 disorders.

18 (d) TECHNICAL SUPPORT.—The Secretary of Health
19 and Human Services shall provide technical support to re-
20 cipients of grants under this section.

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section
23 \$30,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 402. GRANTS TO ENHANCE AND EXPAND RECOVERY**
2 **SUPPORT SERVICES.**

3 Subpart 1 of part B of title V of the Public Health
4 Service Act (42 U.S.C. 290bb et seq.), as amended by sec-
5 tions 306 and 307, is further amended by adding at the
6 end the following:

7 **“SEC. 514E. GRANTS TO ENHANCE AND EXPAND RECOVERY**
8 **SUPPORT SERVICES.**

9 “(a) **IN GENERAL.**—The Secretary, acting through
10 the Administrator of the Substance Abuse and Mental
11 Health Services Administration, shall award grants to
12 State substance abuse agencies and nonprofit organiza-
13 tions to develop, expand, and enhance recovery support
14 services for individuals with substance use disorders.

15 “(b) **ELIGIBLE ENTITIES.**—In the case of an appli-
16 cant that is not a State substance abuse agency, to be
17 eligible to receive a grant under this section, the entity
18 shall—

19 “(1) prepare and submit to the Secretary an
20 application at such time, in such manner, and con-
21 tain such information as the Secretary may require,
22 including a plan for the evaluation of any activities
23 carried out with the funds provided under this sec-
24 tion;

1 “(2) demonstrate the inclusion of individuals in
2 recovery from a substance use disorder in leadership
3 levels or governing bodies of the entity;

4 “(3) have as a primary mission the provision of
5 long-term recovery support for substance use dis-
6 orders; and

7 “(4) be accredited by the Council on the Ac-
8 creditation of Peer Recovery Support Services or
9 meet any applicable State certification requirements
10 regarding the provision of the recovery services in-
11 volved.

12 “(c) USE OF FUNDS.—Amounts awarded under a
13 grant under this section shall be used to provide for the
14 following activities:

15 “(1) Educating and mentoring that assists indi-
16 viduals and families with substance use disorders in
17 navigating systems of care.

18 “(2) Peer recovery support services which in-
19 clude peer coaching and mentoring.

20 “(3) Recovery-focused community education
21 and outreach programs, including training on the
22 use of all forms of opioid overdose antagonists used
23 to counter the effects of an overdose.

24 “(4) Training, mentoring, and education to de-
25 velop and enhance peer mentoring and coaching.

1 “(5) Programs aimed at identifying and reduc-
2 ing stigma and discriminatory practices that serve as
3 barriers to substance use disorder recovery and
4 treatment of these disorders.

5 “(6) Developing partnerships between networks
6 that support recovery and other community organi-
7 zations and services, including—

8 “(A) public and private substance use dis-
9 order treatment programs and systems;

10 “(B) health care providers;

11 “(C) recovery-focused addiction and recov-
12 ery professionals;

13 “(D) faith-based organizations;

14 “(E) organizations focused on criminal jus-
15 tice reform;

16 “(F) schools; and

17 “(G) social service agencies in the commu-
18 nity, including educational, juvenile justice,
19 child welfare, housing, and mental health agen-
20 cies.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section,
23 \$100,000,000 for each of fiscal years 2017 through
24 2021.”.

○