

117TH CONGRESS
1ST SESSION

H. R. 4341

To provide support with respect to the prevention of, treatment for, and recovery from, substance use disorder.

IN THE HOUSE OF REPRESENTATIVES

JULY 1, 2021

Mr. TRONE (for himself, Mr. RYAN, Mr. MCKINLEY, Ms. KUSTER, Mr. FITZPATRICK, Mr. TONKO, Mr. JOYCE of Ohio, Ms. HERRERA BEUTLER, Ms. WILD, Mrs. MCBATH, Mr. TURNER, Ms. CRAIG, Ms. DEAN, Mr. LEVIN of California, Mr. MOONEY, Mrs. TRAHAN, Ms. SPANBERGER, Mr. KATKO, Mr. RUTHERFORD, Mr. WOMACK, Mr. MICHAEL F. DOYLE of Pennsylvania, Ms. BLUNT ROCHESTER, Mr. PAPPAS, Mrs. DINGELL, Mr. CARTER of Louisiana, Mr. BUTTERFIELD, Mr. MORELLE, Ms. DEGETTE, Ms. KELLY of Illinois, Mr. CRIST, Mrs. LEE of Nevada, Ms. BARRAGÁN, and Mr. CÁRDENAS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Ways and Means, Education and Labor, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide support with respect to the prevention of, treatment for, and recovery from, substance use disorder.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 “CARA 3.0 Act of 2021”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

TITLE I—EDUCATION, PREVENTION, AND RESEARCH

Sec. 101. National Education Campaign.

Sec. 102. Research into non-opioid pain management.

Sec. 103. Long-term treatment and recovery support services research.

Sec. 104. National Commission for Excellence on Post-Overdose Response.

Sec. 105. Workforce for prevention, treatment, and recovery support services.

Sec. 106. Reauthorization of community-based coalition enhancement grants to
address local drug crises.

Sec. 107. Access to non-opioid treatments for pain.

TITLE II—TREATMENT

Sec. 201. Evidence-based substance use disorder treatment and intervention
demonstrations.

Sec. 202. Improving treatment for pregnant, postpartum, and parenting
women.

Sec. 203. Require the use of prescription drug monitoring programs.

Sec. 204. Prescriber education.

Sec. 205. Prohibition of utilization control policies or procedures for medica-
tion-assisted treatment under Medicaid.

Sec. 206. Medication-assisted treatment for recovery from substance use dis-
order.

Sec. 207. Telehealth response for e-prescribing addiction therapy services.

Sec. 208. Pilot program on expanding access to treatment.

Sec. 209. Reauthorization of PRAC Ed grant program.

Sec. 210. GAO study on parity.

Sec. 211. Improving substance use disorder prevention workforce act.

TITLE III—RECOVERY

Subtitle A—General Provisions

Sec. 301. Building communities of recovery.

Sec. 302. Recovery in the workplace.

Sec. 303. National youth and young adult recovery initiative.

Subtitle B—Recovery Housing

Sec. 311. Clarifying the role of SAMHSA in promoting the availability of high-
quality recovery housing.

Sec. 312. Developing guidelines for States to promote the availability of high-
quality recovery housing.

- Sec. 313. Coordination of Federal activities to promote the availability of high-quality recovery housing.
- Sec. 314. NAS study and report.
- Sec. 315. Filling research and data gaps.
- Sec. 316. Grants for States to promote the availability of high-quality recovery housing.
- Sec. 317. Reputable providers and analysts of recovery housing services definition.
- Sec. 318. Technical correction.

TITLE IV—CRIMINAL JUSTICE

- Sec. 401. Medication-Assisted Treatment Corrections and Community Reentry Program.
- Sec. 402. Deflection and pre-arrest diversion.
- Sec. 403. Housing.
- Sec. 404. Veterans treatment courts.
- Sec. 405. Infrastructure for reentry.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) In the 1980s and 1990s, pharmaceutical
 4 companies began developing new drugs for pain
 5 treatment, including extended release oxycodone.
 6 These companies aggressively marketed these drugs
 7 to the medical community as a way to address
 8 “under-treatment” of physical pain. Drug companies
 9 distributed 76,000,000,000 oxycodone and
 10 hydrocodone pain pills nationwide from 2006 to
 11 2012.

12 (2) The combination of a rising number of pre-
 13 scriptions, misinformation about the addictive prop-
 14 erties of prescription opioids, and the perception
 15 that prescription drugs are less harmful than illicit
 16 drugs has caused an increase in drug misuse.

1 (3) As legitimate production and illegal diver-
2 sion of opioids skyrocketed, so did the number of
3 opioid overdose deaths. From 1999 to 2017, almost
4 218,000 people died in the United States from
5 overdoses related to prescription opioids. More re-
6 cently, fentanyl, a powerful synthetic opioid, sur-
7 passed prescription opioids as the most lethal over-
8 dose substance and now is linked to nearly 3 times
9 as many deaths.

10 (4) The scale of the opioid crisis is staggering:

11 (A) In 2018, approximately 10,300,000
12 people in the United States age 12 and older
13 misused opioids.

14 (B) On average, 130 people in the United
15 States die every day from an opioid overdose.

16 (C) The opioid crisis has cost the United
17 States economy at least \$631,000,000,000.

18 (D) From 2013 to 2017, the number of
19 children in foster care nationwide increased 10
20 percent to nearly 442,995. Parental drug use
21 was cited as a factor in 36 percent of cases.

22 (5) The opioid crisis has also led to a cascade
23 of other negative health impacts. For example, sy-
24 ringe sharing among people who inject drugs has led

1 to increases in hepatitis C virus infections and infec-
2 tive endocarditis, as well as localized HIV outbreaks.

3 (6) The United States health care system has
4 struggled to catch up to the crisis:

5 (A) The majority of people in the United
6 States with an opioid use disorder do not re-
7 ceive substance use treatment, and many who
8 do receive such treatment do not receive evi-
9 dence-based treatment. Although medication-as-
10 sisted treatment has been endorsed by the Na-
11 tional Institutes of Health and the World
12 Health Organization, only one-third of treat-
13 ment programs offer any of the 3 drugs ap-
14 proved by the Food and Drug Administration
15 for the treatment of opioid use disorder, and
16 just 6 percent of medication-offering facilities
17 provide all 3.

18 (B) Facilities that provide medications for
19 the treatment of opioid disorder are con-
20 centrated in the Northeast and Southwest, leav-
21 ing many of the areas hit hardest by the opioid
22 crisis without access to evidence-based treat-
23 ment. The need is particularly acute in rural
24 areas, which often do not have enough providers
25 to meet the demand.

1 (C) Unlike other health care needs, sub-
2 stance use treatment is largely funded by State
3 and local revenues and Federal block grants,
4 rather than the Medicare program, the Med-
5 icaid program, and private insurance.

6 (D) While new substances, particularly
7 synthetic drugs, continue to make inroads into
8 communities in the United States, funding
9 streams are often dedicated to particular sub-
10 stances, limiting providers' ability to adapt to
11 changing needs.

12 (E) The stigma associated with substance
13 use disorder prevents people from seeking treat-
14 ment. Too often, people enter substance use
15 treatment only after committing a criminal of-
16 fense, whether through a court mandate, as a
17 condition of parole or probation supervision, or
18 as a condition of regaining employment after
19 conviction. In 2003, 36 percent of all substance
20 use treatment admissions, 40 percent of all al-
21 cohol abuse treatment admissions, and 57 per-
22 cent of all marijuana use treatment admissions
23 were referrals from the criminal justice system.

24 (F) The stigma of substance use disorder
25 also limits people's ability to find jobs and

1 housing. These obstacles are exacerbated by the
2 criminalization of substance use disorder—even
3 convictions for drug possession for personal use
4 can create lifelong collateral consequences. The
5 absence of stable housing and employment
6 make it even more difficult for people to live
7 drug free.

8 (7) Not all people in the United States have
9 equal access to substance use treatment in the com-
10 munity. Current research has found that Black and
11 Latinx Americans are less likely to receive substance
12 use treatment when controlling for other relevant
13 factors, like socioeconomic status.

14 (8) Inadequate access to substance use treat-
15 ment can exacerbate other health disparities. Indi-
16 viduals with substance use disorders have higher
17 rates of suicide attempts than individuals in the gen-
18 eral population, high health care expenses, and sig-
19 nificant disability.

20 (9) A comprehensive public health approach
21 that tackles both the causes and the consequences of
22 substance use disorder is necessary to stem the tide.

1 **TITLE I—EDUCATION,**
 2 **PREVENTION, AND RESEARCH**

3 **SEC. 101. NATIONAL EDUCATION CAMPAIGN.**

4 Section 102 of the Comprehensive Addiction and Re-
 5 covery Act of 2016 (42 U.S.C. 290bb–25g) is amended—

6 (1) in subsection (a), by inserting “or other
 7 controlled substances (as defined in section 102 of
 8 the Controlled Substances Act (21 U.S.C. 802))”
 9 after “opioids” each place such term appears;

10 (2) in subsection (b), by striking “opioid” each
 11 place it appears and inserting “substance”;

12 (3) in subsection (c)—

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

15 (B) in paragraph (3), by striking the pe-
 16 riod and inserting a semicolon; and

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

18 “(4) use destigmatizing language promoting hu-
 19 mane and culturally competent (as defined in section
 20 102 of the Developmental Disabilities Assistance
 21 and Bill of Rights Act of 2000 (42 U.S.C. 15002))
 22 treatment of all individuals who experience sub-
 23 stance use disorder, including such individuals who
 24 use medication-assisted treatment for recovery pur-
 25 poses;

1 “(5) educate stakeholders on the evidence base
2 and validation of harm reduction and where to ob-
3 tain harm reduction services;

4 “(6) include information about polysubstance
5 use; and

6 “(7) include information about prevention and
7 treatment using medication-assisted treatment and
8 recovery support.”; and

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

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2022 through 2026.”.

14 **SEC. 102. RESEARCH INTO NON-OPIOD PAIN MANAGE-**
15 **MENT.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services, acting through the Director of the Na-
18 tional Institutes of Health and the Director of the Centers
19 for Disease Control and Prevention, shall carry out re-
20 search with respect to non-opioid methods of pain manage-
21 ment, including non-pharmaceutical remedies for pain and
22 integrative medicine solutions.

23 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
24 out this section, there are authorized to be appropriated

1 such sums as may be necessary for each of fiscal years
2 2022 through 2026.

3 **SEC. 103. LONG-TERM TREATMENT AND RECOVERY SUP-**
4 **PORT SERVICES RESEARCH.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services shall award grants to eligible entities to
7 carry out evidence-based research, over 5-year periods, for
8 different modalities of treatment and recovery support for
9 substance use disorder, including culturally competent (as
10 defined in section 102 of the Developmental Disabilities
11 Assistance and Bill of Rights Act of 2001 (42 U.S.C.
12 15002)) treatment.

13 (b) RESEARCH REQUIREMENTS.—An eligible entity
14 receiving grant funds to carry out evidence-based research
15 under subsection (a) shall, with respect to such research—

16 (1) measure—

17 (A) mortality and morbidity;

18 (B) physical and emotional health;

19 (C) employment;

20 (D) stable housing;

21 (E) criminal justice involvement;

22 (F) family relationships; and

23 (G) other quality-of-life measures; and

24 (2) distinguish long-term outcomes based on—

25 (A) race;

- 1 (B) gender;
- 2 (C) socioeconomic status; and
- 3 (D) other relevant characteristics.

4 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary.

7 **SEC. 104. NATIONAL COMMISSION FOR EXCELLENCE ON**
8 **POST-OVERDOSE RESPONSE.**

9 (a) ESTABLISHMENT.—The Assistant Secretary of
10 Health and Human Services for Mental Health and Sub-
11 stance Use (referred to in this section as the “Assistant
12 Secretary”), in consultation with the Director of the Office
13 of National Drug Control Policy, and the President of the
14 National Academy of Medicine, shall establish an advisory
15 commission to be known as the National Commission for
16 Excellence on Post-Overdose Response (in this section re-
17 ferred to as the “Commission”).

18 (b) DUTIES.—The Commission shall—

19 (1) improve the quality and safety of care for
20 individuals who experience substance use disorder
21 and have experienced drug overdose by providing
22 evidence, practical tools, and other resources for
23 healthcare experts, including—

- 24 (A) researchers and evaluators;
- 25 (B) clinicians and clinical teams;

1 (C) quality improvement experts; and

2 (D) healthcare decision makers;

3 (2) advise the healthcare experts described in
4 paragraph (1) on—

5 (A) achieving equitable outcomes with re-
6 spect to race and socioeconomic status; and

7 (B) effectively and appropriately reducing
8 the rate of—

9 (i) inpatient hospital admissions
10 where equivalent services are available to
11 treat patients in a similar condition
12 through outpatient hospital visits or non-
13 hospital treatment facilities;

14 (ii) emergency department admissions;
15 and

16 (iii) other adverse events related to
17 care for individuals described in such para-
18 graph; and

19 (3) develop best practices and clinical practice
20 guidelines for improving the quality and safety of
21 care for individuals who experience substance use
22 disorder and have experienced drug overdose, that
23 are culturally competent (as defined in section 102
24 of the Developmental Disabilities Assistance and Bill
25 of Rights Act of 2000 (42 U.S.C. 15002)).

1 (c) MEMBERSHIP.—The members of the Commission
2 shall include—

3 (1) a representative of the Substance Abuse
4 and Mental Health Services Administration;

5 (2) a representative of the Office of National
6 Drug Control Policy;

7 (3) a representative of the National Academy of
8 Medicine;

9 (4) a representative of the National Institute on
10 Drug Abuse;

11 (5) a substance use disorder specialist ap-
12 pointed by the Assistant Secretary;

13 (6) a peer recovery specialist appointed by the
14 Assistant Secretary;

15 (7) an individual with experience in harm re-
16 duction; and

17 (8) any other individual that the Assistant Sec-
18 retary determines appropriate.

19 (d) SUNSET.—The Commission shall terminate on
20 the date that is 10 years after the date of the enactment
21 of this Act.

22 **SEC. 105. WORKFORCE FOR PREVENTION, TREATMENT,**
23 **AND RECOVERY SUPPORT SERVICES.**

24 (a) EMPLOYMENT AND TRAINING SERVICES.—Sub-
25 part 2 of part B of title V of the Public Health Service

1 Act (42 U.S.C. 290bb–21 et seq.) is amended by adding
2 at the end the following:

3 **“SEC. 519E. EMPLOYMENT AND TRAINING SERVICES.**

4 “(a) IN GENERAL.—The Director of the Prevention
5 Center shall—

6 “(1) beginning not later than 30 days after the
7 date of enactment of this Act, award grants or enter
8 into contracts with eligible entities to support em-
9 ployment and training services for substance use
10 treatment professionals, including peer recovery spe-
11 cialists; and

12 “(2) subject to the availability of funds appro-
13 priated pursuant to subsection (d), not later than 45
14 days after the date on which an entity submits an
15 application that meets the requirements of the Sec-
16 retary under this section, award funds under this
17 section to such entity.

18 “(b) APPLICATION.—An eligible entity desiring a
19 grant under this section shall submit to the Director of
20 the Prevention Center an application at such time, in such
21 manner, and containing such information as the Director
22 may require.

23 “(c) MINIMUM.—A recipient shall use not less than
24 15 percent of funds awarded under subsection (a) for ac-

1 tivities related to retention of substance use treatment
2 professionals.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2022 through 2026.”.

7 (b) FUNDING FOR MENTAL AND BEHAVIORAL
8 HEALTH EDUCATION AND TRAINING GRANTS.—Section
9 756(f) of the Public Health Service Act (42 U.S.C. 294e–
10 1(f)) is amended—

11 (1) in the matter preceding paragraph (1), by
12 striking “\$50,000,000” and inserting
13 “\$55,000,000”; and

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

15 “(5) For continuing education and other activi-
16 ties to increase retention and to strengthen the sub-
17 stance use disorder workforce, \$5,000,000.”.

18 **SEC. 106. REAUTHORIZATION OF COMMUNITY-BASED COA-**
19 **LITION ENHANCEMENT GRANTS TO ADDRESS**
20 **LOCAL DRUG CRISES.**

21 Section 103(i) of the Comprehensive Addiction and
22 Recovery Act of 2016 (21 U.S.C. 1536(i)) is amended by
23 striking the period at the end and inserting “, and
24 \$10,000,000 for each of fiscal years 2022 through 2026.”.

1 **SEC. 107. ACCESS TO NON-OPIOID TREATMENTS FOR PAIN.**

2 (a) IN GENERAL.—Section 1833(t) of the Social Se-
3 curity Act (42 U.S.C. 1395l(t)) is amended—

4 (1) in paragraph (2)(E), by inserting “, sepa-
5 rate payments for non-opioid treatments under para-
6 graph (16)(G), and” after “payments under para-
7 graph (6) and”; and

8 (2) in paragraph (16), by adding at the end the
9 following new subparagraph:

10 “(G) ACCESS TO NON-OPIOID TREATMENTS
11 FOR PAIN.—

12 “(i) IN GENERAL.—Notwithstanding
13 any other provision of this subsection, with
14 respect to a covered OPD service (or group
15 of services) furnished on or after January
16 1, 2022, and before January 1, 2027, the
17 Secretary shall not package, and shall
18 make a separate payment as specified in
19 clause (ii) for, a non-opioid treatment (as
20 defined in clause (iii)) furnished as part of
21 such service (or group of services).

22 “(ii) AMOUNT OF PAYMENT.—The
23 amount of the payment specified in this
24 clause is, with respect to a non-opioid
25 treatment that is—

1 “(I) a drug or biological product,
2 the amount of payment for such drug
3 or biological determined under section
4 1847A; or

5 “(II) a medical device, the
6 amount of the hospital’s charges for
7 the device, adjusted to cost.

8 “(iii) DEFINITION OF NON-OPIOID
9 TREATMENT.—A ‘non-opioid treatment’
10 means—

11 “(I) a drug or biological product
12 that is indicated to produce analgesia
13 without acting upon the body’s opioid
14 receptors; or

15 “(II) an implantable, reusable, or
16 disposable medical device cleared or
17 approved by the Administrator for
18 Food and Drugs for the intended use
19 of managing or treating pain;
20 that has demonstrated the ability to re-
21 place, reduce, or avoid opioid use or the
22 quantity of opioids prescribed in a clinical
23 trial or through data published in a peer-
24 reviewed journal.”.

1 (b) AMBULATORY SURGICAL CENTER PAYMENT SYS-
2 TEM.—Section 1833(i)(2)(D) of the Social Security Act
3 (42 U.S.C. 1395l(i)(2)(D)) is amended—

4 (1) by aligning the margins of clause (v) with
5 the margins of clause (iv);

6 (2) by redesignating clause (vi) as clause (vii);
7 and

8 (3) by inserting after clause (v) the following
9 new clause:

10 “(vi) In the case of surgical services
11 furnished on or after January 1, 2022, and
12 before January 1, 2027, the payment sys-
13 tem described in clause (i) shall provide, in
14 a budget-neutral manner, for a separate
15 payment for a non-opioid treatment (as de-
16 fined in clause (iii) of subsection
17 (t)(16)(G)) furnished as part of such serv-
18 ices in the amount specified in clause (ii)
19 of such subsection.”.

20 (c) EVALUATION OF THERAPEUTIC SERVICES FOR
21 PAIN MANAGEMENT.—

22 (1) REPORT TO CONGRESS.—Not later than 1
23 year after the date of the enactment of this Act, the
24 Secretary of Health and Human Services, acting
25 through the Administrator of the Centers for Medi-

1 care & Medicaid Services, shall submit to Congress
2 a report on—

3 (A) limitations, gaps, barriers to access, or
4 deficits in coverage under the Medicare pro-
5 gram under title XVIII of the Social Security
6 Act (42 U.S.C. 1395 et seq.) or reimbursement
7 for restorative therapies, behavioral approaches,
8 and complementary and integrative health serv-
9 ices that—

10 (i) are identified by the Pain Manage-
11 ment Best Practices Inter-Agency Task
12 Force under section 101 of the Com-
13 prehensive Addiction and Recovery Act of
14 2016 (42 U.S.C. 201 note); and

15 (ii) have demonstrated the ability to
16 replace or reduce opioid consumption; and

17 (B) recommendations to address the limi-
18 tations, gaps, barriers to access, or deficits
19 identified under subparagraph (A) to improve
20 such coverage and reimbursement for such
21 therapies, approaches, and services.

22 (2) PUBLIC CONSULTATION.—In developing the
23 report described in paragraph (1), the Secretary of
24 Health and Human Services shall consult with ap-
25 propriate entities as determined by the Secretary.

(3) EXCLUSIVE TREATMENT.—Any drug, biological product, or medical device that is a non-opioid treatment (as defined in section 1833(t)(16)(G)(iii) of the Social Security Act, as added by subsection (a)) shall not be considered a therapeutic service for the purpose of the report described in paragraph (1).

TITLE II—TREATMENT

SEC. 201. EVIDENCE-BASED SUBSTANCE USE DISORDER TREATMENT AND INTERVENTION DEMONSTRATIONS.

Section 514B of the Public Health Service Act (42 U.S.C. 290bb–10) is amended—

(1) in subsection (a), by adding at the end the following:

“(3) USE OF FUNDS FOR TRAINING.—Funds awarded under paragraph (1) may be used by a recipient for training emergency room technicians, physicians, nurses, or other health care professionals on identifying the presence of substance use disorders; how effectively to engage with, intervene with respect to, and refer patients for assessment and specialized substance use disorder care, including medication-assisted treatment and care for co-occurring disorders; and offering peer-based interventions

1 in the emergency room and other health care envi-
 2 ronments to connect people to clinical and commu-
 3 nity-based supports for substance use disorder.”;

4 (2) in subsection (d), by inserting “, and Indian
 5 tribes and tribal organizations (as defined in section
 6 4 of the Indian Self-Determination and Education
 7 Assistance Act)” before the period of the first sen-
 8 tence; and

9 (3) in subsection (f), by striking “\$25,000,000
 10 for each of fiscal years 2017 through 2021” and in-
 11 serting “\$300,000,000 for each of fiscal years 2022
 12 through 2026”.

13 **SEC. 202. IMPROVING TREATMENT FOR PREGNANT,**
 14 **POSTPARTUM, AND PARENTING WOMEN.**

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

17 (1) in subsection (m)—

18 (A) by striking “that agrees to use” and
 19 inserting “that agrees—
 20 “(1) to use”;

21 (B) by striking the period at the end and
 22 inserting “; or”; and

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

24 “(2) to—

1 “(A) allow participation in the program
2 supported by the award by individuals taking a
3 drug or combination of drugs approved by the
4 Food and Drug Administration as a medication
5 for addiction treatment, including such individ-
6 uals taking an opioid agonist;

7 “(B) provide culturally competent services
8 (as defined in section 102 of the Developmental
9 Disabilities Assistance and Bill of Rights Act of
10 2000);

11 “(C) ensure flexible lengths of stay in the
12 treatment program; and

13 “(D) use peer recovery advocates in the
14 program supported by the award.”;

15 (2) in subsection (p), by inserting “, and demo-
16 graphic data on the individuals served by programs
17 funded under this section and case outcomes, as re-
18 ported to the Director by award recipients” before
19 the period at the end of the third sentence; and

20 (3) in subsection (s), by striking “\$29,931,000
21 for each of fiscal years 2019 through 2023” and in-
22 serting “100,000,000 for each of fiscal years 2022
23 through 2026”.

1 **SEC. 203. REQUIRE THE USE OF PRESCRIPTION DRUG MON-**
2 **ITORING PROGRAMS.**

3 (a) DEFINITIONS.—In this section:

4 (1) CONTROLLED SUBSTANCE.—The term
5 “controlled substance” has the meaning given the
6 term in section 102 of the Controlled Substances
7 Act (21 U.S.C. 802).

8 (2) COVERED STATE.—The term “covered
9 State” means a State that receives funding under
10 the Harold Rogers Prescription Drug Monitoring
11 Program established under the Departments of
12 Commerce, Justice, and State, the Judiciary, and
13 Related Agencies Appropriations Act, 2002 (Public
14 Law 107–77; 115 Stat. 748), under this Act (or an
15 amendment made by this Act), or under the con-
16 trolled substance monitoring program under section
17 3990 of the Public Health Service Act (42 U.S.C.
18 280g–3).

19 (3) DISPENSER.—The term “dispenser”—

20 (A) means a person licensed or otherwise
21 authorized by a State to deliver a prescription
22 drug product to a patient or an agent of the pa-
23 tient; and

24 (B) does not include a person involved in
25 oversight or payment for prescription drugs.

1 (4) PDMP.—The term “PDMP” means a pre-
2 scription drug monitoring program.

3 (5) PRACTITIONER.—The term “practitioner”
4 means a practitioner registered under section 303(f)
5 of the Controlled Substances Act (21 U.S.C. 823(f))
6 to prescribe, administer, or dispense controlled sub-
7 stances.

8 (6) STATE.—The term “State” means each of
9 the several States and the District of Columbia.

10 (b) IN GENERAL.—Beginning 1 year after the date
11 of enactment of this Act, each covered State shall re-
12 quire—

13 (1) each prescribing practitioner within the cov-
14 ered State or their designee, who shall be licensed or
15 registered healthcare professionals or other employ-
16 ees who report directly to the practitioner, to consult
17 the PDMP of the covered State before initiating
18 treatment with a prescription for a controlled sub-
19 stance listed in schedule II, III, or IV of section
20 202(c) of the Controlled Substances Act (21 U.S.C.
21 812(c)), and every 3 months thereafter as long as
22 the treatment continues;

23 (2) the PDMP of the covered State to provide
24 proactive notification to a practitioner when patterns

1 indicative of controlled substance misuse, including
2 opioid misuse, are detected;

3 (3) each dispenser within the covered State to
4 report each prescription for a controlled substance
5 dispensed by the dispenser to the PDMP not later
6 than 24 hours after the controlled substance is dis-
7 pensed to the patient;

8 (4) that the PDMP make available a quarterly
9 de-identified data set and an annual report for pub-
10 lic and private use, including use by healthcare pro-
11 viders, health plans and health benefits administra-
12 tors, State agencies, and researchers, which shall, at
13 a minimum, meet requirements established by the
14 Attorney General, in coordination with the Secretary
15 of Health and Human Services;

16 (5) each State agency that administers the
17 PDMP to—

18 (A) proactively analyze data available
19 through the PDMP; and

20 (B) provide reports to prescriber licensing
21 boards describing any prescribing practitioner
22 that repeatedly fall outside of expected norms
23 or standard practices for the prescribing practi-
24 tioner's field; and

1 (6) that the data contained in the PDMP of the
2 covered State be made available to other States.

3 (c) NONCOMPLIANCE.—If a covered State fails to
4 comply with subsection (a), the Attorney General or the
5 Secretary of Health and Human Services may withhold
6 grant funds from being awarded to the covered State
7 under the Harold Rogers Prescription Drug Monitoring
8 Program established under the Departments of Com-
9 merce, Justice, and State, the Judiciary, and Related
10 Agencies Appropriations Act, 2002 (Public Law 107–77;
11 115 Stat. 748), under this Act (or an amendment made
12 by this Act), or under the controlled substance monitoring
13 program under section 3990 of the Public Health Service
14 Act (42 U.S.C. 280g–3).

15 **SEC. 204. PRESCRIBER EDUCATION.**

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

18 (1) in subsection (f), in the matter preceding
19 paragraph (1), by striking “The Attorney General
20 shall register” and inserting “Subject to subsection
21 (m), the Attorney General shall register”; and

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

23 “(1) PRESCRIBER EDUCATION.—

24 “(1) DEFINITIONS.—In this subsection—

1 “(A) the term ‘covered agent or employee’
2 means an agent or employee of a covered facil-
3 ity who—

4 “(i) prescribes controlled substances
5 for humans under the registration of the
6 facility under this part; and

7 “(ii) is a medical resident;

8 “(B) the term ‘covered facility’ means a
9 practitioner—

10 “(i) that is a hospital or other institu-
11 tion;

12 “(ii) that is licensed under State law
13 to prescribe controlled substances; and

14 “(iii) under whose registration under
15 this part agents or employees of the practi-
16 tioner prescribe controlled substances;

17 “(C) the term ‘covered individual practi-
18 tioner’ means a practitioner who—

19 “(i) is an individual;

20 “(ii) is not a veterinarian; and

21 “(iii) is licensed under State law to
22 prescribe controlled substances; and

23 “(D) the term ‘specified continuing edu-
24 cation topics’ means—

1 “(i) alternatives to opioids for pain
2 management;

3 “(ii) palliative care;

4 “(iii) substance use disorder;

5 “(iv) adverse events;

6 “(v) potential for dependence;

7 “(vi) tolerance;

8 “(vii) prescribing contraindicated sub-
9 stances;

10 “(viii) medication-assisted treatment;

11 “(ix) overdose prevention and re-
12 sponse, including the administration of
13 naloxone;

14 “(x) culturally competent (as defined
15 in section 102 of the Developmental Dis-
16 abilities Assistance and Bill of Rights Act
17 of 2000 (42 U.S.C. 15002)) services;

18 “(xi) bias and stigma in prescribing
19 trends; and

20 “(xii) any other topic that the Attor-
21 ney General determines appropriate.

22 “(2) CERTIFICATION OF CONTINUING EDU-
23 CATION.—

24 “(A) INDIVIDUAL PRACTITIONERS.—As a
25 condition of granting or renewing the registra-

tion of a covered individual practitioner under this part to dispense controlled substances in schedule II, III, IV, or V, the Attorney General shall require the practitioner to certify that, during the 3-year period preceding the date of the grant or renewal of registration, the practitioner completed course work or training from an organization accredited by the Accreditation Council for Continuing Medical Education (commonly known as the ‘ACCME’), or by a State medical society accreditor recognized by the ACCME, that included not fewer than 3 hours of content on the specified continuing education topics.

“(B) FACILITIES.—As a condition of granting or renewing the registration of a covered facility under this part to dispense controlled substances in schedule II, III, IV, or V, the Attorney General shall require the covered facility to certify that the facility does not allow a covered agent or employee to prescribe controlled substances for humans under the registration of the facility unless, during the preceding 3-year period, the covered agent or employee completed course work or training from

1 an organization accredited by the Accreditation
 2 Council for Continuing Medical Education
 3 (commonly known as the ‘ACCME’), or a State
 4 medical society accreditor recognized by the
 5 ACCME, that included not fewer than 3 hours
 6 of content on the specified continuing education
 7 topics.”.

8 (b) EFFECTIVE DATE.—Subsection (l) of section 303
 9 of the Controlled Substances Act (21 U.S.C. 823), as
 10 added by subsection (a), shall apply to any grant or re-
 11 newal of registration described in such subsection (l) that
 12 occurs on or after the date that is 2 years after the date
 13 of enactment of this Act.

14 **SEC. 205. PROHIBITION OF UTILIZATION CONTROL POLI-**
 15 **CIES OR PROCEDURES FOR MEDICATION-AS-**
 16 **SISTED TREATMENT UNDER MEDICAID.**

17 Section 1905 of the Social Security Act (42 U.S.C.
 18 1396d) is amended—

19 (1) in subsection (a)—

20 (A) in the matter preceding paragraph (1),
 21 by moving the margin of clause (xvi) 4 ems to
 22 the left; and

23 (B) in paragraph (29), by inserting “and
 24 to the extent allowed in paragraph (4) of such

1 subsection” after “paragraph (1) of such sub-
 2 section”; and

3 (2) in subsection (ee), by adding at the end the
 4 following new paragraph:

5 “(4) PROHIBITION OF UTILIZATION CONTROL
 6 POLICIES OR PROCEDURES FOR MEDICATION-AS-
 7 SISTED TREATMENT.—As a condition for a State re-
 8 ceiving payments under section 1903(a) for medical
 9 assistance for medication-assisted treatment, a State
 10 may not impose any utilization control policies or
 11 procedures (as defined by the Secretary), including
 12 prior authorization requirements, with respect to
 13 such treatment.”.

14 **SEC. 206. MEDICATION-ASSISTED TREATMENT FOR RECOV-**
 15 **ERY FROM SUBSTANCE USE DISORDER.**

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

18 (1) by striking paragraph (2);

19 (2) by striking “(g)(1) Except as provided in
 20 paragraph (2), practitioners who dispense narcotic
 21 drugs to individuals for maintenance treatment or
 22 detoxification treatment” and inserting “(g) Practi-
 23 tioners who dispense narcotic drugs (other than nar-
 24 cotic drugs in schedule III, IV, or V) to individuals

1 for maintenance treatment or detoxification treat-
2 ment”;

3 (3) by redesignating subparagraphs (A), (B),
4 and (C) as paragraphs (1), (2), and (3), respectively;
5 and

6 (4) in paragraph (2), as redesignated, by redes-
7 ignating clauses (i) and (ii) as subparagraphs (A)
8 and (B), respectively.

9 (b) TECHNICAL AND CONFORMING EDITS.—

10 (1) IN GENERAL.—

11 (A) Section 304 of the Controlled Sub-
12 stances Act (21 U.S.C. 824) is amended—

13 (i) in subsection (a), by striking
14 “303(g)(1)” each place it appears and in-
15 serting “303(g)”; and

16 (ii) in subsection (d)(1), by striking
17 “303(g)(1)” and inserting “303(g)”.

18 (B) Section 309A(a) of the Controlled
19 Substances Act (21 U.S.C. 829a(a)) is amended
20 by striking paragraph (2) and inserting the fol-
21 lowing:

22 “(2) the controlled substance—

23 “(A) is a narcotic drug in schedule III, IV,
24 or V to be administered for the purpose of
25 maintenance or detoxification treatment; and

1 “(B) is to be administered by injection or
2 implantation;”.

3 (C) Section 520E–4(c) of the Public
4 Health Service Act (42 U.S.C. 290bb–36d(c)) is
5 amended, in the matter preceding paragraph
6 (1), by striking “information on any qualified
7 practitioner that is certified to prescribe medi-
8 cation for opioid dependency under section
9 303(g)(2)(B) of the Controlled Substances Act”
10 and inserting “information on any practitioner
11 who prescribes narcotic drugs in schedule III,
12 IV, or V of section 202 of the Controlled Sub-
13 stances Act for the purpose of maintenance or
14 detoxification treatment”.

15 (D) Section 544(a)(3) of the Public Health
16 Service Act (42 U.S.C. 290dd–3) is amended by
17 striking “any practitioner dispensing narcotic
18 drugs pursuant to section 303(g) of the Con-
19 trolled Substances Act” and inserting “any
20 practitioner dispensing narcotic drugs for the
21 purpose of maintenance or detoxification treat-
22 ment”.

23 (E) Section 1833 of the Social Security
24 Act (42 U.S.C. 1395l) is amended by striking
25 subsection (bb).

1 (F) Section 1834(o) of the Social Security
 2 Act (42 U.S.C. 1395m(o)) is amended by strik-
 3 ing paragraph (3).

4 (G) Section 1866F(c)(3) of the Social Se-
 5 curity Act (42 U.S.C. 1395cc–6(c)(3)) is
 6 amended—

7 (i) in subparagraph (A), by inserting
 8 “and” at the end;

9 (ii) in subparagraph (B), by striking
 10 “; and” and inserting a period; and

11 (iii) by striking subparagraph (C).

12 (H) Section 1903(aa)(2)(C) of the Social
 13 Security Act (42 U.S.C. 1396b(aa)(2)(C)) is
 14 amended—

15 (i) in clause (i), by inserting “and” at
 16 the end;

17 (ii) by striking clause (ii); and

18 (iii) by redesignating clause (iii) as
 19 clause (ii).

20 (2) EFFECTIVE DATE OF MEDICARE AMEND-
 21 MENTS.—The amendments made by subparagraphs
 22 (E) and (F) of paragraph (1) shall take effect one
 23 year after the date of enactment of this Act.

1 **SEC. 207. TELEHEALTH RESPONSE FOR E-PRESCRIBING AD-**
2 **DICTION THERAPY SERVICES.**

3 (a) FUNDING FOR THE TESTING OF INCENTIVE PAY-
4 MENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR
5 ADOPTION AND USE OF CERTIFIED ELECTRONIC
6 HEALTH RECORD TECHNOLOGY.—In addition to amounts
7 appropriated under subsection (f) of section 1115A of the
8 Social Security Act (42 U.S.C. 1315a), there are author-
9 ized to be appropriated to the Center for Medicare and
10 Medicaid Innovation such sums as may be necessary for
11 fiscal year 2022 to design, implement, and evaluate the
12 model under subsection (b)(2)(B)(xxv) of such section.
13 Amounts appropriated under the preceding sentence shall
14 remain available until expended.

15 (b) TELEHEALTH FOR SUBSTANCE USE DISORDER
16 TREATMENT.—

17 (1) SUBSTANCE USE DISORDER SERVICES FUR-
18 NISHED THROUGH TELEHEALTH UNDER MEDI-
19 CARE.—Section 1834(m)(7) of the Social Security
20 Act (42 U.S.C. 1395m(m)(7)) is amended by adding
21 at the end the following: “With respect to telehealth
22 services described in the preceding sentence that are
23 furnished on or after January 1, 2020, nothing shall
24 preclude the furnishing of such services through
25 audio or telephone only technologies in the case
26 where a physician or practitioner has already con-

ducted an in-person medical evaluation or a telehealth evaluation that utilizes both audio and visual capabilities with the eligible telehealth individual.”.

(2) CONTROLLED SUBSTANCES DISPENSED BY MEANS OF THE INTERNET.—Section 309(e)(2) of the Controlled Substances Act (21 U.S.C. 829(e)(2)) is amended—

(A) in subparagraph (A)(i)—

(i) by striking “at least 1 in-person medical evaluation” and inserting the following: “at least—

“(I) 1 in-person medical evaluation”; and

(ii) by adding at the end the following:

“(II) for purposes of prescribing a controlled substance in schedule III or IV, 1 telehealth evaluation; or”; and

(B) by adding at the end the following:

“(D)(i) In this subsection, the term ‘telehealth evaluation’ means a medical evaluation that is conducted in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote

1 from the patient and is communicating with the
2 patient using a telecommunications system re-
3 ferred to in section 1834(m) of the Social Secu-
4 rity Act (42 U.S.C. 1395m(m)) that includes,
5 at a minimum, audio and video equipment per-
6 mitting two-way, real-time interactive commu-
7 nication between the patient and distant site
8 practitioner.

9 “(ii) Nothing in clause (i) shall be con-
10 strued to imply that 1 telehealth evaluation
11 demonstrates that a prescription has been
12 issued for a legitimate medical purpose within
13 the usual course of professional practice.

14 “(iii) A practitioner who prescribes the
15 drugs or combination of drugs that are covered
16 under section 303(g)(2)(C) using the authority
17 under subparagraph (A)(i)(II) of this para-
18 graph shall adhere to nationally recognized evi-
19 dence-based guidelines for the treatment of pa-
20 tients with opioid use disorders and a diversion
21 control plan, as those terms are defined in sec-
22 tion 8.2 of title 42, Code of Federal Regula-
23 tions, as in effect on the date of enactment of
24 this subparagraph.”.

1 **SEC. 208. PILOT PROGRAM ON EXPANDING ACCESS TO**
2 **TREATMENT.**

3 The Secretary of Health and Human Services (re-
4 ferred to in this section as the “Secretary”) shall establish
5 a 5-year pilot program in not less than 5 diverse regions
6 to study the use of mobile methadone clinics in rural and
7 underserved environments. At the end of the pilot pro-
8 gram, the Secretary shall report to Congress on the pro-
9 gram outcomes, including the number of people served and
10 the demographics of people served, including race and in-
11 come.

12 **SEC. 209. REAUTHORIZATION OF PRAC ED GRANT PRO-**
13 **GRAM.**

14 To carry out the Practitioner Education grant pro-
15 gram established by the Substance Abuse and Mental
16 Health Services Administration, there are authorized to
17 be appropriated such sums as may be necessary for each
18 of fiscal years 2022 through 2026.

19 **SEC. 210. GAO STUDY ON PARITY.**

20 The Comptroller General of the United States shall
21 conduct a study examining the reimbursement parity be-
22 tween substance use disorder services and other health
23 care services, and the effect of any inequity in reimburse-
24 ment with respect to substance use disorder services on
25 the substance use disorder workforce, and not later than

1 December 31, 2023, submit a report to Congress on the
2 findings of such study.

3 **SEC. 211. IMPROVING SUBSTANCE USE DISORDER PREVEN-**
4 **TION WORKFORCE ACT.**

5 Subpart 2 of part B of title V of the Public Health
6 Service Act (42 U.S.C. 290bb–21 et seq), as amended by
7 section 105, is further amended by adding at the end the
8 following:

9 **“SEC. 519F. PILOT PROGRAM TO HELP ENHANCE SUB-**
10 **STANCE USE DISORDER PREVENTION WORK-**
11 **FORCE.**

12 “(a) IN GENERAL.—The Director of the Prevention
13 Center (referred to in this section as the ‘Director’) shall
14 develop a pilot program to assist State alcohol and drug
15 agencies in addressing the substance use disorder preven-
16 tion workforce needs in the States.

17 “(b) DEFINITIONS.—In this section, the term ‘State
18 alcohol and drug agency’ means the State agency respon-
19 sible for administering the substance abuse prevention and
20 treatment block grant under subpart II of part B of title
21 XIX.

22 “(c) APPLICATION.—A State alcohol and drug agency
23 may apply to the Director for approval of a grant author-
24 ized in this section. Such application shall include a de-
25 scription of the proposed workforce activities that will be

1 carried out using grant funds, which may include, with
2 respect to substance use disorder prevention—

3 “(1) enhancing or developing training curricula;

4 “(2) supporting or coordinating with institutes
5 of higher education regarding curricula development;

6 “(3) partnering with elementary schools, middle
7 schools, high schools or institutions of higher edu-
8 cation to generate early student interest in avoiding
9 misuse of substances;

10 “(4) enhancing or establishing initiatives re-
11 lated to credentialing or other certification processes
12 recognized by the State alcohol and drug agency, in-
13 cluding scholarships or support for certification costs
14 and testing;

15 “(5) establishing or enhancing initiatives that
16 promote recruitment, professional development, and
17 access to education and training that increase the
18 State’s ability to address diversity, equity, and inclu-
19 sion in the workforce, including communication ini-
20 tiatives or campaigns designed to draw interest in a
21 career in substance use disorder prevention;

22 “(6) supporting loan repayment programs for
23 individuals in the substance use disorder prevention
24 workforce;

1 “(7) establishing or enhancing internships, fel-
2 lowships and other career opportunities; and

3 “(8) retention initiatives that may include
4 training, leadership development or other edu-
5 cational opportunities.

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there are authorized to be appro-
8 priated such sums as may be necessary.

9 **“SEC. 519G. NATIONAL STUDY ON SUBSTANCE USE DIS-**
10 **ORDER WORKFORCE.**

11 “(a) IN GENERAL.—The Director shall conduct a
12 comprehensive national study regarding the substance use
13 disorder prevention workforce. Such study shall include—

14 “(1) an environmental assessment regarding the
15 existing workforce, including demographics, salaries,
16 settings, current or anticipated workforce shortages
17 and other relevant information;

18 “(2) challenges in maintaining support for an
19 adequate substance use disorder prevention work-
20 force and a plan to address such challenges; and

21 “(3) potential programming to help implement
22 the plan.

23 “(b) CONSULTATION.—The Director shall ensure the
24 study under this section is developed in consultation with
25 key substance use disorder prevention workforce stake-

1 holders, including organizations representing State alcohol
 2 and drug agencies, community anti-drug coalitions, work-
 3 force credentialing bodies, researchers, and others.

4 “(c) AUTHORIZATION OF APPROPRIATION.—To carry
 5 out this section, there are authorized to be appropriated
 6 such sums as may be necessary.”.

7 **TITLE III—RECOVERY**

8 **Subtitle A—General Provisions**

9 **SEC. 301. BUILDING COMMUNITIES OF RECOVERY.**

10 (a) IN GENERAL.—Section 547 of the Public Health
 11 Service Act (42 U.S.C. 290ee–2) is amended—

12 (1) by striking subsection (c);

13 (2) by redesignating subsection (d) as sub-
 14 section (c);

15 (3) in subsection (c) (as so redesignated)—

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

18 (B) in paragraph (2)(C)(iv), by striking
 19 the period and inserting “; and”; and

20 (C) by adding at the and the following:

21 “(3) may be used as provided for in subsection
 22 (d).”;

23 (4) by inserting after subsection (c) (as so re-
 24 designated), the following:

1 “(d) ESTABLISHMENT OF REGIONAL TECHNICAL AS-
2 SISTANCE CENTERS.—

3 “(1) IN GENERAL.—Grants awarded under sub-
4 section (b) may be used to provide for the establish-
5 ment of regional technical assistance centers to pro-
6 vide regional technical assistance for the following:

7 “(A) Implementation of regionally driven
8 peer delivered substance use disorder recovery
9 support services before, during, after, or in lieu
10 of substance use disorder treatment.

11 “(B) Establishment of recovery community
12 organizations.

13 “(C) Establishment of recovery community
14 centers.

15 “(D) Naloxone training and dissemination.

16 “(E) Development of connections between
17 recovery support services, community organiza-
18 tions, and community centers and the broader
19 medical community.

20 “(F) Establishment of online recovery sup-
21 port services, with parity to physical health
22 services.

23 “(G) Development of recovery wellness
24 plans to address perceived barriers to recovery,
25 including social determinants of health.

1 “(H) Collect and maintain accurate and
2 reliable data to inform service delivery and
3 monitor and evaluate the impact of culturally
4 competent (as defined in section 102 of the De-
5 velopmental Disabilities Assistance and Bill of
6 Rights Act of 2000) services on health equity
7 outcomes.

8 “(I) Building capacity for recovery commu-
9 nity organizations to meet national accredita-
10 tion standards for the delivery of peer recovery
11 support services.

12 “(J) Expanding or enhancing recovery
13 support service programs.

14 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
15 ceive a grant under paragraph (1), an entity shall
16 be—

17 “(A) a national nonprofit entity with a net-
18 work of local affiliates and partners that are
19 geographically and organizationally diverse; or

20 “(B) a national nonprofit organization led
21 by individuals in personal and family recovery
22 with established networks of recovery commu-
23 nity organizations providing peer recovery sup-
24 port services.

1 “(3) PREFERENCE.—In awarding grants under
2 subsection (b), the Secretary shall give preference to
3 organizations that—

4 “(A) provide culturally competent (as de-
5 fined in section 102 of the Developmental Dis-
6 abilities Assistance and Bill of Rights Act of
7 2000) services, promote racial equity, and are
8 responsive to diverse cultural health beliefs and
9 practices, preferred languages, health literacy,
10 and other communication needs;

11 “(B) allow participation by individuals re-
12 ceiving medication-assisted treatment that in-
13 volves prescription drugs approved by the Food
14 and Drug Administration (at least one of which
15 is an opioid agonist);

16 “(C) use peer recovery advocates; and

17 “(D) meet national best practice and ac-
18 creditation standards.”; and

19 (5) in subsection (f), by striking “2023” and
20 inserting “2021, and \$200,000,000 for each of fiscal
21 years 2022 through 2027”.

22 (b) CONTINUING CARE AND COMMUNITY SUPPORT
23 TO MAINTAIN RECOVERY.—

24 (1) IN GENERAL.—The Secretary shall award
25 grants to peer recovery support service organiza-

(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated, for each of fiscal years 2022 through 2027, \$50,000,000.

15 It is the sense of Congress that an employee who is
16 taking opioid antagonist, opioid agonist, or partial agonist
17 drugs as part of a medication-assisted treatment program
18 shall not be in violation of a drug-free workplace require-
19 ment.

22 (a) DEFINITIONS.—In this section:

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1 (A) a high school that has been accredited
2 as a substance use recovery high school or that
3 is seeking to establish or expand substance use
4 recovery support services;

5 (B) an institution of higher education;

6 (C) a recovery program at an institution of
7 higher education;

8 (D) a nonprofit organization; or

9 (E) a technical assistance center that can
10 help grantees install recovery support service
11 programs aimed at youth and young adults
12 which include recovery coaching, job training,
13 transportation, linkages to community-based
14 services and supports, regularly scheduled alter-
15 native peer group activities, life-skills education,
16 mentoring, and leadership development.

17 (2) HIGH SCHOOL.—The term “high school”
18 has the meaning given the term in section 8101 of
19 the Elementary and Secondary Education Act of
20 1965 (20 U.S.C. 7801).

21 (3) INSTITUTION OF HIGHER EDUCATION.—The
22 term “institution of higher education” has the
23 meaning given the term in section 101 of the Higher
24 Education Act of 1965 (20 U.S.C. 1001).

1 (4) RECOVERY PROGRAM.—The term “recovery
2 program” means a program—

3 (A) to help youth or young adults who are
4 recovering from substance use disorders to ini-
5 tiate, stabilize, and maintain healthy and pro-
6 ductive lives in the community; and

7 (B) that includes peer-to-peer support de-
8 livered by individuals with lived experience in
9 recovery, and communal activities to build re-
10 covery skills and supportive social networks.

11 (b) GRANTS AUTHORIZED.—The Assistant Secretary
12 for Mental Health and Substance Use, in consultation
13 with the Secretary of Education, shall award grants, on
14 a competitive basis, to eligible entities to enable the eligi-
15 ble entities to—

16 (1) provide culturally competent (as defined in
17 section 102 of the Developmental Disabilities Assist-
18 ance and Bill of Rights Act of 2000 (42 U.S.C.
19 15002)) substance use recovery support services to
20 youth and young adults enrolled in high school or an
21 institution of higher education;

22 (2) help build communities of support for youth
23 and young adults in substance use recovery through
24 a spectrum of activities such as counseling, job
25 training, recovery coaching, alternative peer groups,

1 life-skills workshops, family support groups, and
2 health and wellness-oriented social activities; and

3 (3) encourage initiatives designed to help youth
4 and young adults achieve and sustain recovery from
5 substance use disorders.

6 (c) APPLICATION.—An eligible entity desiring a grant
7 under this section shall submit to the Assistant Secretary
8 for Mental Health and Substance Use an application at
9 such time, in such manner, and containing such informa-
10 tion as the Assistant Secretary may require.

11 (d) PREFERENCE.—In awarding grants under sub-
12 section (b), the Assistant Secretary for Mental Health and
13 Substance Use shall give preference to eligible entities that
14 propose to serve students from areas with schools serving
15 a high percentage of children who are counted under sec-
16 tion 1124(c) of the Elementary and Secondary Education
17 Act of 1965 (20 U.S.C. 6333(c)).

18 (e) USE OF FUNDS.—Grants awarded under sub-
19 section (b) may be used for activities to develop, support,
20 or maintain substance use recovery support services for
21 youth or young adults, including—

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

24 (2) hiring dedicated staff for the provision of
25 recovery programs;

1 (3) providing health and wellness-oriented social
2 activities and community engagement;

3 (4) the establishment of a substance use recovery high school;

5 (5) the coordination of a peer delivered substance use recovery program with—

7 (A) substance use disorder treatment programs and systems that utilize culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)) services
10 that reflect the communities they serve;

12 (B) providers of mental health services;

13 (C) primary care providers;

14 (D) the criminal justice system, including
15 the juvenile justice system;

16 (E) employers;

17 (F) recovery housing services;

18 (G) child welfare services;

19 (H) high schools; and

20 (I) institutions of higher education;

21 (6) the development of peer-to-peer support
22 programs or services delivered by individuals with
23 lived experience in substance use disorder recovery;
24 and
25

1 (7) any additional activity that helps youth or
 2 young adults achieve recovery from substance use
 3 disorders.

4 (f) RESOURCE CENTER.—The Assistant Secretary
 5 for Mental Health and Substance Use shall establish a re-
 6 source center to provide technical support to recipients of
 7 grants under this section.

8 (g) AUTHORIZATION OF APPROPRIATIONS.—There
 9 are authorized to be appropriated to carry out this section
 10 \$10,000,000 for each of fiscal years 2022 through 2027.

11 **Subtitle B—Recovery Housing**

12 **SEC. 311. CLARIFYING THE ROLE OF SAMHSA IN PRO-** 13 **MOTING THE AVAILABILITY OF HIGH-QUAL-** 14 **ITY RECOVERY HOUSING.**

15 Section 501(d) of the Public Health Service Act (42
 16 U.S.C. 290aa) is amended—

17 (1) in paragraph (24)(E), by striking “and” at
 18 the end;

19 (2) in paragraph (25), by striking the period at
 20 the end and inserting “; and”; and

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

22 “(26) collaborate with national accrediting enti-
 23 ties and reputable providers and analysts of recovery
 24 housing services and all relevant Federal agencies,
 25 including the Centers for Medicare & Medicaid Serv-

1 ices, the Health Resources and Services Administra-
 2 tion, other offices and agencies within the Depart-
 3 ment of Health and Human Services, the Office of
 4 National Drug Control Policy, the Department of
 5 Justice, the Department of Housing and Urban De-
 6 velopment, and the Department of Agriculture, to
 7 promote the availability of high-quality recovery
 8 housing for individuals with a substance use dis-
 9 order.”.

10 **SEC. 312. DEVELOPING GUIDELINES FOR STATES TO PRO-**
 11 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
 12 **RECOVERY HOUSING.**

13 Title V of the Public Health Service Act is amended
 14 by inserting after section 550 of such Act (42 U.S.C.
 15 290ee–5) (relating to national recovery housing best prac-
 16 tices) the following:

17 **“SEC. 550A. DEVELOPING GUIDELINES FOR STATES TO**
 18 **PROMOTE THE AVAILABILITY OF HIGH-QUAL-**
 19 **ITY RECOVERY HOUSING.**

20 “(a) IN GENERAL.—Not later than one year after the
 21 date of the enactment of this section, the Secretary, acting
 22 through the Assistant Secretary, shall develop, and pub-
 23 lish on the internet website of the Substance Abuse and
 24 Mental Health Services Administration, consensus-based
 25 guidelines and nationally recognized standards for States

1 to promote the availability of high-quality recovery hous-
2 ing for individuals with a substance use disorder. Such
3 guidelines shall—

4 “(1) be developed in consultation with national
5 accrediting entities, reputable providers and analysts
6 of recovery housing services, and States and be con-
7 sistent with the best practices developed under sec-
8 tion 550; and

9 “(2) to the extent practicable, build on existing
10 best practices and suggested guidelines developed
11 previously by the Substance Abuse and Mental
12 Health Services Administration.

13 “(b) PUBLIC COMMENT PERIOD.—Before finalizing
14 guidelines under subsection (a), the Secretary of Health
15 and Human Services shall provide for a public comment
16 period.

17 “(c) EXCLUSION OF GUIDELINE ON TREATMENT
18 SERVICES.—In developing the guidelines under subsection
19 (a), the Secretary may not include any guideline or stand-
20 ard with respect to substance use disorder treatment serv-
21 ices.

22 “(d) SUBSTANCE USE DISORDER TREATMENT SERV-
23 ICES.—In this section, the term ‘substance use disorder
24 treatment services’ means items or services furnished for
25 the treatment of a substance use disorder, including—

1 “(1) medications approved by the Food and
 2 Drug Administration for use in such treatment, ex-
 3 cluding each such medication used to prevent or
 4 treat a drug overdose;

5 “(2) the administering of such medications;

6 “(3) recommendations for such treatment;

7 “(4) clinical assessments and referrals;

8 “(5) counseling with a physician, psychologist,
 9 or mental health professional (including individual
 10 and group therapy); and

11 “(6) toxicology testing.”.

12 **SEC. 313. COORDINATION OF FEDERAL ACTIVITIES TO PRO-**
 13 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
 14 **RECOVERY HOUSING.**

15 Section 550 of the Public Health Service Act (42
 16 U.S.C. 290ee–5) (relating to national recovery housing
 17 best practices) is amended—

18 (1) by redesignating subsections (e), (f), and
 19 (g) as subsections (g), (h), and (i), respectively; and

20 (2) by inserting after subsection (d) the fol-
 21 lowing:

22 “(e) COORDINATION OF FEDERAL ACTIVITIES TO
 23 PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOV-
 24 ERY HOUSING FOR INDIVIDUALS WITH A SUBSTANCE
 25 USE DISORDER.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Assistant Secretary, and the Secretary
3 of the Department of Housing and Urban Develop-
4 ment shall convene and serve as the co-chairs of an
5 interagency working group composed of representa-
6 tives of each of the Federal agencies described in
7 paragraph (2) (referred to in this section as the
8 ‘working group’) for the following purposes:

9 “(A) To increase collaboration, coopera-
10 tion, and consultation among such Federal
11 agencies, with respect to promoting the avail-
12 ability of high-quality recovery housing.

13 “(B) To align the efforts of such agencies
14 and avoid duplication of such efforts by such
15 agencies.

16 “(C) To develop objectives, priorities, and
17 a long-term plan for supporting State, Tribal,
18 and local efforts with respect to the operation
19 of high-quality recovery housing that is con-
20 sistent with the best practices developed under
21 this section.

22 “(D) To coordinate inspection and enforce-
23 ment among Federal and State agencies.

24 “(E) To coordinate data collection on the
25 quality of recovery housing.

1 “(2) FEDERAL AGENCIES DESCRIBED.—The
2 Federal agencies described in this paragraph are the
3 following:

4 “(A) The Department of Health and
5 Human Services.

6 “(B) The Centers for Medicare & Medicaid
7 Services.

8 “(C) The Substance Abuse and Mental
9 Health Services Administration.

10 “(D) The Health Resources and Services
11 Administration.

12 “(E) The Indian Health Service.

13 “(F) The Department of Housing and
14 Urban Development.

15 “(G) The Department of Agriculture.

16 “(H) The Department of Justice.

17 “(I) The Office of National Drug Control
18 Policy.

19 “(J) The Bureau of Indian Affairs.

20 “(K) The Department of Labor.

21 “(L) Any other Federal agency as the co-
22 chairs determine appropriate.

23 “(3) MEETINGS.—The working group shall
24 meet on a quarterly basis.

1 “(4) REPORTS TO CONGRESS.—Beginning not
2 later than one year after the date of the enactment
3 of this section and annually thereafter, the working
4 group shall submit to the Committee on Energy and
5 Commerce, the Committee on Ways and Means, the
6 Committee on Agriculture, and the Committee on
7 Financial Services of the House of Representatives
8 and the Committee on Health, Education, Labor,
9 and Pensions, the Committee on Agriculture, Nutri-
10 tion, and Forestry, and the Committee on Finance
11 of the Senate a report describing the work of the
12 working group and any recommendations of the
13 working group to improve Federal, State, and local
14 policy with respect to recovery housing operations.

15 “(5) AUTHORIZATION OF APPROPRIATIONS.—
16 To carry out this subsection, there are authorized to
17 be appropriated such sums as may be necessary for
18 fiscal years 2022 through 2027.”.

19 **SEC. 314. NAS STUDY AND REPORT.**

20 (a) IN GENERAL.—Not later than 60 days after the
21 date of enactment of this Act, the Secretary of Health and
22 Human Services, acting through the Assistant Secretary
23 for Mental Health and Substance Use, shall enter into an
24 arrangement with the National Academies of Sciences,
25 Engineering, and Medicine to conduct a study, which may

1 include a literature review and case studies as appropriate,
2 on—

3 (1) the quality and effectiveness of recovery
4 housing in the United States, including the avail-
5 ability in the United States of high-quality recovery
6 housing and whether that availability meets the de-
7 mand for such housing in the United States; and

8 (2) State, Tribal, and local regulation and over-
9 sight of recovery housing.

10 (b) TOPICS.—The study under subsection (a) shall
11 include a literature review of studies that—

12 (1) examine the quality of, and effectiveness
13 outcomes for, the types and characteristics of cov-
14 ered recovery housing programs listed in subsection
15 (c); and

16 (2) identify the research and data gaps that
17 must be filled to better report on the quality of, and
18 effectiveness outcomes related to, covered recovery
19 housing.

20 (c) TYPE AND CHARACTERISTICS.—The types and
21 characteristics of covered recovery housing programs re-
22 ferred to in subsection (b) consist of the following:

23 (1) Nonprofit and for-profit covered recovery
24 housing.

25 (2) Private and public covered recovery housing.

1 (3) Covered recovery housing programs that
2 provide services to—

3 (A) residents on a voluntary basis; and

4 (B) residents pursuant to a judicial order.

5 (4) Number of clients served, disaggregated to
6 the extent possible by covered recovery housing serv-
7 ing—

8 (A) 6 or fewer recovering residents;

9 (B) 10 to 13 recovering residents; and

10 (C) 18 or more recovering residents.

11 (5) Bedroom occupancy in a house,
12 disaggregated to the extent possible by—

13 (A) single room occupancy;

14 (B) 2 residents occupying 1 room; and

15 (C) more than 2 residents occupying 1
16 room.

17 (6) Duration of services received by clients,
18 disaggregated to the extent possible according to
19 whether the services were—

20 (A) 30 days or fewer;

21 (B) 31 to 90 days;

22 (C) more than 90 days and fewer than 6
23 months; or

24 (D) 6 months or more.

25 (7) Certification levels of staff.

1 (8) Fraudulent and abusive practices by opera-
2 tors of covered recovery housing and inpatient and
3 outpatient treatment facilities, both individually and
4 in concert, including—

5 (A) deceptive or misleading marketing
6 practices, including—

7 (i) inaccurate outcomes-based mar-
8 keting; and

9 (ii) marketing based on non-evidence-
10 based practices;

11 (B) illegal patient brokering;

12 (C) third-party recruiters;

13 (D) deceptive or misleading marketing
14 practices of treatment facility and recovery
15 housing online aggregators; and

16 (E) the impact of such practices on health
17 care costs and recovery rates.

18 (d) REPORT.—The arrangement under subsection (a)
19 shall require, by not later than 18 months after the date
20 of entering into the agreement—

21 (1) completing the study under such subsection;
22 and

23 (2) making publicly available (including through
24 publication on the internet) a report that contains—

25 (A) the results of the study;

1 (B) the National Academy’s recommenda-
2 tions for Federal, State, and local policies to
3 promote the availability of high-quality recovery
4 housing in the United States;

5 (C) research and data gaps;

6 (D) recommendations for recovery housing
7 quality and effectiveness metrics;

8 (E) recommended mechanisms to collect
9 data on those metrics, including with respect to
10 research and data gaps;

11 (F) recommendations to eliminate restric-
12 tions by recovery housing that exclude individ-
13 uals who take prescribed medications for opioid
14 use disorder; and

15 (G) a summary of allegations, assertions,
16 or formal legal actions on the State and local
17 levels by governments and nongovernmental or-
18 ganizations with respect to the opening and op-
19 eration of recovery housing.

20 (e) DEFINITIONS.—In this subsection:

21 (1) The term “covered recovery housing” means
22 recovery housing that utilizes compensated or volun-
23 teer onsite staff who are not health care profes-
24 sionals to support residents.

1 (2) The term “effectiveness outcomes” may in-
2 clude decreased substance use, reduced probability of
3 relapse or reoccurrence, lower rates of incarceration,
4 higher income, increased employment, and improved
5 family functioning.

6 (3) The term “health care professional” means
7 an individual who is licensed or otherwise authorized
8 by the State to provide health care services.

9 (4) The term “recovery housing” means a
10 shared living environment that is or purports to
11 be—

12 (A) free from alcohol and use of nonpre-
13 scribed drugs; and

14 (B) centered on connection to services that
15 promote sustained recovery from substance use
16 disorders.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
18 out this section, there is authorized to be appropriated
19 \$1,500,000 for fiscal year 2022.

20 **SEC. 315. FILLING RESEARCH AND DATA GAPS.**

21 Not later than 60 days after the completion of the
22 study under section 314, the Secretary of Health and
23 Human Services shall enter into an agreement with an ap-
24 propriate entity to conduct such research as may be nec-

1 essary to fill the research and data gaps identified in re-
 2 porting pursuant to such section.

3 **SEC. 316. GRANTS FOR STATES TO PROMOTE THE AVAIL-**
 4 **ABILITY OF HIGH-QUALITY RECOVERY HOUS-**
 5 **ING.**

6 Section 550 of the Public Health Service Act (42
 7 U.S.C. 290ee–5) (relating to national recovery housing
 8 best practices), as amended by section 313, is further
 9 amended by inserting after subsection (e) (as inserted by
 10 such section 313) the following:

11 “(f) GRANTS FOR IMPLEMENTING NATIONAL RECOV-
 12 ERY HOUSING BEST PRACTICES.—

13 “(1) IN GENERAL.—The Secretary shall award
 14 grants to States (and political subdivisions thereof),
 15 Tribes, and territories—

16 “(A) for the provision of technical assist-
 17 ance by national accrediting entities and rep-
 18 utable providers and analysts of recovery hous-
 19 ing services to implement the guidelines, nation-
 20 ally recognized standards, and recommendations
 21 developed under section 313 of the CARA 3.0
 22 Act of 2021 and this section; and

23 “(B) to promote the availability of high-
 24 quality recovery housing for individuals with a

1 substance use disorder and practices to main-
2 tain housing quality long term.

3 “(2) STATE ENFORCEMENT PLANS.—Beginning
4 not later than 90 days after the date of the enact-
5 ment of this paragraph and every 2 years thereafter,
6 as a condition on the receipt of a grant under para-
7 graph (1), each State (or political subdivisions there-
8 of), Tribe, or territory receiving such a grant shall
9 submit to the Secretary, and make publicly available
10 on a publicly accessible Internet website of the State
11 (or political subdivisions thereof), Tribe, or terri-
12 tory—

13 “(A) the plan of the State (or political sub-
14 divisions thereof), Tribe, or territory, with re-
15 spect to the promotion of high-quality recovery
16 housing for individuals with a substance use
17 disorder located within the jurisdiction of such
18 State (or political subdivisions thereof), Tribe,
19 or territory; and

20 “(B) a description of how such plan is con-
21 sistent with the best practices developed under
22 this section and guidelines developed under sec-
23 tion 550A.

24 “(3) REVIEW OF ACCREDITING ENTITIES.—The
25 Secretary shall periodically review, by developing a

1 rubric to evaluate accreditation, the accrediting enti-
 2 ties providing technical assistance pursuant to para-
 3 graph (1)(A).

4 “(4) AUTHORIZATION OF APPROPRIATIONS.—
 5 To carry out this subsection, there is authorized to
 6 be appropriated \$10,000,000 for each of fiscal years
 7 2023 through 2027.”.

8 **SEC. 317. REPUTABLE PROVIDERS AND ANALYSTS OF RE-**
 9 **COVERY HOUSING SERVICES DEFINITION.**

10 Subsection (h) of section 550 of the Public Health
 11 Service Act (42 U.S.C. 290ee–5) (relating to national re-
 12 covery housing best practices), as redesignated by section
 13 313, is amended by adding at the end the following:

14 “(4) The term ‘reputable providers and analysts
 15 of recovery housing services’ means recovery housing
 16 service providers and analysts that—

17 “(A) use evidence-based approaches;

18 “(B) act in accordance with guidelines
 19 issued by the Assistant Secretary;

20 “(C) have not been found guilty of health
 21 care fraud, patient brokering, or false adver-
 22 tising by the Department of Justice, the De-
 23 partment of Health and Human Services, or a
 24 Medicaid Fraud Control Unit;

1 “(D) have not been found to have violated
 2 Federal, State, or local codes of conduct with
 3 respect to recovery housing for individuals with
 4 a substance use disorder; and

5 “(E) do not employ individuals with a past
 6 conviction of criminal, domestic, or sexual vio-
 7 lence, or significant drug distribution, in the
 8 care or supervision of individuals.”.

9 **SEC. 318. TECHNICAL CORRECTION.**

10 Title V of the Public Health Service Act (42 U.S.C.
 11 290aa et seq.) is amended—

12 (1) by redesignating section 550 (relating to
 13 Sobriety Treatment and Recovery Teams) (42
 14 U.S.C. 290ee–10), as added by section 8214 of Pub-
 15 lic Law 115–271, as section 550B; and

16 (2) moving such section so it appears after sec-
 17 tion 550A, as added by section 312.

18 **TITLE IV—CRIMINAL JUSTICE**

19 **SEC. 401. MEDICATION-ASSISTED TREATMENT CORREC-**
 20 **TIONS AND COMMUNITY REENTRY PROGRAM.**

21 (a) DEFINITIONS.—In this section—

22 (1) the term “Attorney General” means the At-
 23 torney General, acting through the Director of the
 24 National Institute of Corrections;

1 (2) the term “certified recovery coach” means
2 an individual—

3 (A) with knowledge of, or experience with,
4 recovery from a substance use disorder; and

5 (B) who—

6 (i) has completed training through,
7 and is determined to be in good standing
8 by—

9 (I) a single State agency; or

10 (II) a recovery community orga-
11 nization that is capable of conducting
12 that training and making that deter-
13 mination; and

14 (ii) meets the criteria specified by the
15 Attorney General, in consultation with the
16 Secretary of Health and Human Services,
17 for qualifying as a certified recovery coach
18 for the purposes of this Act;

19 (3) the term “correctional facility” has the
20 meaning given the term in section 901 of title I of
21 the Omnibus Crime Control and Safe Streets Act of
22 1968 (34 U.S.C. 10251);

23 (4) the term “covered grant or cooperative
24 agreement” means a grant received, or cooperative
25 agreement entered into, under the Program;

1 (5) the term “covered program” means a pro-
2 gram—

3 (A) to provide medication-assisted treat-
4 ment to individuals who have opioid use dis-
5 order and are incarcerated within the jurisdic-
6 tion of the State or unit of local government
7 carrying out the program; and

8 (B) that is developed, implemented, or ex-
9 panded through a covered grant or cooperative
10 agreement;

11 (6) the term “medication-assisted treatment”
12 means the use of any drug or combination of drugs
13 that have been approved under the Federal Food,
14 Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or
15 section 351 of the Public Health Service Act (42
16 U.S.C. 262) for the treatment of an opioid use dis-
17 order, in combination with evidence-based counseling
18 and behavioral therapies, such as psychosocial coun-
19 seling, overseen by 1 or more social work profes-
20 sionals and 1 or more qualified clinicians, to provide
21 a comprehensive approach to the treatment of sub-
22 stance use disorders;

23 (7) the term “nonprofit organization” means an
24 organization that is described in section 501(c)(3) of

1 the Internal Revenue Code of 1986 and is exempt
2 from taxation under section 501(a) of such Code;

3 (8) the term “Panel” means the medication-as-
4 sisted treatment Corrections and Community Re-
5 entry Application Review Panel established under
6 subsection (f)(2);

7 (9) the term “participant” means an individual
8 who participates in a covered program;

9 (10) the term “political appointee” has the
10 meaning given the term in section 714(h) of title 38,
11 United States Code;

12 (11) the term “Program” means the medica-
13 tion-assisted treatment Corrections and Community
14 Reentry Program established under subsection (b);

15 (12) the term “psychosocial” means the inter-
16 relation of social factors and individual thought and
17 behavior;

18 (13) the term “recovery community organiza-
19 tion” has the meaning given the term in section 547
20 of the Public Health Service Act (42 U.S.C. 290ee–
21 2);

22 (14) the term “single State agency” means,
23 with respect to a State or unit of local government,
24 the single State agency identified by the State, or
25 the State in which the unit of local government is

1 located, in the plan submitted by that State under
2 section 1932(b)(1)(A)(i) of the Public Health Serv-
3 ice Act (42 U.S.C. 300x-32(b)(1)(A)(i));

4 (15) the term “State” means—

5 (A) each State of the United States;

6 (B) the District of Columbia; and

7 (C) each commonwealth, territory, or pos-
8 session of the United States; and

9 (16) the term “unit of local government” has
10 the meaning given the term in section 901 of title
11 I of the Omnibus Crime Control and Safe Streets
12 Act of 1968 (34 U.S.C. 10251), except that such
13 term also includes a Tribal organization, as defined
14 in section 4 of the Indian Self-Determination and
15 Education Assistance Act (25 U.S.C. 5304).

16 (b) AUTHORIZATION.—Not later than 90 days after
17 the date of enactment of this Act, the Attorney General,
18 in consultation with the Secretary of Health and Human
19 Services, shall establish a program—

20 (1) that shall be known as the “medication-as-
21 sisted treatment Corrections and Community Re-
22 entry Program”; and

23 (2) under which the Attorney General—

24 (A) may make grants to, and enter into co-
25 operative agreements with, States or units of

1 local government to develop, implement, or ex-
2 pand 1 or more programs to provide medica-
3 tion-assisted treatment that meets the standard
4 of care generally accepted for the treatment of
5 opioid use disorder to individuals who have
6 opioid use disorder and are incarcerated within
7 the jurisdictions of the States or units of local
8 government; and

9 (B) shall establish a working relationship
10 with 1 or more knowledgeable corrections orga-
11 nizations with expertise in security, medical
12 health, mental health, and substance use dis-
13 order care to oversee and support implementa-
14 tion of the program, including through the use
15 of evidence-based clinical practices.

16 (c) USE OF FUNDS FOR INFRASTRUCTURE.—In de-
17 veloping, implementing, or expanding a medication-as-
18 sisted treatment program under subsection (b)(2)(A), a
19 State or unit of local government may use funds from a
20 grant or cooperative agreement under that subsection to
21 develop the infrastructure necessary to provide the medi-
22 cation-assisted treatment, such as—

23 (1) establishing safe storage facilities for the
24 drugs used in the treatment; and

1 (2) obtaining appropriate licenses for the indi-
2 viduals who will administer the treatment.

3 (d) PURPOSES.—The purposes of the Program are
4 to—

5 (1) develop culturally competent (as defined in
6 section 102 of the Developmental Disabilities Assist-
7 ance and Bill of Rights Act of 2000 (42 U.S.C.
8 15002)) medication-assisted treatment programs in
9 consultation with nonprofit organizations and com-
10 munity organizations that are qualified to provide
11 technical support for the programs;

12 (2) reduce the risk of overdose to participants
13 after the participants are released from incarcer-
14 ation; and

15 (3) reduce the rate of reincarceration.

16 (e) PROGRAM REQUIREMENTS.—In carrying out a
17 covered program, a State or unit of local government—

18 (1) shall ensure that each individual who is
19 newly incarcerated at a correctional facility at which
20 the covered program is carried out, and who was re-
21 ceiving medication-assisted treatment before being
22 incarcerated, continues to receive medication-assisted
23 treatment while incarcerated;

24 (2) in providing medication-assisted treatment
25 under the covered program, shall offer to partici-

1 pants each type of drug that has been approved
2 under the Federal Food, Drug, and Cosmetic Act
3 (21 U.S.C. 301 et seq.) or section 351 of the Public
4 Health Service Act (42 U.S.C. 262) for the treat-
5 ment of an opioid use disorder; and

6 (3) shall use—

7 (A) screening tools with psychometric reli-
8 ability and validity that provide useful clinical
9 data to guide the long-term treatment of par-
10 ticipants who have—

11 (i) opioid use disorder; or

12 (ii) co-occurring opioid use disorder
13 and mental disorders;

14 (B) at each correctional facility at which
15 the covered program is carried out, a sufficient
16 number of personnel, as determined by the At-
17 torney General in light of the number of indi-
18 viduals incarcerated at the correctional facility
19 and the number of those individuals whom the
20 correctional facility has screened and identified
21 as having opioid use disorder, to—

22 (i) monitor participants with active
23 opioid use disorder who begin participation
24 in the covered program while dem-

onstrating, or develop, signs and symptoms
of opioid withdrawal;

(ii) provide evidence-based medically
managed withdrawal care or assistance to
the participants described in clause (i);

(iii) prescribe or otherwise dispense—

(I) the drugs that are offered
under the covered program, as re-
quired under paragraph (1); and

(II) naloxone or any other emer-
gency opioid antagonist approved by
the Commissioner of Food and Drugs
to treat opioid overdose;

(iv) discuss with participants the risks
and benefits of, and differences among, the
opioid antagonist, opioid agonist, and par-
tial agonist drugs used to treat opioid use
disorder; and

(v) prepare a plan for release, includ-
ing connecting participants with mental
health and substance use treatment pro-
grams, medical care, public benefits, and
housing; and

(C) a certified recovery coach, social work
professional, or other qualified clinician who, in

1 order to support the sustained recovery of par-
2 ticipants, shall work with participants who are
3 recovering from opioid use disorder.

4 (f) APPLICATION.—

5 (1) IN GENERAL.—A State or unit of local gov-
6 ernment desiring a covered grant or cooperative
7 agreement shall submit to the Attorney General an
8 application that—

9 (A) shall include—

10 (i) a description of—

11 (I) the objectives of the medica-
12 tion-assisted treatment program that
13 the applicant will develop, implement,
14 or expand under the covered grant or
15 cooperative agreement;

16 (II) the activities that the appli-
17 cant will carry out under the covered
18 program;

19 (III) how the activities described
20 under subclause (II) will achieve the
21 objectives described in subclause (I);

22 (IV) the outreach and education
23 component of the covered program
24 that the applicant will carry out in

1 order to encourage maximum partici-
2 pation in the covered program; and

3 (V) how the applicant will de-
4 velop connections to culturally com-
5 petent (as defined in section 102 of
6 the Developmental Disabilities Assist-
7 ance and Bill of Rights Act of 2000
8 (42 U.S.C. 15002)) substance use and
9 mental health treatment providers,
10 medical professionals, nonprofit orga-
11 nizations, and other State agencies in
12 order to plan for participants to re-
13 ceive a continuum of care and appro-
14 priate wrap-around services after re-
15 lease from incarceration;

16 (ii) if, under the covered program that
17 the applicant will carry out, the applicant
18 will not, in providing medication-assisted
19 treatment, offer to participants not less
20 than 1 drug that uses an opioid antago-
21 nist, not less than 1 drug that uses an
22 opioid agonist, and not less than 1 drug
23 that uses an opioid partial agonist, an ex-
24 planation of why the applicant is unable to
25 or chooses not to offer a drug that uses an

1 opioid antagonist, a drug that uses an
2 opioid agonist, or a drug that uses an
3 opioid partial agonist, as applicable;

4 (iii) a plan for—

5 (I) measuring progress in achiev-
6 ing the objectives described in clause
7 (i)(I), including a strategy to collect
8 data that can be used to measure that
9 progress;

10 (II) collaborating with the single
11 State agency for the applicant or 1 or
12 more nonprofit organizations in the
13 community of the applicant to help
14 ensure that—

15 (aa) if participants so desire,
16 participants have continuity of
17 care after release from incarcer-
18 ation with respect to the form of
19 medication-assisted treatment the
20 participants received during in-
21 carceration, including—

22 (AA) by working with
23 community service providers
24 to assist eligible partici-
25 pants, before release from

1 incarceration in registering
2 for the Medicaid program
3 under title XIX of the Social
4 Security Act (42 U.S.C.
5 1396 et seq.) or other min-
6 imum essential coverage, as
7 defined in section 5000A(f)
8 of the Internal Revenue
9 Code of 1986; and

10 (BB) if a participant
11 cannot afford, or does not
12 qualify for, health insurance
13 that provides coverage with
14 respect to enrollment in a
15 medication-assisted treat-
16 ment program, and if the
17 participant cannot pay the
18 cost of enrolling in a medi-
19 cation-assisted treatment
20 program, by working with
21 units of local government,
22 nonprofit organizations,
23 opioid use disorder treat-
24 ment providers, and entities
25 carrying out programs under

1 substance use disorder
2 grants to, before the partici-
3 pant is released from incar-
4 ceration, identify a resource,
5 other than the applicant or
6 the covered program to be
7 carried out by the applicant,
8 that may be used to pay the
9 cost of enrolling the partici-
10 pant in a medication-as-
11 sisted treatment program;
12 (bb) medications are se-
13 curely stored; and
14 (cc) protocols relating to di-
15 version are maintained; and
16 (III) with respect to each com-
17 munity in which a correctional facility
18 at which a covered program will be
19 carried out is located, collaborating
20 with State agencies responsible for
21 overseeing programs relating to sub-
22 stance use disorder and local public
23 health officials and nonprofit organi-
24 zations in the community to help en-
25 sure that medication-assisted treat-

1 ment provided at each correctional fa-
2 cility at which the covered program
3 will be carried out is also available at
4 locations that are not correctional fa-
5 cilities in those communities, to the
6 greatest extent practicable; and

7 (iv) a certification that—

8 (I) each correctional facility at
9 which the covered program will be
10 carried out has access to a sufficient
11 number of clinicians who are licensed
12 to prescribe or otherwise dispense to
13 participants the drugs for the treat-
14 ment of opioid use disorder required
15 to be offered under subsection (e)(1),
16 which may include clinicians who use
17 telemedicine, in accordance with regu-
18 lations issued by the Administrator of
19 the Drug Enforcement Administra-
20 tion, to provide services under the cov-
21 ered program; and

22 (II) the covered program will
23 provide culturally competent (as de-
24 fined in section 102 of the Develop-
25 mental Disabilities Assistance and Bill

1 of Rights Act of 2000 (42 U.S.C.
2 15002)) evidence-based counseling
3 and behavioral therapies, which may
4 include counseling and therapy admin-
5 istered through the use of telemedi-
6 cine, as appropriate, to participants as
7 part of the medication-assisted treat-
8 ment provided under the covered pro-
9 gram; and

10 (B) may include a statement indicating the
11 number of participants that the applicant ex-
12 pects to serve through the covered program.

13 (2) MEDICATION-ASSISTED TREATMENT COR-
14 RECTIONS AND COMMUNITY REENTRY APPLICATION
15 REVIEW PANEL.—

16 (A) IN GENERAL.—Not later than 60 days
17 after the date of enactment of this Act, the At-
18 torney General shall establish a Medication-As-
19 sisted Treatment Corrections and Community
20 Reentry Application Review Panel that shall—

21 (i) be composed of not fewer than 10
22 individuals and not more than 15 individ-
23 uals; and

24 (ii) include—

1 (I) 1 or more employees, who are
2 not political appointees, of—

3 (aa) the Department of Jus-
4 tice;

5 (bb) the Substance Abuse
6 and Mental Health Service Ad-
7 ministration;

8 (cc) the National Center for
9 Injury Prevention and Control at
10 the Centers for Disease Control
11 and Prevention; and

12 (dd) the Office of National
13 Drug Control Policy; and

14 (II) other stakeholders who—

15 (aa) have expert knowledge
16 relating to the opioid epidemic,
17 drug treatment, health equity,
18 culturally competent (as defined
19 in section 102 of the Develop-
20 mental Disabilities Assistance
21 and Bill of Rights Act of 2000
22 (42 U.S.C. 15002)) care, or com-
23 munity substance use disorder
24 services; and

1 (bb) represent law enforce-
2 ment organizations and public
3 health entities.

4 (B) DUTIES.—

5 (i) IN GENERAL.—The Panel shall—

6 (I) review and evaluate applica-
7 tions for covered grants and coopera-
8 tive agreements; and

9 (II) make recommendations to
10 the Attorney General relating to the
11 awarding of covered grants and coop-
12 erative agreements.

13 (ii) RURAL COMMUNITIES.—In review-
14 ing and evaluating applications under
15 clause (i), the Panel shall take into consid-
16 eration the unique circumstances, including
17 the lack of resources relating to the treat-
18 ment of opioid use disorder, faced by rural
19 States and units of local government.

20 (C) TERMINATION.—The Panel shall ter-
21minate on the last day of fiscal year 2023.

22 (3) PUBLICATION OF CRITERIA IN FEDERAL
23 REGISTER.—Not later than 90 days after the date of
24 enactment of this Act, the Attorney General, in con-

1 sultation with the Panel, shall publish in the Federal
2 Register—

3 (A) the process through which applications
4 submitted under paragraph (1) shall be sub-
5 mitted and evaluated; and

6 (B) the criteria used in awarding covered
7 grants and cooperative agreements.

8 (g) DURATION.—A covered grant or cooperative
9 agreement shall be for a period of not more than 4 years,
10 except that the Attorney General may extend the term of
11 a covered grant or cooperative agreement based on out-
12 come data or extenuating circumstances relating to the
13 covered program carried out under the covered grant or
14 cooperative agreement.

15 (h) REPORT.—

16 (1) IN GENERAL.—Not later than 2 years after
17 the date on which a State or unit of local govern-
18 ment is awarded a covered grant or cooperative
19 agreement, and each year thereafter until the date
20 that is 1 year after the date on which the period of
21 the covered grant or cooperative agreement ends, the
22 State or unit of local government shall submit a re-
23 port to the Attorney General that includes informa-
24 tion relating to the covered program carried out by

1 the State or unit of local government, including in-
2 formation relating to—

3 (A) the goals of the covered program;

4 (B) any evidence-based interventions car-
5 ried out under the covered program;

6 (C) outcomes of the covered program,
7 which shall—

8 (i) be reported in a manner that dis-
9 tinguishes the outcomes based on the cat-
10 egories of, with respect to the participants
11 in the covered program—

12 (I) the race of the participants;

13 and

14 (II) the gender of the partici-
15 pants; and

16 (ii) include information relating to the
17 rate of reincarceration among participants
18 in the covered program, if available; and

19 (D) expenditures under the covered pro-
20 gram.

21 (2) PUBLICATION.—

22 (A) AWARDEE.—A State or unit of local
23 government that submits a report under para-
24 graph (1) shall make the report publicly avail-
25 able on—

1 (i) the website of each correctional fa-
2 cility at which the State or unit of local
3 government carried out the covered grant
4 program; and

5 (ii) if a correctional facility at which
6 the State or unit of local government car-
7 ried out the covered grant program does
8 not operate a website, the website of the
9 State or unit of local government.

10 (B) ATTORNEY GENERAL.—The Attorney
11 General shall make each report received under
12 paragraph (1) publicly available on the website
13 of the National Institute of Corrections.

14 (3) SUBMISSION TO CONGRESS.—Not later than
15 2 years after the date on which the Attorney Gen-
16 eral awards the first covered grant or cooperative
17 agreement, and each year thereafter, the Attorney
18 General shall submit to the Committee on the Judi-
19 ciary of the Senate and the Committee on the Judi-
20 ciary of the House of Representatives a summary
21 and compilation of the reports that the Attorney
22 General has received under paragraph (1) during the
23 year preceding the date on which the Attorney Gen-
24 eral submits the summary and compilation.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated \$50,000,000 to carry
3 out this section for each of fiscal years 2022 through
4 2026.

5 **SEC. 402. DEFLECTION AND PRE-ARREST DIVERSION.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Law enforcement officers and other first re-
8 sponders are at the front line of the opioid epidemic.
9 However, a traditional law enforcement response to
10 substance use often fails to disrupt the cycle of ad-
11 diction and arrest, or reduce the risk of overdose.

12 (2) Law enforcement-assisted deflection and di-
13 version programs have the potential to improve pub-
14 lic health, decrease the number of people entering
15 the criminal justice system for low-level offenses,
16 and address racial disparities.

17 (3) According to the Bureau of Justice Assist-
18 ance of the Department of Justice, “Five pathways
19 have been most commonly associated with opioid
20 overdose prevention and diversion to treatment.”
21 The 5 pathways are—

22 (A) “self-referral”, in which—

23 (i) an individual voluntarily initiates
24 contact with a first responder, such as a
25 law enforcement officer, firefighter, or

1 emergency medical services professional,
2 for a treatment referral (without fear of
3 arrest); and

4 (ii) the first responder personally in-
5 troduces the individual to a treatment pro-
6 vider (commonly known as a “warm hand-
7 off”);

8 (B) “active outreach”, in which a law en-
9 forcement officer or other first responder—

10 (i) identifies or seeks out individuals
11 in need of substance use disorder treat-
12 ment; and

13 (ii) makes a warm handoff of such an
14 individual to a treatment provider, who en-
15 gages the individual in treatment;

16 (C) “naloxone plus”, in which a law en-
17 forcement officer or other first responder en-
18 gages an individual in treatment as a follow-up
19 to an overdose response;

20 (D) “officer prevention referral”, in which
21 a law enforcement officer or other first re-
22 sponder initiates treatment engagement with an
23 individual, but no criminal charges are filed
24 against the individual; and

1 (E) “officer intervention referral”, in
2 which—

3 (i) a law enforcement officer or other
4 first responder initiates treatment engage-
5 ment with an individual; and

6 (ii)(I) criminal charges are filed
7 against the individual and held in abey-
8 ance; or

9 (II) a citation is issued to the indi-
10 vidual.

11 (4) As of the date of enactment of this Act,
12 there are no national best practices or guidelines for
13 law enforcement-assisted deflection and diversion
14 programs.

15 (b) USE OF BYRNE JAG FUNDS FOR DEFLECTION
16 AND DIVERSION PROGRAMS.—Section 501 of title I of the
17 Omnibus Crime Control and Safe Streets Act of 1968 (34
18 U.S.C. 10152) is amended—

19 (1) in subsection (a)(1)(E), by inserting before
20 the period at the end the following: “, including law
21 enforcement-assisted deflection programs and law
22 enforcement-assisted pre-arrest and pre-bookings di-
23 version programs (as those terms are defined in sub-
24 section (h))”; and

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

1 “(h) LAW ENFORCEMENT-ASSISTED DEFLECTION
2 PROGRAMS AND LAW ENFORCEMENT-ASSISTED PRE-AR-
3 REST AND PRE-BOOKING DIVERSION PROGRAMS.—

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

5 “(A) COVERED GRANT.—The term ‘cov-
6 ered grant’ means a grant for a deflection or di-
7 version program awarded under subsection
8 (a)(1)(E).

9 “(B) DEFLECTION OR DIVERSION PRO-
10 GRAM.—The term ‘deflection or diversion pro-
11 gram’ means a law enforcement-assisted deflec-
12 tion program or a law enforcement-assisted pre-
13 arrest or pre-booking diversion, including a pro-
14 gram under which—

15 “(i) an individual voluntarily initiates
16 contact with a first responder for a sub-
17 stance use disorder or mental health treat-
18 ment referral without fear of arrest and re-
19 ceives a warm handoff to such treatment;

20 “(ii) a law enforcement officer or
21 other first responder identifies or seeks out
22 individuals in need of substance use dis-
23 order or mental health treatment and a
24 warm handoff is made to a treatment pro-

1 vider, who engages the individuals in treat-
2 ment;

3 “(iii) a law enforcement officer or
4 other first responder engages an individual
5 in substance use disorder treatment as
6 part of an overdose response;

7 “(iv) a law enforcement officer or
8 other first responder initiates substance
9 use disorder or mental health treatment
10 engagement, but no criminal charges are
11 filed;

12 “(v) a law enforcement officer or
13 other first responder initiates substance
14 use disorder or mental health treatment
15 engagement with an individual; or

16 “(vi) charges are filed against an indi-
17 vidual who has committed an offense that
18 is not a crime against a person, and the
19 primary cause of which appears to be
20 based on a substance use disorder or men-
21 tal health disorder and held in abeyance or
22 a citation is issued to such an individual.

23 “(C) LAW ENFORCEMENT-ASSISTED DE-
24 FLECTION PROGRAM.—The term ‘law enforce-
25 ment-assisted deflection program’ means a pro-

1 gram under which a law enforcement officer,
2 when encountering an individual who is not en-
3 gaged in criminal activity but appears to have
4 a substance use disorder or mental health dis-
5 order, instead of taking no action at the time
6 of contact or taking action at a later time, at-
7 tempts to connect the individual to substance
8 use disorder treatment providers or mental
9 health treatment providers—

10 “(i) without the use of coercion or
11 fear of arrest; and

12 “(ii) using established pathways for
13 connections to local, community-based
14 treatment.

15 “(D) LAW ENFORCEMENT-ASSISTED PRE-
16 ARREST OR PRE-BOOKING DIVERSION PRO-
17 GRAM.—The term ‘law enforcement-assisted
18 pre-arrest or pre-booking diversion program’
19 means a program—

20 “(i) under which a law enforcement
21 officer, when encountering an individual
22 who has committed an offense that is not
23 a crime against a person, and the primary
24 cause of which appears to be based on a
25 substance use disorder or the mental

1 health disorder of the individual, instead of
2 arresting the individual, or instead of
3 booking the individual after having ar-
4 rested the individual, attempts to connect
5 the individual to substance use disorder
6 treatment providers or mental health treat-
7 ment providers—

8 “(I) without the use of coercion;

9 and

10 “(II) using established pathways

11 for connections to local, community-
12 based treatment;

13 “(ii) under which, in the case of pre-
14 arrest diversion, a law enforcement officer
15 described in clause (i) may decide to—

16 “(I) issue a civil citation; or

17 “(II) take no action with respect

18 to the offense for which the officer
19 would otherwise have arrested the in-
20 dividual described in clause (i); and

21 “(iii) that may authorize a law en-
22 forcement officer to refer an individual to
23 substance use disorder treatment providers
24 or mental health treatment providers if the
25 individual appears to have a substance use

1 disorder or mental health disorder and the
2 officer suspects the individual of chronic
3 violations of law but lacks probable cause
4 to arrest the individual (commonly known
5 as a ‘social contact referral’).

6 “(2) SENSE OF CONGRESS REGARDING DEFLEC-
7 TION OR DIVERSION PROGRAMS.—It is the sense of
8 Congress that a deflection or diversion program
9 funded under this subpart should not exclude indi-
10 viduals who are chronically exposed to the criminal
11 justice system.

12 “(3) REPORTS TO ATTORNEY GENERAL.—Not
13 later than 2 years after the date on which a State
14 or unit of local government is awarded a covered
15 grant, and each year thereafter until the date that
16 is 1 year after the date on which the period of the
17 covered grant ends, the State or unit of local govern-
18 ment shall submit a report to the Attorney General
19 that includes information relating to the deflection
20 or diversion program carried out by the State or
21 unit of local government, including information re-
22 lating to—

23 “(A) the goals of the deflection or diver-
24 sion program;

1 “(B) any evidence-based interventions car-
 2 ried out under the deflection or diversion pro-
 3 gram;

4 “(C) outcomes of the deflection or diver-
 5 sion program, which shall—

6 “(i) be reported in a manner that dis-
 7 tinguishes the outcomes based on the cat-
 8 egories of, with respect to the participants
 9 in the deflection or diversion program—

10 “(I) the race of the participants;

11 and

12 “(II) the gender of the partici-
 13 pants; and

14 “(ii) include information relating to
 15 the rate of reincarceration among partici-
 16 pants in the deflection or diversion pro-
 17 gram, if available; and

18 “(D) expenditures under the deflection or
 19 diversion program.”.

20 (c) TECHNICAL ASSISTANCE GRANT PROGRAM.—

21 (1) DEFINITIONS.—In this subsection—

22 (A) the term “deflection or diversion pro-
 23 gram” has the meaning given the term in sub-
 24 section (h) of section 501 of title I of the Omni-
 25 bus Crime Control and Safe Streets Act of

1 1968 (34 U.S.C. 10152), as added by sub-
2 section (b); and

3 (B) the terms “State” and “unit of local
4 government” have the meanings given those
5 terms in section 901 of title I of the Omnibus
6 Crime Control and Safe Streets Act of 1968
7 (34 U.S.C. 10251).

8 (2) GRANT AUTHORIZED.—The Attorney Gen-
9 eral shall award a single grant to an entity with sig-
10 nificant experience in working with law enforcement
11 agencies, community-based treatment providers, and
12 other community-based human service providers to
13 develop or administer both deflection and diversion
14 programs that use each of the 5 pathways described
15 in subsection (a)(3), to promote and maximize the
16 effectiveness and racial equity of deflection or diver-
17 sion programs, in order to—

18 (A) help State and units of local govern-
19 ment launch and expand deflection or diversion
20 programs;

21 (B) develop best practices for deflection or
22 diversion teams, which shall include—

23 (i) recommendations on community
24 input and engagement in order to imple-
25 ment deflection or diversion programs as

1 rapidly as possible and with regard to the
2 particular needs of a community, including
3 regular community meetings and other
4 mechanisms for engagement with—

5 (I) law enforcement agencies;

6 (II) community-based treatment
7 providers and other community-based
8 human service providers;

9 (III) the recovery community;

10 and

11 (IV) the community at-large; and

12 (ii) the implementation of metrics to
13 measure community satisfaction con-
14 cerning the meaningful participation and
15 interaction of the community with the de-
16 flection or diversion program and program
17 stakeholders;

18 (C) develop and publish a training and
19 technical assistance tool kit for deflection or di-
20 version for public education purposes;

21 (D) disseminate uniform criteria and
22 standards for the delivery of deflection or diver-
23 sion program services; and

1 (E) develop outcome measures that can be
2 used to continuously inform and improve social,
3 clinical, financial and racial equity outcomes.

4 (3) TERM.—The term of the grant awarded
5 under paragraph (2) shall be 5 years.

6 (4) AUTHORIZATION OF APPROPRIATIONS.—
7 There are authorized to be appropriated to the At-
8 torney General \$30,000,000 for the grant under
9 paragraph (2).

10 **SEC. 403. HOUSING.**

11 (a) IN GENERAL.—Section 576 of the Quality Hous-
12 ing and Work Responsibility Act of 1998 (42 U.S.C.
13 13661) is amended by striking subsections (a), (b), and
14 (c) and inserting the following:

15 “(a) INELIGIBILITY OF ILLEGAL DRUG USERS AND
16 ALCOHOL ABUSERS.—Notwithstanding any other provi-
17 sion of law, a public housing agency or an owner of feder-
18 ally assisted housing, as determined by the Secretary, may
19 only prohibit admission to the program or admission to
20 federally assisted housing for an individual whom the pub-
21 lic housing agency or owner determines is illegally using
22 a controlled substance or abusing alcohol if—

23 “(1) the agency or owner determines that the
24 individual is using the controlled substance or abus-

1 ing alcohol in a manner that interferes with the
2 health or safety of other residents; and

3 “(2) the individual is not participating in a sub-
4 stance use disorder assessment and treatment.

5 “(b) AUTHORITY TO DENY ADMISSION TO CRIMINAL
6 OFFENDERS.—

7 “(1) IN GENERAL.—Except as provided in sub-
8 section (a), in addition to any other authority to
9 screen applicants, and subject to paragraphs (2) and
10 (3) of this subsection, a public housing agency or an
11 owner of federally assisted housing may only pro-
12 hibit admission to the program or to federally as-
13 sisted housing for an individual based on criminal
14 activity of the individual if the public housing agency
15 or owner determines that the individual, during a
16 reasonable time preceding the date on which the in-
17 dividual would otherwise be selected for admission,
18 was convicted of a crime involving conduct that
19 threatens the health or safety of other residents.

20 “(2) EXCEPTIONS AND LIMITATIONS.—A con-
21 viction that has been vacated, a conviction the
22 record of which has been sealed or expunged, or a
23 conviction for a crime committed by an individual
24 when the individual was less than 18 years of age,

1 shall not be grounds for denial of admission under
2 paragraph (1).

3 “(3) ADMISSION POLICY.—

4 “(A) FACTORS TO CONSIDER.—In evalu-
5 ating the criminal history of an individual
6 under paragraph (1), a public housing agency
7 or an owner of federally assisted housing shall
8 consider—

9 “(i) whether an offense of which the
10 individual was convicted bears a relation-
11 ship to the safety and security of other
12 residents;

13 “(ii) the level of violence, if any, of an
14 offense of which the individual was con-
15 victed;

16 “(iii) the length of time since a con-
17 viction;

18 “(iv) the number of convictions;

19 “(v) if the individual is in recovery for
20 a substance use disorder, whether the indi-
21 vidual was under the influence of alcohol
22 or illegal drugs at the time of an offense;
23 and

24 “(vi) any rehabilitation efforts that
25 the individual has undertaken since the

1 time of a conviction, including completion
2 of a substance use treatment program.

3 “(B) WRITTEN POLICY.—A public housing
4 agency or an owner of federally assisted hous-
5 ing shall establish and make available to appli-
6 cants a written admission policy that enumer-
7 ates the specific factors, including the factors
8 described in subparagraph (A), that will be con-
9 sidered when the public housing agency or
10 owner evaluates the criminal history of an indi-
11 vidual under paragraph (1).”.

12 (b) UPDATING REGULATIONS.—The Secretary of
13 Housing and Urban Development shall amend subpart I
14 of part 5 of title 24, Code of Federal Regulations, as nec-
15 essary to implement the amendment made by subsection
16 (a) of this section.

17 **SEC. 404. VETERANS TREATMENT COURTS.**

18 Section 2991 of title I of the Omnibus Crime Control
19 and Safe Streets Act of 1968 (34 U.S.C. 10651) is amend-
20 ed—

21 (1) in subsection (a)—

22 (A) in paragraph (2)—

23 (i) in the matter preceding subpara-
24 graph (A)—

1 (I) by inserting “, substance use
2 disorder,” after “mental health”; and

3 (II) by inserting “or adults or ju-
4 veniles with substance use disorders”
5 after “mentally ill adults or juve-
6 niles”;

7 (ii) in subparagraph (A), by inserting
8 “or substance use” after “mental health”;
9 and

10 (iii) in subparagraph (B), by inserting
11 “or substance use” after “mental health”;
12 (B) in paragraph (4)—

13 (i) in subparagraph (A), by inserting
14 “or substance use disorder” after “mental
15 health”; and

16 (ii) in subparagraph (C), by inserting
17 “or offenders with substance use dis-
18 orders” after “mentally ill offenders”;

19 (C) in paragraph (5)—

20 (i) in the heading, by inserting “OR
21 SUBSTANCE USE DISORDER” after “MEN-
22 TAL HEALTH”;

23 (ii) by striking “mental health agen-
24 cy” and inserting “mental health or sub-
25 stance use agency”; and

1 (iii) by inserting “, substance use
2 services,” after “mental health services”;

3 (D) in paragraph (9)—

4 (i) in subparagraph (A)—

5 (I) in clause (i)—

6 (aa) in subclause (I), by in-
7 serting “, a substance use dis-
8 order,” after “a mental illness”;
9 and

10 (bb) in subclause (II), by in-
11 serting “, substance use dis-
12 order,” after “mental illness”;
13 and

14 (II) in clause (ii)(II), by inserting
15 “or substance use” after “mental
16 health”;

17 (E) by redesignating paragraph (11) as
18 paragraph (12); and

19 (F) by inserting after paragraph (10) the
20 following:

21 “(11) SUBSTANCE USE COURT.—The term ‘sub-
22 stance use court’ means a judicial program that
23 meets the requirements of part EE of this title.”;

24 (2) in subsection (b)—

25 (A) in paragraph (2)—

1 (i) in subparagraph (A), by inserting
2 “, substance use courts,” after “mental
3 health courts”;

4 (ii) in subparagraph (B)—

5 (I) by inserting “mental health
6 disorders, substance use disorders, or”
7 before “co-occurring mental illness
8 and substance use problems”; and

9 (II) by striking “illnesses” and
10 inserting “disorders, illnesses, or
11 problems”;

12 (iii) in subparagraph (C)—

13 (I) in the matter preceding clause

14 (i)—

15 (aa) by striking “mental
16 health agencies” and inserting
17 “mental health or substance use
18 agencies”; and

19 (bb) by striking “and, where
20 appropriate,” and inserting “or”;
21 and

22 (II) in clause (i), by inserting “,
23 substance use disorders,” after “men-
24 tal illness”; and

- 1 (iv) in subparagraph (D), by inserting
2 “or offender with a substance use dis-
3 order” after “mentally ill offender”; and
4 (B) in paragraph (5)—
5 (i) in subparagraph (B)—
6 (I) in clause (i)—
7 (aa) by inserting “or sub-
8 stance use court” after “mental
9 health court”; and
10 (bb) by striking “mental
11 health agency” and inserting
12 “mental health or substance use
13 agency”; and
14 (II) in clause (ii), by striking
15 “and substance use services for indi-
16 viduals with co-occurring mental
17 health and substance use disorders”
18 and inserting “or substance use serv-
19 ices”;
20 (ii) in subparagraph (C)—
21 (I) in clause (i)(I), by inserting
22 “, substance use disorders,” after
23 “mental illness”;
24 (II) in clause (ii)—

1 (aa) in subclause (II), by in-
2 serting “, substance use,” after
3 “mental health,”;

4 (bb) in subclause (V), by
5 striking “mental health services”
6 and inserting “mental health or
7 substance use services”; and

8 (cc) in subclause (VI), by in-
9 serting “or individuals with sub-
10 stance use disorders” after “men-
11 tally ill individuals”;

12 (iii) in subparagraph (D), by inserting
13 “or offenders with substance use dis-
14 orders” after “mentally ill offenders”;

15 (iv) in subparagraph (E), by inserting
16 “or substance use disorders” after “mental
17 illness”;

18 (v) in subparagraph (H), by striking
19 “and mental health” and inserting “, men-
20 tal health, and substance use”; and

21 (vi) in subparagraph (I)—

22 (I) in clause (i)—

23 (aa) in the heading, by in-
24 serting “, SUBSTANCE USE

1 COURTS,” after “MENTAL
2 HEALTH COURTS”;

3 (bb) by inserting “or sub-
4 stance use courts” after “mental
5 health courts”; and

6 (cc) by inserting “or part
7 EE, as applicable,” after “part
8 V”; and

9 (II) in clause (iv), by inserting
10 “or substance use” after “mental
11 health”;

12 (3) in subsection (c)—

13 (A) in paragraph (1), by inserting “, of-
14 fenders with substance use disorders,” after
15 “mentally ill offenders”;

16 (B) in paragraph (2), by inserting “ and
17 offenders with substance use disorders” after
18 “mentally ill offenders”; and

19 (C) in paragraph (3), by inserting “or sub-
20 stance use courts” after “mental health
21 courts”;

22 (4) in subsection (e)—

23 (A) in paragraph (1), by inserting “or sub-
24 stance use disorders” after “mental illness”;
25 and

1 (B) in paragraph (4), by inserting “or sub-
2 stance use disorders” after “mental illness”;
3 (5) in subsection (h)—

4 (A) in the heading, by inserting “AND OF-
5 FENDERS WITH SUBSTANCE USE DISORDERS”
6 after “MENTALLY ILL OFFENDERS”;

7 (B) in paragraph (1)—

8 (i) in subparagraph (A), by inserting
9 “or substance use disorders” after “mental
10 illnesses”;

11 (ii) in subparagraph (C), by inserting
12 “or offenders with substance use dis-
13 orders” after “mentally ill offenders”;

14 (iii) in subparagraph (D)—

15 (I) by inserting “or substance
16 use” after “mental health”; and

17 (II) by inserting “or offenders
18 with substance use disorders” after
19 “mentally ill offenders”;

20 (iv) in subparagraph (E), by inserting
21 “or substance use disorders” after “mental
22 illnesses”; and

23 (v) in subparagraph (F), by inserting
24 “, substance use disorders,” after “mental
25 health disorders”; and

1 (C) in paragraph (2), by inserting “or sub-
2 stance use disorders” after “mental illnesses”;
3 (6) in subsection (i)(2)—

4 (A) in subparagraph (B)—

5 (i) by redesignating clauses (i), (ii),
6 and (iii) as subclauses (I), (II), and (III),
7 and adjusting the margins accordingly;

8 (ii) in the matter preceding subclause
9 (I), as so redesignated, by striking “shall
10 give priority to applications that—” and
11 inserting the following: “shall give priority
12 to—

13 “(i) applications that—”; and

14 (iii) by striking the period at the end
15 and inserting the following: “; and

16 “(ii) applications to establish or ex-
17 pand veterans treatment court programs
18 that—

19 “(I) allow participation by a vet-
20 eran receiving any type of medication-
21 assisted treatment that involves the
22 use of any drug or combination of
23 drugs that have been approved under
24 the Federal Food, Drug, and Cos-
25 metic Act (21 U.S.C. 301 et seq.) or

1 section 351 of the Public Health Serv-
2 ice Act (42 U.S.C. 262) for the treat-
3 ment of an opioid use disorder;

4 “(II) follow the Adult Drug
5 Court Best Practice Standards pub-
6 lished by the National Association of
7 Drug Court Professionals; and

8 “(III) provide culturally com-
9 petent (as defined in section 102 of
10 the Developmental Disabilities Assist-
11 ance and Bill of Rights Act of 2000
12 (42 U.S.C. 15002)) services.”; and

13 (B) by adding at the end the following:

14 “(C) DISCLOSURE AND REPORTING RE-
15 QUIREMENTS.—

16 “(i) REQUIREMENTS FOR VETERANS
17 TREATMENT COURT PROGRAM GRANT-
18 EES.—An applicant that receives a grant
19 under this subsection to establish or ex-
20 pand a veterans treatment court program
21 shall—

22 “(I) disclose to the Attorney
23 General any contract or relationship
24 between the applicant and a local
25 treatment provider;

1 “(II) track and report to the At-
2 torney General the number of refer-
3 rals to local treatment providers pro-
4 vided by the program; and

5 “(III) track and report to the At-
6 torney General, with respect to each
7 participant in the program—

8 “(aa) each charge brought
9 against the participant;

10 “(bb) the demographics of
11 the participant; and

12 “(cc) the outcome of the
13 participant’s case.

14 “(ii) ATTORNEY GENERAL REPORT.—
15 The Attorney General shall periodically
16 submit to Congress a report containing the
17 information reported to the Attorney Gen-
18 eral under clause (i).

19 “(D) SENSE OF CONGRESS REGARDING
20 VETERANS TREATMENT COURT PROGRAMS.—It
21 is the sense of Congress that a veterans treat-
22 ment court program that receives funding from
23 a grant under this subsection should not ex-
24 clude individuals who are chronically exposed to
25 the criminal justice system.”;

1 (7) in subsection (j)—

2 (A) in paragraph (1), by inserting “or sub-
3 stance use disorders” after “mental illness”;
4 and

5 (B) in paragraph (2)(A), by inserting “or
6 substance use disorders” after “mental ill-
7 nesses”;

8 (8) in subsection (k)(3)(A)(i)(I)(aa), by insert-
9 ing “ or substance use disorders” after “mental ill-
10 nesses”;

11 (9) in subsection (l)—

12 (A) in paragraph (1)(B)(ii), by inserting
13 “or substance use disorder” after “mental ill-
14 ness” each place that term appears; and

15 (B) in paragraph (2)—

16 (i) in subparagraph (C)(iii), by insert-
17 ing “or substance use” after “mental
18 health”; and

19 (ii) in subparagraph (D), by striking
20 “mental health or” and inserting “mental
21 health disorders, substance use disorders,
22 or”; and

23 (10) in subsection (o)(3)—

24 (A) by striking “LIMITATION” and insert-
25 ing “VETERANS”;

1 (B) by striking “Not more than” and in-
 2 serting the following:

3 “(A) LIMITATION.—Not more than”;

4 (C) in subparagraph (A), as so designated,
 5 by striking “this section” and inserting “para-
 6 graph (1)”; and

7 (D) by adding at the end the following:

8 “(B) ADDITIONAL FUNDING.—In addition
 9 to the amounts authorized under paragraph (1),
 10 there are authorized to be appropriated to the
 11 Department of Justice to carry out subsection
 12 (i) \$20,000,000 for each of fiscal years 2022
 13 through 2026.”.

14 **SEC. 405. INFRASTRUCTURE FOR REENTRY.**

15 (a) COMMUNITY ECONOMIC DEVELOPMENT
 16 GRANTS.—Section 680(a)(2) of the Community Services
 17 Block Grant Act (42 U.S.C. 9921(a)(2)) is amended—

18 (1) in subparagraph (A)—

19 (A) by striking “to private, nonprofit orga-
 20 nizations that are community development cor-
 21 porations” and inserting the following: “to—

22 “(i) private, nonprofit community de-
 23 velopment corporations”;

24 (B) by striking the period at the end and
 25 inserting “; or”; and

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

2 “(ii) community development corpora-
3 tions described in clause (i), or partner-
4 ships between such a corporation and an-
5 other private, nonprofit entity, to fund and
6 oversee the construction of facilities for
7 treatment of mental and substance use dis-
8 orders, supportive housing, or of re-entry
9 centers, that are not jails, prisons, or other
10 correctional facilities.”;

11 (2) in subparagraph (C)—

12 (A) by inserting “or partnership” after
13 “corporation” each place it appears;

14 (B) by striking “principal purpose plan-
15 ning” and inserting “principal purpose—

16 “(i) planning”;

17 (C) by striking the period at the end and
18 inserting “; or”; and

19 “(ii) planning or constructing facilities
20 for crisis intervention, treatment of mental
21 and substance use disorders, supportive
22 housing, or of re-entry centers.”; and

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

24 “(F) DEFINITION.—In this paragraph, the
25 term ‘crisis intervention’ means the provision of

1 immediate, short-term assistance to individuals
2 who are experiencing acute emotional, mental,
3 physical, and behavioral distress or problems
4 using a ‘one-stop’ model.”.

5 (b) CDBG ASSISTANCE FOR CONSTRUCTION OF SUB-
6 STANCE ABUSE AND MENTAL HEALTH TREATMENT FA-
7 CILITIES, SUPPORTIVE HOUSING, AND REENTRY CEN-
8 TERS.—Section 105(a) of the Housing and Community
9 Development Act of 1974 (42 U.S.C. 5305(a)) is amend-
10 ed—

11 (1) in paragraph (25), by striking “and” at the
12 end;

13 (2) in paragraph (26), by striking the period at
14 the end and inserting “; and”; and

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

16 “(27) the construction of crisis intervention
17 centers, substance abuse and mental health treat-
18 ment facilities, supportive housing, and reentry cen-
19 ters.”.

20 (c) COMMUNITIES FACILITIES LOAN AND GRANT
21 PROGRAMS.—Section 306(a) of the Consolidated Farm
22 and Rural Development Act (7 U.S.C. 1926(a)) is amend-
23 ed—

24 (1) by inserting after paragraph (6) the fol-
25 lowing:

1 “(7) PROHIBITION ON USE OF LOANS FOR CER-
2 TAIN PURPOSES.—No loan made or insured under
3 this subsection shall be used to support the con-
4 struction, renovation, equipment purchasing, oper-
5 ation, staffing, or any other function of a jail, pris-
6 on, detention center, or other correctional facility.”;
7 and

8 (2) in paragraph (19), by adding at the end the
9 following:

10 “(C) PROHIBITION ON USE OF GRANTS
11 FOR CERTAIN PURPOSES.—No grant made
12 under this paragraph shall be used to support
13 the construction, renovation, equipment pur-
14 chasing, operation, staffing, or any other func-
15 tion of a jail, prison, detention center, or other
16 correctional facility.

17 “(D) INCLUSION OF CERTAIN INFRA-
18 STRUCTURE FOR REENTRY.—In this paragraph,
19 the terms ‘essential community facility’ and ‘fa-
20 cility’ include a crisis intervention center, sub-
21 stance abuse or mental health treatment facil-
22 ity, a supportive housing facility, and a reentry
23 center.”.

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