I

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

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''CARA 3.0 Act of 2021''.

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

SEC. 2. FINDINGS.

Congress finds as follows:

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

(2) The combination of a rising number of prescriptions, misinformation about the addictive properties of prescription opioids, and the perception that prescription drugs are less harmful than illicit drugs has caused an increase in drug misuse.

(3) As legitimate production and illegal diversion of opioids skyrocketed, so did the number of opioid overdose deaths. From 1999 to 2017, almost 218,000 people died in the United States from overdoses related to prescription opioids. More recently, fentanyl, a powerful synthetic opioid, surpassed prescription opioids as the most lethal overdose substance and now is linked to nearly 3 times as many deaths.

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

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

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

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

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

(5) The opioid crisis has also led to a cascade of other negative health impacts. For example, syringe sharing among people who inject drugs has led

to increases in hepatitis C virus infections and infective endocarditis, as well as localized HIV outbreaks.

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

(A) The majority of people in the United States with an opioid use disorder do not receive substance use treatment, and many who do receive such treatment do not receive evidence-based treatment. Although medication-assisted treatment has been endorsed by the National Institutes of Health and the World Health Organization, only one-third of treatment programs offer any of the 3 drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, and just 6 percent of medication-offering facilities provide all 3.

(B) Facilities that provide medications for the treatment of opioid disorder are concentrated in the Northeast and Southwest, leaving many of the areas hit hardest by the opioid crisis without access to evidence-based treatment. The need is particularly acute in rural areas, which often do not have enough providers to meet the demand.

(C) Unlike other health care needs, substance use treatment is largely funded by State and local revenues and Federal block grants, rather than the Medicare program, the Medicaid program, and private insurance.

(D) While new substances, particularly synthetic drugs, continue to make inroads into communities in the United States, funding streams are often dedicated to particular substances, limiting providers' ability to adapt to changing needs.

(E) The stigma associated with substance use disorder prevents people from seeking treatment. Too often, people enter substance use treatment only after committing a criminal offense, whether through a court mandate, as a condition of parole or probation supervision, or as a condition of regaining employment after conviction. In 2003, 36 percent of all substance use treatment admissions, 40 percent of all alcohol abuse treatment admissions, and 57 percent of all marijuana use treatment admissions were referrals from the criminal justice system.

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

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

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

(8) Inadequate access to substance use treatment can exacerbate other health disparities. Individuals with substance use disorders have higher rates of suicide attempts than individuals in the general population, high health care expenses, and significant disability.

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

TITLE I—EDUCATION, PREVENTION, AND RESEARCH

SEC. 101. NATIONAL EDUCATION CAMPAIGN.

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

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

(2) in subsection (b), by striking ''opioid'' each place it appears and inserting ''substance'';

(3) in subsection (c)—

(A) in paragraph (2), by striking ''and'' at the end;

(B) in paragraph (3), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(4) use destigmatizing language promoting humane and culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)) treatment of all individuals who experience substance use disorder, including such individuals who use medication-assisted treatment for recovery purposes;

''(5) educate stakeholders on the evidence base and validation of harm reduction and where to obtain harm reduction services;

''(6) include information about polysubstance use; and

''(7) include information about prevention and treatment using medication-assisted treatment and recovery support.''; and

(4) by adding at the end the following:

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

SEC. 102. RESEARCH INTO NON-OPIOID PAIN MANAGEMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health and the Director of the Centers for Disease Control and Prevention, shall carry out research with respect to non-opioid methods of pain management, including non-pharmaceutical remedies for pain and integrative medicine solutions.

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

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

SEC. 103. LONG-TERM TREATMENT AND RECOVERY SUPPORT SERVICES RESEARCH.

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

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

(1) measure—

(A) mortality and morbidity;

(B) physical and emotional health;

(C) employment;

(D) stable housing;

(E) criminal justice involvement;

(F) family relationships; and

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

(2) distinguish long-term outcomes based on—

(A) race;

(B) gender;

(C) socioeconomic status; and

(D) other relevant characteristics.

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

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

(a) ESTABLISHMENT.—The Assistant Secretary of Health and Human Services for Mental Health and Substance Use (referred to in this section as the ''Assistant Secretary''), in consultation with the Director of the Office of National Drug Control Policy, and the President of the National Academy of Medicine, shall establish an advisory commission to be known as the National Commission for Excellence on Post-Overdose Response (in this section referred to as the ''Commission'').

(b) DUTIES.—The Commission shall—

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

(A) researchers and evaluators;

(B) clinicians and clinical teams;

(C) quality improvement experts; and

(D) healthcare decision makers;

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

(A) achieving equitable outcomes with respect to race and socioeconomic status; and

(B) effectively and appropriately reducing the rate of—

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

(ii) emergency department admissions; and

(iii) other adverse events related to care for individuals described in such paragraph; and

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

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

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

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

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

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

(5) a substance use disorder specialist appointed by the Assistant Secretary;

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

(7) an individual with experience in harm reduction; and

(8) any other individual that the Assistant Secretary determines appropriate.

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

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

(a) EMPLOYMENT AND TRAINING SERVICES.—Subpart 2 of part B of title V of the Public Health Service

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

"SEC. 519E. EMPLOYMENT AND TRAINING SERVICES.

"(a) IN GENERAL.—The Director of the Prevention Center shall—

"(1) beginning not later than 30 days after the date of enactment of this Act, award grants or enter into contracts with eligible entities to support employment and training services for substance use treatment professionals, including peer recovery specialists; and

"(2) subject to the availability of funds appropriated pursuant to subsection (d), not later than 45 days after the date on which an entity submits an application that meets the requirements of the Secretary under this section, award funds under this section to such entity.

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

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

tivities related to retention of substance use treatment professionals.

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

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

(1) in the matter preceding paragraph (1), by striking ''$50,000,000'' and inserting ''$55,000,000''; and

(2) by adding at the end the following:

''(5) For continuing education and other activities to increase retention and to strengthen the substance use disorder workforce, $5,000,000.''.

SEC. 106. REAUTHORIZATION OF COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO ADDRESS LOCAL DRUG CRISES.

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

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

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

(1) in paragraph (2)(E), by inserting ", separate payments for non-opioid treatments under paragraph (16)(G), and" after "payments under paragraph (6) and"; and

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

"(G) ACCESS TO NON-OPIOID TREATMENTS FOR PAIN.—

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

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

''(I) a drug or biological product, the amount of payment for such drug or biological determined under section 1847A; or

''(II) a medical device, the amount of the hospital's charges for the device, adjusted to cost.

''(iii) DEFINITION OF NON-OPIOID TREATMENT.—A 'non-opioid treatment' means—

''(I) a drug or biological product that is indicated to produce analgesia without acting upon the body's opioid receptors; or

''(II) an implantable, reusable, or disposable medical device cleared or approved by the Administrator for Food and Drugs for the intended use of managing or treating pain;

that has demonstrated the ability to replace, reduce, or avoid opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer-reviewed journal.''.

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

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

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

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

"(vi) In the case of surgical services furnished on or after January 1, 2022, and before January 1, 2027, the payment system described in clause (i) shall provide, in a budget-neutral manner, for a separate payment for a non-opioid treatment (as defined in clause (iii) of subsection (t)(16)(G)) furnished as part of such services in the amount specified in clause (ii) of such subsection.".

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

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

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

(A) limitations, gaps, barriers to access, or deficits in coverage under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or reimbursement for restorative therapies, behavioral approaches, and complementary and integrative health services that—

(i) are identified by the Pain Management Best Practices Inter-Agency Task Force under section 101 of the Comprehensive Addiction and Recovery Act of 2016 (42 U.S.C. 201 note); and

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

(B) recommendations to address the limitations, gaps, barriers to access, or deficits identified under subparagraph (A) to improve such coverage and reimbursement for such therapies, approaches, and services.

(2) PUBLIC CONSULTATION.—In developing the report described in paragraph (1), the Secretary of Health and Human Services shall consult with appropriate 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

in the emergency room and other health care environments to connect people to clinical and community-based supports for substance use disorder.'';

(2) in subsection (d), by inserting '', and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act)'' before the period of the first sentence; and

(3) in subsection (f), by striking ''$25,000,000 for each of fiscal years 2017 through 2021'' and inserting ''$300,000,000 for each of fiscal years 2022 through 2026''.

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

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

(1) in subsection (m)—

(A) by striking ''that agrees to use'' and inserting ''that agrees—

''(1) to use'';

(B) by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(2) to—

''(A) allow participation in the program supported by the award by individuals taking a drug or combination of drugs approved by the Food and Drug Administration as a medication for addiction treatment, including such individuals taking an opioid agonist;

''(B) provide culturally competent services (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000);

''(C) ensure flexible lengths of stay in the treatment program; and

''(D) use peer recovery advocates in the program supported by the award.'';

(2) in subsection (p), by inserting '', and demographic data on the individuals served by programs funded under this section and case outcomes, as reported to the Director by award recipients'' before the period at the end of the third sentence; and

(3) in subsection (s), by striking ''$29,931,000 for each of fiscal years 2019 through 2023'' and inserting ''100,000,000 for each of fiscal years 2022 through 2026''.

SEC. 203. REQUIRE THE USE OF PRESCRIPTION DRUG MONITORING PROGRAMS.

(a) DEFINITIONS.—In this section:

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

(2) COVERED STATE.—The term ''covered State'' means a State that receives funding under the Harold Rogers Prescription Drug Monitoring Program established under the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2002 (Public Law 107–77; 115 Stat. 748), under this Act (or an amendment made by this Act), or under the controlled substance monitoring program under section 399O of the Public Health Service Act (42 U.S.C. 280g–3).

(3) DISPENSER.—The term ''dispenser''—

(A) means a person licensed or otherwise authorized by a State to deliver a prescription drug product to a patient or an agent of the patient; and

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

(4) PDMP.—The term ''PDMP'' means a prescription drug monitoring program.

(5) PRACTITIONER.—The term ''practitioner'' means a practitioner registered under section 303(f) of the Controlled Substances Act (21 U.S.C. 823(f)) to prescribe, administer, or dispense controlled substances.

(6) STATE.—The term ''State'' means each of the several States and the District of Columbia.

(b) IN GENERAL.—Beginning 1 year after the date of enactment of this Act, each covered State shall require—

(1) each prescribing practitioner within the covered State or their designee, who shall be licensed or registered healthcare professionals or other employees who report directly to the practitioner, to consult the PDMP of the covered State before initiating treatment with a prescription for a controlled substance listed in schedule II, III, or IV of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)), and every 3 months thereafter as long as the treatment continues;

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

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

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

(4) that the PDMP make available a quarterly de-identified data set and an annual report for public and private use, including use by healthcare providers, health plans and health benefits administrators, State agencies, and researchers, which shall, at a minimum, meet requirements established by the Attorney General, in coordination with the Secretary of Health and Human Services;

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

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

(B) provide reports to prescriber licensing boards describing any prescribing practitioner that repeatedly fall outside of expected norms or standard practices for the prescribing practitioner's field; and

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

(c) NONCOMPLIANCE.—If a covered State fails to comply with subsection (a), the Attorney General or the Secretary of Health and Human Services may withhold grant funds from being awarded to the covered State under the Harold Rogers Prescription Drug Monitoring Program established under the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2002 (Public Law 107–77; 115 Stat. 748), under this Act (or an amendment made by this Act), or under the controlled substance monitoring program under section 399O of the Public Health Service Act (42 U.S.C. 280g–3).

SEC. 204. PRESCRIBER EDUCATION.

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

(1) in subsection (f), in the matter preceding paragraph (1), by striking ''The Attorney General shall register'' and inserting ''Subject to subsection (m), the Attorney General shall register''; and

(2) by adding at the end the following:

''(l) PRESCRIBER EDUCATION.—

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

"(A) the term 'covered agent or employee' means an agent or employee of a covered facility who—

"(i) prescribes controlled substances for humans under the registration of the facility under this part; and

"(ii) is a medical resident;

"(B) the term 'covered facility' means a practitioner—

"(i) that is a hospital or other institution;

"(ii) that is licensed under State law to prescribe controlled substances; and

"(iii) under whose registration under this part agents or employees of the practitioner prescribe controlled substances;

"(C) the term 'covered individual practitioner' means a practitioner who—

"(i) is an individual;

"(ii) is not a veterinarian; and

"(iii) is licensed under State law to prescribe controlled substances; and

"(D) the term 'specified continuing education topics' means—

"(i) alternatives to opioids for pain management;

"(ii) palliative care;

"(iii) substance use disorder;

"(iv) adverse events;

"(v) potential for dependence;

"(vi) tolerance;

"(vii) prescribing contraindicated substances;

"(viii) medication-assisted treatment;

"(ix) overdose prevention and response, including the administration of naloxone;

"(x) 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;

"(xi) bias and stigma in prescribing trends; and

"(xii) any other topic that the Attorney General determines appropriate.

"(2) CERTIFICATION OF CONTINUING EDUCATION.—

"(A) INDIVIDUAL PRACTITIONERS.—As a 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

an organization accredited by the Accreditation Council for Continuing Medical Education (commonly known as the 'ACCME'), or 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) EFFECTIVE DATE.—Subsection (l) of section 303 of the Controlled Substances Act (21 U.S.C. 823), as added by subsection (a), shall apply to any grant or renewal of registration described in such subsection (l) that occurs on or after the date that is 2 years after the date of enactment of this Act.

SEC. 205. PROHIBITION OF UTILIZATION CONTROL POLICIES OR PROCEDURES FOR MEDICATION-ASSISTED TREATMENT UNDER MEDICAID.

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

(1) in subsection (a)—

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

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

subsection'' after ''paragraph (1) of such subsection''; and

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

''(4) PROHIBITION OF UTILIZATION CONTROL POLICIES OR PROCEDURES FOR MEDICATION-ASSISTED TREATMENT.—As a condition for a State receiving payments under section 1903(a) for medical assistance for medication-assisted treatment, a State may not impose any utilization control policies or procedures (as defined by the Secretary), including prior authorization requirements, with respect to such treatment.''.

SEC. 206. MEDICATION-ASSISTED TREATMENT FOR RECOVERY FROM SUBSTANCE USE DISORDER.

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

(1) by striking paragraph (2);

(2) by striking ''(g)(1) Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment'' and inserting ''(g) Practitioners who dispense narcotic drugs (other than narcotic drugs in schedule III, IV, or V) to individuals

for maintenance treatment or detoxification treatment'';

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

(4) in paragraph (2), as redesignated, by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(b) TECHNICAL AND CONFORMING EDITS.—

(1) IN GENERAL.—

(A) Section 304 of the Controlled Substances Act (21 U.S.C. 824) is amended—

(i) in subsection (a), by striking ''303(g)(1)'' each place it appears and inserting ''303(g)''; and

(ii) in subsection (d)(1), by striking ''303(g)(1)'' and inserting ''303(g)''.

(B) Section 309A(a) of the Controlled Substances Act (21 U.S.C. 829a(a)) is amended by striking paragraph (2) and inserting the following:

''(2) the controlled substance—

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

''(B) is to be administered by injection or implantation;''.

(C) Section 520E–4(c) of the Public Health Service Act (42 U.S.C. 290bb–36d(c)) is amended, in the matter preceding paragraph (1), by striking ''information on any qualified practitioner that is certified to prescribe medication for opioid dependency under section 303(g)(2)(B) of the Controlled Substances Act'' and inserting ''information on any practitioner who prescribes narcotic drugs in schedule III, IV, or V of section 202 of the Controlled Substances Act for the purpose of maintenance or detoxification treatment''.

(D) Section 544(a)(3) of the Public Health Service Act (42 U.S.C. 290dd–3) is amended by striking ''any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act'' and inserting ''any practitioner dispensing narcotic drugs for the purpose of maintenance or detoxification treatment''.

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

(F) Section 1834(o) of the Social Security Act (42 U.S.C. 1395m(o)) is amended by striking paragraph (3).

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

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

(ii) in subparagraph (B), by striking ''; and'' and inserting a period; and

(iii) by striking subparagraph (C).

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

(i) in clause (i), by inserting ''and'' at the end;

(ii) by striking clause (ii); and

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

(2) EFFECTIVE DATE OF MEDICARE AMENDMENTS.—The amendments made by subparagraphs (E) and (F) of paragraph (1) shall take effect one year after the date of enactment of this Act.

SEC. 207. TELEHEALTH RESPONSE FOR E-PRESCRIBING ADDICTION THERAPY SERVICES.

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

(b) TELEHEALTH FOR SUBSTANCE USE DISORDER TREATMENT.—

(1) SUBSTANCE USE DISORDER SERVICES FURNISHED THROUGH TELEHEALTH UNDER MEDICARE.—Section 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m(m)(7)) is amended by adding at the end the following: ''With respect to telehealth services described in the preceding sentence that are furnished on or after January 1, 2020, nothing shall preclude the furnishing of such services through audio or telephone only technologies in the case 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

from the patient and is communicating with the patient using a telecommunications system referred to in section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site practitioner.

''(ii) Nothing in clause (i) shall be construed to imply that 1 telehealth evaluation demonstrates that a prescription has been issued for a legitimate medical purpose within the usual course of professional practice.

''(iii) A practitioner who prescribes the drugs or combination of drugs that are covered under section 303(g)(2)(C) using the authority under subparagraph (A)(i)(II) of this paragraph shall adhere to nationally recognized evidence-based guidelines for the treatment of patients with opioid use disorders and a diversion control plan, as those terms are defined in section 8.2 of title 42, Code of Federal Regulations, as in effect on the date of enactment of this subparagraph.''.

SEC. 208. PILOT PROGRAM ON EXPANDING ACCESS TO TREATMENT.

The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a 5-year pilot program in not less than 5 diverse regions to study the use of mobile methadone clinics in rural and underserved environments. At the end of the pilot program, the Secretary shall report to Congress on the program outcomes, including the number of people served and the demographics of people served, including race and income.

SEC. 209. REAUTHORIZATION OF PRAC ED GRANT PROGRAM.

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

SEC. 210. GAO STUDY ON PARITY.

The Comptroller General of the United States shall conduct a study examining the reimbursement parity between substance use disorder services and other health care services, and the effect of any inequity in reimbursement with respect to substance use disorder services on the substance use disorder workforce, and not later than

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

SEC. 211. IMPROVING SUBSTANCE USE DISORDER PREVENTION WORKFORCE ACT.

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

"SEC. 519F. PILOT PROGRAM TO HELP ENHANCE SUBSTANCE USE DISORDER PREVENTION WORKFORCE.

''(a) IN GENERAL.—The Director of the Prevention Center (referred to in this section as the 'Director') shall develop a pilot program to assist State alcohol and drug agencies in addressing the substance use disorder prevention workforce needs in the States.

''(b) DEFINITIONS.—In this section, the term 'State alcohol and drug agency' means the State agency responsible for administering the substance abuse prevention and treatment block grant under subpart II of part B of title XIX.

''(c) APPLICATION.—A State alcohol and drug agency may apply to the Director for approval of a grant authorized in this section. Such application shall include a description of the proposed workforce activities that will be

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

''(1) enhancing or developing training curricula;

''(2) supporting or coordinating with institutes of higher education regarding curricula development;

''(3) partnering with elementary schools, middle schools, high schools or institutions of higher education to generate early student interest in avoiding misuse of substances;

''(4) enhancing or establishing initiatives related to credentialing or other certification processes recognized by the State alcohol and drug agency, including scholarships or support for certification costs and testing;

''(5) establishing or enhancing initiatives that promote recruitment, professional development, and access to education and training that increase the State's ability to address diversity, equity, and inclusion in the workforce, including communication initiatives or campaigns designed to draw interest in a career in substance use disorder prevention;

''(6) supporting loan repayment programs for individuals in the substance use disorder prevention workforce;

''(7) establishing or enhancing internships, fellowships and other career opportunities; and

''(8) retention initiatives that may include training, leadership development or other educational opportunities.

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

''SEC. 519G. NATIONAL STUDY ON SUBSTANCE USE DISORDER WORKFORCE.

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

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

''(2) challenges in maintaining support for an adequate substance use disorder prevention workforce and a plan to address such challenges; and

''(3) potential programming to help implement the plan.

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

holders, including organizations representing State alcohol and drug agencies, community anti-drug coalitions, workforce credentialing bodies, researchers, and others.

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

TITLE III—RECOVERY

Subtitle A—General Provisions

SEC. 301. BUILDING COMMUNITIES OF RECOVERY.

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

(1) by striking subsection (c);

(2) by redesignating subsection (d) as subsection (c);

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

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2)(C)(iv), by striking the period and inserting ''; and''; and

(C) by adding at the and the following:

''(3) may be used as provided for in subsection (d).'';

(4) by inserting after subsection (c) (as so redesignated), the following:

''(d) ESTABLISHMENT OF REGIONAL TECHNICAL ASSISTANCE CENTERS.—

''(1) IN GENERAL.—Grants awarded under subsection (b) may be used to provide for the establishment of regional technical assistance centers to provide regional technical assistance for the following:

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

''(B) Establishment of recovery community organizations.

''(C) Establishment of recovery community centers.

''(D) Naloxone training and dissemination.

''(E) Development of connections between recovery support services, community organizations, and community centers and the broader medical community.

''(F) Establishment of online recovery support services, with parity to physical health services.

''(G) Development of recovery wellness plans to address perceived barriers to recovery, including social determinants of health.

"(H) Collect and maintain accurate and reliable data to inform service delivery and monitor and evaluate the impact of culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000) services on health equity outcomes.

"(I) Building capacity for recovery community organizations to meet national accreditation standards for the delivery of peer recovery support services.

"(J) Expanding or enhancing recovery support service programs.

"(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant under paragraph (1), an entity shall be—

"(A) a national nonprofit entity with a network of local affiliates and partners that are geographically and organizationally diverse; or

"(B) a national nonprofit organization led by individuals in personal and family recovery with established networks of recovery community organizations providing peer recovery support services.

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

"(A) provide culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000) services, promote racial equity, and are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs;

"(B) allow participation by individuals receiving medication-assisted treatment that involves prescription drugs approved by the Food and Drug Administration (at least one of which is an opioid agonist);

"(C) use peer recovery advocates; and

"(D) meet national best practice and accreditation standards."; and

(5) in subsection (f), by striking "2023" and inserting "2021, and $200,000,000 for each of fiscal years 2022 through 2027".

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

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

tions, for the purposes of providing continuing care and ongoing community support for individuals to maintain recovery from substance use disorders.

(2) DEFINITION.—For purposes of this subsection, the term ''peer recovery support service organization'' means an independent nonprofit organization that provides peer recovery support services (as defined by the Secretary), through credentialed peer support professionals.

(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.

SEC. 302. RECOVERY IN THE WORKPLACE.

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

SEC. 303. NATIONAL YOUTH AND YOUNG ADULT RECOVERY INITIATIVE.

(a) DEFINITIONS.—In this section:

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

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

(B) an institution of higher education;

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

(D) a nonprofit organization; or

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

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

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

(4) RECOVERY PROGRAM.—The term ''recovery program'' means a program—

(A) to help youth or young adults who are recovering from substance use disorders to initiate, stabilize, and maintain healthy and productive lives in the community; and

(B) that includes peer-to-peer support delivered by individuals with lived experience in recovery, and communal activities to build recovery skills and supportive social networks.

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

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

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

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

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

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

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

(e) USE OF FUNDS.—Grants awarded under subsection (b) may be used for activities to develop, support, or maintain substance use recovery support services for youth or young adults, including—

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

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

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

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

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

(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 that reflect the communities they serve;

(B) providers of mental health services;

(C) primary care providers;

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

(E) employers;

(F) recovery housing services;

(G) child welfare services;

(H) high schools; and

(I) institutions of higher education;

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

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

(f) RESOURCE CENTER.—The Assistant Secretary for Mental Health and Substance Use shall establish a resource center to provide technical support to recipients of grants under this section.

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

Subtitle B—Recovery Housing

SEC. 311. CLARIFYING THE ROLE OF SAMHSA IN PROMOTING THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

(1) in paragraph (24)(E), by striking ''and'' at the end;

(2) in paragraph (25), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(26) collaborate with national accrediting entities and reputable providers and analysts of recovery housing services and all relevant Federal agencies, including the Centers for Medicare & Medicaid Serv-

ices, the Health Resources and Services Administration, other offices and agencies within the Department of Health and Human Services, the Office of National Drug Control Policy, the Department of Justice, the Department of Housing and Urban Development, and the Department of Agriculture, to promote the availability of high-quality recovery housing for individuals with a substance use disorder.''.

SEC. 312. DEVELOPING GUIDELINES FOR STATES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

''SEC. 550A. DEVELOPING GUIDELINES FOR STATES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

to promote the availability of high-quality recovery housing for individuals with a substance use disorder. Such guidelines shall—

''(1) be developed in consultation with national accrediting entities, reputable providers and analysts of recovery housing services, and States and be consistent with the best practices developed under section 550; and

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

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

''(c) EXCLUSION OF GUIDELINE ON TREATMENT SERVICES.—In developing the guidelines under subsection (a), the Secretary may not include any guideline or standard with respect to substance use disorder treatment services.

''(d) SUBSTANCE USE DISORDER TREATMENT SERVICES.—In this section, the term 'substance use disorder treatment services' means items or services furnished for the treatment of a substance use disorder, including—

''(1) medications approved by the Food and Drug Administration for use in such treatment, excluding each such medication used to prevent or treat a drug overdose;

''(2) the administering of such medications;

''(3) recommendations for such treatment;

''(4) clinical assessments and referrals;

''(5) counseling with a physician, psychologist, or mental health professional (including individual and group therapy); and

''(6) toxicology testing.''.

SEC. 313. COORDINATION OF FEDERAL ACTIVITIES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

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

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

''(e) COORDINATION OF FEDERAL ACTIVITIES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING FOR INDIVIDUALS WITH A SUBSTANCE USE DISORDER.—

"(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, and the Secretary of the Department of Housing and Urban Development shall convene and serve as the co-chairs of an interagency working group composed of representatives of each of the Federal agencies described in paragraph (2) (referred to in this section as the 'working group') for the following purposes:

"(A) To increase collaboration, cooperation, and consultation among such Federal agencies, with respect to promoting the availability of high-quality recovery housing.

"(B) To align the efforts of such agencies and avoid duplication of such efforts by such agencies.

"(C) To develop objectives, priorities, and a long-term plan for supporting State, Tribal, and local efforts with respect to the operation of high-quality recovery housing that is consistent with the best practices developed under this section.

"(D) To coordinate inspection and enforcement among Federal and State agencies.

"(E) To coordinate data collection on the quality of recovery housing.

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

''(A) The Department of Health and Human Services.

''(B) The Centers for Medicare & Medicaid Services.

''(C) The Substance Abuse and Mental Health Services Administration.

''(D) The Health Resources and Services Administration.

''(E) The Indian Health Service.

''(F) The Department of Housing and Urban Development.

''(G) The Department of Agriculture.

''(H) The Department of Justice.

''(I) The Office of National Drug Control Policy.

''(J) The Bureau of Indian Affairs.

''(K) The Department of Labor.

''(L) Any other Federal agency as the co-chairs determine appropriate.

''(3) MEETINGS.—The working group shall meet on a quarterly basis.

"(4) REPORTS TO CONGRESS.—Beginning not later than one year after the date of the enactment of this section and annually thereafter, the working group shall submit to the Committee on Energy and Commerce, the Committee on Ways and Means, the Committee on Agriculture, and the Committee on Financial Services of the House of Representatives and the Committee on Health, Education, Labor, and Pensions, the Committee on Agriculture, Nutrition, and Forestry, and the Committee on Finance of the Senate a report describing the work of the working group and any recommendations of the working group to improve Federal, State, and local policy with respect to recovery housing operations.

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

SEC. 314. NAS STUDY AND REPORT.

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

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

(1) the quality and effectiveness of recovery housing in the United States, including the availability in the United States of high-quality recovery housing and whether that availability meets the demand for such housing in the United States; and

(2) State, Tribal, and local regulation and oversight of recovery housing.

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

(1) examine the quality of, and effectiveness outcomes for, the types and characteristics of covered recovery housing programs listed in subsection (c); and

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

(c) TYPE AND CHARACTERISTICS.—The types and characteristics of covered recovery housing programs referred to in subsection (b) consist of the following:

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

(2) Private and public covered recovery housing.

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

(A) residents on a voluntary basis; and

(B) residents pursuant to a judicial order.

(4) Number of clients served, disaggregated to the extent possible by covered recovery housing serving—

(A) 6 or fewer recovering residents;

(B) 10 to 13 recovering residents; and

(C) 18 or more recovering residents.

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

(A) single room occupancy;

(B) 2 residents occupying 1 room; and

(C) more than 2 residents occupying 1 room.

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

(A) 30 days or fewer;

(B) 31 to 90 days;

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

(D) 6 months or more.

(7) Certification levels of staff.

(8) Fraudulent and abusive practices by operators of covered recovery housing and inpatient and outpatient treatment facilities, both individually and in concert, including—

(A) deceptive or misleading marketing practices, including—

(i) inaccurate outcomes-based marketing; and

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

(B) illegal patient brokering;

(C) third-party recruiters;

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

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

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

(1) completing the study under such subsection; and

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

(A) the results of the study;

(B) the National Academy's recommendations for Federal, State, and local policies to promote the availability of high-quality recovery housing in the United States;

(C) research and data gaps;

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

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

(F) recommendations to eliminate restrictions by recovery housing that exclude individuals who take prescribed medications for opioid use disorder; and

(G) a summary of allegations, assertions, or formal legal actions on the State and local levels by governments and nongovernmental organizations with respect to the opening and operation of recovery housing.

(e) DEFINITIONS.—In this subsection:

(1) The term ''covered recovery housing'' means recovery housing that utilizes compensated or volunteer onsite staff who are not health care professionals to support residents.

(2) The term ''effectiveness outcomes'' may include decreased substance use, reduced probability of relapse or reoccurrence, lower rates of incarceration, higher income, increased employment, and improved family functioning.

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

(4) The term ''recovery housing'' means a shared living environment that is or purports to be—

(A) free from alcohol and use of nonprescribed drugs; and

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

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

SEC. 315. FILLING RESEARCH AND DATA GAPS.

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

essary to fill the research and data gaps identified in reporting pursuant to such section.

SEC. 316. GRANTS FOR STATES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

''(f) GRANTS FOR IMPLEMENTING NATIONAL RECOVERY HOUSING BEST PRACTICES.—

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

''(A) for the provision of technical assistance by national accrediting entities and reputable providers and analysts of recovery housing services to implement the guidelines, nationally recognized standards, and recommendations developed under section 313 of the CARA 3.0 Act of 2021 and this section; and

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

substance use disorder and practices to maintain housing quality long term.

''(2) STATE ENFORCEMENT PLANS.—Beginning not later than 90 days after the date of the enactment of this paragraph and every 2 years thereafter, as a condition on the receipt of a grant under paragraph (1), each State (or political subdivisions thereof), Tribe, or territory receiving such a grant shall submit to the Secretary, and make publicly available on a publicly accessible Internet website of the State (or political subdivisions thereof), Tribe, or territory—

''(A) the plan of the State (or political subdivisions thereof), Tribe, or territory, with respect to the promotion of high-quality recovery housing for individuals with a substance use disorder located within the jurisdiction of such State (or political subdivisions thereof), Tribe, or territory; and

''(B) a description of how such plan is consistent with the best practices developed under this section and guidelines developed under section 550A.

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

rubric to evaluate accreditation, the accrediting entities providing technical assistance pursuant to paragraph (1)(A).

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

SEC. 317. REPUTABLE PROVIDERS AND ANALYSTS OF RECOVERY HOUSING SERVICES DEFINITION.

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

''(4) The term 'reputable providers and analysts of recovery housing services' means recovery housing service providers and analysts that—

''(A) use evidence-based approaches;

''(B) act in accordance with guidelines issued by the Assistant Secretary;

''(C) have not been found guilty of health care fraud, patient brokering, or false advertising by the Department of Justice, the Department of Health and Human Services, or a Medicaid Fraud Control Unit;

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

''(E) do not employ individuals with a past conviction of criminal, domestic, or sexual violence, or significant drug distribution, in the care or supervision of individuals.''.

SEC. 318. TECHNICAL CORRECTION.

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

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

(2) moving such section so it appears after section 550A, as added by section 312.

TITLE IV—CRIMINAL JUSTICE

SEC. 401. MEDICATION-ASSISTED TREATMENT CORRECTIONS AND COMMUNITY REENTRY PROGRAM.

(a) DEFINITIONS.—In this section—

(1) the term ''Attorney General'' means the Attorney General, acting through the Director of the National Institute of Corrections;

(2) the term ''certified recovery coach'' means an individual—

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

(B) who—

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

(I) a single State agency; or

(II) a recovery community organization that is capable of conducting that training and making that determination; and

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

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

(4) the term ''covered grant or cooperative agreement'' means a grant received, or cooperative agreement entered into, under the Program;

(5) the term ''covered program'' means a program—

(A) to provide medication-assisted treatment to individuals who have opioid use disorder and are incarcerated within the jurisdiction of the State or unit of local government carrying out the program; and

(B) that is developed, implemented, or expanded through a covered grant or cooperative agreement;

(6) the term ''medication-assisted treatment'' means the use of any drug or combination of drugs that have been approved under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) for the treatment of an opioid use disorder, in combination with evidence-based counseling and behavioral therapies, such as psychosocial counseling, overseen by 1 or more social work professionals and 1 or more qualified clinicians, to provide a comprehensive approach to the treatment of substance use disorders;

(7) the term ''nonprofit organization'' means an organization that is described in section 501(c)(3) of

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

(8) the term ''Panel'' means the medication-assisted treatment Corrections and Community Reentry Application Review Panel established under subsection (f)(2);

(9) the term ''participant'' means an individual who participates in a covered program;

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

(11) the term ''Program'' means the medication-assisted treatment Corrections and Community Reentry Program established under subsection (b);

(12) the term ''psychosocial'' means the interrelation of social factors and individual thought and behavior;

(13) the term ''recovery community organization'' has the meaning given the term in section 547 of the Public Health Service Act (42 U.S.C. 290ee–2);

(14) the term ''single State agency'' means, with respect to a State or unit of local government, the single State agency identified by the State, or the State in which the unit of local government is

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

(15) the term ''State'' means—

(A) each State of the United States;

(B) the District of Columbia; and

(C) each commonwealth, territory, or possession of the United States; and

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

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

(1) that shall be known as the ''medication-assisted treatment Corrections and Community Reentry Program''; and

(2) under which the Attorney General—

(A) may make grants to, and enter into cooperative agreements with, States or units of

local government to develop, implement, or expand 1 or more programs to provide medication-assisted treatment that meets the standard of care generally accepted for the treatment of opioid use disorder to individuals who have opioid use disorder and are incarcerated within the jurisdictions of the States or units of local government; and

(B) shall establish a working relationship with 1 or more knowledgeable corrections organizations with expertise in security, medical health, mental health, and substance use disorder care to oversee and support implementation of the program, including through the use of evidence-based clinical practices.

(c) USE OF FUNDS FOR INFRASTRUCTURE.—In developing, implementing, or expanding a medication-assisted treatment program under subsection (b)(2)(A), a State or unit of local government may use funds from a grant or cooperative agreement under that subsection to develop the infrastructure necessary to provide the medication-assisted treatment, such as—

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

(2) obtaining appropriate licenses for the individuals who will administer the treatment.

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

(1) develop culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)) medication-assisted treatment programs in consultation with nonprofit organizations and community organizations that are qualified to provide technical support for the programs;

(2) reduce the risk of overdose to participants after the participants are released from incarceration; and

(3) reduce the rate of reincarceration.

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

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

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

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

(3) shall use—

(A) screening tools with psychometric reliability and validity that provide useful clinical data to guide the long-term treatment of participants who have—

(i) opioid use disorder; or

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

(B) at each correctional facility at which the covered program is carried out, a sufficient number of personnel, as determined by the Attorney General in light of the number of individuals incarcerated at the correctional facility and the number of those individuals whom the correctional facility has screened and identified as having opioid use disorder, to—

(i) monitor participants with active opioid use disorder who begin participation 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 required under paragraph (1); and

(II) naloxone or any other emergency 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 partial agonist drugs used to treat opioid use disorder; and

(v) prepare a plan for release, including connecting participants with mental health and substance use treatment programs, medical care, public benefits, and housing; and

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

order to support the sustained recovery of participants, shall work with participants who are recovering from opioid use disorder.

(f) APPLICATION.—

(1) IN GENERAL.—A State or unit of local government desiring a covered grant or cooperative agreement shall submit to the Attorney General an application that—

(A) shall include—

(i) a description of—

(I) the objectives of the medication-assisted treatment program that the applicant will develop, implement, or expand under the covered grant or cooperative agreement;

(II) the activities that the applicant will carry out under the covered program;

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

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

order to encourage maximum participation in the covered program; and

(V) how the applicant will develop connections to culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)) substance use and mental health treatment providers, medical professionals, nonprofit organizations, and other State agencies in order to plan for participants to receive a continuum of care and appropriate wrap-around services after release from incarceration;

(ii) if, under the covered program that the applicant will carry out, the applicant will not, in providing medication-assisted treatment, offer to participants not less than 1 drug that uses an opioid antagonist, not less than 1 drug that uses an opioid agonist, and not less than 1 drug that uses an opioid partial agonist, an explanation of why the applicant is unable to or chooses not to offer a drug that uses an

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

(iii) a plan for—

(I) measuring progress in achieving the objectives described in clause (i)(I), including a strategy to collect data that can be used to measure that progress;

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

(aa) if participants so desire, participants have continuity of care after release from incarceration with respect to the form of medication-assisted treatment the participants received during incarceration, including—

(AA) by working with community service providers to assist eligible participants, before release from

incarceration in registering for the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or other minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Code of 1986; and

(BB) if a participant cannot afford, or does not qualify for, health insurance that provides coverage with respect to enrollment in a medication-assisted treatment program, and if the participant cannot pay the cost of enrolling in a medication-assisted treatment program, by working with units of local government, nonprofit organizations, opioid use disorder treatment providers, and entities carrying out programs under

substance use disorder grants to, before the participant is released from incarceration, identify a resource, other than the applicant or the covered program to be carried out by the applicant, that may be used to pay the cost of enrolling the participant in a medication-assisted treatment program;

(bb) medications are securely stored; and

(cc) protocols relating to diversion are maintained; and

(III) with respect to each community in which a correctional facility at which a covered program will be carried out is located, collaborating with State agencies responsible for overseeing programs relating to substance use disorder and local public health officials and nonprofit organizations in the community to help ensure that medication-assisted treat-

ment provided at each correctional facility at which the covered program will be carried out is also available at locations that are not correctional facilities in those communities, to the greatest extent practicable; and

(iv) a certification that—

(I) each correctional facility at which the covered program will be carried out has access to a sufficient number of clinicians who are licensed to prescribe or otherwise dispense to participants the drugs for the treatment of opioid use disorder required to be offered under subsection (e)(1), which may include clinicians who use telemedicine, in accordance with regulations issued by the Administrator of the Drug Enforcement Administration, to provide services under the covered program; and

(II) the covered program will provide culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill

of Rights Act of 2000 (42 U.S.C. 15002)) evidence-based counseling and behavioral therapies, which may include counseling and therapy administered through the use of telemedicine, as appropriate, to participants as part of the medication-assisted treatment provided under the covered program; and

(B) may include a statement indicating the number of participants that the applicant expects to serve through the covered program.

(2) MEDICATION-ASSISTED TREATMENT CORRECTIONS AND COMMUNITY REENTRY APPLICATION REVIEW PANEL.—

(A) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Attorney General shall establish a Medication-Assisted Treatment Corrections and Community Reentry Application Review Panel that shall—

(i) be composed of not fewer than 10 individuals and not more than 15 individuals; and

(ii) include—

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

(aa) the Department of Justice;

(bb) the Substance Abuse and Mental Health Service Administration;

(cc) the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention; and

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

(II) other stakeholders who—

(aa) have expert knowledge relating to the opioid epidemic, drug treatment, health equity, culturally competent (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)) care, or community substance use disorder services; and

(bb) represent law enforcement organizations and public health entities.

(B) DUTIES.—

(i) IN GENERAL.—The Panel shall—

(I) review and evaluate applications for covered grants and cooperative agreements; and

(II) make recommendations to the Attorney General relating to the awarding of covered grants and cooperative agreements.

(ii) RURAL COMMUNITIES.—In reviewing and evaluating applications under clause (i), the Panel shall take into consideration the unique circumstances, including the lack of resources relating to the treatment of opioid use disorder, faced by rural States and units of local government.

(C) TERMINATION.—The Panel shall terminate on the last day of fiscal year 2023.

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

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

(A) the process through which applications submitted under paragraph (1) shall be submitted and evaluated; and

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

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

(h) REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date on which a State or unit of local government is awarded a covered grant or cooperative agreement, and each year thereafter until the date that is 1 year after the date on which the period of the covered grant or cooperative agreement ends, the State or unit of local government shall submit a report to the Attorney General that includes information relating to the covered program carried out by

the State or unit of local government, including information relating to—

(A) the goals of the covered program;

(B) any evidence-based interventions carried out under the covered program;

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

(i) be reported in a manner that distinguishes the outcomes based on the categories of, with respect to the participants in the covered program—

(I) the race of the participants; and

(II) the gender of the participants; and

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

(D) expenditures under the covered program.

(2) PUBLICATION.—

(A) AWARDEE.—A State or unit of local government that submits a report under paragraph (1) shall make the report publicly available on—

(i) the website of each correctional facility at which the State or unit of local government carried out the covered grant program; and

(ii) if a correctional facility at which the State or unit of local government carried out the covered grant program does not operate a website, the website of the State or unit of local government.

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

(3) SUBMISSION TO CONGRESS.—Not later than 2 years after the date on which the Attorney General awards the first covered grant or cooperative agreement, and each year thereafter, the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a summary and compilation of the reports that the Attorney General has received under paragraph (1) during the year preceding the date on which the Attorney General submits the summary and compilation.

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

SEC. 402. DEFLECTION AND PRE-ARREST DIVERSION.

(a) FINDINGS.—Congress finds the following:

(1) Law enforcement officers and other first responders are at the front line of the opioid epidemic. However, a traditional law enforcement response to substance use often fails to disrupt the cycle of addiction and arrest, or reduce the risk of overdose.

(2) Law enforcement-assisted deflection and diversion programs have the potential to improve public health, decrease the number of people entering the criminal justice system for low-level offenses, and address racial disparities.

(3) According to the Bureau of Justice Assistance of the Department of Justice, ''Five pathways have been most commonly associated with opioid overdose prevention and diversion to treatment.'' The 5 pathways are—

(A) ''self-referral'', in which—

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

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

(ii) the first responder personally introduces the individual to a treatment provider (commonly known as a ''warm handoff'');

(B) ''active outreach'', in which a law enforcement officer or other first responder—

(i) identifies or seeks out individuals in need of substance use disorder treatment; and

(ii) makes a warm handoff of such an individual to a treatment provider, who engages the individual in treatment;

(C) ''naloxone plus'', in which a law enforcement officer or other first responder engages an individual in treatment as a follow-up to an overdose response;

(D) ''officer prevention referral'', in which a law enforcement officer or other first responder initiates treatment engagement with an individual, but no criminal charges are filed against the individual; and

(E) ''officer intervention referral'', in which—

(i) a law enforcement officer or other first responder initiates treatment engagement with an individual; and

(ii)(I) criminal charges are filed against the individual and held in abeyance; or

(II) a citation is issued to the individual.

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

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

(1) in subsection (a)(1)(E), by inserting before the period at the end the following: '', including law enforcement-assisted deflection programs and law enforcement-assisted pre-arrest and pre-booking diversion programs (as those terms are defined in subsection (h))''; and

(2) by adding at the end the following:

"(h) LAW ENFORCEMENT-ASSISTED DEFLECTION PROGRAMS AND LAW ENFORCEMENT-ASSISTED PRE-ARREST AND PRE-BOOKING DIVERSION PROGRAMS.—

"(1) DEFINITIONS.—In this subsection:

"(A) COVERED GRANT.—The term 'covered grant' means a grant for a deflection or diversion program awarded under subsection (a)(1)(E).

"(B) DEFLECTION OR DIVERSION PROGRAM.—The term 'deflection or diversion program' means a law enforcement-assisted deflection program or a law enforcement-assisted pre-arrest or pre-booking diversion, including a program under which—

"(i) an individual voluntarily initiates contact with a first responder for a substance use disorder or mental health treatment referral without fear of arrest and receives a warm handoff to such treatment;

"(ii) a law enforcement officer or other first responder identifies or seeks out individuals in need of substance use disorder or mental health treatment and a warm handoff is made to a treatment pro-

vider, who engages the individuals in treatment;

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

''(iv) a law enforcement officer or other first responder initiates substance use disorder or mental health treatment engagement, but no criminal charges are filed;

''(v) a law enforcement officer or other first responder initiates substance use disorder or mental health treatment engagement with an individual; or

''(vi) charges are filed against an individual who has committed an offense that is not a crime against a person, and the primary cause of which appears to be based on a substance use disorder or mental health disorder and held in abeyance or a citation is issued to such an individual.

''(C) LAW ENFORCEMENT-ASSISTED DEFLECTION PROGRAM.—The term 'law enforcement-assisted deflection program' means a pro-

gram under which a law enforcement officer, when encountering an individual who is not engaged in criminal activity but appears to have a substance use disorder or mental health disorder, instead of taking no action at the time of contact or taking action at a later time, attempts to connect the individual to substance use disorder treatment providers or mental health treatment providers—

''(i) without the use of coercion or fear of arrest; and

''(ii) using established pathways for connections to local, community-based treatment.

''(D) LAW ENFORCEMENT-ASSISTED PRE-ARREST OR PRE-BOOKING DIVERSION PROGRAM.—The term 'law enforcement-assisted pre-arrest or pre-booking diversion program' means a program—

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

health disorder of the individual, instead of arresting the individual, or instead of booking the individual after having arrested the individual, attempts to connect the individual to substance use disorder treatment providers or mental health treatment providers—

''(I) without the use of coercion; and

''(II) using established pathways for connections to local, community-based treatment;

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

''(I) issue a civil citation; or

''(II) take no action with respect to the offense for which the officer would otherwise have arrested the individual described in clause (i); and

''(iii) that may authorize a law enforcement officer to refer an individual to substance use disorder treatment providers or mental health treatment providers if the individual appears to have a substance use

disorder or mental health disorder and the officer suspects the individual of chronic violations of law but lacks probable cause to arrest the individual (commonly known as a 'social contact referral').

''(2) SENSE OF CONGRESS REGARDING DEFLECTION OR DIVERSION PROGRAMS.—It is the sense of Congress that a deflection or diversion program funded under this subpart should not exclude individuals who are chronically exposed to the criminal justice system.

''(3) REPORTS TO ATTORNEY GENERAL.—Not later than 2 years after the date on which a State or unit of local government is awarded a covered grant, and each year thereafter until the date that is 1 year after the date on which the period of the covered grant ends, the State or unit of local government shall submit a report to the Attorney General that includes information relating to the deflection or diversion program carried out by the State or unit of local government, including information relating to—

''(A) the goals of the deflection or diversion program;

''(B) any evidence-based interventions carried out under the deflection or diversion program;

''(C) outcomes of the deflection or diversion program, which shall—

''(i) be reported in a manner that distinguishes the outcomes based on the categories of, with respect to the participants in the deflection or diversion program—

''(I) the race of the participants; and

''(II) the gender of the participants; and

''(ii) include information relating to the rate of reincarceration among participants in the deflection or diversion program, if available; and

''(D) expenditures under the deflection or diversion program.''.

(c) TECHNICAL ASSISTANCE GRANT PROGRAM.—

(1) DEFINITIONS.—In this subsection—

(A) the term ''deflection or diversion program'' has the meaning given the term in subsection (h) of section 501 of title I of the Omnibus Crime Control and Safe Streets Act of

1968 (34 U.S.C. 10152), as added by subsection (b); and

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

(2) GRANT AUTHORIZED.—The Attorney General shall award a single grant to an entity with significant experience in working with law enforcement agencies, community-based treatment providers, and other community-based human service providers to develop or administer both deflection and diversion programs that use each of the 5 pathways described in subsection (a)(3), to promote and maximize the effectiveness and racial equity of deflection or diversion programs, in order to—

(A) help State and units of local government launch and expand deflection or diversion programs;

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

(i) recommendations on community input and engagement in order to implement deflection or diversion programs as

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

(I) law enforcement agencies;

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

(III) the recovery community; and

(IV) the community at-large; and

(ii) the implementation of metrics to measure community satisfaction concerning the meaningful participation and interaction of the community with the deflection or diversion program and program stakeholders;

(C) develop and publish a training and technical assistance tool kit for deflection or diversion for public education purposes;

(D) disseminate uniform criteria and standards for the delivery of deflection or diversion program services; and

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

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

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Attorney General $30,000,000 for the grant under paragraph (2).

SEC. 403. HOUSING.

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

''(a) INELIGIBILITY OF ILLEGAL DRUG USERS AND ALCOHOL ABUSERS.—Notwithstanding any other provision of law, a public housing agency or an owner of federally assisted housing, as determined by the Secretary, may only prohibit admission to the program or admission to federally assisted housing for an individual whom the public housing agency or owner determines is illegally using a controlled substance or abusing alcohol if—

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

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

''(2) the individual is not participating in a substance use disorder assessment and treatment.

''(b) AUTHORITY TO DENY ADMISSION TO CRIMINAL OFFENDERS.—

''(1) IN GENERAL.—Except as provided in subsection (a), in addition to any other authority to screen applicants, and subject to paragraphs (2) and (3) of this subsection, a public housing agency or an owner of federally assisted housing may only prohibit admission to the program or to federally assisted housing for an individual based on criminal activity of the individual if the public housing agency or owner determines that the individual, during a reasonable time preceding the date on which the individual would otherwise be selected for admission, was convicted of a crime involving conduct that threatens the health or safety of other residents.

''(2) EXCEPTIONS AND LIMITATIONS.—A conviction that has been vacated, a conviction the record of which has been sealed or expunged, or a conviction for a crime committed by an individual when the individual was less than 18 years of age,

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

''(3) ADMISSION POLICY.—

''(A) FACTORS TO CONSIDER.—In evaluating the criminal history of an individual under paragraph (1), a public housing agency or an owner of federally assisted housing shall consider—

''(i) whether an offense of which the individual was convicted bears a relationship to the safety and security of other residents;

''(ii) the level of violence, if any, of an offense of which the individual was convicted;

''(iii) the length of time since a conviction;

''(iv) the number of convictions;

''(v) if the individual is in recovery for a substance use disorder, whether the individual was under the influence of alcohol or illegal drugs at the time of an offense; and

''(vi) any rehabilitation efforts that the individual has undertaken since the

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

''(B) WRITTEN POLICY.—A public housing agency or an owner of federally assisted housing shall establish and make available to applicants a written admission policy that enumerates the specific factors, including the factors described in subparagraph (A), that will be considered when the public housing agency or owner evaluates the criminal history of an individual under paragraph (1).''.

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

SEC. 404. VETERANS TREATMENT COURTS.

Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10651) is amended—

(1) in subsection (a)—

(A) in paragraph (2)—

(i) in the matter preceding subparagraph (A)—

(I) by inserting ‘‘, substance use disorder,’’ after ‘‘mental health’’; and

(II) by inserting ‘‘or adults or juveniles with substance use disorders’’ after ‘‘mentally ill adults or juveniles’’;

(ii) in subparagraph (A), by inserting ‘‘or substance use’’ after ‘‘mental health’’; and

(iii) in subparagraph (B), by inserting ‘‘or substance use’’ after ‘‘mental health’’;

(B) in paragraph (4)—

(i) in subparagraph (A), by inserting ‘‘or substance use disorder’’ after ‘‘mental health’’; and

(ii) in subparagraph (C), by inserting ‘‘or offenders with substance use disorders’’ after ‘‘mentally ill offenders’’;

(C) in paragraph (5)—

(i) in the heading, by inserting ‘‘OR SUBSTANCE USE DISORDER’’ after ‘‘MENTAL HEALTH’’;

(ii) by striking ‘‘mental health agency’’ and inserting ‘‘mental health or substance use agency’’; and

(iii) by inserting ", substance use services," after "mental health services";

(D) in paragraph (9)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) in subclause (I), by inserting ", a substance use disorder," after "a mental illness"; and

(bb) in subclause (II), by inserting ", substance use disorder," after "mental illness"; and

(II) in clause (ii)(II), by inserting "or substance use" after "mental health";

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

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

"(11) SUBSTANCE USE COURT.—The term 'substance use court' means a judicial program that meets the requirements of part EE of this title.";

(2) in subsection (b)—

(A) in paragraph (2)—

(i) in subparagraph (A), by inserting ‘‘, substance use courts,’’ after ‘‘mental health courts’’;

(ii) in subparagraph (B)—

(I) by inserting ‘‘mental health disorders, substance use disorders, or’’ before ‘‘co-occurring mental illness and substance use problems’’; and

(II) by striking ‘‘illnesses’’ and inserting ‘‘disorders, illnesses, or problems’’;

(iii) in subparagraph (C)—

(I) in the matter preceding clause (i)—

(aa) by striking ‘‘mental health agencies’’ and inserting ‘‘mental health or substance use agencies’’; and

(bb) by striking ‘‘and, where appropriate,’’ and inserting ‘‘or’’; and

(II) in clause (i), by inserting ‘‘, substance use disorders,’’ after ‘‘mental illness’’; and

(iv) in subparagraph (D), by inserting ''or offender with a substance use disorder'' after ''mentally ill offender''; and

(B) in paragraph (5)—

(i) in subparagraph (B)—

(I) in clause (i)—

(aa) by inserting ''or substance use court'' after ''mental health court''; and

(bb) by striking ''mental health agency'' and inserting ''mental health or substance use agency''; and

(II) in clause (ii), by striking ''and substance use services for individuals with co-occurring mental health and substance use disorders'' and inserting ''or substance use services'';

(ii) in subparagraph (C)—

(I) in clause (i)(I), by inserting '', substance use disorders,'' after ''mental illness'';

(II) in clause (ii)—

(aa) in subclause (II), by inserting ‘‘, substance use,’’ after ‘‘mental health,’’;

(bb) in subclause (V), by striking ‘‘mental health services’’ and inserting ‘‘mental health or substance use services’’; and

(cc) in subclause (VI), by inserting ‘‘or individuals with substance use disorders’’ after ‘‘mentally ill individuals’’;

(iii) in subparagraph (D), by inserting ‘‘or offenders with substance use disorders’’ after ‘‘mentally ill offenders’’;

(iv) in subparagraph (E), by inserting ‘‘or substance use disorders’’ after ‘‘mental illness’’;

(v) in subparagraph (H), by striking ‘‘and mental health’’ and inserting ‘‘, mental health, and substance use’’; and

(vi) in subparagraph (I)—

(I) in clause (i)—

(aa) in the heading, by inserting ‘‘, SUBSTANCE USE

COURTS,'' after ''MENTAL HEALTH COURTS'';

(bb) by inserting ''or substance use courts'' after ''mental health courts''; and

(cc) by inserting ''or part EE, as applicable,'' after ''part V''; and

(II) in clause (iv), by inserting ''or substance use'' after ''mental health'';

(3) in subsection (c)—

(A) in paragraph (1), by inserting '', offenders with substance use disorders,'' after ''mentally ill offenders'';

(B) in paragraph (2), by inserting '' and offenders with substance use disorders'' after ''mentally ill offenders''; and

(C) in paragraph (3), by inserting ''or substance use courts'' after ''mental health courts'';

(4) in subsection (e)—

(A) in paragraph (1), by inserting ''or substance use disorders'' after ''mental illness''; and

(B) in paragraph (4), by inserting ''or substance use disorders'' after ''mental illness'';

(5) in subsection (h)—

(A) in the heading, by inserting ''AND OFFENDERS WITH SUBSTANCE USE DISORDERS'' after ''MENTALLY ILL OFFENDERS'';

(B) in paragraph (1)—

(i) in subparagraph (A), by inserting ''or substance use disorders'' after ''mental illnesses'';

(ii) in subparagraph (C), by inserting ''or offenders with substance use disorders'' after ''mentally ill offenders'';

(iii) in subparagraph (D)—

(I) by inserting ''or substance use'' after ''mental health''; and

(II) by inserting ''or offenders with substance use disorders'' after ''mentally ill offenders'';

(iv) in subparagraph (E), by inserting ''or substance use disorders'' after ''mental illnesses''; and

(v) in subparagraph (F), by inserting '', substance use disorders,'' after ''mental health disorders''; and

(C) in paragraph (2), by inserting ''or substance use disorders'' after ''mental illnesses'';

(6) in subsection (i)(2)—

(A) in subparagraph (B)—

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

(ii) in the matter preceding subclause (I), as so redesignated, by striking ''shall give priority to applications that—'' and inserting the following: ''shall give priority to—

''(i) applications that—''; and

(iii) by striking the period at the end and inserting the following: ''; and

''(ii) applications to establish or expand veterans treatment court programs that—

''(I) allow participation by a veteran receiving any type of medication-assisted treatment that involves the use of any drug or combination of drugs that have been approved under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or

section 351 of the Public Health Service Act (42 U.S.C. 262) for the treatment of an opioid use disorder;

''(II) follow the Adult Drug Court Best Practice Standards published by the National Association of Drug Court Professionals; and

''(III) provide 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.''; and

(B) by adding at the end the following:

''(C) DISCLOSURE AND REPORTING REQUIREMENTS.—

''(i) REQUIREMENTS FOR VETERANS TREATMENT COURT PROGRAM GRANTEES.—An applicant that receives a grant under this subsection to establish or expand a veterans treatment court program shall—

''(I) disclose to the Attorney General any contract or relationship between the applicant and a local treatment provider;

''(II) track and report to the Attorney General the number of referrals to local treatment providers provided by the program; and

''(III) track and report to the Attorney General, with respect to each participant in the program—

''(aa) each charge brought against the participant;

''(bb) the demographics of the participant; and

''(cc) the outcome of the participant's case.

''(ii) ATTORNEY GENERAL REPORT.—The Attorney General shall periodically submit to Congress a report containing the information reported to the Attorney General under clause (i).

''(D) SENSE OF CONGRESS REGARDING VETERANS TREATMENT COURT PROGRAMS.—It is the sense of Congress that a veterans treatment court program that receives funding from a grant under this subsection should not exclude individuals who are chronically exposed to the criminal justice system.'';

(7) in subsection (j)—

(A) in paragraph (1), by inserting ''or substance use disorders'' after ''mental illness''; and

(B) in paragraph (2)(A), by inserting ''or substance use disorders'' after ''mental illnesses'';

(8) in subsection (k)(3)(A)(i)(I)(aa), by inserting '' or substance use disorders'' after ''mental illnesses'';

(9) in subsection (l)—

(A) in paragraph (1)(B)(ii), by inserting ''or substance use disorder'' after ''mental illness'' each place that term appears; and

(B) in paragraph (2)—

(i) in subparagraph (C)(iii), by inserting ''or substance use'' after ''mental health''; and

(ii) in subparagraph (D), by striking ''mental health or'' and inserting ''mental health disorders, substance use disorders, or''; and

(10) in subsection (o)(3)—

(A) by striking ''LIMITATION'' and inserting ''VETERANS'';

(B) by striking ''Not more than'' and inserting the following:

''(A) LIMITATION.—Not more than'';

(C) in subparagraph (A), as so designated, by striking ''this section'' and inserting ''paragraph (1)''; and

(D) by adding at the end the following:

''(B) ADDITIONAL FUNDING.—In addition to the amounts authorized under paragraph (1), there are authorized to be appropriated to the Department of Justice to carry out subsection (i) $20,000,000 for each of fiscal years 2022 through 2026.''.

SEC. 405. INFRASTRUCTURE FOR REENTRY.

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

(1) in subparagraph (A)—

(A) by striking ''to private, nonprofit organizations that are community development corporations'' and inserting the following: ''to—

''(i) private, nonprofit community development corporations'';

(B) by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(ii) community development corporations described in clause (i), or partnerships between such a corporation and another private, nonprofit entity, to fund and oversee the construction of facilities for treatment of mental and substance use disorders, supportive housing, or of re-entry centers, that are not jails, prisons, or other correctional facilities.'';

(2) in subparagraph (C)—

(A) by inserting ''or partnership'' after ''corporation'' each place it appears;

(B) by striking ''principal purpose planning'' and inserting ''principal purpose—

''(i) planning'';

(C) by striking the period at the end and inserting ''; or''; and

''(ii) planning or constructing facilities for crisis intervention, treatment of mental and substance use disorders, supportive housing, or of re-entry centers.''; and

(3) by adding at the end the following:

''(F) DEFINITION.—In this paragraph, the term 'crisis intervention' means the provision of

immediate, short-term assistance to individuals who are experiencing acute emotional, mental, physical, and behavioral distress or problems using a 'one-stop' model.''.

(b) CDBG ASSISTANCE FOR CONSTRUCTION OF SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT FACILITIES, SUPPORTIVE HOUSING, AND REENTRY CENTERS.—Section 105(a) of the Housing and Community Development Act of 1974 (42 U.S.C. 5305(a)) is amended—

(1) in paragraph (25), by striking ''and'' at the end;

(2) in paragraph (26), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(27) the construction of crisis intervention centers, substance abuse and mental health treatment facilities, supportive housing, and reentry centers.''.

(c) COMMUNITIES FACILITIES LOAN AND GRANT PROGRAMS.—Section 306(a) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1926(a)) is amended—

(1) by inserting after paragraph (6) the following:

''(7) PROHIBITION ON USE OF LOANS FOR CERTAIN PURPOSES.—No loan made or insured under this subsection shall be used to support the construction, renovation, equipment purchasing, operation, staffing, or any other function of a jail, prison, detention center, or other correctional facility.'';

and

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

''(C) PROHIBITION ON USE OF GRANTS FOR CERTAIN PURPOSES.—No grant made under this paragraph shall be used to support the construction, renovation, equipment purchasing, operation, staffing, or any other function of a jail, prison, detention center, or other correctional facility.

''(D) INCLUSION OF CERTAIN INFRASTRUCTURE FOR REENTRY.—In this paragraph, the terms 'essential community facility' and 'facility' include a crisis intervention center, substance abuse or mental health treatment facility, a supportive housing facility, and a reentry center.''.

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