every year, and they can write off on their taxes that new computer, that new equipment, that new improvement to their store. A “no” vote hammers America’s Main Street businesses.

Young parents, struggling to raise kids, where every dollar matters, this bill makes sure that, that doubling of the child tax credit is permanent, and millions more Americans, middle-class families, will get help raising their precious children. A “no” vote is to deny American seniors, American families’ ability to write off those taxes.

Now we know, thanks to ObamaCare, high out-of-pocket costs is now the pre-existing condition. This bill makes sure that we stand on the side of those seniors, whether they are battling cancer or some other maladies.

At the end of the day, while some would say, look, we need to raise the SALT cap, let me just say this: That SALT cap is a $10 tax cut for the middle class and a $146,000 tax cut for millionaires. In other words, Democrats who vote “no” they just want more tax cuts for the rich.

And the fact of the matter is, States are seeing a $20 billion windfall. State governments and Governors, all they need do, don’t pocket that money for their budget, pass it on to hard working taxpayers.

At the end of the day, revenues are up. Payroll taxes are up. Social Security and Medicare are strengthened.

So at the end of the day, who do you trust with your hard-earned money? Is it Washington, so they can take it and spend it on their special interests? Is it you? Is it your family? Is it your American Dream?

This bill is about making sure that we choose the American people. We choose you, the middle-class families. We choose you, Main Street America, to better use your money as Washington does.

As we conclude, Mr. Speaker, I would like to thank our tax team, led by Barbara Angus, our Chief Tax Counsel, Aharon Friedman, Randy Gartin, Aaron Junge, Loren Ponds, John Sandell, Donald Schneider, Victoria Glover, John Schoenecker, and Quinton Brady, for doing a remarkable job for us, and for the American people. I urge a “yes” on protecting tax cuts for individuals, middle-class families, and small businesses.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit. The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. LARSON of Connecticut. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are desired, to be considered to under clause 6 of rule XX.

The House will resume proceedings on postponed questions at a later time.

SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT

Mr. WALDEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 1099) providing for the concurrence by the House in the Senate amendment to H.R. 6, with amendments.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

Resolved, That upon the adoption of this resolution the House shall be considered to have taken from the Speaker’s table the bill, H.R. 6, with the Senate amendment thereto, have taken from the Speaker’s table the bill, H.R. 6, with the Senate amendment thereto, and to have concurred in the Senate amendment to the House resolution (H. Res. 1099) providing for the concurrence by the House in the Senate amendment to the House resolution (H. Res. 1099) providing for the concurrence by the House in the Senate amendment to H.R. 6, with amendments.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” or the “SUPPORT for Patients and Communities Act”.

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

Sec. 1. Short title: table of contents.

TITLE I—MEDICAID PROVISIONS TO ADDRESS THE OPIOID CRISIS

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

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

Sec. 1012. Help for moms and babies.

Sec. 1013. Securing flexibility to treat substance use disorders.

Sec. 1014. MACPAC study and report on MAT utilization controls under State Medicaid programs.

Sec. 1015. Opioid addiction treatment programs enhancement.

Sec. 1016. Better data sharing to combat the opioid crisis.

Sec. 1017. Reports on innovative State initiatives and strategies to provide housing-related services and supports to individuals struggling with substance-use disorders under Medicaid.

Sec. 1018. Technical assistance and support for innovative State strategies to provide housing-related support under Medicaid.

TITLE II—MEDICARE PROVISIONS TO ADDRESS THE OPIOID CRISIS

Sec. 2001. Expanding the use of telehealth services for the treatment of opioid use disorder and other substance use disorders.


Sec. 2003. Every prescription conveyed securely.


Sec. 2005. Medicare coverage of certain services furnished by opioid treatment programs.

Sec. 2006. Encouraging appropriate prescribing under Medicare for victims of opioid overdose.

Sec. 2007. Automatic escalation to external review under a Medicare part D drug management program for at-risk beneficiaries.

Sec. 2008. Suspension of payments by Medicare prescription drug plans and MA-PD plans pending investigation of credible allegations of fraud by pharmacies.

TITLE III—FDA AND CONTROLLED SUBSTANCE PROVISIONS

Subtitle A—FDA Provisions

CHAPTER 1—IN GENERAL

Sec. 3001. Clarifying FDA regulation of non-addictive opioids.

Sec. 3002. Evidence-based opioid analgesic prescribing guidelines and report.

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

Sec. 3011. Short title.

Sec. 3012. Notification, nondistribution, and recall of controlled substances.

Sec. 3013. Single source pattern of imported illegal drugs.

Sec. 3014. Strengthening FDA and CBP coordination and capacity.

CHAPTER 3—STOP Illicit Drug Importation

Sec. 3021. Short title.

Sec. 3022. Restricting entrance of illicit drugs.
Sec. 3032. Safety-enhancing packaging and
Sec. 3031. Short title.

CHAPTER 1—MORE FLEXIBILITY WITH RESPECT TO PHARMACists

Sec. 3041. Clarifying FDA postmarket authorizations.
Sec. 3040. Clarifying postmarket authorizations.

Sec. 3241. Controlled substance analogues.
Sec. 3240. Controlled substance analogues.

Sec. 3292. Improvements to prevent drug diversion.
Sec. 3291. Short title.

Sec. 3204. Delivery of a controlled substance
Sec. 3203. Grants to enhance access to substance
use disorder treatment.
Sec. 3202. Medication-assisted treatment for opioid use disorder.
Sec. 3201. Allowing for more flexibility with regard to medication-assisted treatment for opioid use disorders.

Sec. 3259. Duration of program.
Sec. 3258. Eligibility for grant.
Sec. 3257. Authority to make grants.
Sec. 3256. Eligibility for grant.
Sec. 3255. Application.
Sec. 3254. Duration of grants.
Sec. 3253. Accountability and oversight.
Sec. 3252. Duration of program.
Sec. 3251. Authorization of appropriations.

Sec. 4003. Additional religious exemption from health coverage responsibility requirement.
Sec. 4004. Modernizing the reporting of biologics and biologics products.

Sec. 4002. Requiring reporting by group health plans of prescription drug coverage information for purposes of identifying primary payer situations under the Medicare program.

TITLE V—OTHER MEDICARE PROVISIONS

Subtitle A—Mandatory Reporting With Respect to Adult Behavioral Health Measures
Sec. 5001. Mandatory reporting with respect to adult behavioral health measures.

Subtitle B—Medicaid IMD Additional Fee
Sec. 5011. Short title.
Sec. 5012. MACPAC exploratory study and report on institutions for mental disease and requirements and practices under Medicaid.

Subtitle C—CHIP Mental Health and Substance Use Disorder Parity
Sec. 5021. Short title.
Sec. 5022. Ensuring access to mental health and substance use disorder services for children and pregnant women under the Children’s Health Insurance Program.

Subtitle D—Medicaid Reentry
Sec. 5031. Short title.
Sec. 5032. Promoting State innovations to enhance access to care and services for individuals receiving payment under part A of the Medicare program.

Subtitle E—Medicaid Partnership
Sec. 5041. Short title.
Sec. 5042. Medicaid providers are required to note experiences in record systems to help in-need patients.

Subtitle F—IMD CARE Act
Sec. 5051. Short title.
Sec. 5052. State option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases.

Subtitle G—Medicaid Improvement Fund
Sec. 5061. Medicaid Improvement Fund.

TITLE VI—OTHER MEDICARE PROVISIONS

Subtitle A—Testing of Incentive Payments for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology
Sec. 6001. Testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology.

Subtitle B—Abuse Deterrent Access
Sec. 6011. Short title.
Sec. 6012. Study on abuse-deterrent opioid formulations and access barriers under Medicare.

Subtitle C—Medicare Opioid Safety Education
Sec. 6021. Medicare opioid safety education.

Subtitle D—Opioid Addiction Action Plan
Sec. 6031. Short title.
Sec. 6032. Action plan on recommendations for changes under Medicare and Medicaid to prevent opioid addictions and enhance access to medication-assisted treatment.

Subtitle E—Advancing High Quality Treatment for Opioid Use Disorders in Medicare
Sec. 6041. Short title.
Sec. 6042. Opioid use disorder treatment demonstration program.

Subtitle F—Responsible Education Achieves Care and Healthy Outcomes for Users’ Treatment
Sec. 6051. Short title.
Sec. 6052. Grants to provide technical assistance to outlier prescribers of opioids.

Subtitle G—Preventing Addiction for Susceptible Seniors
Sec. 6061. Short title.
Sec. 6062. Electronic prior authorization for covered part D drugs.

Subtitle H—Expanding Oversight of Opioid Prescribing and Payment
Sec. 6071. Short title.
Sec. 6072. Medicare payment Advisory Commission report on opioid payment, adverse incentives, and data under the Medicare program.

Subtitle I—Dr. Todd Graham Pain Management, Treatment, and Recovery
Sec. 6081. Short title.
Sec. 6082. Review and adjustment of payments under the Medicare outpatient prospective payment system to avoid financial incentives to use opioids instead of non-opioid alternative treatments.

Subtitle J—Combating Opioid Abuse for Care in Hospitals
Sec. 6091. Short title.
Sec. 6092. Developing guidance on pain management and opioid use disorder prevention in hospitals receiving payment under part A of the Medicare program.

Subtitle K—Providing Reliable Options for Patients and Educational Resources
Sec. 6101. Short title.
Sec. 6102. Requiring Medicare Advantage plans and part D prescription drug plans to include information on risks associated with opioids and coverage of non-pharmacologic therapies and nonopioid medications or devices used to treat pain.
Sec. 6103. Requiring Medicare Advantage plans and prescription drug plans to provide information on the safe disposal of prescription drug products.

Sec. 6104. Revising measures used under the Hospital Consumer Assessment of Healthcare Providers and Systems survey relating to pain management.

Subtitle I—Fighting the Opioid Epidemic With Sunshine

Sec. 6111. Fighting the opioid epidemic with sunshine.

TITLE VII—PUBLIC HEALTH PROVISIONS

Subtitle A—Awareness and Training

Sec. 7001. Report on effects on public health of synthetic drug use.

Sec. 7002. First responder training.

Subtitle B—Pilot Program for Public Health Laboratories To Detect Fentanyl and Other Synthetic Opioids

Sec. 7011. Pilot program for public health laboratories to detect fentanyl and other synthetic opioids.

Subtitle C—Indexing Narcotics, Fentanyl, and Opioids

Sec. 7021. Establishment of substance use disorder information dashboard.

Sec. 7022. Interdepartmental Substance Use Disorders Coordinating Committee.

Sec. 7023. National milestones to measure success in curtailing the opioid crisis.

Sec. 7024. Study on prescribing limits.

Subtitle D—Ensuring Access to Quality Sober Living

Sec. 7031. National recovery housing best practices.

Subtitle E—Advancing Cutting Edge Research

Sec. 7041. Unique research initiatives.

Sec. 7042. Pain research.

Subtitle F—Jessie’s Law

Sec. 7051. Inclusion of opioid addiction history in patient records.

Sec. 7052. Communication with families during emergencies.

Sec. 7053. Development and dissemination of model training programs for substance use disorder patient records.

Subtitle G—Protecting Pregnant Women and Infants

Sec. 7061. Report on addressing maternal and infant health in the opioid crisis.

Sec. 7062. Protecting moms and infants.

Sec. 7063. Early interventions for pregnant women and infants.

Sec. 7064. Prenatal and postnatal health.

Sec. 7065. Plans of safe care.

Subtitle H—Substance Use Disorder Treatment Workforce

Sec. 7071. Loan repayment program for substance use disorder treatment workforce.

Sec. 7072. Clarification regarding service in schools and other community-based settings.

Sec. 7073. Programs for health care workforce.

Subtitle I—Preventing Overdoses While in Emergency Rooms

Sec. 7081. Program to support coordination and continuation of care for drug overdose patients.

Subtitle J—Alternatives to Opioids in the Emergency Department

Sec. 7091. Emergency department alternatives to opioids demonstration program.

SUBTITLE K—Treatment, Education, and Community Help To Combat Addiction

Sec. 7101. Establishment of regional centers of excellence in substance use disorder treatment and prevention.

Sec. 7102. Youth prevention and recovery.

Subtitle L—Information From National Mental Health and Substance Use Policy Laboratory

Sec. 7111. Information from National Mental Health and Substance Use Policy Laboratory.

Subtitle M—Comprehensive Opioid Recovery Centers

Sec. 7121. Comprehensive opioid recovery centers.

Subtitle N—Trauma-Informed Care

Sec. 7131. CDC surveillance and data collection for child, youth, and adult trauma.

Sec. 7132. Task force to develop best practices for trauma-informed identification, referral, and support.

Subtitle O—National Child Traumatic Stress Initiative

Sec. 7134. Grants to improve trauma support services and mental health care for children and youth in educational settings.

Sec. 7135. Recognizing early childhood trauma related to substance abuse.

Subtitle P—Peer Support Communities of Recovery

Sec. 7151. Building communities of recovery.

Sec. 7152. Peer support technical assistance center.

Subtitle Q—Creating Opportunities That Necessitate New and Enhanced Connections That Improve Opioid Navigation Strategies

Sec. 7161. Preventing overdoses of controlled substances.

Sec. 7162. Prescription drug monitoring program.

Subtitle R—Review of Substance Use Disorder Treatment Providers Receiving Federal Funding

Sec. 7171. Review of substance use disorder treatment providers receiving Federal funding.

Subtitle S—Other Health Provisions

Sec. 7181. State response to the opioid abuse crisis.

Sec. 7182. Report on investigations regarding parity in mental health and substance use disorder benefits.

Sec. 7183. CAREER Act.

TITLE VIII—MISCELLANEOUS

Subtitle A—Synthetic Trafficking and Overdose Prevention

Sec. 8001. Short title.

Sec. 8002. Customs fees.

Sec. 8003. Mandatory advance electronic information for postal shipments.

Sec. 8004. International postal agreements.

Sec. 8005. Cost recoupment.

Sec. 8006. Development of technology to detect illicit narcotics.

Sec. 8007. Civil penalties for postal shipments.

Sec. 8008. Report on violations of arrival, reporting, entry, and clearance requirements and falsity or lack of manifest.

Sec. 8009. Effective date; regulations.

Subtitle B—Opioid Addiction Recovery Fraud Prevention

Sec. 8012. Short title.

Subtitle C—Addressing Economic and Workforce Impacts of the Opioid Crisis

Sec. 8041. Addressing economic and workforce impacts of the opioid crisis.

Subtitle D—Peer Support Counseling Program for Women Veterans

Sec. 8051. Peer support counseling program for women veterans.

Subtitle E—Treating Barriers to Prosperity

Sec. 8061. Short title.

Sec. 8062. Drug abuse mitigation initiative.

Subtitle F—Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed

Sec. 8071. Pilot program to help individuals in recovery from a substance use disorder become stably housed.

Subtitle G—Human Services

Sec. 8081. Supporting family-focused residential treatment.

Sec. 8082. Improving recovery and reuniting families.

Sec. 8083. Building capacity for family-focused residential treatment.

Subtitle H—Reauthorizing and Extending Grants for Recovery From Opioid Use Programs

Sec. 8091. Short title.

Sec. 8092. Reauthorization of the comprehensive opioid abuse grant program.

Subtitle I—Fighting Opioid Abuse in Transportation

Sec. 8101. Short title.

Sec. 8102. Alcohol and controlled substance testing of mechanical employees.

Sec. 8103. Department of Transportation public drug and alcohol testing database.

Sec. 8104. GAO report on Department of Transportation’s collection and use of drug and alcohol testing data.

Sec. 8105. Transportation Workplace Drug and Alcohol Testing Program; addition of fentanyl and other substances.

Sec. 8106. Status reports on hair testing guidelines.


Sec. 8108. Electronic recordkeeping.

Sec. 8109. Status reports on Commercial Driver’s License Drug and Alcohol Clearinghouse.

Subtitle J—Eliminating Kickbacks in Recovery

Sec. 8121. Short title.

Sec. 8122. Criminal penalties.

Subtitle K—Substance Abuse Prevention

Sec. 8201. Short title.

Sec. 8202. Reauthorization of the Office of National Drug Control Policy.

Sec. 8203. Reauthorization of the Drug-Free Communities Program.

Sec. 8204. Reauthorization of the National Community Anti-Drug Coalition Institute.

Sec. 8205. Reauthorization of the High-Intensity Drug Trafficking Area Program.

Sec. 8206. Reauthorization of drug court programs.

Sec. 8207. Drug court training and technical assistance.
Sec. 1001. At-Risk Youth Medicaid Protection

(a) In General.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (25);

(B) by striking the period at the end of paragraph (26) and inserting “; and”;

(C) by inserting after paragraph (26) the following new paragraph:

“(8q) provide that—

“(A) the State shall not terminate eligibility for medical assistance under the State plan for an individual who is an eligible juvenile (as defined in subsection (nn)(2)) because the juvenile is an inmate of a public institution (as defined in subsection (nn)(3)), but may suspend coverage during the period the juvenile is such an inmate;

“(B) in the case of an individual who is an eligible juvenile described in paragraph (2)(A) of subsection (nn), the State shall, prior to the individual’s release from such a public institution, conduct a redetermination of eligibility for medical assistance with respect to such medical assistance (without requiring a new application from the individual) and, if the State determines pursuant to such redetermination that the individual continues to meet the eligibility requirements for such medical assistance, the State shall restore coverage for such medical assistance as of the individual’s release from such public institution; and

“(C) in the case of an individual who is an eligible juvenile described in paragraph (2)(B) of subsection (nn), the State shall process any application for medical assistance submitted by, or on behalf of, such individual under the State plan for medical assistance under the State plan for an individual described in subsection (nn)(2) and such individual’s release from such public institution.

(2) by adding at the end the following new subsection:

“(nn) JUVENILE; ELIGIBLE JUVENILE; PUBLIC INSTITUTION; INMATE.—

(A) JUVENILE.—The term ‘juvenile’ means an individual who—

(i) is under the age of 18; or

(ii) described in subsection (a)(10)(A)(i)(IX).

(B) ELIGIBLE JUVENILE.—The term ‘eligible juvenile’ means a juvenile who is an inmate of a public institution and—

(A) was determined eligible for medical assistance under the State plan immediately before becoming an inmate of such a public institution; or

(B) is determined eligible for such medical assistance while an inmate of a public institution.

(C) INMATE OF A PUBLIC INSTITUTION.—The term ‘inmate of a public institution’ means a patient of a medical institution.’’

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act, including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act for such assistance.

(b) In General.—Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to eligibility of juveniles who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act.

SECTION 1002. Assistance for Former Foster Youth

(a) Coverage Continuity for Former Foster Care Children Up to Age 26.—


(A) in item (bb), by striking “are not described in or enrolled under” and inserting “are not described in and are not enrolled under”;

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

(C) in item (dd), by striking “the State plan under this title or under a waiver of such a”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act, including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act for such assistance.

(b) Guidance.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to States, with respect to Medicaid programs of such States—

(1) on best practices for—

(A) removing barriers and ensuring streamlined, timely access to care for former foster youth up to age 26; and

(B) conducting outreach and raising awareness among such youth regarding Medicaid coverage options for such youth; and

(2) which shall include examples of what successfully extended Medicaid coverage to former foster youth up to age 26.

SEC. 1003. Demonstration Project To Increase Substance Use Provider Capacity under the Medicaid Program

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

“(a) Demonstration Project To Increase Substance Use Provider Capacity.—

“(1) IN GENERAL.—Not later than the date that is 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation, as appropriate, with the Director of the Office of National Drug Control Policy, the Secretary of Health and Human Services determines that it is necessary for such public health and public safety, as determined by the Secretary, to conduct a demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

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

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

“(2) Purpose.—The purpose described in this paragraph is for each State selected under paragraph (4) to increase the treatment capacity of providers participating under the State plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver) through the following activities:

“(A) under the State plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver) through the following activities:

“(B) Activities that, taking into account the results of the assessment described in paragraph (4)(A), support the recruitment, training, and provision of technical assistance for providers participating under the State plan (or a waiver of such plan) that offer substance use disorder treatment or recovery services.

“(C) Improved reimbursement for and expansion of, through the provision of education, training, and assistance, the number or type of treatment capacity of providers participating under the State plan (or waiver) that—

“(i) are authorized to dispense drugs approved by the Food and Drug Administration for individuals with a substance use disorder who need withdrawal management or maintenance treatment for such disorder; and

“(ii) have in effect a registration or waiver under section 303(g) of the Controlled Substances Act for purposes of dispensing narcotic drugs to individuals for maintenance treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use, conduct a 54-month demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

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

“(B) for the remaining 36-month period of such project, provide to each State selected under paragraph (4) payments in accordance with paragraph (5).
“(iii) are qualified under applicable State law to provide substance use disorder treatment or recovery services.

“(D) Improved reimbursement for and expansion of the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) during the period of the demonstration project.

“(I) Activities that, taking into account the results of the assessment described in clause (i), support the development of State infrastructure to, with respect to the provision of substance use disorder treatment or recovery services under the State plan (or a waiver of such plan), recruit prospective providers and provide training and technical assistance to such providers, and provide technical assistance to existing State substance use disorder treatment or recovery service providers.

“(D) FUNDING.—For purposes of subparagraph (A), there is appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000, to remain available until expended.

“(4) POST-PLANNING STATEMENTS.

“(A) IN GENERAL.—The Secretary shall, with respect to the remaining 36-month period of the demonstration project conducted under paragraph (1), select not more than 5 States in accordance with subparagraph (B) for purposes of carrying out the activities described in paragraph (2) and receiving payments in accordance with paragraph (5).

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

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

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

“(iii) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdose rates among individuals enrolled under the State plan (or waiver), including the following:

“(aa) Specific activities to increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

“(II) A review of reimbursement methodologies and other policies related to substance use disorder treatment or recovery services under the State plan (or waiver) that may create barriers to increasing the number of providers delivering such services.

“(III) The development of a plan, taking into consideration the requirements of subparagraph (C), including information required under paragraph (6)(A), to coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1115 for the delivery of substance use services under the State plan, as applicable.

“(IV) The expected financial impact of the demonstration project under this subsection.

“(V) The expected financial impact of the demonstration project under this subsection after the termination of such demonstration project.

“(VI) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1115 for the delivery of substance use services under the State plan, as applicable.

“(II) CONSULTATION.—In completing an application under clause (i), each State shall consult with relevant stakeholders, including Medicaid managed care plans, health care providers, and Medicaid beneficiary advocates, and include in such application a description of such consultation.

“(III) QUALIFIED SUMS DEFINED.—For purposes of subparagraph (A), the term ‘qualified sums’ means, with respect to a State participating under this subsection, the amount equal to the amount expended by the State during the fiscal year 2018 for the purposes of subparagraph (A) with respect to expenditures for substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds 1/4 of such sums expended by the State during fiscal year 2018.

“(C) NON-DUPLICATE OF PAYMENT.—In the case that payment is made under subparagraph (A) with respect to expenditures for substance use disorder treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan), payment may not also be made under subsection (a) with respect to expenditures for the same services so furnished.

“(D) REPORTS.—A State receiving payments under paragraph (5) shall, for the period of the demonstration project under this subsection, submit to the Secretary an annual report with respect to expenditures for substance use disorder treatment or recovery services for which payment is made
to the State under this subsection, on the following:

(i) The specific activities with respect to which payment under this subsection was provided,

(ii) The number of providers that delivered substance use disorder treatment or recovery services in the State under the demonstration project compared to the estimated number of such providers that would have otherwise delivered such services in the absence of such demonstration project,

(iii) The number of individuals enrolled under the State plan (or a waiver of such plan) who received substance use disorder treatment or recovery services under the demonstration project compared to the estimated number of such individuals who would have otherwise received such services in the absence of such demonstration project,

(iv) Other matters as determined by the Secretary.

(B) CMS REPORTS.

(i) INITIAL REPORT.—Not later than Octo-ber 1, 2020, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report—

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

(II) the criteria used in such selection; and

(III) the activities carried out by such States under such planning grants.

(ii) INTERIM REPORT.—Not later than Octo-ber 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report—

(I) on activities carried out under the demonstration project under this subsection;

(II) on the extent to which States selected under paragraph (4) have achieved the stated goals submitted in their applications under subparagraph (C) of such paragraph;

(III) with a description of the strengths and limitations of such demonstration project;

(IV) with a plan for the sustainability of such project.

(iii) FINAL REPORT.—Not later than Octo-ber 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report—

(I) providing updates on the matters re-ported in the interim report under clause (I);

(II) including a description of any changes made with respect to the demonstration project or another section after the sub-mission of such interim report; and

(III) evaluating such demonstration project.

(C) AHRQ REPORT.—Not later than 3 years after the date of the enactment of this subsec-tion, the Director of the Agency for Healthcare Research and Quality, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the expe-riences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

(7) DATA SHARING AND BEST PRACTICES.—During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

(8) CMS FUNDING.—There is appropriated, out of any amounts in the Treasury not other-wise appropriated, $5,000,000 to the Centers for Medicare & Medicaid Services for pur-poses of implementing this subsection. Such amount shall remain available until expended.’’.

SEC. 1004. MEDICAID DRUG REVIEW AND UTILI-ZATION REQUIREMENTS.

(a) Medicaid Drug Utilization Review.— (1) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is further amended by section 1001, is amended by adding at the end the following new paragraph:

‘‘(oo) DRUG REVIEW AND UTILIZATION REQUIRE-MENTS.—

(I) The States have in place a process (as designed and implemented by the State) for designing and implementing a claims review automated process that provides for prospective or retrospective reviews of claims. Nothing in this subpara-graph shall be understood as prohibiting the exercise of clinical judgment from a provider enrolled as a participating provider in a State plan (or waiver of the State plan) or contracting with a managed care entity re-garding the best items and services for an in-dividual enrolled under such State plan (or waiver).

(II) PROGRAM TO MONITOR ANTI-PsYCHOTIC MEDICATIONS BY CHILDREN.—The States have in place a process (as designed and implemented by the State) to identify potential misuse or abuse of controlled substances by individuals enrolled under the State plan (or under a waiver of the State plan), health care providers prescribing controlled substances to individuals or phar-macies dispensing drugs to individuals so en-rolled.

(III) REPORTS.—The States shall include in the annual report submitted to the Secre-tary under section 1927(e)(5)(D) information on the limitations, requirement, pro-gram, and processes applied by the State under subparagraphs (A) through (C) in accor-dance with such manner and time as spec-i-fied by the Secretary.

(b) Clarification.—Nothing shall prevent a State from satisfying the requirement—

(i) described in subparagraph (A) by hav-ing safety edits or a claims review auto-mated process described in such subpara-graph that was in place before October 1, 2019;

(ii) described in subparagraph (B) by hav-ing a program described in such subpara-graph that was in place before such date; or

(iii) described in subparagraph (C) by hav-ing a process described in such subparagraph that was in place before such date.

(c) Annual Report by Secretary.—For each fiscal year beginning with fiscal year 2020, the Secretary shall submit to Congress a report on the most recent year, including an information as the Secretary may require on the most recent information sub-mitted by States under paragraph (1)(D).

(d) Exceptions.—(A) CERTAIN INDIVIDUALS EXEMPTED.—The drug review and utilization requirements under this subsection shall not apply with respect to an individual who—

(i) is receiving hospice or palliative care; or

(ii) is a resident of a long-term care facili-ty, of a facility described in section 1965(k), or of another facility in which currently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(iii) the State elects to treat as exempted from such requirements.

(B) EXCEPTION RELATING TO ENSURING AC-CESS.—In order to ensure reasonable access to health care, the Secretary shall waive the drug review and utilization requirements under this subsection with respect to a State, in the case of natural disasters and similar situations, and in the case of the provi-sion of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(i)(II)).

(C) MANAGED CARE ENTITIES.—Section 1902 of the Social Security Act (42 U.S.C. 1396–2) is amended by adding at the end the fol-low-ing new subsection:
(i) Drug Utilization Review Activities and Requirements.—Beginning not later than October 1, 2019, each contract under a State plan with a managed care entity (other than a primary care case manager) under section 1903(m) shall provide that the entity is in compliance with the applicable provisions of: the Code of Federal Regulations, section 483.3(a)(4) of such title, and section 483.3(e)(5) of such title, as such provisions were in effect on March 1, 2012.

(ii) Identifying and Addressing Inappropriate Prescribing and Billing Practices Under Medicaid.—

(1) Requirement.—Section 1927(g) of the Social Security Act (42 U.S.C. 1396w-8(g)) is amended—

(A) in paragraph (1)(A)—

(1) by striking "of section 1903(1)(10)(B)" and inserting "of section 1902(a)(54)"; and

(2) by striking ", by not later than January 1, 2003,",

(3) by inserting after "gross overuse," the following: "excessive utilization,"; and

(iv) by striking "or inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization"; and

(B) in paragraph (1)—

(1) by inserting after "gross overuse," the following: "excessive utilization,"; and

(ii) by striking "or inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization".

(ii) Effective Date.—The amendments made by paragraph (1) shall take effect with respect to retrospective drug use reviews conducted during the period ending after December 31, 2019.

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

(a) Guidance.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to improve care for infants with neonatal abstinence syndrome and their families. Such guidance shall include—

(1) best practices from States with respect to innovative or evidenced-based payment models for prevention, treatment, plans of safe care, and postdischarge services for mothers and fathers with substance use disorders and babies with neonatal abstinence syndrome that improve care and clinical outcomes;

(2) recommendations for States on available financing options under the Medicaid program under title XIX of such Act and under the Children’s Health Insurance Program under title XXI of such Act for Children’s Health Insurance Program Health Services for pregnant and postpartum women, substance use disorders, infants with neonatal abstinence syndrome, and home-visiting services;

(3) case management and technical assistance to State Medicaid agencies regarding additional flexibilities and incentives related to screening, prevention, and postdischarge services, including support groups, and infant and caregiver bonding, including breastfeeding when it is appropriate; and

(4) guidance regarding suggested terminology and HCPCS codes to identify infants with neonatal abstinence syndrome and neonatal opioid withdrawal syndrome, which could include opioid-exposure, opioid withdrawal not requiring pharmacotherapy, and opioid withdrawal requiring pharmacotherapy.

(b) GAO Study.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to Congress a report addressing gaps in coverage for pregnant women with substance use disorder under the Medicaid program under title XVIII, for postpartum women with substance use disorder who had coverage during their pregnancy under the Medicaid program, and for neonatal abstinence syndrome.

SEC. 1006. MEDICAID HEALTH HOME FOR SUBSTANCE-USE-DisORDER MEDICAID ELIGIBLE INDIVIDUALS.

(a) Extension of Enhanced FMAP for Certain Health Homes for Individuals With Substance Use Disorders.—Section 1906(c) of the Social Security Act (42 U.S.C. 1396w-4(c)) is amended—

(1) in paragraph (1), by inserting "subject to subparagraph (A)" after "the Secretary may, at the request of the State, extend the applicability of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-focused State plan amendment";

(2) in paragraph (2), by striking "in effect for the first fiscal year quarters that the State plan amendment is approved under this section, including for purposes of application of this paragraph.

(b) Report Requirements.—In the case of a State with a SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the applicability of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-focused State plan amendment, in addition to the first fiscal year quarters that the State plan amendment is approved under this section, including for purposes of application of this paragraph.

The term ‘SUD-focused State plan amendment,’ as defined in paragraph (29) of subsection (a) shall not apply to a State plan amendment from additional relevant to the recovery of each such individual.

The access of such individuals to health care.

The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall apply all applicable measures for determining quality, access, and expenditures.

(c) Best Practices.—Not later than October 1, 2020, the Secretary shall make publicly available on the internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on models that focus on prevention, screening, and their families. Such guidance shall in-
Sect. 1007. Caring Recovery for Infants and Babies
(a) State Plan Amendment.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a), as amended by sections 1001 and 1004, is further amended—
(1) in paragraph (84)(C), by striking “and” after the semicolon;
(2) in paragraph (85), by striking the period at the end of paragraph (85); and
(3) by inserting after paragraph (85), the following new paragraph:
“(86) provide, at the option of the State, for making medical assistance available on an inpatient or outpatient basis at a residential pediatric recovery center as defined in subsection (pp) to infants with neonatal abstinence syndrome;
(b) Residential Pediatric Recovery Center Defined.—Section 1902 of such Act (42 U.S.C. 1396a(aa), as amended by sections 1001 and 1004, is further amended by striking “school-based health center” as defined in subsection (pp) to infants with neonatal abstinence syndrome;
(c) Activities to Encourage Caregiver-Infant Bonding.—For purposes of section 1902(a)(86), the term “residential pediatric recovery center” means a center or facility that furnishes items and services for which medical assistance is available under the State plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors.
(d) Counseling and Services.—A residential pediatric recovery center may offer counseling and other services to mothers (and other appropriate family members and caretakers) of infants receiving treatment at such centers if such services are otherwise covered under the State plan, or under a waiver of such plan. Such other services may include the following:
(1) Counseling or referrals for services.
(2) Services to encourage caregiver-infant bonding.
(3) Training on caring for such infants.
(e) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to medical assistance furnished on or after that date, without regard to final regulations to carry out such amendments being promulgated as of such date.
Sect. 1008. Peer Support Enhancement and Evaluation of Benefits
(a) In General.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States, the Secretary, the Committee on Finance of the Senate, and the Committee on Health, Education, Labor, and Pensions of the Senate shall submit to the Congress a report on the provision of peer support services under the Medicaid program.
(b) Content of Report.—
(1) In General.—The report required under subsection (a) shall include the following information:
(A) Information on State coverage of peer support services under Medicaid, including:
(i) the mechanisms through which States may provide such coverage, including through existing statutory authority or through regulations;
(ii) the populations to which States have provided such coverage;
(iii) the payment models, including any alternative payment models, used by States to pay providers of such services; and
(iv) where available, information on Federal and State funding for peer support services.
(B) Information on selected State experiences in providing medical assistance for substance use disorder treatment services delivered via telehealth under Medicaid plans and whether States measure the effects of providing such assistance with respect to:
(i) improving access to behavioral health services;
(ii) improving early detection, and preventing worsening, of behavioral health disorders;
(iii) reducing chronic and comorbid conditions; and
(iv) reducing overall health costs.
(2) Recommendations.—The report required under subsection (a) shall include recommendations, including recommendations for such legislative and administrative actions related to improving services, including peer support services, and access to peer support services under Medicaid as the Comptroller General of the United States determines appropriate.
Sect. 1009. Medicaid Substance Use Disorder Treatment via Telehealth
(a) Definitions.—In this section:
(1) Comptroller General.—The term “Comptroller General” means the Comptroller General of the United States.
(2) School-Based Health Center.—The term “school-based health center” has the meaning given that term in section 3101(c)(9) of the Social Security Act (42 U.S.C. 1397c(c)(9)).
(3) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.
(b) Under-Served Area.—The term “under-served area” means a health professional shortage area (as defined in section 338(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) and a medically under-served area (according to a designation under section 330(b)(3)(A) of the Public Health Service Act (42 U.S.C. 254b(b)(3)(A))).
(c) Guidance to States Regarding Federal Reimbursement for Furnishing Services and Treatment for Substance Use Disorders Using Services Delivered Via Telehealth, Including in School-Based Health Centers.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance to States on the following:
(1) State options for Federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders, including assessment, medical-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimens, using services delivered via telehealth.
(2) Recommendations.—The Comptroller General shall submit to Congress a report on the provision of peer support services under Medicaid in a school-based health center using services delivered via telehealth, particularly in rural and underserved areas. The report shall include an analysis of Medicaid provider reimbursement rates for services and treatment for substance use disorders.
(3) Report.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the evaluation conducted under paragraph (2) and recommendations for such legislation and administrative action as the Comptroller General determines appropriate.
(d) Report on Reducing Barriers to Using Services Delivered Via Telehealth and Remote Patient Monitoring for Pediatric Populations Under Medicaid.—
(1) In General.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives identifying best practices and potential solutions for reducing barriers to using services delivered via telehealth to furnish services and treatment for substance use disorders among pediatric populations under Medicaid.
(2) Report.—The report required under paragraph (1) shall include—
(A) analyses of the best practices, barriers, and potential solutions for using services delivered via telehealth to provide services and treatment for children with substance use disorders, including opioid use disorder; and
(B) a description and analysis of the differences, if any, in furnishing services and treatment for children with substance use disorders using services delivered via telehealth and using services delivered in person, such as, and to the extent feasible, with respect to—
(i) utilization rates;
(ii) costs;
(iii) avoidable inpatient admissions and readmissions;
(iv) quality of care; and
(v) patient, family, and provider satisfaction.
(3) Publication.—The Secretary shall publish the report required under paragraph (1) on a public internet website of the Department of Health and Human Services.
Sect. 1010. Enhancing Patient Access to Non-Opioid Treatment Options
(a) In General.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue 1 or more final guidance documents, or update existing guidance documents, to States regarding mandatory and optional items and other requirements that may be included in a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or under a waiver...
of such a plan, for non-opioid treatment and management of pain, including, but not limited to, evidence-based, non-opioid pharmacological therapies and non-pharmacological therapies.

SEC. 1011. ASSESSING BARRIERS TO OPIOID USE DISORDER TREATMENT.

(a) STUDY.—(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study of the barriers to providing medication used in the treatment of substance use disorders under Medicaid distribution models such as the ‘‘buy-and-bill’’ model and other State Medicaid programs to remove or reduce such barriers.

The study shall include analyses of each of the following models of distribution of substance use disorder treatment medications, particularly buprenorphine, naltrexone, and buprenorphine-naloxone combinations:

(A) The purchasing, storage, and administration of substance use disorder treatment medications by providers;

(B) The dispensing of substance use disorder treatment medications by pharmacists;

(C) The ordering, prescribing, and obtaining of substance use disorder treatment medications on demand from specialty pharmacies by providers.

(b) REQUIREMENTS.—For each model of distribution specified in paragraph (1), the Comptroller General shall evaluate how each model might or could be used to select State Medicaid programs to reduce the barriers related to the provision of substance use disorder treatment by examining what is known about the effects of the model of distribution on—

(A) Medicaid beneficiaries’ access to substance use disorder treatment medications;

(B) the cost to the public of each model of distribution and administrative action as the Comptroller General determines appropriate.

SEC. 1012. HELP FOR MOMS AND BABIES.

(a) T–MSIS SUBSTANCE USE DISORDER DATA PLAN.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 1006, is further amended by adding at the end of section 1905(a)(4)(I) the following new sentence: ‘‘In the case of a State that the Secretary of Health and Human Services determines has not undertaken a study conducted under subsection (a), the Medicaid and CHIP Payment and Access Commission shall make publicly available a report containing the results of the study conducted under subsection (a).’’

SEC. 1013. SECURING FLEXIBILITY TO TREAT SUBSTANCE USE DISORDERS. Section 1906(m) of the Social Security Act (42 U.S.C. 1396m) is amended by adding at the end of such section the following new paragraph: ‘‘(7) Payment shall be made under this title only for services for capita tion payments described in section 498.6(e)(1) of title 42, Code of Federal Regulations (or any successor regulations).’’

SEC. 1014. REPORT AND REPORT ON MAT UTILIZATION CONTROLS UNDER STATE MEDICAID PROGRAMS.

(a) STUDY.—The Medicaid and CHIP Payment and Access Commission shall conduct a study and analysis of utilization control policies applied to medication-assisted treatment for substance use disorders under State Medicaid programs, including policies and procedures applied both in fee-for-service Medicaid and in risk-based managed care Medicaid, which—

(1) include an inventory of such utilization control policies and related protocols for ensuring access to medically necessary treatment;

(2) determine whether managed care utilization control policies and related protocols for medication-assisted treatment for substance use disorders used for each model of distribution and administrative action as the Comptroller General determines appropriate.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), to address the following for each State Medicaid program, including the number of such individuals who—

(i) are enrolled in the State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(ii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(iii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(iv) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(v) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(vi) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(vii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(viii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(ix) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(x) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xi) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xiii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xiv) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xv) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xvi) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xvii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xviii) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xix) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(xx) are enrolled in a State Medicaid plan or a waiver for each type of service under the State Medicaid plan or a waiver for such type of service under a State Medicaid plan;

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines in such case to amend or to continue in effect any policy or provision of such plan (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendment made by the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act if the State legislature has, in the case of a State that has a 2-year legislative session, in each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1015. OPIOID ADDICTION TREATMENT PROGRAMS.

(a) T–MSIS SUBSTANCE USE DISORDER DATA BOOK.—(1) IN GENERAL.—Not later than the date of the enactment of this Act, the Medicaid and CHIP Payment and Access Commission shall make publicly available a report containing the results of the study conducted under subsection (a).

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

SEC. 1016. ASSESSING BARRIERS TO OPIOID USE DISORDER TREATMENT.

(a) STUDY.—(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study of the barriers to providing medication used in the treatment of substance use disorders under Medicaid distribution models such as the ‘‘buy-and-bill’’ model and other State Medicaid programs to remove or reduce such barriers.

The study shall include analyses of each of the following models of distribution of substance use disorder treatment medications, particularly buprenorphine, naltrexone, and buprenorphine-naloxone combinations:

(A) The purchasing, storage, and administration of substance use disorder treatment medications by providers;

(B) The dispensing of substance use disorder treatment medications by pharmacists;

(C) The ordering, prescribing, and obtaining of substance use disorder treatment medications on demand from specialty pharmacies by providers.

(b) REQUIREMENTS.—For each model of distribution specified in paragraph (1), the Comptroller General shall evaluate how each model might or could be used to select State Medicaid programs to reduce the barriers related to the provision of substance use disorder treatment by examining what is known about the effects of the model of distribution on—

(A) Medicaid beneficiaries’ access to substance use disorder treatment medications;

(B) the cost to the public of each model of distribution and administrative action as the Comptroller General determines appropriate.

SEC. 1017. ASSESSING BARRIERS TO OPIOID USE DISORDER TREATMENT.

(a) STUDY.—(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study of the barriers to providing medication used in the treatment of substance use disorders under Medicaid distribution models such as the ‘‘buy-and-bill’’ model and other State Medicaid programs to remove or reduce such barriers.

The study shall include analyses of each of the following models of distribution of substance use disorder treatment medications, particularly buprenorphine, naltrexone, and buprenorphine-naloxone combinations:

(A) The purchasing, storage, and administration of substance use disorder treatment medications by providers;

(B) The dispensing of substance use disorder treatment medications by pharmacists;

(C) The ordering, prescribing, and obtaining of substance use disorder treatment medications on demand from specialty pharmacies by providers.

(b) REQUIREMENTS.—For each model of distribution specified in paragraph (1), the Comptroller General shall evaluate how each model might or could be used to select State Medicaid programs to reduce the barriers related to the provision of substance use disorder treatment by examining what is known about the effects of the model of distribution on—

(A) Medicaid beneficiaries’ access to substance use disorder treatment medications;

(B) the cost to the public of each model of distribution and administrative action as the Comptroller General determines appropriate.

SEC. 1018. ASSESSING BARRIERS TO OPIOID USE DISORDER TREATMENT.

(a) STUDY.—(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study of the barriers to providing medication used in the treatment of substance use disorders under Medicaid distribution models such as the ‘‘buy-and-bill’’ model and other State Medicaid programs to remove or reduce such barriers.

The study shall include analyses of each of the following models of distribution of substance use disorder treatment medications, particularly buprenorphine, naltrexone, and buprenorphine-naloxone combinations:

(A) The purchasing, storage, and administration of substance use disorder treatment medications by providers;

(B) The dispensing of substance use disorder treatment medications by pharmacists;

(C) The ordering, prescribing, and obtaining of substance use disorder treatment medications on demand from specialty pharmacies by providers.

(b) REQUIREMENTS.—For each model of distribution specified in paragraph (1), the Comptroller General shall evaluate how each model might or could be used to select State Medicaid programs to reduce the barriers related to the provision of substance use disorder treatment by examining what is known about the effects of the model of distribution on—

(A) Medicaid beneficiaries’ access to substance use disorder treatment medications;

(B) the cost to the public of each model of distribution and administrative action as the Comptroller General determines appropriate.
(b) Making T-MSIS data on substance use disorders available to researchers—

(1) IN GENERAL.—The Secretary shall publish a notice in the Federal Register to inform the public of the format and content of records notice for the data specified in paragraph (2) for the transformed Medicaid Statistical Information System, in accordance with section 1386b(m) of title 42, United States Code. The notice shall outline policies that protect the security and privacy of the data that, at a minimum, meet the security and privacy policies of SORN 99-70-941 for the Medicaid Statistical Information System.

(2) REQUIRED DATA.—The data covered by the system of records notice required under paragraph (1) shall be sufficient for researchers and States to analyze the prevalence of substance use disorders in the Medicaid beneficiary population and the treatment of substance use disorders under Medicaid across all States (including the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), forms of treatment, and treatment settings.

(3) INITIATION OF DATA-SHARING ACTIVITIES.—Not later than January 1, 2021, the Secretary shall initiate the data-sharing activities outlined in the notice required under paragraph (1).

SEC. 1016. BETTER DATA SHARING TO COMBAT THE OPIOID CRISIS.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)), as amended by section 1013, is further amended by adding at the end the following new paragraph:

"(8)(A) The State agency administering the State plan under this title may have reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State, to the extent that the State agency is permitted to access such databases under State law.

"(B) Such State agency may facilitate reasonable access, as determined by the State, to 1 or more prescription drug monitoring program databases administered or accessed by the State, to the same extent that the State agency is permitted to access such databases under State law.

"(C) Such State agency may provide services to Medicaid beneficiaries and

"(i) any provider enrolled under the State plan to provide services to Medicaid beneficiaries

"(ii) any managed care entity (as defined under section 1922(a)(1)(B)) that has a contract with the State under this subsection or under section 1905(k).

"(C) how and whether States plan to provide Medicaid coverage for housing-related services and support the future, including by covering such services and supports under State Medicaid plans or waiver.

(4) Existing opportunities for States to provide housing-related services and supports through a Medicaid waiver under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), including—

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and support and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) anything learned by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments;

(B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings;

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

(A) challenges experienced by States in designing, securing, and implementing such waivers or amendments; (B) how States developed partnerships with other organizations such as behavioral health agencies, State housing agencies, housing providers, case management providers, and other care coordination providers to deliver housing-related services and supports and to coordinate services provided under Medicaid programs across different treatment settings; (C) how and whether States plan to provide Medicaid coverage for housing-related services and supports in the future, including by covering such services and supports under State Medicaid plans or waiver.

(4) Existing opportunities for States to provide housing-related services and supports through a Medicaid waiver under sections 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or through a State Medicaid plan amendment, as the Assistant in Community Integration Service pilot program, which promotes supportive housing and other housing-based care supports under Medicaid for individuals with substance use disorders and for which Maryland has a waiver approved under such section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n).

(5) Innovative strategies and partnerships developed and implemented by State Medicaid programs or other entities to identify and enroll eligible individuals with substance use disorders experiencing homelessness or at risk of experiencing homelessness in State Medicaid programs.

(b) REPORT.—Not later than 5 years after the date of this Act, the Secretary shall submit a report to Congress describing the strategies developed and adopted by State Medicaid programs that have achieved positive outcomes in increasing housing stability among Medicaid beneficiaries with substance use disorders who are experiencing or at risk of experiencing homelessness in such programs, including the strategies developed and implemented by State Medicaid programs.

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

SEC. 1017. REPORT ON INNOVATIVE STATE INITIATIVES AND STRATEGIES TO PROVIDE HOUSING-RELATED SERVICES AND SUPPORTS TO INDIVIDUALS STRUGGLING WITH SUBSTANCE USE DISORDERS UNDER MEDICAID.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue a report on the development and expansion of innovative State strategies (including through State Medicaid demonstration projects) to provide housing-related services and supports under Medicaid to individuals with substance use disorders.

(b) REPORT.—Not later than 180 days after the date of this Act, the Secretary shall issue a report to Congress detailing a plan of action to carry out the requirements of subsection (a).

TITLE II—MEDICAID PROVISIONS TO ADDRESS THE OPIOID CRISIS

SEC. 2001. EXPANDING THE USE OF TELEREHABILITATION SERVICES FOR THE TREATMENT OF OPIOID USE DISORDER AND OTHER SUBSTANCE USE DISORDERS.

(a) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (2)(B)—

(A) in clause (i), by striking "clause (ii)" and inserting "clause (ii) and paragraph (6)(C)"; and

(B) in clause (ii), by striking "for home dialysis therapy";

(2) in paragraph (4)(C)—

(A) in clause (i), by striking "paragraph (6)" and inserting "paragraphs (5), (6), and (7)"; and

(B) in clause (ii)(X), by inserting "or telehealth services described in paragraphs (5), (6), and (7)" after the period at the end; and

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

"(7) TREATMENT OF SUBSTANCE USE DISORDER SERVICES FURNISHED THROUGH TELEREHABILITATION.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after July 1, 2019, to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary, at an originating site described in paragraph (4)(C)(ii) (other than an originating site described in subclause (i)(X) of such paragraph)."

(b) IMPLEMENTATION.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall implement the amendments made by this section by interim final rule.

(c) REPORT.—Not later than 5 years after the date of this Act, the Secretary shall submit to Congress a report on the impact of the implementation of the amendments made with respect to telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m))—

(A) the utilization of health care items and services under title XVIII of such Act (42 U.S.C. 1395 et seq.) related to substance use disorders, including emergency department visits; and

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

(d) FUNDING.—For purposes of carrying out paragraph (1), in addition to funds otherwise available, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1862 of title 42, United States Code, $30,000,000 to the Medicare & Medicaid Services Program Management Account to remain available until expended.
SEC. 2002. COMPREHENSIVE SCREENINGS FOR SENIORS.

(a) INITIAL PREVENTIVE PHYSICAL EXAMINATION.—Section 1861(e)(1)(A)(v) of the Social Security Act (42 U.S.C. 1395w–25(e)(1)(A)(v)) is amended—

(1) in paragraph (1)—

(A) by striking “(2) and” and inserting “(1)”; and

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

(2) in paragraph (2)—

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

(B) by inserting in subparagraph (M) the following new subparagraph:

“(N) Screening for potential substance use disorders; and

(C) by adding at the end the following new paragraph:

“(4) For purposes of paragraph (1), the term ‘a review of any current opioid prescriptions’ means, with respect to an individual determined to have a current prescription for opioids—

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

(B) an evaluation of the individual’s ser-
vity of pain and current treatment plan;

(C) the provision of information on non- opioids;

(D) a referral to a specialist, as appro-
priate.

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

(1) by redesignating subparagraph (G) as subparagraph (H); and

(2) by inserting after subparagraph (F) the following new subparagraphs:

“(G) Screening for potential substance use disorder and referral for treatment as appro-
priate.

“(H) The furnishing of a review of any cur-
rent opioid prescriptions (as defined in sub-
section (ww)(4)).

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by subsection (a) or (b) shall be construed to prohibit separate pay-
ment for structured assessment and inter-
vention services for substance abuse fur-
ushed to an individual on the same day as an initial preventive physical examination or an annual wellness visit.

(d) EFFECTIVE DATE.—The amendments
made by this section shall apply to examina-
tions and visits furnished on or after Janu-
ary 1, 2020.

SEC. 2003. EVERY PRESCRIPTION CONVEYED SE-
CURELY.

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

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

“(A) IN GENERAL.—Subject to subparagraph (B), a prescription for a covered part D drug under a prescription drug plan (or under an MA–PD plan) for a schedule II, III, IV, or V controlled substance shall be transmitted by a health care practitioner electronically in accordance with an electronic prescription drug program that meets the requirements of paragraph (2).

“(B) EXCEPTION FOR CERTAIN CIR-
CUMSTANCES.—The Secretary shall, through rulemaking, specify circumstances and proc-
esses by which the Secretary may waive the requirement under subparagraph (A), with respect to a covered part D drug, including in the case of—

(i) a prescription issued when the practi-
tioner and dispensing pharmacy are the same entity;

(ii) a prescription issued that cannot be transmitted electronically under the most recently implemented version of the Na-
tional Council for Prescription Drug Pro-
grams SCRIPT Standard;

(iii) a prescription issued by a practi-
tioner who received a waiver or a renewal thereof for a period of time as determined by the Secretary, not to exceed one year, from the requirement to use electronic pre-
scribing due to demonstrated economic hard-
ship, technological considerations that are not reasonably within the control of the practi-
tioner, or other exceptional circumstance demonstrated by the practitioner;

(iv) a prescription issued by a practi-
tioner under circumstances in which, not-
withstanding the practitioner’s ability to submit a prescription electronically as re-
quired by this subpart, the practitioner reasonably determines that it would be impractical for the individual involved to ob-
tain substances prescribed by electronic pre-
scription in a timely manner, and such delay would adversely impact the individual’s medical condition involved;

(v) a prescription issued by a practitioner 

prescribing a drug under a research protocol;

(vi) a prescription issued by a practi-
tioner for a drug for which the Food and Drug Administration requires a prescription to contain electronic prescription such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;

(vii) a prescription issued by a practi-
tioner—

(D) for an individual who receives hospice care under this title; and

(E) that is not covered under the hospice benefit under this title; and

(viii) a prescription issued by a practi-
tioner for an individual who is—

(D) a resident of a nursing facility (as def-
ined in section 1919(a)); and

(E) dually eligible for benefits under this title and title XV.

“(C) DISPENSING.—(i) Nothing in this para-
graph shall be construed as requiring a spon-
sor of a prescription drug plan under this part, MA organization offering an MA–PD plan under part C, or a pharmacist to verify that a practitioner, with respect to a prescrip-
tion for a covered part D drug, has a waiver (or is otherwise exempt) under sub-
paragraph (B) from the requirement under subparagraph (A).

“(ii) Nothing in this paragraph shall be construed as affecting the ability of the plan to cover or the pharmacists’ ability to con-
tinue to dispense covered part D drugs from otherwise valid written, oral, or fax prescrip-
tions that are consistent with laws and regu-
lations.

“(iii) Nothing in this paragraph shall be construed as affecting the ability of an indi-
vidual who is being prescribed a covered part D drug to designate a particular pharmacy to dispense the covered part D drug to the extent consistent with the requirements under subsection (b)(1) and under this para-
graph.

“(D) ENFORCEMENT.—The Secretary shall, through rulemaking, specify circumstances and processes by which the Secretary may waive the requirement under subparagraph (A).

“(E) EFFECTIVE DATE.—The amendments
made by this paragraph (A) shall apply to cov-
erage of drugs prescribed on or after January 1, 2021.

(b) UPDATE OF BIOMETRIC COMPONENT OF SCRIPT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall update the requirements for the biometric compo-
nent of electronic prescription with respect to electronic prescriptions of con-
trolled substances.

SEC. 2004. REQUIRING PRESCRIPTION DRUG PLAN SPONSORS UNDER MEDICARE TO ESTABLISH DRUG MANAGEMENT PROGRAMS FOR AT-RISK BENEFICIARIES.

Section 1860D–3(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended—

(1) in paragraph (1), by inserting after sub-
paragraph (E) the following new subpara-
graph—

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

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

SEC. 2005. MEDICARE COVERAGE OF CERTAIN SERVICES FURNISHED BY OPiOD TREATMENT PROGRAMS.

(a) COVERAGE.—Section 1861(s)(2) of the So-
cial Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (PF), by striking at the end “and”;

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

and

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

“(HH) opioid use disorder treatment serv-
ices (as defined in subsection (jjj));

(b) OPIOID USE DISORDER TREATMENT SER-
VICES AND OPIOD TREATMENT PROGRAM DE-
FINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395w) is amended by adding at the end the following new subsection:

“(jjj) OPIOD USE DISORDER TREATMENT
SERVICES; OPIOD TREATMENT PROGRAM.—

“(1) OPIOID USE DISORDER TREATMENT
SERVICES.—The term ‘opioid use disorder treatment services’ means items and services that are furnished by an opioid treatment program for the treatment of opioid use disorder, including—

(A) opioid agonist and antagonist treat-
ment medications (including oral, injected, or implanted version) that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder;

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

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

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

(E) toxicology testing, and

(F) other items and services that the Secre-
tary determines are appropriate (but in no event to include meals or transportation).

(2) OPIOID TREATMENT PROGRAM.—The term ‘opioid treatment program’ means an entity that is an opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any suc-
cessor regulation) that—

(A) is enrolled under section 1866(d); and

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

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

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

(i) the health and safety of individuals being furnished services under such program; and

(ii) the effective and efficient furnishing of such services.

(c) PAYMENT.—Section 1833(a)(1) of the So-
cial Security Act (42 U.S.C. 1395l(a)(1)) is amended—
TORY OF OPIOID-RELATED OVERDOSE.—

(1) in subparagraph (B), in each of clauses (ii)(III) and (ii)(IV), by striking “and the option of an automatic escalation to external review” and inserting “; including notice that if the determination that a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution”;

(2) in subparagraph (E), by striking “and the option” and all that follows and inserting “the DUR (Drug Utilization Review) exception to postpayment review.”.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply beginning not later than January 1, 2020.

SEC. 2006. ENCOURAGING APPROPRIATE PRESCRIPTION UNDER MEDICARE FOR VICTIMS OF OPIOID OVERDOSE.

Section 1860D–4(c)(5)(C) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended—

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

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

(3) by adding at the end the following new clause:

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

(1) In general.—For plan years beginning not later than January 1, 2021, a part D eligible individual who is not an exempted individual described in clause (ii) and who is identified as such a part D eligible individual with a history of opioid-related overdose (as defined by the Secretary) shall be included as a potentially at-risk beneficiary for opioid treatment program services furnished under the drug management program under this paragraph.

(2) IDENTIFICATION AND NOTICE.—For purposes of this clause, the Secretary shall—

(aa) identify part D eligible individuals with a history of opioid-related overdose (as so defined);

(bb) notify the PDP sponsor of the prescription drug plan in which such an individual is enrolled of such identification.”.

SEC. 2007. AUTOMATIC ESCALATION TO EXTERNAL REVIEW UNDER A MEDICARE PART D DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.

(a) In General.—Section 1860D–4(c)(5)(C) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended—

(1) in subsection (B), in each of clauses (ii)(III) and (ii)(IV), by striking “and the option of an automatic escalation to external review” and inserting “; including notice that if the determination that a PDP sponsor affirms its denial, in whole or in part, the case shall be automatically forwarded to the independent, outside entity contracted with the Secretary for review and resolution”;

(2) in subparagraph (E), by striking “and the option” and all that follows and inserting “the DUR (Drug Utilization Review) exception to postpayment review.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2020.

TITLE III—FDA AND CONTROLLED SUBSTANCE PROVISIONS

Subtitle A—FDA Provisions

CHAPTER 1—IN GENERAL

SEC. 3001. CLARIFYING FDA REGULATION OF NON-ADDICTIVE PAIN PRODUCTS.

(a) Public Meetings.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Commissioner of Food and Drugs, shall hold not less than one public meeting to address the challenges and barriers of developing non-addictive medical products intended to treat acute or chronic pain or addiction, which may include—

(1) the manner by which the Secretary may incorporate the risks of misuse and abuse of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) into the risk benefit assessments under subsections (d) and (e) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), section 707 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k)), or section 515(c) of such Act (21 U.S.C. 360(e)(c)), as applicable;

(2) the application of novel clinical trial designs (consistent with section 302I of the 21st Century Cures Act (Public Law 114–255)), use of real world evidence (consistent with section 505F of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), section 707 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k)), or section 515(c) of such Act (21 U.S.C. 360(e)(c)), as applicable; and

(3) the evidentiary standards and the development of opioid-sparing data for inclusion in the labeling of medical products intended to treat acute or chronic pain; and

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

(b) Rule of Construction.—Nothing in this section shall be construed to limit the authority of the Secretary to conduct postpayment review.

(c) Conforming Amendment.—Section 1862(o)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)(D)), and section 1903(1)(c)(2)(A), a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.

(d) Effective Date.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2020.

SEC. 3002. ANNUAL UPDATES.—The Secretary shall, as determined by the Secretary, annually update the methods by which sponsors may develop such bundles, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine appropriate. In developing such methods, the Secretary may consider payment rates paid to opioid treatment programs for comparable services under State plans under title XIX or under the TRICARE program under chapter 55 of title 10 of the United States Code.

(7) Suspension of Payments Pending Investigation of Credible Allegations of Fraud by Pharmacists.—

(a) In General.—Section 1862(o)(1) shall apply with respect to a PDP sponsor with a contract under this part, a pharmacy, and payments to such pharmacy under this part in the same manner as such section applies with respect to the Secretary, a provider of services or supplier under this title, or a person who provides services or supplier under this title.

(b) Rule of Construction.—Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.

(c) Conforming Amendment.—Section 1862(o)(2)(C) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following new clause:

“(C) considers pain, pain control, or pain management in the labeling of medical products intended to treat acute or chronic pain; and

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

SEC. 3003. FRAUD BY PHARMACIES.—

(a) Application to MA–PD Plans.—Section 1862(o)(1) shall apply with respect to a PDP sponsor with a contract under this part, a pharmacy, and payments to such pharmacy under this part in the same manner as such section applies with respect to the Secretary, a provider of services or supplier under this title, or a person who provides services or supplier under this title.

(b) Rule of Construction.—Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.

(c) Conforming Amendment.—Section 1862(o)(2)(C) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following new clause:

“(C) considers pain, pain control, or pain management in the labeling of medical products intended to treat acute or chronic pain; and

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

SEC. 3004. RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Secretary to conduct postpayment review.
and evaluations of efficacy will be applied across and within review divisions, taking into consideration the etiology of the underlying disease, and the manner in which sponsors may use surrogate endpoints, intermediate endpoints, and real world evidence;

(3) the manner in which the Food and Drug Administration will assess evidence to support the labeling of non-addictive medical products intended to treat acute or chronic pain, including:

(a) alternative data collection methodologies, including the use of novel clinical trial designs (consistent with section 3021 of the 21st Century Cures Act (Public Law 114–255)) and real world evidence (consistent with section 505F of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355)), including patient registries and patient reported outcomes, as appropriate, to support product labeling;

(b) ethical considerations of exposing subjects to controlled substances in clinical trials to develop opioid-sparing data and considerations on data collection methods that reduce harm, which may include the reduction of opioid use as a clinical benefit; and

(c) definitions.

II. GUIDELINES FOR THE EVIDENCE-BASED ANALGESIC PRESCRIBING GUIDELINES AND REPORT

(a) definitions.

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(a) definitions.
SEC. 3013. SINGLE SOURCE PATTERN OF IMPORTED ILLEGAL DRUGS.

Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(cc)), as amended by section 3012 of this Act, is further amended by adding at the end the following:

"(t) SINGLE SOURCE PATTERN OF IMPORTED ILLEGAL DRUGS.—If the Secretary determines that a person subject to debarment as a result of engaging in a pattern of importing or offering for import controlled substances or drugs (as defined in section 306(b)(3)(D)), and such pattern is identified by the Secretary as being offered for import from the same manufacturer, distributor, or importer, the Secretary may by order determine all drugs being offered for import from such person as adulterated or misbranded, unless such person can prove otherwise."

SEC. 3014. STRENGTHENING FDA AND CBP COORDINATION AND CAPACITY.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as the "Secretary"), acting through the Commissioner of Food and Drugs, shall coordinate with the Secretary of Homeland Security to carry out activities related to customs and border protection and in response to illegal controlled substances and drug imports (as defined in section 306(b)(3)(D)), and such pattern is identified by the Secretary as being offered for import from the same manufacturer, distributor, or importer, the Secretary may by order determine all drugs being offered for import from such person as adulterated or misbranded, unless such person can prove otherwise.

(b) FDA IMPORT FACILITIES AND INSPECTION CAPACITY.—

(1) In General.—In carrying out this section, the Secretary shall, in collaboration with the Secretary of Homeland Security and the Postmaster General of the United States Postal Service, provide that import facilities in which the Food and Drug Administration operates or carries out activities related to drug imports within the international mail facilities include—

(A) facility upgrades and improved capacity in order to increase and improve inspection and detection capabilities, which may include—

(i) improvements to facilities, such as upgrades or renovations, and support for the maintenance of import facilities and sites to improve coordination between Federal agencies;

(ii) improvements in equipment and information technologies to identify unapproved, counterfeit, or other unlawful controlled substances for destruction;

(iii) the construction of, or upgrades to, laboratory capacity for purposes of detection and testing of imported goods;

(iv) upgrades to the security of import facilities;

(v) innovative technology and equipment to facilitate improved and near-real-time information sharing between the Food and Drug Administration, the Department of Homeland Security, the United States Postal Service; and

(B) innovative technology, including controlled substance detection and testing equipment and other applicable technology, in order to collaborate with the U.S. Customs and Border Protection to share near-real-time information, including information about test results, as appropriate.

(2) IN GENERAL.—The Secretary shall, in consultation with the Secretary of Homeland Security and the Postmaster General of the United States Postal Service, provide that import facilities in which the Food and Drug Administration operates or carries out activities related to drug imports within the international mail facilities include—

(A) facility upgrades and improved capacity in order to increase and improve inspection and detection capabilities, which may include—

(i) improvements to facilities, such as upgrades or renovations, and support for the maintenance of import facilities and sites to improve coordination between Federal agencies;

(ii) improvements in equipment and information technologies to identify unapproved, counterfeit, or other unlawful controlled substances for destruction;

(iii) the construction of, or upgrades to, laboratory capacity for purposes of detection and testing of imported goods;

(iv) upgrades to the security of import facilities;

(v) innovative technology and equipment to facilitate improved and near-real-time information sharing between the Food and Drug Administration, the Department of Homeland Security, the United States Postal Service; and

(B) innovative technology, including controlled substance detection and testing equipment and other applicable technology, in order to collaborate with the U.S. Customs and Border Protection to share near-real-time information, including information about test results, as appropriate.

(2) IN GENERAL.—The Secretary shall, in consultation with the Secretary of Homeland Security and the Postmaster General of the United States Postal Service, provide that import facilities in which the Food and Drug Administration operates or carries out activities related to drug imports within the international mail facilities include—

(A) facility upgrades and improved capacity in order to increase and improve inspection and detection capabilities, which may include—

(i) improvements to facilities, such as upgrades or renovations, and support for the maintenance of import facilities and sites to improve coordination between Federal agencies;

(ii) improvements in equipment and information technologies to identify unapproved, counterfeit, or other unlawful controlled substances for destruction;

(iii) the construction of, or upgrades to, laboratory capacity for purposes of detection and testing of imported goods;

(iv) upgrades to the security of import facilities;

(v) innovative technology and equipment to facilitate improved and near-real-time information sharing between the Food and Drug Administration, the Department of Homeland Security, the United States Postal Service; and

(B) innovative technology, including controlled substance detection and testing equipment and other applicable technology, in order to collaborate with the U.S. Customs and Border Protection to share near-real-time information, including information about test results, as appropriate.

Section 3012, as amended, is further amended by adding at the end the following:

"(B) shall be interoperable with technology used by other relevant Federal agencies, including the U.S. Customs and Border Protection, as the Secretary determines appropriate and practicable."
“(1) an active ingredient in a drug—
   “(1) that is approved under section 505 or licensed under section 351 of the Public Health Service Act; or
   “(II) that is the
   “(aa) an investigational use exemption has been authorized under section 505(i) of this Act or section 351(a) of the Public Health Service Act;
   “(bb) a substantial clinical investigation has been instituted, and such investigation has been made public; or
   “(ii) that has a chemical structure that is substantially similar to the chemical structure of an active ingredient in a drug or biological product described in subsection (A) or (B).

“2. EFFECT.—This subsection shall not be construed to bear upon any determination of whether an article is a drug within the meaning of section 201(g)(1) of this Act for the purposes described in paragraph (1).”.

CHAPTER 4—SECURING OPIOIDS AND UN-USED NARCOTICS WITH DELIBERATE DISPOSAL OR PACKAGING

SEC. 3031. SHORT TITLE.

This chapter may be cited as the “Securing Opioids and Unused Narcotics with Deliberate Disposal or Packaging”.

SEC. 3032. SAFETY-ENHANCING PACKAGING AND DISPOSAL FEATURES.

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

“(A) by redesignating subparagraph (B) as subparagraph (C); and
   (C) by inserting after subparagraph (A) the following:
   “(ii) that have a chemical structure that is substantially similar to the chemical structure of an active ingredient in a drug or biological product described in subsection (A) or (B).

“2. EFFECT.—This subsection shall not be construed to bear upon any determination of whether an article is a drug within the meaning of section 201(g)(1) of this Act for the purposes described in paragraph (1).”.

CHAPTER 5—POSTAPPROVAL STUDY REQUIREMENTS

SEC. 3041. CLARIFYING FDA POSTMARKET AUTHORITY.

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

(b) SAFETY LABELING CHANGES.—Section 505(o)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(4)) is amended—
   (1) in subparagraph (A) by—
       “(A) striking “SAFETY INFORMATION” and inserting “SAFETY OR NEW EFFECTIVENESS INFORMATION”;
       “(B) by striking “The Secretary becomes aware of new information, including any new safety information or information related to reduced effectiveness, that the Secretary determines may mitigate such risk” and inserting “The Secretary becomes aware of new information, including any new safety information or information related to reduced effectiveness, that the Secretary determines may mitigate such risk”;
   (2) in clause (i) of subparagraph (B), by inserting after the semicolon “, or new effectiveness information”; and
   (3) in subparagraph (C) by striking “SAFETY INFORMATION” and inserting “SAFETY OR NEW EFFECTIVENESS INFORMATION”.

(c) GUIDANCE.—Not less than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance regarding the circumstances under which the Food and Drug Administration, in consultation with other relevant Federal agencies with authorities over drug disposal packaging, which may include requiring that—
   “(A) the drug be made available for dispensing to certain patients in unit dose packaging, packaging that provides a set duration, or another packaging system that the Secretary determines may mitigate such serious risk and is sufficiently available.”;
   “(B) the drug be dispensed to certain patients with a safe disposal packaging or safe disposal system for purposes of rendering drugs nonretrievable (as defined in section 1300.05 of title 21, Code of Federal Regulations (or any successor regulation)) if the Secretary determines that such safe disposal packaging or system may mitigate such serious risk and is sufficiently available.”;
   “(a) ASSURING ACCESS AND MINIMIZING BURDENS.—Section 505-1(f)(2)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(f)(2)(C)) is amended by adding at the end the following:
   “(I) in paragraph (1)—
       “(A) by redesignating subparagraph (B) as subparagraph (C);
       “(B) by inserting after subparagraph (A) the following:
       “(a) the drug be made available for dispensing to certain patients in unit dose packaging, packaging that provides a set duration, or another packaging system that the Secretary determines may mitigate such serious risk and is sufficiently available.”;
       “(B) the drug be dispensed to certain patients with a safe disposal packaging or safe disposal system for purposes of rendering drugs nonretrievable (as defined in section 1300.05 of title 21, Code of Federal Regulations (or any successor regulation)) if the Secretary determines that such safe disposal packaging or system may mitigate such serious risk and is sufficiently available.”;

   (b) ASSURING ACCESS AND MINIMIZING BURDENS.—Section 505-1(f)(2)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(f)(2)(C)) is amended by adding at the end the following:
   “(I) in paragraph (1)—
       “(A) by redesignating subparagraph (B) as subparagraph (C);
       “(B) by inserting after subparagraph (A) the following:
       “(a) the drug be made available for dispensing to certain patients in unit dose packaging, packaging that provides a set duration, or another packaging system that the Secretary determines may mitigate such serious risk and is sufficiently available.”;
   “(b) the drug be dispensed to certain patients with a safe disposal packaging or safe disposal system for purposes of rendering drugs nonretrievable (as defined in section 1300.05 of title 21, Code of Federal Regulations (or any successor regulation)) if the Secretary determines that such safe disposal packaging or system may mitigate such serious risk and is sufficiently available.”;

   (c) APPLICATION TO ABBREVIATED NEW DRUG APPLICATIONS.—Section 505-1(1)(v) (2)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(1)(v)2)(C)) is amended—
   “(1) in paragraph (1)—
       “(A) by redesignating subparagraph (B) as subparagraph (C);
   “(2) in paragraph (2)—
       “(A) in subparagraph (A), by striking “and” at the end;
of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(ii)) is amended—

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

(2) by amending subclause (II) to read as follows:

‘‘(II) a qualifying other practitioner, as defined in clause (iv), who is a nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife;’’.

(d) Definition of Qualifying Other Practitioner.—Section 303(g)(2)(G)(iv) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(iv)) is amended by striking ‘‘nurse practitioner or physician assistant’’ each place it appears and inserting ‘‘nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant’’.

(e) Expiration.—Not more than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration, shall submit to Congress a report that assesses the care provided by qualifying practitioners (as defined in section 303(g)(2)(G)(ii) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(ii))) who are treating, in the case of physicians, more than 100 patients, and in the case of qualified practitioners who are not physicians, more than 30 patients. Such report shall include recommendations on future applicable patient number levels and limits. In preparing such report, the Secretary shall study, with respect to opioid use disorder treatment—

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

(2) the average frequency with which patients receive counseling, including the rates by which such counseling is provided by a qualifying practitioner directly, or by referral;

(3) the frequency of toxicity testing, including the frequency with which random toxicity testing is administered;

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

(5) the treatment retention rates for patients;

(6) overdose and mortality rates; and

(7) any available information regarding the diversion of drugs by patients receiving such treatment from such a qualifying practitioner.

SEC. 3202. Medication-Assisted Treatment for Recovery from Substance Use Disorder.

(a) Waivers for Maintenance Treatment or Detoxification.—Section 303(g)(2)(G)(ii) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(ii)) is amended by adding at the end the following:

‘‘(V) a physician graduated in good standing from an accredited school of allopathic medicine or osteopathic medicine in the United States during the 5-year period immediately preceding the date on which the physician submits to the Secretary a written notification under subparagraph (B) and successfully completed a comprehensive allopathic or osteopathic medicine curriculum or accredited medical residency program that—

‘‘(aa) included not less than 8 hours of training on treating and managing opioid-dependent patients; and

‘‘(bb) included, at a minimum—

‘‘(A) that is included in items (aa) through (gg) of subclause (IV); and

‘‘(BB) training with respect to any other best practice the Secretary determines should be included in subparts of the curriculum, which may include training on pain management, including assessment and appropriate use of opioid and non-opioid alternatives.

(b) Technical Amendment.—The Secretary of Health and Human Services shall consider ways to ensure that an adequate number of qualified practitioners, as defined in section 303(g)(2)(G)(ii) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), who have a specialty in pediatrics or the treatment of children or adolescents, are granted a waiver under such section 303(g)(2) to treat children and adolescents with substance use disorders.

(c) Technical Amendment.—Section 102(d)(4) of the Controlled Substances Act (21 U.S.C. 802(d)(4)) is amended by striking ‘‘Health, Education, and Welfare’’ and inserting ‘‘Health and Human Services’’.

SEC. 3203. Grants to Enhance Access to Substance Use Disorder Treatment.

(a) In General.—The Secretary of Health and Human Services shall establish a grant program under which the Secretary may make grants to accredited schools of allopathic medicine or osteopathic medicine and teaching hospitals located in the United States to support the development of curricula that meet the requirements under section 307, the prescribing practitioner, and the Controlled Substances Act, as applicable, maintain records of all controlled substances delivered, received, administered, or otherwise disposed of under this section, including the persons to whom controlled substances are delivered or otherwise disposed of and such other information as may be required by regulations of the Attorney General.

(b) Modification of Number of Days Before Which Controlled Substance Shall Be Administered.—

‘‘(1) Initial 2-year period.—During the 2-year period beginning on the date of enactment of this Act, the Attorney General, in coordination with the Secretary, may reduce the number of days described in subsection (a)(6) if the Attorney General determines that such reduction is necessary to reduce diversion of controlled substances administered by injection or implantation.

‘‘(A) reduce the risk of diversion; or

‘‘(B) protect the public health.

‘‘(2) Modifications after submission of report.—After the date on which the report described in section 3204(b) of the SUPPORT for Patients and Communities Act is submitted, the Attorney General, in coordination with the Secretary, may modify the number of days described in subsection (a)(6).

‘‘(a) Minimum number of days.—Any modification under this subsection shall be for a period of not less than 7 days.’’.

(b) Study and Report.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a study and submit to Congress a report on access to and potential diversion of controlled substances administered by injection or implantation.

(c) Technical and Conforming Amendment.—The table of contents for the Comprehensive Drug Abuse Prevention and Control Act of 1970 is amended by inserting after the item relating to section 309 the following:

‘‘Sec. 309A. Delivery of a controlled substance by a pharmacy to an administering practitioner.’’.

CHAPTER 2—EMPOWERING PHARMACISTS IN THE FIGHT AGAINST OPIOID ABUSE

SEC. 3211. Short Title.

This chapter may be cited as the ‘‘Empowering Pharmacists in the Fight Against Opioid Abuse Act’’.

SEC. 3212. Programs and Materials for Training on Certain Circumstances Under Which a Pharmacist May Decline to Fill a Prescription.

(a) In General.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Commissioner of Food and Drugs, Director of the Centers for Disease Control and Prevention, and Assistant Secretary for Mental Health and Substance Use, shall develop and disseminate, as appropriate, materials for pharmacists, health care providers, and patients on—

(1) circumstances under which a pharmacist may, consistent with section 309 of the Controlled Substances Act (21 U.S.C. 829) and regulations thereunder, including section 309A, the prescribing practitioner, and the controlled substance, as applicable, maintain records of all controlled substances delivered, received, administered, or otherwise disposed of under this section, including the persons to whom controlled substances are delivered or otherwise disposed of and such other information as may be required by regulations of the Attorney General.

‘‘(2) Modification of Number of Days Before Which Controlled Substance Shall Be Administered.—

‘‘(1) Initial 2-year period.—During the 2-year period beginning on the date of enactment of this Act, the Attorney General, in coordination with the Secretary, may reduce the number of days described in subsection (a)(6) if the Attorney General determines that such reduction is necessary to reduce diversion of controlled substances administered by injection or implantation.

‘‘(A) reduce the risk of diversion; or

‘‘(B) protect the public health.

‘‘(2) Modifications after submission of report.—After the date on which the report described in section 3204(b) of the SUPPORT for Patients and Communities Act is submitted, the Attorney General, in coordination with the Secretary, may modify the number of days described in subsection (a)(6).

‘‘(a) Minimum number of days.—Any modification under this subsection shall be for a period of not less than 7 days.’’.

(b) Study and Report.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study and submit to Congress a report on access to and potential diversion of controlled substances administered by injection or implantation.

(c) Technical and Conforming Amendment.—The table of contents for the Comprehensive Drug Abuse Prevention and Control Act of 1970 is amended by inserting after the item relating to section 309 the following:

‘‘Sec. 309A. Delivery of a controlled substance by a pharmacy to an administering practitioner.’’.

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controlled substance because the pharmacist suspects the prescription is fraudulent, forged, or of doubtful, questionable, or suspicious origin; and
(2) other Federal requirements pertaining to declining to fill a prescription under such circumstances, including the partial fill of prescriptions for certain controlled substances.
(b) MATERIALS INCLUDED.—In developing materials under subsection (a), the Secretary of Health and Human Services shall include information for—
(1) pharmacists on how to decline to fill a prescription and actions to take after declining to fill a prescription; and
(2) other Federal requirements pertaining to declining to fill a prescription under such circumstances, and a description of those circumstances as described in the materials developed under subsection (a).
(c) STAKEHOLDER INPUT.—In developing the programs and materials required under subsection (a), the Secretary of Health and Human Services shall seek input from relevant national, State, and local associations, boards of pharmacy, medical societies, licensure boards, health care practitioners, and patients, including individuals with chronic pain.

CHAPTER 3—SAFE DISPOSAL OF UNUSED MEDICATION

SEC. 3221. SHORT TITLE.
This chapter may be cited as the “Safe Disposal of Unused Medication Act”.

SEC. 3222. DISPOSAL OF CONTROLLED SUBSTANCES OF A HOSPICE PATIENT BY EMPLOYEES OF A QUALIFIED HOSPICE PROGRAM.

(a) IN GENERAL.—Section (g) of section 302 of the Controlled Substances Act (21 U.S.C. 822) is amended by adding at the end the following:
“(5)(A) In the case of a person receiving hospice care, an employee of a qualified hospice program, acting within the scope of employment, may destroy a controlled substance that was lawfully dispensed to the person receiving hospice care, for the purpose of disposal of the controlled substance so long as such disposal occurs on site in accordance with all applicable Federal, State, Tribal, and local law and—
“(i) the disposal occurs after the death of the person receiving hospice care; or
“(ii) the controlled substance is expired; or
“(iii) the employee is—
“(aa) the physician of the person receiving hospice care; and
“(bb) registered under section 303(f); and
“(B) the hospice patient no longer requires the controlled substance because of the plan of the hospice patient has been modified.
“(B) FOR THE PURPOSES OF THIS PARAGRAPH:
“(1) The term ‘hospice care’ and ‘hospice program’ has the same meaning as in the terms in section 1861(dd) of the Social Security Act.
“(ii) The term ‘employee of a qualified hospice program’ means a physician, physician assistant, nurse, or other person who—
“(I) is employed by, or pursuant to arrangements made by, a qualified hospice program;
“(II)(aa) is licensed to perform medical or nursing services by the jurisdiction in which the person receiving hospice care was located;
“(bb) is acting within the scope of such employment in accordance with applicable State law; and
“(II) the employee completed training through the qualified hospice program regarding the disposal of controlled substances in a secure and responsible manner so as to discourage abuse, misuse, or diversion.
“(iii) The term ‘qualified hospice program’ means a hospice program that—
“(I) has written policies and procedures for assisting in the disposal of the controlled substances of a person receiving hospice care after the person’s death;
“(II) at the time the controlled substances are first ordered—
“(aa) provides a copy of the written policies and procedures to the patient or patient representative; and
“(bb) discusses the policies and procedures with the patient or representative and the family in a language and manner that they understand; and
“(I) the hospice program is informed of such disposal by the employee who disposed of the controlled substance;
“(II) at the time when the controlled substance was disposed of, and
“(III) at the time following the disposal of the controlled substance; and
“(cc) documents in the patient’s clinical record that the written policies and procedures were provided and discussed; and
“(III) at the time following the disposal of the controlled substance; and
“(IV) the employee records that disposal occurred.’’.
(b) GUIDANCE.—The Attorney General may issue guidance to programs (as defined in paragraph (5) of section 302(g) of the Controlled Substances Act (21 U.S.C. 822(g)), as added by subsection (a)) to assist the programs in satisfying the requirements under such paragraph.
(c) RULE OF CONSTRUCTION RELATING TO STATE AND LOCAL LAW.—Nothing in this section or the amendments made by this section shall be construed to prevent a State or local government from imposing additional controls or restrictions relating to the regulation of the disposal of controlled substances in hospice care or hospice programs.

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

(a) STUDY.—
(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study on the requirements applicable to, and challenges of, hospice programs with regard to the management and disposal of controlled substances in the home of an individual.

(b) CONTENTS.—In conducting the study under paragraph (1), the Comptroller General shall include—
(1) an overview of any challenges encountered by selected hospice programs regarding the disposal of controlled substances, such as opioids, in a home setting, including any key changes in policies, procedures, or best practices for the disposal of controlled substances over time; and
(2) a description of Federal requirements, including regulations under the Medicare program, for hospice programs regarding the disposal of controlled substances in a home setting, and oversight of compliance with those requirements.

(c) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the results of the study conducted under subsection (a), together with recommendations, if any, for such legislation and administrative action as the Comptroller General determines appropriate.

CHAPTER 4—SPECIAL REGISTRATION FOR TELEMEDICINE CLARIFICATION

SEC. 3231. SHORT TITLE.
This chapter may be cited as the “Special Registration for Telemedicine Clarification Act of 2018”.

SEC. 3232. REGULATIONS RELATING TO A SPECIAL REGISTRATION FOR TELE-MEDICINE.

Section 313(h)(2) of the Controlled Substances Act (21 U.S.C. 831(h)(2)) is amended to read as follows:
“(2) REGULATIONS.—Not later than 1 year after the date of enactment of the SUPPORT for Patients and Communities Act, in consultation with the Secretary, the Attorney General shall promulgate final regulations specifying—
“(A) the limited circumstances in which a special registration under this subsection may be issued; and
“(B) the procedure for obtaining a special registration under this subsection.”.

CHAPTER 5—SYNTHETIC ABUSE AND LABELING OF TOXIC SUBSTANCES

SEC. 3241. CONTROLLED SUBSTANCE ANALOGUES.

Section 203 of the Controlled Substances Act (21 U.S.C. 813) is amended—
(1) by striking ‘‘(A) controlled’’ and inserting—
“(A) ‘‘controlled’’; and
(2) by adding at the end the following:
“(b) DETERMINATION.—In determining whether a controlled substance was intended for human consumption under subsection (a), the following factors may be considered, along with any other relevant factors:
“(1) The marketing, advertising, and labeling of the substance.
“(2) The known efficacy or usefulness of the substance for the marketed, advertised, or labeled purpose.
“(3) The difference between the price at which the substance is sold and the price at which the substance is purported to be or advertised as is normally sold.
“(4) The diversion of the substance from legitimate channels and the clandestine manufacture, manipulation, or distribution of the substance.
“(5) Whether the defendant knew or should have known the substance was intended to be consumed by injection, inhalation, ingestion, or any other immediate means.
“(6) Any controlled substance analogue that is manufactured, formulated, sold, distributed, or marketed with the intent to avoid the provisions of existing drug laws.
“(c) LIMITATION.—For purposes of this section, evidence that a substance was not marketed, advertised, or labeled for human consumption, by itself, shall not be sufficient to establish that the substance was not intended for human consumption.

CHAPTER 6—ACCESS TO INCREASED DRUG DISPOSAL

SEC. 3251. SHORT TITLE.
This chapter may be cited as the “Access to Increased Drug Disposal Act of 2018”.

SEC. 3252. DEFINITIONS.
In this chapter—
(1) the term “Attorney General” means the Attorney General, acting through the Assistant Attorney General for the Office of Justice Programs;
(2) the term “authorized collector” means a narcotic treatment program, a hospital or clinic with an on-site pharmacy, a retail pharmacy, or a reverse distributor, that is authorized as a collector under section 3003; and
(3) the term “eligible collector” means a person who is eligible to be an authorized collector.

SEC. 3253. AUTHORITY TO MAKE GRANTS.
The Attorney General shall award grants to States to enable the States to increase the participation of eligible collectors as authorized collectors.
SEC. 3254. APPLICATION.
A State desiring a covered grant shall submit to the Attorney General an application that, at a minimum—
(1) identifies the single State agency that oversees pharmaceutical care and will be responsible for complying with the requirements of the grant; and
(2) (i) in paragraphs to increase participation rates of eligible collectors as authorized collectors; and
(3) describes how the State will select eligible collectors to be served under the grant.

SEC. 3255. USE OF GRANT FUNDS.
A State that receives a covered grant, and any subrecipient of the grant, may use the grant funds to carry out the dissemination, maintenance, training, purchasing, and disposal of controlled substances associated with the participation of eligible collectors as authorized collectors.

SEC. 3256. ELIGIBILITY FOR GRANT.
The Attorney General shall award a covered grant to 5 States, not less than 3 of which shall be States in the lowest quartile of States based on the participation rate of eligible collectors as authorized collectors, as determined by the Attorney General.

SEC. 3257. DURATION OF GRANTS.
The Attorney General shall determine the period of years for which a covered grant is made to a State.

SEC. 3258. ACCOUNTABILITY AND OVERSIGHT.
The Attorney General shall periodically review the effectiveness of the grant, including changes in the participation rate of eligible collectors as authorized collectors.

SEC. 3259. DURATION OF PROGRAM.
The Attorney General may award covered grants for each of the first 5 fiscal years beginning after the date of enactment of this Act.

SEC. 3260. AUTHORIZATION OF APPROPRIATIONS.
There is authorized to be appropriated to the Attorney General such sums as may be necessary to carry out this chapter.

CHAPTER 7—USING DATA TO PREVENT OPIOID DIVERSION

SEC. 3271. SHORT TITLE.
This chapter may be cited as the “Using Data To Prevent Opioid Diversion Act of 2018”.

SEC. 3272. PURPOSE.
(a) IN GENERAL.—The purpose of this chapter is to provide drug manufacturers and distributors with access to anonymized information through the Automated Reports and Consolidated Orders System to help drug manufacturers and distributors identify suspicious orders, and stop suspicious orders of opioids and reduce diversion rates.

(b) PREVENTION OF CONSTRUCTION.—Nothing in this chapter should be construed to absolve a drug manufacturer, drug distributor, or other Drug Enforcement Administration registrant from the responsibility of the manufacturer, distributor, or other registrant to—
(1) identify, stop, and report suspicious orders; or
(2) maintain effective controls against diversion in accordance with section 385 of the Controlled Substances Act (21 U.S.C. 832) or any successor law or associated regulation.

SEC. 3273. AMENDMENTS.
(a) IN GENERAL.—The Automated Reports of Registrants.—Section 307 of the Controlled Substances Act (21 U.S.C. 827) is amended—

SEC. 3282. STRENGTHENING CONSIDERATIONS FOR DEA OPIOID QUOTAS.
(a) IN GENERAL.—Section 306 of the Controlled Substances Act (21 U.S.C. 826) is amended—

(1) in subsection (a)—
(A) by inserting “(1) after “(a);”;
(B) in the second sentence, by striking “production” and inserting “manufacturing”;
(C) by inserting after paragraph (2), production”;
(D) by adding at the end the following:
"[(2) The Attorney General may, if the Attorney General determines it will assist in avoiding the overproduction, shortages, or diversion of a controlled substance, establish an aggregate or individual production quota under this subsection, or a procurement quota established by the Attorney General by regulation, in terms of pharmaceutical dosage forms prepared from or containing the controlled substance.”

SEC. 3281. SHORT TITLE.
This chapter may be cited as the “Opioid Quota Reform Act”.

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This chapter may be cited as the “Opioid Quota Reform Act”.
"(1)(A) In establishing any quota under this section, or any procurement quota established by the Attorney General by regulation, for fentanyl, oxycodone, hydrocodone, oxymorphone, or hydromorphone (in this subsection referred to as a ‘covered controlled substance’), the Attorney General shall estimate the amount of diversion of the covered controlled substance that occurs in the United States.

(2)(A) For any year for which the approved aggregate production quota for a covered controlled substance is higher than the appropriate average production quota for the covered controlled substance for the previous year, the Attorney General, in consultation with the Secretary of Health and Human Services, shall include in the final order an explanation of why the public health benefits of increasing the quota clearly outweigh the consequences of having an increased volume of the controlled substance available for sale, and potential diversion, in the United States.

(B) Not later than 1 year after the date of enactment of this subsection, and every year thereafter, the Attorney General shall submit to the Committee on the Judiciary, the Committee on Health, Education, Labor, and Pensions, and the Committee on Appropriations of the Senate and the Committee on the Judiciary, the Committee on Energy and Commerce, and the Committee on Appropriations of the House of Representatives the following reports:

(i) An anonymized count of the total number of suspicious orders issued by individual manufacturers that year for the covered controlled substance.

(ii) An anonymized count of how many such suspicious orders were issued any year manufacturing quota that was higher than the quota issued to that manufacturer for the covered controlled substance in the previous year.

(3) Not later than 1 year after the date of enactment of this subsection, the Attorney General shall submit to Congress a report on how the Attorney General, when fixing the aggregate production and manufacturing quotas under this section for covered controlled substances, will:

(A) take into consideration changes in the accepted medical use of the covered controlled substances; and

(B) work with the Secretary of Health and Human Services on methods to appropriately and anonymously estimate the type and amount of covered controlled substances that are submitted for collection from approved drug collection receptacles, mail-back programs, and take-back events.

(b) CONFORMING CHANGE.—The Law Revision Council is directed to amend the heading of section 822 of title 21, United States Code, by striking ‘‘PRODUCTION’’ and inserting ‘‘MANUFACTURING’’.

CHAPTER 9—PREVENTING DRUG DIVERSION

SEC. 2291. SHORT TITLE.
This chapter may be cited as the ‘‘Preventing Drug Diversion Act of 2018’’.

SEC. 2292. IMPROVEMENTS TO PREVENT DRUG DIVERSION.

(a) DEFINITION.—Section 102 of the Controlled Substances Act (21 U.S.C. 802) is amended as follows:

(7) The term ‘‘suspicious order’’ may include, but is not limited to—

(A) an order of a controlled substance of unusual size;

(B) an order of a controlled substance deviating substantially from a normal pattern; and

(C) orders of controlled substances of unusual frequency.”:

(b) SUSPICIOUS ORDERS.—Part C of the Controlled Substances Act (21 U.S.C. 821 et seq.) is amended by adding at the end the following:

SEC. 312. SUSPICIOUS ORDERS.

(1)(A) REPORTING.—Each registrant shall—

(i) design and operate a system to identify suspicious orders for the registrant;

(ii) ensure that the system designed and operated under paragraph (1) by the registrant complies with applicable Federal and State privacy laws; and

(iii) upon discovering a suspicious order or series of orders, notify the Administrator of the Drug Enforcement Administration and the Special Agent in Charge of the Division Office of the Drug Enforcement Administration for the area in which the registrant is located or conducts business.

(b) SUSPICIOUS ORDER DATABASE.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Attorney General shall establish a centralized database for collecting reports of suspicious orders.

(2) SATISFACTION OF REPORTING REQUIREMENTS.—If a registrant reports a suspicious order to the centralized database established under paragraph (1), the registrant shall be considered to have complied with the requirement under subsection (a)(3) to notify the Administrator of the Drug Enforcement Administration and the Special Agent in Charge of the Division Office of the Drug Enforcement Administration for the area in which the registrant is located or conducts business.

(c) SHARING INFORMATION WITH THE STATES.—

(1) IN GENERAL.—The Attorney General shall provide information regarding suspicious orders in a State, including information in the database established under subsection (b)(1), to the point of contact for purposes of administrative, civil, and criminal oversight relating to the diversion of controlled substances for the State, as designated by the Governor or chief executive officer of the State.

(2) REPORTS TO CONGRESS.—The Attorney General shall provide information in accordance with paragraph (1) within a reasonable period of time after obtaining the information.

(3) COORDINATION.—In establishing the process for the provision of information under this subsection, the Attorney General shall coordinate with States to ensure that the Attorney General, in providing the information, as permitted under State law, possessed by the States relating to prescriptions for controlled substances that will assist in enforcing Federal law.

(d) REPORTS TO CONGRESS.

(1) DEFINITION.—In this subsection, the term ‘‘suspicious order’’ has the meaning given to such term in section 312 of the Controlled Substances Act, as amended by this chapter.
medical assistance provided to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) by a managed care entity, or other specified entity (as defined in subparagraph (B) of another such subparagraph) was treated as remis- tances because the State—

(i) has satisfied the requirement of section 938.8 of title 42, Code of Federal Regula- tions (or any successor regulation), by electing—

(ii) in the case of a State described in subparagraph (A) to maintain a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

(ii) in the case of a State not described in subparagraph (C), to apply a minimum med- ical loss ratio that is equal to 85 percent; and

(iii) recovered all or a portion of the expendi- tures as a result of the entity’s failure to meet such ratio.

(3) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a min- imum medical loss ratio (as calculated under subsection (d) of section 488.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this title (or a waiver of the plan) that equal to or greater than 85 percent.

(4) The term ‘managed care entity’ means—

(a) a prepaid inpatient health plan, as de- fined in section 438.2 of title 42, Code of Fed- eral Regulations (or any successor regula- tion); and

(b) a prepaid ambulatory health plan, as defined in such section (or any successor regu- lation).

SEC. 4005. REQUIRING REPORTING BY GROUP ORGANIZATIONS; MANAGEMENT REPORTING TO BEHAVIORAL HEALTH MEASURES.

Subtitle B of title XI of the Medicare Pre- vention, Drug, Improvement, and Mod- ernization Act of 2003 (Public Law 108–173) is amended—

(I) in section 1111, as amended by section 3(2) of the Patient Right to Know Drug Prices Act—

(A) in the paragraph (3) inserted by such section 3(1), by striking “application” and inserting “a biosimilar biological product application”;

(B) in the paragraph (4) inserted by such section 3(1), by inserting “application” be- fore “under section 351(k) of the Public Health Service Act;”;

(C) in the paragraph (5) inserted by such section 3(1), by striking “licensure of a biological product under section 351(k) of the Public Health Service Act” and inserting “under section 351(k) of the Public Health Service Act for licensure of a biological product as biosimilar to, or interchangeable with, a reference product;”;

(D) in paragraph (7), as redesignated and amended by such section 3(1), by striking “or an agreement between 2 or more biosimilar biological product applicants regarding the manufactur- ing, marketing, or sale of a biosimilar biological product;” and

(E) in the paragraph (12) added by such sec- tion 3(1), by inserting “or an agreement between 2 or more biosimilar biological product applicants regarding the manufactur- ing, marketing, or sale of a biosimilar biological product;” and

(II) in section 1122, as amended by section 3(2) of the Patient Right to Know Drug Prices Act—

(A) in subsection (a)—

(i) in paragraph (1), by striking “for which a statement under section 351(i)(3)B(1)(i)(I) of the Public Health Service Act has been pro- vided”; and

(ii) in paragraph (2)—

(5) The term ‘minimum medical loss ratio’ means, with respect to a State, a min- imum medical loss ratio (as calculated under subsection (d) of section 488.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this title (or a waiver of the plan).

The term ‘other specified entity’ means—

(II) in the case of a State described in subparagraph (C), a medicaid managed care organization de- fined in section 1902(a)(11)(B)(ii) of title 42, Code of Federal Regulations (or any successor regulation), by electing—

I. SEC. 5001. MANDATORY REPORTING WITH RESPECT TO ADULT BEHAVIORAL HEALTH MEASURES

Subtitle B of title XI of the Medicare Pre- vention, Drug, Improvement, and Mod- ernization Act of 2003 (Public Law 108–173) is amended—

(II) by adding at the end the following:

(3) SPECIAL RULES—

(A) MEDICAL HEALTH SERVICES DEFINED—

For purposes of this subparagraph, the term ‘medical health services’ does not include routine dental, vision and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(B) ATTENTION REQUIRED.—Clause (ii) of such subparagraph (D) shall apply to an individual for months in a taxable year only if the information provided by the individual is correct and the personal identification number of the individual is ‘looks like’ the same personal identification number as that provided by the individual in the prior year.

(C) CONSTRUCTION.—Nothing in the amend- ment made by subsection (a) shall preempt any State law requiring the provision of medical treatment for children, especially those who are seriously ill.

SEC. 4004. MANDATORY REPORTING BY GROUP ORGANIZATIONS; MANAGEMENT REPORTING TO BEHAVIORAL HEALTH MEASURES.

Subtitle B of title XI of the Medicare Pre- vention, Drug, Improvement, and Mod- ernization Act of 2003 (Public Law 108–173) is amended—

(I) in section 1111, as amended by section 3(1) of the Patient Right to Know Drug Prices Act—

(A) in the paragraph (3) inserted by such section 3(1), by striking “application” and inserting “a biosimilar biological product application;”;

(B) in the paragraph (4) inserted by such section 3(1), by inserting “application” be- fore “under section 351(k) of the Public Health Service Act;”;

(C) in the paragraph (5) inserted by such section 3(1), by striking “licensure of a biological product under section 351(k) of the Public Health Service Act” and inserting “under section 351(k) of the Public Health Service Act for licensure of a biological product as biosimilar to, or interchangeable with, a reference product;”;

(D) in paragraph (7), as redesignated and amended by such section 3(1), by striking “or an agreement between 2 or more biosimilar biological product applicants regarding the manufactur- ing, marketing, or sale of a biosimilar biological product;” and

(E) in the paragraph (12) added by such sec- tion 3(1), by inserting “or an agreement between 2 or more biosimilar biological product applicants regarding the manufactur- ing, marketing, or sale of a biosimilar biological product;” and

(II) in section 1122, as amended by section 3(2) of the Patient Right to Know Drug Prices Act—

(A) in subsection (a)—

(i) in paragraph (1), by striking “for which a statement under section 351(i)(3)B(1)(i)(I) of the Public Health Service Act has been pro- vided”; and

(ii) in paragraph (2)—

(II) by adding at the end the following:

(C) BEHAVIORAL HEALTH MEASURES.—Be- ginning with the State report required under subsection (d)(1) for 2024, the Secretary shall require States to use all behavioral health measures included in the core set of adult health quality measures and any updates or changes to such measures, excepting any such measures referenced under such section (and any updates or changes to such measures) shall include behavioral health measures; and

(2) in subsection (b)—

(A) by striking “the such plan and insert- ing “such plan”;

TITLES V—OTHER MEDICAID PROVISIONS

Subtitle A—Mandatory Reporting With Respect to Adult Behavioral Health Measures

Section 11101 of the Social Security Act (42 U.S.C. 1320b–9b) is amended—

(1) in subsection (b)—

(A) in paragraph (3)—

(i) by striking “Not later than January 1, 2013” and inserting the following:

(II) VOLUNTARY REPORTING.—Not later than January 1, 2013; and

(i) by adding at the end the following:

(B) MANDATORY REPORTING WITH respect to behavioral health measures.—Be- ginning with the State report required under subsection (d)(1) for 2024, the Secretary shall require States to use all behavioral health measures included in the core set of adult health quality measures and any updates or changes to such measures, excepting any such measures referenced under such section (and any updates or changes to such measures) shall include behavioral health measures; and

(2) in subsection (b)—

(A) by striking “the such plan and insert- ing “such plan”;

September 28, 2018 CONGRESSIONAL RECORD—HOUSE H9193
Subtitle B—Medicaid IMD Additional Info
SEC. 5012. MEDICAID LABORATORY STUDY AND REPORT ON INSTITUTIONS FOR MENTAL DISEASES REQUIREMENTS AND PRACTICES UNDER MEDICAID.

(a) IN GENERAL.—Not later than January 1, 2020, the Medicaid and CHIP Payment and Access Commission established under section 1909 of the Social Security Act (42 U.S.C. 1396n) shall conduct an exploratory study, using data from a representative sample of States, and submit to Congress a report on at least the following information, with respect to each individual who is enrolled under Medicaid or CHIP:

(1) general information on the individual;
(2) financial information related to the individual;
(3) whether the individual is a resident of an institution for mental diseases;
(4) whether the individual is a patient in an institution for mental diseases; and
(5) any other information that the Secretary of Health and Human Services deems necessary.

(b) COVERAGE LIMITATIONS.—The Secretary of Health and Human Services may, by regulation, impose limitations on the Medicaid and CHIP programs in order to comply with the study required under this section.

Subtitle C—CHIP Mental Health and Substance Use Disorder Parity
SEC. 5021. SHORT TITLE.
This subtitle may be cited as the "CHIP Mental Health and Substance Use Disorder Parity Act of 2019."
OPPORTUNITIES.—Not later than 1 year after
faith effort by such provider—

(b) QUALIFIED PRESCRIPTION DRUG MONI-
toring Program Described.—A qualified
prescription drug monitoring program de-
scribed in this subsection is, with respect
to a State, a prescription drug monitoring
program for the covered individual through
a qualified prescription drug monitoring
program described in subsection (b) before
prescribing to such individual a con-
trolled substance.

(b)(1) Guidance for States on how States
may establish a prescription drug monitoring
program described in subsection (b) before
prescribing to such individual a controlled
substance.

(b)(2) Aggregate trends with respect to pre-
scription drug monitoring programs described
in subsection (b) before dispensing a con-
trolled substance.

(b)(3) Whether or not the State requires
the number and quantity of daily morphine milli-
gram equivalents prescribed for controlled subst-
cences.

(b)(4) Whether or not the State requires
the types of controlled substances prescribed,
including the dates of such prescrip-
tions, the supplies authorized (including the
duration of such supplies), and the period of
validity of such prescriptions, in different
populations (such as individuals who are el-
derly, individuals with disabilities, and indi-
viduals who are enrolled under both this title
and title XVIII.

(b)(5) An accounting of any data or privacy
breach of a qualified prescription drug moni-
toring program described in subsection (b),
the number of covered individuals affected by
such breach, and a description of the steps
the State has taken to address each such breach,
including, to the extent re-
quired by the State or otherwise determined appropriate by the State, alert-
ing any such impacted individual and law en-
forcement of the breach.

(b)(6) A report on the publicly available website of
the Centers for Medicare & Medicaid Services
a report including the following information:

(1) Whether or not the State requires
the number and quantity of daily morphine milli-
gram equivalents prescribed for controlled subst-
cences.

(2) Whether or not the State requires
the types of controlled substances prescribed,
including the dates of such prescrip-
tions, the supplies authorized (including the
duration of such supplies), and the period of
validity of such prescriptions, in different
populations (such as individuals who are el-
derly, individuals with disabilities, and indi-
viduals who are enrolled under both this title
and title XVIII.

(3) Whether or not the State requires
a detailed explanation as to why the
State does or does not require
pharmacists to check the prescription drug history of a covered individual through a qualified pre-
scription drug monitoring program described in subsection (b) before dispensing a con-
trolled substance to such individual.

(b)(7) An accounting of any data or privacy
breach of a qualified prescription drug moni-
toring program described in subsection (b),
the number of covered individuals affected by
such breach, and a description of the steps
the State has taken to address each such breach,
including, to the extent re-
quired by the State or otherwise determined appropriate by the State, alert-
ing any such impacted individual and law en-
forcement of the breach.

(b)(8) A report on the publicly available website of
the Centers for Medicare & Medicaid Services
a report including the following information:

(1) Whether or not the State requires
the number and quantity of daily morphine milli-
gram equivalents prescribed for controlled subst-
cences.

(2) Whether or not the State requires
the types of controlled substances prescribed,
including the dates of such prescrip-
tions, the supplies authorized (including the
duration of such supplies), and the period of
validity of such prescriptions, in different
populations (such as individuals who are el-
derly, individuals with disabilities, and indi-
viduals who are enrolled under both this title
and title XVIII.

(3) Whether or not the State requires
a detailed explanation as to why the
State does or does not require
pharmacists to check the prescription drug history of a covered individual through a qualified pre-
scription drug monitoring program described in subsection (b) before dispensing a con-
trolled substance to such individual.

(b)(9) An accounting of any data or privacy
breach of a qualified prescription drug moni-
toring program described in subsection (b),
the number of covered individuals affected by
such breach, and a description of the steps
the State has taken to address each such breach,
including, to the extent re-
quired by the State or otherwise determined appropriate by the State, alert-
ing any such impacted individual and law en-
forcement of the breach.

(b)(10) A report on the publicly available website of
the Centers for Medicare & Medicaid Services
a report including the following information:

(1) Whether or not the State requires
the number and quantity of daily morphine milli-
gram equivalents prescribed for controlled subst-
cences.

(2) Whether or not the State requires
the types of controlled substances prescribed,
including the dates of such prescrip-
tions, the supplies authorized (including the
duration of such supplies), and the period of
validity of such prescriptions, in different
populations (such as individuals who are el-
derly, individuals with disabilities, and indi-
viduals who are enrolled under both this title
and title XVIII.

(3) Whether or not the State requires
a detailed explanation as to why the
State does or does not require
pharmacists to check the prescription drug history of a covered individual through a qualified pre-
scription drug monitoring program described in subsection (b) before dispensing a con-
trolled substance to such individual.

(b)(11) An accounting of any data or privacy
breach of a qualified prescription drug moni-
toring program described in subsection (b),
the number of covered individuals affected by
such breach, and a description of the steps
the State has taken to address each such breach,
including, to the extent re-
quired by the State or otherwise determined appropriate by the State, alert-
ing any such impacted individual and law en-
forcement of the breach.

(b)(12) A report on the publicly available website of
the Centers for Medicare & Medicaid Services
a report including the following information:

(1) Whether or not the State requires
the number and quantity of daily morphine milli-
gram equivalents prescribed for controlled subst-
cences.

(2) Whether or not the State requires
the types of controlled substances prescribed,
including the dates of such prescrip-
tions, the supplies authorized (including the
duration of such supplies), and the period of
validity of such prescriptions, in different
populations (such as individuals who are el-
derly, individuals with disabilities, and indi-
viduals who are enrolled under both this title
and title XVIII.

(3) Whether or not the State requires
a detailed explanation as to why the
State does or does not require
pharmacists to check the prescription drug history of a covered individual through a qualified pre-
scription drug monitoring program described in subsection (b) before dispensing a con-
trolled substance to such individual.
apply to such State under section 1903(a) for such quarter, with respect to expenditures by the State for activities under the State plan (or a waiver of such plan) to design, develop, implement, or maintain a prescription drug monitoring program (and to make connections to such program) that satisfies the criteria described in paragraphs (1) and (2) of subsection (c) of section 1903(a).

(2) CONDITION.—The condition described in this paragraph, with respect to a State, is that the State (in this paragraph referred to as the ‘State’), has in place agreements with all States that are contiguous to such administering State that, when combined, provide access to all such contiguous States to access, through the prescription drug monitoring program, the information that is described in subsection (a) with respect to individuals of such administering State and that covered providers in such administering State are able to access through such program.

(g) RULE OF CONSTRUCTION.—Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified prescription drug monitoring program before dispensing controlled substances to such individuals.

(h) DEFINITIONS.—In this section:

(1) CONTROLLED SUBSTANCE.—The term ‘controlled substance’ means a drug that is included in schedule II of section 202(c) of the Controlled Substances Act, or—

(A) may have sources of health care coverage in addition to coverage under such title; or

(B) in the case of services provided under a State plan amendment under paragraph (1) for services described in such paragraph furnished, with respect to a 12-month period, to an eligible institution that is a patient in an eligible institution for mental diseases shall be treated as medical assistance for which payment is made under section 1903(a) but only to the extent that such services are furnished for not more than a period of 30 days (whether or not consecutive) during such 12-month period.

(2) MAINTENANCE OF EFFORT.—(A) AS A CONDITION.—As a condition for a State receiving payments under section 1903(a) for medical assistance provided in accordance with this subsection, the State shall (during the period in which it so furnished such medical assistance through a State plan amendment under this subsection) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title from non-Federal funds for—

(i) items and services furnished to eligible individuals who are patients in eligible institutions for mental diseases that is not less than the level of such funding for such items and services for the most recently ended fiscal year as of the date of enactment of this subsection or, if higher, for the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection; and

(ii) items and services described in paragraph (B) furnished to eligible individuals in outpatient and community-based settings that is not less than the level of such funding for such items and services for the most recently ended fiscal year as of the date of enactment of this subsection or, if higher, for the most recently ended fiscal year as of the date the State submits a State plan amendment to the Secretary to provide such medical assistance in accordance with this subsection.

(3) SERVICES DESCRIBED.—(A) IN GENERAL.—The services described in subparagraph (A)(ii) are—

(i) outpatient and community-based treatment designed to alleviate acute emotional, behavioral, cognitive, or biological distress occurring with, an individual’s use of alcohol and other drugs.

(ii) Other outpatient and community-based services for the treatment of substance abuse.
use disorders, as designated by the Secretary.

(3) STATE REPORTING REQUIREMENT.

(a) In General.—Prior to approval of a State plan amendment under this subsection, as a condition for a State receiving payments under section 1903(a) for medical assistance provided in accordance with this subsection, the State shall report to the Secretary, in accordance with the process established by the Secretary under clause (ii), the information deemed necessary by the Secretary to ensure that the State is in compliance with paragraph (A).

(b) Process.—Not later than the date that is 8 months after the date of enactment of this subsection, the Secretary shall establish, in a manner the Secretary deems appropriate, such information as is necessary to verify a State’s compliance with subparagraph (A).

(4) Ensuring a Continuum of Services.—

(A) In General.—As a condition for a State receiving payments under section 1903(a) for medical assistance provided in accordance with this subsection, the State shall carry out each of the requirements described in subparagraphs (B) through (D).

(B) Prior to approving a State plan amendment under this subsection, the State shall notify the Secretary of the existence of facilities that eligible individuals receive appropriate guidance and clinical screening prior to being furnished with items and services in an eligible institution for mental diseases in accordance with initial and periodic assessments to determine the appropriate level of care, length of stay, and setting for such care for each individual.

(C) Outpatient Services; Inpatient and Residential Services.—

(i) Outpatient Services.—The State shall, at a minimum, provide medical assistance for outpatient services that would otherwise be covered under the State plan, consistent with each of the following outpatient levels of care:

(I) Early intervention for individuals who, for a known reason, are at risk of developing substance-related problems and for individuals for whom there is not yet sufficient information to document a diagnosable substance use disorder.

(II) Outpatient services for less than 9 hours per week for adults, and for less than 6 hours per week per adult for adolescents, that would otherwise be covered under the State plan, consistent with at least 2 of the following outpatient levels of care:

(i) Clinically managed, low-intensity residential services that provide adults and adolescents with 24-hour living support and structure. The State shall report to the Secretary, in accordance with the process established by the Secretary under clause (ii), the information deemed necessary by the Secretary to ensure that the State is in compliance with paragraph (A).

(ii) Clinically managed, medium-intensity residential services that provide adults with 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment.

(iii) Clinically managed, intensive inpatient services for adolescents and adults that provide 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3, and provide counseling services 16 hours per day.

(iv) MEDICALLY MONITORED INPATIENT SERVICES.—The State shall provide medical assistance for items and services that are provided to an individual in an inpatient or a residential care setting where a home or community-based care setting would be more appropriate for the individual, or as preventing a State from conducting or pursuing a demonstration project under section 1115 of the Social Security Act to improve the quality of substance use disorder treatment for eligible populations.

Subtitle G—Medicaid Improvement Fund

SEC. 5061. MEDICAID IMPROVEMENT FUND.

(a) In General.—Section 1941(b) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended by striking “$0” and inserting “$31,000,000.”

TITLE VI—OTHER MEDICARE PROVISIONS

Subtitle A—Testing of Incentive Payments for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology

SEC. 6001. TESTING OF INCENTIVE PAYMENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR ADOPTION AND USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.

Section 1115(a)(3)(B) of the Social Security Act (42 U.S.C. 1315(a)(3)(B)) is amended by adding at the end the following new clause:

“(A) Providing, for the adoption and use of certified EHR technology (as defined in section 1861(ff)(3)(B)), hospitals that participate in the Medicare Incentive Payment Program for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology (as defined in section 1861(ff)(3)(B)) that participate in a State plan under title XIX or a waiver of such plan, treatment facilities that participate in such a State plan or such a waiver, mental health or substance abuse disorder providers that participate in such a State plan or such a waiver, and such social workers (as defined in section 1861(ff)(3)(B)).”

Subtitle B—Abuse Deterrent Access

SEC. 6011. SHORT TITLE.

This subtitle may be cited as the “Abuse Deterrent Access Act of 2018.”

SEC. 6012. TESTING OF INCENTIVE PAYMENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR ADOPTION AND USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.
under part C of title XVIII of the Social Security Act or a prescription drug plan under part D of such title of such Act, taking into account any barriers preventing such individuals from accessing such medications under such MA–PD or part D plans, such as cost-sharing tiers, fail-first requirements, the price of such formulations, and prior authorizations; and

(2) the effectiveness of abuse-deterrent opioid formulations in preventing opioid abuse or misuse, the impact of the use of abuse-deterrent opioid formulations on the use or abuse of other prescription or illicit opioids (including changes in deaths from such opioids); and other public health consequences of abuse-deterrent opioid formulations, such as an increase in rates of human immunodeficiency virus.

(b) DEFINITION OF ABUSE-DETERRENT OPIOID FORMULATION.—In this section, the term "abuse-deterrent opioid formulation" means an opioid that is a prodrug or that has certain abuse-deterrent properties, such as physical or chemical barriers, agonist or antagonist combinations, aversion properties, delivery system mechanisms, or other features designed to prevent abuse of such opioid.

Subtitle C—Medicare Safety Education

SEC. 6021. MEDICARE OPIOID SAFETY EDUCATION

(a) IN GENERAL.—Section 1801 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

"(d) The notice provided under subsection (c) shall include—

"(1) references to educational resources regarding opioid and pain management;

"(2) a description of categories of alternative, non-opioid pain management treatments covered under this title; and

"(3) a service to be beneficial to a physician regarding opioid use and pain management.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to notices distributed prior to each Medicare open enrollment period beginning after January 1, 2019.

Subtitle D—Opioid Addiction Action Plan

SEC. 6001. SHORT TITLE.

This subtitle may be cited as the "Opioid Addiction Action Plan Act".

SEC. 6002. ACTION PLAN ON RECOMMENDATIONS FOR THE 3-YEAR DEMONSTRATION TO SIMPLIFY AND MODERNIZE UNDER MEDICARE AND MEDICAID TO PREVENT OPIOIDS ADDICTIONS AND ENHANCE ACCESS TO MEDICATION-ASSISTED TREATMENT.

(a) IN GENERAL.—Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program related to the access to appropriate opioid dependence treatments for such beneficiaries, and to the extent possible, reduce expenditures under this title. Under the Program, the Secretary shall make payments under subsection (e) to appropriate providers of services and suppliers not under the action plan; and

(b) PARTICIPANTS.—Participants of the Program shall include—

(i) providers and suppliers of services to beneficiaries institutionalized under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicare prospective payment system for inpatient hospital services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)), to determine whether those incentives in precertification are making it more difficult.

(c) STAKEHOLDER MEETINGS.—For purposes of this section, the term 'opioid use disorder treatment services' includes—

(A) reduces the likelihood of hospitalizations and emergency department visits.

(B) increases the use of medication-assisted treatment for opioid use disorders.

(C) improves health outcomes of individuals with opioid use disorders, including by decreasing the incidence of infectious diseases (such as hepatitis C and HIV).

(D) does not increase the total spending on items and services under this title.

(E) reduces deaths from opioid overdose.

(F) reduces the utilization of inpatient residential treatment.

Subtitle E—Advancing High Quality Treatment for Opioid Use Disorders in Medicare

SEC. 6041. SHORT TITLE.

This subtitle may be cited as the "Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act".

SEC. 6042. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866F (42 U.S.C. 1395cc–6) the following new section:

SEC. 1866F. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

(a) IMPLEMENTATION OF 4-YEAR DEMONSTRATION PROGRAM.

(1) IN GENERAL.—Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program under this title (in this section referred to as the "Program") to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce expenditures under this title. Under the Program, the Secretary shall make payments under subsection (e) to appropriate providers of services and suppliers not under the action plan; and

(i) medication-assisted treatment;

(ii) treatment planning;

(iii) psychiatric, psychological, or counseling services (or any combination of such services), as appropriate;

(iv) social support services, as appropriate; and

(v) care management and care coordination services, including coordination with other providers of services and suppliers not on an opioid use disorder care team.

(2) PARTICIPANTS.—Participants of the Program shall include—

(A) beneficiaries institutionalized under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicare prospective payment system for inpatient hospital services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)), to determine whether those incentives in precertification are making it more difficult.

(B) providers and suppliers of services to beneficiaries institutionalized under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicare prospective payment system for inpatient hospital services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)), to determine whether those incentives in precertification are making it more difficult.

(C) reduces the likelihood of hospitalizations and emergency department visits.

(D) increases the use of medication-assisted treatment for opioid use disorders.

(E) improves health outcomes of individuals with opioid use disorders, including by decreasing the incidence of infectious diseases (such as hepatitis C and HIV).

(F) does not increase the total spending on items and services under this title.

(G) reduces deaths from opioid overdose.

(H) reduces the utilization of inpatient residential treatment.

(C) Medicaid Innovation and other federally authorized demonstration projects, including value-based models, that may encourage the use of appropriate medication-assisted treatment approved by the Food and Drug Administration for the treatment of opioid use disorder and other therapies that manage chronic and acute pain and treat and minimize risk of opioid misuse and abuse.

(3) RECOMMENDATIONS.—The Secretary shall make payments under subsection (e) to appropriate providers of services and suppliers not under the action plan; and

(E) reduces deaths from opioid overdose.

(F) reduces the utilization of inpatient residential treatment.

This subtitle may be cited as the "Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act".

SEC. 6042. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866F (42 U.S.C. 1395cc–5) the following new section:

SEC. 1866F. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

(a) IMPLEMENTATION OF 4-YEAR DEMONSTRATION PROGRAM.

(1) IN GENERAL.—Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program under this title (in this section referred to as the "Program") to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce expenditures under this title. Under the Program, the Secretary shall make payments under subsection (e) to appropriate providers of services and suppliers not under the action plan; and

(i) medication-assisted treatment;

(ii) treatment planning;

(iii) psychiatric, psychological, or counseling services (or any combination of such services), as appropriate;

(iv) social support services, as appropriate; and

(v) care management and care coordination services, including coordination with other providers of services and suppliers not on an opioid use disorder care team.

(2) PARTICIPANTS.—Participants of the Program shall include—

(A) beneficiaries institutionalized under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicare prospective payment system for inpatient hospital services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)), to determine whether those incentives in precertification are making it more difficult.

(B) providers and suppliers of services to beneficiaries institutionalized under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicare prospective payment system for inpatient hospital services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)), to determine whether those incentives in precertification are making it more difficult.

(C) reduces the likelihood of hospitalizations and emergency department visits.

(D) increases the use of medication-assisted treatment for opioid use disorders.

(E) improves health outcomes of individuals with opioid use disorders, including by decreasing the incidence of infectious diseases (such as hepatitis C and HIV).

(F) does not increase the total spending on items and services under this title.

(G) reduces deaths from opioid overdose.

(H) reduces the utilization of inpatient residential treatment.

(C) reduces the likelihood of hospitalizations and emergency department visits.

(D) increases the use of medication-assisted treatment for opioid use disorders.

(E) improves health outcomes of individuals with opioid use disorders, including by decreasing the incidence of infectious diseases (such as hepatitis C and HIV).

(F) does not increase the total spending on items and services under this title.

(G) reduces deaths from opioid overdose.

(H) reduces the utilization of inpatient residential treatment.
"(2) CONSULTATION.—In designing the Program, including the criteria under subsection (e)(2)(A), the Secretary shall, not later than 3 months after the date of the enactment of this Act, consult with specialists in the field of addiction, clinicians in the primary care community, and beneficiary groups.

(c) Participants: Opioid Use Disorder Care Teams.—

(1) PARTICIPANTS.—In this section, the term ‘participant’ means an entity or individual—

(i) that is otherwise enrolled under this title and that is—

(II) a physician (as defined in section 1861(r)(1));

(II) a group practice comprised of at least one physician described in subclause (I);

(III) a health care practitioner established by a participant described in paragraph (2);

(IV) a federally qualified health center (as defined in section 1861(aa)(4));

(V) a rural health clinic (as defined in section 1861(aa)(4));

(VI) a community mental health center (as defined in section 1861(ff)(3)(B));

(VII) a clinical certified community behavioral health program (as defined in section 223 of the Protecting Access to Medicare Act of 2014); or

(VIII) any other individual or entity specified by the Secretary;

(ii) that applied for and was selected to participate in the Program pursuant to an application and selection process established by the Secretary; and

(iii) that establishes an opioid use disorder care team (as defined in paragraph (2)) through employing or contracting with health care practitioners described in paragraph (2)(A), and uses such team to furnish or arrange for opioid use disorder treatment services in the outpatient setting under the Program.

(b) PREFERENCE.—In selecting participants for the Program, the Secretary shall give preference to individuals and entities that are located in areas with a prevalence of opioid use disorders that is higher than the national average prevalence.

(2) OPIOID USE DISORDER CARE TEAMS.—

(A) IN GENERAL.—For purposes of this section, the term ‘opioid use disorder care team’ means a group of health care practitioners established by a participant described in paragraph (1)(A) that—

(i) shall include—

(II) a physician (as defined in section 1861(r)(1)) furnishing primary care services or addiction treatment services to an applicable beneficiary; and

(III) an eligible practitioner (as defined in paragraph (3)), who may be a physician who meets the criteria in subclause (I); and

(iv) may include other practitioners licensed under State law to furnish psychiatric, psychological, counseling, and social services to applicable beneficiaries.

(B) FOR RECEIPT OF PAYMENT UNDER PROGRAM.—In order to receive payments under subsection (e), each participant in the Program shall—

(i) furnish opioid use disorder treatment services through opioid use disorder care teams to applicable beneficiaries who agree to receive the services;

(ii) meet established minimum criteria, as established by the Secretary; and

(iii) submit to the Secretary, in such form, manner, and frequency as specified by the Secretary, such reports to each applicable beneficiary for whom opioid use disorder treatment services are furnished by the opioid use disorder care team, data and such other information as the Secretary determines appropriate to—

(1) monitor and evaluate the Program;

(2) determine if minimum criteria are met under clause (i); and

(3) determine the incentive payment under subsection (e).

(3) ELIGIBLE PRACTITIONER DEFINED.—For purposes of this section, the term ‘eligible practitioner’ means a physician or other health care practitioner, such as a nurse practitioner—

(A) is enrolled under section 1866(j)(1);

(B) is authorized to prescribe or dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment; and

(C) has in effect a waiver in accordance with section 330(g) of the Controlled Substances Act for such purpose and is otherwise in compliance with regulations promulgated by the Substance Abuse and Mental Health Services Administration to carry out such section.

(d) PARTICIPATION OF APPLICABLE BENEFICIARIES.—

(1) APPLICABLE BENEFICIARY DEFINED.—In this section, the term ‘applicable beneficiary’ means an individual who—

(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B;

(B) is enrolled in a Medicare Advantage plan under part C;

(C) has a current diagnosis for an opioid use disorder; and

(D) meets such other criteria as the Secretary determines appropriate.

Such term shall include an individual who is dually eligible applicable beneficiaries under title XIX and title XIX if such individual satisfies the criteria described in subparagraphs (A) through (D).

(2) VOLUNTARY BENEFICIARY PARTICIPATION; LIMITATION ON NUMBER OF BENEFICIARIES.—An applicable beneficiary may participate in the Program on a voluntary basis and may terminate participation in the Program at any time. Not more than 20,000 applicable beneficiaries may participate in the Program at any time.

(3) SERVICES.—In order to participate in the Program, an applicable beneficiary shall agree to receive opioid use disorder treatment services from a participant. Participation in the Program shall be—

(A) in general—

(i) a voluntary beneficiary access to services.

Nothing in this section shall be construed as encouraging providers to limit applicable beneficiary access to services covered under this title; and

(ii) pay a higher per applicable beneficiary per month care management fee to participants for the treatment of opioid use disorders.

(4) BENEFICIARY ACCESS TO SERVICES.—In determining criteria described in subparagraph (A), the Secretary shall—

(i) consult with stakeholders, including clinicians in the primary care community and in the field of addiction medicine; and

(ii) consider existing clinical guidelines for the treatment of opioid use disorders.

No duplicate payments shall be made with respect to an applicable beneficiary.

(iii) MULTIPAYER STRATEGY.—In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applicable beneficiaries for the treatment of opioid use disorders.

(5) CRITERIA.—In determining the extent to which each of the purposes described in subsection (b) have been accomplished under the Program, the Secretary shall—

(A) maintain an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program;

(B) REPORTS.—The Secretary shall submit to Congress—

(i) a report with respect to the intermediate and final evaluation under paragraph (1) not later than 6 years after such date.

(6) FUNDING.—
"(1) ADMINISTRATIVE FUNDING.—For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), $5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

"(2) CARE MANAGEMENT FEES AND INCENTIVES.—For purposes of making payments under subsection (e), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 for each of fiscal years 2021 through 2024.

"(3) AVAILABILITY.—Amounts transferred under this subsection for a fiscal year shall be available until expended.

"(i) WAIVERS.—The Secretary may waive any provision of this title as may be necessary to carry out the Program under this section.

Subtitle F—Responsibility Education Achieves Care and Healthy Outcomes for Users' Treatment

SEC. 6051. SHORT TITLE.

This subtitle may be cited as the "Responsibility Education Achieves Care and Healthy Outcomes for Users' Treatment Act of 2018" or the "REACH OUT Act of 2018".

SEC. 6052. GRANTS TO PROVIDE TECHNICAL ASSISTANCE TO OUTLIER PRESCRIBERS OF OPIOIDS.

(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services (in this paragraph referred to as the "Secretary") shall, through the Centers for Medicare & Medicaid Services, award grants, contracts, or cooperative agreements to eligible entities for the purposes described in subsection (b).

(b) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under subsection (a) shall be used to support eligible entities through technical assistance—

(1) to educate and provide outreach to prescribers of opioids about best practices for prescribing opioids;

(2) to educate and provide outreach to prescribers of opioids about non-opioid pain management therapies; and

(3) to reduce the amount of opioid prescriptions purchased by outlier prescribers of opioids.

(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

(d) G EOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall require institutions and entities that have been referred pursuant to subparagraph (a) to participate in, and make available to, at least one entity described in paragraph (1) in each State and one entity described in paragraph (2) in each State.

Sec. 6053. PROGRAM INTEGRITY TRANSPARENCY MEASURES UNDER MEDICARE PART D DRUGS.

(a) IN GENERAL.—Section 1899 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subparagraph—

"(ii) data sharing among such MA plans, Medicare Advantage organizations, PDP sponsors, Medicare Advantage organizations offering such plan, and

"(iii) ELECTRONIC TRANSMISSION.—

"(1) Exclusions.—For purposes of this subparagraph, such electronic transmission described in clause (i) shall not be treated as an electronic transmission described in clause (i)."

"(2) Standards.—In order to be treated, for purposes of this subparagraph, as an electronic transmission described in clause (i), such submission shall comply with technical standards adopted under section 1866(a)(4) of the Social Security Act (42 U.S.C. 1395w–28(c)(4)) to the Secretary.

"(3) MEASURES.—For purposes of this subparagraph, the Secretary shall disseminate the following information to such plan of such transmission described in clause (ii):—

"(A) information submitted to the Secretary by such plan; and

"(B) information submitted to the Secretary by a provider (including a prescriber or supplier) of such plan.

"(4) SECURITIZATION.—The Secretary shall securitize such information described in clause (ii), and shall make such securitized information available to PDP sponsors and Medicare Advantage organizations offering such plan.

(b) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under this section shall be used to support eligible entities through technical assistance—

(1) to educate and provide outreach to prescribers of opioids about best practices for prescribing opioids;

(2) to educate and provide outreach to prescribers of opioids about non-opioid pain management therapies; and

(3) to reduce the amount of opioid prescriptions purchased by outlier prescribers of opioids.

(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall require institutions and entities that have been referred pursuant to subparagraph (a) to participate in, and make available to, at least one entity described in paragraph (1) in each State and one entity described in paragraph (2) in each State.

Sec. 6054. ELECTRONIC PRIOR AUTHORIZATION FOR COVERED PART D DRUGS.

Section 1860D-4(e)(2) of the Social Security Act (42 U.S.C. 1395w–104(e)(2)) is amended by adding at the end the following new subparagraph—

"(E) ELECTRONIC PRIOR AUTHORIZATION.—

"(1) In general.—Not later than January 1, 2021, the program shall provide for the secure electronic transmission of—

"(A) a response, in accordance with this subparagraph, a facsimile, a proprietary payer portal (that does not meet standards specified by the Secretary), or an electronic form shall not be treated as an electronic transmission described in clause (i).

"(B) ELECTRONIC TRANSMISSION.—

"(i) Exclusions.—For purposes of this subparagraph, such electronic transmission described in clause (i), such submission shall comply with technical standards adopted under section 1866(a)(4) of the Social Security Act (42 U.S.C. 1395w–28(c)(4)) to the Secretary.

"(ii) Standards.—In order to be treated, for purposes of this subparagraph, as an electronic transmission described in clause (i), such submission shall comply with technical standards adopted under section 1866(a)(4) of the Social Security Act (42 U.S.C. 1395w–28(c)(4)) to the Secretary.

"(iii) SECURITIZATION.—The Secretary shall securitize such information described in clause (ii), and shall make such securitized information available to PDP sponsors and Medicare Advantage organizations offering such plan.

"(4) SECURITIZATION.—The Secretary shall securitize such information described in clause (ii), and shall make such securitized information available to PDP sponsors and Medicare Advantage organizations offering such plan.

"(5) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under this section shall be used to support eligible entities through technical assistance—

(1) to educate and provide outreach to prescribers of opioids about best practices for prescribing opioids;

(2) to educate and provide outreach to prescribers of opioids about non-opioid pain management therapies; and

(3) to reduce the amount of opioid prescriptions purchased by outlier prescribers of opioids.

(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall require institutions and entities that have been referred pursuant to subparagraph (a) to participate in, and make available to, at least one entity described in paragraph (1) in each State and one entity described in paragraph (2) in each State.
“(A) include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders; and

“(B) be anonymized information submitted by plans without identifying the source of such information.

“(ii) Identification of outlier prescribers.—(I) In general.—The Secretary shall, subject to subclause (III), using the valid prescriber National Provider Identifier numbers included pursuant to subparagraph (A) on claims for covered part D drugs for part D eligible individuals, enroll appropriate prescription drug plans under this part and MA–PD plans under part C and based on the thresholds established under subclause (II), identify prescribers that are outlier prescribers for a period of time specified by the Secretary.

“(II) Establishment of thresholds.—For purposes of this subparagraph (I) and subject to subclause (III), the Secretary shall, after consultation with stakeholders, establish thresholds, based on prescriber specialty and geographic area, for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers of opioids within such specialty and area.

“(III) Exclusions.—The following shall not be included in the analysis for identifying outlier prescribers of opioids under this clause:

“(aa) Claims for covered part D drugs for part D eligible individuals who are receiving hospice care under this title.

“(bb) Claims for covered part D drugs for part D eligible individuals who are receiving oncology services under this title.

“(cc) Prescribers who are the subject of an investigation by the Centers for Medicare & Medicaid Services or the Inspector General of the Department of Health and Human Services.

“(dd) Claims for covered part D drugs for Medicare Advantage plans.

“(ee) Claims for covered part D drugs for Medicare Advantage expansions.

“(f) Reference under part D to program integrity transparency measures.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–27(t)) is amended by adding at the end the following new paragraph:

“(y) Program integrity transparency measures.—For program integrity transparency measures applied with respect to applicable prescription drug plans pursuant to subparagraph (A) on claims for covered part D drugs for part D eligible individuals, based on the thresholds established under this subparagraph, the term ‘opioids’ has the meaning as specified by the Secretary.
(3) A description of how opioid use is tracked and monitored through Medicare claims data and other mechanisms and the identification of any areas in which further data and reporting could improve data collection and understanding of opioid use.

SEC. 6073. NO ADDITIONAL FUNDS AUTHORIZED.

No additional funds are authorized to be appropriated to carry out the requirements of this section. The amounts otherwise authorized to be appropriated shall be included in the amounts authorized under section 300x(g) of the Social Security Act (42 U.S.C. 1395x(g)); Section 6051(a)(3) of the Social Security Act (42 U.S.C. 1395l(a)(3)); Section 6054(a)(3) of the Social Security Act (42 U.S.C. 1395t(a)(3)); Section 6056(a)(3) of the Social Security Act (42 U.S.C. 1395w–2(a)(3)); Section 6062(c)(3) of the Social Security Act (42 U.S.C. 1395s(c)(3)); and Section 6084(e)(2) of the Social Security Act (42 U.S.C. 1395xx(e)(2)), except for funds made available under section 6084(e) of the Social Security Act (42 U.S.C. 1395xx(e)), which shall remain available until expended.

Subtitle I—Dr. Todd Graham Pain Management, Treatment, and Recovery

SEC. 6081. SHORT TITLE.

This subtitle may be cited as the “Dr. Todd Graham Pain Management, Treatment, and Recovery Act of 2018.”

SEC. 6082. REVIEW AND ADJUSTMENT OF PAYMENTS UNDER THE MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM TO AVOID FINANCIAL INCENTIVES TO USE OPIOIDS INSTEAD OF NON-OPIOID ALTERNATIVE TREATMENTS.

(a) OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

“(22) REVIEW AND REVISIONS OF PAYMENTS FOR NON-OPIOID ALTERNATIVE TREATMENTS.—

“(A) IN GENERAL.—With respect to payments under this subsection (aa), the Secretary shall focus on covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification under this subsection:—

“(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;—

“(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and—

“(iii) shall consider the extent to which revisions under this subsection to such payments (such as the creation of additional groups of OPD services to separately code such procedures that utilize opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

“(B) PRIORITY.—In conducting the review under clause (i) of subparagraph (A) and considering the requirements described in such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification under this subsection that primarily include surgical services, and other services determined by the Secretary which generally involve treating pain.

“(C) REVISIONS.—If the Secretary identifies revisions to payments pursuant to subparagraph (A)(i)(iii), the Secretary shall, as determined appropriate by the Secretary, make such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (4)(B).

“(D) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed to preclude the Secretary—

“(i) from conducting a demonstration before making the revisions described in subparagraph (C); or—

“(ii) prior to implementation of this paragraph, the Secretary may make revisions to subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.”.

(b) AMBULATORY SURGICAL CENTERS.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

“(8) The Secretary shall conduct a similar type of review under paragraph (22) of section 1833(t), including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection (aa) and revisions under this paragraph, in an appropriate manner (as determined by the Secretary).”.

SEC. 6083. EXPANDING ACCESS UNDER THE MEDICARE PROGRAM TO ADDICTION TREATMENT IN FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395m(h)) is amended by—

“(1) in paragraphs (2)(A) and (4), by inserting before paragraph (2)(A) the following new paragraph:

“(A) IN GENERAL.—In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally qualified health center services (as defined in section 1861(aa)(3)), including the services described in such paragraph at such clinic, shall remain available until expended.’’.

“(2) by redesignating the subsection (z) relating to medical review of spinal subluxation services as subsection (aa); and—

“(3) by amending—

“(A) in paragraph (1), in subparagraph (C) of such paragraph, by inserting after the word ‘individual’ the word ‘or’;—

“(B) in paragraph (2), in subparagraph (A), the requirements described in such paragraph at such clinic.

“(B) Prior to January 1, 2019, a rural health clinic described in paragraph (1), a rural health clinic with respect to which, beginning on or after January 1, 2019, a payment at such time, in such manner, and containing such information as specified by the Secretary, may be made only one time with respect to each such physician or practitioner.

“(4) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.’’.

(b) RURAL HEALTH CLINICS WITH PHYSICIANS OR OTHER PRACTITIONERS.—Section 1834(o) of the Social Security Act (42 U.S.C. 1395x(o)) is amended by—

“(1) by inserting after paragraph (22) the following new paragraph:

“(23) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.’’.

(c) RURAL HEALTH CLINICS WITH PHYSICIANS OR OTHER PRACTITIONERS.—Section 1834(o) of the Social Security Act (42 U.S.C. 1395x(o)) is amended by—

“(1) by redesignating the subsection (z) relating to medical review of spinal subluxation services as subsection (aa); and—

“(2) by amending—

“(A) in paragraph (1), in subparagraph (C) of such paragraph, by inserting after the word ‘individual’ the word ‘or’;—

“(B) in paragraph (2), in subparagraph (A), the requirements described in such paragraph at such center.

“(B) Prior to January 1, 2019, a Federally qualified health center described in paragraph (1), a Federally qualified health center with respect to which, beginning on or after January 1, 2019, a payment at such time, in such manner, and containing such information as specified by the Secretary, may be made only one time with respect to each such physician or practitioner.

“(4) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.’’.

SEC. 6084. STUDYING THE AVAILABILITY OF SUPPLEMENTAL BENEFITS DESIGNED TO TREAT OR PREVENT SUBSTANCE USE DISORDERS UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit to Congress a report on the availability of supplemental health care benefits (as described in section 1852(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(3)(A))) designed to treat or prevent substance use disorders under Medicare Advantage plans offered under part C of title XVIII of such Act. Such report shall include the analysis described in subsection (c) and any differences in the availability of such benefits under standardized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act (42 U.S.C. 1395w–22(b)(6))) compared to medical assistance under title XIX of such Act and other such Medicare Advantage plans.

(b) CONSULTATION.—The Secretary shall develop the report described in subsection (a) in consultation with relevant stakeholders, including—

(1) individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act;—

(2) entities who advocate on behalf of such individuals;—

(3) Medicare Advantage organizations;—

(4) pharmacy benefit managers; and—

(5) entities that administer MA plans (as such terms are defined in section 1881 of such Act (42 U.S.C. 1395x)).
(c) CONTENTS.—The report described in subsection (a) shall include an analysis on the following:

(1) The extent to which plans described in such plans offer supplemental health care benefits relating to coverage of—

(A) medication-assisted treatments for opioid use, substance use disorder counseling, and support services; and other forms of substance use disorder treatments (whether furnished in an inpatient or outpatient setting); and

(B) non-opioid alternatives for the treatment of pain.

(2) Challenges associated with such plans offering supplemental health care benefits relating to coverage of—

(A) services for the availability of medications; and

(B) other providers of health services.

(3) The impact, if any, of increasing the applicable rebate percentage determined under section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) for plans offering such benefits relating to such coverage on the availability of such benefits relating to such coverage offered under Medicare Advantage plans.

(4) Potential ways to improve upon such coverage to authorize such plans to offer additional supplemental health care benefits relating to such coverage.

SEC. 6085. CLINICAL PSYCHOLOGIST SERVICES ON OR AFTER JANUARY 1, 2016, RELATING TO COVERAGE REQUIREMENTS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT

(a) CMS MANDATE.—Section 11102(b)(2)(B) of the Social Security Act (42 U.S.C. 13152(b)(2)(B)), as amended by section 6001, is further amended by adding at the end the following new clause:

“(xxv) Supporting ways to familiarize individuals with the availability of coverage under part B of title XVIII for qualified psychologist services (as defined in section 1861(i)).”;

“(xxvi) Exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services (such as for treating depression) through use of a 24-hour, 7-day a week help line that may be used by the individuals about the availability of treatment options, including the availability of qualified psychologist services (as defined in section 1861(i)).”;

(b) EXCEPTION.—Nothing in this subsection shall apply later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to the Senate, on mental and behavioral health services under the Medicare program under title XVIII of the Social Security Act, including an examination of the following:

(1) Information about services furnished by psychiatrists, clinical psychologists, and other professionals.

(2) Inflation in ways that Medicare beneficiaries familiarize themselves about the availability of Medicare payment for qualified psychologist services (as defined in section 1861(i)) of the Social Security Act (42 U.S.C. 1395x(ii)) and ways that the provision of such information could be improved.

SEC. 6086. DR. TODD GRAHAM PAIN MANAGEMENT STUDY

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall conduct a study analyzing best practices as well as payment and coverage for pain management services under title XVIII of the Social Security Act and submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report containing options for revising payment to providers and suppliers of services and coverage related to the use of multi-disciplinary, evidence-based, non-opioid treatments for acute and chronic pain management for individuals who are entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act. The Secretary shall make such report available on the public website of the Centers for Medicare & Medicaid Services.

(b) CONSULTATION.—In developing the report described in subsection (a), the Secretary shall consult with—

(1) relevant agencies within the Department of Health and Human Services;

(2) licensed medical and allopathic physicians, behavioral health practitioners, physician assistants, nurse practitioners, dentists, pharmacists, and other providers of health services;

(3) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

(4) substance abuse and mental health professional organizations;

(5) pain management professional organizations and advocacy entities, including individuals who personally suffer chronic pain;

(6) medical professional organizations and medical specialty organizations;

(7) licensed mental health or medical providers who furnish alternative pain management services;

(8) organizations with expertise in the development of innovative medical technologies for pain management;

(9) beneficiary advocacy organizations; and

(10) other organizations with expertise in the assessment, diagnosis, treatment, and management of pain determined appropriate by the Secretary.

(c) CONTENTS.—The report described in subsection (a) shall contain the following:

(1) An analysis of payment and coverage under title XVIII of the Social Security Act with respect to the following:

(A) Evidence-based treatments and technologies for chronic or acute pain, including such treatments that are covered, not covered, or have limited coverage under such title.

(B) Evidence-based treatments and technologies that monitor substance use withdrawal and prevent overdoses of opioids.

(C) Evidence-based treatments and technologies that treat substance use disorders.

(D) Items and services furnished by practitioners through a multi-disciplinary treatment model, including the patient-centered medical home.

(E) Items and services furnished to beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, or have comorbidities and require consultation or management of pain with one or more specialists in pain management, mental health, or addiction treatment.

(2) An evaluation of the following:

(A) Barriers inhibiting individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act to receive treatments and technologies described in subparagraphs (A) through (E) of paragraph (1).

(B) Costs and benefits associated with potential expansion of coverage under such title to include items and services not covered under such title that may be used for the treatment of pain, such as acupuncture, therapy, services furnished by psychologists, and services furnished by integrated pain management programs.

(C) Pain management guidance published by the Federal interagency task force established by the Pain Management Guidelines Act of 2017 by the Department of Veterans Affairs and Department of Defense, including adoption of elements of the Department of Defense and Department of Veterans Affairs rating scale.

(3) An analysis guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids. Such assessment shall consider incorporating into such guidance relevant elements of the ‘‘Va/DoD Clinical Practice Guideline for Opioid Therapies’’ published in February 2017 by the Department of Veterans Affairs and Department of Defense, including adoption of elements of the Department of Defense and Department of Veterans Affairs rating scale.

(4) The options described in subsection (d).

(5) The impact analysis described in subsection (e).

(d) OPTIONS.—The options described in this subsection are, with respect to individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act, legislative and administrative options for accomplishing the following:

(1) Improving coverage of and payment for pain management therapies without the use of opioids, including interventional pain therapies, and options to augment opioid therapy with other clinical and complementary, integrative health services to minimize the risk of substance use disorder, including in a hospital setting.

(2) Improving coverage of and payment for medication devices and non-pharmacological and non-pharmacological therapies approved or cleared by the Food and Drug Administration for the treatment of pain under alternative or augment to opioid therapy.

(3) Improving and disseminating treatment strategies for beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, and treatment strategies to address health disparities related to opioid use and opioid abuse treatment.

(4) Improving and disseminating treatment strategies for beneficiaries with comorbidities who require a consultation or management of pain with one or more specialists in pain management, mental health, or addiction treatment, including in a hospital setting.

(5) Educating providers on risks of co-administration of opioids and other drugs, particularly benzodiazepines.

(6) Ensuring appropriate case management for beneficiaries who transition between inpatient and outpatient hospital settings, or between opioid therapy to non-opioid therapy, and may include the use of care transition plans.

(7) Expanding outreach activities designed to educate providers of services and suppliers of devices under the Medicare program and individuals entitled to benefits under part A or under part B of such title on alternative, non-opioid therapies to manage and treat acute and chronic pain.

(8) Creating a beneficiary education tool on alternatives to opioids for chronic pain management.

(e) IMPACT ANALYSIS.—The impact analysis described in this subsection consists of an analysis of any potential effects implementing the options described in subsection (d) would have—

(1) on expenditures under the Medicare program; and

(2) on preventing or reducing opioid addiction for individuals receiving benefits under the Medicare program.

Subtitle J—Combating Opioid Abuse for Care in Hospitals

SEC. 6091. SHORT TITLE.

This subtitle may be cited as the “Combating Opioid Abuse for Care in Hospitals Act of 2018” or the “COACH Act of 2018”.

This page may contain content in another language. Please refer to the main content of the document for the primary language. The page number and date are included for reference purposes only.
(a) IN GENERAL.—Not later than July 1, 2019, the Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

(b) Developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

(1) medical professional organizations;
(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395aa));
(3) health care consumers or groups representing such consumers; and
(4) other entities determined appropriate by the Secretary.

(c) CONTENT.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection—

(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—
(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;
(B) ways to prevent, recognize, and treat opioid overdoses; and
(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

(A) the adverse effects of prolonged opioid use;
(B) non-opioid, evidence-based, non-pharmacological pain management treatments;
(C) monitoring programs for individuals who have been prescribed opioids; and
(D) the prescription of naloxone along with an initial opioid prescription.

(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include the use of the notification template described in paragraph (4)),

(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

(A) explains the risks and side effects associated with such opioid (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;
(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;
(C) encourages such individuals to talk to their health care providers about such alternatives;
(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual’s behalf, to acknowledge receipt of such notification template;
(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and
(F) includes any other information determined appropriate by the Secretary.

(B) Best practices for such hospitals to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;
(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;
(C) strategies to reduce long-term opioid prescriptions; and
(D) methods to identify such practitioners who may be over-prescribing opioids.

(3) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.

SEC. 6093. DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM.

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a technical expert panel for purposes of reviewing the quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1886(b) and amend such contract as necessary to provide for the establishment of such technical expert panel.

(2) REVIEW AND ASSESSMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a technical expert panel for purposes of reviewing the quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1886(b) and amend such contract as necessary to provide for the establishment of such technical expert panel.

(3) Notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

(A) explains the risks and side effects associated with such opioid (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;
(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;
(C) encourages such individuals to talk to their health care providers about such alternatives;
(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual’s behalf, to acknowledge receipt of such notification template;
(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and
(F) includes any other information determined appropriate by the Secretary.

(B) Best practices for such hospitals to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;
(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;
(C) strategies to reduce long-term opioid prescriptions; and
(D) methods to identify such practitioners who may be over-prescribing opioids.

(3) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.

SEC. 6094. TECHNICAL EXPERT PANEL ON REDUCING SURGICAL SETTING OPIOID USE; DATA COLLECTION ON PERIOPERATIVE OPIOID USE.

(1) TECHNICAL EXPERT PANEL ON REDUCING SURGICAL SETTING OPIOID USE.—

(I) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall convene a technical expert panel, including medical and surgical specialty societies, regional and national organizations, to provide recommendations on reducing opioid use in the inpatient and outpatient surgical settings and on best practices for pain management, including with respect to the following:

(A) Approaches that limit patient exposure to opioids during the perioperative period, including pre-surgical and post-surgical interventions, and that identify such patients at risk of opioid use disorder pre-operation.

(B) Shared decision making with patients and caregivers on pain management, including a review of payment to ensure payment under the Medicare program under title XVIII of the Social Security Act accounts for time spent on shared decision making.

(C) Education on the safe use, storage, and disposal of opioids.

(D) Prevention of opioid misuse and abuse after discharge.

(E) Development of a clinical algorithm to identify and treat at-risk, opiate-tolerant patients, thereby reducing the reliance on opioids for acute pain during the perioperative period.

(II) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing the following:

(A) The diagnosis-group related code identified by the Secretary as having the highest volume of surgeries.
(2) With respect to each of such diagnosis-related group codes so identified, a determination by the Secretary of the data that is both available and reported on opioid use following such surgeries, such as with respect to:
(A) surgical volumes, practices, and opioid prescribing patterns;
(B) opioid consumption, including—
(i) provider-specific data by 90-day episodes of care;
(ii) average daily dose at the hospital, including dosage greater than 90 milligram morphine equivalent;
(iii) post-discharge prescriptions and other combination drugs that are used before and after intervention; and
(iv) quantity and duration of opioid prescription at discharge; and
(v) quantity consumed and number of refills;
(C) regional anesthesia and analgesia practices, including pre-surgical and post-surgical injections;
(D) naloxone reversal;
(E) post-operative respiratory failure;
(F) information about storage and disposal; and
(G) such other information as the Secretary may specify.
(3) Recommendations for improving data collection on perioperative opioid use, including an analysis to identify and reduce barriers to collecting, reporting, and analyzing data described in paragraph (2), including barriers related to technological availability.

SEC. 6095. REQUIRING THE POSTING AND PERIODIC UPDATE OF OPIOID PRESCRIPTIONS—INFORMATION FOR MEDI-CA RE BENEFICIARIES.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall post on the public website of the Centers for Medicare & Medicaid Services all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids and applicable to opioid prescriptions for individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or enrolled under part B of such title of such Act (42 U.S.C. 1395w–104(a)(1)) is amended—
(1) by adding at the end the following new paragraph:

"(XV) opioid prescribing and opioid stewardship practices determined appropriate by the Secretary and in-home disposal;"

(b) UPDATE OF GUIDANCE.—
(1) PERIODIC UPDATE.—The Secretary shall, in consultation with the entities specified in paragraph (2), periodically (as determined appropriate by the Secretary) update guidance described in subsection (a) and revise the posting of such guidance on the website described in such subsection.

(2) CONSULTATION.—The entities specified in this paragraph are the following:

(A) Medical professional organizations.
(B) Providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395)).
(C) Health care consumers or groups representing such consumers.
(D) Other entities determined appropriate by the Secretary.

Subtitle K—Providing Reliable Options for Patients and Educational Resources

SEC. 6101. SHORT TITLE.

This subtitle may be cited as the “Providing Reliable Options for Patients and Educational Resources Act of 2018” or the “PROPER Act of 2018.”

SEC. 6102. REQUIRING MEDICARE ADVANTAGE PLANS AND PART D PRESCRIPTION DRUG PLANS TO INCLUDE INFORMATION ON THE SAFE DISPOSAL OF PRESCRIPTION DRUGS.

(a) MEDICARE ADVANTAGE.—Section 1852 of the Social Security Act (42 U.S.C. 1395ww–104) is amended by adding the following new paragraph:

"(aa) in the case of a MA–PD plan under part C, under such plan; and
(b) in the case of a prescription drug plan, under such plan and under parts A and B."

(b) REQUIRING MEDICARE ADVANTAGE PLANS TO PROVIDE INFORMATION ON THE SAFE DISPOSAL OF PRESCRIPTION DRUGS.

(a) MEDICARE ADVANTAGE.—Section 1852 of the Social Security Act (42 U.S.C. 1395ww–104) is amended by adding the following new paragraph:

"(ii) may include elements that promote—
(A) surgical volumes, practices, and opioid prescribing patterns determined appropriate by the Secretary and in-home disposal;"

(b) R DECISIONS IN HCAHPS.—Section 1886(o)(2)(B) of the Social Security Act (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding the following new clause:

"(aa) in the case of a MA–PD plan under part C, under such plan; and
(b) in the case of a prescription drug plan, under such plan and under parts A and B."

(c) PROVIDING INFORMACIÓN ON THE SAFE DISPOSAL OF PRESCRIPTION DRUGS.

SEC. 6103. REQUIRING MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS TO PROVIDE INFORMATION ON THE SAFE DISPOSAL OF PRESCRIPTION DRUGS.

This subtitle may be cited as the "Pro-

SEC. 6104. REVISIONS MEASURES USED UNDER THE HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS SURVEY RELATING TO PAIN MANAGEMENT.

(a) RESTRICTION ON THE USE OF PAIN QUESTIONS IN HCAHPS.—Section 1886(o)(2)(B)(vii) of the Social Security Act (42 U.S.C. 1395ww(o)(2)(B)(vii)) is amended by adding at the end the following new clause:

"(XII)(aa) With respect to a Hospital Consumer Assessment of Healthcare Providers and Systems survey (or a successor survey) conducted on or after January 1, 2020, such survey may not include questions about communication by hospital staff with an individual about such individual’s pain unless such questions take into account, as applicable, whether an individual experiencing pain was informed about risks associated with the use of opioids and about non-opioid alternatives for the treatment of pain;"

(b) RESTRICTION ON USE OF 2018 AND 2019 PAIN QUESTIONS IN THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.—Section 1886(o)(2)(B) of the Social Security Act (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding at the end the following new clause:

"(aa) in the case of a MA–PD plan under part C, under such plan; and
(b) in the case of a prescription drug plan, under such plan and under parts A and B."

SEC. 6111. FIGHTING THE OPIOID EPIDEMIC WITH SUNSHINE.

(a) INCLUSION OF INFORMATION REGARING PAYMENTS TO ADDITIONAL PRACTITIONERS.—

(1) IN GENERAL.—Section 1128C(h) of the Social Security Act (42 U.S.C. 1320a–7h(e)(6)) is amended—

"(A) in subparagraph (A), by adding at the end the following new clause:

"(ii) with respect to payments years beginning on or after January 1, 2021, shall provide for—

(1) the provision of information to the enrollee on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under section 1886(o)(2)(B), including information on drug Take-back programs that meet such require-
ments determined appropriate by the Secretary and information on in-home disposal; and

(II) cost-effective means by which an enrollee may so safely dispose of such drugs."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to information required to be sub-
mitted under section 1128C(h) of the Social Security Act (42 U.S.C. 1320a–7h) on or after January 1, 2022.
INFORMATION MADE PUBLICLY AVAILABLE.—

SEC. 7001. REPORT ON EFFECTS ON PUBLIC HEALTH OF SYNTHETIC DRUG USE.

(a) In General.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services, in coordination with the Surgeon General of the Public Health Service, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the health effects of new psychoactive substances, including synthetic drugs, used by adolescents and young adults.

(b) NEW PSYCHOACTIVE SUBSTANCE DEFINED.—For purposes of subsection (a), the term ‘new psychoactive substance’ means a controlled substance analogue (as defined in section 102(32) of the Controlled Substances Act (21 U.S.C. 802(32))).

SEC. 7002. FIRST RESPONDER TRAINING.

Section 546 of the Public Health Service Act (42 U.S.C. 295o) is amended—

(1) in subsection (c)—

(A) in paragraph (2), by striking ‘‘and’’ at the end;

(B) in paragraph (3), by striking the period and inserting ‘‘; and’’; and

(C) by adding at the end following:

‘‘(4) train and provide resources for first responders and members of other key community sectors on safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs to protect themselves from exposure to such drugs and respond appropriately when exposure occurs.’’;

(2) in subsection (d), by striking ‘‘and mechanisms for referral to appropriate treatment for an entity receiving a grant under this section’’ and inserting ‘‘mechanisms for referral to appropriate treatment, and safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs’’;

(3) in subsection (f)—

(A) in paragraph (3), by striking ‘‘and’’ at the end;

(B) in paragraph (4), by striking the period and inserting ‘‘; and’’; and

(C) by adding at the end following:

‘‘(5) the number of first responders and members of other key community sectors trained on safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs;’’

(4) by redesignating subsection (g) as subsection (h); and

(5) by inserting after subsection (f) the following:

‘‘(g) OTHER KEY COMMUNITY SECTORS.—In this section, the term ‘other key community sectors’ includes substance use disorder treatment and providers, and those agencies and institutions working with prison and jail populations and offender reentry programs, health care providers, correctional groups, pharmacies, community health centers, tribal health facilities, and mental health providers.’’; and

(6) in subsection (h), as so redesignated, by striking ‘‘for each of fiscal years 2017 through 2021’’ and inserting ‘‘$36,000,000 for each of fiscal years 2019 through 2023’’.

SEC. 7001. PILOT PROGRAM FOR PUBLIC HEALTH LABORATORIES TO DETECT FENTANYL AND OTHER SYNTHETIC OPIOIDS.

(a) GRANTS.—The Secretary of Health and Human Services (referred to in this section as the ‘‘Secretary’’) shall award grants to, or enter into cooperative agreements with, Federal, State, and local agencies to improve coordination between public health laboratories and laboratories operated by law enforcement agencies, such as Customs and Border Protection and the Drug Enforcement Administration, to improve detection of synthetic opioids, including fentanyl and its analogues, as described in subsection (b).

(b) DETECTION ACTIVITIES.—The Secretary, in consultation with the Director of the National Institutes of Health, and its analogues, to enhance—

(A) clinical diagnostics;

(B) postmortem data collection; and

(C) portable testing equipment utilized by law enforcement and public health officials; and

(2) procedures for the identification of new and emerging synthetic opioid formulations and procedures for reporting those findings to appropriate law enforcement agencies and Federal, State, and local public health laboratories and health departments, as appropriate.

(c) LABORATORIES.—The Secretary shall require recipients of grants or cooperative agreements under subsection (a) to—

(1) follow the best practices established under subsection (b) and have the appropriate capabilities to provide laboratory testing of controlled substances, such as synthetic opioids, including fentanyl and its analogues, for the purposes of aggregating and reporting public health information to Federal, State, and local public health officials, laboratories, and other entities the Secretary deems appropriate;

(2) work with law enforcement agencies and public health authorities, as practicable;

(3) provide early warning information to Federal, State, and local agencies and public health authorities regarding trends or other data related to the supply of synthetic opioids, including fentanyl and its analogues;

(4) provide bioovariance capabilities with respect to identifying trends in adverse health outcomes associated with non-fatal exposures; and

(5) provide diagnostic testing, as appropriate and practicable, for non-fatal exposures of emergency personnel, first responders, and others.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2019 through 2023.

SEC. 7002. INTERDEPARTMENTAL SUBSTANCE USE DISORDER INFORMATION DASHBOARD.

(a) ESTABLISHMENT.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall, in coordination with the Director of National Drug Control Policy, establish a committee, to be known as the Interdepartmental Substance Use Disorders Coordinating Committee (in this section referred to as the ‘‘Committee’’), to coordinate Federal activities related to substance use disorders.

(b) MEMBERSHIP.—(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or the designees of such representatives:

(A) The Secretary, who shall serve as the Chair of the Committee.

(B) The Attorney General of the United States.

(C) The Secretary of Labor.

(D) The Secretary of Housing and Urban Development.

(E) The Secretary of Education.

(F) The Secretary of Veterans Affairs.
and evaluate the extent to which Federal substance use disorder prevention and treatment strategies are aligned with State and local substance use disorder prevention and treatment strategies.

(4) make recommendations to the Secretary regarding any appropriate changes with respect to the activities and strategies described in paragraph (2); and

(5) make recommendations to the Secretary regarding public participation in decisions relating to substance use disorders and the public health consequences of opioid use disorder can be better integrated into such decisions; and

(6) make recommendations to ensure that substance use disorder research, services, support, and prevention activities across all Federal agencies are not unnecessarily duplicative.

(1) ANNUAL REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for the life of the Committee, the Committee shall publish on the Internet website of the Department of Health and Human Services, which may include the public information dashboard established pursuant to subsection (b), a report summarizing the activities carried out by the Committee pursuant to subsection (a) and any findings resulting from such activities.

(g) WORKING GROUPS.—The Committee may establish working groups for purposes of carrying out the duties described in subsection (e). Any such working group shall be composed of members of the Committee (or the designees of such members) and may hold such meetings as are necessary to enable the working group to carry out the duties delegated to the working group.

(h) FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee only to the extent that the provisions of such Act do not conflict with the requirements of this section.

(i) WORKING GROUP.—The committee may (1) through (3) of section (b), the Committee shall termi- nate on the date that is 6 years after the date on which the Committee is established under subsection (a).

SEC. 7023. NATIONAL MILESTONES TO MEASURE SUCCESS IN CURTAILING THE OPIOID CRISIS.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), in coordination with the Administrator of the Drug Enforcement Administration and the Director of the Office of National Drug Control Policy, shall develop or identify existing national indicators (referred to in this section as the “national milestones”) to measure success in curtailing the opioid crisis, with the goal of significantly reversing the incidence and prevalence of opioid misuse and abuse, and opioid-related morbidity and mortality rates within 5 years of such date of enactment.

(b) NATIONAL MILESTONES TO END THE OPIOID CRISIS.—The national milestones under subsection (a) shall include the following:

(1) Not fewer than 10 indicators or metrics to accurately and expeditiously measure progress in meeting the goals described in subsection (a), which shall, as appropriate, include, indicators or metrics related to—

(A) the number of fatal and non-fatal opioid overdoses; and

(B) the number of emergency room visits related to opioid misuse and abuse;

(2) the number of individuals in sustained recovery from opioid use disorder

(3) the number of infections associated with illicit drug use, such as HIV, viral hepatitis, and infective endocarditis, and available capacity for treating such infections;

(4) the number of providers prescribing medication-assisted treatment for opioid use disorder, including in clinics, community health centers, jails, and prisons;

(5) the number of individuals receiving treatment for opioid use disorder; and

(6) additional indicators or metrics, as appropriate, such as metrics pertaining to specific populations, including women and children, American Indians and Alaskan Natives, individuals living in rural and non-urban areas, and justice-involved populations, that would further clarify the progress made in addressing the opioid crisis.

(b) EXTENSION OF PERIOD.—If the Secretary determines that the goals described in subsection (a) will not be achieved with respect to any indicator or metric established under subsection (b) within 5 years of the date of enactment of this Act, the Secretary may extend the timeline for meeting such goal with respect to that indicator or metric. The Secretary shall include with any such extension a rationale for why additional time is needed and information on whether significant changes are needed in order to achieve such goal with respect to the indicator or metric.

(c) ANNUAL STATUS UPDATE.—Not later than one year after the date of enactment of this Act, the Secretary shall make available on Internet websites of the Department of Health and Human Services, and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, an update on the progress, including expected progress in the subsequent year, in achieving the goals described in subsection (a). Such update shall include the progress made in the first year or since the previous report, as applicable, in meeting each indicator or metric described in the national milestones.

SEC. 7024. STUDY ON PRESCRIBING LIMITS.

Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Attorney General of the United States, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the impact of Federal and State laws and regulations that limit the length, quantity, and duration of opioid prescriptions. Such report shall address—

(1) the impact of such limits on—

(A) the incidence and prevalence of overdose related to prescription opioids;

(B) the prevalence of opioid use disorders;

(C) the prevalence of opioid use disorder; and

(D) the medically appropriate use of, and access to, opioids, including any impact on travel expenses and pain management outcomes for patients, whether such limits are accompanied by significant rates of negative health outcomes, including suicide, and whether the impact of such limits differs based on the clinical indication for which opioids are prescribed;

(2) whether such limits lead to a significant increase in burden for prescribers of...
opioids or prescribers of treatments for opioid use disorder, including any impact on patient access to treatment, and whether any such burden is mitigated by any factors such as electronic prescribing or telemedicine; and
(3) the impact of such limits on diversion or misuse of any controlled substance in schedule II, III, or IV of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)).

Subtitle D—Ensuring Access to Quality Sober Living

SEC. 7031. NATIONAL RECOVERY HOUSING BEST PRACTICES.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following new section:

"SEC. 550. NATIONAL RECOVERY HOUSING BEST PRACTICES.

"(a) BEST PRACTICES FOR OPERATING RECOVERY HOUSING.—

"(1) IN GENERAL.—The Secretary, in consultation with the individuals and entities specified in paragraph (2), shall identify or facilitate the development of best practices, which may include model laws for implementing suggested minimum standards, for operating recovery housing.

"(2) CONSULTATION.—In carrying out the activities described in paragraph (1), the Secretary shall consult with, as appropriate—

"(A) relevant divisions of the Department of Health and Human Services, including the Substance Abuse and Mental Health Services Administration, the Office of Inspector General, the Indian Health Service, and the Centers for Medicare & Medicaid Services;

"(B) the Secretary of Housing and Urban Development;

"(C) States, or any political subdivisions of such States; tribal health departments, State Medicaid programs, and State Indian health agencies; and

"(D) representatives of health insurance issuers;

"(E) national accrediting entities and reputable providers of, and analysts of, recovery housing services, including Indian tribes, tribal organizations, and tribally designated housing entities that provide recovery housing services, as applicable;

"(F) individuals with a history of substance use disorder; and

"(G) other stakeholders identified by the Secretary.

"(b) IDENTIFICATION OF FRAUDULENT RECOVERY HOUSING OPERATORS.—

"(1) IN GENERAL.—The Secretary, in consultation with the individuals and entities described in paragraph (2), shall identify or facilitate the development of common indicators that could be used to identify potentially fraudulent recovery housing operators.

"(2) DISSEMINATION.—In carrying out the activities described in paragraph (1), the Secretary shall consult with, as appropriate, the individuals and entities specified in subsection (a) and the Attorney General of the United States.

"(3) REQUIREMENTS.—

"(A) PRACTICES FOR IDENTIFICATION AND REPORTING.—In carrying out the activities described in paragraph (1), the Secretary shall consider how law enforcement, public and private payers, and the public can best identify and report fraudulent recovery housing operators.

"(B) FACTORS TO BE CONSIDERED.—In carrying out the activities described in paragraph (1), the Secretary shall identify or develop indicators, which may include indicators related to—

"(i) unusual billing practices;

"(ii) the length of stays; and

"(iii) excessive levels of drug testing (in terms of cost or frequency); and

"(iv) unusually high levels of recidivism.

"(c) DISSEMINATION.—The Secretary shall, as appropriate, disseminate the best practices identified or developed under subsection (a) and the common indicators identified or developed under subsection (b) to—

"(1) State agencies, which may include the provision of technical assistance to State agencies, as applicable, to adopt or implement such best practices;

"(2) Indian tribes, tribal organizations, and tribally designated housing entities;

"(3) the Attorney General of the United States;

"(4) the Secretary of Labor;

"(5) the Secretary of Housing and Urban Development;

"(6) State and local law enforcement agencies;

"(7) health insurance issuers;

"(8) recovery housing entities; and

"(9) the public.

"(d) REQUIREMENTS.—In carrying out the activities described in subsections (a) and (b), the Secretary, in consultation with appropriate individuals and entities described in subsections (a)(2) and (b)(2), shall consider how law enforcement and other agencies to support recovery and prevent relapse, recidivism, or overdose (including overdose death), including—

"(i) by improving access and adherence to treatments, including medication-assisted treatment;

"(ii) on how best to disseminate information on pain care and epidemiological data related to acute and chronic pain; and

"(iii) how to expand the networks of support and partnerships between public entities and private entities to expand collaborative, cross-cutting research.

"(3) The term 'tribally designated housing entity' has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

"(4) The term 'tribally designated housing entity' includes programs, projects, facilities, or services which are operated by an Indian tribe or tribal organization and that are operated consistent with the Department of Health and Human Services (in this section referred to as the "Secretary"), in consultation with appropriate stakeholders, to treat a patient with a history of opioid use disorder, an expert in electronic health records, an expert in the confidentiality of patient health information and records, and a health care provider to facilitate the development of best practices regarding—

"(A) the circumstances under which information that a patient has provided to a health care provider regarding such patient's history of opioid use disorder should, only at the patient's request, be prominently displayed in the medical record (including electronic health records) of such patient; and

"(B) what constitutes the patient's request for the purpose described in subparagraph (A).

"(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $3,000,000 for the period of fiscal years 2019 through 2021.

Subtitle E—Improving Cutting Edge Research

SEC. 7041. UNIQUENESS RESEARCH INITIATIVES.

Section 402l(n)(1) of the Public Health Service Act (42 U.S.C. 288l(n)(1)) is amended—

(1) in subparagraph (A), by striking "or";

(2) in subparagraph (B), by striking the period and inserting "; or"; and

(3) by adding at the end the following:

"(C) high risk research that fosters scientific creativity and increases fundamental biological understanding leading to the prevention, diagnosis, or treatment of diseases and disorders or research urgently required to respond to a public health threat.

"SEC. 7042. PAIN RESEARCH.

Section 242(q) of the Public Health Service Act (42 U.S.C. 284q(b)) is amended—

(1) in paragraph (5)—

"(A) in subparagraph (A), by striking "and treatment" and the term "treatment" and inserting "treatment, and management of pain and diseases and disorders associated with pain, including information on best practices or the utilization of non-pharmacologic treatments, non-addictive medical products, and other drugs of devices approved or cleared by the Food and Drug Administration";

"(B) in subparagraph (B), by striking "on the symptoms and causes of pain;" and inserting the following:

"(i) the symptoms and causes of pain, including the identification of relevant biomarkers and screening models and the epidemiology of acute and chronic pain, including with respect to non-pharmacologic treatments, non-addictive medical products, and other drugs or devices approved or cleared by the Food and Drug Administration; and

"(ii) the diagnosis, prevention, treatment, and management of acute and chronic pain, including with respect to non-pharmacologic treatments, non-addictive medical products, and other drugs or devices approved or cleared by the Food and Drug Administration; and

"(iii) risk factors for, and early warning signs of, substance use disorders in populations with acute and chronic pain; and"

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

"(6) REPORT.—The Secretary shall ensure that recommendations and actions taken by the Director with respect to the topics described in the meetings described in paragraph (4) are included in appropriate reports to Congress.

Subtitle F—Jessie's Law

SEC. 7051. INCLUSION OF OPIOID ADDICTION HISTORICAL TORY IN PATIENT RECORDS.

(a) BEST PRACTICES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary"), in consultation with appropriate stakeholders, shall identify or develop indicators of a patient with a history of opioid use disorder, an expert in electronic health records, an expert in the confidentiality of patient health information and records, and a health care provider to facilitate the development of best practices regarding—

"(A) the circumstances under which information that a patient has provided to a health care provider regarding such patient's history of opioid use disorder should, only at the patient's request, be prominently displayed in the medical record (including electronic health records) of such patient; and

"(B) what constitutes the patient's request for the purpose described in subparagraph (A).

(2) DISSEMINATION.—The Secretary shall disseminate the best practices developed under paragraph (1) to health care providers and State agencies.

(b) REQUIREMENTS.—In identifying or facilitating the development of best practices under subsection (a), as applicable, the Secretary, in consultation with appropriate stakeholders, shall consider—

"(1) the potential for addiction relapse or overdose, including overdose death, when opioid medications are prescribed to a patient recovering from opioid use disorder;

"(2) the benefits of displaying information about a patient's opioid use disorder history
in a manner similar to other potentially lethal medical concerns, including drug allergies and contraindications.

(3) The importance of prominently displaying a consent form before a patient signs it for the use of a patient record when a physician or medical professional is prescribing medication, including methods for avoiding alert fatigue in providers.

(4) The importance of a variety of appropriate medical professionals, including physicians, nurses, and pharmacists, having access to patient records for certain purposes.

(a) The Secretary of Health and Human Services shall develop and disseminate model programs and materials described in subsection (a) and required under this section to—

(1) periodically review and update the model program and materials identified or developed under subsection (a); and

(2) disseminate such updated programs and materials to the individuals described in subsection (a)(1).

(b) USE OF MATERIAL.—For the purposes of carrying out paragraph (a), the Secretary shall—

(1) periodically review and update the model program and materials identified or developed under subsection (a); and

(2) disseminate such updated programs and materials to the individuals described in subsection (a)(1).

(c) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials described in paragraph (a), the Secretary shall solicit the input of relevant stakeholders.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

(1) $1,000,000 for fiscal year 2019;

(2) $2,000,000 for each of fiscal years 2020 and 2021; and

(3) $3,000,000 for each of fiscal years 2022 and 2023.

Subtitle G—Protecting Pregnant Women and Their Infants

SEC. 7061. REPORT ON ADDRESSING MATERNAL AND INFANT HEALTH IN THE OPPIOID CRISIS

(a) In general.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services, in cooperation with relevant stakeholders, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

(1) information on opioid, non-opioid, and non-pharmacologic pain management practices during pregnancy and after pregnancy;

(2) recommendations for increasing public awareness and education about substance use disorders, including opioid use disorders, during and after pregnancy, including available treatment resources in urban and rural areas;

(3) recommendations to prevent, identify, and reduce substance use disorders, including opioid use disorder, among women and their infants; and

(4) an identification of areas in need of further research on acute and chronic pain management during and after pregnancy.

(b) NO ADDITIONAL FUNDS.—No additional funds are authorized to be appropriated for purposes of carrying out subsection (a).

SEC. 7062. PROTECTING MOMS AND INFANTS

(a)/report.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that includes—

(A) data on—

(i) the incidence and prevalence of neonatal abstinence syndrome, and

(ii) the incidence and prevalence of infant mortality; and

(B) additional information or data, as appropriate, the recommendations in the report entitled Protecting Our Infants Act: Final Strategy issued by the Department of Health and Human Services in 2017 and 2018.

(b) SUPPORT OF PARTNERSHIPS BY CENTER FOR SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the Public Health Service Act (42 U.S.C. 290bb(b)) is amended—

(1) by inserting a semicolon at the end;

(2) in paragraph (4), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(15) in cooperation with relevant stakeholders, and in collaboration with the Centers for Disease Control and Prevention, develop educational materials for clinicians to use with pregnant women for shared decision making regarding pain management and the prevention of substance use disorders during pregnancy.”;

(b) GUIDELINES AND RECOMMENDATIONS BY CENTER FOR SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the Public Health Service Act (42 U.S.C. 290bb(b)) is amended—

(1) in paragraph (13), by striking “and” and inserting “and” at the end;

(2) in paragraph (14), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(15) in cooperation with the Secretary, implement and disseminate, as appropriate, the recommendations in the report entitled Protecting Our Infants Act: Final Strategy issued by the Department of Health and Human Services in 2017 and 2018.”.

(c) SUPPORT OF PARTNERSHIPS BY CENTER FOR SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the Public Health Service Act (42 U.S.C. 290bb(b)) is amended—

(1) in subsection (a)–

(A) by amending paragraph (1) to read as follows:

“(1) to collect, analyze, and make available data and information on prenatal smoking and alcohol and other substance abuse and misuse, including—

(A) data on—

(i) the incidence, prevalence, and implications of such activities; and

(B) the incidence and prevalence of implications and outcomes, including neonatal abstinence syndrome, and other health outcomes associated with such activities; and

(ii) additional information or data, as appropriate, the recommendations in the report entitled Protecting Our Infants Act: Final Strategy issued by the Department of Health and Human Services in 2017 and 2018; and

(2) in paragraph (14), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(15) in cooperation with relevant stakeholders, and through public-private partnerships, encourage education about substance use disorders for pregnant women and health care providers who treat pregnant women and their babies.”.

SEC. 7063. EARLY INTERVENTIONS FOR PREGNANT WOMEN AND INFANTS

(a) DEVELOPMENT OF EDUCATIONAL MATERIALS.—

(1) IN GENERAL.—The Secretary, in consultation with the Committee on Substance Abuse Prevention, shall develop, implement, and disseminate, as appropriate, the recommendations in the report entitled Protecting Our Infants Act: Final Strategy issued by the Department of Health and Human Services in 2017 and 2018.

(b) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.—Section 507(b) of the Public Health Service Act (42 U.S.C. 290bb(b)) is amended by striking “$16,900,000 for each of fiscal years 2017 through 2019” and inserting “$16,900,000 for each of fiscal years 2019 through 2023”.

SEC. 7064. PRENATAL AND POSTNATAL HEALTH

Section 317L of the Public Health Service Act (42 U.S.C. 247t–13) is amended—

(1) in subsection (a)–

(A) by amending paragraph (1) to read as follows:

“(1) to collect, analyze, and make available data and information on prenatal smoking and alcohol and other substance abuse and misuse, including—

(A) data on—

(i) the incidence, prevalence, and implications of such activities; and

(B) the incidence and prevalence of implications and outcomes, including neonatal abstinence syndrome, and other health outcomes associated with such activities; and

(2) in paragraph (14), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(15) in cooperation with relevant stakeholders, and through public-private partnerships, encourage education about substance use disorders for pregnant women and health care providers who treat pregnant women and their babies.”.

SEC. 7065. PREGNANCY

Section 200 of the Public Health Service Act (42 U.S.C. 290a–9) is amended—

(1) in subsection (a)–

(A) by amending paragraph (1) to read as follows:

“(1) the incidence, prevalence, and implications of such activities; and

(B) the incidence and prevalence of implications and outcomes, including neonatal abstinence syndrome, and other health outcomes associated with such activities; and

(2) in paragraph (14), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

“(15) in cooperation with relevant stakeholders, and through public-private partnerships, encourage education about substance use disorders for pregnant women and health care providers who treat pregnant women and their babies.”.
poses described in subparagraph (G); and

(b) Secretary shall reserve—

(A) funds available to carry out subparagraph (A), the

(R) by striking “illegal drug use,” and inserting “substance abuse and misuse”; and

(E) by adding at the end the following:

(2) in subsection (b), by inserting “tribal entities, and Federal, tribal, and local governments;”;

(3) by redesignating subsection (c) as subsection (d);

(4) by inserting after subsection (b) the following:

(c) COORDINATING ACTIVITIES.—To carry out this section, the Secretary may—

(1) provide technical and consultative assistance to entities receiving grants under subsection (b);

(2) ensure a pathway for data sharing between States, tribal entities, and the Centers for Disease Control and Prevention;

(3) ensure data collection under this section is consistent with applicable State, Federal, and tribal privacy laws; and

(4) the National Coordinator for Health Information Technology, as appropriate, to assist States and Tribes in implementing systems that use standards recognized by such National Coordinator, as such recognized standards are available, in order to facilitate interoperability between such systems and health information technologies, including certified health information technology:

and

(5) in subsection (d), as so redesignated, by striking “2001 through 2005” and inserting “2019 through 2023”.

SEC. 7065. PLANS OF SAFE CARE.

(a) IN GENERAL.—Section 105(a) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106(a)) is amended by adding at the end the following:

“(7) GRANTS TO STATES TO IMPROVE AND COORDINATE THEIR RESPONSE TO ENSURE THE SAFETY, PERMANENCY, AND WELL-BEING OF INFANTS AFFECTED BY SUBSTANCE USE.—

“(A) PROGRAM AUTHORIZED.—The Secretary is authorized to make grants to States for the purpose of assisting child welfare agencies, social services agencies, substance use disorder treatment agencies, hospitals with labor and delivery units, medical staff, public health and mental health agencies, and maternal and child health agencies to facilitate collaboration in developing, updating, implementing, and monitoring plans of safe care described in section 106(b)(2)(B)(iii).

Section 112(a)(2) shall not apply to the program authorized under this paragraph.

(B) DISTRIBUTION OF FUNDS.—

(1) OF THE amounts made available to carry out subparagraph (A), the Secretary shall reserve—

(I) no more than 3 percent for the purposes described in section 106(b)(2)(B)(iii); and

(II) up to 3 percent for grants to Indian Tribes and tribal organizations to address

the needs of infants born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder (as determined by hospitals, insurance claims, claims submitted to the State Medicaid program, or other records), if available and to the extent practicable, and

(II) the number of infants identified, for whom a plan of safe care was developed, and for whom a referral was made for appropriate services, as reported under section 106(d)(18);

(II) the challenges the State faces in developing, implementing, and monitoring plans of safe care in accordance with section 106(b)(2)(B)(iii);

(III) the State’s lead agency for the grant program and how that agency will coordinate with relevant State entities and programs, including the child welfare agency, the substance use disorder treatment agency, the health care providers, the public health and mental health agencies, programs funded by the Substance Abuse and Mental Health Services Administration, and other services and programs available in the State to effectively carry out any plan of safe care developed, including identification of needed treatment, and other services and programs to ensure the well-being of young children and their families affected by substance use disorder, such as programs carried out under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.) and comprehensive early childhood development services and programs such as Head Start programs;

(III) a description of how the State plans to use funds for activities described in subparagraph (D) for the purpose of ensuring State compliance with requirements under clauses (ii) and (iii) of section 106(b)(2)(B)(i) and

(III) an assurance that the State will comply with requirements to refer a child identified as substance-exposed to early intervention services as required pursuant to a grant under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.).

(D) USF OF FUNDS.—Funds awarded to a State under this paragraph may be used for the following activities, which may be carried out by the State directly, or through grants or subgrants, contracts, or cooperative agreements:

(I) improving State and local systems with respect to the development and implementation of plans of safe care, which—

(II) shall include parent and caregiver engagement, as required under section 106(b)(2)(B)(ii)(I), regarding available treatment and service options, which may include substance-specific care for pregnant, perinatal, and postnatal women; and

(II) may include activities such as—

(aa) increasing access to, or providing, training or educational resources, or protocols for the administration or development of evidence-based and validated screening tools for infants who may be affected by substance use disorder or fetal alcohol spectrum disorder and pregnant, perinatal, and postnatal women; and

(bb) improving assessments used to determine the needs of the infant and family;

(cc) improving ongoing case management services;

(dd) improving access to treatment services, which may be prior to the pregnant woman’s delivery date; and

(II) keeping families safely together when it is in the best interest of the child.

(II) improving programs, procedures, or protocols in consultation and coordination with health professionals, public and private health facilities, and substance use disorder treatment agencies to ensure that—

(bb) The assessment for child protective services is made in a timely manner, as required under section 106(b)(2)(B)(i) (II);

(bb) a plan of safe care is in place, in accordance with section 106(b)(2)(B)(ii)(I), before the infant is discharged from the birth or health care facility; and
“(III) such health and related agency professionals are trained on how to follow such protocols and are aware of the supports that may be provided under a plan of safe care.

“(IV) such professionals and health system leaders, child welfare workers, substance use disorder treatment agencies, and other related professionals such as home visiting agencies, and law enforcement in relevant topics including—

“(I) State mandatory reporting laws established under section 106(b)(2)(B)(i) and the referral process required for notification to child protective services when child abuse or neglect reporting is not mandated;

“(II) the clinical guidance about treating substance use disorder, including existing electronic medical records, technology for improved data collection and monitoring to measure the outcomes achieved through services for the treatment of substance use disorder, including for the treatment of substance use disorder, and implications of prenatal exposure;

“(III) the clinical guidance about treating substance use disorder in pregnant and postpartum women;

“(IV) appropriate screening and interventions for infants affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder and the requirements under section 106(b)(2)(B)(i) and clause (iii) of paragraphs (B)(ii) of this subparagraph, in areas which may include—

“(1) developing a comprehensive, multi-disciplinary assessment and intervention process for infants, pregnant women, and their families who are affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder, that includes meaningful engagement with and takes into account the unique needs of each family and addresses differences between medically supervised and non-medically supervised discharge described in subparagraph (B)(ii) and clause (ii) of this subparagraph, including—

“(1) developing a comprehensive, multi-disciplinary assessment and intervention process for infants, pregnant women, and their families who are affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder, that includes meaningful engagement with and takes into account the unique needs of each family and addresses differences between medically supervised discharge described in subparagraph (B)(ii) and clause (ii) of this subparagraph, including—

“(I) enhancing States’ understanding of requirements and flexibilities under the law, including by clarifying key terms;

“(II) addressing the identified challenges with developing, implementing, and monitoring plans of safe care, including those reported under subparagraph (C)(ii)(I); and

“(III) disseminating best practices on implementation of plans of safe care, on such topics as differential response, collaboration and coordination, and identification and delivery of services for different populations, while recognizing needs of different populations and varying community approaches across States; and

“(IV) helping States improve the long-term safety and well-being of young children and their families;

“(V) supporting States efforts to develop information technology systems to manage plans of safe care; and

“(VI) preparing the Secretary’s report to Congress described in subparagraph (F).

“(H) SUNSET.—The authority under this paragraph shall sunset on September 30, 2023.

“(b) REPEAL.—The Abandoned Infantes Assistance Act of 1988 (42 U.S.C. 5171aa et seq.) is repealed.

“SEC. 7071. LOAN REPAYMENT PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT WORKFORCE.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall carry out a program under which—

“(1) the Secretary enters into agreements with individuals to make payments in accordance with subsection (b) on the principal of and interest on any eligible loan; and

“(2) the individuals each agree to the requirements of service in substance use disorder treatment employment, as described in subsection (d).

“(b) PAYMENTS.—For each year of obligated service by an individual pursuant to an agreement under subsection (a), the Secretary shall pay to such individual—

“(1) the number who received services while in the care of their birth parents;

“(2) the number who receive post-reunification services within 1 year after a reunification has occurred; and

“(3) the number who experienced a return to out-of-home care within 1 year after reunification;

“(c) ELIGIBLE LOANS.—The loans eligible for repayment under this section are each of the following:

“(1) Any loan for education or training for a substance use disorder treatment employment.

“(2) Any loan under part E of title VIII (relating to nursing student loans).
(e) Ineligibility for Double Benefits.—No borrower may, for the same service, receive a reduction of loan obligations or a loan repayment under both—

(1) this section; and

(2) any Federally supported loan forgiveness program, including under section 338B, 338I, or 460 of this Act, or section 428J, 428L, 455(m), or 460 of the Higher Education Act of 1965.

(f) Breach.—

(1) LIQUIDATED DAMAGES FORMULA.—The Secretary may establish a liquidated damages formula to be used in the event of a breach of an agreement entered into under subsection (a). (2) LIMITATION.—The failure by an individual to complete the full period of service obligated pursuant to such an agreement, taken alone, shall not constitute a breach of the agreement, so long as the individual completed in good faith the years of service for which payments were made to the individual.

(3) The term ‘municipality’ means a city, town, or other public body created by or pursuant to State or local laws; and

(4) The term ‘municipality’ means a city, town, or other public body created by or pursuant to State or local laws; and

(g) ADDITIONAL CRITERIA.—The Secretary—

(1) may establish such criteria and rules to carry out this section as the Secretary determines are needed and in addition to the criteria and rules specified in this section; and

(2) shall give notice to the committees specified in subsection (h) of any criteria and rules so established.

(i) DEFINITION.—In this section:

(1) LIQUIDATED DAMAGES FORMULA.—The Secretary may establish a liquidated damages formula to be used in the event of a breach of an agreement entered into under subsection (a).

(2) LIMITATION.—The failure by an individual to complete the full period of service obligated pursuant to such an agreement, taken alone, shall not constitute a breach of the agreement, so long as the individual completed in good faith the years of service for which payments were made to the individual. (3) The term ‘municipality’ means a city, town, or other public body created by or pursuant to State or local laws; and

(4) The term ‘municipality’ means a city, town, or other public body created by or pursuant to State or local laws; and

(h) NOTIFICATION.—Not later than 5 years after the date of enactment of this section, and every other year thereafter, the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on—

(1) the number and location of borrowers who have qualified for loan repayments under this section; and

(2) the impact of this section on the availability of substance use disorder treatment employees nationally and in shortage areas and counties described in subsection (d).

(i) IN GENERAL.—Any service described in subsection (a) that a participant provides under the Scholarship Program or the Loan Repayment Program (referred to in this section as a ‘participant’) is assigned under section 333 may direct such participant to provide services as a behavioral or mental health professional at a school or other community-based setting located in a health professional shortage area.

(2) LIMITATION.—The Secretary may impose a limitation on the number of hours of service described in subsection (a) that a participant may credit towards completing obligated service requirements under the Scholarship Program or the Loan Repayment Program, subject to any limitation imposed under paragraph (2). (3) RULE OF CONSTRUCTION.—The authorization of loans under subsection (a) shall be notwithstanding any other provision of this subpart or subpart II.

SEC. 7072. CLARIFICATION REGARDING SERVICE IN SCHOOLS AND OTHER COMMUNITY-BASED SETTINGS.

(4) A DDITIONAL CRITERIA.—The Secretary—

(a) SCHOLARSHIP TO COMMUNITY-BASED SETTINGS.—An entity to which a participant in the Scholarship Program or the Loan Repayment Program (referred to in this section as a ‘participant’) is assigned under section 333 may direct such participant to provide services as a behavioral or mental health professional at a school or other community-based setting located in a health professional shortage area.

(b) OBLIGATED SERVICE.—

(1) IN GENERAL.—Any service described in subsection (a) that a participant provides under the Scholarship Program or the Loan Repayment Program (referred to in this section as a ‘participant’) is assigned under section 333 may direct such participant to provide services as a behavioral or mental health professional at a school or other community-based setting located in a health professional shortage area.

(2) LIMITATION.—The Secretary may impose a limitation on the number of hours of service described in subsection (a) that a participant may credit towards completing obligated service requirements under the Scholarship Program or the Loan Repayment Program, subject to any limitation imposed under paragraph (2).

(a) ADDITIONAL CRITERIA.—The Secretary may impose a limitation on the number of hours of service described in subsection (a) that a participant may credit towards completing obligated service requirements under the Scholarship Program or the Loan Repayment Program, subject to any limitation imposed under paragraph (2). (3) RULE OF CONSTRUCTION.—The authorization of loans under subsection (a) shall be notwithstanding any other provision of this subpart or subpart II.

SEC. 7073. PROGRAMS FOR HEALTH CARE WORKERS.

(a) PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.—Section 759 of the Public Health Service Act (42 U.S.C. 254f et seq.) is amended—

(1) by striking paragraph (1), (2), (3), (5), and (F) by striking paragraph (5) and inserting the following—

“(5) recent findings, developments, and advancements in pain care research and the development of pain care includes—

(a) the development of non-addictive medical products and non-pharmacologic treatments intended to treat pain; and

(b) the dangers of opioid abuse and misuse, detection of early warning signs of opioid use disorders (which may include best practices related to screening for opioid use disorders, training in pain management, brief intervention, and referral to treatment), and safe disposal options for prescription medications (including such options provided by law enforcement or other innovative deactivation mechanisms).”;

(3) in subsection (d), by inserting “prevention,” after “diagnosis,” and (4) in subsection (e), by striking “2010 through 2012” and inserting “2019 through 2023”;

(b) MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING PROGRAM.—Section 756 of the Public Health Service Act (42 U.S.C. 294e–1) is amended—

(1) in paragraph (a), by inserting “, trauma,” after “focus on child and adolescent mental health”; and

(2) in subsection (e), by striking “treatment-refined care” before “substance use disorder prevention and treatment services”; and

(3) in subsection (f), by striking “2018 through 2022” and inserting “2019 through 2023”.

Subtitle I—Preventing Overdoses While in Emergency Rooms

SEC. 7081. PROGRAM TO SUPPORT COORDINATION AND CONTINUATION OF CARE FOR DRUG OVERDOSE PATIENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall identify or facilitate the development of best practices for—

(1) emergency treatment of known or suspected drug overdose; (2) the use of recovery coaches, as appropriate, to encourage individuals who experience a non-fatal overdose to seek treatment for substance use disorder and to support coordination and continuation of care; (3) coordination and continuation of care and medication, including, as appropriate, through referrals, of individuals after a drug overdose; and

(4) the provision or prescribing of overdose reversal medication, as appropriate.

(b) GRANT ESTABLISHMENT AND PARTICIPATION.—

(1) IN GENERAL.—The Secretary shall award grants on a competitive basis to eligible entities to support implementation of voluntary programs for care and treatment of individuals after a drug overdose, as appropriate, which may include implementation of the best practices described in subsection (a).

(2) ELIGIBLE ENTITY.—In this section, the term “eligible entity” means—

(A) a State substance abuse agency;

(B) an Indian Tribe or tribal organization; or

(C) an entity that offers treatment or other services for individuals in response to, or following, drug overdoses or a drug overdose, such as an emergency department, in coordination with a State substance abuse agency.

(3) APPLICATION.—An eligible entity desiring a grant under this section shall submit an application to the Secretary at such time and in such manner as the Secretary may require, that includes—
(A) evidence that such eligible entity carries out, or is capable of contracting and coordinating with other community entities to carry out, the activities described in paragraph (A); and

(B) evidence that such eligible entity will work with a recovery community organization to recruit, train, hire, mentor, and support personnel and fulfill the requirements described in paragraph (4)(A); and

(C) such additional information as the Secretary may require.

(4) USE OF GRANT FUNDS.—(A) An eligible entity awarded a grant under this section shall use such funds to—

(a) hire or utilize recovery coaches to help support recovery, including by—

(i) connecting patients to a continuum of care services as—

(I) treatment and recovery support programs;

(II) peer support networks;

(III) recovery community organizations;

(IV) health care providers, including physicians and other providers of behavioral health services and primary care; and

(V) education and training providers;

(VI) employers;

(VII) the administration of all drugs or devices approved or cleared under title 21 of the United States Code, including culturally appropriate services, including the administration of all drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat substance use disorders and subsequent continuation of, or referral for, treatment for patients with a substance use disorder who have experienced a non-fatal drug overdose, in order to support long-term treatment, prevent relapse, and reduce recidivism and future overdose; and

(b) establish integrated models of care for individuals who have experienced a non-fatal drug overdose, including patient assessment, follow up, and transportation to and from treatment facilities.

(5) ADDITIONAL PERMISSIBLE USE.—In addition to the uses described in paragraph (4)(A) of this section, a grant awarded under this section may be used, directly or through contractual arrangements, to provide—

(a) all drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat substance use disorders or reverse overdose, pursuant to Federal and State law;

(b) withdrawal and detoxification services that include patient evaluation, stabilization, and preparation for treatment of substance use disorder, including treatment described in subparagraph (A), as appropriate; or

(c) mental health services provided by a certified professional who is licensed and qualified by education, training, or experience to assess the psychosocial background of patients, to contribute to the appropriate treatment plan for patients with substance use disorder, and to monitor patient progress.

(6) PREVENTION.—In awarding grants under this section, the Secretary shall give preference to those applications that meet any or all of the following criteria:

(A) The eligible entity is a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act (42 U.S.C. 1395xv(mm)(1))), a low volume hospital (as defined in section 1886(d)(12)(C)(i) of such Act (42 U.S.C. 1395ww(d)(12)(C)(i))), a sole community hospital (as defined in section 1886(d)(1)(D)(i) of such Act (42 U.S.C. 1395ww(d)(1)(D)(i))) or a hospital that receives disproportionate share hospital payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

(B) The eligible entity is located in a State with an age-adjusted rate of drug overdose deaths that is above the national overdose mortality rate, as determined by the Director of the Centers for Disease Control and Prevention, or under the jurisdiction of an Indian Tribe with an age-adjusted rate of drug overdose deaths that is above the national overdose mortality rate, as determined through appropriate mechanisms as determined by the Secretary in consultation with Indian Tribes.

(C) The eligible entity demonstrates that recovery coaches will be placed in both health care settings and community settings.

(7) PERIOD OF GRANT.—A grant awarded to an eligible entity under this section shall be for a period of not more than 5 years.

(8) DEFINITIONS.—In this section:

(A) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘‘Indian Tribe’’ and ‘‘tribal organization’’ have the meaning given the terms ‘‘Indian tribe’’ and ‘‘tribal organization’’ in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5394).

(B) RECOVERY COACH.—the term ‘‘recovery coach’’ means an individual—

(a) with knowledge of, or experience with, recovery from a substance use disorder; and

(b) who has completed training from, and is determined to be in good standing by, a recovery services organization capable of conducting training and making such determination.

(C) RECOVERY COMMUNITY ORGANIZATION.—The term ‘‘recovery community organization’’ has the meaning given such term in section 574(a) of the Public Health Service Act (42 U.S.C. 290ee–2(a)).

(d) REPORTING REQUIREMENTS.—Each eligible entity awarded a grant under this section shall submit to the Secretary an annual report for each year for which the entity has received such grant that includes information on—

(A) the number of individuals treated by the entity for non-fatal overdoses, including the number of non-fatal overdoses where overdose reversal medication was administered;

(B) the number of individuals administered medication-assisted treatment by the entity; and

(C) the number of individuals referred by the entity to other treatment facilities after a non-fatal overdose, the types of such other treatment facilities, the number of such individuals admitted to such other facilities pursuant to such referrals; and

(D) the frequency and number of patients with treatment or admissions for non-fatal overdoses and evidence of relapse related to substance use disorder.
(1) utilizing information from recipients of a grant under subsection (a) or (b) that have successfully implemented alternatives to opioids programs;

(2) evaluating or facilitating the development of best practices on the use of alternatives to opioids, which may include pain-management strategies that involve non-addictive medications, non-pharmacologic treatments, and technologies or techniques to identify patients at risk for opioid use disorder;

(3) identifying or facilitating the development of best practices on the use of alternatives to opioids to target common painful conditions and include certain patient populations, such as patients, pregnant women, and children; and

(4) disseminating information on the use of alternatives to opioids to providers in acute care settings, which may include emergency departments, outpatient clinics, critical access hospitals, Federally qualified health centers, Indian Health Service health facilities, and tribal hospitals.

(3) recommendations for broader implementation of pain management strategies that encourage the use of alternatives to opioids in hospitals, emergency departments, and other acute care settings;

(2) strategies for the prevention and treatment of, and recovery from, substance use disorders, which resources may include information on—

(1) the neurology and pathology of substance use disorders;

(2) advanced care in the treatment of substance use disorders;

(3) techniques and best practices to support recovery from substance use disorders;

(4) strategies for the prevention and treatment of, and recovery from substance use disorders across patient populations; and

(5) other topic areas that are relevant to the objectives of the section (a) of this subsection.

(d) GEOGRAPHIC DISTRIBUTION.—In awarding cooperative agreements under subsection (a), the Secretary shall account for significant regional differences among eligible entities and shall make an effort to ensure geographic distribution.

(e) EVALUATION.—The Secretary shall evaluate each project carried out by an entity receiving an award under this section and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

(f) FUNDING.—There is authorized to be appropriated $10,000,000 for each of fiscal years 2019 through 2023.

SEC. 7102. YOUTH PREVENTION AND RECOVERY INITIATIVE.

(a) SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN, ADOLESCENTS, AND YOUNG ADULTS.—Section 514 of the Public Health Service Act (42 U.S.C. 290bb-7) is amended—

(1) in the section heading, by striking “CHILDREN AND ADOLESCENTS” and inserting “CHILDREN, ADOLESCENTS, AND YOUNG ADULTS”;

(2) in subsection (a), by striking “children, including” and inserting “children, adolescents, and young adults, including”;

and

(3) by striking “children and adolescents” each place it appears and inserting “children, adolescents, and young adults”.

(b) RESEARCH.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), except as otherwise provided, in consultation with the Secretary of Education and other heads of agencies, including the Assistant Secretary for Mental Health and Substance Use and the Administrator of the Health Resources and Services Administration, as appropriate, shall establish a resource center to provide technical support to recipients of grants under section (c).

(c) YOUTH PREVENTION AND RECOVERY INITIATIVE.

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall administer a program to provide support for communities to support the prevention and treatment of, and recovery from, substance use disorders for children, adolescents, and young adults.

(2) DEFINITIONS.—In this subsection—

(A) ELIGIBLE ENTITY.—The term “eligible entity” means—

(i) a State educational agency that is seeking to establish or expand substance use prevention or recovery support services at one or more high schools;

(ii) a State educational agency;

(iii) an institution of higher education (or consortia of such institutions), which may include a recovery program at an institution of higher education;

(iv) a local board or one-stop operator;

(v) a nonprofit organization with appropriate expertise in providing services or programs for children, adolescents, or young adults, excluding a school;

(vi) a State, political subdivision of a State, Indian tribe, or tribal organization; or

(vii) a high school or dormitory serving high school students that receives funding from the Bureau of Indian Education.

(B) FOSTER CARE.—The term “ foster care” has the meaning given such term in section 1355.20(a) of title 45, Code of Federal Regulations (or any successor regulations).

(C) HIGH SCHOOL.—The term “high school” has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(D) HOMELESS YOUTH.—The term “homeless youth” has the meaning given the term “homeless children or youths” in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a).

(E) INDIAN TRIBAL ORGANIZATION.—The terms “Indian tribe” and “tribal organization” have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(F) INSTITUTION OF HIGHER EDUCATION.—The term “institution of higher education” has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001) and includes a “postsecondary vocational institution” as defined in section 102(c) of such Act (20 U.S.C. 1002(c)).

(G) LOCAL EDUCATIONAL AGENCY.—The term “local educational agency” has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(H) LOCAL BOARD; ONE-STOP OPERATOR.—The terms “local board” and “one-stop operator” have the meanings given such terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

(i) OUT-OF-SCHOOL YOUTH.—The term “out-of-school youth” has the meaning given such term in section 12(a)(1)(B) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3164(a)(1)(B)).

(j) RECOVERY PROGRAM.—The term “recovery program” means a program—

(i) to help children, adolescents, or young adults who are recovering from substance use disorders to maintain healthy and productive lives in the community;
(ii) that includes peer-to-peer support delivered by individuals with lived experience in recovery, and communal activities to build recovery skills and supportive social networks.

(K) STATE EDUCATIONAL AGENCY.—The term "State educational agency" has the meaning given such term in section 8101 of the Elementary and Secondary Education Act (20 U.S.C. 7801).

(3) BEST PRACTICES.—The Secretary, in consultation with the Secretary of Education, shall:

(A) identify or facilitate the development of evidence-based best practices for prevention of substance misuse and abuse by children, adolescents, and young adults, including for specific populations such as youth in foster care, homeless youth, out-of-school youth, and youth at risk of or have experienced trafficking that address—

(i) primary prevention;

(ii) appropriate recovery support services;

(iii) appropriate use of medication-assisted treatment for such individuals, if applicable, and ways of overcoming barriers to the use of medication-assisted treatment in such populations; and

(iv) efficient and effective communication, which may include the use of social media, to maximize outreach efforts;

(B) disseminate such best practices to State educational agencies, local educational agencies, schools and dormitories funded by the Bureau of Indian Education, institutions of higher education, recovery programs at institutions of higher education, local boards, one-stop operators, family and youth homeless providers, and nonprofit organizations, as appropriate;

(C) conduct a rigorous evaluation of each grant funded under this subsection, particularly by comparing (I) indicators described in paragraph (7)(B) and (D) provide technical assistance for grantees under this subsection.

(4) GRANTS AUTHORIZED.—The Secretary, in consultation with the Secretary of Education, shall award 3-year grants, on a competitive basis, to eligible entities to enable such entities, in coordination with Indian tribes, if applicable, and State agencies responsible for carrying out substance use disorder prevention and treatment programs, to carry out programs that—

(A) prevent substance misuse and abuse by children, adolescents, and young adults, which may include prevention education, job training, linkages to community-based services, family support groups, peer mentoring, and recovery coaching; or

(B) treatment or referrals for treatment of substance use disorders, which may include the use of medication-assisted treatment, as appropriate.

(5) SPECIAL CONSIDERATION.—In awarding grants under this subsection, the Secretary shall give special consideration to the unique needs of tribal, urban, suburban, and rural populations.

(6) APPLICATION.—To be eligible for a grant under this subsection, an entity shall submit to the Secretary an application at such time, and in such manner as the Secretary may require. Such report shall include—

(A) a description of how the eligible entity used grant funds, in accordance with this subsection, including the number of children, adolescents, and young adults reached through programming; and

(B) a description, including relevant data, of how the grant program has made an impact on the intended outcomes described in paragraph (7)(B), including—

(i) indicators of student success, which, if the eligible entity is an educational institution, shall include student well-being and academic achievement;

(ii) substance use disorders amongst children, adolescents, and young adults served by the grant during the grant period; and

(iii) other indicators, as the Secretary determines.

(8) REPORT TO CONGRESS.—The Secretary shall, not later than October 1, 2022, submit a report to the Committees on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives regarding the effectiveness of the grant program under this subsection, based on the information submitted in reports required under paragraph (7).

(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $10,000,000 to carry out this subsection for each of fiscal years 2021 through 2023.

Subtitle L—Information From National Mental Health and Substance Use Policy Laboratory

SEC. 7111. INFORMATION FROM NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

Section 501(a)(b) of the Public Health Service Act (42 U.S.C. 290aa-6(b)) is amended—

(1) in paragraph (5) by inserting "and", and" at the end and inserting a semicolon;

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

"(6) issue and periodically update information for entities applying for grants or cooperative agreements, including—

(A) indicators of substance use disorder prevention, treatment, and recovery in developing such application;

(B) goals of the proposed project, including the intended outcomes;

(C) how plans to use grant funds for evidence-based activities, in accordance with this subsection to prevent, provide recovery support for, or treat substance use disorders amongst such individuals, or a combination of such activities; and

(D) how the eligible entity will collaborate with relevant partners, which may include State educational agencies, local educational agencies, institutions of higher education, juvenile justice agencies, prevention and recovery support providers, local service providers, including substance use disorder treatment programs, providers of mental health services, youth serving organizations, family and youth homeless providers, child welfare agencies, and primary care providers, in carrying out the grant program; and

(E) an assurance that the eligible entity will participate in the evaluation described in paragraph (3)(C).

(7) REPORTS TO THE SECRETARY.—Each eligible entity awarded a grant under this subsection shall submit to the Secretary a report at such time and in such manner as the Secretary may require. Such report shall include—

(A) a description of how the eligible entity used grant funds, in accordance with this subsection, including the number of children, adolescents, and young adults reached through programming; and

(B) a description, including relevant data, of how the grant program has made an impact on the intended outcomes described in paragraph (6)(B), including—

(i) indicators of student success, which, if the eligible entity is an educational institution, shall include student well-being and academic achievement;

(ii) substance use disorders amongst children, adolescents, and young adults served by the grant during the grant period; and

(iii) other indicators, as the Secretary determines.

(8) REPORT TO CONGRESS.—The Secretary shall, not later than October 1, 2022, submit a report to the Committees on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives regarding the effectiveness of the grant program under this subsection, based on the information submitted in reports required under paragraph (7).

(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $10,000,000 to carry out this subsection for each of fiscal years 2021 through 2023.
may include carrying out such activities through technology-enabled collaborative learning and capacity building models described in subsection (f);

(2) cooperates in contract and RECOVERY SERVICES. — Each Center shall—

(A) Ensure that intake, evaluations, and periodic patient assessments meet the individual needs of patients, including by reviewing patient placement in treatment settings to support meaningful recovery;

(B) Provide the full continuum of treatment services, including—

(i) all drugs and devices approved or cleared under section 522 of the Federal Food, Drug, and Cosmetic Act and all biological products licensed under section 351 of this Act to treat substance use disorders or reverse overdoses, pursuant to Federal and State law;

(ii) medically supervised withdrawal management, that includes patient evaluation, stabilization, and readiness for and entry into treatment;

(iii) counseling provided by a program counselor or other certified professional who is licensed and qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient, and to monitor patient progress;

(iv) treatment, as appropriate, for patients with co-occurring substance use and mental disorders;

(v) testing, as appropriate, for infections commonly associated with illicit drug use;

(vi) residential rehabilitation, and outpatient and intensive outpatient programs;

(vii) recovery housing;

(viii) community-based and peer recovery support services;

(ix) job training, job placement assistance, and continuing education assistance to support reintegration into the workforce; and

(x) other best practices to provide the full continuum of treatment and services, as determined by the Secretary.

(C) Ensure that all programs covered by the Center include medication-assisted treatment, as appropriate, and do not exclude individuals receiving medication-assisted and other evidence-based therapies.

(D) Periodically conduct patient assessments to support sustained and clinically significant recovery, as defined by the Assistant Secretary for Mental Health and Substance Use.

(E) Provide onsite access to medication, as appropriate, and tocolocy services; for purposes of carrying out this section;

(F) Operate a secure, confidential, and interoperable electronic health information system.

(G) Offer family support services such as child care, family counseling, and parenting interventions to help stabilize families impacted by substance use disorder, as appropriate.

(2) OUTREACH.—Each Center shall carry out outreach activities regarding the services offered through the Centers, which may include—

(A) training and supervising outreach staff, as appropriate, to work with State and local health departments, health care providers, the Indian Health Service, State and local educational agencies, schools funded by the Indian Bureau of Education, institutions of higher education, State and local workforce development boards, State and local community action agencies, public safety officials, first responders, Indian Tribes, child welfare agencies, as appropriate, and other community and public entities, including patients, to identify and respond to community needs;

(B) ensuring that the entities described in subparagraph (A) are aware of the services of the Center; and

(C) disseminating and making publicly available through the Internet, evidence-based resources that educate professionals and the public on opioid use disorder and other substance use disorders, including co-occurring substance use and mental disorders.

(3) DATA REPORTING AND PROGRAM OVERSIGHT.—With respect to a grant awarded under subsection (a), the Secretary—

(A) an evaluation of the effectiveness of services for the treatment of substance use disorders provided by the Centers established or operated pursuant to this section, including by reviewing patient reports submitted to Congress as a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall submit to Congress a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a), an evaluation of the effectiveness of services for the treatment of substance use disorders provided by the Centers established or operated pursuant to this section, including by reviewing patient reports submitted to Congress as a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a); and

(B) a preliminary report, not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a), an evaluation of the effectiveness of services for the treatment of substance use disorders provided by the Centers established or operated pursuant to this section, including by reviewing patient reports submitted to Congress as a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a).

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,000,000 for each of fiscal years 2019 through 2025 for purposes of carrying out this section.

(c) REPORTS TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a), an evaluation of the effectiveness of services for the treatment of substance use disorders provided by the Centers established or operated pursuant to this section, including by reviewing patient reports submitted to Congress as a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a); and

(2) FINAL REPORT.—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary of Health and Human Services shall submit to Congress a final report that includes—

(A) an evaluation of the effectiveness of the comprehensive services provided by the Centers established or operated pursuant to this section, including by reviewing patient reports submitted to Congress as a preliminary report that analyzes data submitted under section 552(h) of the Public Health Service Act, as added by subsection (a), with respect to health outcomes of the population of individuals with substance use disorder who receive services from the Center, which shall include an evaluation of the effectiveness of services for treatment and recovery support and to reduce relapse, recidivism, and overdose; and

(B) recommendations, as appropriate, regarding ways in which Federal programs related to substance use disorders, which may include dissemination of best practices for the treatment of substance use disorders to health care professionals.

Subtitle N—Trauma-Informed Care

SEC. 7131. CDC SURVEILLANCE AND DATA COLLECTION: CHILD, YOUTH, AND ADULT TRAUMA

(a) DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention (referred to in this section as the ‘‘Director’’), in cooperation with the States, collects and reports data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, and other relevant public health surveys or questionnaires.

(b) TIMING.—The collection of data under subsection (a) may occur biennially.

(c) DATA FROM RURAL AREAS.—The Director shall encourage each State that participates in collecting and reporting data under subsection (a) to collect and report data from rural areas within such State, in order to generate a statistically reliable representative sample of such areas.

(d) DATA FROM TRIBAL AREAS.—The Director may, in cooperation with Indian Tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) and pursuant to a written request from an Indian Tribe, provide technical assistance to Indian Tribes to report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, or another relevant public health survey or questionnaire.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $2,000,000 for each of fiscal years 2019 through 2023.

SEC. 7132. TASK FORCE TO DEVELOP BEST PRACTICES FOR TRAUMA-INFORMED IDENTIFICATION, REFERRAL, AND SUPPORT

(a) ESTABLISHMENT.—There is established a task force, to be known as the Interagency Task Force on Trauma-Informed Care (in this section referred to as the ‘‘task force’’), which shall carry out the functions set forth in this section.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The task force shall be composed of the heads of the following Federal departments and agencies, or their designees:

(A) The Centers for Medicare & Medicaid Services.

(B) The Substance Abuse and Mental Health Services Administration.

(C) The Agency for Healthcare Research and Quality.

(D) The Centers for Disease Control and Prevention.

(E) The Indian Health Service.

(F) The Department of Veterans Affairs.

(G) The National Institutes of Health.

(H) The Food and Drug Administration.

(I) The Health Resources and Services Administration.

(J) The Department of Defense.

(K) The Office of Minority Health of the Department of Health and Human Services.

(L) The Administration for Children and Families.

(M) The Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(N) The Office for Civil Rights of the Department of Health and Human Services.

(O) The Office of Juvenile Justice and Delinquency Prevention of the Department of Justice.

(P) The Office of Community Oriented Policing Services of the Department of Justice.

(Q) The Office on Violence Against Women of the Department of Justice.

(R) The National Center for Education Evaluation and Regional Assistance of the Department of Education.

(S) The National Center for Special Education Research of the Institute of Education Sciences.

(T) The Office of Elementary and Secondary Education of the Department of Education.
(U) The Office for Civil Rights of the Department of Education.
(V) The Office of Special Education and Rehabilitative Services of the Department of Education.
(W) The Bureau of Indian Affairs of the Department of the Interior.
(X) The Veterans Health Administration of the Department of Veterans Affairs.
(Y) The Office of Special Needs Assistance Programs of the Department of Housing and Urban Development.
(Z) The Office of Head Start of the Administration for Children and Families.
(AA) The Indian Education of the Department of the Interior.
(CC) Such other Federal agencies as the Secretaries determine to be appropriate.

(2) DUTIES.—The heads of Federal departments and agencies shall appoint the corresponding members of the task force not later than 60 days after the date of enactment of this Act.

(3) CHAIRPERSON.—The task force shall be chaired by the Assistant Secretary for Mental Health and Substance Use, or the Assistant Secretary for Children and Families, as determined by the Secretaries.

(c) TASK FORCE DUTIES.—The task force shall—

(1) solicit input from stakeholders, including Federal service providers, educators, mental health professionals, researchers, experts in infant, child, and youth trauma, child welfare professionals, and the public, in order to inform the activities under paragraph (2); and

(2) identify, evaluate, make recommendations, and update such recommendations not less than annually, to the general public, the Secretary of Education, the Secretary of Health and Human Services, the Secretary of Labor, the Secretary of the Interior, the Attorney General, other relevant cabinet Secretaries, and Congress regarding—

(A) a set of evidence-based, evidence-informed, and promising best practices with respect to—

(i) prevention strategies for individuals at risk of experiencing or being exposed to trauma, including trauma as a result of exposure to substance use; and

(ii) the identification of infants, children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma; and

(iii) the expeditious referral to and implementation of trauma-informed practices and supports that prevent and mitigate the effects of trauma, including trauma as a result of exposure to substance use,

(B) the identification of infants, children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma; and

(C) developing and implementing policies, procedures, or systems that—

(i) are designed to quickly identify infants, children, youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma to the appropriate trauma-informed screening and support and age-appropriate treatment, and to ensure such infants, children, youth, and family members receive such support;

(ii) utilize and develop partnerships with early childhood education programs, local social services organizations, such as organizations serving youth, and clinical mental health or other health care providers with expertise in providing support services and age-appropriate trauma-informed and evidence-based treatment aimed at preventing or mitigating effects of trauma; and

(iii) educate children and youth to—

(I) understand and identify the signs, effects, or symptoms of trauma; and

(II) build resilience and coping skills to mitigate the effects of experiencing trauma;

(iv) promote and support multi-generational practices that assist parents, their children, and others, including custodial caregivers in accessing resources related to, and developing environments conducive to, the prevention and mitigation of trauma; and

(v) collect and utilize data from screenings, referrals, or the provision of services and supports to evaluate outcomes and improve processes for trauma-informed services, at both the individual and culturally sensitive, linguistically appropriate, and specific to age ranges and sex, as applicable; and

(2) recommend best practices that are designed to prevent custodial loss or criminal penalties for parents or guardians in connection with infants, children, and youth who have experienced or are at risk of experiencing trauma.

(3) recommend opportunities for local- and State-level partnerships that—

(A) are designed to quickly identify and refer children and families, as appropriate, who have experienced or are at risk of experiencing exposure to trauma, including related to substance use; and

(B) utilize and develop partnerships with early childhood education programs, local social services organizations, and health care providers to prevent or mitigate the effects of exposure to trauma, including related to substance use;

(C) offer community-based prevention activities including educating families and children on the effects of exposure to trauma, such as trauma related to substance use, and how to build resilience and coping skills to mitigate those effects;

(D) in accordance with Federal privacy protections, utilize non-personally-identifiable data from screenings, referrals, or the provision of services and supports to evaluate and improve processes addressing exposure to trauma, including related to substance use; and

(E) are designed to prevent separation and support reunification of families if in the best interest of the child.

(e) OPERATING PLAN.—Not later than 120 days after the date of enactment of this Act, the task force shall hold the first meeting. Not later than 2 years after such date of enactment, the task force shall submit to the Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, the Congress, and the Federal executive branch a plan for carrying out the activities of the task force described in subsection (c)(2). Such operating plan shall include—

(1) a list of specific activities that the task force plans to carry out for purposes of carrying out duties described in subsection (c)(2), which may include public engagement; and

(a) a plan for carrying out the activities under subsection (c)(2);

(b) a list of members of the task force and other individuals who are not members of the task force that may be consulted to carry out such activities;

(c) an explanation of Federal agency involvement and coordination needed to carry out such activities, including any statutory or regulatory barriers to such coordination;

(2) a budget for carrying out such activities;

(3) a proposed timeline for implementing recommendations and efforts identified under subsection (c); and

(4) other information that the task force determines appropriate as related to its duties.

(f) FINAL REPORT.—Not later than 3 years after the date of the first meeting of the task force, the task force shall submit to the general public, Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, other relevant cabinet Secretaries, the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and Congress, a final report containing all of the findings and recommendations required under this section, and shall make such report available online in an accessible format.

(g) ADDITIONAL REPORTS.—In addition to the final report under subsection (f), the task force shall submit—

(a) a report to Congress identifying any recommendations identified under subsection (c) that require additional legislative authority to implement; and

(b) a report to the Governors describing the opportunities for local- and State-level partnerships, professional development, or best
practices recommended under subsection (d)(3).

(h) DEFINITIONS.—In this section—

(1) the term “early childhood program” means an early childhood program as defined in section 103 of the Higher Education Act of 1965 (20 U.S.C. 1003);

(2) the term “Governor” means the chief executive officer of a State; and

(3) the term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands;

(i) SUNSET.—The task force shall sunset on the date that is 60 days after the submission of the final report under subsection (f), but not later than September 30, 2023.

SEC. 7132. NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.

Section 582(j) of the Public Health Service Act (42 U.S.C. 290hh–1(j)) (relying to grants to address the problems of persons who experience violence-related stress) is amended by striking “$34,887,000 for each of fiscal years 2018 through 2022” and inserting “$63,887,000 for each of fiscal years 2019 through 2023”.

SEC. 7133. GRANTS TO IMPROVE TRAUMA SUP- PORT SERVICES AND MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH IN EDUCATIONAL SETTINGS.

(a) GRANTS, CONTRACTS, AND COOPERATIVE AGREEMENTS.—The Secretary, in coordination with the Assistant Secretary for Mental Health and Substance Use, is authorized to award grants to, or enter into contracts or cooperative agreements with, State educational agencies, local educational agencies, Indian Tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) or their tribal educational agencies, a school operated by the Bureau of Indian Education, a Regional Corporation, or other organizations, to address the needs of children and youth who have experienced trauma and their families.

(b) DURATION.—With respect to a grant, contract, or cooperative agreement awarded or entered into under this section, during which payments under such grant, contract or agreement are made to the recipient may not exceed 4 years.

(c) ELIGIBILITY.—An entity that receives a grant, contract, or cooperative agreement under this section shall use amounts made available under such grant, contract, or cooperative agreement for evidence-based activities, which shall include any of the following:

(1) Collaborative efforts between school-based service systems and trauma-informed support and mental health service systems to provide, develop, or improve screening, referral, and treatment and support services to students, including providing trauma screenings to identify students in need of specialized support.

(2) Implementing schoolwide positive behavioral interventions and supports, or other trauma-informed models of support.

(3) To provide professional development to teachers, school leaders, administrators, specialized instructional support personnel, and mental health professionals that—

(A) fosters safe and stable learning environments and mitigates the adverse effects of trauma, including through social and emotional learning;

(B) improves school capacity to identify, refer, and respond to students to meet the need of trauma support or behavioral health services; or

(C) reflects the best practices for trauma-informed identification, referral, and support developed by the Task Force under section 7132.

(4) Services at a full-service community school that focuses on trauma-informed support, which may include full-time site coordinator, or other activities consistent with services established in section 4 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7275).

(5) Engaging families and communities in efforts to increase awareness of child and youth trauma-informed care and working with communities to implement strategies to promote intervention, as well as longer term coordinated care within the community for children and youth who have experienced trauma and their families.

(6) To provide technical assistance to school systems and mental health agencies.

(7) To evaluate the effectiveness of the program carried out under this section in increasing student access to evidence-based trauma support services and mental health care.

(8) To establish partnerships with or provide subgrants to Head Start agencies (including Early Head Start agencies), public and private preschool programs, child care programs (including providers), or other entities described in subsection (a), to include such entities described in this paragraph in the evidence-based trauma initiatives, activities, support services, and mental health systems established under this section in order to provide, develop, or improve prevention, screening, referral, and treatment and support services to young children and their families.

(d) APPLICATIONS.—To be eligible to receive a grant, contract, or cooperative agreement under this section, an entity described in subsection (a) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, which shall include the following:

(1) A description of the innovative initiatives, activities, or programs to be funded under the grant, contract, or cooperative agreement, including how such program will increase access to evidence-based trauma support services and mental health care for students, and, as applicable, the families of such students.

(2) A description of how the program will provide linguistically appropriate and culturally competent services.

(3) A description of how the program will support students and the school in improving the school climate in order to support an environment conducive to learning.

(4) An assurance that—

(A) persons providing services under the grant, contract, or cooperative agreement are adequately trained to provide such services; and

(B) teachers, school leaders, administrators, specialized instructional support personnel, representatives of local Indian Tribes or tribal organizations as appropriate, other school personnel, and parents or guardians of students participating in services under this section will be engaged and involved in the design and implementation of the services.

(5) A description of how the applicant will support and integrate existing school-based programs with the program in order to provide mental health services for students, as appropriate.

(6) A description of the entities in the community with which the applicant will partner or to which the applicant will provide subgrants in accordance with subsection (c)(8).

(e) INTERAGENCY AGREEMENTS.—
SEC. 7135. RECOGNIZING EARLY CHILDHOOD PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(10) S P E C I A L I Z E D INSTRUCTIONAL SUPPORT PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).


(l) A U T H O R I Z A T I O N OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2019 through 2023.

SEC. 7135. RECOGNIZING EARLY CHILDHOOD CARE AND EDUCATION PROVIDERS AND WORKERS.—(a) D I S S E M I N A T I O N OF INFORMATION.—The Secretary of Health and Human Services shall disseminate information, resources, and, if requested, technical assistance to early childhood care and education providers and professionals working with young children on—

(1) ways to properly recognize children who may be impacted by trauma, including trauma related to substance abuse by a family member or other adult; and

(2) how to respond appropriately in order to provide for the safety and well-being of young children.

(b) G O A L S.—The information, resources, and technical assistance provided under subsection (a) shall—

(1) educate early childhood care and education providers and professionals working with young children on understanding and identifying the early signs and risk factors of children who might be impacted by trauma, including trauma due to exposure to substance abuse;

(2) suggest age-appropriate communication tools, activities, and practices for trauma-informed care, including ways to prevent or mitigate the effects of trauma;

(3) provide options for responding to children affected by trauma, including due to exposure to substance abuse, that consider the needs of the child and family, including recommending resources and referrals for evidence-based services to support such family; and

(4) promote whole-family and multi-generational approaches to keep families safely together when it is in the best interest of the child.

(c) C O O R D I N A T I O N.—The Secretary of Health and Human Services shall coordinate with the task force to develop best practices for trauma-informed identification, referral, and support authorized under section 7132 in disseminating, The, training, information, resources, and technical assistance described under subsection (b).

SEC. 7136. RECOGNIZING INFECTION-RELATED DISEASES.—(a) R U L E OF CONSTRUCTION.—Such information, resources, and, if applicable, technical assistance, shall not be construed to amend the requirements under—

(1) the Child Development Block Grant Act of 1990 (42 U.S.C. 9835 et seq.);

(2) the Head Start Act (42 U.S.C. 9831 et seq.); or

(3) the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.).

Subtitle O—Eliminating Opioid Related Infectious Diseases

SEC. 7141. REAUTHORIZATION AND EXPANSION OF PROGRAM OF SURVEILLANCE AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.—

(1) A U T H O R I Z A T I O N OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the requirements under this section and subsection (b) of this section, $40,000,000 for each of the fiscal years 2019 through 2023.

(2) S P E C I A L I Z E D INSTRUCTIONAL SUPPORT PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) T H E A R M Y.—The term ‘the Army’ means the Secretary of Education.

(4) T H E N A T I V E C L A I MANT.—The term ‘Native claimant’ means the Secretary of Education.

(5) R E G I O N A L CORPORATION.—The term ‘Regional Corporation’ has the meaning given the term in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1621).

(6) S C H O O L.—The term ‘school’ means the Secretary of Education.

(7) S C H O O L L E A D E R.—The term ‘school leader’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(8) S E C R E T A R Y.—The term ‘Secretary’ means the Secretary of Education.

(9) S E C R E T A R Y.—The term ‘Secretary’ means the Secretary of Education.

(10) S P E C I A L I Z E D INSTRUCTIONAL SUPPORT PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).


(l) A U T H O R I Z A T I O N OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2019 through 2023.

SEC. 7137. SUBSIDY AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.—

(1) T H E A R M Y.—The term ‘the Army’ means the Secretary of Education.

(2) S P E C I A L I Z E D INSTRUCTIONAL SUPPORT PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) T H E A R M Y.—The term ‘the Army’ means the Secretary of Education.

(4) T H E N A T I V E C L A I MANT.—The term ‘Native claimant’ means the Secretary of Education.

(5) R E G I O N A L CORPORATION.—The term ‘Regional Corporation’ has the meaning given the term in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1621).

(6) S C H O O L.—The term ‘school’ means the Secretary of Education.

(7) S C H O O L L E A D E R.—The term ‘school leader’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(8) S E C R E T A R Y.—The term ‘Secretary’ means the Secretary of Education.

(9) S E C R E T A R Y.—The term ‘Secretary’ means the Secretary of Education.

(10) S P E C I A L I Z E D INSTRUCTIONAL SUPPORT PERSONNEL.—The term ‘specialized instructional support personnel’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).


(l) A U T H O R I Z A T I O N OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2019 through 2023.

SEC. 7138. BUILDING COMMUNITIES OF RECOVERY

Section 547 of the Public Health Service Act (42 U.S.C. 290ee–2) is amended to read as follows:

SEC. 547. BUILDING COMMUNITIES OF RECOVERY.

(1) A D E F I N I T I O N.—In this section, the term ‘recovery community organization’ means an independent nonprofit organization—

(1) mobilizes resources within and outside of the recovery community, which may include through a peer support network, 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 from substance use disorders who reflect the community served.

(b) G R A N T S A U T H O R I Z E D.—The Secretary shall award grants to recovery community organizations to enable such organizations to develop, expand, and enhance recovery services.

(c) F E R A L S H A R E.—The Federal share of the costs of a program funded by a grant under this section may not exceed 85 percent.

(d) U S E OF FUNDS.—Grants awarded under subsection (b) may be used to—

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

(1) behavioral health providers;

(2) primary care providers and physicians;

(3) educational and vocational schools;

(4) employers; and

(5) housing services;

(6) child welfare agencies; and

(7) other recovery support services that facilitate recovery from substance use disorders, including non-clinical community services

(B) reduce stigma associated with substance use disorders; and

(C) conduct outreach on issues relating to substance use disorders and recovery, including—

(i) identifying the signs of substance use disorder;

(ii) the resources available to individuals with substance use disorders and to families of an individual with a substance use disorder, including programs that mentor and provide support services to children; and

(iii) the resources available to help support individuals in recovery;

(D) related medical outcomes of substance use disorders, the potential of acquiring an infection commonly associated with illicit drug use, and neonatal abstinence syndrome among infants exposed to opioids during pregnancy.

(2) S P E C I A L C O N S I D E R A T I O N.—In carrying out this section, the Secretary shall give special consideration to the unique needs of minority populations, including areas with an age-adjusted rate of drug overdose deaths that is above the national average and areas with a shortage of prevention and treatment services.

(3) A U T H O R I Z A T I O N OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2019 through 2023.

Section 547 of the Public Health Service Act (42 U.S.C. 290ee–2) is amended to read as follows:
SEC. 547A. PEER SUPPORT TECHNICAL ASSISTANCE CENTER.

(a) Establishment.—The Secretary, acting through the Assistant Secretary, shall establish or operate a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support (referred to in this section as "the Center").

(b) Functions.—The Center established under subsection (a) shall provide technical assistance and support to recovery community organizations and peer support networks, including such assistance and support related to—

(1) training on identifying substance use disorder;
(2) the provision of translation services, interpretation, or other such services for clients with limited English speaking proficiency;
(3) data collection to support research, including translational research;
(4) capacity building; and
(5) evaluation and improvement, as necessary, of the effectiveness of such services provided by recovery community organizations.

(c) Best Practices.—The Center established under subsection (a) shall periodically issue best practices for use by recovery community organizations and peer support networks.

(d) Recovery Community Organization.—In this section, the term ‘recovery community organization’ has the meaning given such term in section 547.

(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2019 through 2023.

Subtitle Q—Creating Opportunities That Necessitate New and Enhanced Connections That Improve Opioid Navigation Strategies

SEC. 7161. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.

(a) In General.—Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended by inserting after section 392 (42 U.S.C. 280b–1) the following:

"SEC. 392A. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.

"(a) Evidence-Based Prevention Grants.—

"(1) In General.—The Director of the Centers for Disease Control and Prevention may—

"(A) to the extent practicable, carry out and expand any evidence-based prevention activities described in paragraph (2);
(2) provide technical and assistance to States, localities, and Indian tribes for purposes of carrying out such activity; and
(3) grant awards to States, localities, and Indian tribes for purposes of carrying out such activity.

"(2) Evidence-Based Prevention Activities.—An evidence-based prevention activity described in this paragraph is any of the following activities:

(A) improving the efficiency and use of a new or currently operating prescription drug monitoring program, including by—
(1) encouraging all authorized users (as specified by an appropriate State or other entity) to register with and use the program;
(2) enabling such users to access any updated information collected by the program, if such information is available to the user, and could reasonably be made available under applicable Federal and State law and the policies of the prescription drug monitoring program and not containing any protected health information; and
(3) improving the ease of use of such program;
(B) providing training and technical assistance to States, localities, and Indian tribes for purposes of carrying out such activity;
(C) award grants to States, localities, and Indian tribes for purposes of carrying out such activity; and
(D) coordinate with the Assistant Secretary for Mental Health and Substance Use to provide, under section 505(d)(1)(A) relating to the number of individuals admitted to emergency departments as a result of the abuse of alcohol or other drugs.

"(2) Controlled Substance Overdose Data Collection and Analysis Activities.—A controlled substance overdose data collection and analysis activity described in this paragraph is any of the following activities:

(1) Improving the timeliness of reporting data to the public, including data on fatal and nonfatal overdoses of controlled substances;
(B) Enhancing the comprehensiveness of controlled substance overdose data collection and analysis activity described in this paragraph by any of the following;
(2) Using data to help identify risk factors associated with controlled substance overdose death;
(E) Supporting entities involved in providing information on controlled substance overdoses, including coroners, medical examiners, and public health laboratories to improve the accuracy of postmortem data through the reporting of causes and contributing factors to controlled substances overdoses and analysis of various opioid analogues to controlled substance overdoses among data sources and entities;
(F) Working to enable and encourage the access, exchange, and use of information regarding controlled substance overdoses among data sources and entities.

"(3) Definitions.—In this section:

(A) Controlled Substance.—The term ‘controlled substance’ has the meaning given such term in section 102 of the Controlled Substances Act.
(B) Indian Tribe.—The term ‘Indian tribe’ has the meaning given in section 4 of the Indian Self-Determination and Education Assistance Act.

"(4) Authorization of Appropriations.—For purposes of carrying out this section, section 399O of this Act, and section 102 of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–118), there is authorized to be appropriated $596,000,000 for each of fiscal years 2019 through 2023.

(b) Education and Awareness.—Section 102 of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–118) is amended—

(1) by amending subsection (a) to read as follows:

(A) In General.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and in coordination with the heads of other relevant Federal agencies, shall advance education and awareness regarding the risks related to misuse and abuse of opioids, as appropriate, which may include developing or improving existing programs, conducting activities, and awarding grants that advance the education and awareness of—

1) the public, including patients and consumers—
(A) generally; and
“(B) regarding such risks related to unused opioids and the dispensing options under section 399(f) of the Controlled Substances Act, as applicable; and

“(2) provisions which may include—

“(A) providing for continuing education on appropriate prescribing practices;

“(B) education related to applicable State or Federal laws and regulations, information on the use of non-addictive alternatives for pain management, and the use of overdose reversal drugs, as appropriate;

“(C) provisions and improving the use of evidence-based opioid prescribing guidelines across relevant health care settings, as appropriate, and updating guidelines as necessary;

“(D) implementing strategies, such as best practices, to encourage and facilitate the use of prescriber guidelines, in accordance with State and local law;

“(E) disseminating information to providers about prescribing options for controlled substances, including such options under section 308(f) of the Controlled Substances Act, as applicable; and

“(F) disseminating information, as appropriate, on the National Pain Strategy developed in consultation with the Assistant Secretary for Health; and

“(3) other appropriate entities;”; and

“(2) in subsection (b)—

“(A) striking ‘opioid abuse’ each place such term appears and inserting ‘opioid misuse and abuse’; and

“(B) in paragraph (2), by striking ‘safe dispensing’ and inserting ‘non-addictive treatment options, safe disposal options for prescription medications, and other applicable’;

SEC. 710. PRESCRIPTION DRUG MONITORING PROGRAM.

Section 3990 of the Public Health Service Act (42 U.S.C. 280q–3) is amended to read as follows—

“SEC. 3990. PRESCRIPTION DRUG MONITORING PROGRAM.

“(a) Program.—

“(1) IN GENERAL.—Each fiscal year, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, in coordination with the heads of other departments and agencies as appropriate, shall support States or localities for the purposes of improving the efficiency and use of PDMPs, including—

“(A) establishment and implementation of a PDMP;

“(B) maintenance of a PDMP;

“(C) improvements to a PDMP by—

“(i) enhancing functional components to work toward—

“(I) universal use of PDMPs among prescribers and their delegates, to the extent that State laws allow;

“(II) more timely inclusion of data within a PDMP;

“(III) active management of the PDMP, in part by establishing compliance or corrective measures for providers to inform prescribing; and

“(IV) ensuring the highest level of ease in use of and access to PDMPs by providers and their delegates, to the extent that State laws allow;

“(ii) in consultation with the Office of the National Coordinator for Health Information Technology, improving the intrastate interoperability of PDMPs by—

“(I) making PDMPs more actionable by integrating PDMPs within electronic health records and health information technology infrastructure; and

“(II) linking PDMP data to other data systems within the State, including—

“(aa) pharmacy benefit managers, medical examiners and coroners, and the State’s Medicaid program;

“(bb) worker’s compensation data; and

“(cc) prescribing data of providers of the Department of Veterans Affairs and the Indian Health Service within the State;

“(iii) in consultation with the Director of the National Coordinator for Health Information Technology, improving the interstate interoperability of PDMPs through—

“(I) sharing prescription data in near real-time across State lines; and

“(II) integration of automated queries for multistate PDMP data and analytics into clinician work processes when such use of such data and analytics by practitioners and dispensers is appropriate, and updating guidelines as necessary;

“(iv) improving the ability to include treatment availability resources and referral capabilities within the PDMP.

“(2) LEGISLATION.—As a condition on the receipt of support under this section, the Secretary shall require a State or locality to demonstrate that it has enacted legislation or regulations—

“(A) to provide for the implementation of the PDMP; and

“(B) to permit the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained by the PDMP.

“(3) PDMP STRATEGIES.—The Secretary shall encourage, establish, or modify the PDMP to implement strategies that improve—

“(I) the reporting of dispensing in the State or local dispensing of controlled substances, including automatic reporting when a practitioner occurs not later than 24 hours after the dispensing event;

“(II) the consultation of the PDMP by each prescribing practitioner, or their designee, in the State or locality before initiating treatment with a controlled substance, or any substance as appropriate; and the State to be reported to the PDMP, and over the course of ongoing treatment for each prescribing event;

“(III) the consultation of the PDMP before dispensing a controlled substance, or any substance as required by the State to be reported to the PDMP;

“(IV) the proactive notification to a practitioner when patterns indicative of controlled substance misuse by a patient, including opioid misuse, are detected;

“(V) the exchange of such data in the PDMP to other States, as allowable under State law; and

“(VI) the availability of nonidentifiable information to the Centers for Disease Control and Prevention for surveillance, epidemiology, statistical research, or educational purposes.

“(4) DRUG MISUSE AND ABUSE.—In consultation with practitioners, dispensers, and other relevant and interested stakeholders, a State receiving support under this section—

“(I) shall establish a program to notify practitioners and dispensers of information that will help to identify and prevent the unlawful diversion or misuse of controlled substances;

“(II) may, to the extent permitted under State law, notify the appropriate authorities responsible for carrying out drug diversion investigations if the State determines that information in the PDMP maintained by the State indicates an unlawful diversion or abuse of a controlled substance;

“(III) may conduct analyses of controlled substance program data for purposes of providing appropriate State agencies with aggregated program data on such analyses in as close to real-time as practicable, regarding prescription patterns flagged as potentially presenting a risk of misuse, abuse, addiction, overdose, or diversion; and

“(4) may access information about prescriptions, such as claims data, to ensure that such prescribing and dispensing history is updated as in close to real-time as practicable, in compliance with applicable Federal and State laws and provided that such reports shall not include protected health information; and

“(5) make access information about prescriptions, such as claims data, to ensure that such prescribing and dispensing history is updated as in close to real-time as practicable, in compliance with applicable Federal and State laws and provided that such reports shall not include protected health information.

“(5) EVALUATION AND REPORTING.—As a condition on receipt of support under this section, the State shall report on interoperability with PDMPs of other States and Federal agencies, where appropriate, in the State to the Secretary.

“(6) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving support under this section shall take steps to—

“(1) facilitate prescriber and dispenser access, and their delegates, as permitted by State law, to use the PDMP, to the extent practicable;

“(2) educate prescribers and dispensers, and their delegates on the benefits of the use of PDMPs.

“(g) ELECTRONIC FORMAT.—The Secretary may issue guidelines specifying a uniform electronic format for the reporting, sharing, and disclosure of information pursuant to PDMPs. To the extent possible, such guidelines shall be consistent with standards recognized by the Office of the National Coordinator for Health Information Technology.

“(h) RULES OF CONSTRUCTION.—

“(1) FUNCTIONS OTHERWISE AUTHORIZED BY LAW.—Nothing in this section shall be construed to restrict the Secretary from exercising any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

“(2) ADDITIONAL PRIVACY PROTECTIONS.—Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

“(3) FEDERAL PRIVACY REQUIREMENTS.—Nothing in this section shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) and section 543 of this Act.

“(4) NO FEDERAL PRIVATE CAUSE OF ACTION.—Nothing in this section shall be construed as creating any Federal private cause of action.

“(5) PROGRESS REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall—

“(1) complete a study that—

“(A) determines the progress of grantees in establishing and implementing PDMPs consistent with this section; and

“(B) provides an analysis of the extent to which the operation of PDMP has—

“(I) decreased prescription abuse, misuse, and diversion; or

“(II) decreased overdose and, where applicable, diversion of, and overdose with, controlled substances;
(ii) established or strengthened initiatives to ensure linkages to substance use disorder treatment services; or

(iii) affected patient access to appropriate care by participating in PDMPs;

(3) the Secretary, in consultation with Indian Tribes, shall conduct a review of the provision of substance use disorder treatment services, and

(b) the Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to States that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).

Subtitle S—Other Health Provisions

SEC. 718. STATE RESPONSE TO THE OPIOID ABUSE CRISIS.

(a) In General.—The Secretary of Health and Human Services shall:

(1) submit a report to the Congress on the progress of States in establishing, implementing, or maintaining a PDMP consistent with this section;

(2) submit a report to the Congress on the results of the study; and

(3) submit a report to the Congress on recommendations of the Secretary for additional Federal or State requirements.

(b) Definitions.—For purposes of this section:

(1) the term ‘clinical workflow’ means the integration of automated queries for prescription drug monitoring programs data and analytics into health information technologies such as electronic health record systems, health information exchange, and/or pharmacy dispensing software systems, thus streamlining provider access through automated queries;

(2) the term ‘disposition’ means the ability of a PDMP to electronically share reported data with respect to a PDMP;

(3) the term ‘intrastate interoperability’ means the ability of a PDMP to share data with a PDMP located in such other State.

SEC. 7171. REVIEW OF SUBSTANCE USE DISORDER TREATMENT PROVIDERS RECEIVING FEDERAL FUNDING

(a) In General.—The Secretary of Health and Human Services shall conduct a review of entities that receive Federal funding for the provision of substance use disorder treatment services. The review shall include:

(1) the length of time the entity has provided substance use disorder treatment services and the geographic area served by the entity;

(2) a detailed analysis of the patient population served by the entity, including but not limited to the number of patients, types of diagnosis, treatment providers, and the demographic information of such patients, including sex, race, ethnicity, and socioeconomic status;

(3) the types of substance use disorder for which the entity has the experience, capability, and capacity to provide such services;

(4) an analysis of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat;

(5) an analysis of what is needed in order to improve the entity’s ability to meet the addiction treatment needs of the communities served by that entity.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to States that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).

Subtitle S—Other Health Provisions

SEC. 718. STATE RESPONSE TO THE OPIOID ABUSE CRISIS.

(a) In General.—The Secretary of Health and Human Services shall:

(1) submit a report to the Congress on the progress of States in establishing, implementing, or maintaining a PDMP consistent with this section;

(2) submit a report to the Congress on the results of the study; and

(3) submit a report to the Congress on recommendations of the Secretary for additional Federal or State requirements.

(b) Definitions.—For purposes of this section:

(1) the term ‘clinical workflow’ means the integration of automated queries for prescription drug monitoring programs data and analytics into health information technologies such as electronic health record systems, health information exchange, and/or pharmacy dispensing software systems, thus streamlining provider access through automated queries;

(2) the term ‘disposition’ means the ability of a PDMP to electronically share reported data with respect to a PDMP;

(3) the term ‘intrastate interoperability’ means the ability of a PDMP to share data with a PDMP located in such other State.

SEC. 7171. REVIEW OF SUBSTANCE USE DISORDER TREATMENT PROVIDERS RECEIVING FEDERAL FUNDING

(a) In General.—The Secretary of Health and Human Services shall conduct a review of entities that receive Federal funding for the provision of substance use disorder treatment services. The review shall include:

(1) the length of time the entity has provided substance use disorder treatment services and the geographic area served by the entity;

(2) a detailed analysis of the patient population served by the entity, including but not limited to the number of patients, types of diagnosis, treatment providers, and the demographic information of such patients, including sex, race, ethnicity, and socioeconomic status;

(3) the types of substance use disorder for which the entity has the experience, capability, and capacity to provide such services;

(4) an analysis of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat;

(5) an analysis of what is needed in order to improve the entity’s ability to meet the addiction treatment needs of the communities served by that entity.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to States that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).

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(4) an analysis of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat;

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(3) the types of substance use disorder for which the entity has the experience, capability, and capacity to provide such services;

(4) an analysis of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat;

(5) an analysis of what is needed in order to improve the entity’s ability to meet the addiction treatment needs of the communities served by that entity.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to States that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).

Subtitle S—Other Health Provisions

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(1) submit a report to the Congress on the progress of States in establishing, implementing, or maintaining a PDMP consistent with this section;

(2) submit a report to the Congress on the results of the study; and

(3) submit a report to the Congress on recommendations of the Secretary for additional Federal or State requirements.

(b) Definitions.—For purposes of this section:

(1) the term ‘clinical workflow’ means the integration of automated queries for prescription drug monitoring programs data and analytics into health information technologies such as electronic health record systems, health information exchange, and/or pharmacy dispensing software systems, thus streamlining provider access through automated queries;

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(1) the length of time the entity has provided substance use disorder treatment services and the geographic area served by the entity;

(2) a detailed analysis of the patient population served by the entity, including but not limited to the number of patients, types of diagnosis, treatment providers, and the demographic information of such patients, including sex, race, ethnicity, and socioeconomic status;

(3) the types of substance use disorder for which the entity has the experience, capability, and capacity to provide such services;

(4) an analysis of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat;

(5) an analysis of what is needed in order to improve the entity’s ability to meet the addiction treatment needs of the communities served by that entity.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to States that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).
(f) REPORT TO CONGRESS.—Not later than 1 year after the date on which amounts are first awarded after the date of enactment of this subsection, pursuant to subsection (b), and after demonstrating the ability to partner with local stakeholders, which may include local employers, community stakeholders, the local workforce investment board, local and State governments, and Indian Tribes or tribal organizations, as applicable, to—

(1) identify gaps in the workforce due to the prevalence of substance use disorders; and

(2) in coordination with statewide employ-

ment and training activities, including co-

ordination and alignment of activities car-

ried out by entities providing funds under section 8041, help individuals in recov-

ery from a substance use disorder transition into the workforce, including by providing career services, training services as de-

scribed in paragraph (2) of section 134(c) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3174(c)), and related services described in section 134(a)(5) of such Act (29 U.S.C. 3174(a)); and

(g) USE OF FUNDS.—An entity receiving a grant under this subsection shall use the funds to conduct one or more of the following activities:

(1) Hire case managers, care coordinators, providers of peer recovery services, and other services, as described in section 547(a) of the Public Health Service Act (42 U.S.C. 290ee-2(a)), or other professionals, as appropriate, to pro-

vide services that support treatment, recov-

ery, and rehabilitation, and prevent relapse, recidivism, and overdose, including by encou-

aging—

(A) the development and strengthening of daily living skills; and

(B) the use of counseling, care coordina-

tion, and other services, to support recovery from substance use disorders.

(2) Implement or utilize innovative tech-

nologies, which may include the use of tele-

medicine.

(3) In coordination with the lead State agency with responsibility for a workforce investment activity or local board described in subsection (b), provide—

(A) short-term pre-vocational training serv-

ices; and

(B) training services that are directly linked to the employment opportunities in the local area or the planning region.

(4) SUPPORT FOR STATE STRATEGY.—An eli-

gible entity shall include in its application under subsection (f) information describing how the services and activities proposed in such application are aligned with the State, outlying area, or Tribal strategy, as applicable, for addressing issues described in such application and how such entity will coordi-

nate with existing services to deliver serv-

ices as described in such application.

(5) DATA REPORTING AND PROGRAM OVER-

SIGHT.—Each eligible entity awarded a grant under this section shall submit to the Sec-

retary a report at such time and in such manner as the Secretary may require. Such report shall include a description of—

(1) the programs and activities funded by the grant;

(2) outcomes of the population of individ-

uals with a substance use disorder the grantee served through activities described in sub-

section (g); and

(3) any other information that the Sec-

retary may require for the purpose of ensur-

ing that the grantee is complying with all of the requirements of the grant.

(j) REPORT TO CONGRESS.—Not later than 2 years after the end of the first year of the
grant period under this section, the Secretary shall submit to Congress a preliminary report that analyzes reports submitted under subsection (i).

(2) To the Secretary—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that includes—

(A) a description of how the grant funding was used, including the number of individuals who received services under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items;

(B) recommendations related to best practices for health care professionals to support individuals in substance use disorder treatment or recovery to live independently and participate in the workforce.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $5,000,000 for each of fiscal years 2019 through 2023 for purposes of carrying out this section.

TITLE VIII—MISCELLANEOUS

Subtitle A—Synthetics Trafficking and Overdose Prevention

SEC. 8001. SHORT TITLE.

This subtitle may be cited as the "Synthetic Opioids Trafficking and Overdose Prevention Act of 2018" or "STOP Act of 2018".

SEC. 8002. CUSTOMS FEES.

(a) IN GENERAL.—Section 13031(b)(9) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)) is amended by—

(1) in paragraph (6), by inserting "and section 4331 of title 39, United States Code," after "(b)(9)(D))";

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting "(other than Inbound EMS items described in subsection (b)(9)(D)) after "(C)"); and

(B) in paragraph (2)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting "(other than Inbound EMS items described in subsection (b)(9)(D)) after "(B)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 8003. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.

(1) IN GENERAL.—Section 4331(a)(9)(N) of the Tariff Act of 1930 (19 U.S.C. 1451), the provisions of which are in effect for mail shipments described in paragraph (1), are amended by inserting "under this subparagraph, except as provided for in this subparagraph, and" before "(iv) Inbound EMS items.

(2) F INAL REPORT .—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that analyzes reports submitted under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ("other than an item subject to a fee under subsection (b)(9)(D)) after "customs officer";

and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ("other than Inbound EMS items described in subsection (b)(9)(D)) after "(release)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

SEC. 8004. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.

(1) IN GENERAL.—Section 4331(a)(9)(N) of the Tariff Act of 1930 (19 U.S.C. 1451), the provisions of which are in effect for mail shipments described in paragraph (1), are amended by inserting "under this subparagraph, except as provided for in this subparagraph, and" before "(iv) Inbound EMS items.

(2) F INAL REPORT .—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that analyzes reports submitted under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ("other than an item subject to a fee under subsection (b)(9)(D)) after "customs officer";

and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ("other than Inbound EMS items described in subsection (b)(9)(D)) after "(release)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 8005. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.

(1) IN GENERAL.—Section 4331(a)(9)(N) of the Tariff Act of 1930 (19 U.S.C. 1451), the provisions of which are in effect for mail shipments described in paragraph (1), are amended by inserting "under this subparagraph, except as provided for in this subparagraph, and" before "(iv) Inbound EMS items.

(2) F INAL REPORT .—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that analyzes reports submitted under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ("other than an item subject to a fee under subsection (b)(9)(D)) after "customs officer";

and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ("other than Inbound EMS items described in subsection (b)(9)(D)) after "(release)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 8006. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.

(1) IN GENERAL.—Section 4331(a)(9)(N) of the Tariff Act of 1930 (19 U.S.C. 1451), the provisions of which are in effect for mail shipments described in paragraph (1), are amended by inserting "under this subparagraph, except as provided for in this subparagraph, and" before "(iv) Inbound EMS items.

(2) F INAL REPORT .—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that analyzes reports submitted under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ("other than an item subject to a fee under subsection (b)(9)(D)) after "customs officer";

and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ("other than Inbound EMS items described in subsection (b)(9)(D)) after "(release)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 8007. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.

(1) IN GENERAL.—Section 4331(a)(9)(N) of the Tariff Act of 1930 (19 U.S.C. 1451), the provisions of which are in effect for mail shipments described in paragraph (1), are amended by inserting "under this subparagraph, except as provided for in this subparagraph, and" before "(iv) Inbound EMS items.

(2) F INAL REPORT .—Not later than 2 years after submitting the preliminary report required under paragraph (1), the Secretary shall submit to Congress a final report that analyzes reports submitted under subsection (g)(3) and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who received services provided in connection with the processing of Inbound EMS items.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ("other than an item subject to a fee under subsection (b)(9)(D)) after "customs officer";

and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ("other than Inbound EMS items described in subsection (b)(9)(D)) after "(release)"); and

(B) in the flush of the end, by inserting "or of Inbound EMS items described in subsection (b)(9)(D)), after "(C)."

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.
(viii) Nothing in this subparagraph shall be construed to limit the authority of the Secretary to obtain information relating to international mail shipments from private carriers or other appropriate parties.

(ix) In this subparagraph, the term ‘appropriate congressional committees’ means—

(I) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(II) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

(b) Capacity Building.—

(1) In General.—Section 348(a) of the Trade Act of 2002 (19 U.S.C. 2561 note) is amended by adding at the end the following:

“(2) J OINT STRATEGIC PLAN ON CAPACITY BUILDING.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Homeland Security and the Postmaster General shall and submit to the appropriate congressional committees a joint strategic plan detailing specific performance measures for achieving—

(A) the transmission of information as required by section 343(a)(3)(K) of the Trade Act of 2002 (19 U.S.C. 2561 note) is amended by adding at the end the following:

(B) The presentation of the Postal Service to U.S. Customs and Border Protection of all mail targeted by U.S. Customs and Border Protection for inspection.

(C) ADVANCE INFORMATION.—Not later than 60 days after the date of the enactment of this Act, the Secretary to obtain information relating to international mail parcels.

(2) R EPORT AND CONSULTATIONS BY SECRETARY OF HOMELAND SECURITY AND POSTMASTER GENERAL.—

(1) Report.—Not later than 180 days after the date of enactment of this Act, and annually thereafter until 3 years after the Postmaster General has met the requirement under clause (vi) of subparagraph (K) of section 343 of the Trade Act of 2002, as amended, the Secretary of Homeland Security and the Postmaster General shall, in consultation with the Secretary of Homeland Security and the heads of other Federal agencies, as appropriate, provide technical assistance to other countries to implement the requirements of this Act.

(2) Joint Strategic Plan on Capacity Building.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with the Postmaster General, shall, in consultation with the appropriate congressional committees a report on compliance with that subparagraph that includes the following:

(A) An assessment of the status of the regulations required to be promulgated under that subparagraph.

(B) An update regarding new and existing agreements reached with foreign postal operators for the transmission of the information required by that subparagraph.

(C) A summary of the progress made in achieving the transmission of that information.

(3) ADVANCE ELECTRONIC INFORMATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Homeland Security, in consultation with the Postmaster General, shall, in consultation with the appropriate congressional committees, submit to the Committee on Finance of the Senate, the Committee on Homeland Security and Governmental Affairs of the Senate, and the Committee on Ways and Means of the House of Representatives, a report on advance electronic information by foreign postal operators for targeting purposes.

(4) Appropriate Congressional Committees Defined.—In this section, the term ‘appropriate congressional committees’ means—

(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

(c) Report and Consultations by Secretary of Homeland Security and Postmaster General.—

(1) Report.—Not later than 180 days after the date of enactment of this Act, and annually thereafter until 3 years after the Postmaster General has met the requirement under clause (vi) of subparagraph (K) of section 343 of the Trade Act of 2002, as amended, the Secretary of Homeland Security and the Postmaster General shall, in consultation with the Secretary of Homeland Security and the heads of other Federal agencies, as appropriate, provide technical assistance to other countries to implement the requirements of this Act.

(2) Joint Strategic Plan on Capacity Building.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Homeland Security and the Postmaster General shall, in consultation with the Secretary of Homeland Security and the heads of other Federal agencies, as appropriate, may provide technical assistance to other countries to implement the requirements of this Act.

(3) Consultations.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall consult with the appropriate congressional committees a joint strategic plan detailing specific performance measures for achieving—

(A) the transmission of information as required by section 343(a)(3)(K) of the Trade Act of 2002 (19 U.S.C. 2561 note) is amended by adding at the end the following:

(B) The presentation of the Postal Service to U.S. Customs and Border Protection of all mail targeted by U.S. Customs and Border Protection for inspection.

(C) ADVANCE INFORMATION.—Not later than 60 days after the date of the enactment of this Act, the Secretary to obtain information relating to international mail parcels.

(2) R EPORT AND CONSULTATIONS BY SECRETARY OF HOMELAND SECURITY AND POSTMASTER GENERAL.—

(1) Report.—Not later than 180 days after the date of enactment of this Act, the Secretary to obtain information relating to international mail parcels.

(2) Joint Strategic Plan on Capacity Building.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with the Postmaster General, shall, in consultation with the appropriate congressional committees a report on compliance with that subparagraph that includes the following:

(A) An assessment of the status of the regulations required to be promulgated under that subparagraph.

(B) An update regarding new and existing agreements reached with foreign postal operators for the transmission of the information required by that subparagraph.

(C) A summary of the progress made in achieving the transmission of that information.

(3) ADVANCE ELECTRONIC INFORMATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Homeland Security, in consultation with the Postmaster General, shall, in consultation with the appropriate congressional committees, submit to the Committee on Finance of the Senate, the Committee on Homeland Security and Governmental Affairs of the Senate, and the Committee on Ways and Means of the House of Representatives, a report on advance electronic information by foreign postal operators for targeting purposes.

(4) Appropriate Congressional Committees Defined.—In this section, the term ‘appropriate congressional committees’ means—

(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

(d) Government Accountability Office Report.—Not later than June 30, 2019, the Secretary shall submit to the appropriate congressional committees a report—

(1) assessing the progress of the United States Postal Service in achieving the transmission of the information required by subparagraph (K) of section 343(a)(3) of the Trade Act of 2002, as amended by subsection (a)(1), for the percentage of shipments required by that subparagraph.

(2) assessing the quality of the information received from foreign postal operators for targeting purposes.

(3) assessing the specific percentage of targeted mail presented by the Postal Service to U.S. Customs and Border Protection for inspection.

(4) describing the costs of collecting the information required by such subparagraph (K) from foreign postal operators and the costs of implementing the use of that information; and

(5) assessing the benefits of receiving that information with respect to international mail shipments.

(6) assessing the feasibility of assessing a customs fee under section 1303(b)(9) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as added by paragraph (1), on international mail shipments other than Inbound Express Mail service in a manner consistent with the obligations of the United States under international postal agreements and to improve the compliance of the Postal Service with the requirements of such agreements.

(7) identifying recommendations, including recommendations for legislation, to improve the compliance of the Postal Service with the requirements of such agreements.

(8) assessing of whether the detection of illicit synthetic opioids in the international mail would be improved by—

(A) requiring the Postal Service to serve as the consignee for international mail shipments containing goods; or

(B) designating a customs broker to act as an importer of record for international mail shipments containing goods.

(e) Technical Correction.—Section 343 of the Trade Act of 2002 (Public Law 107–216; 19 U.S.C. 2561 note) is amended by striking “ADVANCED” and inserting “ADVANCE”.

(f) Appropriate Congressional Committees Defined.—In this section, the term ‘appropriate congressional committees’ means—

(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

SEC. 8004. INTERNATIONAL POSTAL AGREEMENTS.

(a) Existing Agreements.—

(1) In General.—In the event that any provision of this subtitle, or any amendment made by this subtitle, is determined to be in violation of obligations of the United States under any postal treaty, convention, or other international agreement related to international postal service, or any amendment to such an agreement, that is related to the ability of the United States to secure the provision of advance electronic information by foreign postal operators, the Secretary of State should consult with the appropriate congressional committees (as defined in section 8003(i)).

(2) Expedited Negotiation of New Agreement.—To the extent that any new postal treaty, convention, or other international agreement related to international postal services would improve the ability of the United States to secure the provision of advance electronic information by foreign postal operators as required by regulations prescribed under section 343(a)(3)(K) of the Trade Act of 2002, as amended by subsection (a)(1), the Secretary of State should negotiate to amend the relevant provisions of the agreement so that the United States is no longer in violation of the agreement.

(3) Rule of Construction.—Nothing in this subsection shall be construed to permit derogation from the requirements of this Act or any amendment made by this subtitle or any amendment made by this subsection.

(b) Future Agreements.—

(1) Consultations.—Before entering into, or after the date of the enactment of this Act, any postal treaty, convention, or other international agreement related to international postal services, or any amendment to such an agreement, that is related to the ability of the United States to secure the provision of advance electronic information by foreign postal operators, the Secretary of State should consult with the appropriate congressional committees (as defined in section 8003(i)).
SEC. 8005. COST RECOVERY.

(a) IN GENERAL.—The United States Postal Service shall, to the extent practicable and otherwise recoverable by law, ensure that all costs associated with complying with this subtitle and amendments made by this subtitle are charged directly to foreign shippers or foreign postal operators.

(b) COSTS NOT CONSIDERED REVENUE.—The recovery of costs described in subsection (a) shall not be deemed revenue for purposes of subchapter I and II of chapter 36 of title 39, United States Code, or regulations prescribed under that chapter.

SEC. 8006. DEVELOPMENT OF TECHNOLOGY TO DETECT ILLICIT NARCOTICS.

(a) IN GENERAL.—The Postmaster General and the Commissioner of U.S. Customs and Border Protection, in coordinated coordination with the heads of other agencies as appropriate, shall collaborate to identify and develop technology for the detection of illicit fentanyl, other synthetic opioids, and other narcotics and psychoactive substances entering the United States by mail.

(b) OUTREACH TO PRIVATE SECTOR.—The Postmaster General and the Commissioner shall conduct outreach to private sector entities to gather information regarding the technologies to gather information regarding the technologies that the United States Postal Service and U.S. Customs and Border Protection, in coordination with the heads of other agencies as appropriate, shall collaborate to identify and develop technology for the detection of illicit fentanyl, other synthetic opioids, and other narcotics and psychoactive substances entering the United States.

SEC. 8007. CIVIL PENALTIES FOR POSTAL SHIPMENTS.

Section 436 of the Tariff Act of 1930 (19 U.S.C. 1436) is amended by adding at the end the following new subsection:

"(e) CIVIL PENALTIES FOR POSTAL SHIPMENTS.—


'(2) MODIFICATION OF CIVIL PENALTY.—'(A) IN GENERAL.—U.S. Customs and Border Protection shall reduce or dismiss a civil penalty imposed pursuant to paragraph (1) if U.S. Customs and Border Protection determines that the United States Postal Service—

'(i) has a low error rate in compliance with section 343(a)(3)(K) of the Trade Act of 2002;

'(ii) is cooperating with U.S. Customs and Border Protection with respect to the violation of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002;

'(iii) has taken remedial action to prevent future violations of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002;

'(B) WRITTEN NOTIFICATION.—U.S. Customs and Border Protection shall issue a written notification to the Postal Service with respect to each exercise of the authority of the United States Postal Service by the Federal Trade Commission Act (15 U.S.C. 321 et seq.) that occurred during the previous 2 years.

SEC. 8008. REPORT ON VIOLATIONS OF ARRIVAL REPORTING, ENTRY, AND CLEARANCE REQUIREMENTS AND FALSE OR LACK OF MANIFEST.

(a) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection shall submit to the appropriate congressional committees an annual report that contains the information described in subsection (b) with respect to each violation of section 436 of the Tariff Act of 1930 (19 U.S.C. 1436), as amended by section 3434 of such Act (15 U.S.C. 3154) that occurred during the previous year.

(b) INFORMATION DESCRIBED.—The information described in this subsection is the following:

'(1) The name and address of the violator.

'(2) The specific violation that was committed.

'(3) The location or port of entry through which the items were transported.

'(4) An inventory of the items seized, including a description of the items and the quantity seized.

'(5) The location from which the items originated.

'(6) The entity responsible for the apprehension or seizure, organized by location or port of entry.

'(7) The amount of penalties assessed by U.S. Customs and Border Protection, organized by name of the violator and location or port of entry.

'(8) The amount of penalties that U.S. Customs and Border Protection could have levied, organized by name of the violator and location or port of entry.

'(9) The rationale for negotiating lower penalties, organized by name of the violator and location or port of entry.

'(c) APPROPRIATE CONGRESSIONAL COMMITTEES DEFINED.—In this section, the ‘‘appropriate congressional committees’’ means—

'(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

'(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

SEC. 8009. EFFECTIVE DATE; REGULATIONS.

(a) EFFECTIVE DATE.—This subtitle and the amendments made by this subtitle shall take effect on the date of the enactment of this Act.

(b) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall—

'(1) publish final regulations under this subtitle; and

'(2) publish final regulations under this subtitle that are necessary to carry out this subtitle and the amendments made by this subtitle.

SEC. 8010. OPIOID ADDICTION TREATMENT PREVENTION.

SEC. 8011. OPIOID ADDICTION TREATMENT AND PREVENTION PROGRAMS.

SEC. 8012. SHORT TITLE.

This subtitle may be cited as the ‘‘Opioid Addiction Recovery Fraud Prevention Act of 2019’’.

SEC. 8013. UNFAIR OR DECEPTIVE ACTS OR PRACTICES WITH RESPECT TO SUBSTANCE USE DISORDER TREATMENT SERVICES AND PRODUCTS.

(a) UNLAWFUL ACTIVITY.—It is unlawful to engage in an unfair or deceptive act or practice with respect to any substance use disorder treatment service or substance use disorder treatment product.

(b) ENFORCEMENT BY THE FEDERAL TRADE COMMISSION.—

'(1) UNFAIR OR DECEPTIVE ACTS OR PRACTICES.—A violation of this section shall be treated as a violation of a rule under section 18 of the Federal Trade Commission Act (15 U.S.C. 53a) regarding unfair or deceptive acts or practices.

'(2) POWERS OF THE FEDERAL TRADE COMMISSION.—

'(A) IN GENERAL.—The Federal Trade Commission shall enforce this section in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made part of this section.

'(B) PRIVILEGES AND IMMUNITIES.—Any person who violates subsection (a) shall be subject to the privileges and entitled to the privileges and immunities provided in the Federal Trade Commission Act as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated and made part of this section.

(c) AUTHORITY PRESERVED.—Nothing in this subtitle shall be construed to limit the authority of the Federal Trade Commission over the Food and Drug Administration under any other provision of law.

Subtitle C—Addressing Economic and Workforce Impacts of the Opioid Crisis

SEC. 8041. ADDRESSING ECONOMIC AND WORKFORCE IMPACTS OF THE OPIOID CRISIS.

(a) DEFINITIONS.—Except as otherwise expressly provided, in this section:

'(1) WIOA DEFINITIONS.—The terms ‘‘core program’’, ‘‘individual with a barrier to employment’’, ‘‘local area’’, ‘‘local board’’, ‘‘local partnerships’’, ‘‘outlying area’’, ‘‘State’’, ‘‘State board’’, and ‘‘supportive services’’ have the meanings given the terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

'(2) EDUCATION PROVIDER.—The term ‘‘education provider’’ means—

'(A) an institution of higher education, as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1002(c)); or

'(B) a postsecondary vocational institution, as defined in section 102(c) of such Act (20 U.S.C. 1002(o)).

'(3) ELIGIBLE ENTITY.—The term ‘‘eligible entity’’ means—

'(A) a State workforce agency; or

'(B) an outlying area; or

'(C) a Tribal entity.

'(4) PARTICIPATING PARTNERSHIP.—The term ‘‘participating partnership’’ means a partnership—

'(A) evidenced by a written contract or agreement; and

'(B) including, as members of the partnership—

'(i) a local board receiving a subgrant under subsection (d) and 1 or more of the following:

'(I) The eligible entity.

'(II) A treatment provider.

'(III) An employer or industry organization.

'(IV) An education provider.

'(V) A legal service or law enforcement organization.

'(VI) A faith-based or community-based organization.
(vii) Other State or local agencies, including counties or local governments.
(viii) Other organizations, as determined to be necessary by the local board.

(x) information that may be provided to tribal organizations.

(5) PROGRAM PARTICIPANT.—The term “program participant” means an individual who—

(A) is a member of a population of workers described in subsection (e)(2) that is served by a participating partnership through the pilot program under this section; and

(B) enrolls with the applicable participating partnership to receive any of the services described in subsection (e)(3).

(6) PEER RECOVERY SUPPORT SERVICES.—The term “provider of peer recovery support services” means a provider that delivers peer recovery support services through an organization described in section 547(a) of the Public Health Service Act (42 U.S.C. 290ee–2(a)).

(7) SECRETARY.—The term “Secretary” means the Secretary of Labor.

(8) STATE WORKFORCE AGENCY.—The term “State workforce agency” means the lead State agency with responsibility for the administration of programs under chapter 2 or 3 of title I of the Workforce Innovation and Opportunity Act (29 U.S.C. 3161 et seq., 3171 et seq.).

(9) SUBSTANCE USE DISORDER.—The term “substance use disorder” has the meaning given such term by the Assistant Secretary for Mental Health and Substance Use.

(10) TREATMENT PROVIDER.—The term “treatment provider” means—

(A) a health care provider that—

(i) offers services for treating substance use disorders and is licensed in accordance with applicable State law to provide such services; and

(ii) has a state health insurance for such services, including coverage under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(B) may include—

(i) a nonprofit provider of peer recovery support services;

(ii) a community health care provider;

(iii) a Federally qualified health center (as defined in section 1381(aa) of the Social Security Act (42 U.S.C. 1385a));

(iv) an Indian health program (as defined in section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1685)), including an Indian health program that serves an urban center (as defined in such section); and

(v) a qualified health center as defined in section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 1771).

(11) TRIBAL ENTITY.—The term “Tribal entity” includes any Indian Tribe, tribal organization, Indian-controlled organization serving Indian Tribes, Native American organization, or Alaska Native entity, as such terms are defined or used in section 166 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3166).

(b) PILOT PROGRAM AND GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall carry out a pilot program to address economic and workforce impacts associated with a high rate of a substance use disorder. In carrying out the pilot program, the Secretary shall make grants, on a competitive basis, to eligible entities to enable such entities to make subgrants to local boards to assist the economic and workforce impacts associated with a high rate of a substance use disorder.

(2) GRANT AMOUNTS.—The Secretary shall make grants in an amount that is not less than $500,000, and not more than $5,000,000, for a fiscal year.

(c) GRANT APPLICATIONS.—

(1) IN GENERAL.—An eligible entity applying for a grant under this section shall submit an application to the Secretary at such time and in such manner as the Secretary may reasonably require, including the information described in this subsection.

(2) SIGNIFICANT IMPACT ON COMMUNITY BY OPIOID AND SUBSTANCE USE DISORDER-RELATED PROBLEMS.—

(A) DEMONSTRATION.—An eligible entity shall include in the application—

(i) information that demonstrates significant impact on the community by problems related to opioid abuse or another substance use disorder;

(ii) identifying the counties, communities, regions, or local areas that have been significantly impacted and will be served through the grant application; and

(iii) demonstrating for each service area, an area equal to or greater than the national increase in such problems, between—

(aa) 1999; and

(bb) 2016 or the latest year for which data are available from the Centers for Disease Control and Prevention;

(iii) a Federally qualified health center (as defined in section 1381(aa) of the Social Security Act (42 U.S.C. 1385a));

(iv) an Indian health program (as defined in section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1685)), including an Indian health program that serves an urban center (as defined in such section); and

(v) a qualified health center as defined in section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 1771).

(2) TRIBAL ENTITY.—The term “Tribal entity” includes any Indian Tribe, tribal organization, Indian-controlled organization serving Indian Tribes, Native American organization, or Alaska Native entity, as such terms are defined or used in section 166 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3166).

(b) PILOT PROGRAM AND GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall carry out a pilot program to address economic and workforce impacts associated with a high rate of a substance use disorder. In carrying out the pilot program, the Secretary shall make grants, on a competitive basis, to eligible entities to enable such entities to make subgrants to local boards to assist the economic and workforce impacts associated with a high rate of a substance use disorder.

(2) GRANT AMOUNTS.—The Secretary shall make grants in an amount that is not less than $500,000, and not more than $5,000,000, for a fiscal year.

(c) GRANT APPLICATIONS.—

(1) IN GENERAL.—An eligible entity applying for a grant under this section shall submit an application to the Secretary at such time and in such manner as the Secretary may reasonably require, including the information described in this subsection.

(2) SIGNIFICANT IMPACT ON COMMUNITY BY OPIOID AND SUBSTANCE USE DISORDER-RELATED PROBLEMS.—

(A) DEMONSTRATION.—An eligible entity shall include in the application—

(i) information that demonstrates significant impact on the community by problems related to opioid abuse or another substance use disorder;

(ii) identifying the counties, communities, regions, or local areas that have been significantly impacted and will be served through the grant application; and

(iii) demonstrating for each service area, an area equal to or greater than the national increase in such problems, between—

(aa) 1999; and

(bb) 2016 or the latest year for which data are available from the Centers for Disease Control and Prevention;

(i) geography (such as urban and rural distribution); and

(ii) significantly impacted service areas as described in subsection (c)(2).

(C) TIMING OF SUBGRANT FUNDS DISTRIBUTION.—An eligible entity making subgrants under this subsection shall disburse subgrant funds to a local board receiving a subgrant from the eligible entity by the later of—

(i) the date that is 90 days after the date on which the Secretary receives the funds available to the eligible entity; or

(ii) the date that is 15 days after the date that the eligible entity makes the subgrant under paragraph (A).

(2) SUBGRANT APPLICATION.—

(A) IN GENERAL.—A local board desiring to receive a subgrant under this subsection from an eligible entity shall submit an application at such time and in such manner as the eligible entity may reasonably require, including the information described in this paragraph.

(B) CONTENTS.—Each application described in subparagraph (A) shall include—

(i) an analysis of the estimated performance of the local board in carrying out the proposed services and activities under the subgrant;

(ii) the ability of the local board to establish a participating partnership; and

(iii) information on economic indicators, labor market analyses, information from public announcements, and demographic and industry data.

(iv) information on rapid response activities (as defined in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102)) that have been or will be conducted, including demographic and industry data from employer or worker surveys or through other methods;

(v) data or documentation, beyond anecdotal evidence, showing that employers face challenges filling job vacancies due to a lack of skilled workers able to pass a drug test; or

(vi) information on economic indicators, labor market analyses, information from public announcements, and demographic and industry data.

(II) demonstrating for each service area, an area equal to or greater than the national increase in such problems, between—

(aa) 1999; and

(bb) 2016 or the latest year for which data are available from the Centers for Disease Control and Prevention;
(aa) data from the National Center for Health Statistics of the Centers for Disease Control and Prevention;
(bb) data from the Center for Behavioral Health Statistics and Quality of the Substance Abuse and Mental Health Services Administration;
(cc) State vital statistics;
(dd) workers’ compensation department records;
(ee) reports from local coroners; or
(ff) other relevant data; and
(ii) in the case of a local board proposing to serve a subgrantee described in subsection (e)(2)(B), a demonstration of the workforce shortage in the professional area to be addressed by the subgrant (which may include substance use disorder treatment and related services, non-addictive pain therapy and pain management services, mental health services, and support services, or mental health care), which shall include information that can demonstrate such a shortage, such as—
(I) the distance between—
(aa) communities affected by opioid abuse or another substance use disorder; and
(bb) facilities or professionals offering substance use disorder services in the area; or
(ii) the maximum capacity of facilities or professionals to serve individuals in an affected community, or increases in arrests related to non-substance use disorder, overdose deaths, or nonfatal overdose emergencies in the community.
(e) PROGRAM AND ACTIVITIES.—
(1) IN GENERAL.—Each local board that receives a subgrant under subsection (d) shall carry out the services and activities described in this subsection through a partnering partnership.
(2) SELECTION OF POPULATION TO BE SERVED.—A participating partnership shall elect to provide services and activities under the subgrant (which may include substance use disorder treatment and related services, non-addictive pain therapy and pain management services, mental health services, and support services, or mental health care), which shall include information that can demonstrate such a shortage, such as—
(I) the distance between—
(aa) communities affected by opioid abuse or another substance use disorder; and
(bb) facilities or professionals offering substance use disorder services in the area; or
(ii) the maximum capacity of facilities or professionals to serve individuals in an affected community, or increases in arrests related to non-substance use disorder, overdose deaths, or nonfatal overdose emergencies in the community.
(3) SERVICES AND ACTIVITIES.—
(I) IN GENERAL.—Each local board that receives a subgrant under subsection (d) shall carry out the services and activities described in this subsection through a partnering partnership.
(II) NON-TRADITIONAL WORK ACTIVITIES.—
(A) OFFICE- BASED TREATMENT AND RECOVERY SERVICES.—Offering career services and training services may include—
(i) Services provided to program participants who are in a pre-employment stage of the program which may include—
(I) initial education and skills assessments;
(II) traditional classroom training funded through individual training accounts under chapter 3 of subtitle B of title I of the Workforce Innovation and Opportunity Act (29 U.S.C. 3117 et seq.);
(III) services to promote employability skills such as punctuality, personal maintenance skills, and professional conduct;
(IV) in-depth interviewing and evaluation to identify employment barriers and to develop individual employment plans; and
(V) career planning that includes—
(aa) career pathways leading to in-demand, high-wage jobs; and
(bb) job coaching, job matching, and job placement services;
(VI) provision of payments and fees for employment and training related applications, tests, and certifications; or
(VII) any other appropriate career service or training service described in section 134(c) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3174(c));
(B) WORK BASED LEARNING.—A participating partnership may offer participants to assist the program participants in the design of a work-based learning program for participants who are in a pre-employment stage of the program, which may include—
(i) case management and support services, including a continuation of the services described in clause (i) that is conducted in collaboration with the employers of such participants;
(II) mentorship services and job retention support for such participants; or
(III) targeted training for managers and workers working with such participants (such as mentors), and human resource representatives in the business in which such participants are employed.
(C) OFFICE- BASED TREATMENT AND RECOVERY SERVICES.—In offering career services and training services, employers working with such participants (such as mentors), and human resource representatives in the business in which such participants are employed.
(G) **Proven and promising practices.**—Leading efforts in the service area to identify and promote proven and promising strategies and initiatives for meeting the needs of employers and program participants.

(4) **Limitations.**—A participating partnership may not use—

(A) more than 10 percent of the funds received under a subgrant under subsection (d) for the administrative costs of the partnership;

(B) more than 10 percent of the funds received under a subgrant for the provision of treatment and recovery services, as described in paragraph (3)(D); and

(C) more than 10 percent of the funds received under a subgrant for the provision of supportive services described in paragraph (3)(E) to program participants.

(f) **Performance accountability.**—

(1) Reports.—The Secretary shall establish quarterly reporting requirements for recipients of grants and subgrants under this section that, to the extent practicable, are based on the performance accountability system under section 116 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3181(c)) and, in the case of a grant awarded to an eligible entity described in subsection (a)(3)(C), section 166(h) of such Act (29 U.S.C. 3221(h)), includes the indicators described in section (c)(1)(A)(i) of such section 116 and the requirements for local area performance reports under subsection (d) of such section 116.

(2) **Evaluations.**—

(A) **Authority to enter into agreements.**—The Secretary shall ensure that an independent evaluation, conducted on the pilot program carried out under this section to determine the impact of the program on employment of individuals with substance use disorders. The Secretary shall enter into an agreement with eligible entities receiving grants under this section to pay for all or part of such evaluation.

(B) **Methodologies to be used.**—The independent evaluation conducted under this paragraph shall use experimental designs using random assignment or, when random assignment is not feasible, other reliable, evidence-based research methodologies that allow for the strongest possible causal inferences.

(g) **Funding.**—

(1) **Covered fiscal year.**—In this subsection, the term "covered fiscal year" means any fiscal year 2019 through fiscal year 2023.

(2) **Using funding for national dislocated worker grants.**—Subject to paragraph (4) and notwithstanding section 132(a)(2)(A) and subtitle D of the Workforce Innovation and Opportunity Act (29 U.S.C. 3121(a)(2)(A) et seq.), the Secretary may use, to carry out the pilot program under this section for a covered fiscal year—

(A) funds available to carry out section 170 of such Act (29 U.S.C. 3225) for that fiscal year; and

(B) funds made available to carry out section 170 of such Act (29 U.S.C. 3225) for that fiscal year; and

(C) funds that remain available under such section 172(i) of such Act (29 U.S.C. 3227(i)).

(3) **Availability of funds.**—Funds appropriated under section 136(c) of such Act (29 U.S.C. 3181(c)) and made available to carry out section 170 of such Act for a fiscal year shall remain available for use under paragraph (2) for a subsequent fiscal year until expended.

(4) **Limitation.**—The Secretary may not use more than $100,000,000 of the funds described in paragraph (2) for any covered fiscal year under this section.

**Subtitle D—Peer Support Counseling Program for Women Veterans**

**SEC. 8051. PEER SUPPORT COUNSELING PROGRAM FOR WOMEN VETERANS.**

(a) **In general.**—Section 172(f) of title 38, United States Code, is amended by adding at the end the following paragraph:

"(4)(A) As part of the counseling program under this subsection, the Secretary shall emphasize appointing peer support counselors for women veterans. To the degree practicable, the Secretary shall seek to recruit, retain, and support peer support counselors with expertise in—

(i) female gender-specific issues and services;

(ii) the provision of information about services and benefits provided under laws administered by the Secretary; or

(iii) employment mentoring.

(B) To the degree practicable, the Secretary shall emphasize facilitating peer support counseling for women veterans who are eligible for counseling and services under section 1720D of this title, have post-traumatic stress disorder or suffer from another mental health condition, are homeless or at risk of becoming homeless, or are otherwise at increased risk of suicide, as determined by the Secretary.

(C) The Secretary shall conduct outreach to inform women veterans about the program and the assistance available under this paragraph.

(D) In carrying out this paragraph, the Secretary shall coordinate with such community organizations, State and local governments, institutions of higher education, chambers of commerce, local business organizations, organizations that provide legal assistance, and other organizations as the Secretary considers appropriate.

(E) In carrying out this paragraph, the Secretary shall provide adequate training for peer support counselors, including training carried out under the national program of training required by section 394(c) of the Caregivers and Veterans Omnibus Health Services Act of 2010 (38 U.S.C. 1712A note)."

(b) **Funding.**—The Secretary of Veterans Affairs shall carry out paragraph (4) of section 1720F(j) of title 38, United States Code, as added by subsection (a), using funds other than funds otherwise made available to the Secretary. No additional funds are authorized to be appropriated by reason of such paragraph.

(c) **Reports.**—Not later than 2 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 peer support counseling program under section 1720F(j) of title 38, United States Code, as amended by this section. Such report shall include—

(1) the number of peer support counselors in the program;

(2) an assessment of the effectiveness of the program; and

(3) a description of the oversight of the program.

**Subtitle E—Treating Barriers to Prosperity**

**SEC. 8061. SHORT TITLE.**

This subtitle may be cited as the "Treating Barriers to Prosperity Act of 2018".

**SEC. 8062. DRUG ABUSE MITIGATION INITIATIVE.**

(a) **In general.**—Chapter 145 of title 40, United States Code, is amended by inserting after section 14509 the following:

"§ 14510. Drug abuse mitigation initiative.

(4) As part of the counseling program under this subsection, the Appalachian Regional Commission may provide technical assistance to, make grants to, enter into contracts with, or otherwise provide amounts to individuals or entities in the Appalachian region for projects and activities to address drug abuse, including opioid abuse, in the region, including projects and activities—

(1) to facilitate the sharing of best practices among States, Counties, and other experts in the region with respect to reducing such abuse;

(2) to initiate or expand programs designed to eliminate or combat the harm to the workforce and economic growth of the region that results from such abuse;

(3) to attract and retain relevant health care services, businesses, and workers in the region;

(4) to develop relevant infrastructure, including broadband infrastructure that supports the use of telemedicine.

(b) **Limitation on grants.**—Of the cost of any activity eligible for a grant under this section—

(1) not more than 50 percent may be provided from amounts appropriated to carry out this section; and

(2) notwithstanding paragraph (1)—

(A) in the case of a project to be carried out in a county for which a distressed county designation is in effect under section 14526, not more than 80 percent may be provided from amounts appropriated to carry out this section; and

(B) in the case of a project to be carried out in a county for which an at-risk designation is in effect under section 14526, not more than 80 percent may be provided from amounts appropriated to carry out this section.

(c) **Sources of assistance.**—Subject to subsection (b), a grant provided under this section may be provided from amounts made available to carry out this section in combination with amounts appropriated to carry out this section—

(1) under any other Federal program (subject to the availability of subsequent appropriations); or

(2) from any other source.

(d) **Federal share.**—Notwithstanding any provision of law limiting the Federal share under any other Federal program, amounts made available to carry out this section may be used to increase that Federal share, as the Appalachian Regional Commission determines to be appropriate.

(e) **Clerical amendment.**—The analysis for chapter 145 of title 40, United States Code, is amended by inserting after the item relating to section 14509 the following:

"14510. Drug abuse mitigation initiative."

**Subtitle F—Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed**

**SEC. 8071. PILOT PROGRAM TO HELP INDIVIDUALS IN RECOVERY FROM A SUBSTANCE USE DISORDER BECOME STABLY HOUSED.**

(a) **Authorization of appropriations.**—There is authorized to be appropriated under this section such sums as may be necessary for each of fiscal years 2019 through 2023 for assistance to States to provide individuals in recovery from a substance use disorder stable, temporary housing for a period of not more than 2 years or until the individual secures permanent housing, whichever is earlier.

(b) **Allocation of appropriated amounts.**—

(1) **In general.**—The amounts appropriated under this section shall be allocated based on a formula funding mandate established by the Secretary of Housing and Urban Development (referred to in this section, the "mandate") not later than 60 days after the date of enactment of this Act.

(2) **Criteria.**—

(A) **In general.**—The funding formula required under paragraph (1) shall ensure that any amounts appropriated or otherwise made available..."
though such funds were community development, health plans, recipients of family-focused residential treatment, parenting education and skills development, the provision, assessment, or coordination of care and services for children, families, or other individuals in need of assistance, and children who temporarily lost custody of their children; and, consistent with such elements and protocol, shall provide

"(D) home visiting services coordinated with the family and children,

"(B) assistance in receiving the appropriate benefits to aid the parent or guardian in recovery;

"(C) services to assist the parent or guardian in prioritizing issues identified in assessments, establishing goals for resolving such issues that are consistent with the goals of the treatment provider, child welfare agency, courts, and other agencies involved with the parent or guardian or their children, and making a coordinated plan for achieving such goals;

"(D) home visiting services coordinated with the family and children,

"(A) assessments to evaluate the needs of the parent or guardian;

"(B) assistance in receiving the appropriate benefits to aid the parent or guardian in recovery;

"(C) services to assist the parent or guardian in prioritizing issues identified in assessments, establishing goals for resolving such issues that are consistent with the goals of the treatment provider, child welfare agency, courts, and other agencies involved with the parent or guardian or their children, and making a coordinated plan for achieving such goals;

"(D) home visiting services coordinated with the family and children,

"(A) assessments to evaluate the needs of the parent or guardian;

"(B) assistance in receiving the appropriate benefits to aid the parent or guardian in recovery;

"(C) services to assist the parent or guardian in prioritizing issues identified in assessments, establishing goals for resolving such issues that are consistent with the goals of the treatment provider, child welfare agency, courts, and other agencies involved with the parent or guardian or their children, and making a coordinated plan for achieving such goals;

"(D) home visiting services coordinated with the family and children,
components: a pilot phase, an impact study, and an implementation study.

(3) PILOT PHASE.—The pilot phase component of the evaluation shall consist of the following components:

(i) a demonstration of the feasibility of the entity or entities conducting the family recovery and reunification program under the project to ensure—

(A) the program implementation adheres closely to the elements and protocol determined to be most effective in other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children; and

(B) random assignment of parents or guardians and their children to be participants in the program or to be part of the program's control group being carried out.

(4) IMPACT STUDY.—The impact study component of the evaluation shall determine the impacts of the family recovery and reunification program conducted under the project on the parents and guardians and their children participating in the program.

The impact study component shall—

(i) be conducted using an experimental design that uses a random assignment research methodology;

(ii) be consistent with previous studies of other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children, measures used for parents and guardians and their children covering multiple time periods, including for a period of 5 years; and

(iii) include measurements of family stability and parent, guardian, and child safety for program participants and the program control group that are consistent with measurements of such factors for participants and control groups from previous studies of other recovery coaching programs so as to allow results of the impact study to be compared with the results of such prior studies, including with respect to comparisons between program participants and the program control group regarding—

(A) safe family reunification;

(B) time to reunification;

(C) permanency (such as through measures of reunification, adoption, or placement with guardians or other kin);

(D) safety (such as through measures of subsequent maltreatment);

(E) parental or guardian treatment persistence and satisfaction agreement and results in increased family reunification and protect children so as to make sure the program conducted under the project adheres closely to the elements and protocols needed for effective in such other recovery coaching programs;

(iv) assist the entity or entities in securing adequate coaching, treatment, child welfare, and other resources needed to successfully conduct the family recovery and reunification program under the project; and

(v) ensure the entity or entities will be able to monitor the impacts of the program in the area or areas in which it is conducted for at least 5 years after parents or guardians and their children are randomly assigned to participate in the program or to be part of the program's control group.

(5) EVALUATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall, through contracts or agreements with 1 or more entities, conduct and evaluate the family recovery and reunification program under the project.

(B) REQUIREMENTS.—In identifying 1 or more entities to conduct the evaluation of the family recovery and reunification program, the Secretary shall—

(i) determine that the area or areas in which the program will be conducted have sufficient substance use disorder treatment providers and resources (other than those provided with funds made available to carry out the project) to successfully conduct the program;

(ii) determine that the area or areas in which the program will be conducted have enough potential program participants, and will serve a sufficient number of parents or guardians and their children, so as to allow for the formation of a control group, evaluation results to be adequately powered, and preliminary results of the evaluation to be available within 4 years of the program's implementation;

(iii) provide the entity or entities with technical assistance and training, including by working with 1 or more entities that have or have been involved in recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children so as to make sure the program conducted under the project adheres closely to the elements and protocols needed for effective in such other recovery coaching programs;

(iv) assist the entity or entities in securing adequate coaching, treatment, child welfare, and other resources needed to successfully conduct the family recovery and reunification program under the project; and

(v) ensure the entity or entities will be able to monitor the impacts of the program in the area or areas in which it is conducted for at least 5 years after parents or guardians and their children are randomly assigned to participate in the program or to be part of the program's control group.

(6) EVALUATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary, in consultation with the program's principal entity or entities, shall conduct an evaluation to determine whether the program implemented as described and resulted in improvements for children and families. The evaluation shall have 3 components: a pilot phase, an impact study, and an implementation study.

(B) PILOT PHASE.—The pilot phase component of the evaluation shall consist of the following components:

(i) the program implementation adheres closely to the elements and protocol determined to be most effective in other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children; and

(ii) random assignment of parents or guardians and their children to be participants in the program or to be part of the program's control group being carried out.

(C) IMPACT STUDY.—The impact study component of the evaluation shall determine the impacts of the family recovery and reunification program conducted under the project on the parents and guardians and their children participating in the program. The impact study component shall—

(i) be conducted using an experimental design that uses a random assignment research methodology;

(ii) be consistent with previous studies of other recovery coaching programs that have been rigorously evaluated and shown to increase family reunification and protect children, measures used for parents and guardians and their children covering multiple time periods, including for a period of 5 years; and

(iii) include measurements of family stability and parent, guardian, and child safety for program participants and the program control group that are consistent with measurements of such factors for participants and control groups from previous studies of other recovery coaching programs so as to allow results of the impact study to be compared with the results of such prior studies, including with respect to comparisons between program participants and the program control group regarding—

(1) safe family reunification;

(2) time to reunification;

(3) permanency (such as through measures of reunification, adoption, or placement with guardians or other kin);

(4) safety (such as through measures of subsequent maltreatment);

(5) parental or guardian treatment persistence and satisfaction agreement and results in increased family reunification and protect children so as to make sure the program conducted under the project adheres closely to the elements and protocols needed for effective in such other recovery coaching programs;

(6) assist the entity or entities in securing adequate coaching, treatment, child welfare, and other resources needed to successfully conduct the family recovery and reunification program under the project; and

(7) ensure the entity or entities will be able to monitor the impacts of the program in the area or areas in which it is conducted for at least 5 years after parents or guardians and their children are randomly assigned to participate in the program or to be part of the program's control group.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means a State, county, local, or tribal health or child welfare agency, a private nonprofit organization, a research organization, a treatment service provider, an institution of higher education (as defined under section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)), or another entity specified by the Secretary.

(b) FAMILY-FOCUSED RESIDENTIAL TREATMENT PROGRAM.—The term "family-focused residential treatment program" means a high-quality, evidence-based residential program that provides treatment and care primarily for substance use disorder treatment for pregnant and postpartum women and parents and guardians that allows children to reside with such women or their parents or guardians during treatment to the extent appropriate and applicable.
(3) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) SUPPORT FOR THE DEVELOPMENT OF EVIDENCE-BASED FOCUS-FACED RESIDENTIAL TREATMENT PROGRAMS.—

(1) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to eligible entities for purposes of identifying, selecting, and evaluating family-focused residential treatment programs to increase the availability of such programs that meet the requirements of promising, supported, or well-supported practices specified in section 471(e)(4)(C) of the Social Security Act (42 U.S.C. 671(e)(4)(C)) as added by the Family First Prevention Services Act enacted under title VII of division E of Public Law 115–123.

(2) EVALUATION REQUIREMENT.—The Secretary shall require any evaluation of a family-focused residential treatment program by an eligible entity that uses funds awarded under this section for all or part of the costs of the evaluation to be designed to assist in the determination of whether the program may qualify as a promising, supported, or well-supported practice in accordance with the requirements of such section 471(e)(4)(C).

Subtitle H—Reauthorizing and Extending Grants for Recovery From Opioid Use Programs

SEC. 8091. SHORT TITLE.

This subtitle may be cited as the “Reauthorizing and Extending Grants for Recovery From Opioid Use Programs Act of 2018” or the “REGROUP Act of 2018”.

SEC. 8092. REAUTHORIZATION OF THE COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

Section 1001(a)(27) of the Omnibus Crime Control and Safe Streets Act of 1968 (51 U.S.C. 10261(a)(27)) is amended by striking “through 2021” and inserting “and 2018, and $330,000,000 for each of fiscal years 2019 through 2023”.

Subtitle I—Fighting Opioid Abuse in Transportation

SEC. 8101. SHORT TITLE.

This subtitle may be cited as the “Fighting Opioid Abuse in Transportation Act”.

SEC. 8102. AMENDMENTS TO OUTER CONTROLLOR SUBSTANCE TESTING OF MECHANICAL EMPLOYEES.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Transportation shall publish a rule in the Federal Register revising the regulations promulgated under section 21904 of Title 49, United States Code, to cover all employees of railroad carriers who perform mechanical activities.

(b) DEFINITION OF MECHANICAL ACTIVITIES.—For the purposes of the rule under subsection (a), the Secretary shall define the term “mechanical activities” by regulation.

SEC. 8103. DEPARTMENT OF TRANSPORTATION PUBLIC DRUG AND ALCOHOL TESTING DATABASE.

(a) IN GENERAL.—Subject to subsection (c), the Secretary of Transportation shall—

(1) not later than March 31, 2019, establish and make publicly available on its website a database of the drug and alcohol testing data reported by employers for each mode of transportation; and

(2) update the database annually.

(b) CONTENTS.—The database under subsection (a) shall include, for each mode of transportation—

(1) the total number of drug and alcohol tests by type of substance tested;

(2) the drug and alcohol test results by type of substance tested;

(3) the reason for the drug or alcohol test, such as pre-employment, random, post-accident, reasonable suspicion or cause, return-to-duty, or follow-up, by type of substance tested; and

(4) the number of individuals who refused testing.

(c) COMMERCIALLY SENSITIVE DATA.—The Department of Transportation shall not release any commercially sensitive data or personally identifiable data furnished by an employer under this section unless the data is aggregated or otherwise in a form that does not identify the employer providing the data.

(d) SAVINGS CLAUSE.—Nothing in this section may be construed as limiting or otherwise affecting the requirements of the Secretary of Transportation to adhere to requirements applicable to confidential business information and sensitive security information, consistent with applicable law.

SEC. 8104. GAO REPORT ON DEPARTMENT OF TRANSPORTATION’S COLLECTION AND USE OF DRUG AND ALCOHOL TESTING DATA.

(a) IN GENERAL.—Not later than 2 years after the date the Department of Transportation public drug and alcohol testing database is established under section 8103, the Comptroller General of the United States shall—

(1) review the Department of Transportation Drug and Alcohol Testing Management Information System; and

(2) submit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives a report on the review, including recommendations under subsection (c).

(b) CONTENTS.—The report under subsection (a) shall include—

(1) a description of the process the Department of Transportation uses to collect and record drug and alcohol testing data submitted by employers for each mode of transportation;

(2) an assessment of whether and, if so, how the Department of Transportation uses the data described in paragraph (1) in carrying out its responsibilities; and

(3) an assessment of whether the Department of Transportation public drug and alcohol testing database under section 8103 could be made more effective; and

(c) RECOMMENDATIONS.—The report under subsection (a) may include recommendations regarding—

(1) how the Department of Transportation can best use the data described in subsection (b)(1); and

(2) any improvements that could be made to the process described in subsection (b)(1); whether and, if so, how the Department of Transportation uses the data described in subsection (b)(1); and

(3) other recommendations as the Comptroller General determines appropriate.

SEC. 8105. TRANSPORTATION WORKPLACE DRUG TESTING PANEL.

(a) IN GENERAL.—Subject to subsection (c), the Secretary of Health and Human Services shall establish a new panel to include representatives from the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives to provide advice on expanding the list of substances authorized to be tested to include the substance or substances determined to be justified for inclusion.

(b) DUTIES.—The panel established under this section shall—

(1) delay the publication of the notices described in sections 55402 and 55403 of the Fixing America’s Surface Transportation Act (Public Law 114-94; 129 Stat. 1312), the Secretary of Health and Human Services makes a determination or publishes a notice under this section; or

(2) limit or otherwise affect any authority of the Secretary of Health and Human Services to expand the list of authorized substances to include an additional substance.

SEC. 8106. STATUS REPORTS ON HAIR TESTING GUIDELINES.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, and annually thereafter until the date that the Secretary of Health and Human Services publishes in the Federal Register a final notice of scientific and technical guidelines for hair testing in accordance with section 55402(b) of the Fixing America’s Surface Transportation Act (Public Law 114-94; 129 Stat. 1312), the Secretary of Health and Human Services shall submit to the Comptroller General of the United States a report on—

(1) the status of the hair testing guidelines; and

(2) an explanation for why the hair testing guidelines have not been issued; and

(b) consider whether to include with the determination under subparagraph (A) a separate determination on whether a revision of the Mandatory Guidelines for Federal Workplace Drug Testing Programs shall be published in the Federal Register for testing to include any other drugs or other substances listed in schedule I and II of section 202 of the Controlled Substances Act (21 U.S.C. 812) is justified based on the criteria described in subparagraph (A).

(2) REVISION OF GUIDELINES.—If an expansion of the substance list is determined to be justified under paragraph (1), the Secretary of Health and Human Services shall—

(A) notify the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives of the determination; and

(B) publish in the Federal Register, not later than 18 months after the date of the determination under that paragraph, a final notice of the revision of the Mandatory Guidelines for Federal Workplace Drug Testing Programs to expand the list of substances authorized to be tested to include the substance or substances determined to be justified for inclusion.

(3) REPORT.—If an expansion of the substance list is determined not to be justified under paragraph (1), the Secretary of Health and Human Services shall—

(A) notify the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives of the report explaining, in detail, the reasons the expansion of the list of authorized substances is not justified; and

(B) publish in the Federal Register, not later than 18 months after the date of the final notice published under paragraph (1), a final rule revising part 40 of title 49, Code of Federal Regulations, to include such substances in the Department of Transportation’s drug testing guidelines.

(c) FEDERAL WORKPLACE DRUG TESTING GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS.—As revised by the Secretary of Health and Human Services under subsection (a), the drug testing guidelines for Federal Workplace Drug Testing Programs shall—

(1) delaying the publication of the notices described in sections 55402 and 55403 of the Fixing America’s Surface Transportation Act (Public Law 114-94; 129 Stat. 1312), the Secretary of Health and Human Services makes a determination or publishes a notice under this section; or

(2) limit or otherwise affect any authority of the Secretary of Health and Human Services to expand the list of authorized substances to include an additional substance.

SEC. 8109. STATUS REPORTS ON HAIR TESTING GUIDELINES.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, and annually thereafter until the date that the Secretary of Health and Human Services publishes in the Federal Register a final notice of scientific and technical guidelines for hair testing in accordance with section 55402(b) of the Fixing America’s Surface Transportation Act (Public Law 114-94; 129 Stat. 1312), the Secretary of Health and Human Services shall submit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Transportation and Infrastructure of the House of Representatives a report on—

(1) the status of the hair testing guidelines; and

(2) an explanation for why the hair testing guidelines have not been issued; and
(3) an estimated date of completion of the hair testing guidelines.

(b) REQUIREMENT.—To the extent practicable and consistent with the objective of the final notice of scientific and technical guidelines described in subsection (a), to detect illegal or unauthorized use of substances by the individual being tested, the final notice of scientific and technical guidelines, and any other pertinent guidance issued by the Secretary of Health and Human Services, shall eliminate the risk of positive test results, of the individual being tested, caused solely by the use of others and not caused by the drug use of the individual being tested.

SEC. 8107. MANDATORY GUIDELINES FOR FEDERAL WORKPLACE DRUG TESTING PROGRAMS USING ORAL FLUID.

(a) DEADLINE.—Not later than December 31, 2018, the Secretary of Health and Human Services shall publish in the Federal Register a final notice of the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid, based on the notice of proposed mandatory guidelines published in the Federal Register on May 15, 2015 (94 FR 28054).

(b) REQUIREMENT.—To the extent practicable and consistent with the objectives of the testing described in subsection (a) to detect illegal or unauthorized use of substances by the individual being tested, the final notice of scientific and technical guidelines under that subsection, as determined by the Secretary of Health and Human Services, shall eliminate the risk of positive test results, of the individual being tested, caused solely by the drug use of others and not caused by the drug use of the individual being tested.

(3) DEFINITION OF CONSTRUCTION.—Nothing in this section may be construed as requiring the Secretary of Health and Human Services to issue a notice of proposed mandatory guideline under subsection (a).

SEC. 8108. ELECTRONIC RECORDKEEPING.

(a) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) ensure that each certified laboratory that requests approval for the use of complete paperless electronic Federal Drug Testing Custody and Control Forms for the National Laboratory Certification Program’s Electronic Custody and Control Form systems receives approval for those completely paperless electronic forms instead of paper forms that include any combination of electronic traditional handwritten signatures executed on paper forms; and

(2) establish a deadline for a certified laboratory to request approval under paragraph (1).

(b) SAVINGS CLAUSE.—Nothing in this section may be construed as limiting or otherwise affecting any authority of the Secretary of Health and Human Services to

(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed to the applicable beneficiary under the Medicare program from the items related to section 219 the following:

(2) a discount in the price of an applicable drug of a manufacturer that is furnished to a particular recovery home, clinical treatment facility, or laboratory;

(3) a discount in the price of an applicable drug of a manufacturer that is furnished to a particular recovery home, clinical treatment facility, or laboratory;

(4) a payment made by a principal to an agent as compensation for the services of the agent under a personal services and management contract that meets the requirements of section 1001.952(d) of title 42, Code of Federal Regulations, or any successor regulation of an agent or otherwise by a health care benefit program if—

(1) the waiver or discount is not routinely provided; and

(2) the waiver or discount is provided in good faith;

(5) a remuneration made pursuant to an alternative payment model (as defined in section 1833(z)(3)(A) of the Social Security Act) pursuant to a waiver or discount of a remuneration use by a State, health insurance issuer, or group health plan if the Secretary of Health and Human Services has determined that a statute, regulation, or any other applicable provision of law on the same subject matter.

(6) a remuneration described in section 1123(b)(3)(D) of the Social Security Act (42 U.S.C. 1320a–7b).

(2) the term ‘clinical treatment facility’ means a medical setting , other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use, pursuant to licensure or certification under State law.

(3) the term ‘health care benefit program’ has the meaning given in the term ‘applicable drug’ under section 332 of the Public Health Service Act (42 U.S.C. 263a).

(c) REGULATIONS.—The Administrator of the Federal Motor Carrier Safety Administration shall—

(1) establish a deadline for a certified laboratory to request approval for the use of complete paperless electronic Federal Drug Testing Custody and Control Forms for the National Laboratory Certification Program’s Electronic Custody and Control Form systems receives approval for those completely paperless electronic forms instead of paper forms that include any combination of electronic traditional handwritten signatures executed on paper forms; and

(2) establish a deadline for a certified laboratory to request approval under paragraph (1).

(b) SAVINGS CLAUSE.—Nothing in this section may be construed as limiting or otherwise affecting any authority of the Secretary of Health and Human Services to

(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed to the applicable beneficiary under the Medicare program from the items related to section 219 the following:

(2) a discount in the price of an applicable drug of a manufacturer that is furnished to a particular recovery home, clinical treatment facility, or laboratory;

Act of 2006 (Public Law 109–469; 120 Stat. 3502), as amended by

section 1024 (21 U.S.C. 1524), by striking subsections (a) and (b) and inserting the following:

(a) IN GENERAL.—There is authorized to be appropriated to the Office of National Drug Control Policy to pay administrative costs associated with the responsibilities of the Office under this chapter: 

(i) in subchapter I (21 U.S.C. 1531 et seq.),

(A) by striking “substance abuse” each place it appears and inserting “substance use and misuse”;

and

(B) in section 1032(b)(1)(A) (21 U.S.C. 1532(b)(1)(A)), by striking clause (iii) and inserting the following: 

(‘‘(iii) RENEWAL GRANTS.—Subject to clause (iv), the Administrator may award a renewal grant to a grant recipient under this subchapter for each fiscal year of the 4-fiscal-year period following the first fiscal year for which the initial additional grant is awarded in an amount not to exceed the following: ‘‘

(I) For the first and second fiscal years of the 4-fiscal-year period, the amount of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year is not less than 125 percent of the amount awarded.

(II) For the third and fourth fiscal years of the 4-fiscal-year period, the amount of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year is not less than 150 percent of the amount awarded.’’; and

(iv) by striking paragraph (1) and inserting the following: 

‘‘(1) G RANTS AUTHORIZED.—The Director shall, using amounts authorized to be appropriated by subsection (d), make a competitive grant to provide for the continuation of the National Community Anti-drug Coalition Institute.’’

(b) ELIGIBLE ORGANIZATIONS.—An organization eligible for a grant under subsection (a) is any national nonprofit organization that represents, provides technical assistance and training to, and has special expertise in, the development and support of community anti-drug coalitions under this subchapter.

(c) USE OF GRANT AMOUNT.—The organization eligible for the grant under subsection (a) shall continue a National Community Anti-Drug Coalition Institute to— 

(1) provide education, training, and technical assistance to coalition leaders and community teams, with emphasis on the development of coalitions serving economically disadvantaged areas;

(2) develop and use standardized evaluation tools, mechanisms, and measures to better assess and document coalition performance and outcomes; and

(3) bridge the research gap in substance use and misuse.

SEC. 8204. REAUTHORIZATION OF THE NATIONAL COMMUNITY ANTI-DRUG COALITION INSTITUTE.

SEC. 8205. REAUTHORIZATION OF THE HIGH-INTENSITY DRUG TRAFFICKING AREA PROGRAM.

SEC. 8206. REAUTHORIZATION OF DRUG COURT PROGRAM.

SEC. 8207. DRUG COURT TRAINING AND TECHNICAL ASSISTANCE.

SEC. 8208. DRUG OVERDOSE RESPONSE STRATEGY IMPLEMENTATION.
funds appropriated to carry out this section to implement a drug overdose response strategy in high intensity drug trafficking areas on a nationwide basis by—

(1) targeting multi-disciplinary efforts to prevent, reduce, and respond to drug overdoses, including the uniform reporting of fatal and non-fatal overdoses to public health services and may make grants to State law enforcement agencies in high intensity drug trafficking areas that have experienced high rates of fentanyl and new psychoactive substances for the purposes of—

(1) purchasing portable equipment to test for fentanyl and other substances;

(2) training law enforcement officers and other first responders on best practices for handling fentanyl and other substances; and

(3) enabling collaborative deployment of prevention, intervention, and enforcement resources to address substance use addiction and narcotics trafficking.’’.

SEC. 8209. PROTECTING LAW ENFORCEMENT OFFICERS FROM ACCIDENTAL EXPOSURE.

Section 707 of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1706), as amended by section 8208, is amended by adding at the end the following:

‘‘(s) SUPPLEMENTAL GRANTS.—The Director is authorized to use not more than $10,000,000 of the amounts otherwise appropriated to carry out this section to provide supplemental competitive grants to high intensity drug trafficking areas that have experienced high seizures of fentanyl and new psychoactive substances for the purposes of—

(1) purchasing portable equipment to test for fentanyl and other substances;

(2) training law enforcement officers and first responders on best practices for handling fentanyl and other substances; and

(3) enabling collaborative deployment of prevention, intervention, and enforcement resources to address substance use addiction and narcotics trafficking.’’.

SEC. 8210. COPS ANTI-METH PROGRAM.


(1) by redesignating subsection (k) as subsection (l); and

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

‘‘(k) COPS ANTI-METH PROGRAM.—The Attorney General shall use amounts otherwise appropriated to carry out this section to provide grants to State and local governments, and to support the salaries of full-time employees, to establish and operate anti-fentanyl drug control programs. Such programs may provide for the—

(1) Expansion of resource center services with professional, clinical staff that provide, for families and individuals impacted by a substance use disorder, support, access to treatment resources, brief assessments, medication and overdose prevention education, compassionate listening services, recovery support or peer specialists, bereavement and grief support, and case management;

(2) Continued development of health information technology systems that leverage new and upcoming technology and techniques for prevention, intervention, and filling resource gaps in communities that are underserved;

(3) Enhancement and operation of treatment and recovery resources, easy-to-read scientific and evidence-based education on addiction and substance use disorders, and other informational tools for families and individuals impacted by a substance use disorder and their caretakers, such as law enforcement agencies;

(4) Provision of training and technical assistance to State and local governments, law enforcement agencies, health care systems, research institutions, and other stakeholders;

(5) Expanding upon and implementing educational information using evidence-based information on substance use disorders;

(6) Expansion of training of community stakeholders, law enforcement officers, and families across a broad-range of addiction, health, and related topics on substance use disorders, local issues and community-specific issues related to addiction epidemic;

(7) Program evaluation.’’.}

SEC. 8213. REIMBURSEMENT OF SUBSTANCE USE DISORDER TREATMENT PROFESSIONALS.

Not later than January 1, 2020, the Comptroller General of the United States shall submit to Congress a report examining how substance use disorder services are reimbursed.

SEC. 8214. SOBRIETY TREATMENT AND RECOVERY TEAM PROGRAM.

Title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

‘‘SEC. 550. SOBRIETY TREATMENT AND RECOVERY TEAMS.

(a) IN GENERAL.—The Secretary may make grants to States, funds of local government, or tribal governments to establish or expand Sobriety Treatment And Recovery Team (referred to in this section as ‘START’ or ‘Sobriety Team’ or ‘Sobriety Programs’) to determine the effectiveness of pairing social workers or mentors with families that are struggling with a substance use disorder and child abuse or neglect, to help provide peer support, intensive treatment, and child welfare services to such families.

(b) ALLOWABLE USES.—A grant awarded under this section may be used for one or more of the following activities:

(1) Training eligible staff, including social workers, social services coordinators, child welfare specialists, substance use disorder treatment professionals, and mentors.

(2) Expanding access to substance use disorder treatment services and drug testing.

(3) Enhancing data sharing with law enforcement agencies, child welfare agencies, substance use disorder treatment providers, judges, and court personnel.

(4) Program evaluation and technical assistance.

(c) PROGRAM REQUIREMENTS.—A State, unit of local government, or tribal government receiving a grant under this section shall—

(1) serve only families for which—

(A) there is an open record with the child welfare agency; and

(B) substance use disorder was a reason for the record or finding described in paragraph (1); and

(2) coordinate any grants awarded under this section with any grant awarded under section 437(f) of the Social Security Act focused on improving outcomes for children affected by substance abuse.

(d) TECHNICAL ASSISTANCE.—The Secretary may reserve not more than 5 percent of funds provided under this section to provide technical assistance on the establishment or expansion of programs funded under this section from the National Center on Substance Abuse and Child Welfare.’’.}

SEC. 8215. PROVIDER EDUCATION.

Not later than 60 days after the date of enactment of this Act, the Attorney General, in consultation with the Secretary of Health and Human Services, shall complete the plan related to medical registration coordination required by Senate Report 114–209, which accompanied the Veterans Care Financial Protection Act of 2017 (Public Law 115–131; 132 Stat. 334).


(1) by striking paragraphs (5), (12), and (13); and

(2) by redesigning paragraph (11) as paragraph (17);

(3) by redesigning paragraphs (9) and (10) as paragraphs (14) and (15), respectively;

(4) by redesigning paragraphs (6), (7), and (8) as paragraphs (10), (11), and (12), respectively;

(5) by redesigning paragraphs (1), (2), (3), and (4) as paragraphs (3), (4), (5), and (6), respectively;

(6) by inserting before paragraph (3), as so redesignated, the following:

‘‘(1) AGENCY.—The term ‘agency’ has the meaning given the term ‘executive agency’ in section 102 of title 31, United States Code.

(2) APPROPRIATE CONGRESSIONAL COMMITMENTS.—

(A) IN GENERAL.—The term ‘appropriate congressional committees’ means—

(i) the Committees on the Judiciary, the Committee on Appropriations, and the Committee on Health, Education, Labor, and Pensions of the Senate; and

(ii) the Committee on Oversight and Government Reform, the Committee on the Judiciary, the Committee on Energy and Commerce, and the Committee on Appropriations of the House of Representatives;

(B) SUBMISSION TO CONGRESS.—Any submission to Congress shall mean submission to the appropriate congressional committees.

(7) by amending paragraph (3), as so redesignated, to read as follows:

‘‘(3) DEMAND REDUCTION.—The term ‘demand reduction’ means any activity conducted by a National Drug Control Program Agency, other than an enforcement activity,
that is intended to reduce or prevent the use of drugs or support, expand, or provide treat-
ment and recovery efforts, including—
(A) education about the dangers of illicit drug use;
(B) services, programs, or strategies to prevent substance use disorder, including evidence-based education campaigns, com-
munity education programs, collection and disposal of unused prescription drugs, and services to at-risk populations to prevent or delay initial use of an illicit drug;
(C) substance use disorder treatment;
(D) support for long-term recovery from substance use disorders;
(E) drug-free workplace programs;
(F) drug testing, including the testing of employees;
(G) interventions for illicit drug use and dependence;
(H) expanding availability of access to health care services for the treatment of substance use disorders;
(I) international drug control coordina-
tion and cooperation with respect to activi-
ties described in this paragraph;
(J) pre- and post-arrest criminal justice interventions, including diversion programs, drug courts, and the provision of evidence-based treatment to individuals with substance use disorders who are arrested or under supervision for criminal justice involve-
ment, including medication assisted treat-
ment;
(K) other coordinated and joint initia-
tives among Federal, State, local, and Tribal agencies to promote comprehensive drug control strategies designed to reduce the demand for, and the availability of, illegal drugs;
(1) international illicit drug use edu-
cation, prevention, treatment, recovery, re-
search, treatment of substance use disor-
ders, and services to at-risk populations to
reduce the demand for, and the availability of, illegal drugs; and
(M) research related to illicit drug use and any of the activities described in this
paragraph.

(b) by inserting “, including any report, plan, or strategy required to be incorpo-
rated into or issued concurrently with such strat-
egy” before the period at the end;
(11) by inserting after paragraph (12), as so redesignated, the following:
(13) NONPROFIT ORGANIZATION.—The term ‘nonprofit organization’ means an organiza-
tion described in section 501(c)(3) of the Internal Revenue Code of 1986 and ex-
empt from tax under section 501(a) of such Code.
(12) in paragraph (14), as so redesignated, by striking “Unless the context clearly indi-
cates otherwise, the” and inserting “The”;
(13) by inserting after paragraph (15), as so redesignated, the following:
(16) SUBSTANCE USE DISORDER TREAT-
MENT.—The term ‘substance use disorder treatment’ means an evidence-based, profes-
sionally directed, deliberate, and planned regimen including evaluation, observation, medical monitoring, and rehabilitative serv-
ces and interventions such as pharmacotherapy, behavioral therapy, and individual and group counseling, on an inpa-
tient or outpatient basis, to help patients with substance use disorder reach recover-
y;
and
(14) in paragraph (17), as so redesignated—
(A) by redesigning subparagraphs (B), (C), (D), and (E), as subparagraphs (C), (D), (E), and (F), re-
spectively;
(B) by inserting after subparagraph (A) the follow-
ing:
(“B) domestic law enforcement;”;
(C) in subparagraph (E), as so redesignated, by striking “and” at the end;
(D) in subparagraph (F), as so redesignated, by striking the period at the end and insert-
ing a semicolon;
(E) by adding at the end the following:
(“G) activities to prevent the diversion of drugs for their illicit use; and
(H) research related to any of the activi-
ties described in this paragraph.”.

SEC. 8217. AMENDMENTS TO ADMINISTRATION OF THE OFFICE.
(a) RESPONSIBILITIES OF OFFICE.—Section 708(a) of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1702(a)) is amended—
(1) by striking paragraph (1) and inserting the follow-
ing:
(1) lead the national drug control effort, including coordinating with the National Drug Control Policy; and
(2) in paragraph (2), by inserting before the semi-
colon the following: “, including the Na-
tional Drug Control Strategy”;
(3) in paragraph (3), by striking “and” at the end;
and
(4) by striking paragraph (4) and all that fol-
low through “the National Academy of Sciences” and inserting the follow-
ing:
(4) evaluate the effectiveness of national drug control policy efforts, including the Na-
tional Drug Control Program Agencies’ pro-
grams and any other grant programs directed to imple-
dment of specific drug control policy goals and performance measurements and moni-
toring the agencies’ program-level spending;
(5) (B) Demand Reduction Coordinator, as de-
scribed in section 704(c)(4).
(6) in paragraph (5), by inserting “such offic-
al” and inserting “such officer or em-
ployee”;
and
(7) in paragraph (6), by inserting “such offic-
al” and inserting “such officer or em-
ployee”.

(b) in section 702(d) of the Office of National Drug Control Policy Reau-
thorization Act of 1998 (21 U.S.C. 1702(d)), as amended—
(1) by inserting “, including any report, plan, or strategy required to be incorpo-
rated into or issued concurrently with such strat-
egy” before the period at the end;
(1) in paragraph (19), by striking "; and" and inserting a semicolon; 
(2) in paragraph (20), by striking the period at the end and inserting "; and"; and 
(3) by adding at the end the following: 
"(21) in order to formulate the national drug control policies, goals, objectives, and priorities— 
(A) consult with and assist— 
(i) State and local governments; 
(ii) National Drug Control Program Agencies; 
(iii) each committee, working group, council, or other entity established under this chapter, as appropriate; 
(iv) the public; 
(v) appropriate congressional committees; and 
(vi) any other person in the discretion of the Director; and 
(B) may— 
(i) establish advisory councils; 
(ii) acquire data from agencies; and 
(iii) request data from any other entity. ".

(2) NATIONAL DRUG CONTROL PROGRAM BUDGET.—Section 704(c) of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1703(c)) is amended— 
(1) in paragraph (A), by striking "paragraph (I)(C);" and inserting the following: "(I) the fund level for each National Drug Control Program agency; and 
(ii) alternative funding structures that could improve progress on achieving the goals of the National Drug Control Strategy; and"; 
(B) in subparagraph (B), strike the President; and inserting "the President and Congress:"; and 
(C) by striking subparagraph (C); 
(2) in paragraph (3)(E), by striking clause (i) and inserting the following: "(i) funds may only be used for— 
(I) expansion of demand reduction activities; 
(II) interdiction of illicit drugs on the high seas, in United States territorial waters, and other ports of entry by officers and employees of National Drug Control Program Agencies and domestic and foreign law enforcement officers; 
(III) accurate assessment and monitoring of international drug production and interdiction programs and policies; 
(IV) activities to facilitate and enhance the sharing of domestic and foreign intelligence information among National Drug Control Program Agencies related to the production and trafficking of drugs in the United States, and agencies; and 
(V) research related to any of these activities; 
(ii) in subsection (e)(2)(A), by striking "Notwithstanding any other provision of law" and inserting "Subject to the availability of appropriations;"; and 
(iii) by adding at the end the following: 
"(1) MODEL ACTS PROGRAM.— 
(I) IN GENERAL.—The Director shall provide for or shall enter into an agreement with a nonprofit organization to— 
(A) advise States on establishing laws and policies to address illicit drug use issues; and 
(B) revise such model State drug laws and drug enforcement laws that do not properly address those issues or that take into consideration changes in illicit drug use issues in the State involved. 
(2) AUTHORIZATION OF APPROPRIATIONS.— 
There is authorized to be appropriated to carry out this subsection $1,250,000 for each of fiscal years 2018 through 2023. 
(j) STATE, LOCAL, AND TRIBAL AFFAIRS COORDINATOR.— 
(1) ESTABLISHMENT.—The Director, or the head of an entity designated by the Director, in coordination with the Secretary of Health and Human Services, shall track federally-funded grant programs to— 
(A) ensure the public has electronic access to information identifying— 
(i) all drug control grants and pertinent identifying information for each grant; 
(ii) any available performance metrics, evaluations, or other information indicating the effectiveness of such programs; 
(iii) facilitate efforts to identify duplications, overlaps, or gaps in funding that provide increased accountability of Federally-funded grants for substance use disorder treatment, prevention, and enforcement; and 
(iv) identify barriers in the grant application process impediments that applicants currently have in the grant application process with applicable agencies. 
(k) NATIONAL DRUG CONTROL AGENCIES.— 
The head of each National Drug Control Program Agency shall provide to the Director a complete list of all drug control program grants programs and any other relevant information for inclusion in the system developed under paragraph (1) and annually update such list. 
(l) SUPPORTING EXISTING SYSTEMS.—The Director may meet the requirements of this subsection by utilizing, updating, or improving existing Federal information systems to ensure the requirements of this subsection. 
(m) REPORT.—Not later than 3 years after the date of enactment of this subsection, the Director shall submit to Congress a report examining implementation of this subsection.".
(a) EMERGING THREATS COMMITTEE.— 

The Director shall designate or appoint a United States Emerging and Continuing Threats Coordinator to perform the duties of that position described in this section and such other duties as may be determined by the Director. The Director shall determine whether the coordinator position is a non-career appointee in the Senior Executive Service or a career appointee in a position at level 15 of the General Schedule (or equivalent).

(b) EMERGING THREATS COMMITTEE.— 

(i) IN GENERAL.—The Emerging Threats Committee shall—

(1) monitor evolving and emerging drug threats in the United States;

(2) discuss evolving and emerging drug trends in the United States using the criteria required to be established under paragraph (c);

(3) prepare in the formulation of and oversee implementation of any plan described in this subsection;

(4) provide such other advice to the Coordinator and Director concerning strategy and policies for emerging drug threats and trends as the Committee determines to be appropriate;

(5) disseminate and facilitate the sharing of information with Federal, State, local, and Tribal officials and other entities as directed by the Director of pertinent information and data relating to—

(i) recent trends in drug supply and demand;

(ii) fatal and nonfatal overdose;

(iii) demand for and availability of evidence-based substance use disorder treatment, including the extent of the untreated need, and treatment admission trends;

(iv) recent trends in drug interdiction, supply, and demand from State, local, and Tribal officials and other entities, and other subject matter as determined necessary by the Director;

(6) CHAIRPERSON.—The Director shall designate one of the members of the Emerging Threats Committee to serve as Chairperson.

(7) MEMBERS.—The Director shall appoint other members of the Committee, which shall include—

(A) representatives from National Drug Control Program Agencies or other agencies;

(B) representatives from State, local, and Tribal officials and other relevant entities;

(C) representatives from other entities as designated by the Director.

(8) MEETINGS.—The members of the Emerging Threats Committee shall meet, in person and not through any delegate or representative, not less frequently than once per calendar year, before June 1. At the call of the Director or the Chairperson, the Emerging Threats Committee may hold additional meetings as the members may choose.

(9) CONTRACT, AGREEMENT, AND OTHER AUTHORITY.—The Director may award contracts, enter into interagency agreements, manage individual projects, and conduct other activities to support the identification of emerging drug threats and in support of the development, implementation, and assessment of any Emerging Threat Response Plan.

(10) CRITERIA TO IDENTIFY EMERGING DRUG THREATS.—Not later than 180 days after the date on which the Committee first meets, the Committee shall develop and recommend to the Director criteria to be used to identify an emerging drug threat or the termination of such designation based on information gathered by the Committee, statistical data, and other evidence.

(11) DESIGNATION.— 

(11) IN GENERAL.—The Director, in consultation with the Committee, and the head of each National Drug Control Program Agency may designate an emerging drug threat in the United States.

(12) STANDARDS FOR DESIGNATION.—The Director, in consultation with the Coordinator, shall promulgate and make publicly available standards by which a designation under paragraph (1) and the termination of such designation may be made. In developing such standards, the Director shall consider the recommendations of the Committee and other criteria the Director considers to be appropriate.

(13) PUBLIC STATEMENT REQUIRED.—The Director shall publish a public written statement on the portal of the Office explaining the designation of an emerging drug threat or the termination of such designation and shall notify the appropriate congressional committees of the availability of such statement when a designation or termination of such designation has been made.

(14) PLAN.— 

(1) PUBLIC AVAILABILITY OF PLAN.—Not later than 90 days after making a designation under subsection (c), the Director shall publish and make publicly available an Emerging Threat Response Plan and notify the President of the United States and congressional committees of such plan's availability.

(2) TIMING.—Concurrently with the annual submissions under section 706(g), the Director shall update the plan and report on implementation of the plan, until the Director determines that a designation under subsection (c) is no longer appropriate.

(3) CONTENTS OF AN EMERGING THREAT RESPONSE PLAN.—The plan shall include in the plan required under this subsection—

(A) a comprehensive strategic assessment of the emerging drug threat, including the threat, and the drug designated as the emerging drug threat and for expanding the availability and effectiveness of evidence-based substance use disorder treatment and prevention programs to reduce the demand for the emerging drug threat;

(B) comprehensive, research-based, short- and long-term, and quantifiable goals for addressing the emerging drug threat, including for reducing the supply of the drug designated as the emerging drug threat and for expanding the availability and effectiveness of evidence-based substance use disorder treatment and prevention programs to address the threat;

(C) performance measures pertaining to the plan's goals, including quantifiable and measurable objectives and specific targets;

(D) the level of funding needed to implement the plan, including whether funding is available to support implementation of the plan or whether additional appropriations are necessary to implement the plan;

(E) a response strategy for the media campaign under subsection (f), including goals as described in subparagraph (B) of this paragraph and performance measures, as described in subparagraph (C) of this paragraph; and

(F) any other information necessary to inform the public of the status, progress, or response of an emerging drug threat.

(4) IMPLEMENTATION.—

(A) IN GENERAL.—Not later than 120 days after the date on which a designation is made under subsection (c), the Director, in consultation with the President, the appropriate congressional committees, and the head of each National Drug Control Program Agency, shall issue guidance on implementation of the plan described in this subsection to the National Drug Control Program Agencies and any other relevant agency determined to be necessary by the Director.

(5) COORDINATOR'S RESPONSIBILITIES.—The Coordinator shall—

(i) direct the implementation of the plan among the agencies identified in the plan, State, local, and Tribal governmental, and other relevant entities;

(ii) facilitate information-sharing between agencies identified in the plan, State, local, and Tribal governments, and other relevant entities; and

(iii) monitor implementation of the plan by coordinating the development and implementation of comprehensive systems to support performance measurement and adherence to the plan by agencies identified in the plan, where appropriate.


(7) PLAN, AND MEDIA CAMPAIGN.


(B) REPRESENTATIVES.—The President shall ensure that the Federal agencies involved in the United States Emerging and Continuing Threats Response Plan, and media campaign would be appropriate to address the threat.

(C) NATIONAL ANTI-DRUG MEDIA CAMPAIGN.—

(1) IN GENERAL.—The Director shall, to the extent feasible and appropriate, conduct a national anti-drug media campaign (referred to in this subtitle as the 'national media campaign') in accordance with this subsection for the purposes of—

(A) preventing substance abuse among people in the United States;

(B) encouraging individuals affected by substance use disorders to seek treatment and providing such individuals with information on—

(i) how to recognize addiction issues;

(ii) what forms of evidence-based treatment options are available; and

(iii) how to access such treatment;

(C) combating the stigma of addiction and substance use disorders, including the stigma of treating such disorders with medication-assisted treatment therapies; and

(D) informing the public about the dangers of any drug identified by the Director as an emerging drug threat as appropriate.

(2) USE OF FUNDS.—

(A) IN GENERAL.—Amounts made available to carry out this subsection for the national media campaign may only be used for the following:

(B) purchase of media time and space, including the strategic planning for, tracking, and accounting of, such purchases.
“(ii) Creative and talent costs, consistent with subparagraph (B)(i).
“(iii) Advertising production costs, which may include television, radio, internet, social media, and other commercial marketing venues.
“(iv) Testing and evaluation of advertising.
“(v) Evaluation of the effectiveness of the national media campaign.
“(vi) Costs of contracts to carry out activities authorized by this subsection.
“(vii) Partnerships with professional and civic community-based organizations, including faith-based organizations, and government organizations related to the national media campaign.
“(viii) Entertainment industry outreach, interactive outreach, media projects and activities, public information, news media outreach, and corporate sponsorship and participation.
“(ix) Operational and management expenses.
“(B) SPECIFIC REQUIREMENTS.—
“(i) CREATIVE SERVICES.—In using amounts for creative and talent costs under subparagraph (A)(ii), the Director shall use creative services at no cost to the Government wherever feasible and may only procure creative services for advertising—
“(I) responding to a high-priority or emergent campaign need that cannot timely be obtained at no cost; or
“(II) intended to reach a minority, ethnic, or other social audience that cannot reasonably be obtained at no cost.
“(ii) TESTING AND EVALUATION OF ADVERTISING.—In using amounts for testing and evaluation of advertising under subparagraph (A)(iv), the Director shall test all advertisements prior to use in the national media campaign to ensure that the advertisements are effective with the target audience and meet industry-accepted standards. The Director may waive this requirement for advertisements using no more than 10 percent of the purchase of advertising time purchased under this subsection in a fiscal year and no more than 10 percent of the advertising space purchased under this subsection in a fiscal year, if the advertisements respond to emergent and time-sensitive campaign needs or the advertisements will not be widely utilized in the national media campaign.
“(iii) CONSULTATION.—For the planning of the campaign under paragraph (1), the Director may consult with—
“(I) the head of any appropriate National Drug Control Program Agency;
“(II) experts on the designated drug;
“(III) Tribal leaders, Tribal government officials and relevant agencies;
“(IV) communications professionals;
“(V) the public; and
“(VI) appropriate congressional committees.
“(iv) EVALUATION OF EFFECTIVENESS OF NATIONAL MEDIA CAMPAIGN.—In using amounts for the effectiveness of the national media campaign under subparagraph (A)(v), the Director shall—
“(I) designate an independent entity to evaluate by April 20 of each year the effectiveness of the national media campaign based on data from—
“(aa) the Monitoring the Future Study published by the Department of Health and Human Services;
“(bb) the National Survey on Drug Use and Health; and
“(cc) other relevant studies or publications, as determined by the Director, including tracking and evaluation data collected according to marketing and advertising industry standards.
“(II) ensure that the effectiveness of the national media campaign is evaluated in a manner that enables consideration of whether the national media campaign has contributed to changes in attitude or behaviors among the target audience with respect to substance use and such other measures of evaluation as the Director determines are appropriate.
“(v) ADVERTISING.—In carrying out this subsection, the Director shall ensure that sufficient funds are allocated to meet the stated goals of the national media campaign.
“(vi) RESPONSIBILITIES AND FUNCTIONS UNDER THIS SUBSECTION.—
“(A) IN GENERAL.—The Director shall determine the overall purposes and strategy of the national media campaign.
“(B) DIRECTOR.—
“(i) IN GENERAL.—The Director shall approve—
“(I) the strategy of the national media campaign;
“(II) all advertising and promotional material used in the national media campaign; and
“(III) the plan for the purchase of advertising time and space for the national media campaign.
“(ii) IMPLEMENTATION.—The Director shall be responsible for implementing a focused national media campaign to meet the purposes set forth in paragraph (1) and shall ensure—
“(I) information disseminated through the campaign is accurate and scientifically valid; and
“(II) the campaign is designed using strategies demonstrated to be the most effective in achieving the goals and requirements of paragraph (1), which may include—
“(aa) a media campaign, as described in paragraph (2);
“(bb) local, regional, or population specific messaging;
“(cc) the development of websites to publicize and disseminate information;
“(dd) conducting outreach and providing educational resources for parents;
“(ee) collaborating with law enforcement agencies; and
“(ff) providing support for school-based public health education classes to improve teen knowledge about the effects of substance use.
“(vii) Partnerships with professional and civic community-based organizations, including faith-based organizations, and government organizations related to the national media campaign.
“(D) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(E) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(F) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(G) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(H) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(I) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(J) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(K) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(L) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(M) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(N) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(O) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(P) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(Q) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(R) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(S) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(T) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(U) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(V) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(W) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(X) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(Y) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(Z) To fund advertising that does not directly relate to substance abuse prevention consistent with the purposes of the national media campaign includes a clear anti-drug message. Such message is not required to be the primary message of the match advertising.
“(aa) a media campaign, as described in paragraph (2);
“(bb) local, regional, or population specific messaging;
“(cc) the development of websites to publicize and disseminate information;
“(dd) conducting outreach and providing educational resources for parents;
“(ee) collaborating with law enforcement agencies; and
“(ff) providing support for school-based public health education classes to improve teen knowledge about the effects of substance use.
“(5) PROHIBITIONS.—None of the amounts made available under paragraph (2) may be obligated or expended for any of the following:
“(A) To supplant current anti-drug community-based coalitions.
“(B) To supplant pro bono public service time lost by local, regional, and national broadcast networks for other public service campaigns.
“(C) For partisan political purposes, or to express or support or oppose any candidate who is directly elected or appointed to any federal or state office, cabinet level official, or other Federal official employed pursuant to section 213 of Schedule C of title 5, Code of Federal Regulations.
“(D) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(E) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(F) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(G) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(H) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(I) To fund advertising that does not contain a primary message intended to reduce or prevent substance use.
“(J) A review and evaluation of the effectiveness of the national media campaign strategy for the past year.
“(K) REQUIRED NOTICE FOR COMMUNICATION FROM THE OFFICE.—Any communication, including an advertisement, paid for or otherwise disseminated by the Office directly or through a contract awarded by the Office shall include a prominent notice informing the audience that the communication was paid for by the Office.
“(L) AUTHORIZATION OF Appropriations.—There is authorized to be appropriated to the Office to carry out this section, $25,000,000 for each of fiscal years 2018 through 2023.”.

September 28, 2018
CONGRESSIONAL RECORD—HOUSE H9239
SEC. 8219. DRUG INTERDICTON.

(a) REPEAL.—This first section 711 of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1710) is repealed.


(1) in subsection (a)—

(A) in paragraph (1)—

(i) striking “The United” and inserting “The Director shall designate or appoint an appointee in the Senior Executive Service or an appointee in a position at level 15 of the General Schedule (or equivalent) as the United”;

(ii) by striking “shall” and inserting “to”;

(B) in paragraph (2)(B)—

(i) by striking “March 1” and inserting “September 1”;

(ii) by striking paragraph (3) and inserting paragraph (4); and

(C) in paragraph (5)—

(i) by striking “also, at his discretion,”; and

(ii) by striking “the Office of Supply Reduction” and inserting “assist in carrying out such responsibilities”; and

(D) in paragraph (6)—

(i) in subparagraph (B), by striking “The United” and inserting “and inserting”;

(bb) by inserting “the Director, acting through” before “the United States”; and

(cc) by inserting a comma after “Coordinator’s”;

(dd) by striking “a report on behalf of the Director”; and

(ee) by striking “which shall include” and inserting “and includes”;

(II) by redesignating clauses (I), (II), and (III) as subclauses (I), (II), and (III), and adjusting the margins accordingly;

(III) by redesignating subclause (I), as so redesignated, the following:

“(i) includes—”;

(IV) in clause (i), as so redesignated—

(aa) by striking “as well as” and inserting “and”;

(bb) by striking the period at the end and inserting “and”;

(ccc) in subclause III, as so redesignated—

(AA) by striking “as well as” and inserting “and”;

(II) by inserting “the period at the end” and inserting “; and”;

(bb) by striking the period at the end and inserting “; and”;

(V) by adding at the end the following:

“(ii) may include recommendations for changes to existing law;”;

(III) by redesigning subparagraph (C), as so redesignated, the following:

“(1) by striking “Chairperson” and inserting “Chairperson”;

(2) by striking “Chairman” and inserting “Chairperson”;

(3) by inserting “the Director” and inserting “the”;

(4) by striking “current” and inserting “current”;

(5) by striking “in the” and inserting “in the”;

(6) by striking “and” and inserting “and”;

(II) by inserting a comma after “Chairperson”;

(l) in the first sentence, by striking “a report”;

(III) by inserting “a report” after “committees”;

(IV) by striking the second sentence and inserting the following: “The report required under this paragraph shall be in unclassified form, but may include a classified annex”; and

(3) by adding at the end the following:

“(c) INTERNATIONAL COORDINATION.—The Director may facilitate international drug control coordination efforts.”.

SEC. 8220. GAO AUDIT.

Not later than 4 years after the date of enactment of this Act, and every 4 years thereafter, the Comptroller General of the United States shall—

(1) conduct an audit relating to the programs and operations of—

(A) the Office; and

(B) certain programs within the Office, including—

(i) the High Intensity Drug Trafficking Areas Program; and

(ii) the Drug-Free Communities Program; and

(II) by adding at the end the following:

“(c) STRATEGY BASED ON EVIDENCE.—The Director shall develop and effectively implement the National Drug Control Strategy based on—

(A) a mission statement detailing the major functions of the National Drug Control Strategy submitted under subsection (a); and

(B) in paragraph (2)(B)—

(i) by striking “paragraph (3)” and inserting “paragraph (2)”;


(iii) by inserting a comma after “the”;

(II) in paragraph (3) of section 704(f) of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1708(f)); and

(III) in paragraph (4) of section 704(f) of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1708(f)); and

(II) by striking “either” each place it appears in the definition of that term.

(III) by inserting “a report” after “Chairperson”;

(IV) by inserting “the Director” and inserting “the”;

(V) by striking “current” and inserting “current”;

(VI) by striking “in the” and inserting “in the”;

(VII) by striking “and” and inserting “and”;

(VIII) by striking “the” and inserting “the”;

(II) by inserting a comma after “Chairperson”;

(l) in the first sentence, by striking “a report”;

(III) by inserting “a report” after “committees”;

(IV) by striking the second sentence and inserting the following: “The report required under this paragraph shall be in unclassified form, but may include a classified annex”; and

(3) by adding at the end the following:

“(c) INTERNATIONAL COORDINATION.—The Director may facilitate international drug control coordination efforts.”.

SEC. 8221. NATIONAL DRUG CONTROL STRATEGY.

(a) IN GENERAL.—Section 706 of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1708(f)) is amended to read as follows:

“SEC. 706. NATIONAL DRUG CONTROL STRATEGY.

“(a) IN GENERAL.—

“(1) STATEMENT OF DRUG POLICY PRIORITIES.—The Director shall establish drug policies and objectives and submit to the appropriations committees a report containing an evaluation of and recommendations on the—

(A) policies and activities of the programs and operations of the Drug Control Program and budget priorities.

(B) economy, efficiency, and effectiveness in the administration of the reviewed programs and operations; and

(C) policies and the consequences of illicit drug use in the United States.

“(2) NATIONAL DRUG CONTROL STRATEGY SUBMITTED BY THE PRESIDENT.—Not later than the first Monday in February following the year in which the term of the President expires, and each year thereafter, the President shall submit to Congress a National Drug Control Strategy.

“(3) DEVELOPMENT OF THE NATIONAL DRUG CONTROL STRATEGY.—

“(a) IN GENERAL.—

“(i) PROMULGATION.—The Director shall promulgate the National Drug Control Strateg-
substance use disorders and a strategy for
stance use disorders, which shall—
(iii) identify the specific resources re-
quired to enable the relevant National Drug
Control Agencies to implement that strat-
y.
(ii) describe the specific roles and res-
ponsibilities of the relevant National Drug
Control Programs and agencies for plan-
ing the use of evidence-based substance use
disorder treatment;
(i) set forth the Government’s strategy
for preventing the illegal trafficking of drugs
to or through Indian reservations and the
United States and Mexico for the purpose
of illegal trafficking of drugs across such
border; and
(ii) recommendations for criminal pen-
salties for persons who construct or use such
a tunnel or subterranean passage for such a
purpose.
(C) REQUIREMENT FOR NORTHERN BORDER COUNTERNARCOTICS STRATEGY.—
(i) PURPOSES.—The Northern Border
Counternarcotics Strategy shall—
(i) set forth the strategy of the Federal
Government for preventing the illegal traf-
icking of drugs across the international bor-
der between the United States and Canada,
including through ports of entry and be-
tween ports of entry on the border.
(ii) state the specific roles and respon-
sibilities of each relevant National Drug
Control Program Agency for implementing
the strategy;
(iii) identify the specific resources re-
quired to enable the relevant National Drug
Control Program Agencies to implement the
strategy;
(iv) be designed to promote, and not
hinder, legitimate trade and travel; and
(v) reflect the unique nature of small
communities along the international border
between the United States and Canada, ongo-
ing cooperation and coordination with Cana-
dian government enforcement authorities, and vari-
ations in the volumes of vehicles and pedes-
trians crossing through ports of entry along the
international border between the United States
and Canada.
(K) A description of how each goal estab-
lished under subparagraph (B) was deter-
mined, including—
(i) a list of policy-relevant questions for
which the Director and each National Drug
Control Program Agency intends to develop
evidence to support the National Drug
Control Program and Strategy;
(ii) a list of anticipated challenges for
which the Director and each National Drug
Control Program Agency intends to develop
evidence to enable the relevant National Drug
Control Program Agency to determine the
requirements of this section—
(i) the inclusion of data and information
relevant to the strategy; and
(ii) the inclusion of data and information
relevant to the strategy;
(iii) the inclusion of data and information
relevant to the strategy;
(iv) the inclusion of data and information
relevant to the strategy;
(i) a list of policy-relevant questions for
which the Director and each National Drug
Control Program Agency intends to develop
evidence to support the National Drug
Control Program and Strategy;
(ii) a list of anticipated challenges for
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relevant to the strategy; and
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relevant to the strategy;
(iii) the inclusion of data and information
relevant to the strategy;
(iv) the inclusion of data and information
relevant to the strategy;
(i) a list of policy-relevant questions for
which the Director and each National Drug
Control Program Agency intends to develop
evidence to support the National Drug
Control Program and Strategy;
(ii) a list of anticipated challenges for
which the Director and each National Drug
Control Program Agency intends to develop
evidence to enable the relevant National Drug
Control Program Agency to determine the
requirements of this section—
(i) the inclusion of data and information
relevant to the strategy; and
(ii) the inclusion of data and information
relevant to the strategy;
(iii) the inclusion of data and information
relevant to the strategy;
(iv) the inclusion of data and information
relevant to the strategy;
after the first Monday in February following the year in which the term of the President so commences, the Director shall send a notification to the appropriate congressional committees—

(1) explaining why the Strategy was not submitted; and

(2) specify the date by which the Strategy will be submitted.

(d) Drug Control Data Dashboard.—

(1) In general.—The Director shall collect and disseminate, such information as the Director determines is appropriate, but not less than the information described in this subsection. The data shall be published to the online portal of the Office to be known as the Drug Control Data Dashboard.

(2) Process for development.—The Director shall publish to the online portal of the Office in a machine-readable, sortable, and searchable format, or to the extent practicable, establish a data dashboard on the online portal of the Office to be known as the Drug Control Data Dashboard. To the extent practicable, when establishing the Drug Control Data Dashboard, the Director shall ensure that the user interface of the dashboard is constructed with modern design standards. To the extent practicable, the data available on the dashboard shall be publicly available in a machine-readable format and searchable by year, agency, drug, and location.

(3) Data.—The data included in the Drug Control Data Dashboard shall be updated quarterly to the extent practicable, but not less frequently than annually and shall include, at a minimum, the following:—

(A) For each substance identified by the Director as having a significant impact on the public health, the Director shall collect and disseminate the following data:

(i) data sufficient to show the quantities of such substance available in the United States, including—

(II) the total amount seized and disrupted in the calendar year and each of the previous 3 calendar years, including to the extent practicable, the amount seized by State, local, and Tribal governments; and

(III) the known and estimated flows into the United States from all sources in the calendar year and each of the previous 3 calendar years; and

(ii) the known and estimated levels of domestic production in the calendar year and each of the previous 3 calendar years, including the levels of domestic production if the drug is a prescription drug, as determined under the Federal Food, Drug, and Cosmetic Act, for which a listing is in effect under section 202 of the Controlled Substances Act (21 U.S.C. 812); and

(iii) the average street price for the calendar year and the highest known street price during the preceding 10-year period; and

(iv) the prevalence of use of such substance, including—

(I) the number of persons who have committed to the use of such substance in the workplace and productivity lost by such use;

(II) the extent of use of such substance by arrestees, probationers, and parolees;

(III) the extent of activity related to such substance;

(IV) to the extent practicable, related prosecutions by State, local, and Tribal governments; and

(B) For the calendar year and each of the previous three years data sufficient to show, disaggregated by State and, to the extent feasible, by region within a State, county, or city, the following:

(I) The number of fatal and non-fatal overdoses, including any drug identified under subparagraph (A)(i).

(ii) The prevalence of substance use disorders.

(iii) The number of individuals who have received substance use disorder treatment, including medication assisted treatment, for a substance use disorder, including treatment provided through publicly-financed health care programs.

(iv) The extent of the unmet need for substance use disorder treatment, including the unmet need for medication-assisted treatment.

(C) Data sufficient to show the extent of prescription drug diversion, trafficking, and misuse in the calendar year and each of the previous 3 calendar years.

(D) Any quantifiable measures the Director determines to be appropriate to detail progress toward the achievement of the goals of the National Drug Control Strategy.

(2) Development of an annual National Drug Control Assessment.—

(i) Timing.—Not later than the first Monday in February in each calendar year, the Director shall submit to the President, Congress, and the appropriate congressional committees, a report assessing the progress of each National Drug Control Program Agency toward achieving each goal, objective, and target contained in the National Drug Control Strategy for the previous fiscal year.

(ii) Process for development of the annual assessment.—Not later than November 1 of each year, the head of each National Drug Control Program Agency shall submit, in accordance with guidance issued by the Director, to the Director an evaluation of progress by the agency with respect to the National Drug Control Strategy goals using the performance measures for the agency developed under this title, including progress with respect to—

(A) success in achieving the goals of the National Drug Control Strategy;

(B) success in reducing domestic and foreign sources of illegal drugs;

(C) success in ensuring access to and increasing the effectiveness of substance use disorder treatment;

(D) success in protecting the borders of the United States (and in particular the Southwestern border of the United States) from penetration by illegal narcotics;

(E) success in reducing crime associated with drug use in the United States;

(F) success in reducing the negative health and social consequences of drug use in the United States;

(G) implementation of evidence-based substance use disorder treatment and prevention programs in the United States and improvements in the adequacy and effectiveness of such programs; and

(H) success in increasing the prevention of illicit drug use.

(iii) Contents of the annual assessment.—The Director shall include in the annual assessment required under paragraph (1)—

(A) a summary of each evaluation received by the Director under paragraph (2); and

(B) a summary of the progress of each National Drug Control Program Agency toward the National Drug Control Strategy goals of the agency using the performance measures for the agency developed under this chapter;

(C) an assessment of the effectiveness of each National Drug Control Program Agency and progress toward the National Drug Control Strategy for the previous year, including a specific evaluation of whether the applicable goals, measures, objectives, and targets for the previous year were met; and

(D) the assessments required under this subsection shall be based on the Performance Measurement System.


(1) by striking section 703(b) (21 U.S.C. 1702(b));

(2) by striking section 704 (21 U.S.C. 1703)—

(A) in subsection (c)—

(i) in paragraph (3)(C)—

(1) by striking drug treatment’’; and

(ii) by striking the semicolon at the end of clause (i) and inserting “; and”;

(iii) by striking clauses (iv), (vi), and (vii); and

(iv) by redesignating clause (v) as clause (iv); and

(B) in paragraph (4)(A), by striking “$1,000,000” and inserting “$5,000,000 or 10 percent of a specific program or account’’; and

(B) by striking the first paragraph (5); and

(ii) by striking the second paragraph (4); and

(3) by striking section 708 (21 U.S.C. 1707).

Subtitle L—Budgetary Effects

SEC. 8231. BUDGETARY EFFECTS.

(a) In General.—The budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 9(d) of the Statutory Pay-As-You-Go Act of 2010 (2 U.S.C. 923(d)).

(b) SENATE PAYGO SCORECARDS.—The budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 4106 of H. Con. Res. 71 (115th Congress).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Oregon (Mr. WALDEN) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Oregon.

Mr. WALDEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material in the Record on the resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Oregon?
There was no objection.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

I have dozens and dozens of letters of support for this legislation; 90 or 100 different letters of support from different groups, 124 names, it looks like, that I will include in the RECORD.

Statements and Letters of Support from:


1. A New PATH, San Diego, California
2. Addiction Policy Forum
3. AIDS United
4. Alabama, Addiction Policy Forum
5. Alaska, Addiction Policy Forum
6. American Correctional Association
7. Arizona, Addiction Policy Forum
8. Association of Prosecuting Attorneys
9. Beyond Addiction Ministry, WI
10. Brave Health
11. CADA of Northwest Louisiana
12. California Consortium of Addiction Programs & Professionals (CCAPP)
13. California, Addiction Policy Forum
14. Campaign for Youth Justice
15. Caron Treatment Centers
16. CFC Loud N Clear Foundation, Farmingdale, New Jersey
17. Chicago Recovering Communities Coalition, Chicago, Illinois
18. Colorado, Addiction Policy Forum
19. Community Anti-Drug Coalitions of America (CADCA)
20. Connecticut Certification Board
22. Connecticut, Addiction Policy Forum
23. COPES
24. Dar-June Recovery Support Services & Cafe, Green Bay, Wisconsin
25. Delaware, Addiction Policy Forum
26. Delphi Behavioral Health Group
27. Disease Free Kentucky
28. El Paso Alliance, El Paso, Texas
29. Faces & Voices of Recovery
30. FAVOR Low Country, Charleston, South Carolina
31. FAVOR Tri-County, Rock Hill, South Carolina
32. FedCURB
33. Fellowship Foundation Recovery Community Organization, Margate, Florida
34. Floridians for Recovery, West Palm Beach, Florida
35. Foundation for Recovery, Las Vegas, Nevada
36. Friends of Emmett
37. H.O.P.E.S. Forever
38. Healthcare Leadership Council
39. IC & RC
40. Idaho, Addiction Policy Forum
41. Illinois Association of Behavioral Health
42. Illinois, Addiction Policy Forum
43. Indiana, Addiction Policy Forum
44. Institute for Behavior and Health (IBH)
45. Iowa, Addiction Policy Forum
46. Jackson Area Recovery Community, Jackson, Michigan
47. Kansas, Addiction Policy Forum
48. Kentucky, Addiction Policy Forum
49. Kingston NH Lions Foundation
50. Lifehouse Recovery Connection, San Diego, California
51. Maine Alliance for Addiction Recovery, Augusta, Maine
52. Maine, Addiction Policy Forum
53. Maryland House Detox
54. Maryland, Addiction Policy Forum
55. Massachusetts, Addiction Policy Forum
56. Michigan, Addiction Policy Forum
57. Minnesota Recovery Connection, Minneapolis, Minnesota
58. Minnesota, Addiction Policy Forum
59. Mississippi Recovery Network, Jefferson City, Missouri
60. Missouri, Addiction Policy Forum
61. Montana, Addiction Policy Forum
62. National Association of Social Workers (NASW)
63. National Prevention Science Coalition
64. National Recovery Council
65. Navigate Recovery Gwinnett, Gwinnett County, Georgia
67. Nevada, Addiction Policy Forum
68. New Hampshire, Addiction Policy Forum
69. New Jersey, Addiction Policy Forum
70. New Mexico, Addiction Policy Forum
71. New York, Addiction Policy Forum
72. North Carolina, Addiction Policy Forum
73. North Dakota, Addiction Policy Forum
74. Ohio Citizen Advocates for Addiction Recovery, Columbus, Ohio
75. Ohio, Addiction Policy Forum
76. Oklahoma, Addiction Policy Forum
77. Oregon, Addiction Policy Forum
78. PEER Wellness Center
79. Peer360 Addiction Recovery Alliance, Bay City, Michigan
81. Pennsylvania, Addiction Policy Forum
82. People Advocating Recovery, Louisville, Kentucky
83. Phoenix House Recovery Residences
84. PLR Athens, Athens, Georgia
85. Reality Check, Jaffrey, New Hampshire
86. Recovery Wisconsin, Cheyenne, Wyoming
87. Recovery Communities of North Carolina, Raleigh, North Carolina
88. Recovery Community Connection, Williamsport, Pennsylvania
89. Recovery Community of Durham, Durham, North Carolina
90. Recovery Data Solutions
91. Rhode Island, Addiction Policy Forum
92. ROCover Fitness, Rochester, New York
93. Shatterproof
94. Smart Approaches to Marijuana Action (SAM Action)
95. SMART Recovery, Nationwide
96. Sobriety Matters
97. Solutions Recovery, Oskosh, Wisconsin
98. South Dakota, Addiction Policy Forum
99. SpiritWorks Foundation, Williamsburg, Virginia
100. Springs Recovery Connection, Colorado Springs, Colorado
101. Strengthening the Mid-Atlantic Region for Tomorrow (SMART)
102. Tennessee, Addiction Policy Forum
103. Texas, Addiction Policy Forum
104. The DOOL—DeKalb Open Opportunity for Recovery, Decatur, Georgia
105. The McShin Foundation, Richmond, Virginia
106. The Moyer Foundation
107. The Phoenix, Nationwide
108. The RASE Project, Harrisburg, Pennsylvania
109. The Solano Project, Fairfield, California
110. Treatment Communities of America
111. Trilogy Recovery Community, Walla Walla, Washington
112. Trust for America’s Health
113. Utah, Addiction Policy Forum
114. Vermont, Addiction Policy Forum
115. Virginia, Addiction Policy Forum
116. Voices of Hope Lexington, Lexington, Kentucky
117. Voices of Recovery San Mateo County, San Mateo, California
118. WAI-AM, Inc. and RISE Recovery Community, Lansing, Michigan
119. Washington, Addiction Policy Forum
120. Washtenaw Recovery Advocacy Project (WRAP), Ann Arbor, Michigan
121. West Virginia, Addiction Policy Forum
122. Wisconsin Voices for Recovery, Madison, Wisconsin
123. Wyoming, Addiction Policy Forum
124. Wyoming, Addiction Policy Forum

Mr. WALDEN. Mr. Speaker, I rise today in support of H.R. 6. This is the SUPPORT for Patients and Communities Act that your Energy and Commerce Committee has worked on diligently for nearly 2 years.

In my own case, in 10 roundtables throughout Oregon, I have heard from everyday people on the frontlines of this fight in our communities. They are the victims. They are the families. They are medical treatment advocates. They are local law enforcement, and they are first responders. They are our neighbors. They are our loved ones.

Each of these people puts a name and a face to what I would say is the worst drug epidemic we have seen in America, the opioid crisis.

I have heard from Oregon families, I have heard from Mike and Winnie, from Grants Pass, who have seen their loved one struggle with addiction. Mike’s sister who died, she was a nurse, became addicted, and overdosed. He told me that at a townhall in a community forum. Their son struggles with his addiction to this day from a sports injury starting with opioids, ending with heroin.

We will never know what could have become of the 72,000 Americans who died last year.

Every 24 hours, 1,000 people go to emergency rooms overdosing from opioids. Roughly 115 die.

I heard it from Paula, whose two sons and stepson struggle with their opioid addiction today.

As a parent, I can only imagine what parents of children with opioid addiction must feel every time the phone rings. They think it may be that call.

For the millions of people currently struggling with addiction, please know, don’t give up. It is never too late to seek help. We stand with you.

Mr. Speaker, this legislation is a product of months of bipartisan, bicameral work, eight House committees involved, I think probably every Member of this House, five Senate committees, dozen and dozens of Members of Congress.

And the faces that we came to know are the parents and the children whom they lost, Amanda Beatrice Gray being one of them, a beautiful young woman, talented, struggling with her issues, overdosed on heroin heavily laced with fentanyl.

We are here for them, Mr. Speaker. We are here for our neighbors, for our
loved ones, who deal with this crisis every day of their life, and in the great joined cause of those who lost.

Mr. Speaker, because we are going to hear from a lot of our Members who have put so much work into this, I reserve my time.

Mr. FALLONE. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act. This bill is the product of months of hard work by several committees in the House and Senate. It is important that we pass this bill today as another step in addressing the opioid crisis that is ravaging every community in our Nation.

Last year, a record 72,000 Americans died of drug overdoses; that is about 200 people dying every day, and this is a national crisis that is devastating families and that this Congress must act on.

And while this legislation will not solve every problem, I do believe it includes important policies that will help turn the tide of this tragic opioid epidemic. It will also improve treatment options for those battling other substance-related disorders.

I am proud that H.R. 6 builds upon CARA, the Comprehensive Addiction and Recovery Act, by including a provision championed by my colleague, Congressman TOXO, that would allow all advanced practice registered nurses to treat patients with opiod- use disorder. It also gives nurse practitioners and physician assistants the authority to treat patients with bupen permenantly, and it codifies the 275 patient physician cap. This is a critical step in expanding access to the treatment of these drugs, one of the major challenges that we continue to face in the fight against this epidemic.

Mr. Speaker, the legislation also expands access to coverage. It includes an important provision that I worked on with Ways and Means Committee ranking member NEAL that expands Medicare coverage of opioid treatment programs and medication-assisted treatment.

In the Medicaid space, I am pleased to see the inclusion of several Democatic priorities. This bill requires State Medicaid programs to cover all forms of medication-assisted treatment, which plays a critical and life-saving role in treating opioid use disorder.

It provides grants to State Medicaid programs to help increase the number of substance use disorder providers and services. It increases access to mental health and substance use disorder treatment for children and pregnant women covered by CHIP, and it ensures former foster youth are able to keep their Medicaid coverage across State lines up to the age of 26. And it improves the continuity of Medicaid coverage for juveniles in the justice system.

I am also pleased that we have been able to improve upon the House-passed IMD policy. This bill adds new safeguards to ensure that States continue to provide an adequate level of outpatient services and offer medication-assisted treatment. It does this by making clear that this policy does not impact the more comprehensive efforts to provide care. It is in use that is ongoing in many States today.

H.R. 6 also includes provisions from my legislation, the SCREEN Act, that would give the Food and Drug Administration the ability to take action against illicit controlled substances coming in through international mail facilities across the country. FDA will now be able to prohibit the importation of drugs by people who have repeatedly imported illicit drugs. It also allows the agency to cease dis- tribution of or recall controlled substances, like opioids, if they are endangering patients.

These provisions also provide FDA expanded authority and capacity needed to more effectively combat the influx of deadly synthetic opioids, like fentanyl, from reaching our shores through the illicit drug trade.

It also provides the Federal Trade Commission with stronger enforcement tools to go after bad actors that are taking advantage of the suffering of individuals combating addictions.

Mr. Speaker, there is one provision that is concerning and that I do want to mention. It did not go through regular order and was not properly vetted. In fact, it was added at the very last minute. That is a proposal by Senator RUBIO to create a new criminal antikickback statute.

I know this proposal is well-intentioned in addressing the serious problem of patient brokers who are taking advantage of individuals with opioid disorders by directing them to substandard or fraudulent providers in exchange for kickbacks. This is an issue, but since the bill was introduced last Tuesday night, multiple stakeholders have raised concerns that the language does not do what we think it does. It may have unintended consequences.

Mr. Speaker, I hope this is a good lesson to all of us that passing legislation that has not been properly vetted, and that the public has not had an adequate opportunity to review, is unwise. I hope to get a commitment from Chair- man WALDEN and Chairman GOODLATTE to work to address any technical problems with this provision in the upcoming months.

In closing, Mr. Speaker, these are all policies that have the potential to make a real impact on this epidemic, but our work here is not complete. An epidemic of this size will take a long-term commitment to improving health insurance coverage, treatment, access, and affordability.

This bill is an important step, but I want to stress that we have to do a lot more. The opioid crisis continues to get worse. A lot more needs to be done to provide treatment and expand the treatment infrastructure. More resources are needed to support the families and communities impacted by this crisis. So what we are doing today is clearly helpful, but it is not enough.

Mr. Speaker, I reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I am honored to yield 1 minute to the gentleman from Texas (Mr. BRADY), the distinguished and talented chairman of the House Ways and Means Committee.

Mr. BRADY of Texas. Mr. Speaker, I thank Chairman WALDEN and Ranking Member PALLONE for their work. The opioid crisis, as you know, has im- pacted every community in America, has robbed countless individuals of their full potential. We all know someone who lost a loved one because they were exposed to opioids and then, sometimes, in routine surgery, they didn’t even need it.

This can be prevented, and that is why I rise today in support of H.R. 6. This is bicameral and bipartisan. It adds to this crisis by putting many commonsense measures to reduce the unnecessary prescribing of opioids and get people treatment once they become addicted.

Mr. Speaker, I want to thank the ranking member of the Ways and Means Committee, Mr. NEAL; the ranking member of the Health Subcommittee, Mr. LEVIN; as well as leaders on our side and Mr. ROSKAM, Mr. CURBELO, Mr. PAULSEN, and Mr. BISHOP from Florida (Mr. BRADY), the honorable Mr. PALLONE for their work. The distinguished and talented chairman of the Ways and Means Committee, Mr. WALDEN, and Mr. BRADY, the chairman of the Ways and Means Committee, for the good work that they have offered on this as well.

The opioid crisis is not a partisan issue. It is a health, safety, family, community, and economic issue. Everybody in this Chamber today has a family member or knows someone close to them who is connected to the opioid crisis.

H.R. 6 represents the best of bipar- tisan and bicameral negotiation. This is, indeed, the way policy can and should be done.

The bill includes a number of Demo- cratic priorities to expand treatment options for our neighbors, family members, and friends suffering from opioid use disorders. It includes my bill, with Member PALLONE, that would require Members of Congress to cover opioid treatment programs so that our Nation’s seniors might have more outpatient options for treatment.
Opioid use disorders are rapidly growing among Medicare beneficiaries. In 13 States, the highest rate of opioid-related inpatient hospital stays is amongst those over 65. This policy would give Medicare beneficiaries increased access to a range of medication and behavioral treatment options, leading to more hope for long-term recovery.

I am also pleased that H.R. 6 includes the Securing the International Mail Against Opioids Act, which would help to stop the flow of opioids through the United States. This legislation stems from the STOP Act, a bill that I worked on with Mr. Tiberi before his retirement earlier this year. I want to commend him, in addition to Trade Subcommittee Ranking Member Pascrell, for their work on this bipartisan legislation.

While the bill before us is a step in the right direction, this epidemic is not going to turn around overnight. It needs a thoughtful, long-term, sustainable approach that requires significant Federal investments. H.R. 6 represents the initial step in addressing this crisis, but it cannot be the end. Part of that long-term approach must include protecting and strengthening Medicaid and the Affordable Care Act.

I want to take a moment to thank the staff on both sides of the aisle for their usual good work in this Chamber, for the weeks of hard effort they put in bringing this bill to fruition. The effort exemplifies bipartisan cooperation, and a particular thanks to House and Senate legislative counsel who worked long nights and weekends to finish the bill.

Thanks also to the CMS Office of Legislation and the staff of the Congressional Budget Office who played a critical role in finalizing the bill.

This is a complicated issue, and H.R. 6 is not going to solve the public health epidemic. It is not a panacea but at the moment, but it certainly is a good step. I encourage all of us here in this Chamber today and in Congress to continue to work together to develop policy solutions for members of our community who are suffering from this terrible epidemic.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentlewoman from Indiana (Mrs. BROOKS), and concur in my colleague’s comments in praise of the staff that we worked with to get this done. The gentlewoman has been a real leader.

Mrs. BROOKS of Indiana. Mr. Speaker, the opioid and heroin crisis continues to hit Hoosiers hard. Sadly, we haven’t turned the tide yet. It is a root cause of America’s in every State in our Nation. We must support those battling addiction.

I have met with so many Hoosiers battling addiction. I visited treatment centers and recovery houses like the La Verne Lodge for men and Ohana House Sober Living for women. I have talked with addicts and those battling addiction about what is working and what is not working with different recovery options.

Passing the strong bipartisan bill before us today is critically important. It will help ensure that more people have better access to treatments, and we can try to save more lives across this country.

Mr. PALLONE. Mr. Speaker, I yield 4 minutes to the gentleman from Maryland (Mr. CUMMINGS), the ranking member of the Oversight and Government Reform Committee.

Mr. CUMMINGS. Mr. Speaker, I want to thank Mr. PALLONE for yielding, and for his great work on this legislation.

Mr. Speaker, I rise in support of provisions in this package reauthorizing and reforming the Office of National Drug Control Policy to improve coordination of our national response to the drug crisis.

At my request, the bill creates a demand reduction coordinator position, parallel to the existing interdiction coordinator, to promote the reduction initiatives, including efforts to expand treatment.

Among other critical reforms, this legislation also requires ONDCP to report whether drug control program funding is sufficient to achieve the goals of the National Drug Control Strategy. It requires the compilation of essential data on overdoses, deaths, and interdiction in a data dashboard, so the American people have a clear, accessible picture of the effectiveness of efforts to combat the drug crisis.

I thank Chairman GOWDY, Chairman MEADOWS, and Vice Ranking Member CONNOLLY for working with me to develop legislation that will reform ONDCP. I thank Chairman GRASSLEY, Ranking Member FEINSTEIN, and Senator CORNYN for their leadership.

Let me also give special thanks to the committee staff and, I must say, to the majority and the minority staff. They did a phenomenal job working hard in conference and throughout this effort. Without their extraordinary efforts, this legislation would not be in this package today.

Mr. Speaker, I close with a simple warning. There are a lot of people suffering. Almost 198 people die a day—a day. Those are the people who are dying, but there are a lot of people in the pipeline who are in so much pain, they don’t even know they are in pain. And while the efforts of H.R. 6 are important, without significantly expanding access to treatment and wrap-around services through long-term, sustained funding, we continue to nibble at the edges of our national crisis, and the crisis will continue to worsen.

Mr. Speaker, I thank the gentleman for yielding.

Mr. WALDEN. Mr. Speaker, I am also pleased that H.R. 6 includes the Securing the International Mail Against Opioids Act, which would help to stop the flow of opioids through the United States. This legislation stems from the STOP Act, a bill that I worked on with Mr. Tiberi before his retirement earlier this year. I want to commend him, in addition to Trade Subcommittee Ranking Member Pascrell, for their work on this bipartisan legislation.

Mr. Speaker, I rise today to talk about something that is really close to all of our hearts. We have reached a point in this country where opioid overdoses claim more than 100 lives every single day.

Think about that for a moment, more than 100 lives every day. Mothers and fathers are burying sons and daughters, or in some cases, sons and daughters are burying mothers and fathers.

I bring this up simply to impart the gravity of the situation, which makes our response all the more urgent. But while the situation is certainly grave, that does not mean that we should ever lose hope.

As we have worked on this legislation we will soon send to the President, we all had to go out and gain an understanding of the facts on this issue. Everybody on both sides of the aisle spent so much time on this bill. In doing that, we have gleaned so much understanding.

And that is, after all, how our Republic works. That is what the people’s House does. We learn from our constituents. We hear their stories. We see the suffering, and then we act.

This is a fantastic moment of people coming together to solve a problem. I think, in this process, we gained something very special.

Many of us heard the stories from incredible souls who have known un-speakable loneliness and who struggle with drug addiction. They made it through to the other side.

We met family members and friends who have known the pain and the fear that accompanies loving someone wrestling with addiction. Every one of us knows somebody or is related to somebody who has gone through this.

We met those who will never again have the chance to see the ones that they love so much.

Amid the overwhelming darkness, we have gotten to see their spark, their strength. From this pain has come something more powerful: resolve and a passion to make sure that others have a safe place to turn, that this doesn’t happen to their family.

Witnessing this kind of strength, witnessing this kind of resilience, that is what helped produce this legislation. Through these bills, we are trying to ensure that anyone who needs help is not too isolated to receive it.

We are giving our communities the resources that they need to provide stronger treatment networks and support systems. That is where the healing happens. That is where Americans are at our best.

If this legislation can save one life and bring help to one person, that is what matters.

It is going to do far more than that.

So I want to thank all of those who were brave enough to share their stories with all of us. I want to thank all of those people who all of us met with
for being brave, for coming here, for meeting us, and for testifying and giving us their stories. And for all of those who are continuing to struggle in silence, I want them to know that there is no shame in their trials. In our own ways, we all fall.

In our Catholic tradition, we look to St. Jude as the patron saint of lost causes, a keeper of those some in society may have written off. To me, his guardianship is written in this legislation. There are no lost causes. No one is permanently down. It is about offering a helping hand, and it is about opening our hearts.

Mr. Speaker, I am very proud of this legislation. I am so thankful to my colleagues on both sides of the aisle who came together to put these families and to put these communities first.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. Tonko), a member of the committee.

Mr. TONKO. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, all across my district, I have stories of individuals and families whose lives have been irrevocably changed by the scourge of the opioid epidemic: a father who lost his daughter too young and is pouring his grief into advocacy, a former neighbor who was left behind two young children, a young man who is walking the hard path of recovery and showing others how to do the same.

These are the stories I hear day in and day out. They fill my heart; they fill my soul, because of them, I am so very proud to cast a vote today in support of H.R. 6.

Mr. WALDEN. Mr. Speaker, it is now my privilege to yield 30 seconds to the gentleman from Ohio (Mr. Latta), the very effective chairman of our Digital Commerce and Consumer Protection Subcommittee.

Mr. LATTA. Mr. Speaker, I thank the gentleman for yielding.

I am particularly proud that this bill incorporates legislation that I have introduced, along with my good friend Representative BEN RAY LUJAN of New Mexico, which will provide a meaningful expansion to our country's addiction treatment by allowing additional healthcare providers, such as nurse midwives, to prescribe buprenorphine, a medication-assisted treatment for opioid use disorder.

In addition, this provision will make permanent buprenorphine-prescribing authority for nurse practitioners and physician assistants and allow certain providers to treat more patients in the first year of their license.

Mr. Speaker, I urge my colleagues to support H.R. 6.

Mr. TONKO. These individuals are highly vulnerable to opioid overdose due to lack of effective addiction treatment while incarcerated. By passing this legislation, we will allow States to engage in demonstration projects to improve medical care and transition-related services to Medicaid-eligible incarcerated individuals in the 30 days prior to their release, reducing the risk of overdose for these individuals as they come back into the community for a second chance. I truly believe that this provision will transform lives.

I thank Ranking Member PALLONE, Chairman WALDEN, and their staffs for their continued efforts in this process. Without their dedicated, bipartisan work, we would not be making this progress today.

Mr. Speaker, I urge my colleagues to support H.R. 6.

Mr. WALDEN. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. Burgess), the country is well served by his chairmanship of the Subcommittee on Health.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, H.R. 6 is by far the most comprehensive legislation to address this national crisis. While more work remains—and I am the first to admit it—it provides meaningful solutions and vital resources for our States and localities.

Many of the priorities developed by the Energy and Commerce Committee are included in H.R. 6, like the 21st Century Tools for Pain and Addiction Treatment Act, partially repealing the institutions for mental disease exclusion and strengthening interagency coordination at our international mail facilities so that, perhaps, once and for all, we can do something about this poison coming into our country from eastern Asia to the detriment of our citizens.

I believe H.R. 6 could have been stronger. It could have included language aligning 42 CFR Part 2 with HIPAA. That stand-alone bill received 357 votes in this House. And I promise you, you will see it again. I am concerned about expanding prescriptive authority for nonphysicians, and I hope we will be able to look at that again in the future.

But I cannot let the perfect be the enemy of the good. I urge our Members to support this product today.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Michigan (Mrs. Dingell), also a member of the committee.

Mrs. DINGELL. Mr. Speaker, I thank Ranking Member PALLONE for yielding and Chairman WALDEN for his leadership in bringing this bill to the floor.

Mr. Speaker, I rise in strong support of H.R. 6, the SUPPORT for Patients and Communities Act. This is a critical first step in addressing the opioid epidemic.

I have lived on all sides of this. I lived in a home with a father who was an opioid addict before anyone knew what it was. I had a sister who died of a drug overdose. Yet I also live with a man who has very serious chronic pain and needs opioids to live his life comfortably.

We cannot let the pendulum swing too far in either direction, and we cannot be denying medication to those who need it. I am confident that this legislation strikes the right balance.

This bill has four provisions which I authored included in it: The ACE Research Act, which I co-sponsored with my friend Mr. Upton, will spur innovative research into nonopioid pain medications at NIH and will help lead the next big breakthrough and bring benefits to patients. We need nonaddictive pain drugs.

I am also pleased that Jessie's Law, which I introduced, will not be denied, with Mr. Walberg, is in this. This provision, which is named after a young woman we lost far too soon, would require HHS to establish best practices to ensure that medical professionals have full knowledge of their patient's opioid history.

The Safe Disposal of Unused Medication Act fixes a critical gap in our laws by permitting hospice employees from dispensing of unused opioids after a patient has passed away or the medication is no longer needed.

Finally, I was pleased to work on language with Dr. Bucshon to ensure that the Welcome to Medicare wellness program includes a beneficiary's current opioid prescriptions and screening for potential substance use disorder.

As we pass this legislation to combat this epidemic which has claimed so many lives, we cannot forget the 22 million people who do live in pain. We cannot let the pendulum go either way.

Mr. WALDEN. Mr. Speaker, it is now my privilege to yield 30 seconds to the gentleman from Ohio (Mr. LATTA), the very effective chairman of our Digital Commerce and Consumer Protection Subcommittee.

Mr. LATTA. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 6. This legislation will make a significant difference to tens of thousands of Americans who are struggling with addiction.

I am also pleased that my bill, the INFO Act, is part of the fight against the opioid crisis. The INFO Act is essential to ensuring we are providing behavioral health professionals, advocates, physicians, and families with the tools, resources, and funding information they need to prevent, identify, and treat addiction.

Furthermore, H.R. 6 is critically important to stop the flow of illegal opioids, prevent the misuse of drugs, and help those who are addicted. With 190 Americans dying every day from overdoses, it is time to act now.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Texas...
Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from New Mexico (Mr. BEN RAY LUJÁN).

Mr. BEN RAY LUJÁN of New Mexico. Mr. Speaker, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act.

This is an important step forward in the fight against the Nation's opioid epidemic. However, this Congress must acknowledge that this is not the end. Healthcare is a right, not a privilege. There is much more work to do to ensure that families get the help that they deserve.

I am pleased that this package includes language that I have championed to address gaps in prevention and gaps in access to treatment. In addition, this bill will create pathways to behavioral healthcare jobs in communities like New Mexico.

Still, Congress must do more. As we have heard from Representative CUMMINGS, this is going to take much more money, investment, and comprehensive legislation.

Mr. WALDEN. Mr. Speaker, I am privileged to yield 30 seconds to the gentleman from Kentucky (Mr. GUTHRIE).

Mr. GUTHRIE. Mr. Speaker, I rise in support of the SUPPORT for Patients and Communities Act.

One of the main things I hear back home is how our Nation's ongoing opioid crisis has affected either themselves, their loved ones, or their community.

Mothers, fathers, children, bankers, dentists, bus drivers, or high school athletes, anyone can fall victim to opioid use disorder. That is why I am proud to work with my colleagues in support of the act so that we can help these people who are suffering from this terrible epidemic.

Mr. Speaker, I urge my colleagues to support this critical legislation so that we can deliver relief to those communities.

Mr. PALLONE. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, before we conclude debate, let me just take a moment to thank everyone for all of their hard work getting this bill across the finish line.

This bill represents a collection of Member ideas and policies across the political spectrum. Many people may not know this, but the staff of the House and Senate committees negotiated this bill in a matter of weeks, and that is no small feat. It took a lot of effort and hard work to pull this off. It is a product we can all be proud of.

So let me thank all legislative counsel and CBO for their efforts as well.

Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, the SUPPORT for Patients and Communities Act is the product of a year of hearings and investigations into America's opioid crisis.

This thoughtful bipartisan legislation will provide more tools to our communities to combat the opioid epidemic that we included my legislative efforts to help Medicare beneficiaries, begin reforms to the sober home industry, and address the problem of patient brokering.

We need to pass this bill and give our constituents the help they need.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Ohio (Mr. JOHNSON), who is a leader on this issue.

Mr. JOHNSON of Ohio. Mr. Speaker, today is the culmination of months of tireless work driven by heartbreaking stories of people whose lives were destroyed by opioid addiction, and, just importantly, the powerful stories of hope and recovery.

I am grateful for the hard work of my colleagues and our Energy and Commerce staff. I am proud that my legislation to improve how health professional students are taught to recognize, prevent, and address addiction, as well as to expand the availability of telehealth and peer support services for those struggling with addiction is included.

Mr. Speaker, I am looking forward to continuing the hard work ahead on this very important issue, and I urge support for the bill.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Indiana (Mr. BUCSHON), who is a talented physician on our committee.

Mr. BUCSHON. Mr. Speaker, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act.

This bipartisan bill will help our struggling communities to combat the opioid epidemic by increasing access and improving care to those in need and preventing new occurrences of opioid misuse and abuse.

Section 2002, which I authored, would provide screening for chronic pain, address possible non-opioid pain alternatives, and increase early detection of opioid use disorder in seniors as they enter Medicare.

Mr. Speaker, I am proud to have worked with my colleagues on solutions to this serious epidemic, and I urge support of H.R. 6.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan (Mr. WALBERG) to speak on the measure.
Mr. WALBERG. Mr. Speaker, I rise today in strong support of this bipartisan package to address the opioid crisis devastating our communities.

This legislation includes two provisions authored by myself and my good friend from Michigan, Congresswoman Debbie Dingell.

One will help safely dispose of unused drugs and prevent their diversion into the community. The other, Jessie’s Law, honors the memory of Jessie Grubb and will help prevent future overdose tragedies under medical care.

Mr. Speaker, this critical legislation will help save and rebuild lives. I urge its passage today, and I look forward to its quickly advancing to the President’s desk.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Georgia (Mr. CARTER), who is our resident pharmacist on the Energy and Commerce Committee.

Mr. CARTER of Georgia. Mr. Speaker, I do thank to thank Chairman Walden and Burgess for working so hard with our partners across the aisle as well as across the Capitol to come to a consensus on this critical legislation necessary to combat the opioid epidemic.

As the only pharmacist currently serving in Congress, I have seen families saved by pain medications and have seen families torn apart by the same drugs.

Since this body began tackling the opioid epidemic, I have said there are three major components to this crisis: prevention, law enforcement, and treatment.

This legislation touches all three prongs of the opioid crisis with a number of creative solutions in addition to providing offsets to ensure that solving a public health crisis does not lead to a fiscal one.

This package is not a silver bullet, but as legislators we need to do everything in our capacity to prevent the addiction and overdoses that occur every day in the United States.

Mr. Speaker, I would like to thank Chairman Walden and Burgess for working so hard with our partners across the aisle as well as across the Capitol to come to a consensus on this critical legislation necessary to combat the opioid epidemic.

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This legislation touches all three prongs of the opioid crisis with a number of creative solutions in addition to providing offsets to ensure that solving a public health crisis does not lead to a fiscal one.

I voted for many of these bills when they came before Energy and Commerce for markup, and once again I want to offer my full support for this legislation.

I am pleased that this package includes three of my own bills, the Special Registration for Telemedicine Clarification Act, the Abuse Deterrent Access Act, and the Empowering Pharmacists in the Fight Against Opioid Abuse Act.

This package is not a silver bullet—but as legislators we need to do everything in our capacity to prevent the addiction and overdoses that occur every day in the United States.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Illinois (Mr. ROSEKAM).

Mr. ROSEKAM. Mr. Speaker, what a joy it is to be on the floor today. What a joy it is to be amongst a group of people who have set aside partisanship and have come together to address a crisis that is crushing our constituents. What a joy it is to be a part of the process and among a group of people who are trying to find common ground.

This is a good day, Mr. Speaker. There is good work that is happening. I chair the Health Subcommittee, and it was incredible to see the work that that subcommittee did on the Ways and Means Committee.

Mr. Speaker, I pleased to strongly endorse this bill, and I urge its passage.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I am honored to yield 30 seconds to the gentleman from Minnesota (Mr. PAULSEN), who has worked so hard for these issues.

Mr. PAULSEN. Mr. Speaker, I am excited to support this legislation. It is bipartisan.

Minnesotans and those who are on the front lines of the opioid crisis will be helped, and it will aid the millions of American families who are affected by this epidemic.

It includes a bipartisan measure that I authored that will help prevent opioid addiction among seniors by educating them on alternative pain management treatments, and the proper, safe disposal of prescription painkillers. It will help more than 90,000 at-risk seniors from descending into a deadly spiral of addiction.

The end result will be less addiction, fewer overdoses, and safer Minnesota communities.

Mr. Speaker, I thank the chairman for yielding time.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Ohio (Mr. RENACCI) to speak on the measure.

Mr. RENACCI. Mr. Speaker, I rise in support of this legislation which includes my bipartisan bill, the Strengthening Partnerships to Prevent Opioid Abuse Act.

The opioid epidemic has hit my home State of Ohio particularly hard, with thousands of Ohioans dying from drug overdoses every year.

This bill will make it easier for Medicare Advantage Part D drug plans, and HHS to combat fraud, waste, and abuse and prevent the overprescribing of opioids to vulnerable seniors.

I would like to thank members of the conference committee as well as their staff for including my bill in this package and for their hard work to pass legislation to address the opioid epidemic.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, may I inquire as to how much time each side has remaining?

The SPEAKER pro tempore. The gentleman from Michigan (Mr. BISHOP.)

Mr. BISHOP of Michigan. Mr. Speaker, I rise in strong support of H.R. 6 which will make great strides toward ending the opioid crisis once and for all.

I am pleased this package includes my bill, the STOP Act, which is targeted legislation to help stop synthetic opioids like fentanyl and carfentanil from entering our country through the international mail system.

I want to make sure I thank all the parents, educators, law enforcement, emergency response personnel, healthcare professionals, victims, and those suffering from addiction who have been working with me to ensure this legislation gets signed into law.

Your hard work has made a real difference.

Mr. Speaker, I also want to thank my colleagues for their support, and I urge a “yes” vote on the underlying bill, H.R. 6.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, few States have been harder hit than Kentucky in this effort on opioids, a terrible tragedy.

Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Kentucky (Mr. BARR).

Mr. BARR. Mr. Speaker, on behalf of the families of the Commonwealth of Kentucky which suffers from the third highest opioid overdose mortality rate in the Nation, I rise today in support of H.R. 6, and I thank the chairman for his leadership on this.

This legislation marks a critical investment to help individuals and families struggling with addiction rise above addiction and transition back into the workforce.

Specifically, H.R. 6 includes my legislation, the CAREER Act, which creates a demonstration program to promote evidence-based transitional housing that pairs recovery support with life skills, workplace training, and job placement.

I would like to thank the many nonprofits in my home State of Kentucky for inspiring this legislation.
Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Pennsylvania (Mr. BARLETTA). There is a lot of enthusiasm for this legislation, Mr. Speaker. We want to hear from Mr. BARLETTA about his thoughts on it. He has been a real leader on it.

Mr. BARLETTA. Mr. Speaker, I rise today in support of H.R. 6 which includes my bill, the Treating Barriers to Proximosity Act.

The Appalachian region, including much of my home State of Pennsylvania, has an overdose death rate 65 percent higher than the rest of the country for people ages 15 to 64. My legislation will allow communities to use Appalachian Regional Commission funding for everything from attracting doctors to putting in broadband for telemedicine. It will spur economic growth in communities hit hardest by the opioid epidemic, while also helping those struggling with addiction by breaking down barriers to employment.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentlewoman from California (Mrs. MIMI WALTERS) who is from the West Coast and is a real leader on our committee.

Mrs. WALTERS of California. Mr. Speaker, I rise in support of H.R. 6 and the IMD exclusion repeal. I am grateful to my colleagues for their bipartisan and bicameral support of this legislation.

I fought to ensure the IMD exclusion repeal was part of this final agreement because increasing inpatient treatment options is essential in our fight against the opioid epidemic.

The Orange County Board of Supervisors agrees with leading addiction treatment groups: the IMD exclusion repeal and the IMD CARE Act are the most important steps we can take to end drug overdose deaths in Orange County.

Mr. Speaker, I urge my colleagues to support this legislation to address this public health crisis.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentlewoman from Indiana (Mrs. WALORSKI), who is also a real worker on this legislation, to speak on the measure.

Mrs. WALORSKI. Mr. Speaker, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act. It includes my bill, named for Dr. Todd Graham, who was senselessly murdered last year over an opioid prescription.

With this legislation, we build on Dr. Graham’s legacy of treating patients not only for their pain, but for their underlying causes. Today we are taking bipartisan action to expand access to nonopioid alternatives and give our communities better tools to prevent and treat addiction.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan (Mr. MITCHELL). Mr. MITCHELL. Mr. Speaker, I rise today in support of H.R. 6 as did my colleagues.

The opioid crisis has impacted nearly every community across this country, and in order to most effectively combat this crisis, we must establish a comprehensive response plan.

I am pleased this bill includes a version of my amendment offered in committee to establish a system to track Federal funding for drug control efforts, ensuring the government knows exactly where the money is being spent, how it is being used, and if it is working.

Mr. Speaker, I support this bill, and I ask my colleagues to do so as well.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, we have heard from doctors, we have heard from pharmacists, and we have heard from many family members. I have never heard from somebody who has a distinguished career in law enforcement. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. KNIGHT) to speak on this legislation.

Mr. KNIGHT. Mr. Speaker, as a police officer and a street cop in L.A., I have seen the problems that the opioid epidemic has done to our communities. It has literally destroyed families and hurt our communities to no end. H.R. 6 is a much-needed display of bipartisanship to address the ongoing opioid crisis and epidemic.

Many of the issues that have come out of this bill spur development of national best practices for substance abuse recovery housing and incorporating opioid treatment in the back in Recovery Act, to establish meaningful penalties for profiteering off other people’s pain and addiction through illicit referrals.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield 30 seconds to the gentleman from Virginia (Mr. BRAT) to speak on the measure.

Mr. BRAT. Mr. Speaker, I rise today to thank Chairman BRADY, Chairwoman FOXX, and Chairman WALDEN for addressing opioid and substance abuse disorders and their work on H.R. 6, the SUPPORT for Patients and Communities Act. I am grateful to my colleagues for their support of the crisis with the urgency it deserves.

In my district, this crisis has affected way too many. I am also grateful that my bill, H.R. 5809, the Recognizing the Elimination of Trauma Related to Substance Abuse Act of 2018 was included in the final package before us today.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I don’t believe I have any other speakers on my side of the aisle pending, so I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I do urge support for this legislation. It is a good bill. It expands access in a number of ways in communities. But I do also want to point out that there are limitations to the bill. In other words, we do need to do a lot more.

For example, we still haven’t expanded Medicaid coverage in many States. Medicaid coverage is crucial, in terms of providing treatment. But I especially thank our team: Josh Trent, Kristen Shatynski, Caleb Graff, Dan Butler, James Paluskiewicz, Danielle Steele, Adam Buckalew, Melissa Kirsch, Long, Peter Keilty, and Jenn Sherman, and the whole team at the Energy and Commerce Committee on both sides of the aisle.

We worked through a lot of difficult issues, issues where we didn’t start on the same side, but we ended on the same page as we listened to each other, as we listened to our constituents at home.

I want to close by urging everyone to support this bipartisan and bicameral bill, because it does do a lot. At the same time, I remind my colleagues that we have a lot more to do if we are going to address this opioid crisis, which actually is getting worse instead of better.

Mr. Speaker, I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, before I close, I want to especially thank our staff on both sides of the aisle for their incredible work. They have worked day and night, literally, and all through the weekend—also, the folks at the Congressional Budget Office and Legislative Counsel. But I especially thank our team: Josh Trent, Kristen Shatynski, Caleb Graff, Dan Butler, James Paluskiewicz, Danielle Steele, Adam Buckalew, Melissa Kirsch, Long, Peter Keilty, and Jenn Sherman, and the whole team at the Energy and Commerce Committee on both sides of the aisle.

We worked through a lot of difficult issues, issues where we didn’t start on the same side, but we ended on the same page as we listened to each other, as we listened to our constituents at home.

I want to close by thanking all of you for your work on this bill. I ask my colleagues to do so as well. I yield back to the Speaker.
at a very young age through an overdose. And it is about her parents. It is about Mike and Winnie. It is about Paula, and it is about her sons and sister. It is about a woman I met in Hermiston who had to travel 5 hours to find a pharmacy that would overflow her treatment on Suboxone because nobody was available. We help fix that in this legislation.

It is about my friends at Winding Waters in Enterprise, Oregon, who I was with last week, and the sheriff and others, who talked about the continuing problems and challenges they face and who have given me great guidance on these and other issues.

From one end of my district to another, from one end of our country to another, we have all listened. We have heard. Frankly, we have cried as we have heard the stories of parents who help their children through addiction, only to drop them off at college and a matter of days later retrieve a body.

That is what brings us together here today, Mr. Speaker. It is their stories that are woven deeply into this legislation. It is because of them that we will make a difference and we will do it right.

We will know that, as we pass this today and the Senate after us, that more work does remain to be done. We are on a journey together, though, and we will find solutions.

Mr. Speaker, I thank my colleagues on both sides of the aisle. I thank our staffs. I thank the American people who have reached out to us, counseled us, and helped.

Mr. Speaker, I urge my colleagues to strongly support passage of the SUPPORT Act. For patients and for communities, H.R. 6 needs to become law, and it will shortly.

Mr. Speaker, I yield back the balance of my time.

Ms. MAXINE WATERS of California. Mr. Speaker, I rise to support H.R. 6, the SUPPORT for Patients and Communities Act, a bipartisan, bicameral solution to opioid addiction and other forms of substance abuse.

A comprehensive, common-sense, and compassionate approach to substance use disorders is long overdue. For far too long, many communities throughout the United States have been devastated by substance use disorders. However, despite the widespread suffering that millions of people—particularly African Americans during the crack cocaine epidemic—endured and still endure today, few states, and local communities, in many instances, have pursued punitive measures in lieu of effective solutions to ensure that all communities can adequately heal from the devastating impacts of addiction.

I am especially pleased that this bill now includes my amendment to the House version of H.R. 6, which requires the Department of Health and Human Services (HHS) to conduct a review of the organizations, government agencies, and other entities that receive federal funding to provide substance use disorder treatment services. In addition, the amendment directs HHS to develop, and submit to Congress, a plan to direct appropriate resources to address the inadequacies in services or funding identified through the review.

I am also pleased that this bill addresses concerns that I raised about the opioid legislation in the House that allowed states to use Medicaid funds to provide treatment to persons with opioid use disorders in Institutions for Mental Disease (IMDs), but did not allow similar treatment for persons with other types of substance use disorders. In order to seriously address substance use disorders in communities throughout the United States, it is critical that we include persons who suffer from all types of substance use disorders, including those that involve alcohol, cocaine, and methamphetamine, as well as opioids.

I offered an amendment to the legislation in the House aimed at addressing my concern about the exclusion of non-opioid forms of substance use disorders from treatment in IMDs. While my amendment was not accepted, I am pleased that efforts were made to address my concern. The final version of H.R. 6 allows for the allocation of a larger share of funding in IMDs for persons with all types of substance use disorders and also includes safeguards to ensure that states do not reduce the availability of community-based treatment for persons suffering from substance use disorders.

While I appreciate the work that has been done on many components of this bill, I still have some important concerns. As the Ranking Member of the House Committee on Financial Services, which has jurisdiction over housing programs, I am concerned that this bill falls short when it comes to providing housing for people with substance use disorders. The bill includes a provision that creates a new grant program to provide temporary housing assistance to help people with substance use disorders, but this new funding will only be available in half of the states. This will leave the other half of the states continuing to struggle with the challenges of helping people with substance use disorders who are in need of housing. Furthermore, this bill does nothing to address the overly punitive and unfair policies governing our federal housing programs that create unnecessary barriers to housing for people who have criminal backgrounds related to substance use disorders.

I am encouraged that there is bipartisan support for addressing the housing needs of persons suffering from substance use disorders, but I am disheartened that Congress continues to fall short in its efforts to provide comprehensive solutions that will help people suffering from substance use disorders in every state of the country. As we work to address the opioid crisis at hand, let’s not forget that Congress still has a lot of work to do in the way of criminal justice reform to address the ongoing painful and discriminatory impacts of the war on drugs era.

Despite these concerns, I believe this bill includes some valuable bipartisan solutions that direct a step in the right direction. I urge all of my colleagues to support H.R. 6, and I look forward to continuing to work with my colleagues to address the scourge of substance use disorders in communities throughout the United States.

Mr. WALDEN. Mr. Speaker, I include the following letters in the RECORD.
month, First Focus, the State Policy and Advocacy Reform Center, and PosterClub held a congressional briefing on the importance of Medicaid to foster children and youth.

Family-Focused Residential Treatment: This provision promotes family-based residential treatment for substance use disorders, by authorizing the HHS Secretary to issue guidance to states on how they can support such treatment facilities.

Recovery and Reunifying Families: This provision provides the replication of effective recovery coach programs to improve outcomes for children and families in the child welfare system who are impacted by substance use disorders.

Family-Focused Residential Treatment: This provision creates a grant program to promote family-based residential treatment programs, which are critical to helping parents and families get the treatment they need to overcome addiction.

Plans of Safe Care: This provision provides grants to states to improve and coordinate their response to ensure the safety, permanency, and well-being of infants affected by substance use.

Trauma-Informed Care: This provision gives the Center for Disease Control (CDC) authority to work with states to collect and report data on adverse childhood experiences. It also directs the CDC to form a task force to promote best practices in treating children impacted by trauma and to recommend guidelines to federal agencies regarding its coordination and response to substance use disorders and other forms of trauma that affect children and families.

At-Risk Youth: Medicaid Protection: This legislation would ensure that incarcerated youth are simply suspended, rather than terminated, from Medicaid while they are incarcerated. It would require states to automatically restore full eligibility to youth upon release from incarceration, and to take any steps necessary to make sure that youth begin receiving medical assistance benefits immediately.

The Fiscal Year 2019 annual spending bill for the Departments of Labor, Health and Human Services, Education and Related Agencies (H.R. 6157) includes $3.8 billion for combating the opioid crisis, and the bill should be praised by Noonan. Adequate federal funding for these new programs benefitting our foster children is critical. Looking ahead to Fiscal Year 2020, though, these gains would be jeopardized if Congress fails to lift the budget cap for non-defense discretionary spending established by the 2011 Budget Control Act. If budget caps are allowed, this type of spending will go down by $55 billion. Congress must prioritize children in our federal budget decisions immediately.

Mr. WALDEN. Mr. Speaker, I include the following letter in the Record:

ADAM'S AMERICAN BENEFITS COUNCIL, Washington, DC, September 27, 2018.

Hon. MITCH MCCONNELL, Majority Leader, U.S. Senate, Washington, DC.

Hon. CHUCK SCHUMER, Minority Leader, U.S. Senate, Washington, DC.

Hon. PAUL RYAN, Speaker, House of Representatives, Washington, DC.

Hon. NANCY PELOSI, Minority Leader, House of Representatives, Washington, DC.

DEAR LEADER MCCONNELL, LEADER SCHUMER, SPEAKER RYAN AND LEADER PELOSI: The America’s opioid epidemic (the Council) supports the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treat-
create comprehensive opioid recovery centers (CORCs).

Improve access to telehealth services.

Streamline Medicaid coverage for incarcerated pregnant women.

Ensure mental health parity for pregnant women and children within the CHIP program.

Codify MAT prescribing regulations allowing Nurse Practitioners and Physician Assistants to prescribe buprenorphine as well as increased flexibility for patient caps, and allowing additional advanced practice nurses to prescribe for a period of 5 years.

We particularly want to highlight our strong support for H.R. 6008, which authorizes $38 million to support expanded access to MAT at FQHCs and rural health clinics under the Medicare program. We believe this provision will be of great assistance to health centers who are initiating and expanding opioid use disorder treatment programs in underserved areas across the country.

Thank you again for all your hard work to bring this bill to fruition. We know there is more work we can do together to turn the tide of this public health crisis and look forward to continuing to work with you to address the needs of communities across the country.

Sincerely,

TOM VAN COVERDEN,
President and CEO of NACHC.

MR. WALDEN. Mr. Speaker, I include the following letters in the RECORD.

TO THE MEMBERS OF THE U.S. HOUSE OF REPRESENTATIVES: The U.S. Chamber of Commerce strongly supports the bipartisan H.R. 6, the “Opioid Crisis Response Act of 2018.” The chamber, along with many other stakeholders, notes that the votes related to this bill in our annual How They Voted scorecard.

The opioid epidemic is ravaging families and employers’ efforts to staff workforce needs, creating new jobs, and expand commerce.

We applaud Congress for crafting comprehensive legislation to tackle the myriad of causes, such as the flood of illicit drugs into the public sphere, by removing a litany of barriers that inhibit prevention, recovery, and treatment options.

The Chamber is pleased that H.R. 6 does not include the expanded end stage renal disease (ESRD) provision included in an earlier version of the bill. That policy would have burdened employers already struggling to provide health benefits with hundreds of millions of dollars in additional health care costs.

While H.R. 6 is important, more remains to be done. The Chamber urges Congress to address the 42 CFR Part 2 statute as hundreds of health care organizations have called for. Congress should align currently conflicting elements of health care organizations have called for. We are also pleased that the bill builds on the nation’s opioid crisis and to urge your support for the final bill, the Support for Patients and Communities Act (HR 6).

Catholic Health providers recognize that each human life is sacred and possesses inalienable worth, and that health care is essential to promoting and protecting the inherent dignity of every individual. We also recognize that supportive and readily available substance use disorder (SUD) treatment elements are essential facets of holistic, person-centered and effective health care. The first principle in our Vision for U.S. Health Care affirms our call to pay special attention to those most likely to lack access to health care, many of whom are in desperate need of SUD services. This commitment is why the Catholic health ministry strongly supports efforts to increase access to these services and ensure they are delivered in a way that provides access to the full range of health care services. CHA has supported many of the provisions in H.R. 6, particularly those that would increase access to care under Medicaid and care for such vulnerable populations as children and pregnant women, as well as provisions to streamline access to telehealth services. We are particularly pleased that the final version of this legislation includes the IMD Care Act, to provide state Medicaid programs with the discretion to cover care during FY2019–23 in certain Institutions for Mental Diseases (IMD) that may be otherwise non-federally-reimbursable under the IMD exclusion. We are also pleased that the bill includes measures to ensure access to mental health and substance use disorder services for children and pregnant women under the Children’s Health Insurance Program (CHIP). However, we are disappointed that legislation introduced in the Senate (S. 1850, the Protecting Jessica Grubb’s Legacy Act) and the House (HR 6082, the Support for Patients and Communities Act (HR 6082) to align current regulations for SUD treatment records with existing patient protection under HIPAA, fixation treatment, payment and health care operations was not included in HR 6. For health providers, the alignment of SUD records with other medical records is essential to effective care. It enables the flow of patient information among providers that is critical to the timely and effective delivery of treatment and adherence to safety and quality. Given the broad and bipartisan support for HR 6082, we continue to urge the Senate to approve this bill as well before the end of the 115th Congress.

Thank you again for your attention to the urgent matter of opioid and other substance use disorders. We believe the goal of our Catholic health ministry in providing the best possible care and treatment for those who need it, and we hope approval of the Support for Patients and Communities Act will provide effective additional resources for doing so.

Sincerely,

Mr. WALDEN. Mr. Speaker, I include the following letters in the RECORD.

From the American Society of Addiction Medicine

The American Society of Addiction Medicine (ASAM) today applauds US House and Senate leaders for announcing a bipartisan agreement on an opioid legislative package that includes key provisions to bolster the country’s addiction treatment workforce, help provide standard of care-based treatment for individuals with a substance use disorder (SUD), and help ensure coverage and payment models facilitate comprehensive, coordinated care for patients seeking treatment for a SUD.

On behalf of America’s addiction medicine professionals and other clinicians on the frontlines of this crisis, ASAM applauds our Congressional leaders for working together to include key provisions that will help close the treatment gap and save lives, addiction medicine experts say.

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Mr. WALDEN. Mr. Speaker, I include the following letters in the RECORD.
Hon. NANCY PELOSI, House of Representatives, Washington, DC.

Hon. MITCH MCCONNELL, Minority Leader, U.S. Senate, Washington, DC.

As you know, the Centers for Disease Control and Prevention recently reported that more than 72,000 Americans died of a drug overdose in 2017, a staggering increase from 63,600 in 2016. With nearly 200 Americans dying each day as a result of drug overdose, the opioid crisis is an urgent and serious public health and safety issue that needs to be addressed through a comprehensive response.

We are grateful to Congress for addressing this urgent need to improve policies and resources to help the millions impacted by addiction nationwide. We thank Members on both sides of the aisle and the 15 congressional committees for their thoughtful, evidence-based legislation. We strongly support the SUPPORT for Patients and Communities Act and its multifaceted, nuanced approach to addressing the opioid crisis and all substance use disorders.

Key provisions include:

**HEALTHCARE INTEGRATION**
- **Treatment, Education, and Community Help To Combat Addiction (Section 7101)**—Expands medical education and training resources for healthcare providers to better address addiction, pain, and the opioid crisis.
- **Preventing Overdoses While in Emergency Rooms (Section 7081)**—Improves emergency departments ability to effectively screen, treat, and connect substance use disorder patients with care.
- **Alternatives to Opioids in the Emergency Department (Section 7085)**—Establishes model comprehensive pain management protocols in order to limit the use of opioid medications in emergency departments.
- **Inclusion of Opioid Addiction History in Patient records (Section 7051)**—Requires HHS to develop best practices for prominently displaying substance use disorder treatment information in electronic health records, when requested by the patient.

**TREATMENT CAPACITY EXPANSION**

**CARE Act (Section 5052)**—Expands Medicaid coverage up to 30 days for individuals in treatment for opioid use disorder in a treatment facility for all substance use disorders, lifting the 16 bed restriction.

**Expansion of Telehealth Services (Section 1009, 2001, 2232)**—Expands access to substance use disorder treatment and other services through the use of telehealth.

**Comprehensive Opioid Recovery Centers (Section 7211)**—Establishes model comprehensive treatment and recovery centers to ensure individuals have access to quality treatment and care.

**Supporting family-focused residential treatment (Section 8081, 8083)**—Enhanced family-focused residential treatment; $20 million in funding to award to states to develop, enhance, or evaluate family-focused treatment programs to increase the number of evidence-based programs.

**TREATMENT WORKFORCE EXPANSION**

**Substance Use Disorder Workforce Loan Repayment (Section 7071)**—Enhances the substance use disorder treatment workforce by creating a student loan repayment program for healthcare providers.

**Addressing economic and workforce impacts of the opioid crisis (Section 8041)**—Awards grants to support substance use disorder and mental health treatment workforce shortages.

**MEDICATION ASSISTED TREATMENT**

**More Flexibility for Prescribing Medication for Addiction (Section 2001, 3002)**—Increases the number of waivered health care providers that can prescribe or dispense treatment for substance use disorder, such as certified nurses and accredited physicians.

**Grants to enhance access to substance use disorder treatment (Section 2335)**—Authorizes grants to enhance the sobriety treatment and recovery teams for patients and communities with a small number of families, providing peer support, intensive treatment and child welfare services.

**Expanding Access to Medication in In-Patient Facilities (Section 5052)**—Expands Medicaid coverage up to 30 days for in-patient facilities that applies to providers who provide a minimum of two types of medicines to treat opioid use disorder.

**ENDING ILLEGAL PATIENT BROKERING**

Criminal penalties (Section 8122)—This provision makes it illegal to pay or receive kickbacks in return for referring a patient to recovery homes or clinical treatment facilities.

**RECOVERY SUPPORTS**

**CAREER Act (Section 7183)**—Improves resources and wrap-around support services for individuals in recovery from a substance use disorder who are transitioning from treatment programs to independent living and the workforce.

**Ensuring Access to Quality Sober Living (Section 7503)**—Develops and disseminates best practices for operating recovery housing to ensure individuals are living in a safe and supportive environment.

**Inclusion of Opioid Use Disorder in the Opioid Treatment Act (Section 7151, 7152)**—Awards grants to recovery communities organizations to provide regional training and technical assistance in order to improve peer recovery support services nationwide.

**Improving recovery and reunifying families (Section 8092)**—Provides $5 million to HHS to replicate a successful “fourth phase” program for parents with children in foster care due to parental substance use.

**PREVENTION**

**Drug-Free Communities Reauthorization (Section 8203)**—Reauthorizes the Drug-Free Communities Program to mobilize communities to prevent youth substance use and extends the National Community Anti-Drug Coalition Institute.

**HELPING MOTHERS AND BABIES**

Sobriety Treatment and Recovery Teams (START; Section 8214)—Establishes and expands the implementation of the START Program, which pairs parents and family mentors with a small number of families, providing peer support, intensive treatment and child welfare services.

**Helping Families Recovering for Children and Babies (Section 1007)**—Expands Medicaid coverage for infants with neonatal abstinence syndrome who are receiving care in residential pediatric recovery centers.

Health Insurance for Former Foster Youth (Section 1002)—Allows former foster youth to keep their Medicaid coverage across state lines until age 26.

**Modifies IMD Exclusion for Pregnant and Postpartum Women (Section 1012)**—Allows states to receive federal funding for inpatient care for women who are receiving care for substance use disorder in a treatment facility to receive other Medicaid-covered care, such as prenatal services.

**Report on addressing maternal and infant health in the opioid crisis (Section 7061)**—Studies best practices of pain management, prevention, identification, and reduction of opioid and other substance use disorders during pregnancy.

**Early interventions for pregnant women and infants (Section 7063)**—Develops and disseminates best practices for educational curricula to use with pregnant women for shared decision-making regarding pain management during pregnancy.

**Maternal and Postpartum Health (Section 7064)**—Authorizes data collection and analysis of neonatal abstinence syndrome and...
other outcomes related to prenatal substance abuse and misuse, including prenatal opioid abuse and misuse.

**HELPING PATIENTS AND FAMILIES IN CRISIS**

Communication with families during emergencies (Section 7052)—Reminds healthcare professionals that they are allowed under current federal privacy laws to notify families, caregivers, and health care providers of overdose emergencies involving a loved one.

Families and Patients in Crisis (Section 8212)—Grants to expand services for patients and families impacted by substance use disorder and in crisis.

**LAW ENFORCEMENT**

Reauthorization of Key Law Enforcement Programs (Section 8205–8212)—Reauthorizes law enforcement programs through the Office of National Drug Control Policy, such as programs such as the High Intensity Drug Trafficking Area programs, drug courts, COPS Anti-Meth Program, and COPS anti-heroine task force program.

First Responder Training (Section 7002)—Expands first responder training, authorized through the Comprehensive Addiction and Recovery Act, to include training on safety around fentanyl and other synthetic and dangerous drugs.

Public Health Laboratories Detecting Fentanyl and Other Synthetic Opioids (Section 7011)—Improves coordination between public health laboratories and laboratories operated by law enforcement to improve detection of fentanyl and other synthetic opioids.

Synthetic Trafficking and Overdose Prevention (Section 8006, 8007)—Improves Federal agencies ability to detect synthetic opioids and other substances from entering the United States through the mail.

Opioid Addiction Recovery Fraud Prevention (Sections 8021–8023)—Subjects those who engage in unfair or deceptive acts with respect to substance use disorder treatment services or substance use disorder treatment products to civil penalties for first time violations by the FTC; includes a savings clause for existing FTC and FDA authorities.

Reauthorization of the comprehensive opioid abuse grant program (Section 8002)—Reauthorizes comprehensive opioid abuse grant program at the Department of Justice.

**PRESCRIPTION MEDICATION SAFETY AND DISPOSAL**

Empowering Pharmacists in the Fight Against Overdose and Abuse (Section 3212)—Develops and disseminates training resources to help pharmacists better detect fraudulent attempts to fill prescription medications; Safe Disposal of Unused Medication (Section 3222)—Allows hospice workers to dispose of unused medications on site or in patients homes; Access to Increased Drug Disposal (Section 3231–3230)—Awards grants to states to enhance access of prescription drug disposal programs.

**SAFETY-ENHANCING PACKAGING AND DISPOSAL FEATURES**

Requires certain opioids to be packaged into 3 or 7 day supply, and requires safe prescription drug disposal options to be given to patients upon receiving medications.

**PRISONER REENTRY**

Promoting State innovations to ease transition from incarceration to the community for certain individuals (Section 5032)—Requires the HHS Secretary to convene a stakeholder group to produce a report of best practices for states to promote health care related transitions for inmates of public institutions.

We commend Congress for its leadership and the bipartisan, bicameral work it has undertaken to address the ever worsening opioid crisis. We are pleased that this package continues our comprehensive approach to addressing the opioid crisis, across the entire continuum of care prevention, treatment and recovery support. In addition, it fully recognizes addiction as the medical condition that it is and contains meaningful programs aimed at helping patients and families struggling with this disease. For all of these reasons, we urge the quick passage of the final agreement of the SUPPORT for Patients and Communities Act (H.R. 6).

Sincerely,

1. A New PATH, San Diego, California
2. Addiction Policy Forum
3. AIDS United
4. Alabama, Addiction Policy Forum
5. Alaska, Addiction Policy Forum
6. American Correctional Association
7. Arizona, Addiction Policy Forum
8. Association of Prosecuting Attorneys
9. Beyond Addiction Ministry, WI
10. Brave Health
11. CARES of Northwest Louisiana
12. California Consortium of Addiction Programs & Professionals (CCAPP)
13. California, Addiction Policy Forum
14. Campbell County Substance Abuse
15. Caron Treatment Centers
16. CPC Loud N Clear Foundation, Farmingdale, New Jersey
17. Chicago Recovery Communities Coalition, Chicago, Illinois
18. Colorado, Addiction Policy Forum
19. Community Anti-Drug Coalitions of America (CADCA)
20. Connecticut Certification Board
22. Connecticut, Addiction Policy Forum
23. COPES
24. DarJune Recovery Support Services & Cafe, Green Bay, Wisconsin
25. Delaware, Addiction Policy Forum
26. Delphi Behavioral Health Group
27. DisposeRx
28. El Paso Alliance, El Paso, Texas
29. Faces & Voices of Recovery
30. FAVOR Low Country, Charleston, South Carolina
31. FAVOR Tri-County, Rock Hill, South Carolina
32. FeCuRe
33. Fellowship Foundation Recovery Community Organization, Margate, Florida
34. Floridians for Recovery, West Palm Beach, Florida
35. Foundation for Recovery, Las Vegas, Nevada
36. Friends of Emmett
37. H.O.P.E.S. Forever
38. Healthcare Leadership Council
39. IC & RC
40. Idaho, Addiction Policy Forum
41. Illinois Association of Behavioral Health
42. Illinois, Addiction Policy Forum
43. Indiana, Addiction Policy Forum
44. Institute on Addolor and Health (IBH)
45. Iowa, Addiction Policy Forum
46. Jackson Area Recovery Community, Jackson, Michigan
47. Kansas, Addiction Policy Forum
48. Kentucky, Addiction Policy Forum
49. Kingston NH Lions Foundation
50. Lifehouse Recovery Connection, San Diego, California
51. Maine Alliance for Addiction Recovery, Augusta, Maine
52. Maine, Addiction Policy Forum
53. Maryland House Detox
54. Maryland, Addiction Policy Forum
55. Massachusetts, Addiction Policy Forum
56. Michigan, Addiction Policy Forum
57. Minnesota Recovery Connection, Minneapolis, Minnesota
58. Minnesota, Addiction Policy Forum
59. Missouri Recovery Network, Jefferson City, Missouri
60. Missouri, Addiction Policy Forum
61. Montana, Addiction Policy Forum
62. National Association of Social Workers (NASW)
63. National Prevention Science Coalition
64. National Safety Council
65. Navigate Recovery Gwinnett, Gwinnett County, Georgia
67. Nevada, Addiction Policy Forum
68. New Hampshire, Addiction Policy Forum
69. New Jersey, Addiction Policy Forum
70. New Mexico, Addiction Policy Forum
71. New York, Addiction Policy Forum
72. North Carolina, Addiction Policy Forum
73. North Dakota, Addiction Policy Forum
74. Ohio Citizens Advocates for Addiction Recovery, Columbus, Ohio
75. Ohio, Addiction Policy Forum
76. Oklahoma, Addiction Policy Forum
77. Oregon, Addiction Policy Forum
78. PEER Wellness Center
79. PEER360 Recovery Alliance, Bay City, Michigan
80. Pennsylvania, Addiction Policy Forum
81. People Advocating Recovery, Louisville, Kentucky
82. Phoenix House Recovery Residences
83. Phoenix House, Athens, Georgia
84. Reality Check, Jaffrey, New Hampshire
85. Recovering Wyoming, Cheyenne, Wyoming
86. Recovery Communities of North Carolina
87. Raleigh, North Carolina
88. Recovery Community Connection, Williamsport, Pennsylvania
89. Recovery Community of Durham, Durham, North Carolina
90. Recovery Data Solutions
91. Rhode Island, Addiction Policy Forum
92. ROcovery Fitness, Rochester, New York
93. Shatterproof
94. Smart Approaches to Marijuana Action (SAM Action)
95. SMART Recovery, Nationwide
96. Sobriety Matters
97. Solutions Recovery, Oskosh, Wisconsin
98. South Dakota, Addiction Policy Forum
99. SpiritWorks Foundation, Williamsburg, Virginia
100. Springs Recovery Connection, Colorado Springs, Colorado
101. Strengthening the Mid-Atlantic Region for Tomorrow (SMART)
102. Tennessee, Addiction Policy Forum
103. Texas, Addiction Policy Forum
104. The DOER—DeKalb Open Opportunity for Recovery, Decatur, Georgia
105. The McShin Foundation, Richmond, Virginia
106. The Moyer Foundation
107. The Phoenix, Nationwide
108. The RASE Project, Harrisburg, Pennsylvania
109. The Solano Project, Fairfield, California
110. Treatment Communities of America
111. Trillogy Recovery Community, Walla, Washington
112. Trust for America’s Health
113. Utah, Addiction Policy Forum
114. Vermont, Addiction Policy Forum
115. Virginia, Addiction Policy Forum
116. Voices of Hope Lexington, Lexington, Kentucky
117. Voices of Recovery San Mateo County, San Carlos, California
118. WAI-IAM, Inc. and RISE Recovery Community, Lansing, Michigan
WASHINGTON, D.C. — The House voted 216-18 on Friday to recommit to the Senate the tax legislation it passed Thursday, with an eye toward striking a compromise on tax policy before Congress goes on vacation later this month.

The House voted to send the bill back to Senate with 184 Democrats voting in favor, 18 Republicans voting against and two members not voting.

The vote was 218-18, with 19 Republicans voting against and one member not voting.

The vote was on a motion to suspend the rules and agree to the resolution, H. Res. 1099.

The resolution, sponsored by Rep. Kevin McCarthy, R-Calif., and Rep. Steve Scalise, R-La., would send the tax bill back to the Senate with a few changes, including an increase in the child tax credit.

The bill would also extend several provisions of the tax code that are set to expire at the end of the year.

The House-passed legislation would also extend the so-called “赣州” tax cut law, which was signed into law by President Donald Trump in December 2017.

The赣州 tax cut law provides a number of tax breaks for businesses and individuals, including a temporary 20 percent business tax rate.

The赣州 tax cut law would expire at the end of 2019, but the House-passed legislation would extend it through 2023.

The House also voted to extend the赣州 tax cut law for two years, to 2021.

The赣州 tax cut law would also be extended for two years, to 2022.

The House vote on the赣州 tax cut law was 216-18, with 18 Republicans voting against and two members not voting.

The赣州 tax cut law would also be extended for two years, to 2022.

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