I

114TH CONGRESS
2D SESSION

H. R. 5189

To address the opioid abuse crisis.

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 2016

Ms. KUSTER introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Veterans' Affairs, Education and the Workforce, Ways and Means, Armed Services, and Natural Resources, 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

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A BILL

To address the opioid abuse crisis.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Opioid Abuse Crisis Act of 2016".

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

TITLE I—PUBLIC HEALTH PROVISIONS

SEC. 101. FUNDING FOR OPIOID AND HEROIN ABUSE PREVENTION AND TREATMENT.

(a) FUNDING.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $600,000,000 for fiscal year 2017, to improve opioid prescribing practices and expand access to substance use treatments to reduce opioid use disorders and overdose, to be made available in accordance with this Act.

(b) STATE TARGETED RESPONSE COOPERATIVE AGREEMENTS.—Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 509 the following:

"SEC. 510. STATE TARGETED RESPONSE COOPERATIVE AGREEMENTS.

''(a) IN GENERAL.—The Secretary shall enter into additional targeted response cooperative agreements with States under this title to expand opioid treatment capacity and make services more affordable to those who cannot afford such services.

''(b) AWARDING OF FUNDING.—The Secretary shall allocate funding to States under this section based on—

''(1) the severity of the opioid epidemic in the State; and

''(2) the strength of the strategy of the State to respond to such epidemic.

''(c) USE OF FUNDS.—Amounts received by a State under this section shall be used to expand treatment capacity and make services more affordable to those who cannot afford such services and to help individuals seek treatment, successfully complete treatment, and sustain recovery.

''(d) FUNDING.—Of the amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Ex-

pansion and Modernization Act for fiscal year 2017, $460,000,000 shall be made available to carry out this section, to remain available until expended.''.

(c) TREATMENT FOR PRESCRIPTION DRUG ABUSE AND HEROIN USE.—Section 331(b) of the Public Health Service Act (42 U.S.C. 254d(b)) is amended by adding at the end the following:

''(3)(A) The Secretary shall use amounts made available under subparagraph (B) to support enhanced loan repayment awards to increase the number of clinicians in the Corps with medication assisted treatment training to treat individuals with opioid use disorders through loan repayments to clinicians.

''(B) Of the amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, $25,000,000 shall be made available to carry out this section, to remain available until expended.''.

(d) EVALUATION OF MEDICATION-ASSISTED TREATMENT.—Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 510, as added by subsection (b), the following:

"SEC. 511. EVALUATION OF MEDICATION-ASSISTED TREATMENT.

''(a) IN GENERAL.—In order to assess the treatment outcomes of patients with opioid addiction receiving medication-assisted treatment, the Secretary shall evaluate the short, medium, and long-term outcomes of such substance abuse treatment programs in order to increase effectiveness in reducing opioid use disorders, overdose, and death.

''(b) FUNDING.—Of the amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, $15,000,000 shall be made available to carry out this section, to remain available until expended.''.

SEC. 102. OPIOID OVERDOSE REVERSAL DRUGS PRESCRIBING GRANT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than six months after the date of the enactment of this Act, the Secretary of Health and Human Services may establish, in accordance with this section, a five-year opioid overdose reversal drugs prescribing grant program (in this section referred to as the ''grant program'').

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

(3) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means a federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), an opioid treatment program under part 8 of title 42, Code of Federal Regulations, any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)), or any other entity that the Secretary deems appropriate.

(4) PRESCRIBING.—For purposes of this section, the term ''prescribing'' means, with respect to an opioid overdose reversal drug, such as naloxone, the practice of prescribing such drug—

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

(B) in conjunction with an opioid agonist approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for the treatment of opioid abuse disorder;

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

(D) in other circumstances, as identified by the Secretary, in which a provider identifies

a patient is at an elevated risk for an intentional or unintentional drug overdose from heroin or prescription opioid therapies.

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

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

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

(3) how such program will work to try to identify State, local, or private funding to continue the program after expiration of the grant.

(c) USE OF FUNDS.—An eligible entity receiving a grant under this section may use the grant for any of the following activities, but may use not more than 20 percent of the grant funds for activities described in paragraphs (4) and (5):

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

(2) To train and provide resources for health care providers and pharmacists on the prescribing of opioid overdose reversal drugs, such as naloxone.

(3) To establish mechanisms and processes for tracking patients participating in the program described in paragraph (1) and the health outcomes of such patients.

(4) To purchase opioid overdose reversal drugs, such as naloxone, for distribution under the program described in paragraph (1).

(5) To offset the co-pays and other cost sharing associated with opioid overdose reversal drugs, such as naloxone, to ensure that cost is not a limiting factor for eligible patients.

(6) To conduct community outreach, in conjunction with community-based organizations, designed to raise awareness of prescribing practices, and the availability of opioid overdose reversal drugs, such as naloxone.

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

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

(1) the number of prescribers trained;

(2) the number of prescribers who have co-prescribed an opioid overdose reversal drug, such as naloxone, to at least one patient;

(3) the total number of prescriptions written for opioid overdose reversal drugs, such as naloxone;

(4) the percentage of patients at elevated risk who received a prescription for an opioid overdose reversal drug, such as naloxone;

(5) the number of patients reporting use of an opioid overdose reversal drug, such as naloxone; and

(6) any other outcome measures that the Secretary deems appropriate.

(e) REPORTS BY SECRETARY.—For each year of the grant program under this section, the Secretary of Health and Human Services shall submit to the appropriate committees of the House of Representatives and the Senate a report aggregating the information received from the

grant recipients for such year under subsection (d) and evaluating the outcomes achieved by the programs funded by grants made under this section.

(f) PROVIDING INFORMATION TO PRESCRIBERS IN CERTAIN FEDERAL HEALTH CARE AND MEDICAL FACILITIES ON BEST PRACTICES FOR PRESCRIBING OPIOID OVERDOSE REVERSAL DRUGS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') may, as appropriate, provide information to prescribers within Federally qualified health centers (as defined in paragraph (4) of section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), and the health care facilities of the Indian Health Service, on best practices for prescribing opioid overdose reversal drugs, such as naloxone, for patients receiving chronic opioid therapy, patients being treated for opioid use disorders, and other patients that a provider identifies as having an elevated risk of overdose from heroin or prescription opioid therapies.

(2) NOT ESTABLISHING A MEDICAL STANDARD OF CARE.—The information on best practices provided under this section shall not be construed as

constituting or establishing a medical standard of care for prescribing opioid overdose reversal drugs, such as naloxone, for patients described in paragraph (1).

(3) NO AUTHORIZATION OF ANY ADDITIONAL APPROPRIATIONS.—The Secretary shall carry out this subsection through funds otherwise appropriated and nothing in this subsection shall be construed as authorizing the appropriations of additional funds to carry out this subsection.

(4) ELEVATED RISK OF OVERDOSE DEFINED.—In this subsection, the term ''elevated risk of overdose'' has the meaning given such term by the Secretary, which—

(A) may be based on the criteria provided in the Opioid Overdose Toolkit published by the Substance Abuse and Mental Health Services Administration (SAMHSA); and

(B) may include patients on a first course opioid treatment, patients using extended-release and long-acting opioid analgesics, and patients with a respiratory disease or other comorbidities.

(g) FUNDING.—There is authorized to be appropriated $5,000,000 to carry out this section (other than

subsection (f)) for the period of fiscal years 2017 through 2021, of which $5,000,000 shall be made available from amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, to remain available until expended.

SEC. 103. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

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

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

''(1) PARTIAL FILLS.—

''(A) IN GENERAL.—A prescription for a controlled substance in schedule II may be partially filled if—

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

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

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

"(iv) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

"(B) OTHER CIRCUMSTANCES.—A prescription for a controlled substance in schedule II may be partially filled in accordance with section 1306.13 of title 21, Code of Federal Regulations (as in effect on the date of enactment of the Opioid Abuse Crisis Act of 2016).

"(2) REMAINING PORTIONS.—

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

"(i) may be filled; and

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

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

"(i) may be filled; and

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

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

SEC. 104. OPIOID USE DISORDER TREATMENT MODERNIZATION.

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

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

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

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

''(I) all schedule III, IV, and V drugs, as well as unscheduled medications approved by the Food and Drug Administration, for the

treatment of opioid use disorder, including such drugs and medications for maintenance, detoxification, overdose reversal, and relapse prevention, as available; and

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

''(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclauses (II) and (III), the applicable number is 30.

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

''(III) The applicable number is 300 if the practitioner is a qualifying physician meeting the requirement of subclause (VI) and, not sooner than 1 year after the date on which the physician submitted a second notification under subclause (II), the practitioner submits a third notification to the Secretary of the need and intent of the physician to treat up to 300 patients.

''(IV) The Secretary may by regulation change such total number.

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

''(VI) For purposes of subclause (III), a qualifying physician meets the requirement of this subclause if the physician—

''(aa) holds a special certification in addiction psychiatry or addiction medicine as described in clause (ii) from the American Board of Medical Specialties, the American Board of Addiction Medicine, the American Osteopathic Association, the American Society of Addiction Medicine, or such other organization as the Secretary determines to be appropriate for purposes of this subclause; or

''(bb) has completed not fewer than 24 hours of training, with respect to the treatment and management of opiate-dependent patients, addressing the topics listed in subparagraph (G)(ii)(IV).

The Secretary may review and update the requirements of this subclause.

''(iv) In the case of a third notification under clause (iii)(III), the qualifying physician maintains and implements a diversion control plan that contains specific measures to reduce the likelihood of the diversion of controlled substances prescribed by the physician for the treatment of opioid use disorder.

''(v) In the case of a third notification under clause (iii)(III), the qualifying physician obtains a written agreement from each patient, including the patient's signature, that the patient—

''(I) will receive an initial assessment and treatment plan and periodic assessments and treatment plans thereafter;

''(II) will be subject to medication adherence and substance use monitoring;

''(III) understands available treatment options, including all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including their potential risks and benefits; and

''(IV) understands that receiving regular counseling services is critical to recovery.

''(vi) The practitioner will comply with the reporting requirements of subparagraph (D)(i)(IV).'';

(2) in subparagraph (D)—

(A) in clause (i), by adding at the end the following:

''(IV) The practitioner reports to the Secretary, at such times and in such manner as specified by the Secretary, such information and assurances as the Secretary determines necessary to assess whether the practitioner continues to meet the requirements for a waiver under this paragraph.'';

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

(C) in clause (iii)—

(i) by inserting ''and shall forward such determination to the Attorney General'' before the period at the end of the first sentence; and

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

(3) in subparagraph (G)—

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

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall address—

''(aa) opioid maintenance and detoxification;

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

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

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

"(ee) counseling and recovery support services;

"(ff) staffing roles and considerations;

"(gg) diversion control; and

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

(B) by adding at the end the following:

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

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

"(II) a qualifying other practitioner, as defined in clause (iv).

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

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

"(II) The nurse practitioner or physician assistant satisfies 1 or more of the following:

"(aa) Has completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV)

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

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

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

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

The Secretary may review and update the requirements for being a qualifying other practitioner under this clause.''; and

(4) in subparagraph (H)—

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

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

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

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

(b) RECOMMENDATION OF REVOCATION OR SUSPENSION OF REGISTRATION IN CASE OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary of Health and Human

Services may recommend to the Attorney General that the registration of a practitioner be revoked or suspended if the Secretary determines, according to such criteria as the Secretary establishes by regulation, that a practitioner who is registered under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is not in substantial compliance with the requirements of such section, as amended by this Act.

(c) OPIOID DEFINED.—Section 102(18) of the Controlled Substances Act (21 U.S.C. 802(18)) is amended by inserting ''or 'opioid' '' after ''The term 'opiate' ''.

(d) REPORTS TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and not less than over every 5 years thereafter, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration and experts in opioid use disorder research and treatment, shall—

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

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

(2) CONTENTS.—Each report under paragraph (1) shall include an assessment of—

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

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

(C) whether there is further need to increase or decrease the number of patients a waivered practitioner is permitted to treat, as provided for by the amendment made by subsection (a)(1);

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

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

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

(G) the use of prescription drug monitoring programs by practitioners who are permitted to dispense narcotic drugs to individuals pursuant to a waiver under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2));

(H) the findings resulting from inspections by the Drug Enforcement Administration of practitioners described in subparagraph (G); and

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

SEC. 105. NURTURING AND SUPPORTING HEALTHY BABIES.

(a) GAO REPORT ON NEONATAL ABSTINENCE SYNDROME (NAS).—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of

the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate a report on neonatal abstinence syndrome (in this section referred to as ''NAS'') in the United States.

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

(A) The prevalence of NAS in the United States, including the proportion of children born in the United States with NAS who are eligible for medical assistance under State Medicaid programs under title XIX of the Social Security Act at birth and the costs associated with NAS through such programs.

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

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

(D) The prevalence of utilization of various care settings under State Medicaid programs

for treatment of infants with NAS and any Federal barriers to treating such infants under such programs, particularly in non-hospital-based settings.

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

(b) EXCLUDING ABUSE-DETERRENT FORMULATIONS OF PRESCRIPTION DRUGS FROM THE MEDICAID ADDITIONAL REBATE REQUIREMENT FOR NEW FORMULATIONS OF PRESCRIPTION DRUGS.—

(1) IN GENERAL.—The last sentence of section 1927(c)(2)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)(C)) is amended by inserting before the period at the end the following: ", but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act.

(c) LIMITING DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.—

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

"SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

''(a) REFERENCE TO PREDICTIVE MODELING TECHNOLOGIES REQUIREMENTS.—For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI, see section 4241 of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m).

''(b) LIMITING DISCLOSURE OF PREDICTIVE MODELING TECHNOLOGIES.—In implementing such provisions under such section 4241 with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

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

''(2) LIMITATION WITH RESPECT TO USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.—

''(A) IN GENERAL.—A State agency may not use or disclose covered algorithms used or developed for purposes of such section except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under title XIX or the State child health plan (or a waiver of the plan) under the Children's Health Insurance Program under title XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud and abuse with respect to such programs.

''(B) INFORMATION SECURITY.—A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered algo-

rithms used or developed for purposes of such section 4241 and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

''(C) PROCEDURAL REQUIREMENTS.—State agencies to which information is disclosed pursuant to such section 4241 shall adhere to uniform procedures established by the Secretary.

''(c) COVERED ALGORITHM DEFINED.—In this section, the term 'covered algorithm'—

''(1) means a predictive modeling or other analytics technology, as used for purposes of section 4241(a) of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m(a)) to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI; and

''(2) includes the mathematical expressions utilized in the application of such technology and the means by which such technology is developed.''.

(2) CONFORMING AMENDMENTS.—

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

(i) in paragraph (80), by striking ''and'' at the end;

(ii) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after paragraph (81) the following new paragraph:

''(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

(B) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7) of the Social Security Act (42 U.S.C. 1397bb(a)(7)) is amended—

(i) in subparagraph (A), by striking '', and'' at the end and inserting a semicolon;

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

(iii) by adding at the end the following new subparagraph:

''(C) to ensure that the State agency involved is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

(d) MEDICAID IMPROVEMENT FUND.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended to read as follows:

''(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for fiscal year 2021 and thereafter, $5,000,000.''.

SEC. 106. IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN.

(a) REAUTHORIZATION OF RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended—

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

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

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

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

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

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

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

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

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

''(B) help State substance abuse agencies address identified gaps in services furnished to

such women along the continuum of care, including services provided to women in nonresidential based settings; and

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

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

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

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

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

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

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

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

''(3) REQUIRED SERVICES.—

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

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

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

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

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

"(5) EVALUATION AND REPORT TO CONGRESS.—The Director of the Center for Behavioral Health Statistics and Quality shall fund an evaluation of the pilot program at the conclusion of the first grant cycle funded by the pilot program. The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on such evaluation. The report shall include at a minimum outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs; engagement in treatment services; retention in the appropriate level and duration of services; increased access to the use of medi-

cations approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and other appropriate measures.

''(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term 'State substance abuse agency' means, with respect to a State, the agency in such State that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.''.

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

made available to carry out this section for fiscal year 2016.''.

(c) CUT-GO COMPLIANCE.—Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by striking ''through 2018'' and inserting ''through 2016, $133,300,000 for fiscal year 2017, and $138,300,000 for fiscal year 2018''.

SEC. 107. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN EMERGENCY MEDICAL TECHNICIANS.

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

''SEC. 315. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN EMERGENCY MEDICAL TECHNICIANS.

''(a) PROGRAM.—The Secretary shall establish a program consisting of awarding demonstration grants to States to streamline State requirements and procedures in order to assist veterans who completed military emergency medical technician training while serving in the Armed Forces of the United States to meet certification,

licensure, and other requirements applicable to becoming an emergency medical technician in the State.

''(b) USE OF FUNDS.—Amounts received as a demonstration grant under this section shall be used to prepare and implement a plan to streamline State requirements and procedures as described in subsection (a), including by—

''(1) determining the extent to which the requirements for the education, training, and skill level of emergency medical technicians in the State are equivalent to requirements for the education, training, and skill level of military emergency medical technicians; and

''(2) identifying methods, such as waivers, for military emergency medical technicians to forgo or meet any such equivalent State requirements.

''(c) ELIGIBILITY.—To be eligible for a grant under this section, a State shall demonstrate that the State has a shortage of emergency medical technicians.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(e) FUNDING.—No additional funds are authorized to be appropriated for the purpose of carrying out this

section. This section shall be carried out using amounts otherwise available for such purpose.''.

SEC. 108. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

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

(b) AMENDMENT.—Title III of the Public Health Service Act is amended by inserting after part D of such title (42 U.S.C. 254b et seq.) the following new part E:

''PART E—OPIOID USE DISORDER

''SEC. 341. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

''(a) REPORT.—The Secretary shall—

''(1) not later than 24 months after the date of the enactment of this section, make publicly available a report determining the extent to which informational materials and resources described in subsection (b) are available to teenagers and adolescents who play youth sports, families of such teenagers

and adolescents, nurses, youth sports groups, and relevant health care provider groups; and

''(2) for purposes of educating and preventing addiction in teenagers and adolescents who are injured playing youth sports and are subsequently prescribed an opioid, not later than 12 months after such report is made publicly available and taking into consideration the findings of such report, develop and, in coordination with youth sports groups, disseminate informational materials and resources described in subsection (b) for teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups.

''(b) MATERIALS AND RESOURCES DESCRIBED.—For purposes of this section, the informational materials and resources described in this subsection are informational materials and resources with respect to youth sports injuries for which opioids are potentially prescribed and subsequently potentially lead to addiction, including materials and resources focused on the dangers of opioid use and misuse, treatment options for such injuries that do not involve the use of opioids, and how to seek treatment for addiction.

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

SEC. 109. LALI'S LAW.

(a) OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAM.—Part E of title III of the Public Health Service Act, as added by section 109, is amended by adding at the end the following

''SEC. 342. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

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

''(1) developing standing orders for pharmacies regarding opioid overdose reversal medication;

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

''(3) implementing best practices for persons authorized to prescribe medication regarding—

''(A) prescribing opioids for the treatment of chronic pain;

''(B) co-prescribing opioid overdose reversal medication with opioids; and

"(C) discussing the purpose and administration of opioid overdose reversal medication with patients;

"(4) developing or adapting training materials and methods for persons authorized to prescribe or dispense medication to use in educating the public regarding—

"(A) when and how to administer opioid overdose reversal medication; and

"(B) steps to be taken after administering opioid overdose reversal medication; and

"(5) educating the public regarding—

"(A) the public health benefits of opioid overdose reversal medication; and

"(B) the availability of opioid overdose reversal medication without a person-specific prescription.

"(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders regarding opioid overdose reversal medication.

"(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary shall give preference to States that—

''(1) have not issued standing orders regarding opioid overdose reversal medication;

''(2) authorize standing orders that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer opioid overdose reversal medication;

''(3) authorize standing orders that permit police, fire, or emergency medical services agencies to acquire and administer opioid overdose reversal medication;

''(4) have a higher per capita rate of opioid overdoses than other applicant States; or

''(5) meet any other criteria deemed appropriate by the Secretary.

''(d) GRANT TERMS.—

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

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

''(3) AMOUNT.—A grant under this section may not exceed $500,000.

''(4) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(5).

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

''(f) REPORTING.—Not later than 3 months after the Secretary disburses the first grant payment to any State under this section and every 6 months thereafter for 3 years, such State shall submit a report to the Secretary that includes the following:

''(1) The name and ZIP Code of each pharmacy in the State that dispenses opioid overdose reversal medication under a standing order.

''(2) The total number of opioid overdose reversal medication doses dispensed by each such pharmacy, specifying how many were dispensed with or without a person-specific prescription.

''(3) The number of pharmacists in the State who have participated in training pursuant to subsection (a)(4).

''(g) DEFINITIONS.—In this section:

''(1) OPIOID OVERDOSE REVERSAL MEDICATION.—The term 'opioid overdose reversal medication' means any drug, including naloxone, that—

''(A) blocks opioids from attaching to, but does not itself activate, opioid receptors; or

''(B) inhibits the effects of opioids on opioid receptors.

''(2) STANDING ORDER.—The term 'standing order' means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.

''(h) AUTHORIZATION OF APPROPRIATIONS.—

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

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

(b) CUT-GO COMPLIANCE.—Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by inserting before the period at the end the following: ''(except such dollar amount shall be reduced by $5,000,000 for fiscal year 2017)''.

SEC. 110. OPIOID REVIEW MODERNIZATION.

(a) FDA OPIOID ACTION PLAN.—Chapter V of the Federal Food, Drug, and Cosmetic Act is amended by inserting after section 569 of such Act (21 U.S.C. 350bbb–8) the following:

"SEC. 569–1. OPIOID ACTION PLAN.

"(a) NEW DRUG APPLICATION.—

"(1) IN GENERAL.—Subject to paragraph (2), prior to the approval pursuant to an application under section 505(b) of a new drug that is an opioid and does not have abuse-deterrent properties, the Secretary shall refer the application to an advisory committee of the Food and Drug Administration to seek recommendations from such advisory committee.

"(2) PUBLIC HEALTH EXEMPTION.—A referral to an advisory committee under paragraph (1) is not required with respect to a new drug if the Secretary—

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

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

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

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

"(c) SUNSET.—The requirements of subsections (a) and (b) shall cease to be effective on October 1, 2022.".

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

section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1), including recommendations on—

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

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

(c) GUIDANCE ON EVALUATING THE ABUSE DETERRENCE OF GENERIC SOLID ORAL OPIOID DRUG PRODUCTS.—Not later than 2 years after the end of the period for public comment on the draft guidance entitled ''General Principals for Evaluating the Abuse Deterrence of Generic Solid Oral Opioid Drug Products'' issued by the Center for Drug Evaluation and Research of the Food and Drug Administration in March 2016, the Commissioner of Food and Drugs shall publish in the Federal Register a final version of such guidance.

SEC. 111. STUDY ON TREATMENT INFRASTRUCTURE.

Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall initiate an evaluation, and submit to Congress a report, of the inpatient and outpatient treatment capacity, availability, and needs of the United States, which shall include, to the extent data are available—

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

(2) the capacity of inpatient clinical stabilization programs, transitional residential support services, and residential rehabilitation programs;

(3) the capacity of demographic specific residential or inpatient treatment programs, such as those designed for pregnant women or adolescents;

(4) geographical differences of the availability of residential and outpatient treatment and recovery options for substance use disorders across the continuum of care;

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

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

(7) an assessment of the need for residential and outpatient treatment for substance use disorders across the continuum of care;

(8) the availability of residential and outpatient treatment programs to American Indians and Alaska

Natives through an Indian health program (as defined by section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)); and

(9) the barriers (including technological barriers) at the Federal, State, and local levels to real-time reporting of de-identified information on drug overdoses and ways to overcome such barriers.

SEC. 112. NATIONAL YOUTH RECOVERY INITIATIVE.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.) is amended by adding at the end the following:

"SEC. 2999A. NATIONAL YOUTH RECOVERY INITIATIVE.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

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

''(B) an accredited high school that is seeking to establish or expand recovery support services;

''(C) an institution of higher education;

''(D) a recovery program at a nonprofit collegiate institution; or

''(E) a nonprofit organization.

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

''(3) RECOVERY PROGRAM.—The term 'recovery program'—

''(A) means a program to help individuals who are recovering from substance use disorders to initiate, stabilize, and maintain healthy and productive lives in the community; and

''(B) includes peer-to-peer support and communal activities to build recovery skills and supportive social networks.

''(b) GRANTS AUTHORIZED.—The Secretary of Health and Human Services, in coordination with the Secretary of Education, may award grants to eligible entities to enable the entities to—

''(1) provide substance use disorder recovery support services to young people in high school and enrolled in institutions of higher education;

''(2) help build communities of support for young people in recovery through a spectrum of activities such as counseling and health- and wellness-oriented social activities; and

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

''(c) USE OF FUNDS.—Grants awarded under subsection (b) may be used for activities to develop, support, and maintain youth recovery support services, including—

''(1) the development and maintenance of a dedicated physical space for recovery programs;

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

''(3) health- and wellness-oriented social activities and community engagement;

''(4) establishment of recovery high schools;

''(5) coordination of recovery programs with—

''(A) substance use disorder treatment programs and systems;

''(B) providers of mental health services;

''(C) primary care providers and physicians;

''(D) the criminal justice system, including the juvenile justice system;

''(E) employers;

''(F) housing services;

''(G) child welfare services;

''(H) high schools and institutions of higher education; and

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

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

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

''(d) FUNDING.—There is authorized to be appropriated $5,000,000 to carry out this section for each of fiscal years 2017 through 2021, of which $5,000,000 shall be made available from amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, to remain available until expended.''.

SEC. 113. BUILDING COMMUNITIES OF RECOVERY.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 113, is amended by adding at the end the following:

"SEC. 2999B. BUILDING COMMUNITIES OF RECOVERY.

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

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

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

''(b) GRANTS AUTHORIZED.—The Secretary of Health and Human Services may award grants to recovery community organizations to enable such organizations to develop, expand, and enhance recovery services.

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

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

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

''(2) may be used to—

''(A) advocate for individuals in recovery from substance use disorders;

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

"(i) substance use disorder treatment programs and systems;

"(ii) providers of mental health services;

"(iii) primary care providers and physicians;

"(iv) the criminal justice system;

"(v) employers;

"(vi) housing services;

"(vii) child welfare agencies; and

"(viii) other recovery support services that facilitate recovery from substance use disorders;

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

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

"(i) how to identify the signs of addiction;

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

''(iii) the resources that are available to help support individuals in recovery; and

''(iv) information on the medical consequences of substance use disorders, including neonatal abstinence syndrome and potential infection with human immunodeficiency virus and viral hepatitis; and

''(E) carry out other activities that strengthen the network of community support for individuals in recovery.

''(e) FUNDING.—Of the amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, $25,000,000 shall be made available to carry out this section, to remain available until expended''.

TITLE II—COMPREHENSIVE OPIOID ABUSE REDUCTION

SEC. 201. COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

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

"PART LL—COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM

"SEC. 3021. DESCRIPTION.

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

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

''(A) pre-booking or post-booking components, which may include the activities described in part HH of this title;

''(B) training for criminal justice agency personnel on substance use disorders and co-oc-

curring mental illness and substance use disorders;

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

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

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

"(2) In the case of a State, facilitating or enhancing planning and collaboration between State criminal justice agencies and State substance abuse systems in order to more efficiently and effectively carry out programs described in paragraph (1) that address problems related to opioid abuse.

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

"(4) Investigative purposes to locate or investigate illicit activities related to the unlawful distribution of opioids.

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

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

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

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

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

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

''(2) units of local government; or

''(3) tribal organizations.

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

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

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

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

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

"SEC. 3022. APPLICATIONS.

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

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

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

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

''(A) the programs to be funded by the grant meet all the requirements of this part;

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

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

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

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

''SEC. 3023. REVIEW OF APPLICATIONS.

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

''SEC. 3024. GEOGRAPHIC DIVERSITY.

''The Attorney General shall ensure equitable geographic distribution of grants under this part and take into consideration the needs of underserved populations, including rural and tribal communities.

''SEC. 3025. DEFINITIONS.

''In this part:

''(1) The term 'first responder' includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (includ-

ing an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of professional duties, responds to fire, medical, hazardous material, or other similar emergencies.

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

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

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

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

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

"(A) court;

"(B) prison;

"(C) jail;

"(D) law enforcement agency; or

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

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

(b) FUNDING.—There is authorized to be appropriated $65,000,000 to carry out this section, section 203, and section 204 (including the amendments made by such sections) for the period of fiscal years 2017 through 2021, of which $65,000,000 shall be made available from amounts appropriated under section 101(a) of the Opioid Use Disorder Treatment Expansion and Modernization Act for fiscal year 2017, to remain available until expended.

SEC. 202. AUDIT AND ACCOUNTABILITY OF GRANTEES.

(a) DEFINITIONS.—In this section—

(1) the term ''covered grant program'' means a grant program operated by the Department of Justice;

(2) the term ''covered grantee'' means a recipient of a grant from a covered grant program;

(3) the term ''nonprofit'', when used with respect to an organization, means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986, and is exempt from taxation under section 501(a) of such Code; and

(4) the term ''unresolved audit finding'' means an audit report finding in a final audit report of the Inspector General of the Department of Justice that a covered grantee has used grant funds awarded to that grantee under a covered grant program for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved during a 12-month period prior to the date on which the final audit report is issued.

(b) AUDIT REQUIREMENT.—Beginning in fiscal year 2016, and annually thereafter, the Inspector General of the Department of Justice shall conduct audits of covered grantees to prevent waste, fraud, and abuse of funds awarded under covered grant programs. The Inspector

General shall determine the appropriate number of covered grantees to be audited each year.

(c) MANDATORY EXCLUSION.—A grantee that is found to have an unresolved audit finding under an audit conducted under subsection (b) may not receive grant funds under a covered grant program in the fiscal year following the fiscal year to which the finding relates.

(d) REIMBURSEMENT.—If a covered grantee is awarded funds under the covered grant program from which it received a grant award during the 1-fiscal-year period during which the covered grantee is ineligible for an allocation of grant funds under subsection (c), the Attorney General shall—

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

(2) seek to recoup the costs of the repayment to the Fund from the covered grantee that was improperly awarded the grant funds.

(e) PRIORITY OF GRANT AWARDS.—The Attorney General, in awarding grants under a covered grant program shall give priority to eligible entities that during the 2-year period preceding the application for a grant have not been found to have an unresolved audit finding.

(f) NONPROFIT REQUIREMENTS.—

(1) PROHIBITION.—A nonprofit organization that holds money in offshore accounts for the purpose of avoiding the tax described in section 511(a) of the Internal Revenue Code of 1986, shall not be eligible to receive, directly or indirectly, any funds from a covered grant program.

(2) DISCLOSURE.—Each nonprofit organization that is a covered grantee shall disclose in its application for such a grant, as a condition of receipt of such a grant, the compensation of its officers, directors, and trustees. Such disclosure shall include a description of the criteria relied on to determine such compensation.

SEC. 203. VETERANS TREATMENT COURTS.

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

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

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

''(i) ASSISTING VETERANS.—

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

''(A) PEER TO PEER SERVICES OR PROGRAMS.—The term 'peer to peer services or

programs' means services or programs that connect qualified veterans with other veterans for the purpose of providing support and mentorship to assist qualified veterans in obtaining treatment, recovery, stabilization, or rehabilitation.

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

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

''(ii) was discharged or released from such service under conditions other than dishonorable.

''(C) VETERANS TREATMENT COURT PROGRAM.—The term 'veterans treatment court program' means a court program involving collaboration among criminal justice, veterans, and mental health and substance abuse agencies that provides qualified veterans with—

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

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

''(iii) alternatives to incarceration; or

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

''(2) VETERANS ASSISTANCE PROGRAM.—

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

''(i) veterans treatment court programs;

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

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

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

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

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

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

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

SEC. 204. EMERGENCY FEDERAL LAW ENFORCEMENT ASSISTANCE.

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

SEC. 205. OPIOID PROGRAM EVALUATION ACT.

(a) SHORT TITLE.—This section may be cited as the ''Opioid Program Evaluation Act'' or the ''OPEN Act''.

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

(1) EVALUATION OF JUSTICE DEPARTMENT COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—Not later than 5 years after the date of enactment of this Act, the Attorney General shall complete an evaluation of the effectiveness of the Comprehensive Opioid Abuse Grant Program under part LL of the Omnibus Crime Control and Safe Streets Act of 1968 administered by the Department of Justice based upon the information reported under paragraph (4) of this subsection.

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

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

Program and the metrics by which the achievement of such outcomes shall be determined.

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

(5) PUBLICATION OF DATA AND FINDINGS.—

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

(B) PUBLICATION OF EVALUATION.—In the case of the interim evaluation under paragraph (2), and the final evaluation under paragraph (1), the Secretary shall arrange for an independent, external evaluator to, not later than 90 days after such an evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the

Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate. Such report shall also be published along with the data used to make such evaluation.

(6) ARRANGEMENT WITH THE NATIONAL ACADEMY OF SCIENCES.—For purposes of paragraphs (1), (2), and (3), the Attorney General shall enter into an arrangement with the National Academy of Sciences.

(c) EVALUATION OF PERFORMANCE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM.—

(1) EVALUATION OF JUSTICE DEPARTMENT COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—Not later than 5 years after the date of enactment of this Act, the Secretary of Health and Human Services shall complete an evaluation of any program administered by the Secretary that provides grants for the primary purpose of providing assistance in addressing problems pertaining to opioid abuse based upon the information reported under paragraph (4) of this subsection.

(2) INTERIM EVALUATION.—Not later than 3 years after the date of enactment of this Act, the Secretary shall complete an interim evaluation as-

sessing the nature and extent of the incidence of opioid abuse and illegal opioid distribution in the United States.

(3) METRICS AND OUTCOMES FOR EVALUATION.—Not later than 180 days after the date of enactment of this Act, the Secretary shall identify outcomes that are to be achieved by activities funded by the programs described in paragraph (1) and the metrics by which the achievement of such outcomes shall be determined.

(4) METRICS DATA COLLECTION.—The Secretary shall require grantees under the programs described in paragraph (1) to collect and annually report to the Department of Health and Human Services data based upon the metrics identified under paragraph (3).

(5) PUBLICATION OF DATA AND FINDINGS.—

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

(B) PUBLICATION OF EVALUATION.—In the case of the interim evaluation under subparagraph (B), and each final evaluation under

paragraph (1), the Secretary shall arrange for an independent, external evaluator to, not later than 90 days after such an evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate. Such report shall also be published along with the data used to make such evaluation.

(6) ARRANGEMENT WITH AN INDEPENDENT, EXTERNAL EVALUATOR.—For purposes of paragraphs (1), (2), (3), and (5), the Secretary shall enter into an arrangement with an independent, external evaluator.

(d) DEFINITION.—In this section, the term ''opioid'' has the meaning given the term ''opiate'' in section 102 of the Controlled Substances Act (21 U.S.C. 802).

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

SEC. 206. GOOD SAMARITAN ASSESSMENT ACT.

(a) GAO STUDY ON GOOD SAMARITAN LAWS PERTAINING TO TREATMENT OF OPIOID OVERDOSES.—The

Comptroller General of the United States shall submit to the Committee on the Judiciary of the House of Representatives, the Committee on Oversight and Government Reform of the House of Representatives, the Committee on the Judiciary of the Senate, and the Committee on Homeland Security and Governmental Affairs of the Senate a report on—

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

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

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

(b) DEFINITIONS.—In this section—

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

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

TITLE III—PROMOTING RESPONSIBLE OPIOID MANAGEMENT AND INCORPORATING SCIENTIFIC EXPERTISE

SEC. 301. SHORT TITLE.

This title may be cited as the ''Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act'' or the ''Jason Simcakoski PROMISE Act''.

Subtitle A—Opioid Therapy and Pain Management

SEC. 311. GUIDELINES ON MANAGEMENT OF OPIOID THERAPY BY DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE AND IMPLEMENTATION OF SUCH GUIDELINES BY DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall jointly update the VA/DOD Clinical Practice Guideline for Man-

agement of Opioid Therapy for Chronic Pain to include the following:

(1) In accordance with subsection (b), common recommended guidelines for safely prescribing opioids for the treatment of chronic, non-cancer pain in outpatient settings as compiled by the Director of the Centers for Disease Control and Prevention.

(2) Enhanced guidance with respect to—

(A) the administration of two or more drugs that may result in a life-limiting drug-to-drug interaction, including benzodiazepines;

(B) the treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; and

(C) the use of opioid therapy to treat mental health disorders other than opioid use disorder.

(3) Enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, such as post-traumatic stress disorder, psychiatric disorders, or a history of substance abuse or addiction, that requires a consultation or comanagement of opioid therapy with one or more specialists in pain management, mental health, or addictions.

(4) Enhanced guidance with respect to the conduct by health care providers of an effective assessment for patients receiving opioid therapy, including patients on long-term opioid therapy, to determine—

(A) whether opioid therapy is meeting the expected goals of the patient and health care provider of relieving pain, improving function, and providing patient satisfaction; and

(B) whether opioid therapy should be continued.

(5) Guidance that each health care provider of the Department of Veterans Affairs and the Department of Defense, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or successor tool), which shall include the ability to access the most recent patient information from the prescription drug monitoring program of each State that has such a program to assess the risk for adverse outcomes of opioid therapy for the patient, including with respect to the concurrent use of controlled substances, including benzodiazepines.

(6) Guidelines to govern the methodologies used by health care providers of the Department of Veterans Affairs and the Department of Defense to safely titrate and taper opioid therapy when adjusting or discriminating the use of opioid therapy, including with respect to—

(A) prescription of the lowest effective dose based on patient need;

(B) use of opioid only for a limited period of time; and

(C) augmentation of opioid therapy with other pain management therapies and modalities.

(7) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient health care settings, which may include the use of care transition plans.

(8) Guidelines with respect to appropriate transfer of case management responsibility for patients receiving opioid therapy who transition from receiving care furnished by the Secretary of Defense to receiving care furnished by other health care providers after the patient has been discharged or separated from the Armed Forces.

(9) Enhanced standards with respect to the use of routine and random urine drug tests for all patients before and during opioid therapy to help prevent substance abuse, dependence, and diversion, including—

(A) that such tests occur not less frequently than once each year; and

(B) that health care providers appropriately interpret and respond to the results from such tests to tailor pain therapy, safeguards, and risk management strategies to each patient.

(10) Guidance that health care providers discuss with patients, before initiating opioid therapy, options for pain management therapies without the use of opioids and options to augment opioid therapy with other clinical and complementary and integrative health services to minimize opioid dependence.

(b) TREATMENT OF CERTAIN GUIDELINES DEVELOPED AFTER DEADLINE.—If the Director of the Centers for Disease Control and Prevention issues the guidelines described in paragraph (1) of subsection (a) after the date on which the Secretary of Veterans Affairs and the Secretary of Defense jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for

Chronic Pain pursuant to such subsection, the Secretaries shall jointly modify the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain to incorporate such guidelines of the Director.

(c) CONSULTATION BEFORE UPDATE.—Before updating the guideline under subsection (a), the Secretary of Veterans Affairs and the Secretary of Defense shall jointly consult with the Pain Management Working Group of the Department of Veterans Affairs–Department of Defense Joint Executive Committee established by section 320 of title 38, United States Code.

(d) DEFINITIONS.—In this section:

(1) The term ''controlled substance'' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term ''State'' means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 312. IMPROVEMENT OF OPIOID SAFETY MEASURES BY DEPARTMENT OF VETERANS AFFAIRS.

(a) EXPANSION OF OPIOID SAFETY INITIATIVE.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall expand

the Opioid Safety Initiative of the Department of Veterans Affairs to include all medical facilities of the Department.

(b) PAIN MANAGEMENT EDUCATION AND TRAINING.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the Secretary shall require all employees of the Department responsible for prescribing opioids to receive education and training described in paragraph (2).

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

(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.

(B) The use of evidence-based pain management therapies, including cognitive-behavioral therapy, non-opioid alternatives, and non-drug methods and procedures to managing pain

and related health conditions including complementary alternative medicines.

(C) Screening and identification of patients with substance use disorder, including drug-seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appropriate addiction treatment professionals if addiction is identified or strongly suspected.

(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other controlled substances.

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

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

(c) PAIN MANAGEMENT TEAMS.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related.

(2) ESTABLISHMENT OF PROTOCOLS.—

(A) IN GENERAL.—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department.

(B) CONSULTATION ON PRESCRIPTION OF OPIOIDS.—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

(3) REPORT.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the director of each medical facility of the Department shall submit to the Under Secretary for Health and the director of the Veterans Integrated Service Network in which the medical facility is located a report identifying the health care professionals that have been designated as members of the pain management team at the medical facility pursuant to paragraph (1).

(B) ELEMENTS.—Each report submitted under subparagraph (A) with respect to a medical facility of the Department shall include—

(i) a certification as to whether all members of the pain management team at the medical facility have completed the

education and training required under subsection (b); and

(ii) a plan for the management and referral of patients to such pain management team if health care providers without expertise in prescribing analgesics prescribe opioid medications to treat acute and chronic pain that is non-cancer related.

(d) TRACKING AND MONITORING OF OPIOID USE.—

(1) PRESCRIPTION DRUG MONITORING PROGRAMS OF STATES.—In carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool of the Department, the Secretary shall—

(A) ensure access by health care providers of the Department to information on controlled substances, including opioids and benzodiazepines, prescribed to veterans who receive care outside the Department through the prescription drug monitoring program of each State with such a program, including by seeking to enter into memoranda of understanding with States to allow shared access of such information between States and the Department;

(B) include such information in the Opioid Therapy Risk Report; and

(C) require health care providers of the Department to submit to the prescription drug monitoring program of each State information on prescriptions of controlled substances received by veterans in that State under the laws administered by the Secretary.

(2) REPORT ON TRACKING OF DATA ON OPIOID USE.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of improving the Opioid Therapy Risk Report tool of the Department to allow for more advanced real-time tracking of and access to data on—

(A) the key clinical indicators with respect to the totality of opioid use by veterans;

(B) concurrent prescribing by health care providers of the Department of opioids in different health care settings, including data on concurrent prescribing of opioids to treat men-

tal health disorders other than opioid use disorder; and

(C) mail-order prescriptions of opioid prescribed to veterans under the laws administered by the Secretary.

(e) AVAILABILITY OF OPIOID RECEPTOR ANTAGONISTS.—

(1) INCREASED AVAILABILITY AND USE.—

(A) IN GENERAL.—The Secretary shall maximize the availability of opioid receptor antagonists approved by the Food and Drug Administration, including naloxone, to veterans.

(B) AVAILABILITY, TRAINING, AND DISTRIBUTING.—In carrying out subparagraph (A), not later than 90 days after the date of the enactment of this Act, the Secretary shall—

(i) equip each pharmacy of the Department with opioid receptor antagonists approved by the Food and Drug Administration to be dispensed to outpatients as needed; and

(ii) expand the Overdose Education and Naloxone Distribution program of the Department to ensure that all veterans in receipt of health care under laws adminis-

tered by the Secretary who are at risk of opioid overdose may access such opioid receptor antagonists and training on the proper administration of such opioid receptor antagonists.

(C) VETERANS WHO ARE AT RISK.—For purposes of subparagraph (B), veterans who are at risk of opioid overdose include—

(i) veterans receiving long-term opioid therapy;

(ii) veterans receiving opioid therapy who have a history of substance use disorder or prior instances of overdose; and

(iii) veterans who are at risk as determined by a health care provider who is treating the veteran.

(2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on carrying out paragraph (1), including an assessment of any remaining steps to be carried out by the Secretary to carry out such paragraph.

(f) INCLUSION OF CERTAIN INFORMATION AND CAPABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF THE DEPARTMENT.—

(1) INFORMATION.—The Secretary shall include in the Opioid Therapy Risk Report tool of the Department—

(A) information on the most recent time the tool was accessed by a health care provider of the Department with respect to each veteran; and

(B) information on the results of the most recent urine drug test for each veteran.

(2) CAPABILITIES.—The Secretary shall include in the Opioid Therapy Risk Report tool the ability of the health care providers of the Department to determine whether a health care provider of the Department prescribed opioids to a veteran without checking the information in the tool with respect to the veteran.

(g) NOTIFICATIONS OF RISK IN COMPUTERIZED HEALTH RECORD.—The Secretary shall modify the computerized patient record system of the Department to ensure that any health care provider that accesses the record of a veteran, regardless of the reason the veteran seeks

care from the health care provider, will be immediately notified whether the veteran—

(1) is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose;

(2) has a history of opioid abuse; or

(3) is at risk of becoming an opioid abuser as determined by a health care provider who is treating the veteran.

(h) DEFINITIONS.—In this section:

(1) The term ''controlled substance'' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term ''State'' means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 313. STRENGTHENING OF JOINT WORKING GROUP ON PAIN MANAGEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the Pain Management Working Group of the Health Execu-

tive Committee of the Department of Veterans Affairs–Department of Defense Joint Executive Committee established under section 320 of title 38, United States Code, includes a focus on the following:

(1) The opioid prescribing practices of health care providers of each Department.

(2) The ability of each Department to manage acute and chronic pain among individuals receiving health care from the Department, including training health care providers with respect to pain management.

(3) The use by each Department of complementary and integrative health and complementary alternative medicines in treating such individuals.

(4) The concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines.

(5) The practice by health care providers of each Department of prescribing opioids to treat mental health disorders.

(6) The coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from the

Department of Defense to receiving health care from the Department of Veterans Affairs.

(7) The ability of each Department to identify and treat substance use disorders among individuals receiving health care from that Department.

(b) COORDINATION AND CONSULTATION.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a)—

(1) coordinates the activities of the working group with other relevant working groups established under section 320 of title 38, United States Code, including the working groups on evidence-based practice, patient safety, pharmacy, psychological health, and psychological health;

(2) consults with other relevant Federal agencies, including the Centers for Disease Control and Prevention, with respect to the activities of the working group; and

(3) consults with the Department of Veterans Affairs and the Department of Defense with respect to, reviews, and comments on the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, or any successor guideline, before any update to the guideline is released.

(c) CONSULTATIONS.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a) is able to meaningfully consult with respect to the updated guideline required under subsection (a) of section 311, as required by subsection (b) of such section, not later than 1 year after the date of enactment of this Act.

SEC. 314. REVIEW, INVESTIGATION, AND REPORT ON USE OF OPIOIDS IN TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMPTROLLER GENERAL REPORT.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Opioid Safety Initiative of the Department of Veterans Affairs and the opioid prescribing practices of health care providers of the Department.

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

(A) Recommendations on such improvements to the Opioid Safety Initiative of the De-

partment as the Comptroller General considers appropriate.

(B) Information with respect to—

(i) deaths resulting from sentinel events involving veterans prescribed opioids by a health care provider of the Department;

(ii) overall prescription rates and prescriptions indications of opioids to treat non-cancer, non-palliative, and non-hospice care patients;

(iii) the prescription rates and prescriptions indications of benzodiazepines and opioids concomitantly by health care providers of the Department;

(iv) the practice by health care providers of the Department of prescribing opioids to treat patients without any pain, including to treat patients with mental health disorders other than opioid use disorder; and

(v) the effectiveness of opioid therapy for patients receiving such therapy, including the effectiveness of long-term opioid therapy.

(C) An evaluation of processes of the Department in place to oversee opioid use among veterans, including procedures to identify and remedy potential over-prescribing of opioids by health care providers of the Department.

(D) An assessment of the implementation by the Secretary of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(b) QUARTERLY PROGRESS REPORT ON IMPLEMENTATION OF COMPTROLLER GENERAL RECOMMENDATIONS.—Not later than two years after the date of the enactment of this Act, and not later than 30 days after the end of each quarter thereafter, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a progress report detailing the actions by the Secretary during the period covered by the report to address any outstanding findings and recommendations by the Comptroller General of the United States under subsection (a) with respect to the Veterans Health Administration.

(c) ANNUAL REVIEW OF PRESCRIPTION RATES.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually for the

following five years, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report, with respect to each medical facility of the Department of Veterans Affairs, to collect and review information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients that contains, for the one-year period preceding the submission of the report, the following:

(1) The number of patients and the percentage of the patient population of the Department who were prescribed benzodiazepines and opioids concurrently by a health care provider of the Department.

(2) The number of patients and the percentage of the patient population of the Department without any pain who were prescribed opioids by a health care provider of the Department, including those who were prescribed benzodiazepines and opioids concurrently.

(3) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were treated with opioids by a health care provider of the Department on an inpatient-basis and who also received prescription opioids

by mail from the Department while being treated on an inpatient-basis.

(4) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were prescribed opioids concurrently by a health care provider of the Department and a health care provider that is not health care provider of the Department.

(5) With respect to each medical facility of the Department, information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients, including information on—

(A) the prescription rate at which each health care provider at the facility prescribed benzodiazepines and opioids concurrently to such patients and the aggregate such prescription rate for all health care providers at the facility;

(B) the prescription rate at which each health care provider at the facility prescribed benzodiazepines or opioids to such patients to treat conditions for which benzodiazepines or opioids are not approved treatment and the ag-

gregate such prescription rate for all health care providers at the facility;

(C) the prescription rate at which each health care provider at the facility prescribed or dispensed mail-order prescriptions of opioids to such patients while such patients were being treated with opioids on an inpatient-basis and the aggregate of such prescription rate for all health care providers at the facility; and

(D) the prescription rate at which each health care provider at the facility prescribed opioids to such patients who were also concurrently prescribed opioids by a health care provider that is not a health care provider of the Department and the aggregate of such prescription rates for all health care providers at the facility.

(6) With respect to each medical facility of the Department, the number of times a pharmacist at the facility overrode a critical drug interaction warning with respect to an interaction between opioids and another medication before dispensing such medication to a veteran.

(d) INVESTIGATION OF PRESCRIPTION RATES.—If the Secretary determines that a prescription rate with re-

spect to a health care provider or medical facility of the Department conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, the Secretary shall—

(1) immediately notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of such determination, including information relating to such determination, prescription rate, and health care provider or medical facility, as the case may be; and

(2) through the Office of the Medical Inspector of the Veterans Health Administration, conduct a full investigation of the health care provider or medical facility, as the case may be.

(e) PRESCRIPTION RATE DEFINED.—In this section, the term ''prescription rate'' means, with respect to a health care provider or medical facility of the Department, each of the following:

(1) The number of patients treated with opioids by the health care provider or at the medical facility, as the case may be, divided by the total number of pharmacy users of that health care provider or medical facility.

(2) The average number of morphine equivalents per day prescribed by the health care provider or at the medical facility, as the case may be, to patients being treated with opioids.

(3) Of the patients being treated with opioids by the health care provider or at the medical facility, as the case may be, the average number of prescriptions of opioids per patient.

Subtitle B—Patient Advocacy

SEC. 321. COMMUNITY MEETINGS ON IMPROVING CARE FURNISHED BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMMUNITY MEETINGS.—

(1) MEDICAL CENTERS.—Not later than 90 days after the date of the enactment of this Act, and not less frequently than once every 90 days thereafter, the Secretary shall ensure that each medical facility of the Department of Veterans Affairs hosts a community meeting open to the public on improving health care furnished by the Secretary.

(2) COMMUNITY BASED OUTPATIENT CLINICS.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually thereafter, the Secretary shall ensure that each community based outpatient clinic of the De-

partment hosts a community meeting open to the public on improving health care furnished by the Secretary.

(b) ATTENDANCE BY DIRECTOR OF VETERANS INTEGRATED SERVICE NETWORK OR DESIGNEE.—

(1) IN GENERAL.—Each community meeting hosted by a medical facility or community based outpatient clinic under subsection (a) shall be attended by the Director of the Veterans Integrated Service Network in which the medical facility or community based outpatient clinic, as the case may be, is located. Subject to paragraph (2), the Director may delegate such attendance only to an employee who works in the Office of the Director.

(2) ATTENDANCE BY DIRECTOR.—Each Director of a Veterans Integrated Service Network shall personally attend not less than one community meeting under subsection (a) hosted by each medical facility located in the Veterans Integrated Service Network each year.

(c) NOTICE.—The Secretary shall notify the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and each Member of Congress (as defined in section 314) who represents the area in which the medical facility is located

of a community meeting under subsection (a) by not later than 10 days before such community meeting occurs.

SEC. 322. IMPROVEMENT OF AWARENESS OF PATIENT ADVOCACY PROGRAM AND PATIENT BILL OF RIGHTS OF DEPARTMENT OF VETERANS AFFAIRS.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients and family members of patients at each medical facility of the Department of Veterans Affairs—

(1) display the purposes of the Patient Advocacy Program of the Department and the contact information for the patient advocate at such medical facility; and

(2) display the rights and responsibilities of—

(A) patients and family members and patients at such medical facility; and

(B) with respect to community living centers and other residential facilities of the Department, residents and family members of residents at such medical facility.

SEC. 323. COMPTROLLER GENERAL REPORT ON PATIENT ADVOCACY PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Patient Advocacy Program of the Department of Veterans Affairs (in this section referred to as the ''Program'').

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) A description of the Program, including—

(A) the purpose of the Program;

(B) the activities carried out under the Program; and

(C) the sufficiency of the Program in achieving the purpose of the Program.

(2) An assessment of the sufficiency of staffing of employees of the Department responsible for carrying out the Program.

(3) An assessment of the sufficiency of the training of such employees.

(4) An assessment of—

(A) the awareness of the Program among veterans and family members of veterans; and

(B) the use of the Program by veterans and family members of veterans.

(5) Such recommendations and proposals for improving or modifying the Program as the Comptroller General considers appropriate.

(6) Such other information with respect to the Program as the Comptroller General considers appropriate.

Subtitle C—Complementary and Integrative Health

SEC. 331. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

(a) ESTABLISHMENT.—There is established a commission to be known as the ''Creating Options for Veterans' Expedited Recovery'' or the ''COVER Commission'' (in this Act referred to as the ''Commission''). The Commission shall examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health conditions of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department facilities

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

(b) DUTIES.—The Commission shall perform the following duties:

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

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

(A) the experience of veterans with the Department of Veterans Affairs when seeking medical assistance for mental health issues through the health care system of the Department;

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

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

(D) the experience, if any, of veterans with respect to the complementary alternative treatment therapies described in paragraph (3);

(E) the prevalence of prescribing prescription medication among veterans seeking treatment through the health care system of the Department as remedies for addressing mental health issues; and

(F) the outreach efforts of the Secretary regarding the availability of benefits and treatments for veterans for addressing mental health issues, including by identifying ways to reduce barriers to gaps in such benefits and treatments.

(3) Examine available research on complementary alternative treatment therapies for mental health issues and identify what benefits could be made with the inclusion of such treatments for veterans, including with respect to—

(A) music therapy;

(B) equine therapy;

(C) training and caring for service dogs;

(D) yoga therapy;

(E) acupuncture therapy;

(F) meditation therapy;

(G) outdoor sports therapy;

(H) hyperbaric oxygen therapy;

(I) accelerated resolution therapy;

(J) art therapy;

(K) magnetic resonance therapy; and

(L) other therapies the Commission determines appropriate.

(4) Study the sufficiency of the resources of the Department to ensure the delivery of quality health care for mental health issues among veterans seeking treatment within the Department.

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

(A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans;

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

(C) the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues;

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

(E) the efforts of the Department to expand complementary alternative treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered with the Department.

(c) MEMBERSHIP.—

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

(A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(B) Two members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(C) Two members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(D) Two members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(E) Two members appointed by the President, at least one of whom shall be a veteran.

(2) QUALIFICATIONS.—Members of the Commission shall be—

(A) individuals who are of recognized standing and distinction within the medical community with a background in treating mental health;

(B) individuals with experience working with the military and veteran population; and

(C) individuals who do not have a financial interest in any of the complementary alternative treatments reviewed by the Commission.

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

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

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

(6) APPOINTMENT DEADLINE.—The appointment of members of the Commission in this section shall be made not later than 90 days after the date of the enactment of this Act.

(d) POWERS OF COMMISSION.—

(1) MEETINGS.—

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

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

(B) MEETING.—The Commission shall regularly meet at the call of the Chairman. Such meetings may be carried out through the use of telephonic or other appropriate telecommunication technology if the Commission determines that such technology will allow the members to communicate simultaneously.

(2) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive evidence as the Commission considers advisable to carry out the responsibilities of the Commission.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission.

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

ganizations as the Commission determines appropriate.

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

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

(7) COMPENSATION OF MEMBERS; TRAVEL EXPENSES.—Each member shall serve without pay but shall receive travel expenses to perform the duties of the Commission, including per diem in lieu of substances, at rates authorized under subchapter I of chapter 57 of title 5, United States Code.

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

the provisions of title 5, United States Code, governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at a level IV of the Executive Schedule under section 5316 of title 5, United States Code.

(9) PERSONNEL AS FEDERAL EMPLOYEES.—

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

(B) MEMBERS OF THE COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

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

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

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

(12) POSTAL SERVICE.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

(13) PHYSICAL FACILITIES AND EQUIPMENT.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act. These administrative services may include human resource management, budget, leasing accounting, and payroll services.

(e) REPORT.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—Not later than 60 days after the date on which the Commission first meets, and each 30-day period thereafter ending on the date on which the Commission submits the final report under paragraph (2), the

Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the President a report detailing the level of cooperation the Secretary of Veterans Affairs (and the heads of other departments or agencies of the Federal Government) has provided to the Commission.

(B) OTHER REPORTS.—In carrying out its duties, at times that the Commission determines appropriate, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate and any other appropriate entities an interim report with respect to the findings identified by the Commission.

(2) FINAL REPORT.—Not later than 18 months after the first meeting of the Commission, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate, the President, and the Secretary of Veterans Affairs a final report on the findings of the Commission. Such report shall include the following:

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

findings of the Commission pursuant to subsection (b).

(B) An analysis of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating veterans with mental health care issues, and an examination of the prevalence and efficacy of prescription drugs as a means for treatment.

(C) The findings of the patient-centered survey conducted within each of the Veterans Integrated Service Networks pursuant to subsection (b)(2).

(D) An examination of complementary alternative treatments described in subsection (b)(3) and the potential benefits of incorporating such treatments in the therapy models used by the Secretary for treating veterans with mental health issues.

(3) PLAN.—Not later than 90 days after the date on which the Commission submits the final report under paragraph (2), the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate a report on the following:

(A) An action plan for implementing the recommendations established by the Commission on such solutions and remedies for improving wellness-based outcomes for veterans with mental health care issues.

(B) A feasible timeframe on when the complementary alternative treatments described in subsection (b)(3) can be implemented Department-wide.

(C) With respect to each recommendation established by the Commission, including any complementary alternative treatment, that the Secretary determines is not appropriate or feasible to implement, a justification for such determination and an alternative solution to improve the efficacy of the therapy models used by the Secretary for treating veterans with mental health issues.

(f) TERMINATION OF COMMISSION.—The Commission shall terminate 30 days after the Commission submits the final report under subsection (e)(2).

SEC. 332. PILOT PROGRAM ON INTEGRATION OF COMPLEMENTARY ALTERNATIVE MEDICINES AND RELATED ISSUES FOR VETERANS AND FAMILY MEMBERS OF VETERANS.

(a) PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the date on which the Secretary of Veterans Affairs receives the final report under section 331(e), the Secretary shall commence a pilot program to assess the feasibility and advisability of using wellness-based programs (as defined by the Secretary) to complement the provision of pain management and related health care services, including mental health care services, to veterans.

(2) MATTERS ADDRESSED.—In carrying out the pilot program, the Secretary shall assess the following:

(A) Means of improving coordination between Federal, State, local, and community providers of health care in the provision of pain management and related health care services to veterans.

(B) Means of enhancing outreach, and coordination of outreach, by and among providers of health care referred to in subparagraph (A)

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

(C) Means of using wellness-based programs of providers of health care referred to in subparagraph (A) as complements to the provision by the Department of pain management and related health care services to veterans.

(D) Whether wellness-based programs described in subparagraph (C)—

(i) are effective in enhancing the quality of life and well-being of veterans;

(ii) are effective in increasing the adherence of veterans to the primary pain management and related health care services provided such veterans by the Department;

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

(iv) are effective in encouraging veterans receiving health care from the Department to adopt a more healthy lifestyle.

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

(c) LOCATIONS.—

(1) FACILITIES.—The Secretary shall carry out the pilot program under subsection (a)(1) at facilities of the Department providing pain management and related health care services, including mental health care services, to veterans. In selecting such facilities to carry out the pilot program, the Secretary shall select not fewer than 15 medical centers of the Department, of which not fewer than two shall be polytrauma rehabilitation centers of the Department.

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

(d) PROVISION OF SERVICES.—Under the pilot program under subsection (a)(1), the Secretary shall provide covered services to covered veterans by integrating com-

plementary and alternative medicines and integrative health services with other services provided by the Department at the medical centers selected under subsection (c).

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

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

(2) experiences chronic pain;

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

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

(f) COVERED SERVICES.—

(1) IN GENERAL.—For purposes of the pilot program, covered services are services consisting of complementary and integrative health services as selected by the Secretary.

(2) ADMINISTRATION OF SERVICES.—Covered services shall be administered under the pilot program as follows:

(A) Covered services shall be administered by professionals or other instructors with ap-

propriate training and expertise in complementary and integrative health services who are employees of the Department or with whom the Department enters into an agreement to provide such services.

(B) Covered services shall be included as part of the Patient Aligned Care Teams initiative of the Office of Patient Care Services, Primary Care Program Office, in coordination with the Office of Patient Centered Care and Cultural Transformation.

(C) Covered services shall be made available to—

(i) covered veterans who have received conventional treatments from the Department for the conditions for which the covered veteran seeks complementary and integrative health services under the pilot program; and

(ii) covered veterans who have not received conventional treatments from the Department for such conditions.

(g) REPORTS.—

(1) IN GENERAL.—Not later than 30 months after the date on which the Secretary commences the

pilot program under subsection (a)(1), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the pilot program.

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

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

(i) the use and efficacy of the complementary and integrative health services established under the pilot program;

(ii) the outreach conducted by the Secretary to inform veterans and community organizations about the pilot program; and

(iii) an assessment of the benefit of the pilot program to covered veterans in mental health diagnoses, pain management, and treatment of chronic illness.

(B) Identification of any unresolved barriers that impede the ability of the Secretary to incorporate complementary and integrative

health services with other health care services provided by the Department.

(C) Such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(h) COMPLEMENTARY AND INTEGRATIVE HEALTH DEFINED.—In this section, the term ''complementary and integrative health'' shall have the meaning given that term by the National Institutes of Health.

Subtitle D—Fitness of Health Care Providers

SEC. 341. ADDITIONAL REQUIREMENTS FOR HIRING OF HEALTH CARE PROVIDERS BY DEPARTMENT OF VETERANS AFFAIRS.

As part of the hiring process for each health care provider considered for a position at the Department of Veterans Affairs after the date of the enactment of the Act, the Secretary of Veterans Affairs shall require from the medical board of each State in which the health care provider has a medical license—

(1) information on any violation of the requirements of the medical license of the health care provider during the 20-year period preceding the consideration of the health care provider by the Department; and

(2) information on whether the health care provider has entered into any settlement agreement for the disciplinary charge relating to the practice of medicine by the health care provider.

SEC. 342. PROVISION OF INFORMATION ON HEALTH CARE PROVIDERS OF DEPARTMENT OF VETERANS AFFAIRS TO STATE MEDICAL BOARDS.

Notwithstanding section 552a of title 5, United States Code, with respect to each health care provider of the Department of Veterans Affairs who has violated a requirement of the medical license of the health care provider, the Secretary of Veterans Affairs shall provide to the medical board of each State in which the health care provider is licensed detailed information with respect to such violation, regardless of whether such board has formally requested such information.

SEC. 343. REPORT ON COMPLIANCE BY DEPARTMENT OF VETERANS AFFAIRS WITH REVIEWS OF HEALTH CARE PROVIDERS LEAVING THE DEPARTMENT OR TRANSFERRING TO OTHER FACILITIES.

Not later than two years after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House

of Representatives a report on the compliance by the Department of Veterans Affairs with the policy of the Department—

(1) to conduct a review of each health care provider of the Department who transfers to another medical facility of the Department, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider; and

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

Subtitle E—Other Veterans Matters

SEC. 351. AUDIT OF VETERANS HEALTH ADMINISTRATION PROGRAMS OF DEPARTMENT OF VETERANS AFFAIRS.

(a) AUDIT.—The Secretary of Veterans Affairs shall seek to enter into a contract with a nongovernmental entity under which the entity shall conduct a audits of the programs of the Veterans Health Administration of the Department of Veterans Affairs to identify ways to improve the furnishing of benefits and health care administered by the Veterans Health Administration to veterans and families of veterans.

(b) AUDIT REQUIREMENTS.—In carrying out each audit under subsection (a), the entity shall perform the following:

(1) Five-year risk assessments to identify the functions, staff organizations, and staff offices of the Veterans Health Administration that would lead towards the greatest improvement in furnishing of benefits and health care to veterans and families of veterans.

(2) Development of plans that are informed by the risk assessment under paragraph (1) to conduct audits of the functions, staff organizations, and staff offices identified under paragraph (1).

(3) Conduct audits in accordance with the plans developed pursuant to paragraph (2).

(c) REPORTS.—Not later than 90 days after the date on which each audit is completed under subsection (a), the Secretary shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report that includes—

(1) a summary of the audit;

(2) the findings of the entity that conducted the audit with respect to the audit; and

(3) such recommendations as the Secretary determines appropriate for legislative or administrative

action to improve the furnishing of benefits and health care to veterans and families of veterans.

TITLE IV—IMPROVING SAFE CARE FOR PREVENTING INFANT ABUSE AND NEGLECT

SEC. 401. SHORT TITLE.

This title may be cited as the ''Improving Safe Care for the Prevention of Infant Abuse and Neglect Act''.

SEC. 402. BEST PRACTICES FOR DEVELOPMENT OF PLANS OF SAFE CARE.

Section 103(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5104(b)) is amended—

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

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

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

SEC. 403. STATE PLANS.

Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)(iii)) is amended by inserting before the period at the end the following: ''to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through addressing the health of the affected family or caregiver''.

SEC. 404. DATA REPORTS.

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

''(17) The total number of infants—

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

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

''(C) for whom referrals are made for appropriate services, including services for the affected family or caregiver, as may be necessary under subsection (b)(2)(B)(iii).''.

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

SEC. 405. MONITORING AND OVERSIGHT.

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

"SEC. 114. MONITORING AND OVERSIGHT.

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

''(1) shall—

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

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

''(2) may include—

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

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

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

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

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

"Sec. 114. Monitoring and oversight.".

SEC. 406. RULE OF CONSTRUCTION.

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

TITLE V—OTHER PROVISIONS

SEC. 501. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER MEDICARE PARTS C AND D.

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

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

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

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

''(B) REQUIREMENT FOR NOTICES.—

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

prescription drug plan until such sponsor—

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

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

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

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

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

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

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

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

"(VI) clear instructions that explain how the beneficiary can contact

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

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

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

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

''(II) that such beneficiary is subject to the requirements of the

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

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

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

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

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

''(iv) TIMING OF NOTICES.—

"(I) IN GENERAL.—Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 60 days after an initial notice described in clause (ii) is provided to the beneficiary.

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

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

"(i) IN GENERAL.—For purposes of this paragraph, the term 'at-risk bene-

ficiary for prescription drug abuse' means a part D eligible individual who is not an exempted individual described in clause (ii) and—

"(I) who is identified as such an at-risk beneficiary through the use of clinical guidelines developed by the Secretary in consultation with PDP sponsors and other stakeholders described in section 3141(f)(2)(A) of the 21st Century Cures Act; or

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

"(ii) EXEMPTED INDIVIDUAL DESCRIBED.—An exempted individual de-

scribed in this clause is an individual who—

"(I) receives hospice care under this title;

"(II) is a resident of a long-term care facility, of an intermediate care facility for the mentally retarded, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

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

"(D) SELECTION OF PRESCRIBERS AND PHARMACIES.—

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

otherwise provided in this subparagraph), select—

"(I) one or more individuals who are authorized to prescribe frequently abused drugs (referred to in this paragraph as 'prescribers') who may write prescriptions for such drugs for such beneficiary; and

"(II) one or more pharmacies that may dispense such drugs to such beneficiary.

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

"(I) a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to frequently abused drugs (as defined in subparagraph (G)), taking into account geographic location, beneficiary preference, impact on cost-sharing, and reasonable travel time; and

"(II) a PDP sponsor shall ensure such access (including access to prescribers and pharmacies with respect

to frequently abused drugs) in the case of individuals with multiple residences and in the case of natural disasters and similar emergency situations.

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

''(I) review such preferences;

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

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

''(iv) EXCEPTION REGARDING BENEFICIARY PREFERENCES.—In the case that the PDP sponsor determines that a change to the selection of prescriber or pharmacy under clause (iii)(II) by the PDP sponsor is contributing or would contribute to pre-

scription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in clause (iii).

''(v) CONFIRMATION.—Before selecting a prescriber (or prescribers) or pharmacy (or pharmacies) under this subparagraph, a PDP sponsor must request and receive confirmation from such a prescriber or pharmacy acknowledging and accepting that the beneficiary involved is in the drug management program for at-risk beneficiaries.

''(E) TERMINATIONS AND APPEALS.—The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, and the selection of prescriber or pharmacy under subparagraph (D) with respect to such individual shall be subject to reconsideration and appeal under subsection (h) and the

option of an automatic escalation to external review to the extent provided by the Secretary.

"(F) TERMINATION OF IDENTIFICATION.—

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

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

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

"(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph

(C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

''(G) FREQUENTLY ABUSED DRUG.—For purposes of this subsection, the term 'frequently abused drug' means a drug that is a controlled substance that the Secretary determines to be frequently abused or diverted.

''(H) DATA DISCLOSURE.—In the case of an at-risk beneficiary for prescription drug abuse whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, such PDP sponsor shall disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part to other PDP sponsors that request such data.

''(I) EDUCATION.—The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-

risk beneficiaries described in this paragraph, including education—

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

"(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.

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

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

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

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

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

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

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

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

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

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

"(ii) Retrospective utilization review to identify—

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

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

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

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

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

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

"(ii) the name and prescription records of individuals described in paragraph (5)(C).".

(c) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

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

"(j) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

"(1) ACCESS TO INFORMATION.—Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA–PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for

prescription drug abuse, as defined in section 1860D–4(c)(5)(C).

''(2) REQUIREMENT FOR ACKNOWLEDGMENT OF REFERRALS.—If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

''(A) acknowledge to the sponsor or organization receipt of the referral; and

''(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described such paragraph, shall inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

''(3) MAKING DATA AVAILABLE TO OTHER ENTITIES.—

''(A) IN GENERAL.—For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MED-

ICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

''(B) HIPAA COMPLIANT INFORMATION ONLY.—Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).''.

(2) OIG STUDY AND REPORT ON EFFECTIVENESS OF MEDICS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the effectiveness of Medicare drug integrity contractors with which the Secretary of Health and Human Services has entered into a contract under section 1893 of the Social Security Act (42 U.S.C. 1395ddd)

in identifying, combating, and preventing fraud under the Medicare Program, including under the authority provided under section 1893(j) of the Social Security Act, added by paragraph (1).

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A). Such report shall include such recommendations for improvements in the effectiveness of such contractors as the Inspector General determines appropriate.

(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—Section 1860D–42 of the Social Security Act (42 U.S.C. 1395w–152) is amended by adding at the end the following new subsection:

''(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and

that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.''.

(e) SENSE OF CONGRESS REGARDING USE OF TECHNOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of Congress that MA organizations and PDP sponsors should consider using e-prescribing and other health information technology tools to support combating fraud under MA–PD plans and prescription drug plans under parts C and D of the Medicare Program.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to prescription drug plans (and MA–PD plans) for plan years beginning more than 1 year after the date of the enactment of this Act.

(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

(A) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title of such Act, advocacy groups representing such individuals,

physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B).

(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

(i) the anticipated impact of drug management programs for at-risk beneficiaries under paragraph (5) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors, and enrollees in MA–PD plans, who are at-risk beneficiaries for prescription drug abuse (as defined in subparagraph (C) of such paragraph);

(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title

XVIII of the Social Security Act that allow an automatic escalation to external review of claims submitted under such part);

(iii) the types of enrollees that should be treated as exempted individuals, as described in subparagraph (C)(ii) of such paragraph;

(iv) the manner in which terms and definitions in such paragraph should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph;

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

(vi) with respect to a PDP sponsor (or Medicare Advantage organization) that establishes a drug management program for at-risk beneficiaries under such paragraph, the responsibilities of such PDP sponsor (or organization) with respect to the implementation of such program.

(g) RULEMAKING.—The Secretary of Health and Human Services shall promulgate regulations based on the input gathered pursuant to subsection (f)(2)(A).

SEC. 502. EXCLUSION OF AUTHORIZED GENERIC DRUGS FROM CALCULATION OF AVERAGE MANUFACTURER PRICE FOR BRAND NAME DRUGS.

(a) IN GENERAL.—Section 1927(k)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)(C)) is amended—

(1) in the subparagraph heading, by striking ''INCLUSION'' and inserting ''EXCLUSION'';

(2) by striking ''a new drug application'' and inserting ''the manufacturer's new drug application''; and

(3) by striking ''inclusive'' and inserting ''exclusive''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect one year after the date of the enactment of this section.

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