

SUPPORT FOR PATIENTS AND COMMUNITIES  
 REAUTHORIZATION ACT OF 2025

MAY 29, 2025.—Committed to the Committee of the Whole House on the State of  
 the Union and ordered to be printed

Mr. GUTHRIE, from the Committee on Energy and Commerce,  
 submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 2483]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2483) to reauthorize certain programs that provide for opioid use disorder prevention, treatment, and recovery, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:  
Strike all after the enacting clause and insert the following:

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

(a) **SHORT TITLE.**—This Act may be cited as the “SUPPORT for Patients and Communities Reauthorization Act of 2025”.

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

Sec. 1. Short title; table of contents.

**TITLE I—PREVENTION**

Sec. 101. Prenatal and postnatal health.  
Sec. 102. Monitoring and education regarding infections associated with illicit drug use and other risk factors.  
Sec. 103. Preventing overdoses of controlled substances.  
Sec. 104. Support for individuals and families impacted by fetal alcohol spectrum disorder.  
Sec. 105. Promoting state choice in PDMP systems.  
Sec. 106. First responder training program.  
Sec. 107. Donald J. Cohen National Child Traumatic Stress Initiative.  
Sec. 108. Protecting suicide prevention lifeline from cybersecurity incidents.  
Sec. 109. Monitoring and reporting of child, youth, and adult trauma.  
Sec. 110. Bruce’s law.  
Sec. 111. Guidance on at-home drug disposal systems.  
Sec. 112. Assessment of opioid drugs and actions.  
Sec. 113. Grant program for State and Tribal response to opioid use disorders.

**TITLE II—TREATMENT**

Sec. 201. Residential treatment program for pregnant and postpartum women.  
Sec. 202. Improving access to addiction medicine providers.  
Sec. 203. Mental and behavioral health education and training grants.  
Sec. 204. Loan repayment program for substance use disorder treatment workforce.  
Sec. 205. Development and dissemination of model training programs for substance use disorder patient records.  
Sec. 206. Task force on best practices for trauma-informed identification, referral, and support.  
Sec. 207. Grants to enhance access to substance use disorder treatment.  
Sec. 208. State guidance related to individuals with serious mental illness and children with serious emotional disturbance.  
Sec. 209. Reviewing the scheduling of approved products containing a combination of buprenorphine and naloxone.

**TITLE III—RECOVERY**

Sec. 301. Building communities of recovery.  
Sec. 302. Peer support technical assistance center.  
Sec. 303. Comprehensive opioid recovery centers.  
Sec. 304. Youth prevention and recovery.  
Sec. 305. CAREER Act.  
Sec. 306. Addressing economic and workforce impacts of the opioid crisis.

**TITLE IV—MISCELLANEOUS MATTERS**

Sec. 401. Delivery of a controlled substance by a pharmacy to a prescribing practitioner.  
Sec. 402. Required training for prescribers of controlled substances.

## **TITLE I—PREVENTION**

**SEC. 101. PRENATAL AND POSTNATAL HEALTH.**

Section 317L(d) of the Public Health Service Act (42 U.S.C. 247b–13(d)) is amended by striking “such sums as may be necessary for each of the fiscal years 2019 through 2023” and inserting “\$4,250,000 for each of fiscal years 2026 through 2030”.

**SEC. 102. MONITORING AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.**

Section 317N(d) of the Public Health Service Act (42 U.S.C. 247b–15(d)) is amended by striking “fiscal years 2019 through 2023” and inserting “fiscal years 2026 through 2030”.

**SEC. 103. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.**

(a) **IN GENERAL.**—Section 392A of the Public Health Service Act (42 U.S.C. 280b–1) is amended—

- (1) in subsection (a)(2)—
  - (A) in subparagraph (C), by inserting “and associated risks” before the period at the end; and
  - (B) in subparagraph (D), by striking “opioids” and inserting “substances causing overdose”; and
- (2) in subsection (b)(2)—
  - (A) in subparagraph (B), by inserting “, and associated risk factors,” after “such overdoses”;
  - (B) in subparagraph (C), by striking “coding” and inserting “monitoring and identifying”;

- (C) in subparagraph (E)—
- (i) by inserting a comma after “public health laboratories”; and
  - (ii) by inserting “and other emerging substances related” after “analogues”; and
- (D) in subparagraph (F), by inserting “and associated risk factors” after “overdoses”.
- (b) ADDITIONAL GRANTS.—Section 392A(a)(3) of the Public Health Service Act (42 U.S.C. 280b–1(a)(3)) is amended—
- (1) in the matter preceding subparagraph (A), by striking “and Indian Tribes—” and inserting “and Indian Tribes for the following purposes:”;
  - (2) by amending subparagraph (A) to read as follows:
    - “(A) To carry out innovative projects for grantees to detect, identify, and rapidly respond to controlled substance misuse, abuse, and overdoses, and associated risk factors, including changes in patterns of such controlled substance use. Such projects may include the use of innovative, evidence-based strategies for detecting such patterns, such as wastewater surveillance, if proven to support actionable prevention strategies, in a manner consistent with applicable Federal and State privacy laws.”; and
    - (3) in subparagraph (B), by striking “for any” and inserting “For any”.
- (c) AUTHORIZATION OF APPROPRIATIONS.—Section 392A(e) of the Public Health Service Act (42 U.S.C. 280b–1(e)) is amended by striking “\$496,000,000 for each of fiscal years 2019 through 2023” and inserting “\$505,579,000 for each of fiscal years 2026 through 2030”.

**SEC. 104. SUPPORT FOR INDIVIDUALS AND FAMILIES IMPACTED BY FETAL ALCOHOL SPECTRUM DISORDER.**

(a) IN GENERAL.—Part O of title III of the Public Health Service Act (42 U.S.C. 280f et seq.) is amended to read as follows:

**“PART O—FETAL ALCOHOL SPECTRUM DISORDER  
PREVENTION AND SERVICES PROGRAM**

**“SEC. 399H. FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION, INTERVENTION, AND SERVICES DELIVERY PROGRAM.**

“(a) IN GENERAL.—The Secretary shall establish or continue activities to support a comprehensive fetal alcohol spectrum disorders (referred to in this section as ‘FASD’) education, prevention, identification, intervention, and services delivery program, which may include—

“(1) an education and public awareness program to support, conduct, and evaluate the effectiveness of—

“(A) educational programs targeting health professions schools, social and other supportive services, educators and counselors and other service providers in all phases of childhood development, and other relevant service providers, concerning the prevention, identification, and provision of services for infants, children, adolescents, and adults with FASD;

“(B) strategies to educate school-age children, including pregnant and high-risk youth, concerning FASD;

“(C) public and community awareness programs concerning FASD; and

“(D) strategies to coordinate information and services across affected community agencies, including agencies providing social services such as foster care, adoption, and social work, agencies providing health services, and agencies involved in education, vocational training, and civil and criminal justice;

“(2) supporting and conducting research on FASD, as appropriate, including to—

“(A) develop appropriate medical diagnostic methods for identifying FASD; and

“(B) develop effective culturally and linguistically appropriate evidence-based or evidence-informed interventions and appropriate supports for preventing prenatal alcohol exposure, which may co-occur with exposure to other substances;

“(3) building State and Tribal capacity for the identification, treatment, and support of individuals with FASD and their families, which may include—

“(A) utilizing and adapting existing Federal, State, or Tribal programs to include FASD identification and FASD-informed support;

“(B) developing and expanding screening and diagnostic capacity for FASD;

“(C) developing, implementing, and evaluating targeted FASD-informed intervention programs for FASD;

“(D) providing training with respect to FASD for professionals across relevant sectors; and

“(E) disseminating information about FASD and support services to affected individuals and their families; and

“(4) an applied research program concerning intervention and prevention to support and conduct service demonstration projects, clinical studies and other research models providing advocacy, educational and vocational training, counseling, medical and mental health, and other supportive services, as well as models that integrate and coordinate such services, that are aimed at the unique challenges facing individuals with fetal alcohol spectrum disorder or fetal alcohol effect and their families.

“(b) GRANTS AND TECHNICAL ASSISTANCE.—

“(1) IN GENERAL.—The Secretary may award grants, cooperative agreements and contracts and provide technical assistance to eligible entities to carry out subsection (a).

“(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant, or enter into a cooperative agreement or contract, under this section, an entity shall—

“(A) be a State, Indian Tribe or Tribal organization, local government, scientific or academic institution, or nonprofit organization; and

“(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the activities that the entity intends to carry out using amounts received under this section.

“(3) ADDITIONAL APPLICATION CONTENTS.—The Secretary may require that an eligible entity include in the application submitted under paragraph (2)(B)—

“(A) a designation of an individual to serve as a FASD State or Tribal coordinator of activities such eligible entity proposes to carry out through a grant, cooperative agreement, or contract under this section; and

“(B) a description of an advisory committee the entity will establish to provide guidance for the entity on developing and implementing a statewide or Tribal strategic plan to prevent FASD and provide for the identification, treatment, and support of individuals with FASD and their families.

“(c) DEFINITION OF FASD-INFORMED.—For purposes of this section, the term ‘FASD-informed’, with respect to support or an intervention program, means that such support or intervention program uses culturally and linguistically informed evidence-based or practice-based interventions and appropriate resources to support an improved quality of life for an individual with FASD and the family of such individual.

**“SEC. 399I. STRENGTHENING CAPACITY AND EDUCATION FOR FETAL ALCOHOL SPECTRUM DISORDERS.**

“(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements, as the Secretary determines appropriate, to public or nonprofit private entities with demonstrated expertise in the field of fetal alcohol spectrum disorders (referred to in this section as ‘FASD’). Such awards shall be for the purposes of building local, Tribal, State, and nationwide capacities to prevent the occurrence of FASD by carrying out the programs described in subsection (b).

“(b) PROGRAMS.—An entity receiving an award under subsection (a) may use such award for the following purposes:

“(1) Developing and supporting public education and outreach activities to raise public awareness of the risks associated with alcohol consumption during pregnancy.

“(2) Acting as a clearinghouse for evidence-based resources on FASD prevention, identification, and culturally and linguistically appropriate best practices to help inform systems of care for individuals with FASD across their lifespan.

“(3) Increasing awareness and understanding of efficacious, evidence-based screening tools and culturally and linguistically appropriate evidence-based intervention services and best practices, which may include improving the capacity for State, Tribal, and local affiliates.

“(4) Providing technical assistance to recipients of grants, cooperative agreements, or contracts under section 399H, as appropriate.

“(c) APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(d) SUBCONTRACTING.—A public or private nonprofit entity may carry out the following activities required under this section through contracts or cooperative agree-

ments with other public and private nonprofit entities with demonstrated expertise in FASD:

- “(1) Resource development and dissemination.
- “(2) Intervention services.
- “(3) Training and technical assistance.

**“SEC. 399J. AUTHORIZATION OF APPROPRIATIONS.**

“There are authorized to be appropriated to carry out this part \$12,500,000 for each of fiscal years 2026 through 2030.”

(b) REPORT.—Not later than 4 years after the date of enactment of this Act, and every year thereafter, the Secretary of Health and Human Services shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report containing—

- (1) a review of the activities carried out pursuant to sections 399H and 399I of the Public Health Service Act, as amended, to advance public education and awareness of fetal alcohol spectrum disorders (referred to in this section as “FASD”);
- (2) a description of—
  - (A) the activities carried out pursuant to such sections 399H and 399I to identify, prevent, and treat FASD; and
  - (B) methods used to evaluate the outcomes of such activities; and
- (3) an assessment of activities carried out pursuant to such sections 399H and 399I to support individuals with FASD.

**SEC. 105. PROMOTING STATE CHOICE IN PDMP SYSTEMS.**

Section 399O(h) of the Public Health Service Act (42 U.S.C. 280g–3(h)) is amended by adding at the end the following:

- “(5) PROMOTING STATE CHOICE.—Nothing in this section shall be construed to authorize the Secretary to require States to use a specific vendor or a specific interoperability connection other than to align with nationally recognized, consensus-based open standards, such as in accordance with sections 3001 and 3004.”

**SEC. 106. FIRST RESPONDER TRAINING PROGRAM.**

Section 546 of the Public Health Service Act (42 U.S.C. 290ee–1) is amended—

- (1) in subsection (a), by striking “tribes and tribal” and inserting “Tribes and Tribal”;
- (2) in subsections (a), (c), and (d)—
  - (A) by striking “approved or cleared” each place it appears and inserting “approved, cleared, or otherwise legally marketed”; and
  - (B) by striking “opioid” each place it appears;
- (3) in subsection (f)—
  - (A) by striking “approved or cleared” each place it appears and inserting “approved, cleared, or otherwise legally marketed”;
  - (B) in paragraph (1), by striking “opioid”;
  - (C) in paragraph (2)—
    - (i) by striking “opioid and heroin” and inserting “opioid, heroin, and other drug”; and
    - (ii) by striking “opioid overdose” and inserting “overdose”; and
  - (D) in paragraph (3), by striking “opioid and heroin”; and
- (4) in subsection (h), by striking “\$36,000,000 for each of fiscal years 2019 through 2023” and inserting “\$57,000,000 for each of fiscal years 2026 through 2030”.

**SEC. 107. DONALD J. COHEN NATIONAL CHILD TRAUMATIC STRESS INITIATIVE.**

(a) TECHNICAL AMENDMENT.—The second part G of title V of the Public Health Service Act (42 U.S.C. 290kk et seq.), as added by section 144 of the Community Renewal Tax Relief Act of 2000 (Public Law 106–554), is amended—

- (1) by redesignating such part as part J; and
- (2) by redesignating sections 581 through 584 as sections 596 through 596C, respectively.

(b) IN GENERAL.—Section 582 of the Public Health Service Act (42 U.S.C. 290hh–1) is amended—

- (1) in the section heading, by striking “VIOLENCE RELATED STRESS” and inserting “TRAUMATIC EVENTS”;
- (2) in subsection (a)—
  - (A) in the matter preceding paragraph (1), by striking “tribes and tribal” and inserting “Tribes and Tribal”; and
  - (B) in paragraph (2), by inserting “and dissemination” after “the development”;

(3) in subsection (b), by inserting “and dissemination” after “the development”;

(4) in subsection (d)—

(A) by striking “The NCTSI” and inserting the following:

“(1) COORDINATING CENTER.—The NCTSI”; and

(B) by adding at the end the following:

“(2) NCTSI GRANTEEES.—In carrying out subsection (a)(2), NCTSI grantees shall develop trainings and other resources, as applicable and appropriate, to support implementation of the evidence-based practices developed and disseminated under such subsection.”;

(5) in subsection (e)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly;

(B) in subparagraph (A), as so redesignated, by inserting “and implementation” after “the dissemination”;

(C) by striking “The NCTSI” and inserting the following:

“(1) COORDINATING CENTER.—The NCTSI”; and

(D) by adding at the end the following:

“(2) NCTSI GRANTEEES.—NCTSI grantees shall, as appropriate, collaborate with other such grantees, the NCTSI coordinating center, and the Secretary in carrying out subsections (a)(2) and (d)(2).”;

(6) by amending subsection (h) to read as follows:

“(h) APPLICATION AND EVALUATION.—To be eligible to receive a grant, contract, or cooperative agreement under subsection (a), a public or nonprofit private entity or an Indian Tribe or Tribal organization shall submit to the Secretary an application at such time, in such manner, and containing such information and assurances as the Secretary may require, including—

“(1) a plan for the evaluation of the activities funded under the grant, contract, or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period; and

“(2) a description of how such entity, Indian Tribe, or Tribal organization will support efforts led by the Secretary or the NCTSI coordinating center, as applicable, to evaluate activities carried out under this section.”; and

(7) by amending subsection (j) to read as follows:

“(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

“(1) \$98,887,000 for fiscal year 2026;

“(2) \$98,887,000 for fiscal year 2027;

“(3) \$98,887,000 for fiscal year 2028;

“(4) \$100,000,000 for fiscal year 2029; and

“(5) \$100,000,000 for fiscal year 2030.”.

**SEC. 108. PROTECTING SUICIDE PREVENTION LIFELINE FROM CYBERSECURITY INCIDENTS.**

(a) NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.—Section 520E–3(b) of the Public Health Service Act (42 U.S.C. 290bb–36c(b)) is amended—

(1) in paragraph (4), by striking “and” at the end;

(2) in paragraph (5), by striking the period at the end and inserting “; and”;

and

(3) by adding at the end the following:

“(6) taking such steps as may be necessary to ensure the suicide prevention hotline is protected from cybersecurity incidents and eliminates known cybersecurity vulnerabilities.”.

(b) REPORTING.—Section 520E–3 of the Public Health Service Act (42 U.S.C. 290bb–36c) is amended—

(1) by redesignating subsection (f) as subsection (g); and

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

“(f) CYBERSECURITY REPORTING.—

“(1) NOTIFICATION.—

“(A) IN GENERAL.—The program’s network administrator receiving Federal funding pursuant to subsection (a) shall report to the Assistant Secretary, in a manner that protects personal privacy, consistent with applicable Federal and State privacy laws—

“(i) any identified cybersecurity vulnerabilities to the program within a reasonable amount of time after identification of such a vulnerability; and

“(ii) any identified cybersecurity incidents to the program within a reasonable amount of time after identification of such incident.

“(B) LOCAL AND REGIONAL CRISIS CENTERS.—Local and regional crisis centers participating in the program shall report to the program’s network ad-

ministrator identified under subparagraph (A), in a manner that protects personal privacy, consistent with applicable Federal and State privacy laws—

“(i) any identified cybersecurity vulnerabilities to the program within a reasonable amount of time after identification of such vulnerability; and

“(ii) any identified cybersecurity incidents to the program within a reasonable amount of time after identification of such incident.

“(2) NOTIFICATION.—If the program’s network administrator receiving funding pursuant to subsection (a) discovers, or is informed by a local or regional crisis center pursuant to paragraph (1)(B) of, a cybersecurity vulnerability or incident, within a reasonable amount of time after such discovery or receipt of information, such entity shall report the vulnerability or incident to the Assistant Secretary.

“(3) CLARIFICATION.—

“(A) OVERSIGHT.—

“(i) LOCAL AND REGIONAL CRISIS CENTERS.—Except as provided in clause (ii), local and regional crisis centers participating in the program shall oversee all technology each center employs in the provision of services as a participant in the program.

“(ii) NETWORK ADMINISTRATOR.—The program’s network administrator receiving Federal funding pursuant to subsection (a) shall oversee the technology each crisis center employs in the provision of services as a participant in the program if such oversight responsibilities are established in the applicable network participation agreement.

“(B) SUPPLEMENT, NOT SUPPLANT.—The cybersecurity incident reporting requirements under this subsection shall supplement, and not supplant, cybersecurity incident reporting requirements under other provisions of applicable Federal law that are in effect on the date of the enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025.”.

(c) STUDY.—Not later than 180 days after the date of the enactment of this Act, the Comptroller General of the United States shall—

(1) conduct and complete a study that evaluates cybersecurity risks and vulnerabilities associated with the 9–8–8 National Suicide Prevention Lifeline; and

(2) submit a report on the findings of such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

#### SEC. 109. MONITORING AND REPORTING OF CHILD, YOUTH, AND ADULT TRAUMA.

Section 7131(e) of the SUPPORT for Patients and Communities Act (42 U.S.C. 242t(e)) is amended by striking “\$2,000,000 for each of fiscal years 2019 through 2023” and inserting “\$9,000,000 for each of fiscal years 2026 through 2030”.

#### SEC. 110. BRUCE’S LAW.

(a) YOUTH PREVENTION AND RECOVERY.—Section 7102(c) of the SUPPORT for Patients and Communities Act (42 U.S.C. 290bb–7a(c)) is amended—

(1) in paragraph (3)(A)(i), by inserting “, which may include strategies to increase education and awareness of the potency and dangers of synthetic opioids (including drugs contaminated with fentanyl) and, as appropriate, other emerging drug use or misuse issues” before the semicolon; and

(2) in paragraph (4)(A), by inserting “and strategies to increase education and awareness of the potency and dangers of synthetic opioids (including drugs contaminated with fentanyl) and, as appropriate, emerging drug use or misuse issues” before the semicolon.

(b) INTERDEPARTMENTAL SUBSTANCE USE DISORDERS COORDINATING COMMITTEE.—Section 7022 of the SUPPORT for Patients and Communities Act (42 U.S.C. 290aa note) is amended—

(1) by striking subsection (g) and inserting the following:

“(g) WORKING GROUPS.—

“(1) IN GENERAL.—The Committee may establish working groups for purposes of carrying out the duties described in subsection (e). Any such working group shall be composed of members of the Committee (or the designees of such members) and may hold such meetings as are necessary to carry out the duties delegated to the working group.

“(2) ADDITIONAL FEDERAL INTERAGENCY WORK GROUP ON FENTANYL CONTAMINATION OF ILLEGAL DRUGS.—

“(A) ESTABLISHMENT.—The Secretary, acting through the Committee, shall establish a Federal Interagency Work Group on Fentanyl Contamination of Illegal Drugs (referred to in this paragraph as the ‘Work Group’)

consisting of representatives from relevant Federal departments and agencies on the Committee.

“(B) CONSULTATION.—The Work Group shall consult with relevant stakeholders and subject matter experts, including—

“(i) State, Tribal, and local subject matter experts in reducing, preventing, and responding to drug overdose caused by fentanyl contamination of illicit drugs; and

“(ii) family members of both adults and youth who have overdosed by fentanyl contaminated illicit drugs.

“(C) DUTIES.—The Work Group shall—

“(i) examine Federal efforts to reduce and prevent drug overdose by fentanyl-contaminated illicit drugs;

“(ii) identify strategies to improve State, Tribal, and local responses to overdose by fentanyl-contaminated illicit drugs;

“(iii) coordinate with the Secretary, as appropriate, in carrying out activities to raise public awareness of synthetic opioids and other emerging drug use and misuse issues;

“(iv) make recommendations to Congress for improving Federal programs, including with respect to the coordination of efforts across such programs; and

“(v) make recommendations for educating youth on the potency and dangers of drugs contaminated by fentanyl.

“(D) ANNUAL REPORT TO SECRETARY.—The Work Group shall annually prepare and submit to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Workforce of the House of Representatives, a report on the activities carried out by the Work Group under subparagraph (C), including recommendations to reduce and prevent drug overdose by fentanyl contamination of illegal drugs, in all populations, and specifically among youth at risk for substance misuse.”; and

(2) by striking subsection (i) and inserting the following:

“(i) SUNSET.—The Committee shall terminate on September 30, 2030.”.

**SEC. 111. GUIDANCE ON AT-HOME DRUG DISPOSAL SYSTEMS.**

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, shall publish guidance to facilitate the use of at-home safe disposal systems for applicable drugs.

(b) CONTENTS.—The guidance under subsection (a) shall include—

(1) recommended standards for effective at-home drug disposal systems to meet applicable requirements enforced by the Food and Drug Administration;

(2) recommended information to include as instructions for use to disseminate with at-home drug disposal systems;

(3) best practices and educational tools to support the use of an at-home drug disposal system, as appropriate; and

(4) recommended use of licensed health providers for the dissemination of education, instruction, and at-home drug disposal systems, as appropriate.

**SEC. 112. ASSESSMENT OF OPIOID DRUGS AND ACTIONS.**

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall publish on the website of the Food and Drug Administration (referred to in this section as the “FDA”) a report that outlines a plan for assessing opioid analgesic drugs that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that addresses the public health effects of such opioid analgesic drugs as part of the benefit-risk assessment and the activities of the FDA that relate to facilitating the development of nonaddictive medical products intended to treat pain or addiction. Such report shall include—

(1) an update on the actions taken by the FDA to consider the effectiveness, safety, benefit-risk profile, and use of approved opioid analgesic drugs;

(2) a timeline for an assessment of the potential need, as appropriate, for labeling changes, revised or additional postmarketing requirements, enforcement actions, or withdrawals for opioid analgesic drugs;

(3) an overview of the steps that the FDA has taken to support the development and approval of nonaddictive medical products intended to treat pain or addiction, and actions planned to further support the development and approval of such products; and

(4) an overview of the consideration by the FDA of clinical trial methodologies for analgesic drugs, including the enriched enrollment randomized withdrawal methodology, and the benefits and drawbacks associated with different trial

methodologies for such drugs, incorporating any public input received under subsection (b).

(b) PUBLIC INPUT.—In carrying out subsection (a), the Secretary shall provide an opportunity for public input concerning the regulation by the FDA of opioid analgesic drugs, including scientific evidence that relates to conditions of use, safety, or benefit-risk assessment (including consideration of the public health effects) of such opioid analgesic drugs.

**SEC. 113. GRANT PROGRAM FOR STATE AND TRIBAL RESPONSE TO OPIOID USE DISORDERS.**

The activities carried out pursuant to section 1003(b)(4)(A) of the 21st Century Cures Act (42 U.S.C. 290ee–3a(b)(4)(A)) may include facilitating access to products used to prevent overdose deaths by detecting the presence of one or more substances, such as fentanyl and xylazine test strips, to the extent the purchase and possession of such products is consistent with Federal and State law.

## **TITLE II—TREATMENT**

**SEC. 201. RESIDENTIAL TREATMENT PROGRAM FOR PREGNANT AND POSTPARTUM WOMEN.**

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

(1) in subsection (d)(11)(C), by striking “providing health services” and inserting “providing health care services”;

(2) in subsection (g)—

(A) by inserting “a plan describing” after “will provide”; and

(B) by adding at the end the following: “Such plan may include a description of how such applicant will target outreach to women disproportionately impacted by maternal substance use disorder.”; and

(3) in subsection (s), by striking “\$29,931,000 for each of fiscal years 2019 through 2023” and inserting “\$38,931,000 for each of fiscal years 2026 through 2030”.

**SEC. 202. IMPROVING ACCESS TO ADDICTION MEDICINE PROVIDERS.**

Section 597 of the Public Health Service Act (42 U.S.C. 290ll) is amended—

(1) in subsection (a)(1), by inserting “diagnosis,” after “related to”; and

(2) in subsection (b), by inserting “addiction medicine,” after “psychiatry.”.

**SEC. 203. 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 by striking “fiscal years 2023 through 2027” and inserting “fiscal years 2026 through 2030”.

**SEC. 204. LOAN REPAYMENT PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT WORKFORCE.**

Section 781(j) of the Public Health Service Act (42 U.S.C. 295h(j)) is amended by striking “\$25,000,000 for each of fiscal years 2019 through 2023” and inserting “\$40,000,000 for each of fiscal years 2026 through 2030”.

**SEC. 205. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS FOR SUBSTANCE USE DISORDER PATIENT RECORDS.**

Section 7053 of the SUPPORT for Patients and Communities Act (42 U.S.C. 290dd–2 note) is amended by striking subsection (e).

**SEC. 206. TASK FORCE ON BEST PRACTICES FOR TRAUMA-INFORMED IDENTIFICATION, REFERRAL, AND SUPPORT.**

Section 7132 of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 4046) is amended—

(1) in subsection (b)(1)—

(A) by redesignating subparagraph (CC) as subparagraph (DD); and

(B) by inserting after subparagraph (BB) the following:

“(CC) The Administration for Community Living.”;

(2) in subsection (d)(1), in the matter preceding subparagraph (A), by inserting “, developmental disability service providers” before “, individuals who are”; and

(3) in subsection (i), by striking “2023” and inserting “2030”.

**SEC. 207. GRANTS TO ENHANCE ACCESS TO SUBSTANCE USE DISORDER TREATMENT.**

Section 3203 of the SUPPORT for Patients and Communities Act (21 U.S.C. 823 note) is amended—

(1) by striking subsection (b); and

(2) by striking “(a) IN GENERAL.—The Secretary” and inserting the following: “The Secretary”.

**SEC. 208. STATE GUIDANCE RELATED TO INDIVIDUALS WITH SERIOUS MENTAL ILLNESS AND CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.**

(a) **REVIEW OF USE OF CERTAIN FUNDING.**—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Assistant Secretary for Mental Health and Substance Use, shall conduct a review of State use of funds made available under the Community Mental Health Services Block Grant program under subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) (referred to in this section as the “block grant program”) for first episode psychosis activities. Such review shall consider the following:

- (1) How States use funds for evidence-based treatments and services according to the standard of care for individuals with early serious mental illness and children with a serious emotional disturbance.
- (2) The percentages of the State funding under the block grant program expended on early serious mental illness and first episode psychosis, and the number of individuals served under such funds.

(b) **REPORT AND GUIDANCE.**—

(1) **REPORT.**—Not later than 180 days after the completion of the review under subsection (a), the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives a report describing—

- (A) the findings of the review under subsection (a); and
- (B) any recommendations for changes to the block grant program that would facilitate improved outcomes for individuals with serious mental illness and children with serious emotional disturbance.

(2) **GUIDANCE.**—Not later than 1 year after the date on which the report is submitted under paragraph (1), the Secretary shall update the guidance provided to States under the block grant program on coordinated specialty care and other evidence-based mental health care services for individuals with serious mental illness and children with a serious emotional disturbance, based on the findings and recommendations of such report.

**SEC. 209. REVIEWING THE SCHEDULING OF APPROVED PRODUCTS CONTAINING A COMBINATION OF BUPRENORPHINE AND NALOXONE.**

(a) **SECRETARY OF HHS.**—The Secretary of Health and Human Services shall, consistent with the requirements and procedures set forth in sections 201 and 202 of the Controlled Substances Act (21 U.S.C. 811, 812)—

- (1) review the relevant data pertaining to the scheduling of products containing a combination of buprenorphine and naloxone that have been approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and
- (2) if appropriate, request that the Attorney General initiate rulemaking proceedings to revise the schedules accordingly with respect to such products.

(b) **ATTORNEY GENERAL.**—The Attorney General shall review any request made by the Secretary of Health and Human Services under subsection (a)(2) and determine whether to initiate proceedings to revise the schedules in accordance with the criteria set forth in sections 201 and 202 of the Controlled Substances Act (21 U.S.C. 811, 812).

## **TITLE III—RECOVERY**

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

Section 547(f) of the Public Health Service Act (42 U.S.C. 290ee–2(f)) is amended by striking “\$5,000,000 for each of fiscal years 2019 through 2023” and inserting “\$17,000,000 for each of fiscal years 2026 through 2030”.

**SEC. 302. PEER SUPPORT TECHNICAL ASSISTANCE CENTER.**

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

(1) in subsection (b)(4), by striking “building; and” and inserting the following: “building, such as—

- “(A) professional development of peer support specialists; and
  - “(B) making recovery support services available in nonclinical settings;
- and”;

(2) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively;

(3) by inserting after subsection (c) the following:

“(d) **REGIONAL CENTERS.**—

“(1) IN GENERAL.—The Secretary may establish one regional technical assistance center (referred to in this subsection as the ‘Regional Center’), with existing resources, to assist the Center in carrying out activities described in subsection (b) within the geographic region of such Regional Center in a manner that is tailored to the needs of such region.

“(2) EVALUATION.—Not later than 4 years after the date of enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025, the Secretary shall evaluate the activities of the Regional Center and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the findings of such evaluation, including—

“(A) a description of the distinct roles and responsibilities of the Regional Center and the Center;

“(B) available information relating to the outcomes of the Regional Center under this subsection, such as any impact on the operations and efficiency of the Center relating to requests for technical assistance and support within the region of such Regional Center;

“(C) a description of any gaps or areas of duplication relating to the activities of the Regional Center and the Center within such region; and

“(D) recommendations relating to the modification, expansion, or termination of the Regional Center under this subsection.

“(3) TERMINATION.—This subsection shall terminate on September 30, 2030.”;

and

(4) in subsection (f), as so redesignated, by striking “\$1,000,000 for each of fiscal years 2019 through 2023” and inserting “\$2,000,000 for each of fiscal years 2026 through 2030”.

#### SEC. 303. COMPREHENSIVE OPIOID RECOVERY CENTERS.

Section 552 of the Public Health Service Act (42 U.S.C. 290ee–7) is amended—

(1) in subsection (d)(2)—

(A) in the matter preceding subparagraph (A), by striking “and in such manner” and inserting “, in such manner, and containing such information and assurances, including relevant documentation,”; and

(B) in subparagraph (A), by striking “is capable of coordinating with other entities to carry out” and inserting “has the demonstrated capability to carry out, through referral or contractual arrangements”;

(2) in subsection (h)—

(A) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively, and adjusting the margins accordingly;

(B) by striking “With respect to” and inserting the following:

“(1) IN GENERAL.—With respect to”; and

(C) by adding at the end the following:

“(2) ADDITIONAL REPORTING FOR CERTAIN ELIGIBLE ENTITIES.—An entity carrying out activities described in subsection (g) through referral or contractual arrangements shall include in the submissions required under paragraph (1) information related to the status of such referrals or contractual arrangements, including an assessment of whether such referrals or contractual arrangements are supporting the ability of such entity to carry out such activities.”; and

(3) in subsection (j), by striking “2019 through 2023” and inserting “2026 through 2030”.

#### SEC. 304. YOUTH PREVENTION AND RECOVERY.

Section 7102(c) of the SUPPORT for Patients and Communities Act (42 U.S.C. 290bb–7a(c)) (as amended by section 110(a)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)—

(i) in clause (i)—

(I) by inserting “, or a consortium of local educational agencies,” after “a local educational agency”; and

(II) by striking “high schools” and inserting “secondary schools”; and

(ii) in clause (vi), by striking “tribe, or tribal” and inserting “Tribe, or Tribal”;

(B) by amending subparagraph (E) to read as follows:

“(E) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal organization’ have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).”;

(C) by redesignating subparagraph (K) as subparagraph (L); and

(D) by inserting after subparagraph (J) the following:

- “(K) SECONDARY SCHOOL.—The term ‘secondary school’ has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).”;
- (2) in paragraph (3)(A), in the matter preceding clause (i)—  
 (A) by striking “and abuse”; and  
 (B) by inserting “at increased risk for substance misuse” after “specific populations”;
- (3) in paragraph (4)—  
 (A) in the matter preceding subparagraph (A), by striking “Indian tribes” and inserting “Indian Tribes”;
- (B) in subparagraph (A), by striking “and abuse”; and  
 (C) in subparagraph (B), by striking “peer mentoring” and inserting “peer-to-peer support”;
- (4) in paragraph (5), by striking “tribal” and inserting “Tribal”;
- (5) in paragraph (6)(A)—  
 (A) in clause (iv), by striking “; and” and inserting a semicolon; and  
 (B) by adding at the end the following:  
 “(vi) a plan to sustain the activities carried out under the grant program, after the grant program has ended; and”;
- (6) in paragraph (8), by striking “2022” and inserting “2028”; and  
 (7) by amending paragraph (9) to read as follows:  
 “(9) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated—  
 “(A) \$10,000,000 for fiscal year 2026;  
 “(B) \$12,000,000 for fiscal year 2027;  
 “(C) \$13,000,000 for fiscal year 2028;  
 “(D) \$14,000,000 for fiscal year 2029; and  
 “(E) \$15,000,000 for fiscal year 2030.”.

**SEC. 305. CAREER ACT.**

(a) IN GENERAL.—Section 7183 of the SUPPORT for Patients and Communities Act (42 U.S.C. 290ee–8) is amended—

- (1) in the section heading, by inserting “; TREATMENT, RECOVERY, AND WORK-FORCE SUPPORT GRANTS” after “CAREER ACT”;
- (2) in subsection (b), by inserting “each” before “for a period”;
- (3) in subsection (c)—  
 (A) in paragraph (1), by striking “the rates described in paragraph (2)” and inserting “the average rates for calendar years 2018 through 2022 described in paragraph (2)”;
- (B) by amending paragraph (2) to read as follows:  
 “(2) RATES.—The rates described in this paragraph are the following:  
 “(A) The highest age-adjusted average rates of drug overdose deaths for calendar years 2018 through 2022 based on data from the Centers for Disease Control and Prevention, including, if necessary, provisional data for calendar year 2022.  
 “(B) The highest average rates of unemployment for calendar years 2018 through 2022 based on data provided by the Bureau of Labor Statistics.  
 “(C) The lowest average labor force participation rates for calendar years 2018 through 2022 based on data provided by the Bureau of Labor Statistics.”;
- (4) in subsection (g)—  
 (A) in each of paragraphs (1) and (3), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and adjusting the margins accordingly;
- (B) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively, and adjusting the margins accordingly;
- (C) in the matter preceding subparagraph (A) (as so redesignated), by striking “An entity” and inserting the following:  
 “(1) IN GENERAL.—An entity”; and  
 (D) by adding at the end the following:  
 “(2) TRANSPORTATION SERVICES.—An entity receiving a grant under this section may use not more than 5 percent of the funds for providing transportation for individuals to participate in an activity supported by a grant under this section, which transportation shall be to or from a place of work or a place where the individual is receiving vocational education or job training services or receiving services directly linked to treatment of or recovery from a substance use disorder.

“(3) LIMITATION.—The Secretary may not require an entity to, or give priority to an entity that plans to, use the funds of a grant under this section for activities that are not specified in this subsection.”;

(5) in subsection (i)(2), by inserting “, which shall include employment and earnings outcomes described in subclauses (I) and (III) of section 116(b)(2)(A)(i) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141(b)(2)(A)(i)) with respect to the participation of such individuals with a substance use disorder in programs and activities funded by the grant under this section” after “subsection (g)”;

(6) in subsection (j)—

(A) in paragraph (1), by inserting “for grants awarded prior to the date of enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025” after “grant period under this section”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking “2 years after submitting the preliminary report required under paragraph (1)” and inserting “September 30, 2030”; and

(ii) in subparagraph (A), by striking “(g)(3)” and inserting “(g)(1)(C)”; and

(7) in subsection (k), by striking “\$5,000,000 for each of fiscal years 2019 through 2023” and inserting “\$12,000,000 for each of fiscal years 2026 through 2030”.

(b) REAUTHORIZATION OF THE CAREER ACT; RECOVERY HOUSING PILOT PROGRAM.—

(1) IN GENERAL.—Section 8071 of the SUPPORT for Patients and Communities Act (42 U.S.C. 5301 note; Public Law 115–271) is amended—

(A) by striking the section heading and inserting “**CAREER ACT; RECOVERY HOUSING PILOT PROGRAM**”;

(B) in subsection (a), by striking “through 2023” and inserting “through 2030”;

(C) in subsection (b)—

(i) in paragraph (1), by striking “not later than 60 days after the date of enactment of this Act” and inserting “not later than 60 days after the date of enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025”; and

(ii) in paragraph (2)(B)(i)—

(I) in subclause (I)—

(aa) by striking “for calendar years 2013 through 2017”; and

(bb) by inserting “for calendar years 2018 through 2022” after “rates of unemployment”;

(II) in subclause (II)—

(aa) by striking “for calendar years 2013 through 2017”; and

(bb) by inserting “for calendar years 2018 through 2022” after “participation rates”; and

(III) by striking subclause (III) and inserting the following:

“(III) The highest age-adjusted average rates of drug overdose deaths for calendar years 2018 through 2022 based on data from the Centers for Disease Control and Prevention, including, if necessary, provisional data for calendar year 2022.”; and

(D) in subsection (f), by striking “For the 2-year period following the date of enactment of this Act, the” and inserting “The”.

(2) CONFORMING AMENDMENT.—Subtitle F of title VIII of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 4095) is amended by striking the subtitle heading and inserting the following: “**Subtitle F—CAREER Act; Recovery Housing Pilot Program**”.

(c) CLERICAL AMENDMENTS.—The table of contents in section 1(b) of the SUPPORT for Patients and Communities Act (Public Law 115–271; 132 Stat. 3894) is amended—

(1) by striking the item relating to section 7183 and inserting the following:

“Sec. 7183. CAREER Act; treatment, recovery, and workforce support grants.”;

(2) by striking the item relating to subtitle F of title VIII and inserting the following:

“Subtitle F—CAREER Act; Recovery Housing Pilot Program”; and

(3) by striking the item relating to section 8071 and inserting the following:

“Sec. 8071. CAREER Act; Recovery Housing Pilot Program.”.

**SEC. 306. ADDRESSING ECONOMIC AND WORKFORCE IMPACTS OF THE OPIOID CRISIS.**

Section 8041(g)(1) of the SUPPORT for Patients and Communities Act (29 U.S.C. 3225a(g)(1)) is amended by striking “2023” and inserting “2030”.

**TITLE IV—MISCELLANEOUS MATTERS****SEC. 401. DELIVERY OF A CONTROLLED SUBSTANCE BY A PHARMACY TO A PRESCRIBING PRACTITIONER.**

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 is a drug in schedule III, IV, or V to be administered—

“(A) by injection or implantation for the purpose of maintenance or detoxification treatment; or

“(B) subject to a risk evaluation and mitigation strategy pursuant to section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1) that includes elements to assure safe use of the drug described in subsection (f)(3)(E) of such section, including a requirement for post-administration monitoring by a health care provider;”.

**SEC. 402. REQUIRED TRAINING FOR PRESCRIBERS OF CONTROLLED SUBSTANCES.**

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

(1) by redesignating the second subsection designated as subsection (l) as subsection (m); and

(2) in subsection (m)(1), as so redesignated—

(A) in subparagraph (A)—

(i) in clause (iv)—

(I) in subclause (I)—

(aa) by inserting “the American Academy of Family Physicians, the American Podiatric Medical Association, the Academy of General Dentistry, the American Optometric Association,” before “or any other organization”;

(bb) by striking “or the Commission” and inserting “, the Commission”; and

(cc) by inserting “, or the Council on Podiatric Medical Education” before the semicolon at the end; and

(II) in subclause (III), by inserting “or the American Academy of Family Physicians” after “Association”; and

(ii) in clause (v), in the matter preceding subclause (I)—

(I) by striking “osteopathic medicine, dental surgery” and inserting “osteopathic medicine, podiatric medicine, dental surgery”; and

(II) by striking “or dental medicine curriculum” and inserting “or dental or podiatric medicine curriculum”; and

(B) in subparagraph (B)—

(i) in clause (i)—

(I) by inserting “the American Pharmacists Association, the Accreditation Council on Pharmacy Education, the American Psychiatric Nurses Association, the American Academy of Nursing, the American Academy of Family Physicians,” before “or any other organization”; and

(II) by inserting “, the American Academy of Family Physicians,” before “or the Accreditation Council”; and

(ii) in clause (ii)—

(I) by striking “or accredited school” and inserting “, an accredited school”; and

(II) by inserting “, or an accredited school of pharmacy” before “in the United States”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as if enacted on December 29, 2022.

**PURPOSE AND SUMMARY**

The bill reauthorizes key public health programs that help prevent drug overdoses, provide access to treatment for those in need, and support opportunities for those recovering from substance use disorder.

## BACKGROUND AND NEED FOR LEGISLATION

The United States is currently facing an overdose crisis. Substance addiction, abuse, and misuse remain a major public health issue. Over 107,000 Americans lost their lives to a drug overdose in 2023.<sup>1</sup> In addition, 40 to 60 percent of individuals treated for substance use disorders will relapse at least once.<sup>2</sup> Lastly, over 93 percent of people with a past-year substance use disorder (SUD) did not receive specialty treatment.<sup>3</sup>

Congress took action to address the crisis in 2016 with the passage of the Comprehensive Addiction and Recovery Act and the 21st Century Cares Act, which established new funding for prevention, treatment, and recovery services for people struggling with substance use disorder. The two laws attempted to address a growing prescription opioid epidemic that, at the time, was killing as many as 50,000 to 60,000 Americans per year.<sup>4</sup> However, as overdose deaths rose to nearly 70,000 deaths per year, Congress took further action in 2018 to tackle the evolving crisis by passing the Substance Use-Disorder Prevention That Promotes Opioid Recovery And Treatment For Patients And Communities Act (or SUPPORT Act).<sup>5</sup> The SUPPORT Act was the largest investment in overdose prevention programs by funding efforts to improve care, including efforts to reduce barriers to all levels of the care continuum and allocate resources to states and providers for the purposes of preventing and treating substance use disorder.

Congress' work proved to be initially successful, evidenced by annual overdose deaths decreasing for the first time since 2018.<sup>6</sup> However, the current landscape has changed since 2018. Fentanyl is now the primary driver of overdoses in the United States, accounting for 70 percent of all overdose deaths.<sup>7</sup> Further, the country is grappling with a mental health crisis, fueled by the COVID-19 pandemic, which has driven millions of new Americans to use and misuse drugs for the first time and set back countless others on their road to recovery.<sup>8</sup>

Key provisions from the SUPPORT Act expired in 2023. The SUPPORT for Patients and Communities Reauthorization Act of 2025 would advance SUD treatment for patients and allocate resources to strengthen the addiction treatment and workforce.

<sup>1</sup> U.S. Drug Enforcement Administration (DEA), *DEA Releases 2024 National Drug Threat Assessment*, (May 2024), <https://www.dea.gov/press-releases/2024/05/09/dea-releases-2024-national-drug-threat-assessment>.

<sup>2</sup> Maria Sugue, *2025 Addiction Statistics: Accurate Data on Substance Abuse in the US*, ADDICTION GROUP (Feb. 17, 2025), <https://www.addictiongroup.org/resources/addiction-statistics/>.

<sup>3</sup> *Id.*

<sup>4</sup> U.S. Centers for Disease Control and Prevention (CDC), *Drug Overdose Deaths in the United States, 1999–2016*, NATIONAL CENTER FOR HEALTH STATISTICS (Dec. 2017), <https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf>.

<sup>5</sup> CDC, *Drug Overdose Deaths in the United States, 1999–2018*, NATIONAL CENTER FOR HEALTH STATISTICS (Jan. 2020), <https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf>.

<sup>6</sup> CDC, *U.S. Overdose Deaths Decrease in 2023, First Time since 2018*, NATIONAL CENTER FOR HEALTH STATISTICS (May 2024), [https://www.cdc.gov/nchs/pressroom/nchs\\_press\\_releases/2024/20240515.htm](https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2024/20240515.htm).

<sup>7</sup> DEA, *DEA Releases 2024 National Drug Threat Assessment*, (May 2024), <https://www.dea.gov/press-releases/2024/05/09/dea-releases-2024-national-drug-threat-assessment>.

<sup>8</sup> CDC, *Overdose Deaths Accelerating During COVID-19*, CDC ARCHIVE (Dec. 2020), <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>.

## COMMITTEE ACTION

On June 9, 2023, the Subcommittee on Health held a field hearing in Gettysburg, Pennsylvania, on issues related to substance use disorder.<sup>9</sup> The title of the hearing was “Addressing the Opioid Crisis: Examining the SUPPORT Act Five Years Later.” The Subcommittee received testimony from:

- Emily Keller, Special Secretary of Opioid Response, Opioid Operational Command Center, Office of Governor Wes Moore;
- Mike Straley, Founder, Leah’s Legacy Foundation;
- Mitchell Crawford, DO, Medical Director, Specialized Treatment and Recovery, WellSpan Health, Director, Addiction Services, WellSpan Health; and
- William Ceravola, Reading Township Police Department.

On June 21, 2023, the Subcommittee on Health held a hearing on H.R. 4531.<sup>10</sup> The title of the hearing was “Responding to America’s Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act.” The Subcommittee received testimony from:

- Matthew Strait, Deputy Assistant Administrator, Office of Diversion Control for the Drug Enforcement Administration;
- Christopher Jones, Director of the National Center for Injury Prevention and Control for the Centers for Disease Control and Prevention;
- Diana Espinosa, Principal Deputy Administrator of the Health Resources and Services Administration, Acting Deputy Assistant Secretary for Mental Health and Substance Use;
- Tom Coderre, Acting Deputy Assistant Secretary for Mental Health and Substance Use; and
- Jonathan Blum, Principal Deputy Administrator and Chief Operating Officer for the Centers for Medicare and Medicaid Services.

On July 13, 2023, the Subcommittee on Health met in open markup session and forwarded H.R. 4531, without amendment, to the full Committee by a voice vote.

On July 19, 2023, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 4531, as amended, favorably reported to the House by a record vote of 48 yeas and 0 nays.

On April 29, 2025, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 2483, as amended, favorably reported to the House by a record vote of 36 yeas and 13 nays.

## COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

<sup>9</sup>During the 118th Congress, this hearing was used to develop H.R. 4531.

<sup>10</sup>Provisions of H.R. 4531 were reintroduced in the 119th Congress as H.R. 2483.

**COMMITTEE ON ENERGY AND COMMERCE  
119TH CONGRESS  
ROLL CALL VOTE # 11**

**BILL:** H.R. 2483

**AMENDMENT:** Final Passage, As Amended

**DISPOSITION:** Agreed to, by a roll call vote of 36 yeas and 13 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Guthrie	X			Mr. Pallone		X	
Mr. Latta	X			Ms. DeGette		X	
Mr. Griffith	X			Ms. Schakowsky		X	
Mr. Bilirakis	X			Ms. Matsui		X	
Mr. Hudson	X			Ms. Castor		X	
Mr. Carter (GA)	X			Mr. Tonko		X	
Mr. Palmer	X			Ms. Clarke		X	
Mr. Dunn	X			Mr. Ruiz	X		
Mr. Crenshaw	X			Mr. Peters	X		
Mr. Joyce	X			Mrs. Dingell	X		
Mr. Weber	X			Mr. Veasey		X	
Mr. Allen	X			Ms. Kelly		X	
Mr. Balderson	X			Ms. Barragán	X		
Mr. Fulcher	X			Mr. Soto	X		
Mr. Pfluger				Ms. Schrier	X		
Mrs. Harshbarger	X			Ms. Trahan	X		
Mrs. Miller-Meeks	X			Ms. Fletcher		X	
Mrs. Cammack	X			Ms. Ocasio-Cortez		X	
Mr. Obernolte	X			Mr. Auchincloss	X		
Mr. James				Mr. Carter (LA)	X		
Mr. Bentz	X			Mr. Menendez		X	
Mrs. Houchin	X			Mr. Mullin		X	
Mr. Fry				Mr. Landsman	X		
Ms. Lee	X			Ms. McClellan	X		
Mr. Langworthy	X						
Mr. Kean	X						
Mr. Rulli							
Mr. Evans							
Mr. Goldman	X						
Mrs. Fedorchak	X						

04/29/2025

## OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, the Committee held hearings and made findings that are reflected in this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY,  
AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that H.R. 2483 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

## CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII, at the time this report was filed, the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974 was not available.

## FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

## STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to reauthorize certain programs that provide for opioid use disorder prevention, recovery, and treatment, and for other purposes.

## DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 2483 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

## RELATED COMMITTEE AND SUBCOMMITTEE HEARINGS

Pursuant to clause 3(c)(6) of rule XIII, the following related hearings were used to develop or consider H.R. 2483:

- On June 9, 2023, the Subcommittee on Health held a field hearing in Gettysburg, Pennsylvania, on issues related to substance use disorder.<sup>11</sup> The title of the hearing was “Addressing the Opioid Crisis: Examining the SUPPORT Act Five Years Later.” The Subcommittee received testimony from:
  - Emily Keller, Special Secretary of Opioid Response, Opioid Operational Command Center, Office of Governor Wes Moore;
  - Mike Straley, Founder, Leah’s Legacy Foundation;
  - Mitchell Crawford, DO, Medical Director, Specialized Treatment and Recovery, WellSpan Health, Director, Addiction Services, WellSpan Health; and

<sup>11</sup>During the 118th Congress, this hearing was used to develop H.R. 4531.

- William Ceravola, Reading Township Police Department.
- On June 21, 2023, the Subcommittee on Health held a hearing on H.R. 4531. The title of the hearing was “Responding to America’s Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act.” Subcommittee received testimony from:
  - Matthew Strait, Deputy Assistant Administrator, Office of Diversion Control for the Drug Enforcement Administration;
  - Christopher Jones, Director of the National Center for Injury Prevention and Control for the Centers for Disease Control and Prevention;
  - Diana Espinosa, Principal Deputy Administrator of the Health Resources and Services Administration, Acting Deputy Assistant Secretary for Mental Health and Substance Use;
  - Tom Coderre, Acting Deputy Assistant Secretary for Mental Health and Substance Use; and
  - Jonathan Blum, Principal Deputy Administrator and Chief Operating Officer for the Centers for Medicare and Medicaid Services.

#### COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974. At the time this report was filed, the estimate was not available.

#### EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 2483 contains no earmarks, limited tax benefits, or limited tariff benefits.

#### ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

#### APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

#### SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

##### *Section 1. Short title; table of contents*

Section 1 provides that the Act may be cited as the “SUPPORT for Patients and Communities Reauthorization Act of 2025.” In addition, this section also provides a table of contents for the Act.

## TITLE I—PREVENTION

*Section 101. Prenatal and postnatal health*

This section reauthorizes section 317L of the Public Health Service Act for fiscal year (FY) 2026 through FY 2030 to continue activities to address neonatal abstinence syndrome and prenatal substance use and misuse, as well as to continue efforts to understand the outcomes of treating opioid use disorder during pregnancy.

*Section 102. Monitoring and education regarding infections associated with illicit drug use and other risk factors*

This section reauthorizes section 317N of the Public Health Service Act for FY 2026 through FY 2030 to continue efforts to prevent and respond to infections commonly associated with illicit drug use.

*Section 103. Preventing overdoses of controlled substances*

This section reauthorizes section 392A of the Public Health Service Act for FY 2026 through FY 2030 to continue support for State efforts to enhance overdose data collection and improve prescription drug monitoring programs (PDMP).

*Section 104. Support for individuals and families impacted by fetal alcohol spectrum disorder*

This section reauthorizes federal fetal alcohol spectrum disorder programs under the Department of Health and Human Services (HHS) that support prevention, education, intervention, and research for FY 2026 through FY 2030.

*Section 105. Promoting state choice in PDMP systems*

This section clarifies that HHS cannot require states to use a specific vendor or interoperability connection in PDMP systems.

*Section 106. First responder training*

This section reauthorizes section 546 of the Public Health Service Act for FY 2026 through FY 2030. This program helps support first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

*Section 107. Donald J. Cohen National Child Traumatic Stress Initiative*

This section reauthorizes section 582 of the Public Health Service Act for FY 2026 through FY 2030. This program supports training initiatives focused on mental, behavioral, and biological aspects of psychological trauma response, prevention of long-term consequences of child trauma, and early intervention services to address long-term impacts of child trauma.

*Section 108. Protecting suicide prevention lifeline from cybersecurity incidents*

This section requires internal coordination within HHS and improved reporting mechanisms to protect the 9–8–8 Suicide & Crisis Lifeline from cybersecurity incidents. This also requires a study

and report to Congress of any cybersecurity vulnerabilities associated with the Lifeline.

*Section 109. Monitoring and reporting of child, youth, and adult trauma*

This section reauthorizes section 7131(e) of the SUPPORT for Patients and Communities Act for FY 2026 through FY 2030 to continue efforts to collect and report information on adverse childhood experiences.

*Section 110. Bruce's law*

This section allows HHS to develop a public education and awareness campaign focused on drug overdose prevention, detection of early warning signs of addiction among youth, and dangers of drugs that could be contaminated with fentanyl. In addition, this section allows the Secretary of HHS to begin a Federal Interagency Working Group on Fentanyl Contamination of Illegal Drugs.

*Section 111. Guidance on at-home drug disposal systems*

This section directs the Food and Drug Administration (FDA), in consultation with the Drug Enforcement Administration (DEA), to issue guidance to facilitate the use of at-home safe disposal systems. Such guidance shall include recommended standards to meet relevant requirements, recommended instructions for use both at-home and for licensed health providers disseminating information, as well as best practices and educational tools to support effective use of such systems.

*Section 112. Assessment of opioid drugs and actions*

This section requires the Secretary of HHS to publish a report outlining a plan for assessing approved opioid analgesic drugs that addresses the public health effects of these drugs as part of a benefit-risk assessment, as well as an update on FDA's activities related to developing nonaddictive medical products. This section requires that HHS provide an opportunity for public input regarding FDA's regulation of opioid analgesic drugs.

*Section 113. Grant program for State and Tribal response to opioid use disorders*

This section clarifies that the Substance Abuse and Mental Health Services Administration's (SAMHSA's) State and Tribal opioid response grants may be used for fentanyl or xylazine test strips in States where they are legal.

TITLE II—TREATMENT

*Section 201. Residential treatment program for pregnant and postpartum women*

This section reauthorizes section 508 of the Public Health Service Act for FY 2026 through FY 2030. This program helps support residential treatment recovery services for pregnant and postpartum women with substance use disorder.

*Section 202. Improving access to addiction medicine providers*

This section adds addiction medicine specialists to the eligible entities under the Fellowship Program.

*Section 203. Mental and behavioral health education and training grants*

This section reauthorizes section 756 of the Public Health Service Act for FY 2026 through FY 2030. This program helps recruit and educate students to pursue careers in the fields of behavioral and mental health, including substance use disorder treatment.

*Section 204. Loan repayment program for substance use disorder treatment workforce*

This section reauthorizes section 781 of the Public Health Service Act for FY 2026 through FY 2030. This program, known as the “STAR Loan Repayment Program,” helps recruit and retain substance use disorder professionals.

*Section 205. Development and dissemination of model training programs for substance use disorder patient records*

This section strikes the authorization of appropriations for Section 7053 of the SUPPORT for Patients and Communities Act.

*Section 206. Task force on best practices for trauma-informed identification, referral, and support*

This section extends the authority for section 7132 of the SUPPORT Act, known as the Interagency Task Force on Trauma-Informed Care, to identify, evaluate, and make recommendations on best practices with respect to children and youth who may experience trauma, through 2030.

*Section 207. Grants to enhance access to substance use disorder treatment*

This section strikes the authorization of appropriations for Section 3203 of the SUPPORT for Patients and Communities Act.

*Section 208. State guidance related to individuals with serious mental illness and children with serious emotional disturbance*

This section requires SAMHSA to review State uses of funding for activities to identify and address early serious mental illness and children with a serious emotional disturbance under the Community Mental Health Services Block Grant program. This also requires the Secretary to publish a report to Congress and update related guidance to States based on its findings to improve the quality of care provided through Block Grant funds.

*Section 209. Reviewing the scheduling of approved products containing a combination of buprenorphine and naloxone*

This section requires HHS and DEA to review the scheduling of buprenorphine-naloxone combination products under the Controlled Substances Act.

## TITLE III—RECOVERY

*Section 301. Building communities of recovery*

This section reauthorizes section 547 of the Public Health Service Act for FY 2026 through FY 2030. This program helps support recovery community organizations to develop, expand, and enhance recovery services.

*Section 302. Peer support technical assistance center*

This section reauthorizes the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support, which supports recovery community organizations and peer support networks that provide substance use disorder peer support services. Additionally, this allows for a regional approach to providing this technical assistance.

*Section 303. Comprehensive opioid recovery centers*

This section reauthorizes section 552 of the Public Health Service Act for FY 2026 through FY 2030. This program supports the operation of comprehensive opioid recovery centers that provide a full spectrum of treatment and recovery support services for individuals with substance use disorder.

*Section 304. Youth prevention and recovery*

This section reauthorizes section 7102 of the SUPPORT Act for FY 2026 through FY 2030. This program provides support for prevention, treatment, and recovery for children, adolescents, and young adults suffering from substance use disorder.

*Section 305. CAREER Act*

This section reauthorizes Section 7183 and 8071 of the SUPPORT Act for FY 2026 through FY 2030. This program provides grants for substance use disorder treatment programs that help individuals in recovery re-enter the workforce, including support for recovery housing.

*Section 306. Addressing economic and workforce impacts of the opioid crisis*

This section reauthorizes section 8041 of the SUPPORT Act for FY 2026 through FY 2030 to continue resources to address various economic impacts associated with a high rate of substance use disorder in a given area.

## TITLE IV—MISCELLANEOUS MATTERS

*Section 401. Delivery of a controlled substance by a pharmacy to a prescribing practitioner*

This section clarifies that pharmacies may deliver a Schedule III, IV, or V controlled substance to an administering practitioner, with post administration monitoring requirements, in lieu of delivering such substances to the ultimate user.

*Section 402. Required training for prescribers of controlled substances*

This section makes technical changes to training requirements for prescribers of opioids by including additional professional societies and accrediting bodies.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

**PUBLIC HEALTH SERVICE ACT**

\* \* \* \* \*

**TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE**

\* \* \* \* \*

**PART B—FEDERAL-STATE COOPERATION**

\* \* \* \* \*

**PRENATAL AND POSTNATAL HEALTH**

SEC. 317L. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out programs—

(1) to collect, analyze, and make available data on prenatal smoking and alcohol and other substance abuse and misuse, including—

(A) data on—

(i) the incidence, prevalence, and implications of such activities; and

(ii) the incidence and prevalence of implications and outcomes, including neonatal abstinence syndrome and other maternal and child health outcomes associated with such activities; and

(B) additional information or data, as appropriate, on family health history, medication exposures during pregnancy, demographic information, such as race, ethnicity, geographic location, and family history, and other relevant information, to inform such analysis;

(2) to conduct applied epidemiological research on the prevention and long-term outcomes associated with prenatal and postnatal smoking, alcohol and other substance abuse and misuse;

(3) to support, conduct, and evaluate the effectiveness of educational, treatment, and cessation programs;

(4) to provide information and education to the public on the prevention and implications of prenatal and postnatal smoking, alcohol and other substance abuse and misuse; and

(5) to issue public reports on the analysis of data described in paragraph (1), including analysis of—

(A) long-term outcomes of children affected by neonatal abstinence syndrome;

(B) health outcomes associated with prenatal smoking, alcohol, and substance abuse and misuse; and

(C) relevant studies, evaluations, or information the Secretary determines to be appropriate.

(b) GRANTS.—In carrying out subsection (a), the Secretary may award grants to and enter into contracts with States, local governments, tribal entities, scientific and academic institutions, federally qualified health centers, and other public and nonprofit entities, and may provide technical and consultative assistance to such entities.

(c) COORDINATING ACTIVITIES.—To carry out this section, the Secretary may—

(1) provide technical and consultative assistance to entities receiving grants under subsection (b);

(2) ensure a pathway for data sharing between States, tribal entities, and the Centers for Disease Control and Prevention;

(3) ensure data collection under this section is consistent with applicable State, Federal, and Tribal privacy laws; and

(4) coordinate with the National Coordinator for Health Information Technology, as appropriate, to assist States and Tribes in implementing systems that use standards recognized by such National Coordinator, as such recognized standards are available, in order to facilitate interoperability between such systems and health information technology systems, including certified health information technology.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated [such sums as may be necessary for each of the fiscal years 2019 through 2023] *\$4,250,000 for each of fiscal years 2026 through 2030.*

\* \* \* \* \*

**SEC. 317N. SURVEILLANCE AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may (directly or through grants to public and nonprofit private entities) provide for programs for the following:

(1) To cooperate with States and Indian tribes in implementing or maintaining a national system to determine the incidence of infections commonly associated with illicit drug use, such as viral hepatitis, human immunodeficiency virus, and infective endocarditis, and to assist the States in determining the prevalence of such infections, which may include the reporting of cases of such infections.

(2) To identify, counsel, and offer testing to individuals who are at risk of infections described in paragraph (1) resulting from illicit drug use, receiving blood transfusions prior to July 1992, or other risk factors.

(3) To provide appropriate referrals for counseling, testing, and medical treatment of individuals identified under para-

graph (2) and to ensure, to the extent practicable, the provision of appropriate follow-up services.

(4) To develop and disseminate public information and education programs for the detection and control of infections described in paragraph (1), with priority given to high-risk populations as determined by the Secretary.

(5) To improve the education, training, and skills of health professionals in the detection and control of infections described in paragraph (1), including to improve coordination of treatment of substance use disorders and infectious diseases, with priority given to substance use disorder treatment providers, pediatricians and other primary care providers, obstetrician-gynecologists, and infectious disease clinicians, including HIV clinicians.

(b) LABORATORY PROCEDURES.—The Secretary may (directly or through grants to public and nonprofit private entities) carry out programs to provide for improvements in the quality of clinical-laboratory procedures regarding infections described in subsection (a)(1).

(c) DEFINITION.—In this section, the term “Indian tribe” has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$40,000,000 for each of the [fiscal years 2019 through 2023] *fiscal years 2026 through 2030*.

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PART J—PREVENTION AND CONTROL OF INJURIES

\* \* \* \* \*

**SEC. 392A. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.**

(a) EVIDENCE-BASED PREVENTION GRANTS.—

(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may—

(A) to the extent practicable, carry out and expand any evidence-based prevention activities described in paragraph (2);

(B) provide training and technical assistance to States, localities, and Indian Tribes for purposes of carrying out such activity; and

(C) award grants to States, localities, and Indian Tribes for purposes of carrying out such activity.

(2) EVIDENCE-BASED PREVENTION ACTIVITIES.—An evidence-based prevention activity described in this paragraph is any of the following activities:

(A) Improving the efficiency and use of a new or currently operating prescription drug monitoring program, including by—

(i) encouraging all authorized users (as specified by the State or other entity) to register with and use the program;

(ii) enabling such users to access any updates to information collected by the program in as close to real-time as possible;

(iii) improving the ease of use of such program;  
 (iv) providing for a mechanism for the program to notify authorized users of any potential misuse or abuse of controlled substances and any detection of inappropriate prescribing or dispensing practices relating to such substances;

(v) encouraging the analysis of prescription drug monitoring data for purposes of providing de-identified, aggregate reports based on such analysis to State public health agencies, State substance abuse agencies, State licensing boards, and other appropriate State agencies, as permitted under applicable Federal and State law and the policies of the prescription drug monitoring program and not containing any protected health information, to prevent inappropriate prescribing, drug diversion, or abuse and misuse of controlled substances, and to facilitate better coordination among agencies;

(vi) enhancing interoperability between the program and any health information technology (including certified health information technology), including by integrating program data into such technology;

(vii) updating program capabilities to respond to technological innovation for purposes of appropriately addressing the occurrence and evolution of controlled substance overdoses;

(viii) facilitating and encouraging data exchange between the program and the prescription drug monitoring programs of other States;

(ix) enhancing data collection and quality, including improving patient matching and proactively monitoring data quality;

(x) providing prescriber and dispenser practice tools, including prescriber practice insight reports for practitioners to review their prescribing patterns in comparison to such patterns of other practitioners in the specialty; and

(xi) meeting the purpose of the program established under section 399O, as described in section 399O(a).

(B) Promoting community or health system interventions.

(C) Evaluating interventions to prevent controlled substance overdoses *and associated risks*.

(D) Implementing projects to advance an innovative prevention approach with respect to new and emerging public health crises and opportunities to address such crises, such as enhancing public education and awareness on the risks associated with **[opioids]** *substances causing overdose*.

(3) ADDITIONAL GRANTS.—The Director may award grants to States, localities, **[and Indian Tribes—]** *and Indian Tribes for the following purposes:*

**[(A) to carry out innovative projects for grantees to rapidly respond to controlled substance misuse, abuse, and overdoses, including changes in patterns of controlled substance use; and]**

(A) *To carry out innovative projects for grantees to detect, identify, and rapidly respond to controlled substance misuse, abuse, and overdoses, and associated risk factors, including changes in patterns of such controlled substance use. Such projects may include the use of innovative, evidence-based strategies for detecting such patterns, such as wastewater surveillance, if proven to support actionable prevention strategies, in a manner consistent with applicable Federal and State privacy laws.*

(B) **[for any]** *For any other evidence-based activity for preventing controlled substance misuse, abuse, and overdoses as the Director determines appropriate.*

(4) RESEARCH.—The Director, in coordination with the Assistant Secretary for Mental Health and Substance Use and the National Mental Health and Substance Use Policy Laboratory established under section 501A, as appropriate and applicable, may conduct studies and evaluations to address substance use disorders, including preventing substance use disorders or other related topics the Director determines appropriate.

(b) ENHANCED CONTROLLED SUBSTANCE OVERDOSE DATA COLLECTION, ANALYSIS, AND DISSEMINATION GRANTS.—

(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may—

(A) to the extent practicable, carry out any controlled substance overdose data collection activities described in paragraph (2);

(B) provide training and technical assistance to States, localities, and Indian Tribes for purposes of carrying out such activity;

(C) award grants to States, localities, and Indian Tribes for purposes of carrying out such activity; and

(D) coordinate with the Assistant Secretary for Mental Health and Substance Use to collect data pursuant to section 505(d)(1)(A) (relating to the number of individuals admitted to emergency departments as a result of the abuse of alcohol or other drugs).

(2) CONTROLLED SUBSTANCE OVERDOSE DATA COLLECTION AND ANALYSIS ACTIVITIES.—A controlled substance overdose data collection, analysis, and dissemination activity described in this paragraph is any of the following activities:

(A) Improving the timeliness of reporting data to the public, including data on fatal and nonfatal overdoses of controlled substances.

(B) Enhancing the comprehensiveness of controlled substance overdose data by collecting information on such overdoses, *and associated risk factors*, from appropriate sources such as toxicology reports, autopsy reports, death scene investigations, and emergency departments.

(C) Modernizing the system for **[coding]** *monitoring and identifying* causes of death related to controlled substance overdoses to use an electronic-based system.

(D) Using data to help identify risk factors associated with controlled substance overdoses.

(E) Supporting entities involved in providing information on controlled substance overdoses, such as coroners, medical examiners, and public health laboratories, to improve accurate testing and standardized reporting of causes and contributing factors to controlled substances overdoses and analysis of various opioid analogues *and other emerging substances related* to controlled substance overdoses.

(F) Working to enable and encourage the access, exchange, and use of information regarding controlled substance overdoses *and associated risk factors* among data sources and entities.

(c) PRIORITY.—In awarding grants to States under subsections (a) and (b), the Director of the Centers for Disease Control and Prevention may give priority to jurisdictions with a disproportionately high rate of drug overdoses or drug overdose deaths, as applicable.

(d) DEFINITIONS.—In this section:

(1) CONTROLLED SUBSTANCE.—The term “controlled substance” has the meaning given that term in section 102 of the Controlled Substances Act.

(2) INDIAN TRIBE.—The term “Indian tribe” has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act.

(e) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, section 399O of this Act, and section 102 of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), there is authorized to be appropriated **[\$496,000,000 for each of fiscal years 2019 through 2023]** *\$505,579,000 for each of fiscal years 2026 through 2030.*

\* \* \* \* \*

**[PART O—FETAL ALCOHOL SYNDROME PREVENTION AND SERVICES PROGRAM**

**[SEC. 399H. ESTABLISHMENT OF FETAL ALCOHOL SYNDROME PREVENTION AND SERVICES PROGRAM.**

**[(a) FETAL ALCOHOL SYNDROME PREVENTION, INTERVENTION AND SERVICES DELIVERY PROGRAM.—**The Secretary shall establish a comprehensive Fetal Alcohol Syndrome and Fetal Alcohol Effect prevention, intervention and services delivery program that shall include—

**[(1) an education and public awareness program to support, conduct, and evaluate the effectiveness of—**

**[(A) educational programs targeting medical schools, social and other supportive services, educators and counselors and other service providers in all phases of childhood development, and other relevant service providers, concerning the prevention, identification, and provision of services for children, adolescents and adults with Fetal Alcohol Syndrome and Fetal Alcohol Effect;**

**[(B) strategies to educate school-age children, including pregnant and high risk youth, concerning Fetal Alcohol Syndrome and Fetal Alcohol Effect;**

[(C) public and community awareness programs concerning Fetal Alcohol Syndrome and Fetal Alcohol Effect; and

[(D) strategies to coordinate information and services across affected community agencies, including agencies providing social services such as foster care, adoption, and social work, medical and mental health services, and agencies involved in education, vocational training and civil and criminal justice;

[(2) a prevention and diagnosis program to support clinical studies, demonstrations and other research as appropriate to—

[(A) develop appropriate medical diagnostic methods for identifying Fetal Alcohol Syndrome and Fetal Alcohol Effect; and

[(B) develop effective prevention services and interventions for pregnant, alcohol-dependent women; and

[(3) an applied research program concerning intervention and prevention to support and conduct service demonstration projects, clinical studies and other research models providing advocacy, educational and vocational training, counseling, medical and mental health, and other supportive services, as well as models that integrate and coordinate such services, that are aimed at the unique challenges facing individuals with Fetal Alcohol Syndrome or Fetal Alcohol Effect and their families.

[(b) GRANTS AND TECHNICAL ASSISTANCE.—The Secretary may award grants, cooperative agreements and contracts and provide technical assistance to eligible entities described in section 399I to carry out subsection (a).

[(c) DISSEMINATION OF CRITERIA.—In carrying out this section, the Secretary shall develop a procedure for disseminating the Fetal Alcohol Syndrome and Fetal Alcohol Effect diagnostic criteria developed pursuant to section 705 of the ADAMHA Reorganization Act (42 U.S.C. 485n note) to health care providers, educators, social workers, child welfare workers, and other individuals.

[(d) NATIONAL TASK FORCE.—

[(1) IN GENERAL.—The Secretary shall establish a task force to be known as the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect (referred to in this subsection as the “Task Force”) to foster coordination among all governmental agencies, academic bodies and community groups that conduct or support Fetal Alcohol Syndrome and Fetal Alcohol Effect research, programs, and surveillance, and otherwise meet the general needs of populations actually or potentially impacted by Fetal Alcohol Syndrome and Fetal Alcohol Effect.

[(2) MEMBERSHIP.—The Task Force established pursuant to paragraph (1) shall—

[(A) be chaired by an individual to be appointed by the Secretary and staffed by the Administration; and

[(B) include the Chairperson of the Interagency Coordinating Committee on Fetal Alcohol Syndrome of the Department of Health and Human Services, individuals with Fetal Alcohol Syndrome and Fetal Alcohol Effect, and representatives from advocacy and research organizations such as the Research Society on Alcoholism, the FAS Family Resource Institute, the National Organization of Fetal

Alcohol Syndrome, the Arc, the academic community, and Federal, State and local government agencies and offices.

[(3) FUNCTIONS.—The Task Force shall—

[(A) advise Federal, State and local programs and research concerning Fetal Alcohol Syndrome and Fetal Alcohol Effect, including programs and research concerning education and public awareness for relevant service providers, school-age children, women at-risk, and the general public, medical diagnosis, interventions for women at-risk of giving birth to children with Fetal Alcohol Syndrome and Fetal Alcohol Effect, and beneficial services for individuals with Fetal Alcohol Syndrome and Fetal Alcohol Effect and their families;

[(B) coordinate its efforts with the Interagency Coordinating Committee on Fetal Alcohol Syndrome of the Department of Health and Human Services; and

[(C) report on a biennial basis to the Secretary and relevant committees of Congress on the current and planned activities of the participating agencies.

[(4) TIME FOR APPOINTMENT.—The members of the Task Force shall be appointed by the Secretary not later than 6 months after the date of enactment of this part.

**[SEC. 399I. ELIGIBILITY.**

[(To be eligible to receive a grant, or enter into a cooperative agreement or contract under this part, an entity shall—

[(1) be a State, Indian tribal government, local government, scientific or academic institution, or nonprofit organization; and

[(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may prescribe, including a description of the activities that the entity intends to carry out using amounts received under this part.

**[SEC. 399J. AUTHORIZATION OF APPROPRIATIONS.**

[(a) IN GENERAL.—There are authorized to be appropriated to carry out this part, \$27,000,000 for each of the fiscal years 1999 through 2003.

[(b) TASK FORCE.—From amounts appropriated for a fiscal year under subsection (a), the Secretary may use not to exceed \$2,000,000 of such amounts for the operations of the National Task Force under section 399H(d).

**[SEC. 399K. SUNSET PROVISION.**

[(This part shall not apply on the date that is 7 years after the date on which all members of the National Task Force have been appointed under section 399H(d)(1).]

**PART O—FETAL ALCOHOL SPECTRUM DISORDER PREVENTION AND SERVICES PROGRAM**

**SEC. 399H. FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION, INTERVENTION, AND SERVICES DELIVERY PROGRAM.**

(a) *IN GENERAL.*—The Secretary shall establish or continue activities to support a comprehensive fetal alcohol spectrum disorders (referred to in this section as “FASD”) education, prevention, identification, intervention, and services delivery program, which may include—

(1) an education and public awareness program to support, conduct, and evaluate the effectiveness of—

(A) educational programs targeting health professions schools, social and other supportive services, educators and counselors and other service providers in all phases of childhood development, and other relevant service providers, concerning the prevention, identification, and provision of services for infants, children, adolescents, and adults with FASD;

(B) strategies to educate school-age children, including pregnant and high-risk youth, concerning FASD;

(C) public and community awareness programs concerning FASD; and

(D) strategies to coordinate information and services across affected community agencies, including agencies providing social services such as foster care, adoption, and social work, agencies providing health services, and agencies involved in education, vocational training, and civil and criminal justice;

(2) supporting and conducting research on FASD, as appropriate, including to—

(A) develop appropriate medical diagnostic methods for identifying FASD; and

(B) develop effective culturally and linguistically appropriate evidence-based or evidence-informed interventions and appropriate supports for preventing prenatal alcohol exposure, which may co-occur with exposure to other substances;

(3) building State and Tribal capacity for the identification, treatment, and support of individuals with FASD and their families, which may include—

(A) utilizing and adapting existing Federal, State, or Tribal programs to include FASD identification and FASD-informed support;

(B) developing and expanding screening and diagnostic capacity for FASD;

(C) developing, implementing, and evaluating targeted FASD-informed intervention programs for FASD;

(D) providing training with respect to FASD for professionals across relevant sectors; and

(E) disseminating information about FASD and support services to affected individuals and their families; and

(4) an applied research program concerning intervention and prevention to support and conduct service demonstration

*projects, clinical studies and other research models providing advocacy, educational and vocational training, counseling, medical and mental health, and other supportive services, as well as models that integrate and coordinate such services, that are aimed at the unique challenges facing individuals with fetal alcohol spectrum disorder or fetal alcohol effect and their families.*

**(b) GRANTS AND TECHNICAL ASSISTANCE.—**

*(1) IN GENERAL.—The Secretary may award grants, cooperative agreements and contracts and provide technical assistance to eligible entities to carry out subsection (a).*

*(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant, or enter into a cooperative agreement or contract, under this section, an entity shall—*

*(A) be a State, Indian Tribe or Tribal organization, local government, scientific or academic institution, or nonprofit organization; and*

*(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the activities that the entity intends to carry out using amounts received under this section.*

*(3) ADDITIONAL APPLICATION CONTENTS.—The Secretary may require that an eligible entity include in the application submitted under paragraph (2)(B)—*

*(A) a designation of an individual to serve as a FASD State or Tribal coordinator of activities such eligible entity proposes to carry out through a grant, cooperative agreement, or contract under this section; and*

*(B) a description of an advisory committee the entity will establish to provide guidance for the entity on developing and implementing a statewide or Tribal strategic plan to prevent FASD and provide for the identification, treatment, and support of individuals with FASD and their families.*

*(c) DEFINITION OF FASD-INFORMED.—For purposes of this section, the term “FASD-informed”, with respect to support or an intervention program, means that such support or intervention program uses culturally and linguistically informed evidence-based or practice-based interventions and appropriate resources to support an improved quality of life for an individual with FASD and the family of such individual.*

**SEC. 399I. STRENGTHENING CAPACITY AND EDUCATION FOR FETAL ALCOHOL SPECTRUM DISORDERS.**

*(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements, as the Secretary determines appropriate, to public or nonprofit private entities with demonstrated expertise in the field of fetal alcohol spectrum disorders (referred to in this section as “FASD”). Such awards shall be for the purposes of building local, Tribal, State, and nationwide capacities to prevent the occurrence of FASD by carrying out the programs described in subsection (b).*

*(b) PROGRAMS.—An entity receiving an award under subsection (a) may use such award for the following purposes:*

(1) *Developing and supporting public education and outreach activities to raise public awareness of the risks associated with alcohol consumption during pregnancy.*

(2) *Acting as a clearinghouse for evidence-based resources on FASD prevention, identification, and culturally and linguistically appropriate best practices to help inform systems of care for individuals with FASD across their lifespan.*

(3) *Increasing awareness and understanding of efficacious, evidence-based screening tools and culturally and linguistically appropriate evidence-based intervention services and best practices, which may include improving the capacity for State, Tribal, and local affiliates.*

(4) *Providing technical assistance to recipients of grants, cooperative agreements, or contracts under section 399H, as appropriate.*

(c) *APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.*

(d) *SUBCONTRACTING.—A public or private nonprofit entity may carry out the following activities required under this section through contracts or cooperative agreements with other public and private nonprofit entities with demonstrated expertise in FASD:*

(1) *Resource development and dissemination.*

(2) *Intervention services.*

(3) *Training and technical assistance.*

**SEC. 399J. AUTHORIZATION OF APPROPRIATIONS.**

*There are authorized to be appropriated to carry out this part \$12,500,000 for each of fiscal years 2026 through 2030.*

**PART P—ADDITIONAL PROGRAMS**

\* \* \* \* \*

**SEC. 399O. PRESCRIPTION DRUG MONITORING PROGRAM.**

(a) PROGRAM.—

(1) IN GENERAL.—Each fiscal year, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, in coordination with the heads of other departments and agencies as appropriate, shall support States or localities for the purpose of improving the efficiency and use of PDMPs, including—

(A) establishment and implementation of a PDMP;

(B) maintenance of a PDMP;

(C) improvements to a PDMP by—

(i) enhancing functional components to work toward—

(I) universal use of PDMPs among providers and their delegates, to the extent that State laws allow;

(II) more timely inclusion of data within a PDMP;

(III) active management of the PDMP, in part by sending proactive or unsolicited reports to providers to inform prescribing; and

- (IV) ensuring the highest level of ease in use of and access to PDMPs by providers and their delegates, to the extent that State laws allow;
- (ii) in consultation with the Office of the National Coordinator for Health Information Technology, improving the intrastate interoperability of PDMPs by—
  - (I) making PDMPs more actionable by integrating PDMPs within electronic health records and health information technology infrastructure; and
  - (II) linking PDMP data to other data systems within the State, including—
    - (aa) the data of pharmacy benefit managers, medical examiners and coroners, and the State’s Medicaid program;
    - (bb) worker’s compensation data; and
    - (cc) prescribing data of providers of the Department of Veterans Affairs and the Indian Health Service within the State;
  - (iii) in consultation with the Office of the National Coordinator for Health Information Technology, improving the interstate interoperability of PDMPs through—
    - (I) sharing of dispensing data in near-real time across State lines; and
    - (II) integration of automated queries for multistate PDMP data and analytics into clinical workflow to improve the use of such data and analytics by practitioners and dispensers; or
    - (iv) improving the ability to include treatment availability resources and referral capabilities within the PDMP.
- (2) LEGISLATION.—As a condition on the receipt of support under this section, the Secretary shall require a State or locality to demonstrate that it has enacted legislation or regulations—
  - (A) to provide for the implementation of the PDMP; and
  - (B) to permit the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained by the PDMP.
- (b) PDMP STRATEGIES.—The Secretary shall encourage a State or locality, in establishing, improving, or maintaining a PDMP, to implement strategies that improve—
  - (1) the reporting of dispensing in the State or locality of a controlled substance to an ultimate user so the reporting occurs not later than 24 hours after the dispensing event;
  - (2) the consultation of the PDMP by each prescribing practitioner, or their designee, in the State or locality before initiating treatment with a controlled substance, or any substance as required by the State to be reported to the PDMP, and over the course of ongoing treatment for each prescribing event;
  - (3) the consultation of the PDMP before dispensing a controlled substance, or any substance as required by the State to be reported to the PDMP;

(4) the proactive notification to a practitioner when patterns indicative of controlled substance misuse by a patient, including opioid misuse, are detected;

(5) the availability of data in the PDMP to other States, as allowable under State law; and

(6) the availability of nonidentifiable information to the Centers for Disease Control and Prevention for surveillance, epidemiology, statistical research, or educational purposes.

(c) **DRUG MISUSE AND ABUSE.**—In consultation with practitioners, dispensers, and other relevant and interested stakeholders, a State receiving support under this section—

(1) shall establish a program to notify practitioners and dispensers of information that will help to identify and prevent the unlawful diversion or misuse of controlled substances;

(2) may, to the extent permitted under State law, notify the appropriate authorities responsible for carrying out drug diversion investigations if the State determines that information in the PDMP maintained by the State indicates an unlawful diversion or abuse of a controlled substance;

(3) may conduct analyses of controlled substance program data for purposes of providing appropriate State agencies with aggregate reports based on such analyses in as close to real-time as practicable, regarding prescription patterns flagged as potentially presenting a risk of misuse, abuse, addiction, overdose, and other aggregate information, as appropriate and in compliance with applicable Federal and State laws and provided that such reports shall not include protected health information; and

(4) may access information about prescriptions, such as claims data, to ensure that such prescribing and dispensing history is updated in as close to real-time as practicable, in compliance with applicable Federal and State laws and provided that such information shall not include protected health information.

(d) **EVALUATION AND REPORTING.**—As a condition on receipt of support under this section, the State shall report on interoperability with PDMPs of other States and Federal agencies, where appropriate, intrastate interoperability with health information technology systems such as electronic health records, health information exchanges, and e-prescribing, where appropriate, and whether or not the State provides automatic, up-to-date, or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.

(e) **EVALUATION AND REPORTING.**—A State receiving support under this section shall provide the Secretary with aggregate non-identifiable information, as permitted by State law, to enable the Secretary—

(1) to evaluate the success of the State's program in achieving the purpose described in subsection (a); or

(2) to prepare and submit to the Congress the report required by subsection (i)(2).

(f) **EDUCATION AND ACCESS TO THE MONITORING SYSTEM.**—A State receiving support under this section shall take steps to—

(1) facilitate prescribers and dispensers, and their delegates, as permitted by State law, to use the PDMP, to the extent practicable; and

(2) educate prescribers and dispensers, and their delegates on the benefits of the use of PDMPs.

(g) ELECTRONIC FORMAT.—The Secretary may issue guidelines specifying a uniform electronic format for the reporting, sharing, and disclosure of information pursuant to PDMPs. To the extent possible, such guidelines shall be consistent with standards recognized by the Office of the National Coordinator for Health Information Technology.

(h) RULES OF CONSTRUCTION.—

(1) FUNCTIONS OTHERWISE AUTHORIZED BY LAW.—Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

(2) ADDITIONAL PRIVACY PROTECTIONS.—Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

(3) FEDERAL PRIVACY REQUIREMENTS.—Nothing in this section shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) and section 543 of this Act.

(4) NO FEDERAL PRIVATE CAUSE OF ACTION.—Nothing in this section shall be construed to create a Federal private cause of action.

(5) PROMOTING STATE CHOICE.—*Nothing in this section shall be construed to authorize the Secretary to require States to use a specific vendor or a specific interoperability connection other than to align with nationally recognized, consensus-based open standards, such as in accordance with sections 3001 and 3004.*

(i) PROGRESS REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall—

(1) complete a study that—

(A) determines the progress of grantees in establishing and implementing PDMPs consistent with this section;

(B) provides an analysis of the extent to which the operation of PDMPs has—

(i) reduced inappropriate use, abuse, diversion of, and overdose with, controlled substances;

(ii) established or strengthened initiatives to ensure linkages to substance use disorder treatment services;

or

(iii) affected patient access to appropriate care in States operating PDMPs;

(C) determine the progress of grantees in achieving interstate interoperability and intrastate interoperability of PDMPs, including an assessment of technical, legal, and financial barriers to such progress and recommendations for addressing these barriers;

(D) determines the progress of grantees in implementing near real-time electronic PDMPs;

(E) provides an analysis of the privacy protections in place for the information reported to the PDMP in each State or locality receiving support under this section and any recommendations of the Secretary for additional Federal or State requirements for protection of this information;

(F) determines the progress of States or localities in implementing technological alternatives to centralized data storage, such as peer-to-peer file sharing or data pointer systems, in PDMPs and the potential for such alternatives to enhance the privacy and security of individually identifiable data; and

(G) evaluates the penalties that States or localities have enacted for the unauthorized use and disclosure of information maintained in PDMPs, and the criteria used by the Secretary to determine whether such penalties qualify as appropriate for purposes of subsection (a)(2); and

(2) submit a report to the Congress on the results of the study.

(j) ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—A State or locality may establish an advisory council to assist in the establishment, improvement, or maintenance of a PDMP consistent with this section.

(2) LIMITATION.—A State or locality may not use Federal funds for the operations of an advisory council to assist in the establishment, improvement, or maintenance of a PDMP.

(3) SENSE OF CONGRESS.—It is the sense of the Congress that, in establishing an advisory council to assist in the establishment, improvement, or maintenance of a PDMP, a State or locality should consult with appropriate professional boards and other interested parties.

(k) DEFINITIONS.—For purposes of this section:

(1) The term “controlled substance” means a controlled substance (as defined in section 102 of the Controlled Substances Act) in schedule II, III, or IV of section 202 of such Act.

(2) The term “dispense” means to deliver a controlled substance to an ultimate user by, or pursuant to the lawful order of, a practitioner, irrespective of whether the dispenser uses the Internet or other means to effect such delivery.

(3) The term “dispenser” means a physician, pharmacist, or other person that dispenses a controlled substance to an ultimate user.

(4) The term “interstate interoperability” with respect to a PDMP means the ability of the PDMP to electronically share reported information with another State if the information concerns either the dispensing of a controlled substance to an ultimate user who resides in such other State, or the dispensing of a controlled substance prescribed by a practitioner whose principal place of business is located in such other State.

(5) The term “intrastate interoperability” with respect to a PDMP means the integration of PDMP data within electronic health records and health information technology infrastructure or linking of a PDMP to other data systems within the State, including the State’s Medicaid program, workers’ compensation programs, and medical examiners or coroners.

(6) The term “nonidentifiable information” means information that does not identify a practitioner, dispenser, or an ultimate user and with respect to which there is no reasonable basis to believe that the information can be used to identify a practitioner, dispenser, or an ultimate user.

(7) The term “PDMP” means a prescription drug monitoring program that is State-controlled.

(8) The term “practitioner” means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which the individual practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

(9) The term “State” means each of the 50 States, the District of Columbia, and any commonwealth or territory of the United States.

(10) The term “ultimate user” means a person who has obtained from a dispenser, and who possesses, a controlled substance for the person’s own use, for the use of a member of the person’s household, or for the use of an animal owned by the person or by a member of the person’s household.

(11) The term “clinical workflow” means the integration of automated queries for prescription drug monitoring programs data and analytics into health information technologies such as electronic health record systems, health information exchanges, and/or pharmacy dispensing software systems, thus streamlining provider access through automated queries.

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TITLE V—SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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PART B—CENTERS AND PROGRAMS

Subpart 1—Center for Substance Abuse Treatment

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RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN

SEC. 508. (a) IN GENERAL.—The Director of the Center for Substance Abuse Treatment (referred to in this section as the “Director”) shall provide awards of grants, including the grants under subsection (r), cooperative agreements or contracts to public and nonprofit private entities for the purpose of providing to pregnant and postpartum women treatment for substance use disorders through programs in which, during the course of receiving treatment—

- (1) the women reside in or receive outpatient treatment services from facilities provided by the programs;
- (2) the minor children of the women reside with the women in such facilities, if the women so request; and

- (3) the services described in subsection (d) are available to or on behalf of the women.
- (b) AVAILABILITY OF SERVICES FOR EACH PARTICIPANT.—A funding agreement for an award under subsection (a) for an applicant is that, in the program operated pursuant to such subsection—
- (1) treatment services and each supplemental service will be available through the applicant, either directly or through agreements with other public or nonprofit private entities; and
  - (2) the services will be made available to each woman admitted to the program and her children.
- (c) INDIVIDUALIZED PLAN OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—
- (1) in providing authorized services for an eligible woman pursuant to such subsection, the applicant will, in consultation with the women, prepare an individualized plan for the provision of services for the woman and her children; and
  - (2) treatment services under the plan will include—
    - (A) individual, group, and family counseling, as appropriate, regarding substance use disorders; and
    - (B) follow-up services to assist the woman in preventing a relapse into such a disorder.
- (d) REQUIRED SUPPLEMENTAL SERVICES.—In the case of an eligible woman, the services referred to in subsection (a)(3) are as follows:
- (1) Prenatal and postpartum health care.
  - (2) Referrals for necessary hospital services.
  - (3) For the infants and children of the woman—
    - (A) pediatric health care, including treatment for any perinatal effects of a maternal substance use disorder and including screenings regarding the physical and mental development of the infants and children;
    - (B) counseling and other mental health services, in the case of children; and
    - (C) comprehensive social services.
  - (4) Providing therapeutic, comprehensive child care for children during the periods in which the woman is engaged in therapy or in other necessary health and rehabilitative activities.
  - (5) Training in parenting.
  - (6) Counseling on the human immunodeficiency virus and on acquired immune deficiency syndrome.
  - (7) Counseling on domestic violence and sexual abuse.
  - (8) Counseling on obtaining employment, including the importance of graduating from a secondary school.
  - (9) Reasonable efforts to preserve and support the family unit of the woman, including promoting the appropriate involvement of parents and others, and counseling the children of the woman.
  - (10) Planning for and counseling to assist reentry into society, both before and after discharge, including referrals to any public or nonprofit private entities in the community involved that provide services appropriate for the woman and the children of the woman.
  - (11) Case management services, including—

- (A) assessing the extent to which authorized services are appropriate for the woman and any child of such woman;
  - (B) in the case of the services that are appropriate, ensuring that the services are provided in a coordinated manner;
  - (C) assistance in establishing eligibility for assistance under Federal, State, and local programs [providing health services] *providing health care services*, mental health services, housing services, employment services, educational services, or social services; and
  - (D) family reunification with children in kinship or foster care arrangements, where safe and appropriate.
- (e) MINIMUM QUALIFICATIONS FOR RECEIPT OF AWARD.—
- (1) CERTIFICATION BY RELEVANT STATE AGENCY.—With respect to the principal agency of the State involved that administers programs relating to substance use disorders, the Director may make an award under subsection (a) to an applicant only if the agency has certified to the Director that—
    - (A) the applicant has the capacity to carry out a program described in subsection (a);
    - (B) the plans of the applicant for such a program are consistent with the policies of such agency regarding the treatment of substance use disorders; and
    - (C) the applicant, or any entity through which the applicant will provide authorized services, meets all applicable State licensure or certification requirements regarding the provision of the services involved.
  - (2) STATUS AS MEDICAID PROVIDER.—
    - (A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Director may make an award under subsection (a) only if, in the case of any authorized service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State involved—
      - (i) the applicant for the award will provide the service directly, and the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or
      - (ii) the applicant will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement plan and is qualified to receive such payments.
    - (B) WAIVER OF PARTICIPATION AGREEMENTS.—
      - (i) IN GENERAL.—In the case of an entity making an agreement pursuant to subparagraph (A)(ii) regarding the provision of services, the requirement established in such subparagraph regarding a participation agreement shall be waived by the Director if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits plan.
      - (ii) DONATIONS.—A determination by the Director of whether an entity referred to in clause (i) meets the

criteria for a waiver under such clause shall be made without regard to whether the entity accepts voluntary donations regarding the provision of services to the public.

(C) NONAPPLICATION OF CERTAIN REQUIREMENTS.—With respect to any authorized service that is available pursuant to the State plan described in subparagraph (A), the requirements established in such subparagraph shall not apply to the provision of any such service by an institution for mental diseases to an individual who has attained 21 years of age and who has not attained 65 years of age. For purposes of the preceding sentence, the term “institution for mental diseases” has the meaning given such term in section 1905(i) of the Social Security Act.

(f) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—With respect to the costs of the program to be carried out by an applicant pursuant to subsection (a), a funding agreement for an award under such subsection is that the applicant will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that—

(A) for the first fiscal year for which the applicant receives payments under an award under such subsection, is not less than \$1 for each \$9 of Federal funds provided in the award;

(B) for any second such fiscal year, is not less than \$1 for each \$9 of Federal funds provided in the award; and

(C) for any subsequent such fiscal year, is not less than \$1 for each \$3 of Federal funds provided in the award.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(g) OUTREACH.—A funding agreement for an award under subsection (a) for an applicant is that the applicant will provide *a plan describing* outreach services in the community involved to identify women who have a substance use disorder and to encourage the women to undergo treatment for such disorder. *Such plan may include a description of how such applicant will target outreach to women disproportionately impacted by maternal substance use disorder.*

(h) ACCESSIBILITY OF PROGRAM; CULTURAL CONTEXT OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—

(1) the program operated pursuant to such subsection will be operated at a location that is accessible to low-income pregnant and postpartum women; and

(2) authorized services will be provided in the language and the cultural context that is most appropriate.

(i) CONTINUING EDUCATION.—A funding agreement for an award under subsection (a) is that the applicant involved will provide for continuing education in treatment services for the individuals who

will provide treatment in the program to be operated by the applicant pursuant to such subsection.

(j) IMPOSITION OF CHARGES.—A funding agreement for an award under subsection (a) for an applicant is that, if a charge is imposed for the provision of authorized services to or on behalf of an eligible woman, such charge—

(1) will be made according to a schedule of charges that is made available to the public;

(2) will be adjusted to reflect the income of the woman involved; and

(3) will not be imposed on any such woman with an income of less than 185 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(k) REPORTS TO DIRECTOR.—A funding agreement for an award under subsection (a) is that the applicant involved will submit to the Director a report—

(1) describing the utilization and costs of services provided under the award;

(2) specifying the number of women served, the number of infants served, and the type and costs of services provided; and

(3) providing such other information as the Director determines to be appropriate.

(l) REQUIREMENT OF APPLICATION.—The Director may make an award under subsection (a) only if an application for the award is submitted to the Director containing such agreements, and the application is in such form, is made in such manner, and contains such other agreements and such assurances and information as the Director determines to be necessary to carry out this section.

(m) ALLOCATION OF AWARDS.—In making awards under subsection (a), the Director shall give priority to an applicant that agrees to use the award for a program serving an area that is a rural area, an area designated under section 332 by the Secretary as a health professional shortage area, or an area determined by the Director to have a shortage of family-based substance use disorder treatment options.

(n) DURATION OF AWARD.—The period during which payments are made to an entity from an award under subsection (a) may not exceed 5 years. The provision of such payments shall be subject to annual approval by the Director of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. This subsection may not be construed to establish a limitation on the number of awards under such subsection that may be made to an entity.

(o) EVALUATIONS; DISSEMINATION OF FINDINGS.—The Director shall, directly or through contract, provide for the conduct of evaluations of programs carried out pursuant to subsection (a). The Director shall disseminate to the States the findings made as a result of the evaluations.

(p) REPORTS TO CONGRESS.—Not later than October 1, 1994, the Director shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing programs carried out pursuant to this section (other than subsection (r)).

Every 2 years thereafter, the Director shall prepare a report describing such programs carried out during the preceding 2 years, and shall submit the report to the Assistant Secretary for inclusion in the biennial report under section 501(m). Each report under this subsection shall include a summary of any evaluations conducted under subsection (m) during the period with respect to which the report is prepared.

(q) DEFINITIONS.—For purposes of this section:

(1) The term “authorized services” means treatment services and supplemental services.

(2) The term “eligible woman” means a woman who has been admitted to a program operated pursuant to subsection (a).

(3) The term “funding agreement”, with respect to an award under subsection (a), means that the Director may make the award only if the applicant makes the agreement involved.

(4) The term “treatment services” means treatment for a substance use disorder, including the counseling and services described in subsection (c)(2).

(5) The term “supplemental services” means the services described in subsection (d).

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

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

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

(B) to help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential-based settings; and

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

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

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

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

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

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

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

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

(3) REQUIRED SERVICES.—

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

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

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

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

(4) EVALUATION AND REPORT TO CONGRESS.—

(A) IN GENERAL.—The Director of the Center for Behavioral Health Statistics and Quality shall evaluate the pilot program at the conclusion of the first grant cycle funded by the pilot program.

(B) REPORT.—Not later than September 30, 2026, the Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the evaluation under subparagraph (A). The report shall include, at a minimum—

(i) outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs;

(ii) engagement in treatment services;

(iii) retention in the appropriate level and duration of services;

(iv) increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and

(v) other appropriate measures.

(C) RECOMMENDATION.—The report under subparagraph (B) shall include a recommendation by the Director of the Center for Substance Abuse Treatment as to whether the pilot program under this subsection should be extended.

(5) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term “State substance abuse agency” means, with respect to a State, the agency in such State

that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.

(s) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated ~~[\$29,931,000 for each of fiscal years 2019 through 2023]~~ *\$38,931,000 for each of fiscal years 2026 through 2030*. Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.

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Subpart 3—Center for Mental Health Services

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**SEC. 520E-3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.**

(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline program (referred to in this section as the “program”), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016.

(b) ACTIVITIES.—In maintaining the program, the activities of the Secretary shall include—

- (1) supporting and coordinating a network of crisis centers across the United States for providing suicide prevention and mental health crisis intervention services, including appropriate follow-up services, to individuals seeking help at any time, day or night;
- (2) maintaining a suicide prevention hotline to link callers to local emergency, mental health, and social services resources;
- (3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans’ suicide prevention hotline;
- (4) improving awareness of the program for suicide prevention and mental health crisis intervention services, including by conducting an awareness initiative and ongoing outreach to the public; **[and]**
- (5) improving the collection and analysis of demographic information, in a manner that protects personal privacy, consistent with applicable Federal and State privacy laws, in order to understand disparities in access to the program among individuals who are seeking help**[.]; and**
- (6) *taking such steps as may be necessary to ensure the suicide prevention hotline is protected from cybersecurity incidents and eliminates known cybersecurity vulnerabilities.*

(c) PLAN.—

(1) IN GENERAL.—For purposes of supporting the crisis centers under subsection (b)(1) and maintaining the suicide prevention hotline under subsection (b)(2), the Secretary shall de-

velop and implement a plan to ensure the provision of high-quality services.

(2) CONTENTS.—The plan required by paragraph (1) shall include the following:

(A) Program evaluation, including performance measures to assess progress toward the goals and objectives of the program and to improve the responsiveness and performance of the hotline, including at all backup call centers.

(B) Requirements that crisis centers and backup centers must meet—

(i) to participate in the network under subsection (b)(1); and

(ii) to ensure that each telephone call and applicable other communication received by the hotline, including at backup call centers, is answered in a timely manner, consistent with evidence-based guidance or other guidance or best practices, as appropriate.

(C) Specific recommendations and strategies for implementing evidence-based practices, including with respect to followup and communicating the availability of resources in the community for individuals in need.

(D) Criteria for carrying out periodic testing of the hotline during each fiscal year, including at crisis centers and backup centers, to identify and address any problems in a timely manner.

(3) CONSULTATION.—In developing requirements under paragraph (2)(B), the Secretary shall consult with State departments of health, local governments, Indian Tribes, and Tribal organizations.

(4) INITIAL PLAN; UPDATES.—The Secretary shall—

(A) not later than 1 year after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, complete development of the initial plan under paragraph (1) and make such plan publicly available; and

(B) periodically thereafter, update such plan and make the updated plan publicly available.

(d) IMPROVING EPIDEMIOLOGICAL DATA.—The Secretary shall, as appropriate, formalize and strengthen agreements between the Suicide Prevention Lifeline program and the Centers for Disease Control and Prevention with respect to the secure sharing of de-identified epidemiological data. Such agreements shall include appropriate privacy and security protections that meet the requirements of applicable Federal law, at a minimum.

(e) DATA TO ASSIST STATE AND LOCAL SUICIDE PREVENTION ACTIVITIES.—The Secretary shall ensure that the aggregated information collected and any applicable analyses conducted under subsection (b)(5), including from local call centers, as applicable, are made available in a usable format to State and local agencies in order to inform suicide prevention activities.

(f) CYBERSECURITY REPORTING.—

(1) NOTIFICATION.—

(A) IN GENERAL.—*The program's network administrator receiving Federal funding pursuant to subsection (a) shall report to the Assistant Secretary, in a manner that protects*

*personal privacy, consistent with applicable Federal and State privacy laws—*

*(i) any identified cybersecurity vulnerabilities to the program within a reasonable amount of time after identification of such a vulnerability; and*

*(ii) any identified cybersecurity incidents to the program within a reasonable amount of time after identification of such incident.*

*(B) LOCAL AND REGIONAL CRISIS CENTERS.—Local and regional crisis centers participating in the program shall report to the program’s network administrator identified under subparagraph (A), in a manner that protects personal privacy, consistent with applicable Federal and State privacy laws—*

*(i) any identified cybersecurity vulnerabilities to the program within a reasonable amount of time after identification of such vulnerability; and*

*(ii) any identified cybersecurity incidents to the program within a reasonable amount of time after identification of such incident.*

*(2) NOTIFICATION.—If the program’s network administrator receiving funding pursuant to subsection (a) discovers, or is informed by a local or regional crisis center pursuant to paragraph (1)(B) of, a cybersecurity vulnerability or incident, within a reasonable amount of time after such discovery or receipt of information, such entity shall report the vulnerability or incident to the Assistant Secretary.*

*(3) CLARIFICATION.—*

*(A) OVERSIGHT.—*

*(i) LOCAL AND REGIONAL CRISIS CENTERS.—Except as provided in clause (ii), local and regional crisis centers participating in the program shall oversee all technology each center employs in the provision of services as a participant in the program.*

*(ii) NETWORK ADMINISTRATOR.—The program’s network administrator receiving Federal funding pursuant to subsection (a) shall oversee the technology each crisis center employs in the provision of services as a participant in the program if such oversight responsibilities are established in the applicable network participation agreement.*

*(B) SUPPLEMENT, NOT SUPPLANT.—The cybersecurity incident reporting requirements under this subsection shall supplement, and not supplant, cybersecurity incident reporting requirements under other provisions of applicable Federal law that are in effect on the date of the enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025.*

**[(f)] (g) AUTHORIZATION OF APPROPRIATIONS.—**To carry out this section, there are authorized to be appropriated \$101,621,000 for each of fiscal years 2023 through 2027.

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PART D—MISCELLANEOUS PROVISIONS RELATING TO SUBSTANCE  
ABUSE AND MENTAL HEALTH

\* \* \* \* \*

**SEC. 546. FIRST RESPONDER TRAINING.**

(a) **PROGRAM AUTHORIZED.**—The Secretary shall make grants to States, local governmental entities, and Indian **[tribes and tribal Tribes and Tribal]** organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) to allow first responders and members of other key community sectors to administer a drug or device **[approved or cleared]** *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected **[opioid]** overdose.

(b) **APPLICATION.**—

(1) **IN GENERAL.**—An entity seeking a grant under this section shall submit an application to the Secretary—

(A) that meets the criteria under paragraph (2); and

(B) at such time, in such manner, and accompanied by such information as the Secretary may require.

(2) **CRITERIA.**—An entity, in submitting an application under paragraph (1), shall—

(A) describe the evidence-based methodology and outcome measurements that will be used to evaluate the program funded with a grant under this section, and specifically explain how such measurements will provide valid measures of the impact of the program;

(B) describe how the program could be broadly replicated if demonstrated to be effective;

(C) identify the governmental and community agencies with which the entity will coordinate to implement the program; and

(D) describe how the entity will ensure that law enforcement agencies will coordinate with their corresponding State substance abuse and mental health agencies to identify protocols and resources that are available to overdose victims and families, including information on treatment and recovery resources.

(c) **USE OF FUNDS.**—An entity shall use a grant received under this section to—

(1) make a drug or device **[approved or cleared]** *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected **[opioid]** overdose available to be carried and administered by first responders and members of other key community sectors;

(2) train and provide resources for first responders and members of other key community sectors on carrying and administering a drug or device **[approved or cleared]** *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected **[opioid]** overdose;

(3) establish processes, protocols, and mechanisms for referral to appropriate treatment, which may include an outreach

coordinator or team to connect individuals receiving [opioid] overdose reversal drugs to followup services; and

(4) train and provide resources for first responders and members of other key community sectors on safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs to protect themselves from exposure to such drugs and respond appropriately when exposure occurs.

(d) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall make a grant for the purpose of providing technical assistance and training on the use of a drug or device [approved or cleared] *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected [opioid] overdose, mechanisms for referral to appropriate treatment, and safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs.

(e) GEOGRAPHIC DISTRIBUTION.—In making grants under this section, the Secretary shall ensure that not less than 20 percent of grant funds are awarded to eligible entities that are not located in metropolitan statistical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

(f) EVALUATION.—The Secretary shall conduct an evaluation of grants made under this section to determine—

(1) the number of first responders and members of other key community sectors equipped with a drug or device [approved or cleared] *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected [opioid] overdose;

(2) the number of [opioid and heroin] *opioid, heroin, and other drug* overdoses reversed by first responders and members of other key community sectors receiving training and supplies of a drug or device [approved or cleared] *approved, cleared, or otherwise legally marketed* under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected [opioid overdose] *overdose*, through a grant received under this section;

(3) the number of responses to requests for services by the entity or subgrantee, to [opioid and heroin] overdose;

(4) the extent to which overdose victims and families receive information about treatment services and available data describing treatment admissions; and

(5) the number of first responders and members of other key community sectors trained on safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs.

(g) OTHER KEY COMMUNITY SECTORS.—In this section, the term “other key community sectors” includes substance use disorder treatment providers, emergency medical services agencies, agencies and organizations working with prison and jail populations and offender reentry programs, health care providers, harm reduction groups, pharmacies, community health centers, tribal health facilities, and mental health providers.

(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated **【\$36,000,000 for each of fiscal years 2019 through 2023】** *\$57,000,000 for each of fiscal years 2026 through 2030.*

**SEC. 547. BUILDING COMMUNITIES OF RECOVERY.**

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

(1) mobilizes resources within and outside of the recovery community, which may include through a peer support network, to increase the prevalence and quality of long-term recovery from substance use disorders; and

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

(b) GRANTS AUTHORIZED.—The Secretary shall award grants to recovery community organizations to enable such organizations to develop, expand, and enhance recovery services.

(c) FEDERAL SHARE.—The Federal share of the costs of a program funded by a grant under this section may not exceed 85 percent.

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

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

(2) may be used to—

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

(i) behavioral health providers;

(ii) primary care providers and physicians;

(iii) educational and vocational schools;

(iv) employers;

(v) housing services;

(vi) child welfare agencies; and

(vii) other recovery support services that facilitate recovery from substance use disorders, including non-clinical community services;

(B) reduce stigma associated with substance use disorders; and

(C) conduct outreach on issues relating to substance use disorders and recovery, including—

(i) identifying the signs of substance use disorder;

(ii) the resources available to individuals with substance use disorder and to families of an individual with a substance use disorder, including programs that mentor and provide support services to children;

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

(iv) related medical outcomes of substance use disorders, the potential of acquiring an infection commonly associated with illicit drug use, and neonatal abstinence syndrome among infants exposed to opioids during pregnancy.

(e) SPECIAL CONSIDERATION.—In carrying out this section, the Secretary shall give special consideration to the unique needs of rural areas, including areas with an age-adjusted rate of drug over-

dose deaths that is above the national average and areas with a shortage of prevention and treatment services.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section **[\$5,000,000 for each of fiscal years 2019 through 2023] \$17,000,000 for each of fiscal years 2026 through 2030.**

**SEC. 547A. PEER SUPPORT TECHNICAL ASSISTANCE CENTER.**

(a) **ESTABLISHMENT.**—The Secretary, acting through the Assistant Secretary, shall establish or operate a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support (referred to in this section as the “Center”).

(b) **FUNCTIONS.**—The Center established under subsection (a) shall provide technical assistance and support to recovery community organizations and peer support networks, including such assistance and support related to—

(1) training on identifying—

(A) signs of substance use disorder;

(B) resources to assist individuals with a substance use disorder, or resources for families of an individual with a substance use disorder; and

(C) best practices for the delivery of recovery support services;

(2) the provision of translation services, interpretation, or other such services for clients with limited English speaking proficiency;

(3) data collection to support research, including for translational research;

(4) capacity **[building; and]** *building, such as—*

(A) *professional development of peer support specialists; and*

(B) *making recovery support services available in non-clinical settings; and*

(5) evaluation and improvement, as necessary, of the effectiveness of such services provided by recovery community organizations.

(c) **BEST PRACTICES.**—The Center established under subsection (a) shall periodically issue best practices for use by recovery community organizations and peer support networks.

(d) **REGIONAL CENTERS.**—

(1) **IN GENERAL.**—*The Secretary may establish one regional technical assistance center (referred to in this subsection as the “Regional Center”), with existing resources, to assist the Center in carrying out activities described in subsection (b) within the geographic region of such Regional Center in a manner that is tailored to the needs of such region.*

(2) **EVALUATION.**—*Not later than 4 years after the date of enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025, the Secretary shall evaluate the activities of the Regional Center and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the findings of such evaluation, including—*

(A) *a description of the distinct roles and responsibilities of the Regional Center and the Center;*

(B) available information relating to the outcomes of the Regional Center under this subsection, such as any impact on the operations and efficiency of the Center relating to requests for technical assistance and support within the region of such Regional Center;

(C) a description of any gaps or areas of duplication relating to the activities of the Regional Center and the Center within such region; and

(D) recommendations relating to the modification, expansion, or termination of the Regional Center under this subsection.

(3) **TERMINATION.**—This subsection shall terminate on September 30, 2030.

[(d)] (e) **RECOVERY COMMUNITY ORGANIZATION.**—In this section, the term “recovery community organization” has the meaning given such term in section 547.

[(e)] (f) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section [[\$1,000,000 for each of fiscal years 2019 through 2023] \$2,000,000 for each of fiscal years 2026 through 2030.

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#### **SEC. 552. COMPREHENSIVE OPIOID RECOVERY CENTERS.**

(a) **IN GENERAL.**—The Secretary shall award grants on a competitive basis to eligible entities to establish or operate a comprehensive opioid recovery center (referred to in this section as a “Center”). A Center may be a single entity or an integrated delivery network.

(b) **GRANT PERIOD.**—

(1) **IN GENERAL.**—A grant awarded under subsection (a) shall be for a period of not less than 3 years and not more than 5 years.

(2) **RENEWAL.**—A grant awarded under subsection (a) may be renewed, on a competitive basis, for additional periods of time, as determined by the Secretary. In determining whether to renew a grant under this paragraph, the Secretary shall consider the data submitted under subsection (h).

(c) **MINIMUM NUMBER OF CENTERS.**—The Secretary shall allocate the amounts made available under subsection (j) such that not fewer than 10 grants may be awarded. Not more than one grant shall be made to entities in a single State for any one period.

(d) **APPLICATION.**—

(1) **ELIGIBLE ENTITY.**—An entity is eligible for a grant under this section if the entity offers treatment and other services for individuals with a substance use disorder.

(2) **SUBMISSION OF APPLICATION.**—In order to be eligible for a grant under subsection (a), an entity shall submit an application to the Secretary at such time [and in such manner], *in such manner, and containing such information and assurances, including relevant documentation,* as the Secretary may require. Such application shall include—

(A) evidence that such entity carries out, or [is capable of coordinating with other entities to carry out] *has the demonstrated capability to carry out, through referral or*

*contractual arrangements*, the activities described in subsection (g); and

(B) such other information as the Secretary may require.

(e) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities—

(1) located in a State with an age-adjusted rate of drug overdose deaths that is above the national overdose mortality rate, as determined by the Director of the Centers for Disease Control and Prevention; or

(2) serving an Indian Tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) with an age-adjusted rate of drug overdose deaths that is above the national overdose mortality rate, as determined through appropriate mechanisms determined by the Secretary in consultation with Indian Tribes.

(f) PREFERENCE.—In awarding grants under subsection (a), the Secretary may give preference to eligible entities utilizing technology-enabled collaborative learning and capacity building models, including such models as defined in section 2 of the Expanding Capacity for Health Outcomes Act (Public Law 114–270; 130 Stat. 1395), to conduct the activities described in this section.

(g) CENTER ACTIVITIES.—Each Center shall, at a minimum, carry out the following activities directly, through referral, or through contractual arrangements, which may include carrying out such activities through technology-enabled collaborative learning and capacity building models described in subsection (f):

(1) TREATMENT AND RECOVERY SERVICES.—Each Center shall—

(A) Ensure that intake, evaluations, and periodic patient assessments meet the individualized clinical needs of patients, including by reviewing patient placement in treatment settings to support meaningful recovery.

(B) Provide the full continuum of treatment services, including—

(i) all drugs and devices approved or cleared under the Federal Food, Drug, and Cosmetic Act and all biological products licensed under section 351 of this Act to treat substance use disorders or reverse overdoses, pursuant to Federal and State law;

(ii) medically supervised withdrawal management, that includes patient evaluation, stabilization, and readiness for and entry into treatment;

(iii) counseling provided by a program counselor or other certified professional who is licensed and qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient, and to monitor patient progress;

(iv) treatment, as appropriate, for patients with co-occurring substance use and mental disorders;

(v) testing, as appropriate, for infections commonly associated with illicit drug use;

(vi) residential rehabilitation, and outpatient and intensive outpatient programs;

(vii) recovery housing;

(viii) community-based and peer recovery support services;

(ix) job training, job placement assistance, and continuing education assistance to support reintegration into the workforce; and

(x) other best practices to provide the full continuum of treatment and services, as determined by the Secretary.

(C) Ensure that all programs covered by the Center include medication-assisted treatment, as appropriate, and do not exclude individuals receiving medication-assisted treatment from any service.

(D) Periodically conduct patient assessments to support sustained and clinically significant recovery, as defined by the Assistant Secretary for Mental Health and Substance Use.

(E) Provide onsite access to medication, as appropriate, and toxicology services; for purposes of carrying out this section.

(F) Operate a secure, confidential, and interoperable electronic health information system.

(G) Offer family support services such as child care, family counseling, and parenting interventions to help stabilize families impacted by substance use disorder, as appropriate.

(2) OUTREACH.—Each Center shall carry out outreach activities regarding the services offered through the Centers, which may include—

(A) training and supervising outreach staff, as appropriate, to work with State and local health departments, health care providers, the Indian Health Service, State and local educational agencies, schools funded by the Indian Bureau of Education, institutions of higher education, State and local workforce development boards, State and local community action agencies, public safety officials, first responders, Indian Tribes, child welfare agencies, as appropriate, and other community partners and the public, including patients, to identify and respond to community needs;

(B) ensuring that the entities described in subparagraph (A) are aware of the services of the Center; and

(C) disseminating and making publicly available, including through the internet, evidence-based resources that educate professionals and the public on opioid use disorder and other substance use disorders, including co-occurring substance use and mental disorders.

(h) DATA REPORTING AND PROGRAM OVERSIGHT.—【With respect to】

(1) *IN GENERAL.*—*With respect to a grant awarded under subsection (a), not later than 90 days after the end of the first year of the grant period, and annually thereafter for the duration of the grant period (including the duration of any renewal period for such grant), the entity shall submit data, as appropriate, to the Secretary regarding—*

[(1)] (A) the programs and activities funded by the grant;

[(2)] (B) health outcomes of the population of individuals with a substance use disorder who received services from the Center, evaluated by an independent program evaluator through the use of outcomes measures, as determined by the Secretary;

[(3)] (C) the retention rate of program participants; and

[(4)] (D) any other information that the Secretary may require for the purpose of—ensuring that the Center is complying with all the requirements of the grant, including providing the full continuum of services described in subsection (g)(1)(B).

(2) *ADDITIONAL REPORTING FOR CERTAIN ELIGIBLE ENTITIES.*—An entity carrying out activities described in subsection (g) through referral or contractual arrangements shall include in the submissions required under paragraph (1) information related to the status of such referrals or contractual arrangements, including an assessment of whether such referrals or contractual arrangements are supporting the ability of such entity to carry out such activities.

(i) *PRIVACY.*—The provisions of this section, including with respect to data reporting and program oversight, shall be subject to all applicable Federal and State privacy laws.

(j) *AUTHORIZATION OF APPROPRIATIONS.*—There is authorized to be appropriated \$10,000,000 for each of fiscal years [2019 through 2023] 2026 through 2030 for purposes of carrying out this section.

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PART G—PROJECTS FOR CHILDREN AND VIOLENCE

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**SEC. 582. GRANTS TO ADDRESS THE PROBLEMS OF PERSONS WHO EXPERIENCE [VIOLENCE RELATED STRESS] TRAUMATIC EVENTS.**

(a) *IN GENERAL.*—The Secretary shall award grants, contracts or cooperative agreements to public and nonprofit private entities, as well as to Indian [tribes and tribal] *Tribes and Tribal* organizations, for the purpose of developing and maintaining programs that provide for—

(1) the continued operation of the National Child Traumatic Stress Initiative (referred to in this section as the “NCTSI”), which includes a cooperative agreement with a coordinating center, that focuses on the mental, behavioral, and biological aspects of psychological trauma response, prevention of the long-term consequences of child trauma, and early intervention services and treatment to address the long-term consequences of child trauma; and

(2) the development *and dissemination* of knowledge with regard to evidence-based practices for identifying and treating mental, behavioral, and biological disorders of children and youth resulting from witnessing or experiencing a traumatic event.

(b) *PRIORITIES.*—In awarding grants, contracts or cooperative agreements under subsection (a)(2) (related to the development *and*

*dissemination* of knowledge on evidence-based practices for treating mental, behavioral, and biological disorders associated with psychological trauma), the Secretary shall give priority to universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research experience in the field of trauma-related mental disorders.

(c) CHILD OUTCOME DATA.—The NCTSI coordinating center described in subsection (a)(1) shall collect, analyze, report, and make publicly available, as appropriate, NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based treatment and services for children and families served by the NCTSI grantees.

(d) TRAINING.—

(1) COORDINATING CENTER.—The NCTSI coordinating center shall facilitate the coordination of training initiatives in evidence-based and trauma-informed treatments, interventions, and practices offered to NCTSI grantees, providers, and partners.

(2) NCTSI GRANTEES.—*In carrying out subsection (a)(2), NCTSI grantees shall develop trainings and other resources, as applicable and appropriate, to support implementation of the evidence-based practices developed and disseminated under such subsection.*

(e) DISSEMINATION AND COLLABORATION.—

(1) COORDINATING CENTER.—The NCTSI coordinating center shall, as appropriate, collaborate with—

【(1)】 (A) the Secretary, in the dissemination and implementation of evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders; and

【(2)】 (B) appropriate agencies that conduct or fund research within the Department of Health and Human Services, for purposes of sharing NCTSI expertise, evaluation data, and other activities, as appropriate.

(2) NCTSI GRANTEES.—*NCTSI grantees shall, as appropriate, collaborate with other such grantees, the NCTSI coordinating center, and the Secretary in carrying out subsections (a)(2) and (d)(2).*

(f) REVIEW.—The Secretary shall, consistent with the peer-review process, ensure that NCTSI applications are reviewed by appropriate experts in the field as part of a consensus-review process. The Secretary shall include review criteria related to expertise and experience in child trauma and evidence-based practices.

(g) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts or cooperative agreements under subsection (a) are distributed equitably among the regions of the United States and among urban and rural areas.

【(h) EVALUATION.—The Secretary, as part of the application process, shall require that each applicant for a grant, contract or cooperative agreement under subsection (a) submit a plan for the rigorous evaluation of the activities funded under the grant, contract or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period.】

(h) APPLICATION AND EVALUATION.—*To be eligible to receive a grant, contract, or cooperative agreement under subsection (a), a*

public or nonprofit private entity or an Indian Tribe or Tribal organization shall submit to the Secretary an application at such time, in such manner, and containing such information and assurances as the Secretary may require, including—

(1) a plan for the evaluation of the activities funded under the grant, contract, or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period; and

(2) a description of how such entity, Indian Tribe, or Tribal organization will support efforts led by the Secretary or the NCTSI coordinating center, as applicable, to evaluate activities carried out under this section.

(i) DURATION OF AWARDS.—With respect to a grant, contract or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the recipient shall not be less than 4 years, but shall not exceed 5 years. Such grants, contracts or agreements may be renewed.

[(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$63,887,000 for each of fiscal years 2019 through 2023.]

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

(1) \$98,887,000 for fiscal year 2026;

(2) \$98,887,000 for fiscal year 2027;

(3) \$98,887,000 for fiscal year 2028;

(4) \$100,000,000 for fiscal year 2029; and

(5) \$100,000,000 for fiscal year 2030.

(k) SHORT TITLE.—This section may be cited as the “Donald J. Cohen National Child Traumatic Stress Initiative”.

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#### PART [G] J—SERVICES PROVIDED THROUGH RELIGIOUS ORGANIZATIONS

##### SEC. [581.] 596. APPLICABILITY TO DESIGNATED PROGRAMS.

(a) DESIGNATED PROGRAMS.—Subject to subsection (b), this part applies to discretionary and formula grant programs administered by the Substance Abuse and Mental Health Services Administration that make awards of financial assistance to public or private entities for the purpose of carrying out activities to prevent or treat substance abuse (in this part referred to as a “designated program”). Designated programs include the program under subpart II of part B of title XIX (relating to formula grants to the States).

(b) LIMITATION.—This part does not apply to any award of financial assistance under a designated program for a purpose other than the purpose specified in subsection (a).

(c) DEFINITIONS.—For purposes of this part (and subject to subsection (b)):

(1) The term “designated program” has the meaning given such term in subsection (a).

(2) The term “financial assistance” means a grant, cooperative agreement, or contract.

(3) The term “program beneficiary” means an individual who receives program services.

(4) The term “program participant” means a public or private entity that has received financial assistance under a designated program.

(5) The term “program services” means treatment for substance abuse, or preventive services regarding such abuse, provided pursuant to an award of financial assistance under a designated program.

(6) The term “religious organization” means a nonprofit religious organization.

**SEC. [582.] 596A. RELIGIOUS ORGANIZATIONS AS PROGRAM PARTICIPANTS.**

(a) **IN GENERAL.**—Notwithstanding any other provision of law, a religious organization, on the same basis as any other nonprofit private provider—

(1) may receive financial assistance under a designated program; and

(2) may be a provider of services under a designated program.

(b) **RELIGIOUS ORGANIZATIONS.**—The purpose of this section is to allow religious organizations to be program participants on the same basis as any other nonprofit private provider without impairing the religious character of such organizations, and without diminishing the religious freedom of program beneficiaries.

(c) **NONDISCRIMINATION AGAINST RELIGIOUS ORGANIZATIONS.**—

(1) **ELIGIBILITY AS PROGRAM PARTICIPANTS.**—Religious organizations are eligible to be program participants on the same basis as any other nonprofit private organization as long as the programs are implemented consistent with the Establishment Clause and Free Exercise Clause of the First Amendment to the United States Constitution. Nothing in this Act shall be construed to restrict the ability of the Federal Government, or a State or local government receiving funds under such programs, to apply to religious organizations the same eligibility conditions in designated programs as are applied to any other nonprofit private organization.

(2) **NONDISCRIMINATION.**—Neither the Federal Government nor a State or local government receiving funds under designated programs shall discriminate against an organization that is or applies to be a program participant on the basis that the organization has a religious character.

(d) **RELIGIOUS CHARACTER AND FREEDOM.**—

(1) **RELIGIOUS ORGANIZATIONS.**—Except as provided in this section, any religious organization that is a program participant shall retain its independence from Federal, State, and local government, including such organization’s control over the definition, development, practice, and expression of its religious beliefs.

(2) **ADDITIONAL SAFEGUARDS.**—Neither the Federal Government nor a State shall require a religious organization to—

(A) alter its form of internal governance; or

(B) remove religious art, icons, scripture, or other symbols,

in order to be a program participant.

(e) **EMPLOYMENT PRACTICES.**—Nothing in this section shall be construed to modify or affect the provisions of any other Federal or

State law or regulation that relates to discrimination in employment. A religious organization's exemption provided under section 702 of the Civil Rights Act of 1964 regarding employment practices shall not be affected by its participation in, or receipt of funds from, a designated program.

(f) RIGHTS OF PROGRAM BENEFICIARIES.—

(1) IN GENERAL.—If an individual who is a program beneficiary or a prospective program beneficiary objects to the religious character of a program participant, within a reasonable period of time after the date of such objection such program participant shall refer such individual to, and the appropriate Federal, State, or local government that administers a designated program or is a program participant shall provide to such individual (if otherwise eligible for such services), program services that—

(A) are from an alternative provider that is accessible to, and has the capacity to provide such services to, such individual; and

(B) have a value that is not less than the value of the services that the individual would have received from the program participant to which the individual had such objection.

Upon referring a program beneficiary to an alternative provider, the program participant shall notify the appropriate Federal, State, or local government agency that administers the program of such referral.

(2) NOTICES.—Program participants, public agencies that refer individuals to designated programs, and the appropriate Federal, State, or local governments that administer designated programs or are program participants shall ensure that notice is provided to program beneficiaries or prospective program beneficiaries of their rights under this section.

(3) ADDITIONAL REQUIREMENTS.—A program participant making a referral pursuant to paragraph (1) shall—

(A) prior to making such referral, consider any list that the State or local government makes available of entities in the geographic area that provide program services; and

(B) ensure that the individual makes contact with the alternative provider to which the individual is referred.

(4) NONDISCRIMINATION.—A religious organization that is a program participant shall not in providing program services or engaging in outreach activities under designated programs discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(g) FISCAL ACCOUNTABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), any religious organization that is a program participant shall be subject to the same regulations as other recipients of awards of Federal financial assistance to account, in accordance with generally accepted auditing principles, for the use of the funds provided under such awards.

(2) LIMITED AUDIT.—With respect to the award involved, a religious organization that is a program participant shall segregate Federal amounts provided under award into a separate

account from non-Federal funds. Only the award funds shall be subject to audit by the government.

(h) COMPLIANCE.—With respect to compliance with this section by an agency, a religious organization may obtain judicial review of agency action in accordance with chapter 7 of title 5, United States Code.

**SEC. [583.] 596B. LIMITATIONS ON USE OF FUNDS FOR CERTAIN PURPOSES.**

No funds provided under a designated program shall be expended for sectarian worship, instruction, or proselytization.

**SEC. [584.] 596C. EDUCATIONAL REQUIREMENTS FOR PERSONNEL IN DRUG TREATMENT PROGRAMS.**

(a) FINDINGS.—The Congress finds that—

(1) establishing unduly rigid or uniform educational qualification for counselors and other personnel in drug treatment programs may undermine the effectiveness of such programs; and

(2) such educational requirements for counselors and other personnel may hinder or prevent the provision of needed drug treatment services.

(b) NONDISCRIMINATION.—In determining whether personnel of a program participant that has a record of successful drug treatment for the preceding three years have satisfied State or local requirements for education and training, a State or local government shall not discriminate against education and training provided to such personnel by a religious organization, so long as such education and training includes basic content substantially equivalent to the content provided by nonreligious organizations that the State or local government would credit for purposes of determining whether the relevant requirements have been satisfied.

## **PART K—MINORITY FELLOWSHIP PROGRAM**

**SEC. 597. FELLOWSHIPS.**

(a) IN GENERAL.—The Secretary shall maintain a program, to be known as the Minority Fellowship Program, under which the Secretary shall award fellowships, which may include stipends, for the purposes of—

(1) increasing the knowledge of mental and substance use disorders practitioners on issues related to *diagnosis*, prevention, treatment, and recovery support for individuals who are from racial and ethnic minority populations and who have a mental or substance use disorder;

(2) improving the quality of mental and substance use disorder prevention and treatment services delivered to racial and ethnic minority populations; and

(3) increasing the number of culturally competent mental and substance use disorders professionals who teach, administer services, conduct research, and provide direct mental or substance use disorder services to racial and ethnic minority populations.

(b) TRAINING COVERED.—The fellowships awarded under subsection (a) shall be for postbaccalaureate training (including for master's and doctoral degrees) for mental and substance use dis-

order treatment professionals, including in the fields of psychiatry, *addiction medicine*, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$25,000,000 for each of fiscal years 2023 through 2027.

## **TITLE VII—HEALTH PROFESSIONS EDUCATION**

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### **PART D—INTERDISCIPLINARY, COMMUNITY- BASED LINKAGES**

\* \* \* \* \*

#### **SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.**

(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions to support the recruitment of students for, and education and clinical experience of the students in—

(1) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing (which may include master's and doctoral level programs), social work, school social work, substance use disorder prevention and treatment, marriage and family therapy, occupational therapy (which may include master's and doctoral level programs), school counseling, or professional counseling, including such programs with a focus on child and adolescent mental health, trauma, and transitional-age youth;

(2) accredited doctoral, internship, and post-doctoral residency programs of health service psychology (including clinical psychology, counseling, and school psychology) for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral health services, including trauma-informed care and substance use disorder prevention and treatment services, as well as the development of faculty in health service psychology;

(3) accredited master's and doctoral degree programs of social work for the development and implementation of interdisciplinary training of social work graduate students for providing behavioral health services, including trauma-informed care and substance use disorder prevention and treatment services, and the development of faculty in social work; and

(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training in a behavioral health-related paraprofessional field with preference for preservice or in-service training of paraprofessional child and adolescent mental health workers, including training to increase skills

and capacity to meet the needs of children and adolescents who have experienced trauma.

(b) **ELIGIBILITY REQUIREMENTS.**—To be eligible for a grant under this section, an institution shall demonstrate—

(1) an ability to recruit and place the students described in subsection (a) in areas with a high need and high demand population;

(2) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

(3) knowledge and understanding of the concerns of the individuals and groups described in paragraph (2), especially individuals with mental disorder symptoms or diagnoses, particularly children and adolescents, and transitional-age youth;

(4) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency; and

(5) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require.

(c) **INSTITUTIONAL REQUIREMENT.**—For grants awarded under paragraphs (2) and (3) of subsection (a), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

(d) **PRIORITY.**—In selecting grant recipients under this section, the Secretary shall give priority to—

(1) programs that have demonstrated the ability to train psychology, psychiatry, and social work professionals to work in integrated care settings for purposes of recipients under paragraphs (1), (2), and (3) of subsection (a); and

(2) programs for paraprofessionals that emphasize the role of the family and the lived experience of the consumer and family-paraprofessional partnerships for purposes of recipients under subsection (a)(4).

(e) **REPORT TO CONGRESS.**—Not later than 4 years after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary shall include in the biennial report submitted to Congress under section 501(m) an assessment on the effectiveness of the grants under this section in—

(1) providing graduate students support for experiential training (internship or field placement);

(2) recruiting students interested in behavioral health practice;

(3) recruiting students in accordance with subsection (b)(1);

(4) developing and implementing interprofessional training and integration within primary care;

(5) developing and implementing accredited field placements and internships; and

(6) collecting data on the number of students trained in behavioral health care and the number of available accredited internships and field placements.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—For each of [fiscal years 2023 through 2027] *fiscal years 2026 through 2030*, there are authorized to be appropriated to carry out this section \$50,000,000, to be allocated as follows:

- (1) For grants described in subsection (a)(1), \$15,000,000.
- (2) For grants described in subsection (a)(2), \$15,000,000.
- (3) For grants described in subsection (a)(3), \$10,000,000.
- (4) For grants described in subsection (a)(4), \$10,000,000.

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## PART F—SUBSTANCE USE DISORDER TREATMENT WORKFORCE

### SEC. 781. LOAN REPAYMENT PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT WORKFORCE.

(a) **IN GENERAL.**—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall carry out a program under which—

- (1) the Secretary enters into agreements with individuals to make payments in accordance with subsection (b) on the principal of and interest on any eligible loan; and
- (2) the individuals each agree to the requirements of service in substance use disorder treatment employment, as described in subsection (d).

(b) **PAYMENTS.**—For each year of obligated service by an individual pursuant to an agreement under subsection (a), the Secretary shall make a payment to such individual as follows:

- (1) **SERVICE IN A SHORTAGE AREA.**—The Secretary shall pay—
  - (A) for each year of obligated service by an individual pursuant to an agreement under subsection (a),  $\frac{1}{6}$  of the principal of and interest on each eligible loan of the individual which is outstanding on the date the individual began service pursuant to the agreement; and
  - (B) for completion of the sixth and final year of such service, the remainder of such principal and interest.

(2) **MAXIMUM AMOUNT.**—The total amount of payments under this section to any individual shall not exceed \$250,000.

(c) **ELIGIBLE LOANS.**—The loans eligible for repayment under this section are each of the following:

- (1) Any loan for education or training for a substance use disorder treatment employment.
- (2) Any loan under part E of title VIII (relating to nursing student loans).
- (3) Any Federal Direct Stafford Loan, Federal Direct PLUS Loan, Federal Direct Unsubsidized Stafford Loan, or Federal Direct Consolidation Loan (as such terms are used in section 455 of the Higher Education Act of 1965).
- (4) Any Federal Perkins Loan under part E of title I of the Higher Education Act of 1965.
- (5) Any other Federal loan as determined appropriate by the Secretary.

(d) **REQUIREMENTS OF SERVICE.**—Any individual receiving payments under this program as required by an agreement under subsection (a) shall agree to an annual commitment to full-time employment, with no more than 1 year passing between any 2 years of covered employment, in substance use disorder treatment employment in the United States in—

- (1) a Mental Health Professional Shortage Area, as designated under section 332; or
  - (2) a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past 3 years for which official data is available from the State, is higher than the most recent available national average overdose death rate per 100,000 people, as reported by the Centers for Disease Control and Prevention.
- (e) INELIGIBILITY FOR DOUBLE BENEFITS.—No borrower may, for the same service, receive a reduction of loan obligations or a loan repayment under both—
- (1) this section; and
  - (2) any Federally supported loan forgiveness program, including under section 338B, 338I, or 846 of this Act, or section 428J, 428L, 455(m), or 460 of the Higher Education Act of 1965.
- (f) BREACH.—
- (1) LIQUIDATED DAMAGES FORMULA.—The Secretary may establish a liquidated damages formula to be used in the event of a breach of an agreement entered into under subsection (a).
  - (2) LIMITATION.—The failure by an individual to complete the full period of service obligated pursuant to such an agreement, taken alone, shall not constitute a breach of the agreement, so long as the individual completed in good faith the years of service for which payments were made to the individual under this section.
- (g) ADDITIONAL CRITERIA.—The Secretary—
- (1) may establish such criteria and rules to carry out this section as the Secretary determines are needed and in addition to the criteria and rules specified in this section; and
  - (2) shall give notice to the committees specified in subsection (h) of any criteria and rules so established.
- (h) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this section, and every other year thereafter, the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on—
- (1) the number and location of borrowers who have qualified for loan repayments under this section; and
  - (2) the impact of this section on the availability of substance use disorder treatment employees nationally and in shortage areas and counties described in subsection (d).
- (i) DEFINITION.—In this section:
- (1) The terms “Indian tribe” and “tribal organization” have the meanings given those terms in section 4 of the Indian Self-Determination and Education Assistance Act.
  - (2) The term “municipality” means a city, town, or other public body created by or pursuant to State law, or an Indian tribe.
  - (3) The term “substance use disorder treatment employment” means full-time employment (including a fellowship)—
    - (A) where the primary intent and function of the position is the direct treatment or recovery support of patients with or in recovery from a substance use disorder, includ-

ing master’s level social workers, psychologists, counselors, marriage and family therapists, psychiatric mental health practitioners, occupational therapists, psychology doctoral interns, and behavioral health paraprofessionals and physicians, physician assistants, and nurses, who are licensed or certified in accordance with applicable State and Federal laws; and

(B) which is located at a substance use disorder treatment program, private physician practice, hospital or health system-affiliated inpatient treatment center or outpatient clinic (including an academic medical center-affiliated treatment program), correctional facility or program, youth detention center or program, inpatient psychiatric facility, crisis stabilization unit, community health center, community mental health or other specialty community behavioral health center, recovery center, school, community-based organization, telehealth platform, migrant health center, health program or facility operated by an Indian tribe or tribal organization, Federal medical facility, or any other facility as determined appropriate for purposes of this section by the Secretary.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section **[\$25,000,000 for each of fiscal years 2019 through 2023]** *\$40,000,000 for each of fiscal years 2026 through 2030.*

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**SUPPORT FOR PATIENTS AND COMMUNITIES ACT**

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

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

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

Sec. 1. Short title; table of contents.

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**TITLE VII—PUBLIC HEALTH PROVISIONS**

\* \* \* \* \*

**Subtitle S—Other Health Provisions**

\* \* \* \* \*

**[Sec. 7183. CAREER Act.]**

*Sec. 7183. CAREER Act; treatment, recovery, and workforce support grants.*

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**TITLE VIII—MISCELLANEOUS**

\* \* \* \* \*

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

*Subtitle F—CAREER Act; Recovery Housing Pilot Program*

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

*Sec. 8071. CAREER Act; Recovery Housing Pilot Program.*

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**TITLE III—FDA AND CONTROLLED  
SUBSTANCE PROVISIONS**

\* \* \* \* \*

**Subtitle B—Controlled Substance  
Provisions**

**CHAPTER 1—MORE FLEXIBILITY WITH RESPECT TO  
MEDICATION-ASSISTED TREATMENT FOR OPIOID USE  
DISORDERS**

\* \* \* \* \*

**SEC. 3203. GRANTS TO ENHANCE ACCESS TO SUBSTANCE USE DIS-  
ORDER TREATMENT.**

**[(a) IN GENERAL.—]**The Secretary of Health and Human Services shall establish a grant program under which the Secretary may make grants to accredited schools of allopathic medicine or osteopathic medicine and teaching hospitals located in the United States to support the development of curricula that meet the requirements under subclause (VIII) of section 303(g)(2)(G)(ii) of the Controlled Substances Act, as added by section 3202(a) of this Act.

**[(b) AUTHORIZATION OF APPROPRIATIONS.—]**There is authorized to be appropriated, for grants under subsection (a), \$4,000,000 for each of fiscal years 2019 through 2023.]

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**TITLE VII—PUBLIC HEALTH  
PROVISIONS**

\* \* \* \* \*

**Subtitle C—Indexing Narcotics, Fentanyl,  
and Opioids**

\* \* \* \* \*

**SEC. 7022. INTERDEPARTMENTAL SUBSTANCE USE DISORDERS CO-  
ORDINATING COMMITTEE.**

(a) **ESTABLISHMENT.—**Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall, in coordination with the Director of National Drug Control Policy, establish a committee, to be known as the Interdepartmental Substance

Use Disorders Coordinating Committee (in this section referred to as the “Committee”), to coordinate Federal activities related to substance use disorders.

(b) MEMBERSHIP.—

(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or the designees of such representatives:

(A) The Secretary, who shall serve as the Chair of the Committee.

(B) The Attorney General of the United States.

(C) The Secretary of Labor.

(D) The Secretary of Housing and Urban Development.

(E) The Secretary of Education.

(F) The Secretary of Veterans Affairs.

(G) The Commissioner of Social Security.

(H) The Assistant Secretary for Mental Health and Substance Use.

(I) The Director of National Drug Control Policy.

(J) Representatives of other Federal agencies that support or conduct activities or programs related to substance use disorders, as determined appropriate by the Secretary.

(2) NON-FEDERAL MEMBERS.—The Committee shall include a minimum of 15 non-Federal members appointed by the Secretary, of which—

(A) at least two such members shall be an individual who has received treatment for a diagnosis of a substance use disorder;

(B) at least two such members shall be a director of a State substance abuse agency;

(C) at least two such members shall be a representative of a leading research, advocacy, or service organization for adults with substance use disorder;

(D) at least two such members shall—

(i) be a physician, licensed mental health professional, advance practice registered nurse, or physician assistant; and

(ii) have experience in treating individuals with substance use disorders;

(E) at least one such member shall be a substance use disorder treatment professional who provides treatment services at a certified opioid treatment program;

(F) at least one such member shall be a substance use disorder treatment professional who has research or clinical experience in working with racial and ethnic minority populations;

(G) at least one such member shall be a substance use disorder treatment professional who has research or clinical mental health experience in working with medically underserved populations;

(H) at least one such member shall be a State-certified substance use disorder peer support specialist;

(I) at least one such member shall be a drug court judge or a judge with experience in adjudicating cases related to substance use disorder;

(J) at least one such member shall be a public safety officer with extensive experience in interacting with adults with a substance use disorder; and

(K) at least one such member shall be an individual with experience providing services for homeless individuals with a substance use disorder.

(c) TERMS.—

(1) IN GENERAL.—A member of the Committee appointed under subsection (b)(2) shall be appointed for a term of 3 years and may be reappointed for one or more 3-year terms.

(2) VACANCIES.—A vacancy on the Committee shall be filled in the same manner in which the original appointment was made. Any individual appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term and may serve after the expiration of such term until a successor has been appointed.

(d) MEETINGS.—The Committee shall meet not fewer than two times each year.

(e) DUTIES.—The Committee shall—

(1) identify areas for improved coordination of activities, if any, related to substance use disorders, including research, services, supports, and prevention activities across all relevant Federal agencies;

(2) identify and provide to the Secretary recommendations for improving Federal programs for the prevention and treatment of, and recovery from, substance use disorders, including by expanding access to prevention, treatment, and recovery services;

(3) analyze substance use disorder prevention and treatment strategies in different regions of and populations in the United States and evaluate the extent to which Federal substance use disorder prevention and treatment strategies are aligned with State and local substance use disorder prevention and treatment strategies;

(4) make recommendations to the Secretary regarding any appropriate changes with respect to the activities and strategies described in paragraphs (1) through (3);

(5) make recommendations to the Secretary regarding public participation in decisions relating to substance use disorders and the process by which public feedback can be better integrated into such decisions; and

(6) make recommendations to ensure that substance use disorder research, services, supports, and prevention activities of the Department of Health and Human Services and other Federal agencies are not unnecessarily duplicative.

(f) ANNUAL REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for the life of the Committee, the Committee shall publish on the Internet website of the Department of Health and Human Services, which may include the public information dashboard established under section 1711 of the Public Health Service Act, as added by section 7021, a report summarizing the activities carried out by the Committee pursuant to subsection (e), including any findings resulting from such activities.

[(g) WORKING GROUPS.—The Committee may establish working groups for purposes of carrying out the duties described in subsection (e). Any such working group shall be composed of members of the Committee (or the designees of such members) and may hold such meetings as are necessary to enable the working group to carry out the duties delegated to the working group.]

(g) WORKING GROUPS.—

(1) IN GENERAL.—*The Committee may establish working groups for purposes of carrying out the duties described in subsection (e). Any such working group shall be composed of members of the Committee (or the designees of such members) and may hold such meetings as are necessary to carry out the duties delegated to the working group.*

(2) ADDITIONAL FEDERAL INTERAGENCY WORK GROUP ON FENTANYL CONTAMINATION OF ILLEGAL DRUGS.—

(A) ESTABLISHMENT.—*The Secretary, acting through the Committee, shall establish a Federal Interagency Work Group on Fentanyl Contamination of Illegal Drugs (referred to in this paragraph as the “Work Group”) consisting of representatives from relevant Federal departments and agencies on the Committee.*

(B) CONSULTATION.—*The Work Group shall consult with relevant stakeholders and subject matter experts, including—*

*(i) State, Tribal, and local subject matter experts in reducing, preventing, and responding to drug overdose caused by fentanyl contamination of illicit drugs; and*

*(ii) family members of both adults and youth who have overdosed by fentanyl contaminated illicit drugs.*

(C) DUTIES.—*The Work Group shall—*

*(i) examine Federal efforts to reduce and prevent drug overdose by fentanyl-contaminated illicit drugs;*

*(ii) identify strategies to improve State, Tribal, and local responses to overdose by fentanyl-contaminated illicit drugs;*

*(iii) coordinate with the Secretary, as appropriate, in carrying out activities to raise public awareness of synthetic opioids and other emerging drug use and misuse issues;*

*(iv) make recommendations to Congress for improving Federal programs, including with respect to the coordination of efforts across such programs; and*

*(v) make recommendations for educating youth on the potency and dangers of drugs contaminated by fentanyl.*

(D) ANNUAL REPORT TO SECRETARY.—*The Work Group shall annually prepare and submit to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Workforce of the House of Representatives, a report on the activities carried out by the Work Group under subparagraph (C), including recommendations to reduce and prevent drug overdose by fentanyl contamination of illegal drugs, in all populations, and specifically among youth at risk for substance misuse.*

(h) **FEDERAL ADVISORY COMMITTEE ACT.**—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee only to the extent that the provisions of such Act do not conflict with the requirements of this section.

[(i) **SUNSET.**—The Committee shall terminate on the date that is 6 years after the date on which the Committee is established under subsection (a).]

(i) *SUNSET.*—*The Committee shall terminate on September 30, 2030.*

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## Subtitle F—Jessie’s Law

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### **SEC. 7053. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS FOR SUBSTANCE USE DISORDER PATIENT RECORDS.**

(a) **INITIAL PROGRAMS AND MATERIALS.**—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”), in consultation with appropriate experts, shall identify the following model programs and materials (or if no such programs or materials exist, recognize private or public entities to develop and disseminate such programs and materials):

(1) Model programs and materials for training health care providers (including physicians, emergency medical personnel, psychiatrists, psychologists, counselors, therapists, nurse practitioners, physician assistants, behavioral health facilities and clinics, care managers, and hospitals, including individuals such as general counsels or regulatory compliance staff who are responsible for establishing provider privacy policies) concerning the permitted uses and disclosures, consistent with the standards and regulations governing the privacy and security of substance use disorder patient records promulgated by the Secretary under section 543 of the Public Health Service Act (42 U.S.C. 290dd-2) for the confidentiality of patient records.

(2) Model programs and materials for training patients and their families regarding their rights to protect and obtain information under the standards and regulations described in paragraph (1).

(b) **REQUIREMENTS.**—The model programs and materials described in paragraphs (1) and (2) of subsection (a) shall address circumstances under which disclosure of substance use disorder patient records is needed to—

(1) facilitate communication between substance use disorder treatment providers and other health care providers to promote and provide the best possible integrated care;

(2) avoid inappropriate prescribing that can lead to dangerous drug interactions, overdose, or relapse; and

(3) notify and involve families and caregivers when individuals experience an overdose.

(c) **PERIODIC UPDATES.**—The Secretary shall—

(1) periodically review and update the model program and materials identified or developed under subsection (a); and

(2) disseminate such updated programs and materials to the individuals described in subsection (a)(1).

(d) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials under this section, the Secretary shall solicit the input of relevant stakeholders.

[(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

[(1) \$4,000,000 for fiscal year 2019;

[(2) \$2,000,000 for each of fiscal years 2020 and 2021; and

[(3) \$1,000,000 for each of fiscal years 2022 and 2023.]

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## Subtitle K—Treatment, Education, and Community Help To Combat Addiction

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### SEC. 7102. YOUTH PREVENTION AND RECOVERY.

(a) SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN, ADOLESCENTS, AND YOUNG ADULTS.—Section 514 of the Public Health Service Act (42 U.S.C. 290bb-7) is amended—

(1) in the section heading, by striking “children and adolescents” and inserting “children, adolescents, and young adults”;

(2) in subsection (a)(2), by striking “children, including” and inserting “children, adolescents, and young adults, including”; and

(3) by striking “children and adolescents” each place it appears and inserting “children, adolescents, and young adults”.

(b) RESOURCE CENTER.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”, except as otherwise provided), in consultation with the Secretary of Education and other heads of agencies, including the Assistant Secretary for Mental Health and Substance Use and the Administrator of the Health Resources and Services Administration, as appropriate, shall establish a resource center to provide technical support to recipients of grants under subsection (c).

(c) YOUTH PREVENTION AND RECOVERY INITIATIVE.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall administer a program to provide support for communities to support the prevention of, treatment of, and recovery from, substance use disorders for children, adolescents, and young adults.

(2) DEFINITIONS.—In this subsection:

(A) ELIGIBLE ENTITY.—The term “eligible entity” means—

(i) a local educational agency, or a consortium of local educational agencies, that is seeking to establish or expand substance use prevention or recovery support services at one or more [high schools] secondary schools;

(ii) a State educational agency;

(iii) an institution of higher education (or consortia of such institutions), which may include a recovery program at an institution of higher education;

- (iv) a local board or one-stop operator;
- (v) a nonprofit organization with appropriate expertise in providing services or programs for children, adolescents, or young adults, excluding a school;
- (vi) a State, political subdivision of a State, Indian **Tribe, or Tribal** organization; or
- (vii) a high school or dormitory serving high school students that receives funding from the Bureau of Indian Education.

(B) FOSTER CARE.—The term “foster care” has the meaning given such term in section 1355.20(a) of title 45, Code of Federal Regulations (or any successor regulations).

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

(D) HOMELESS YOUTH.—The term “homeless youth” has the meaning given the term “homeless children or youths” in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a).

**[(E) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms “Indian tribe” and “tribal organization” have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).]**

*(E) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms “Indian Tribe” and “Tribal organization” have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).*

(F) INSTITUTION OF HIGHER EDUCATION.—The term “institution of higher education” has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001) and includes a “postsecondary vocational institution” as defined in section 102(c) of such Act (20 U.S.C. 1002(c)).

(G) LOCAL EDUCATIONAL AGENCY.—The term “local educational agency” has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(H) LOCAL BOARD; ONE-STOP OPERATOR.—The terms “local board” and “one-stop operator” have the meanings given such terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

(I) OUT-OF-SCHOOL YOUTH.—The term “out-of-school youth” has the meaning given such term in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3164(a)(1)(B)).

(J) RECOVERY PROGRAM.—The term “recovery program” means a program—

- (i) to help children, adolescents, or young adults who are recovering from substance use disorders to initiate, stabilize, and maintain healthy and productive lives in the community; and
- (ii) that includes peer-to-peer support delivered by individuals with lived experience in recovery, and com-

munal activities to build recovery skills and supportive social networks.

(K) *SECONDARY SCHOOL.*—The term “secondary school” has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

[(K)] (L) *STATE EDUCATIONAL AGENCY.*—The term “State educational agency” has the meaning given such term in section 8101 of the Elementary and Secondary Education Act (20 U.S.C. 7801).

(3) *BEST PRACTICES.*—The Secretary, in consultation with the Secretary of Education, shall—

(A) identify or facilitate the development of evidence-based best practices for prevention of substance misuse [and abuse] by children, adolescents, and young adults, including for specific populations *at increased risk for substance misuse* such as youth in foster care, homeless youth, out-of-school youth, and youth who are at risk of or have experienced trafficking that address—

(i) primary prevention, *which may include strategies to increase education and awareness of the potency and dangers of synthetic opioids (including drugs contaminated with fentanyl) and, as appropriate, other emerging drug use or misuse issues;*

(ii) appropriate recovery support services;

(iii) appropriate use of medication-assisted treatment for such individuals, if applicable, and ways of overcoming barriers to the use of medication-assisted treatment in such population; and

(iv) efficient and effective communication, which may include the use of social media, to maximize outreach efforts;

(B) disseminate such best practices to State educational agencies, local educational agencies, schools and dormitories funded by the Bureau of Indian Education, institutions of higher education, recovery programs at institutions of higher education, local boards, one-stop operators, family and youth homeless providers, and nonprofit organizations, as appropriate;

(C) conduct a rigorous evaluation of each grant funded under this subsection, particularly its impact on the indicators described in paragraph (7)(B); and

(D) provide technical assistance for grantees under this subsection.

(4) *GRANTS AUTHORIZED.*—The Secretary, in consultation with the Secretary of Education, shall award 3-year grants, on a competitive basis, to eligible entities to enable such entities, in coordination with [Indian tribes] *Indian Tribes*, if applicable, and State agencies responsible for carrying out substance use disorder prevention and treatment programs, to carry out evidence-based programs for—

(A) prevention of substance misuse [and abuse] by children, adolescents, and young adults, which may include primary prevention *and strategies to increase education and awareness of the potency and dangers of synthetic*

*opioids (including drugs contaminated with fentanyl) and, as appropriate, emerging drug use or misuse issues;*

(B) recovery support services for children, adolescents, and young adults, which may include counseling, job training, linkages to community-based services, family support groups, [peer mentoring] *peer-to-peer support*, and recovery coaching; or

(C) treatment or referrals for treatment of substance use disorders, which may include the use of medication-assisted treatment, as appropriate.

(5) SPECIAL CONSIDERATION.—In awarding grants under this subsection, the Secretary shall give special consideration to the unique needs of [tribal] *Tribal*, urban, suburban, and rural populations.

(6) APPLICATION.—To be eligible for a grant under this subsection, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require. Such application shall include—

(A) a description of—

(i) the impact of substance use disorders in the population that will be served by the grant program;

(ii) how the eligible entity has solicited input from relevant stakeholders, which may include faculty, teachers, staff, families, students, and experts in substance use disorder prevention, treatment, and recovery in developing such application;

(iii) the goals of the proposed project, including the intended outcomes;

(iv) how the eligible entity plans to use grant funds for evidence-based activities, in accordance with this subsection to prevent, provide recovery support for, or treat substance use disorders amongst such individuals, or a combination of such activities[; and];

(v) how the eligible entity will collaborate with relevant partners, which may include State educational agencies, local educational agencies, institutions of higher education, juvenile justice agencies, prevention and recovery support providers, local service providers, including substance use disorder treatment programs, providers of mental health services, youth serving organizations, family and youth homeless providers, child welfare agencies, and primary care providers, in carrying out the grant program; and

(vi) *a plan to sustain the activities carried out under the grant program, after the grant program has ended; and*

(B) an assurance that the eligible entity will participate in the evaluation described in paragraph (3)(C).

(7) REPORTS TO THE SECRETARY.—Each eligible entity awarded a grant under this subsection shall submit to the Secretary a report at such time and in such manner as the Secretary may require. Such report shall include—

(A) a description of how the eligible entity used grant funds, in accordance with this subsection, including the

number of children, adolescents, and young adults reached through programming; and

(B) a description, including relevant data, of how the grant program has made an impact on the intended outcomes described in paragraph (6)(A)(iii), including—

(i) indicators of student success, which, if the eligible entity is an educational institution, shall include student well-being and academic achievement;

(ii) substance use disorders amongst children, adolescents, and young adults, including the number of overdoses and deaths amongst children, adolescents, and young adults served by the grant during the grant period; and

(iii) other indicators, as the Secretary determines appropriate.

(8) REPORT TO CONGRESS.—The Secretary shall, not later than October 1, ~~2022~~ 2028, submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives a report summarizing the effectiveness of the grant program under this subsection, based on the information submitted in reports required under paragraph (7).

[(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated \$10,000,000 to carry out this subsection for each of fiscal years 2019 through 2023.]

(9) AUTHORIZATION OF APPROPRIATIONS.—*To carry out this subsection, there are authorized to be appropriated—*

- (A) \$10,000,000 for fiscal year 2026;
- (B) \$12,000,000 for fiscal year 2027;
- (C) \$13,000,000 for fiscal year 2028;
- (D) \$14,000,000 for fiscal year 2029; and
- (E) \$15,000,000 for fiscal year 2030.

\* \* \* \* \*

## Subtitle N—Trauma-Informed Care

### SEC. 7131. CDC SURVEILLANCE AND DATA COLLECTION FOR CHILD, YOUTH, AND ADULT TRAUMA.

(a) DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”) may, in cooperation with the States, collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, and other relevant public health surveys or questionnaires.

(b) TIMING.—The collection of data under subsection (a) may occur biennially.

(c) DATA FROM RURAL AREAS.—The Director shall encourage each State that participates in collecting and reporting data under subsection (a) to collect and report data from rural areas within such State, in order to generate a statistically reliable representation of such areas.

(d) DATA FROM TRIBAL AREAS.—The Director may, in cooperation with Indian Tribes (as defined in section 4 of the Indian Self-Deter-

mination and Education Assistance Act) and pursuant to a written request from an Indian Tribe, provide technical assistance to such Indian Tribe to collect and report data on adverse childhood experiences through the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, or another relevant public health survey or questionnaire.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated ~~【\$2,000,000 for each of fiscal years 2019 through 2023】~~ *\$9,000,000 for each of fiscal years 2026 through 2030.*

**SEC. 7132. TASK FORCE TO DEVELOP BEST PRACTICES FOR TRAUMA-INFORMED IDENTIFICATION, REFERRAL, AND SUPPORT.**

(a) ESTABLISHMENT.—There is established a task force, to be known as the Interagency Task Force on Trauma-Informed Care (in this section referred to as the “task force”) that shall identify, evaluate, and make recommendations regarding—

- (1) best practices with respect to children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma; and
- (2) ways in which Federal agencies can better coordinate to improve the Federal response to families impacted by substance use disorders and other forms of trauma.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The task force shall be composed of the heads of the following Federal departments and agencies, or their designees:

- (A) The Centers for Medicare & Medicaid Services.
- (B) The Substance Abuse and Mental Health Services Administration.
- (C) The Agency for Healthcare Research and Quality.
- (D) The Centers for Disease Control and Prevention.
- (E) The Indian Health Service.
- (F) The Department of Veterans Affairs.
- (G) The National Institutes of Health.
- (H) The Food and Drug Administration.
- (I) The Health Resources and Services Administration.
- (J) The Department of Defense.
- (K) The Office of Minority Health of the Department of Health and Human Services.
- (L) The Administration for Children and Families.
- (M) The Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.
- (N) The Office for Civil Rights of the Department of Health and Human Services.
- (O) The Office of Juvenile Justice and Delinquency Prevention of the Department of Justice.
- (P) The Office of Community Oriented Policing Services of the Department of Justice.
- (Q) The Office on Violence Against Women of the Department of Justice.
- (R) The National Center for Education Evaluation and Regional Assistance of the Department of Education.
- (S) The National Center for Special Education Research of the Institute of Education Science.

(T) The Office of Elementary and Secondary Education of the Department of Education.

(U) The Office for Civil Rights of the Department of Education.

(V) The Office of Special Education and Rehabilitative Services of the Department of Education.

(W) The Bureau of Indian Affairs of the Department of the Interior.

(X) The Veterans Health Administration of the Department of Veterans Affairs.

(Y) The Office of Special Needs Assistance Programs of the Department of Housing and Urban Development.

(Z) The Office of Head Start of the Administration for Children and Families.

(AA) The Children's Bureau of the Administration for Children and Families.

(BB) The Bureau of Indian Education of the Department of the Interior.

(CC) *The Administration for Community Living.*

[(CC)] (DD) Such other Federal agencies as the Secretaries determine to be appropriate.

(2) DATE OF APPOINTMENTS.—The heads of Federal departments and agencies shall appoint the corresponding members of the task force not later than 60 days after the date of enactment of this Act.

(3) CHAIRPERSON.—The task force shall be chaired by the Assistant Secretary for Mental Health and Substance Use, or the Assistant Secretary's designee.

(c) TASK FORCE DUTIES.—The task force shall—

(1) solicit input from stakeholders, including frontline service providers, educators, mental health professionals, researchers, experts in infant, child, and youth trauma, child welfare professionals, and the public, in order to inform the activities under paragraph (2); and

(2) identify, evaluate, make recommendations, and update such recommendations not less than annually, to the general public, the Secretary of Education, the Secretary of Health and Human Services, the Secretary of Labor, the Secretary of the Interior, the Attorney General, and other relevant cabinet Secretaries, and Congress regarding—

(A) a set of evidence-based, evidence-informed, and promising best practices with respect to—

(i) prevention strategies for individuals at risk of experiencing or being exposed to trauma, including trauma as a result of exposure to substance use;

(ii) the identification of infants, children and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma;

(iii) the expeditious referral to and implementation of trauma-informed practices and supports that prevent and mitigate the effects of trauma, which may include whole-family and multi-generational approaches; and

(iv) community based or multi-generational practices that support children and their families;

(B) a national strategy on how the task force and member agencies will collaborate, prioritize options for, and implement a coordinated approach, which may include—

- (i) data sharing;
- (ii) providing support to infants, children, and youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma;
- (iii) identifying options for coordinating existing grants that support infants, children, and youth, and their families as appropriate, who have experienced, or are at risk of experiencing, exposure to substance use or other trauma, including trauma related to substance use; and
- (iv) other ways to improve coordination, planning, and communication within and across Federal agencies, offices, and programs, to better serve children and families impacted by substance use disorders; and

(C) existing Federal authorities at the Department of Education, Department of Health and Human Services, Department of Justice, Department of Labor, Department of the Interior, and other relevant agencies, and specific Federal grant programs to disseminate best practices on, provide training in, or deliver services through, trauma-informed practices, and disseminate such information—

- (i) in writing to relevant program offices at such agencies to encourage grant applicants in writing to use such funds, where appropriate, for trauma-informed practices; and
- (ii) to the general public through the internet website of the task force.

(d) BEST PRACTICES.—In identifying, evaluating, and recommending the set of best practices under subsection (c), the task force shall—

(1) include guidelines for providing professional development and education for front-line services providers, including school personnel, early childhood education program providers, providers from child- or youth-serving organizations, housing and homeless providers, primary and behavioral health care providers, child welfare and social services providers, juvenile and family court personnel, health care providers, *developmental disability service providers*, individuals who are mandatory reporters of child abuse or neglect, trained nonclinical providers (including peer mentors and clergy), and first responders, in—

(A) understanding and identifying early signs and risk factors of trauma in infants, children, and youth, and their families as appropriate, including through screening processes and services;

(B) providing practices to prevent and mitigate the impact of trauma, including by fostering safe and stable environments and relationships; and

(C) developing and implementing policies, procedures, or systems that—

- (i) are designed to quickly refer infants, children, youth, and their families as appropriate, who have experienced or are at risk of experiencing trauma to the

appropriate trauma-informed screening and support and age-appropriate treatment, and to ensure such infants, children, youth, and family members receive such support;

(ii) utilize and develop partnerships with early childhood education programs, local social services organizations, such as organizations serving youth, and clinical mental health or other health care providers with expertise in providing support services and age-appropriate trauma-informed and evidence-based treatment aimed at preventing or mitigating the effects of trauma;

(iii) educate children and youth to—

(I) understand and identify the signs, effects, or symptoms of trauma; and

(II) build the resilience and coping skills to mitigate the effects of experiencing trauma;

(iv) promote and support multi-generational practices that assist parents, foster parents, and kinship and other caregivers in accessing resources related to, and developing environments conducive to, the prevention and mitigation of trauma; and

(v) collect and utilize data from screenings, referrals, or the provision of services and supports to evaluate outcomes and improve processes for trauma-informed services and supports that are culturally sensitive, linguistically appropriate, and specific to age ranges and sex, as applicable;

(2) recommend best practices that are designed to avoid unwarranted custody loss or criminal penalties for parents or guardians in connection with infants, children, and youth who have experienced or are at risk of experiencing trauma; and

(3) recommend opportunities for local- and State-level partnerships that—

(A) are designed to quickly identify and refer children and families, as appropriate, who have experienced or are at risk of experiencing exposure to trauma, including related to substance use;

(B) utilize and develop partnerships with early childhood education programs, local social services organizations, and health care services aimed at preventing or mitigating the effects of exposure to trauma, including related to substance use;

(C) offer community-based prevention activities, including educating families and children on the effects of exposure to trauma, such as trauma related to substance use, and how to build resilience and coping skills to mitigate those effects;

(D) in accordance with Federal privacy protections, utilize non-personally-identifiable data from screenings, referrals, or the provision of services and supports to evaluate and improve processes addressing exposure to trauma, including related to substance use; and

(E) are designed to prevent separation and support reunification of families if in the best interest of the child.

(e) OPERATING PLAN.—Not later than 120 days after the date of enactment of this Act, the task force shall hold the first meeting. Not later than 2 years after such date of enactment, the task force shall submit to the Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, and Congress an operating plan for carrying out the activities of the task force described in subsection (c)(2). Such operating plan shall include—

(1) a list of specific activities that the task force plans to carry out for purposes of carrying out duties described in subsection (c)(2), which may include public engagement;

(2) a plan for carrying out the activities under subsection (c)(2);

(3) a list of members of the task force and other individuals who are not members of the task force that may be consulted to carry out such activities;

(4) an explanation of Federal agency involvement and coordination needed to carry out such activities, including any statutory or regulatory barriers to such coordination;

(5) a budget for carrying out such activities;

(6) a proposed timeline for implementing recommendations and efforts identified under subsection (c); and

(7) other information that the task force determines appropriate as related to its duties.

(f) FINAL REPORT.—Not later than 3 years after the date of the first meeting of the task force, the task force shall submit to the general public, Secretary of Education, Secretary of Health and Human Services, Secretary of Labor, Secretary of the Interior, the Attorney General, other relevant cabinet Secretaries, the Committee on Energy and Commerce and the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and Congress, a final report containing all of the findings and recommendations required under this section, and shall make such report available online in an accessible format.

(g) ADDITIONAL REPORTS.—In addition to the final report under subsection (f), the task force shall submit—

(1) a report to Congress identifying any recommendations identified under subsection (c) that require additional legislative authority to implement; and

(2) a report to the Governors describing the opportunities for local- and State-level partnerships, professional development, or best practices recommended under subsection (d)(3).

(h) DEFINITIONS.—In this section—

(1) the term “early childhood education program” has the meaning given such term in section 103 of the Higher Education Act of 1965 (20 U.S.C. 1003);

(2) The term “Governor” means the chief executive officer of a State; and

(3) the term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(i) SUNSET.—The task force shall sunset on the date that is 60 days after the submission of the final report under subsection (f), but not later than September 30, ~~2023~~ 2030.

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## Subtitle S—Other Health Provisions

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### SEC. 7183. CAREER ACT; TREATMENT, RECOVERY, AND WORKFORCE SUPPORT GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), in consultation with the Secretary of Labor, shall continue or establish a program to support individuals in substance use disorder treatment and recovery to live independently and participate in the workforce.

(b) GRANTS AUTHORIZED.—In carrying out the activities under this section, the Secretary shall, on a competitive basis, award grants *each* for a period of not more than 5 years to entities to enable such entities to carry out evidence-based programs to help individuals in substance use disorder treatment and recovery to live independently and participate in the workforce. Such entities shall coordinate, as applicable, with Indian tribes or tribal organizations (as applicable), State boards and local boards (as defined in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102), lead State agencies with responsibility for a workforce investment activity (as defined in such section 3), and State agencies responsible for carrying out substance use disorder prevention and treatment programs.

(c) PRIORITY.—

(1) IN GENERAL.—In awarding grants under this section, the Secretary shall give priority based on the State in which the entity is located. Priority shall be given among States according to a formula based on ~~the rates described in paragraph (2)~~ *the average rates for calendar years 2018 through 2022 described in paragraph (2)* and weighted as described in paragraph (3).

~~(2) RATES.—The rates described in this paragraph are the following:~~

~~[(A) The amount by which the rate of drug overdose deaths in the State, adjusted for age, is above the national overdose mortality rate, as determined by the Director of the Centers for Disease Control and Prevention.~~

~~[(B) The amount by which the rate of unemployment for the State, based on data provided by the Bureau of Labor Statistics for the preceding 5 calendar years for which there is available data, is above the national average.~~

~~[(C) The amount by which rate of labor force participation in the State, based on data provided by the Bureau of Labor Statistics for the preceding 5 calendar years for which there is available data, is below the national average.]~~

~~(2) RATES.—The rates described in this paragraph are the following:~~

(A) *The highest age-adjusted average rates of drug overdose deaths for calendar years 2018 through 2022 based on data from the Centers for Disease Control and Prevention, including, if necessary, provisional data for calendar year 2022.*

(B) *The highest average rates of unemployment for calendar years 2018 through 2022 based on data provided by the Bureau of Labor Statistics.*

(C) *The lowest average labor force participation rates for calendar years 2018 through 2022 based on data provided by the Bureau of Labor Statistics.*

(3) WEIGHTING.—The rates described in paragraph (2) shall be weighted as follows:

(A) The rate described in paragraph (2)(A) shall be weighted 70 percent.

(B) The rate described in paragraph (2)(B) shall be weighted 15 percent.

(C) The rate described in paragraph (2)(C) shall be weighted 15 percent.

(d) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to entities located in areas within States with the greatest need, with such need based on the highest mortality rate related to substance use disorder.

(e) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term “eligible entity” means an entity that offers treatment or recovery services for individuals with substance use disorders, and partners with one or more local or State stakeholders, which may include local employers, community organizations, the local workforce development board, local and State governments, and Indian Tribes or tribal organizations, to support recovery, independent living, and participation in the workforce.

(2) INDIAN TRIBES; TRIBAL ORGANIZATION.—The terms “Indian Tribe” and “tribal organization” have the meanings given the terms “Indian tribe” and “tribal organization” in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(3) STATE.—The term “State” includes only the several States and the District of Columbia.

(f) APPLICATIONS.—An eligible entity shall submit an application at such time and in such manner as the Secretary may require. In submitting an application, the entity shall demonstrate the ability to partner with local stakeholders, which may include local employers, community stakeholders, the local workforce development board, local and State governments, and Indian Tribes or tribal organizations, as applicable, to—

(1) identify gaps in the workforce due to the prevalence of substance use disorders;

(2) in coordination with statewide employment and training activities, including coordination and alignment of activities carried out by entities provided grant funds under section 8041, help individuals in recovery from a substance use disorder transition into the workforce, including by providing career services, training services as described in paragraph (2) of section 134(c) of the Workforce Innovation and Opportunity Act

(29 U.S.C. 3174(c)), and related services described in section 134(a)(3) of such Act (42 U.S.C. 3174(a)); and

(3) assist employers with informing their employees of the resources, such as resources related to substance use disorders that are available to their employees.

(g) USE OF FUNDS.—**[An entity]**

(1) *IN GENERAL.*—*An entity receiving a grant under this section shall use the funds to conduct one or more of the following activities:*

**[(1)]** (A) Hire case managers, care coordinators, providers of peer recovery support services, as described in section 547(a) of the Public Health Service Act (42 U.S.C. 290ee-2(a)), or other professionals, as appropriate, to provide services that support treatment, recovery, and rehabilitation, and prevent relapse, recidivism, and overdose, including by encouraging—

**[(A)]** (i) the development and strengthening of daily living skills; and

**[(B)]** (ii) the use of counseling, care coordination, and other services, as appropriate, to support recovery from substance use disorders.

**[(2)]** (B) Implement or utilize innovative technologies, which may include the use of telemedicine.

**[(3)]** (C) In coordination with the lead State agency with responsibility for a workforce investment activity or local board described in subsection (b), provide—

**[(A)]** (i) short-term prevocational training services; and

**[(B)]** (ii) training services that are directly linked to the employment opportunities in the local area or the planning region.

(2) *TRANSPORTATION SERVICES.*—*An entity receiving a grant under this section may use not more than 5 percent of the funds for providing transportation for individuals to participate in an activity supported by a grant under this section, which transportation shall be to or from a place of work or a place where the individual is receiving vocational education or job training services or receiving services directly linked to treatment of or recovery from a substance use disorder.*

(3) *LIMITATION.*—*The Secretary may not require an entity to, or give priority to an entity that plans to, use the funds of a grant under this section for activities that are not specified in this subsection.*

(h) *SUPPORT FOR STATE STRATEGY.*—*An eligible entity shall include in its application under subsection (f) information describing how the services and activities proposed in such application are aligned with the State, outlying area, or Tribal strategy, as applicable, for addressing issues described in such application and how such entity will coordinate with existing systems to deliver services as described in such application.*

(i) *DATA REPORTING AND PROGRAM OVERSIGHT.*—*Each eligible entity awarded a grant under this section shall submit to the Secretary a report at such time and in such manner as the Secretary may require. Such report shall include a description of—*

(1) the programs and activities funded by the grant;

(2) outcomes of the population of individuals with a substance use disorder the grantee served through activities described in subsection (g), *which shall include employment and earnings outcomes described in subclauses (I) and (III) of section 116(b)(2)(A)(i) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141(b)(2)(A)(i)) with respect to the participation of such individuals with a substance use disorder in programs and activities funded by the grant under this section;* and

(3) any other information that the Secretary may require for the purpose of ensuring that the grantee is complying with all of the requirements of the grant.

(j) REPORTS TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than 2 years after the end of the first year of the grant period under this section for grants awarded prior to the date of enactment of the *SUPPORT for Patients and Communities Reauthorization Act of 2025*, the Secretary shall submit to Congress a preliminary report that analyzes reports submitted under subsection (i).

(2) FINAL REPORT.—Not later than **2** years after submitting the preliminary report required under paragraph (1) **September 30, 2030**, the Secretary shall submit to Congress a final report that includes—

(A) a description of how the grant funding was used, including the number of individuals who received services under subsection **[(g)(3)] (g)(1)(C)** and an evaluation of the effectiveness of the activities conducted by the grantee with respect to outcomes of the population of individuals with substance use disorder who receive services from the grantee; and

(B) recommendations related to best practices for health care professionals to support individuals in substance use disorder treatment or recovery to live independently and participate in the workforce.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated **[\$5,000,000 for each of fiscal years 2019 through 2023]** *\$12,000,000 for each of fiscal years 2026 through 2030* for purposes of carrying out this section.

## TITLE VIII—MISCELLANEOUS

\* \* \* \* \*

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

#### SEC. 8041. ADDRESSING ECONOMIC AND WORKFORCE IMPACTS OF THE OPIOID CRISIS.

(a) DEFINITIONS.—Except as otherwise expressly provided, in this section:

(1) WIOA DEFINITIONS.—The terms “core program”, “individual with a barrier to employment”, “local area”, “local board”, “one-stop operator”, “outlying area”, “State”, “State board”, and “supportive services” have the meanings given the

terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

(2) EDUCATION PROVIDER.—The term “education provider” means—

(A) an institution of higher education, as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001); or

(B) a postsecondary vocational institution, as defined in section 102(c) of such Act (20 U.S.C. 1002(c)).

(3) ELIGIBLE ENTITY.—The term “eligible entity” means—

(A) a State workforce agency;

(B) an outlying area; or

(C) a Tribal entity.

(4) PARTICIPATING PARTNERSHIP.—The term “participating partnership” means a partnership—

(A) evidenced by a written contract or agreement; and

(B) including, as members of the partnership, a local board receiving a subgrant under subsection (d) and 1 or more of the following:

(i) The eligible entity.

(ii) A treatment provider.

(iii) An employer or industry organization.

(iv) An education provider.

(v) A legal service or law enforcement organization.

(vi) A faith-based or community-based organization.

(vii) Other State or local agencies, including counties or local governments.

(viii) Other organizations, as determined to be necessary by the local board.

(ix) Indian Tribes or tribal organizations.

(5) PROGRAM PARTICIPANT.—The term “program participant” means an individual who—

(A) is a member of a population of workers described in subsection (e)(2) that is served by a participating partnership through the pilot program under this section; and

(B) enrolls with the applicable participating partnership to receive any of the services described in subsection (e)(3).

(6) PROVIDER OF PEER RECOVERY SUPPORT SERVICES.—The term “provider of peer recovery support services” means a provider that delivers peer recovery support services through an organization described in section 547(a) of the Public Health Service Act (42 U.S.C. 290ee-2(a)).

(7) SECRETARY.—The term “Secretary” means the Secretary of Labor.

(8) STATE WORKFORCE AGENCY.—The term “State workforce agency” means the lead State agency with responsibility for the administration of a program under chapter 2 or 3 of subtitle B of title I of the Workforce Innovation and Opportunity Act (29 U.S.C. 3161 et seq., 3171 et seq.).

(9) SUBSTANCE USE DISORDER.—The term “substance use disorder” has the meaning given such term by the Assistant Secretary for Mental Health and Substance Use.

(10) TREATMENT PROVIDER.—The term “treatment provider”—

(A) means a health care provider that—

(i) offers services for treating substance use disorders and is licensed in accordance with applicable State law to provide such services; and

(ii) accepts health insurance for such services, including coverage under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(B) may include—

(i) a nonprofit provider of peer recovery support services;

(ii) a community health care provider;

(iii) a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x));

(iv) an Indian health program (as defined in section 3 of the Indian Health Care Improvement Act (25 U.S.C. 1603)), including an Indian health program that serves an urban center (as defined in such section); and

(v) a Native Hawaiian health center (as defined in section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11711)).

(11) TRIBAL ENTITY.—The term “Tribal entity” includes any Indian Tribe, tribal organization, Indian-controlled organization serving Indians, Native Hawaiian organization, or Alaska Native entity, as such terms are defined or used in section 166 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3221).

(b) PILOT PROGRAM AND GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall carry out a pilot program to address economic and workforce impacts associated with a high rate of a substance use disorder. In carrying out the pilot program, the Secretary shall make grants, on a competitive basis, to eligible entities to enable such entities to make subgrants to local boards to address the economic and workforce impacts associated with a high rate of a substance use disorder.

(2) GRANT AMOUNTS.—The Secretary shall make each such grant in an amount that is not less than \$500,000, and not more than \$5,000,000, for a fiscal year.

(c) GRANT APPLICATIONS.—

(1) IN GENERAL.—An eligible entity applying for a grant under this section shall submit an application to the Secretary at such time and in such form and manner as the Secretary may reasonably require, including the information described in this subsection.

(2) SIGNIFICANT IMPACT ON COMMUNITY BY OPIOID AND SUBSTANCE USE DISORDER-RELATED PROBLEMS.—

(A) DEMONSTRATION.—An eligible entity shall include in the application—

(i) information that demonstrates significant impact on the community by problems related to opioid abuse or another substance use disorder, by—

(I) identifying the counties, communities, regions, or local areas that have been significantly

impacted and will be served through the grant (each referred to in this section as a “service area”); and

(II) demonstrating for each such service area, an increase equal to or greater than the national increase in such problems, between—

(aa) 1999; and

(bb) 2016 or the latest year for which data are available; and

(ii) a description of how the eligible entity will prioritize support for significantly impacted service areas described in clause (i)(I).

(B) INFORMATION.—To meet the requirements described in subparagraph (A)(i)(II), the eligible entity may use information including data on—

(i) the incidence or prevalence of opioid abuse and other substance use disorders;

(ii) the age-adjusted rate of drug overdose deaths, as determined by the Director of the Centers for Disease Control and Prevention;

(iii) the rate of non-fatal hospitalizations related to opioid abuse or other substance use disorders;

(iv) the number of arrests or convictions, or a relevant law enforcement statistic, that reasonably shows an increase in opioid abuse or another substance use disorder; or

(v) in the case of an eligible entity described in subsection (a)(3)(C), other alternative relevant data as determined appropriate by the Secretary.

(C) SUPPORT FOR STATE STRATEGY.—The eligible entity may include in the application information describing how the proposed services and activities are aligned with the State, outlying area, or Tribal strategy, as applicable, for addressing problems described in subparagraph (A) in specific service areas or across the State, outlying area, or Tribal land.

(3) ECONOMIC AND EMPLOYMENT CONDITIONS DEMONSTRATE ADDITIONAL FEDERAL SUPPORT NEEDED.—

(A) DEMONSTRATION.—An eligible entity shall include in the application information that demonstrates that a high rate of a substance use disorder has caused, or is coincident to—

(i) an economic or employment downturn in the service area; or

(ii) persistent economically depressed conditions in such service area.

(B) INFORMATION.—To meet the requirements of subparagraph (A), an eligible entity may use information including—

(i) documentation of any layoff, announced future layoff, legacy industry decline, decrease in an employment or labor market participation rate, or economic impact, whether or not the result described in this clause is overtly related to a high rate of a substance use disorder;

(ii) documentation showing decreased economic activity related to, caused by, or contributing to a high rate of a substance use disorder, including a description of how the service area has been impacted, or will be impacted, by such a decrease;

(iii) information on economic indicators, labor market analyses, information from public announcements, and demographic and industry data;

(iv) information on rapid response activities (as defined in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102)) that have been or will be conducted, including demographic data gathered by employer or worker surveys or through other methods;

(v) data or documentation, beyond anecdotal evidence, showing that employers face challenges filling job vacancies due to a lack of skilled workers able to pass a drug test; or

(vi) any additional relevant data or information on the economy, workforce, or another aspect of the service area to support the application.

(d) SUBGRANT AUTHORIZATION AND APPLICATION PROCESS.—

(1) SUBGRANTS AUTHORIZED.—

(A) IN GENERAL.—An eligible entity receiving a grant under subsection (b)—

(i) may use not more than 5 percent of the grant funds for the administrative costs of carrying out the grant;

(ii) in the case of an eligible entity described in subparagraph (A) or (B) of subsection (a)(3), shall use the remaining grant funds to make subgrants to local entities in the service area to carry out the services and activities described in subsection (e); and

(iii) in the case of an eligible entity described in subsection (a)(3)(C), shall use the remaining grant funds to carry out the services and activities described in subsection (e).

(B) EQUITABLE DISTRIBUTION.—In making subgrants under this subsection, an eligible entity shall ensure, to the extent practicable, the equitable distribution of subgrants, based on—

(i) geography (such as urban and rural distribution); and

(ii) significantly impacted service areas as described in subsection (c)(2).

(C) TIMING OF SUBGRANT FUNDS DISTRIBUTION.—An eligible entity making subgrants under this subsection shall disburse subgrant funds to a local board receiving a subgrant from the eligible entity by the later of—

(i) the date that is 90 days after the date on which the Secretary makes the funds available to the eligible entity; or

(ii) the date that is 15 days after the date that the eligible entity makes the subgrant under subparagraph (A)(ii).

(2) SUBGRANT APPLICATION.—

(A) IN GENERAL.—A local board desiring to receive a subgrant under this subsection from an eligible entity shall submit an application at such time and in such manner as the eligible entity may reasonably require, including the information described in this paragraph.

(B) CONTENTS.—Each application described in subparagraph (A) shall include—

(i) an analysis of the estimated performance of the local board in carrying out the proposed services and activities under the subgrant—

(I) based on—

(aa) primary indicators of performance described in section 116(c)(1)(A)(i) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141(c)(1)(A)(i), to assess estimated effectiveness of the proposed services and activities, including the estimated number of individuals with a substance use disorder who may be served by the proposed services and activities;

(bb) the record of the local board in serving individuals with a barrier to employment; and

(cc) the ability of the local board to establish a participating partnership; and

(II) which may include or utilize—

(aa) data from the National Center for Health Statistics of the Centers for Disease Control and Prevention;

(bb) data from the Center for Behavioral Health Statistics and Quality of the Substance Abuse and Mental Health Services Administration;

(cc) State vital statistics;

(dd) municipal police department records;

(ee) reports from local coroners; or

(ff) other relevant data; and

(ii) in the case of a local board proposing to serve a population described in subsection (e)(2)(B), a demonstration of the workforce shortage in the professional area to be addressed under the subgrant (which may include substance use disorder treatment and related services, non-addictive pain therapy and pain management services, mental health care treatment services, emergency response services, or mental health care), which shall include information that can demonstrate such a shortage, such as—

(I) the distance between—

(aa) communities affected by opioid abuse or another substance use disorder; and

(bb) facilities or professionals offering services in the professional area; or

(II) the maximum capacity of facilities or professionals to serve individuals in an affected community, or increases in arrests related to opioid or another substance use disorder, overdose deaths,

or nonfatal overdose emergencies in the community.

(e) SUBGRANT SERVICES AND ACTIVITIES.—

(1) IN GENERAL.—Each local board that receives a subgrant under subsection (d) shall carry out the services and activities described in this subsection through a participating partnership.

(2) SELECTION OF POPULATION TO BE SERVED.—A participating partnership shall elect to provide services and activities under the subgrant to one or both of the following populations of workers:

(A) Workers, including dislocated workers, individuals with barriers to employment, new entrants in the workforce, or incumbent workers (employed or underemployed), each of whom—

(i) is directly or indirectly affected by a high rate of a substance use disorder; and

(ii) voluntarily confirms that the worker, or a friend or family member of the worker, has a history of opioid abuse or another substance use disorder.

(B) Workers, including dislocated workers, individuals with barriers to employment, new entrants in the workforce, or incumbent workers (employed or underemployed), who—

(i) seek to transition to professions that support individuals with a substance use disorder or at risk for developing such disorder, such as professions that provide—

(I) substance use disorder treatment and related services;

(II) services offered through providers of peer recovery support services;

(III) non-addictive pain therapy and pain management services;

(IV) emergency response services; or

(V) mental health care; and

(ii) need new or upgraded skills to better serve such a population of struggling or at-risk individuals.

(3) SERVICES AND ACTIVITIES.—Each participating partnership shall use funds available through a subgrant under this subsection to carry out 1 or more of the following:

(A) ENGAGING EMPLOYERS.—Engaging with employers to—

(i) learn about the skill and hiring requirements of employers;

(ii) learn about the support needed by employers to hire and retain program participants, and other individuals with a substance use disorder, and the support needed by such employers to obtain their commitment to testing creative solutions to employing program participants and such individuals;

(iii) connect employers and workers to on-the-job or customized training programs before or after layoff to help facilitate reemployment;

(iv) connect employers with an education provider to develop classroom instruction to complement on-the-job learning for program participants and such individuals;

(v) help employers develop the curriculum design of a work-based learning program for program participants and such individuals;

(vi) help employers employ program participants or such individuals engaging in a work-based learning program for a transitional period before hiring such a program participant or individual for full-time employment of not less than 30 hours a week; or

(vii) connect employers to program participants receiving concurrent outpatient treatment and job training services.

(B) SCREENING SERVICES.—Providing screening services, which may include—

(i) using an evidence-based screening method to screen each individual seeking participation in the pilot program to determine whether the individual has a substance use disorder;

(ii) conducting an assessment of each such individual to determine the services needed for such individual to obtain or retain employment, including an assessment of strengths and general work readiness; or

(iii) accepting walk-ins or referrals from employers, labor organizations, or other entities recommending individuals to participate in such program.

(C) INDIVIDUAL TREATMENT AND EMPLOYMENT PLAN.—Developing an individual treatment and employment plan for each program participant—

(i) in coordination, as appropriate, with other programs serving the participant such as the core programs within the workforce development system under the Workforce Innovation and Opportunity Act (29 U.S.C. 3101 et seq.); and

(ii) which shall include providing a case manager to work with each participant to develop the plan, which may include—

(I) identifying employment and career goals;

(II) exploring career pathways that lead to in-demand industries and sectors, as determined by the State board and the head of the State workforce agency or, as applicable, the Tribal entity;

(III) setting appropriate achievement objectives to attain the employment and career goals identified under subclause (I); or

(IV) developing the appropriate combination of services to enable the participant to achieve the employment and career goals identified under subclause (I).

(D) OUTPATIENT TREATMENT AND RECOVERY CARE.—In the case of a participating partnership serving program participants described in paragraph (2)(A) with a sub-

stance use disorder, providing individualized and group outpatient treatment and recovery services for such program participants that are offered during the day and evening, and on weekends. Such treatment and recovery services—

(i) shall be based on a model that utilizes combined behavioral interventions and other evidence-based or evidence-informed interventions; and

(ii) may include additional services such as—

(I) health, mental health, addiction, or other forms of outpatient treatment that may impact a substance use disorder and co-occurring conditions;

(II) drug testing for a current substance use disorder prior to enrollment in career or training services or prior to employment;

(III) linkages to community services, including services offered by partner organizations designed to support program participants; or

(IV) referrals to health care, including referrals to substance use disorder treatment and mental health services.

(E) SUPPORTIVE SERVICES.—Providing supportive services, which shall include services such as—

(i) coordinated wraparound services to provide maximum support for program participants to assist the program participants in maintaining employment and recovery for not less than 12 months, as appropriate;

(ii) assistance in establishing eligibility for assistance under Federal, State, Tribal, and local programs providing health services, mental health services, vocational services, housing services, transportation services, social services, or services through early childhood education programs (as defined in section 103 of the Higher Education Act of 1965 (20 U.S.C. 1003));

(iii) services offered through providers of peer recovery support services;

(iv) networking and mentorship opportunities; or

(v) any supportive services determined necessary by the local board.

(F) CAREER AND JOB TRAINING SERVICES.—Offering career services and training services, and related services, concurrently or sequentially with the services provided under subparagraphs (B) through (E). Such services shall include the following:

(i) Services provided to program participants who are in a pre-employment stage of the program, which may include—

(I) initial education and skills assessments;

(II) traditional classroom training funded through individual training accounts under chapter 3 of subtitle B of title I of the Workforce Innovation and Opportunity Act (29 U.S.C. 3171 et seq.);

(III) services to promote employability skills such as punctuality, personal maintenance skills, and professional conduct;

(IV) in-depth interviewing and evaluation to identify employment barriers and to develop individual employment plans;

(V) career planning that includes—

(aa) career pathways leading to in-demand, high-wage jobs; and

(bb) job coaching, job matching, and job placement services;

(VI) provision of payments and fees for employment and training-related applications, tests, and certifications; or

(VII) any other appropriate career service or training service described in section 134(c) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3174(c)).

(ii) Services provided to program participants during their first 6 months of employment to ensure job retention, which may include—

(I) case management and support services, including a continuation of the services described in clause (i);

(II) a continuation of skills training, and career and technical education, described in clause (i) that is conducted in collaboration with the employers of such participants;

(III) mentorship services and job retention support for such participants; or

(IV) targeted training for managers and workers working with such participants (such as mentors), and human resource representatives in the business in which such participants are employed.

(iii) Services to assist program participants in maintaining employment for not less than 12 months, as appropriate.

(G) **PROVEN AND PROMISING PRACTICES.**—Leading efforts in the service area to identify and promote proven and promising strategies and initiatives for meeting the needs of employers and program participants.

(4) **LIMITATIONS.**—A participating partnership may not use—

(A) more than 10 percent of the funds received under a subgrant under subsection (d) for the administrative costs of the partnership;

(B) more than 10 percent of the funds received under such subgrant for the provision of treatment and recovery services, as described in paragraph (3)(D); and

(C) more than 10 percent of the funds received under such subgrant for the provision of supportive services described in paragraph (3)(E) to program participants.

(f) **PERFORMANCE ACCOUNTABILITY.**—

(1) **REPORTS.**—The Secretary shall establish quarterly reporting requirements for recipients of grants and subgrants under this section that, to the extent practicable, are based on the

performance accountability system under section 116 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141) and, in the case of a grant awarded to an eligible entity described in subsection (a)(3)(C), section 166(h) of such Act (29 U.S.C. 3221(h)), including the indicators described in subsection (c)(1)(A)(i) of such section 116 and the requirements for local area performance reports under subsection (d) of such section 116.

(2) EVALUATIONS.—

(A) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary shall ensure that an independent evaluation is conducted on the pilot program carried out under this section to determine the impact of the program on employment of individuals with substance use disorders. The Secretary shall enter into an agreement with eligible entities receiving grants under this section to pay for all or part of such evaluation.

(B) METHODOLOGIES TO BE USED.—The independent evaluation required under this paragraph shall use experimental designs using random assignment or, when random assignment is not feasible, other reliable, evidence-based research methodologies that allow for the strongest possible causal inferences.

(g) FUNDING.—

(1) COVERED FISCAL YEAR.—In this subsection, the term “covered fiscal year” means any of fiscal years 2019 through **2023** 2030.

(2) USING FUNDING FOR NATIONAL DISLOCATED WORKER GRANTS.—Subject to paragraph (4) and notwithstanding section 132(a)(2)(A) and subtitle D of the Workforce Innovation and Opportunity Act (29 U.S.C. 3172(a)(2)(A), 3221 et seq.), the Secretary may use, to carry out the pilot program under this section for a covered fiscal year—

(A) funds made available to carry out section 170 of such Act (29 U.S.C. 3225) for that fiscal year;

(B) funds made available to carry out section 170 of such Act that remain available for that fiscal year; and

(C) funds that remain available under section 172(f) of such Act (29 U.S.C. 3227(f)).

(3) AVAILABILITY OF FUNDS.—Funds appropriated under section 136(c) of such Act (29 U.S.C. 3181(c)) and made available to carry out section 170 of such Act for a fiscal year shall remain available for use under paragraph (2) for a subsequent fiscal year until expended.

(4) LIMITATION.—The Secretary may not use more than \$100,000,000 of the funds described in paragraph (2) for any covered fiscal year under this section.

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**Subtitle F— [Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed]**  
***Subtitle F—CAREER Act; Recovery Housing Pilot Program***

**SEC. 8071. [PILOT PROGRAM TO HELP INDIVIDUALS IN RECOVERY FROM A SUBSTANCE USE DISORDER BECOME STABLY HOUSED.] CAREER ACT; RECOVERY HOUSING PILOT PROGRAM.**

(a) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated under this section such sums as may be necessary for each of fiscal years 2019 **[through 2023]** *through 2030* for assistance to States to provide individuals in recovery from a substance use disorder stable, temporary housing for a period of not more than 2 years or until the individual secures permanent housing, whichever is earlier.

(b) **ALLOCATION OF APPROPRIATED AMOUNTS.**—

(1) **IN GENERAL.**—The amounts appropriated or otherwise made available to States under this section shall be allocated based on a funding formula established by the Secretary of Housing and Urban Development (referred to in this section as the “Secretary”) **[not later than 60 days after the date of enactment of this Act]** *not later than 60 days after the date of enactment of the SUPPORT for Patients and Communities Reauthorization Act of 2025.*

(2) **CRITERIA.**—

(A) **IN GENERAL.**—The funding formula required under paragraph (1) shall ensure that any amounts appropriated or otherwise made available under this section are allocated to States with an age-adjusted rate of drug overdose deaths that is above the national overdose mortality rate, according to the Centers for Disease Control and Prevention.

(B) **PRIORITY.**—

(i) **IN GENERAL.**—Among such States, priority shall be given to States with the greatest need, as such need is determined by the Secretary based on the following factors, and weighting such factors as described in clause (ii):

(I) The highest average rates of unemployment *for calendar years 2018 through 2022* based on data provided by the Bureau of Labor Statistics **[for calendar years 2013 through 2017]**.

(II) The lowest average labor force participation rates *for calendar years 2018 through 2022* based on data provided by the Bureau of Labor Statistics **[for calendar years 2013 through 2017]**.

**[(III) The highest age-adjusted rates of drug overdose deaths based on data from the Centers for Disease Control and Prevention.]**

*(III) The highest age-adjusted average rates of drug overdose deaths for calendar years 2018*

*through 2022 based on data from the Centers for Disease Control and Prevention, including, if necessary, provisional data for calendar year 2022.*

(ii) **WEIGHTING.**—The factors described in clause (i) shall be weighted as follows:

(I) The rate described in clause (i)(I) shall be weighted at 15 percent.

(II) The rate described in clause (i)(II) shall be weighted at 15 percent.

(III) The rate described in clause (i)(III) shall be weighted at 70 percent.

(3) **DISTRIBUTION.**—Amounts appropriated or otherwise made available under this section shall be distributed according to the funding formula established by the Secretary under paragraph (1) not later than 30 days after the establishment of such formula.

(c) **USE OF FUNDS.**—

(1) **IN GENERAL.**—Any State that receives amounts pursuant to this section shall expend at least 30 percent of such funds within one year of the date funds become available to the grantee for obligation.

(2) **PRIORITY.**—Any State that receives amounts pursuant to this section shall distribute such amounts giving priority to entities with the greatest need and ability to deliver effective assistance in a timely manner.

(3) **ADMINISTRATIVE COSTS.**—Any State that receives amounts pursuant to this section may use up to 5 percent of any grant for administrative costs.

(d) **RULES OF CONSTRUCTION.**—

(1) **IN GENERAL.**—Except as otherwise provided by this section, amounts appropriated, or amounts otherwise made available to States under this section shall be treated as though such funds were community development block grant funds under title I of the Housing and Community Development Act of 1974 (42 U.S.C. 5301 et seq.).

(2) **NO MATCH.**—No matching funds shall be required in order for a State to receive any amounts under this section.

(e) **AUTHORITY TO WAIVE OR SPECIFY ALTERNATIVE REQUIREMENTS.**—

(1) **IN GENERAL.**—In administering any amounts appropriated or otherwise made available under this section, the Secretary may waive or specify alternative requirements to any provision under title I of the Housing and Community Development Act of 1974 (42 U.S.C. 5301 et seq.) except for requirements related to fair housing, nondiscrimination, labor standards, the environment, and requirements that activities benefit persons of low- and moderate-income, upon a finding that such a waiver is necessary to expedite or facilitate the use of such funds.

(2) **NOTICE OF INTENT.**—The Secretary shall provide written notice of its intent to exercise the authority to specify alternative requirements under paragraph (1) to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representa-

tives not later than 15 business days before such exercise of authority occurs.

(3) NOTICE TO THE PUBLIC.—The Secretary shall provide written notice of its intent to exercise the authority to specify alternative requirements under paragraph (1) to the public via notice, on the internet website of the Department of Housing and Urban Development, and by other appropriate means, not later than 15 business days before such exercise of authority occurs.

(f) TECHNICAL ASSISTANCE.—[For the 2-year period following the date of enactment of this Act, the] *The* Secretary may use not more than 2 percent of the funds made available under this section for technical assistance to grantees.

(g) STATE.—For purposes of this section the term “State” includes any State as defined in section 102 of the Housing and Community Development Act of 1974 (42 U.S.C. 5302) and the District of Columbia.

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**CONTROLLED SUBSTANCES ACT**

\* \* \* \* \*

**TITLE II—CONTROL AND ENFORCEMENT**

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**PART C—REGISTRATION OF MANUFACTURERS, DISTRIBUTORS, AND DISPENSERS OF CONTROLLED SUBSTANCES; PIPERIDINE REPORTING**

\* \* \* \* \*

**REGISTRATION REQUIREMENTS**

SEC. 303. (a) The Attorney General shall register an applicant to manufacture controlled substances in schedule I or II if he determines that such registration is consistent with the public interest and with United States obligations under international treaties, conventions, or protocols in effect on the effective date of this part. In determining the public interest, the following factors shall be considered:

- (1) maintenance of effective controls against diversion of particular controlled substances and any controlled substance in schedule I or II compounded therefrom into other than legitimate medical, scientific, research, or industrial channels, by limiting the importation and bulk manufacture of such controlled substances to a number of establishments which can produce an adequate and uninterrupted supply of these substances under adequately competitive conditions for legitimate medical, scientific, research, and industrial purposes;
- (2) compliance with applicable State and local law;
- (3) promotion of technical advances in the art of manufacturing these substances and the development of new substances;

(4) prior conviction record of applicant under Federal and State laws relating to the manufacture, distribution, or dispensing of such substances;

(5) past experience in the manufacture of controlled substances, and the existence in the establishment of effective control against diversion; and

(6) such other factors as may be relevant to and consistent with the public health and safety.

(b) The Attorney General shall register an applicant to distribute a controlled substance in schedule I or II unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;

(2) compliance with applicable State and local law;

(3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(4) past experience in the distribution of controlled substances; and

(5) such other factors as may be relevant to and consistent with the public health and safety.

(c)(1)(A) As it relates to applications to manufacture marijuana for research purposes, when the Attorney General places a notice in the Federal Register to increase the number of entities registered under this Act to manufacture marijuana to supply appropriately registered researchers in the United States, the Attorney General shall, not later than 60 days after the date on which the Attorney General receives a completed application—

(i) approve the application; or

(ii) request supplemental information.

(B) For purposes of subparagraph (A), an application shall be deemed complete when the applicant has submitted documentation showing each of the following:

(i) The requirements designated in the notice in the Federal Register are satisfied.

(ii) The requirements under this Act are satisfied.

(iii) The applicant will limit the transfer and sale of any marijuana manufactured under this subsection—

(I) to researchers who are registered under this Act to conduct research with controlled substances in schedule I; and

(II) for purposes of use in preclinical research or in a clinical investigation pursuant to an investigational new drug exemption under 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i)).

(iv) The applicant will transfer or sell any marijuana manufactured under this subsection only with prior, written consent for the transfer or sale by the Attorney General.

(v) The applicant has completed the application and review process under subsection (a) for the bulk manufacture of controlled substances in schedule I.

(vi) The applicant has established and begun operation of a process for storage and handling of controlled substances in schedule I, including for inventory control and monitoring security in accordance with section 105 of the Medical Marijuana and Cannabidiol Research Expansion Act.

(vii) The applicant is licensed by each State in which the applicant will conduct operations under this subsection, to manufacture marijuana, if that State requires such a license.

(C) Not later than 30 days after the date on which the Attorney General receives supplemental information requested under subparagraph (A)(ii) with respect to an application, the Attorney General shall approve or deny the application.

(2) If an application described in this subsection is denied, the Attorney General shall provide a written explanation of the basis of denial to the applicant.

(d) Registration granted under subsections (a) and (b) of this section shall not entitle a registrant to (1) manufacture or distribute controlled substances in schedule I or II other than those specified in the registration, or (2) manufacture any quantity of those controlled substances in excess of the quota assigned pursuant to section 306.

(e) The Attorney General shall register an applicant to manufacture controlled substances in schedule III, IV, or V, unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances and any controlled substance in schedule III, IV, or V compounded therefrom into other than legitimate medical, scientific, or industrial channels;

(2) compliance with applicable State and local law;

(3) promotion of technical advances in the art of manufacturing these substances and the development of new substances;

(4) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(5) past experience in the manufacture, distribution, and dispensing of controlled substances, and the existence in the establishment of effective controls against diversion; and

(6) such other factors as may be relevant to and consistent with the public health and safety.

(f) The Attorney General shall register an applicant to distribute controlled substances in schedule III, IV, or V, unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;

(2) compliance with applicable State and local law;

(3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(4) past experience in the distribution of controlled substances; and

(5) such other factors as may be relevant to and consistent with the public health and safety.

(g)(1) The Attorney General shall register practitioners (including pharmacies, as distinguished from pharmacists) to dispense, or conduct research with, controlled substances in schedule II, III, IV, or V and shall modify the registrations of pharmacies so registered to authorize them to dispense controlled substances by means of the Internet, if the applicant is authorized to dispense, or conduct research with respect to, controlled substances under the laws of the State in which he practices. The Attorney General may deny an application for such registration or such modification of registration if the Attorney General determines that the issuance of such registration or modification would be inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(A) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(B) The applicant's experience in dispensing, or conducting research with respect to controlled substances.

(C) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(D) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(E) Such other conduct which may threaten the public health and safety.

Separate registration under this part for practitioners engaging in research with controlled substances in schedule II, III, IV, or V, who are already registered under this part in another capacity, shall not be required.

(2) (A) Registration applications by practitioners wishing to conduct research with controlled substances in schedule I shall be referred to the Secretary, who shall determine the qualifications and competency of each practitioner requesting registration, as well as the merits of the research protocol. The Secretary, in determining the merits of each research protocol, shall consult with the Attorney General as to effective procedures to adequately safeguard against diversion of such controlled substances from legitimate medical or scientific use. Registration for the purpose of bona fide research with controlled substances in schedule I by a practitioner deemed qualified by the Secretary may be denied by the Attorney General only on a ground specified in section 304(a).

(B)(i) The Attorney General shall register a practitioner to conduct research with marijuana (including any derivative, extract, preparation, and compound thereof) if—

(I) the applicant's research protocol has been reviewed and allowed—

(aa) by the Secretary of Health and Human Services under section 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i));

(bb) by the National Institutes of Health or another Federal agency that funds scientific research; or

- (cc) pursuant to sections 1301.18 and 1301.32 of title 21, Code of Federal Regulations, or any successors thereto; and
- (II) the applicant has demonstrated to the Attorney General that there are effective procedures in place to adequately safeguard against diversion of the controlled substance for legitimate medical or scientific use pursuant to section 105 of the Medical Marijuana and Cannabidiol Research Expansion Act, including demonstrating that the security measures are adequate for storing the quantity of marijuana the applicant would be authorized to possess.
- (ii) The Attorney General may deny an application for registration under this subparagraph only if the Attorney General determines that the issuance of the registration would be inconsistent with the public interest. In determining the public interest, the Attorney General shall consider the factors listed in—
  - (I) subparagraphs (B) through (E) of paragraph (1); and
  - (II) subparagraph (A) of paragraph (1), if the applicable State requires practitioners conducting research to register with a board or authority described in such subparagraph (A).
- (iii)(I) Not later than 60 days after the date on which the Attorney General receives a complete application for registration under this subparagraph, the Attorney General shall—
  - (aa) approve the application; or
  - (bb) request supplemental information.
- (II) For purposes of subclause (I), an application shall be deemed complete when the applicant has submitted documentation showing that the requirements under clause (i) are satisfied.
- (iv) Not later than 30 days after the date on which the Attorney General receives supplemental information as described in clause (iii)(I)(bb) in connection with an application described in this subparagraph, the Attorney General shall approve or deny the application.
- (v) If an application described in this subparagraph is denied, the Attorney General shall provide a written explanation of the basis of denial to the applicant.
- (vi)(I) If the Attorney General grants an application for registration under clause (i), the registrant may amend or supplement the research protocol without notification to, or review by, the Drug Enforcement Administration if the registrant does not change—
  - (aa) the quantity or type of marijuana or cannabidiol (including any derivative, extract, preparation, and compound thereof);
  - (bb) the source of such marijuana or cannabidiol; or
  - (cc) the conditions under which such marijuana or cannabidiol is stored, tracked, or administered.
- (II)(aa) If a registrant under clause (i) seeks to change the type of marijuana or cannabidiol (including any derivative, extract, preparation, and compound thereof), the source of such marijuana or cannabidiol, or the conditions under which such marijuana or cannabidiol is stored, tracked, or administered, the registrant shall notify the Attorney General via registered mail, or an electronic means permitted by the Attorney General, not later than 30 days before implementing an amended or supplemental research protocol.

(bb) A registrant may proceed with an amended or supplemental research protocol described in item (aa) if the Attorney General does not explicitly object during the 30-day period beginning on the date on which the Attorney General receives the notice under item (aa).

(cc) The Attorney General may only object to an amended or supplemental research protocol under this subclause if additional security measures are needed to safeguard against diversion or abuse.

(dd) If a registrant under clause (i) seeks to address additional security measures identified by the Attorney General under item (cc), the registrant shall notify the Attorney General via registered mail, or an electronic means permitted by the Attorney General, not later than 30 days before implementing an amended or supplemental research protocol.

(ee) A registrant may proceed with an amended or supplemental research protocol described in item (dd) if the Attorney General does not explicitly object during the 30-day period beginning on the date on which the Attorney General receives the notice under item (dd).

(III)(aa) If a registrant under clause (i) seeks to change the quantity of marijuana needed for research and the change in quantity does not impact the factors described in item (bb) or (cc) of subclause (I) of this clause, the registrant shall notify the Attorney General via registered mail or using an electronic means permitted by the Attorney General.

(bb) A notification under item (aa) shall include—

(AA) the Drug Enforcement Administration registration number of the registrant;

(BB) the quantity of marijuana or cannabidiol already obtained;

(CC) the quantity of additional marijuana or cannabidiol needed to complete the research; and

(DD) an attestation that the change in quantity does not impact the source of the marijuana or cannabidiol or the conditions under which the marijuana or cannabidiol is stored, tracked, or administered.

(cc) The Attorney General shall ensure that—

(AA) any registered mail return receipt with respect to a notification under item (aa) is submitted for delivery to the registrant providing the notification not later than 3 days after receipt of the notification by the Attorney General; and

(BB) notice of receipt of a notification using an electronic means permitted under item (aa) is provided to the registrant providing the notification not later than 3 days after receipt of the notification by the Attorney General.

(dd)(AA) On and after the date described in subitem (BB), a registrant that submits a notification in accordance with item (aa) may proceed with the research as if the change in quantity has been approved on such date, unless the Attorney General notifies the registrant of an objection described in item (ee).

(BB) The date described in this subitem is the date on which a registrant submitting a notification under item (aa) receives the registered mail return receipt with respect to the notification or the date on which the registrant receives notice that the notification

using an electronic means permitted under item (aa) was received by the Attorney General, as the case may be.

(ee) A notification submitted under item (aa) shall be deemed to be approved unless the Attorney General, not later than 10 days after receiving the notification, explicitly objects based on a finding that the change in quantity—

(AA) does impact the source of the marijuana or cannabidiol or the conditions under which the marijuana or cannabidiol is stored, tracked, or administered; or

(BB) necessitates that the registrant implement additional security measures to safeguard against diversion or abuse.

(IV) Nothing in this clause shall limit the authority of the Secretary of Health and Human Services over requirements related to research protocols, including changes in—

(aa) the method of administration of marijuana or cannabidiol;

(bb) the dosing of marijuana or cannabidiol; and

(cc) the number of individuals or patients involved in research.

(3) Article 7 of the Convention on Psychotropic Substances shall not be construed to prohibit, or impose additional restrictions upon, research involving drugs or other substances scheduled under the convention which is conducted in conformity with this subsection and other applicable provisions of this title.

(h)(1) Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose. The Attorney General shall register an applicant to dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment (or both)—

(A) if the applicant is a practitioner who is determined by the Secretary to be qualified (under standards established by the Secretary) to engage in the treatment with respect to which registration is sought;

(B) if the Attorney General determines that the applicant will comply with standards established by the Attorney General respecting (i) security of stocks of narcotic drugs for such treatment, and (ii) the maintenance of records (in accordance with section 307) on such drugs; and

(C) if the Secretary determines that the applicant will comply with standards established by the Secretary (after consultation with the Attorney General) respecting the quantities of narcotic drugs which may be provided for unsupervised use by individuals in such treatment.

(2)(A) Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

(B) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a practitioner are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxi-

fication treatment, the practitioner submit to the Secretary a notification of the intent of the practitioner to begin dispensing the drugs or combinations for such purpose, and that the notification contain the following certifications by the practitioner:

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

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

(I) all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention; and

(II) appropriate counseling and other appropriate ancillary services.

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

(II) The applicable number is—

(aa) 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients;

(bb) 100 if the practitioner holds additional credentialing, as defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations);

(cc) 100 if the practitioner provides medication-assisted treatment (MAT) using covered medications (as such terms are defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations)) in a qualified practice setting (as described in section 8.615 of title 42, Code of Federal Regulations (or successor regulations)); or

(dd) 275 if the practitioner meets the requirements specified in sections 8.610 through 8.655 of title 42, Code of Federal Regulations (or successor regulations).

(III) The Secretary may by regulation change such applicable number.

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

(C) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to narcotic drugs in schedule III, IV, or V or combinations of such drugs are as follows:

(i) The drugs or combinations of drugs have, under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act, been approved for use in maintenance or detoxification treatment.

(ii) The drugs or combinations of drugs have not been the subject of an adverse determination. For purposes of this clause, an adverse determination is a determination published in the Federal Register and made by the Secretary, after consultation with the Attorney General, that the use of the drugs

or combinations of drugs for maintenance or detoxification treatment requires additional standards respecting the qualifications of practitioners to provide such treatment, or requires standards respecting the quantities of the drugs that may be provided for unsupervised use.

(D)(i) A waiver under subparagraph (A) with respect to a practitioner is not in effect unless (in addition to conditions under subparagraphs (B) and (C)) the following conditions are met:

(I) The notification under subparagraph (B) is in writing and states the name of the practitioner.

(II) The notification identifies the registration issued for the practitioner pursuant to subsection (g).

(III) If the practitioner is a member of a group practice, the notification states the names of the other practitioners in the practice and identifies the registrations issued for the other practitioners pursuant to subsection (g).

(ii) Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B), the Attorney General shall assign the practitioner involved an identification number under this paragraph for inclusion with the registration issued for the practitioner pursuant to subsection (g). The identification number so assigned shall be appropriate to preserve the confidentiality of patients for whom the practitioner has dispensed narcotic drugs under a waiver under subparagraph (A).

(iii) Not later than 45 days after the date on which the Secretary receives a notification under subparagraph (B), the Secretary shall make a determination of whether the practitioner involved meets all requirements for a waiver under subparagraph (B) and shall forward such determination to the Attorney General. If the Secretary fails to make such determination by the end of the such 45-day period, the Attorney General shall assign the practitioner an identification number described in clause (ii) at the end of such period.

(E)(i) If a practitioner is not registered under paragraph (1) and, in violation of the conditions specified in subparagraphs (B) through (D), dispenses narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, the Attorney General may, for purposes of section 304(a)(4), consider the practitioner to have committed an act that renders the registration of the practitioner pursuant to subsection (g) to be inconsistent with the public interest.

(ii)(I) Upon the expiration of 45 days from the date on which the Secretary receives a notification under subparagraph (B), a practitioner who in good faith submits a notification under subparagraph (B) and reasonably believes that the conditions specified in subparagraphs (B) through (D) have been met shall, in dispensing narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, be considered to have a waiver under subparagraph (A) until notified otherwise by the Secretary, except that such a practitioner may commence to prescribe or dispense such narcotic drugs for such purposes prior to the expiration of such 45-day period if it facilitates the treatment of an individual patient and both the Secretary and

the Attorney General are notified by the practitioner of the intent to commence prescribing or dispensing such narcotic drugs.

(II) For purposes of subclause (I), the publication in the Federal Register of an adverse determination by the Secretary pursuant to subparagraph (C)(ii) shall (with respect to the narcotic drug or combination involved) be considered to be a notification provided by the Secretary to practitioners, effective upon the expiration of the 30-day period beginning on the date on which the adverse determination is so published.

(F)(i) With respect to the dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, a practitioner may, in his or her discretion, dispense such drugs or combinations for such treatment under a registration under paragraph (1) or a waiver under subparagraph (A) (subject to meeting the applicable conditions).

(ii) This paragraph may not be construed as having any legal effect on the conditions for obtaining a registration under paragraph (1), including with respect to the number of patients who may be served under such a registration.

(G) For purposes of this paragraph:

(i) The term “group practice” has the meaning given such term in section 1877(h)(4) of the Social Security Act.

(ii) The term “qualifying physician” means a physician who is licensed under State law and who meets one or more of the following conditions:

(I) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.

(II) The physician holds an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine.

(III) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall include—

(aa) opioid maintenance and detoxification;

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

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

(dd) individualized treatment planning, overdose reversal, and relapse prevention;

(ee) counseling and recovery support services;

(ff) staffing roles and considerations;

(gg) diversion control; and

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

(V) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

(VI) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

(VII) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

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

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

(bb) included, at a minimum—

(AA) the training described in items (aa) through (gg) of subclause (IV); and

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

(iii) The term “qualifying practitioner” means—

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

(II) a qualifying other practitioner, as defined in clause (iv), who is a nurse practitioner or physician assistant; or

(III) for the period beginning on October 1, 2018, and ending on October 1, 2023, a qualifying other practitioner, as defined in clause (iv), who is a clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife.

(iv) The term “qualifying other practitioner” means a nurse practitioner, clinical nurse specialist, certified registered nurse

anesthetist, certified nurse midwife, or physician assistant who satisfies each of the following:

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

(II) The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant has—

(aa) completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or

(bb) has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant to treat and manage opiate-dependent patients.

(III) The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may, by regulation, revise the requirements for being a qualifying other practitioner under this clause.

(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary shall issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

(I) Approval of additional credentialing bodies and the responsibilities of additional credentialing bodies.

(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

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

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

(ii) Not later than 18 months after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.

(I) Notwithstanding section 708, nothing in this paragraph shall be construed to preempt any State law that—

(i) permits a qualifying practitioner to dispense narcotic drugs in schedule III, IV, or V, or combinations of such drugs, for maintenance or detoxification treatment in accordance with this paragraph to a total number of patients that is more than 30 or less than the total number applicable to the qualifying practitioner under subparagraph (B)(iii)(II) if a State enacts a law modifying such total number and the Attorney General is notified by the State of such modification; or

(ii) requires a qualifying practitioner to comply with additional requirements relating to the dispensing of narcotic drugs in schedule III, IV, or V, or combinations of such drugs, including requirements relating to the practice setting in which the qualifying practitioner practices and education, training, and reporting requirements.

(i) The Attorney General shall register an applicant to distribute a list I chemical unless the Attorney General determines that registration of the applicant is inconsistent with the public interest. Registration under this subsection shall not be required for the distribution of a drug product that is exempted under clause (iv) or (v) of section 102(39)(A). In determining the public interest for the purposes of this subsection, the Attorney General shall consider—

(1) maintenance by the applicant of effective controls against diversion of listed chemicals into other than legitimate channels;

(2) compliance by the applicant with applicable Federal, State, and local law;

(3) any prior conviction record of the applicant under Federal or State laws relating to controlled substances or to chemicals controlled under Federal or State law;

(4) any past experience of the applicant in the manufacture and distribution of chemicals; and

(5) such other factors as are relevant to and consistent with the public health and safety.

(j)(1) For purposes of registration to manufacture a controlled substance under subsection (e) for use only in a clinical trial, the Attorney General shall register the applicant, or serve an order to show cause upon the applicant in accordance with section 304(c), not later than 180 days after the date on which the application is accepted for filing.

(2) For purposes of registration to manufacture a controlled substance under subsection (a) for use only in a clinical trial, the Attorney General shall, in accordance with the regulations issued by

the Attorney General, issue a notice of application not later than 90 days after the application is accepted for filing. Not later than 90 days after the date on which the period for comment pursuant to such notice ends, the Attorney General shall register the applicant, or serve an order to show cause upon the applicant in accordance with section 304(c), unless the Attorney General has granted a hearing on the application under section 1008(i) of the Controlled Substances Import and Export Act.

(k) EMERGENCY MEDICAL SERVICES THAT ADMINISTER CONTROLLED SUBSTANCES.—

(1) REGISTRATION.—For the purpose of enabling emergency medical services professionals to administer controlled substances in schedule II, III, IV, or V to ultimate users receiving emergency medical services in accordance with the requirements of this subsection, the Attorney General—

(A) shall register an emergency medical services agency if the agency submits an application demonstrating it is authorized to conduct such activity under the laws of each State in which the agency practices; and

(B) may deny an application for such registration if the Attorney General determines that the issuance of such registration would be inconsistent with the requirements of this subsection or the public interest based on the factors listed in subsection (g).

(2) OPTION FOR SINGLE REGISTRATION.—In registering an emergency medical services agency pursuant to paragraph (1), the Attorney General shall allow such agency the option of a single registration in each State where the agency administers controlled substances in lieu of requiring a separate registration for each location of the emergency medical services agency.

(3) HOSPITAL-BASED AGENCY.—If a hospital-based emergency medical services agency is registered under subsection (g), the agency may use the registration of the hospital to administer controlled substances in accordance with this subsection without being registered under this subsection.

(4) ADMINISTRATION OUTSIDE PHYSICAL PRESENCE OF MEDICAL DIRECTOR OR AUTHORIZING MEDICAL PROFESSIONAL.—Emergency medical services professionals of a registered emergency medical services agency may administer controlled substances in schedule II, III, IV, or V outside the physical presence of a medical director or authorizing medical professional in the course of providing emergency medical services if the administration is—

(A) authorized by the law of the State in which it occurs; and

(B) pursuant to—

(i) a standing order that is issued and adopted by one or more medical directors of the agency, including any such order that may be developed by a specific State authority; or

(ii) a verbal order that is—

(I) issued in accordance with a policy of the agency; and

(II) provided by a medical director or authorizing medical professional in response to a request by the emergency medical services professional with respect to a specific patient—

(aa) in the case of a mass casualty incident;

or

(bb) to ensure the proper care and treatment of a specific patient.

(5) DELIVERY.—A registered emergency medical services agency may deliver controlled substances from a registered location of the agency to an unregistered location of the agency only if the agency—

(A) designates the unregistered location for such delivery; and

(B) notifies the Attorney General at least 30 days prior to first delivering controlled substances to the unregistered location.

(6) STORAGE.—A registered emergency medical services agency may store controlled substances—

(A) at a registered location of the agency;

(B) at any designated location of the agency or in an emergency services vehicle situated at a registered or designated location of the agency; or

(C) in an emergency medical services vehicle used by the agency that is—

(i) traveling from, or returning to, a registered or designated location of the agency in the course of responding to an emergency; or

(ii) otherwise actively in use by the agency under circumstances that provide for security of the controlled substances consistent with the requirements established by regulations of the Attorney General.

(7) NO TREATMENT AS DISTRIBUTION.—The delivery of controlled substances by a registered emergency medical services agency pursuant to this subsection shall not be treated as distribution for purposes of section 308.

(8) RESTOCKING OF EMERGENCY MEDICAL SERVICES VEHICLES AT A HOSPITAL.—Notwithstanding paragraph (13)(J), a registered emergency medical services agency may receive controlled substances from a hospital for purposes of restocking an emergency medical services vehicle following an emergency response, and without being subject to the requirements of section 308, provided all of the following conditions are satisfied:

(A) The registered or designated location of the agency where the vehicle is primarily situated maintains a record of such receipt in accordance with paragraph (9).

(B) The hospital maintains a record of such delivery to the agency in accordance with section 307.

(C) If the vehicle is primarily situated at a designated location, such location notifies the registered location of the agency within 72 hours of the vehicle receiving the controlled substances.

(9) MAINTENANCE OF RECORDS.—

(A) IN GENERAL.—A registered emergency medical services agency shall maintain records in accordance with sub-

sections (a) and (b) of section 307 of all controlled substances that are received, administered, or otherwise disposed of pursuant to the agency's registration, without regard to subsection 307(c)(1)(B).

(B) REQUIREMENTS.—Such records—

(i) shall include records of deliveries of controlled substances between all locations of the agency; and

(ii) shall be maintained, whether electronically or otherwise, at each registered and designated location of the agency where the controlled substances involved are received, administered, or otherwise disposed of.

(10) OTHER REQUIREMENTS.—A registered emergency medical services agency, under the supervision of a medical director, shall be responsible for ensuring that—

(A) all emergency medical services professionals who administer controlled substances using the agency's registration act in accordance with the requirements of this subsection;

(B) the recordkeeping requirements of paragraph (9) are met with respect to a registered location and each designated location of the agency;

(C) the applicable physical security requirements established by regulation of the Attorney General are complied with wherever controlled substances are stored by the agency in accordance with paragraph (6); and

(D) the agency maintains, at a registered location of the agency, a record of the standing orders issued or adopted in accordance with paragraph (9).

(11) REGULATIONS.—The Attorney General may issue regulations—

(A) specifying, with regard to delivery of controlled substances under paragraph (5)—

(i) the types of locations that may be designated under such paragraph; and

(ii) the manner in which a notification under paragraph (5)(B) must be made;

(B) specifying, with regard to the storage of controlled substances under paragraph (6), the manner in which such substances must be stored at registered and designated locations, including in emergency medical service vehicles; and

(C) addressing the ability of hospitals, emergency medical services agencies, registered locations, and designated locations to deliver controlled substances to each other in the event of—

(i) shortages of such substances;

(ii) a public health emergency; or

(iii) a mass casualty event.

(12) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to limit the authority vested in the Attorney General by other provisions of this title to take measures to prevent diversion of controlled substances; or

(B) to override the authority of any State to regulate the provision of emergency medical services consistent with this subsection.

(13) DEFINITIONS.—In this section:

(A) The term “authorizing medical professional” means an emergency or other physician, or another medical professional (including an advanced practice registered nurse or physician assistant)—

- (i) who is registered under this Act;
- (ii) who is acting within the scope of the registration; and
- (iii) whose scope of practice under a State license or certification includes the ability to provide verbal orders.

(B) The term “designated location” means a location designated by an emergency medical services agency under paragraph (5).

(C) The term “emergency medical services” means emergency medical response and emergency mobile medical services provided outside of a fixed medical facility.

(D) The term “emergency medical services agency” means an organization providing emergency medical services, including such an organization that—

- (i) is governmental (including fire-based and hospital-based agencies), nongovernmental (including hospital-based agencies), private, or volunteer-based;
- (ii) provides emergency medical services by ground, air, or otherwise; and
- (iii) is authorized by the State in which the organization is providing such services to provide emergency medical care, including the administering of controlled substances, to members of the general public on an emergency basis.

(E) The term “emergency medical services professional” means a health care professional (including a nurse, paramedic, or emergency medical technician) licensed or certified by the State in which the professional practices and credentialed by a medical director of the respective emergency medical services agency to provide emergency medical services within the scope of the professional’s State license or certification.

(F) The term “emergency medical services vehicle” means an ambulance, fire apparatus, supervisor truck, or other vehicle used by an emergency medical services agency for the purpose of providing or facilitating emergency medical care and transport or transporting controlled substances to and from the registered and designated locations.

(G) The term “hospital-based” means, with respect to an agency, owned or operated by a hospital.

(H) The term “medical director” means a physician who is registered under subsection (g) and provides medical oversight for an emergency medical services agency.

(I) The term “medical oversight” means supervision of the provision of medical care by an emergency medical services agency.

(J) The term “registered emergency medical services agency” means—

(i) an emergency medical services agency that is registered pursuant to this subsection; or

(ii) a hospital-based emergency medical services agency that is covered by the registration of the hospital under subsection (g).

(K) The term “registered location” means a location that appears on the certificate of registration issued to an emergency medical services agency under this subsection or subsection (g), which shall be where the agency receives controlled substances from distributors.

(L) The term “specific State authority” means a governmental agency or other such authority, including a regional oversight and coordinating body, that, pursuant to State law or regulation, develops clinical protocols regarding the delivery of emergency medical services in the geographic jurisdiction of such agency or authority within the State that may be adopted by medical directors.

(M) The term “standing order” means a written medical protocol in which a medical director determines in advance the medical criteria that must be met before administering controlled substances to individuals in need of emergency medical services.

(N) The term “verbal order” means an oral directive that is given through any method of communication including by radio or telephone, directly to an emergency medical services professional, to contemporaneously administer a controlled substance to individuals in need of emergency medical services outside the physical presence of the medical director or authorizing medical professional.

(1) In this section, the phrase “factors as may be relevant to and consistent with the public health and safety” means factors that are relevant to and consistent with the findings contained in section 101.

**[(1)] (m) REQUIRED TRAINING FOR PRESCRIBERS.—**

(1) TRAINING REQUIRED.—As a condition on registration under this section to dispense controlled substances in schedule II, III, IV, or V, the Attorney General shall require any qualified practitioner, beginning with the first applicable registration for the practitioner, to meet the following:

(A) If the practitioner is a physician (as defined under section 1861(r) of the Social Security Act) and the practitioner meets one or more of the following conditions:

(i) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.

(ii) The physician holds a board certification from the American Board of Addiction Medicine.

(iii) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

(iv) The physician has, with respect to the treatment and management of patients with opioid or other substance use disorders, or the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid or other substance use disorders, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by—

(I) the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Dental Association, the American Association of Oral and Maxillofacial Surgeons, the American Psychiatric Association, *the American Academy of Family Physicians*, *the American Podiatric Medical Association*, *the Academy of General Dentistry*, *the American Optometric Association*, or any other organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) [or the Commission], *the Commission for Continuing Education Provider Recognition (CCEPR)*, or *the Council on Podiatric Medical Education*;

(II) any organization accredited by a State medical society accreditor that is recognized by the ACCME or the CCEPR;

(III) any organization accredited by the American Osteopathic Association or *the American Academy of Family Physicians* to provide continuing medical education; or

(IV) any organization approved by the Assistant Secretary for Mental Health and Substance Use, the ACCME, or the CCEPR.

(v) The physician graduated in good standing from an accredited school of allopathic medicine, [osteopathic medicine, dental surgery] *osteopathic medicine*, *podiatric medicine*, *dental surgery*, or dental medicine in the United States during the 5-year period immediately preceding the date on which the physician first registers or renews under this section and has successfully completed a comprehensive allopathic or osteopathic medicine curriculum or accredited medical residency or dental surgery [or dental medicine curriculum] or *dental or podiatric medicine curriculum* that included not less than 8 hours of training on—

(I) treating and managing patients with opioid or other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder; or

(II) the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with

or at risk of developing opioid and other substance use disorders.

(B) If the practitioner is not a physician (as defined under section 1861(r) of the Social Security Act), the practitioner is legally authorized by the State to dispense controlled substances under schedule II, III, IV, or V and is dispensing such substances within such State in accordance with all applicable State laws, and the practitioner meets one or more of the following conditions:

(i) The practitioner has completed not fewer than 8 hours of training with respect to the treatment and management of patients with opioid or other substance use disorders (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Associates, *the American Pharmacists Association, the Accreditation Council on Pharmacy Education, the American Psychiatric Nurses Association, the American Academy of Nursing, the American Academy of Family Physicians*, or any other organization approved or accredited by the Assistant Secretary for Mental Health and Substance Use, *the American Academy of Family Physicians*, or the Accreditation Council for Continuing Medical Education.

(ii) The practitioner has graduated in good standing from an accredited physician assistant school [or accredited school], *an accredited school of advanced practice nursing, or an accredited school of pharmacy* in the United States during the 5-year period immediately preceding the date on which the practitioner first registers or renews under this section and has successfully completed a comprehensive physician assistant or advanced practice nursing curriculum that included not fewer than 8 hours of training on treating and managing patients with opioid and other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder.

(2) ONE-TIME TRAINING.—

(A) IN GENERAL.—The Attorney General shall not require any qualified practitioner to complete the training described in clause (iv) or (v) of paragraph (1)(A) or clause (i) or (ii) of paragraph (1)(B) more than once.

(B) NOTIFICATION.—Not later than 90 days after the date of the enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, the Attorney General shall provide to qualified practitioners a single written, electronic notification of the training described in clauses

(iv) and (v) of paragraph (1)(A) or clauses (i) and (ii) of paragraph (1)(B).

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to preclude the use, by a qualified practitioner, of training received pursuant to this subsection to satisfy registration requirements of a State or for some other lawful purpose; or

(B) to preempt any additional requirements by a State related to the dispensing of controlled substances under schedule II, III, IV, or V.

(4) DEFINITIONS.—In this section:

(A) FIRST APPLICABLE REGISTRATION.—The term “first applicable registration” means the first registration or renewal of registration by a qualified practitioner under this section that occurs on or after the date that is 180 days after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022.

(B) QUALIFIED PRACTITIONER.—In this subsection, the term “qualified practitioner” means a practitioner who—

- (i) is licensed under State law to prescribe controlled substances; and
- (ii) is not solely a veterinarian.

\* \* \* \* \*

DELIVERY OF A CONTROLLED SUBSTANCE BY A PHARMACY TO AN ADMINISTERING PRACTITIONER

SEC. 309A. (a) IN GENERAL.—Notwithstanding section 102(10), a pharmacy may deliver a controlled substance to a practitioner in accordance with a prescription that meets the requirements of this title and the regulations issued by the Attorney General under this title, for the purpose of administering the controlled substance by the practitioner if—

(1) the controlled substance is delivered by the pharmacy to the prescribing practitioner or the practitioner administering the controlled substance, as applicable, at the location listed on the practitioner’s certificate of registration issued under this title;

[(2) the controlled substance is to be administered for the purpose of maintenance or detoxification treatment under section 303(h)(2) and is to be administered by injection or implantation;]

(2) *the controlled substance is a drug in schedule III, IV, or V to be administered—*

*(A) by injection or implantation for the purpose of maintenance or detoxification treatment; or*

*(B) subject to a risk evaluation and mitigation strategy pursuant to section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1) that includes elements to assure safe use of the drug described in subsection (f)(3)(E) of such section, including a requirement for post-administration monitoring by a health care provider;*

(3) the pharmacy and the practitioner are authorized to conduct the activities specified in this section under the law of the State in which such activities take place;

(4) the prescription is not issued to supply any practitioner with a stock of controlled substances for the purpose of general dispensing to patients;

(5) except as provided in subsection (b), the controlled substance is to be administered only to the patient named on the prescription not later than 45 days after the date of receipt of the controlled substance by the practitioner; and

(6) notwithstanding any exceptions under section 307, the prescribing practitioner, and the practitioner administering the controlled substance, as applicable, maintain complete and accurate records of all controlled substances delivered, received, administered, or otherwise disposed of under this section, including the persons to whom controlled substances were delivered and such other information as may be required by regulations of the Attorney General.

(b) MODIFICATION OF NUMBER OF DAYS BEFORE WHICH CONTROLLED SUBSTANCE SHALL BE ADMINISTERED.—

(1) INITIAL 2-YEAR PERIOD.—During the 2-year period beginning on the date of enactment of this section, the Attorney General, in coordination with the Secretary, may reduce the number of days described in subsection (a)(5) if the Attorney General determines that such reduction will—

- (A) reduce the risk of diversion; or
- (B) protect the public health.

(2) MODIFICATIONS AFTER SUBMISSION OF REPORT.—After the date on which the report described in section 3204(b) of the SUPPORT for Patients and Communities Act is submitted, the Attorney General, in coordination with the Secretary, may modify the number of days described in subsection (a)(5).

(3) MINIMUM NUMBER OF DAYS.—Any modification under this subsection shall be for a period of not less than 7 days.

\* \* \* \* \*

## MINORITY VIEWS

H.R. 2483, the SUPPORT for Patients and Communities Reauthorization Act of 2025, reauthorizes public health programs that help address the ongoing opioid epidemic. This historically bipartisan bill should have continued to earn bipartisan support, but Congressional Republicans have refused to conduct proper oversight of the Trump Administration’s dismantling of the Substance Abuse and Mental Health Services Administration (SAMHSA), the agency responsible for the United States’ response to ongoing mental health and substance use disorder crises and for carrying out many of the programs reauthorized by H.R. 2483.

On February 14, 2025, the Trump Administration fired approximately 100 probationary employees at SAMHSA.<sup>1</sup> This was more than 10 percent of the agency’s workforce.<sup>2</sup> On April 1, 2025, there was another round of mass firing at the agency as part of a department-wide Reduction in Force (RIF), including senior officials such as the Director of the Center for Mental Health Services and the Director of the Center for Substance Use Treatment.<sup>3</sup> The Administration has refused to answer written questions regarding exactly how many people were fired, despite repeated requests from the Ranking Member and Minority Committee staff. However, reports indicate that up to 50 percent of the agency’s staff have been fired.<sup>4</sup>

In March, the Trump Administration also revealed plans to eliminate SAMHSA altogether and combine mental health and substance use programs with unrelated programs such as occupational health and safety and toxic substances in a new “Administration for a Healthy America.”<sup>5</sup> This action will deprioritize mental health and substance use efforts within the federal government, and it has been opposed by dozens of leading mental health and substance use groups.<sup>6</sup>

At the same time, the Trump Administration illegally rescinded over \$1 billion from state and local behavioral health programs under Mental Health and Substance Use Block Grant funding.<sup>7</sup> These funds were appropriated by the American Rescue Plan Act during the COVID–19 pandemic, but the funding was never limited

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<sup>1</sup> *‘Deliberate Trauma’: SAMHSA Employees Detail a Federal Agency in Shambles*, STAT (Mar. 12, 2025).

<sup>2</sup> Department of Health and Human Services, *Fiscal Year 2025 Substance Use and Mental Health Services Administration Justification of Estimates for Appropriations Committees*. (<https://www.samhsa.gov/sites/default/files/samhsa-fy-2025-cj.pdf>) (accessed Apr. 30, 2025).

<sup>3</sup> *SAMHSA Firings Continue, Devastating U.S. Mental Health Agency*, MindSite News (Apr. 1, 2025).

<sup>4</sup> *As SAMHSA Cuts Loom, Behavioral Health Orgs Fight to Protect Funding*, Filter (Apr. 17, 2025).

<sup>5</sup> Department of Health and Human Services, *HHS Announces Transformation to Make America Healthy Again* (Mar. 27, 2025) (press release).

<sup>6</sup> Legal Action Center, *Joint Statement Opposing SAMHSA Cuts and Any Harmful HHS Restructuring* (Apr. 15, 2025) (press release).

<sup>7</sup> *Trump Administration Abruptly Cuts Billions From State Health Services*, The New York Times (Mar. 26, 2025).

to be used only for COVID–19 activities or during a public health emergency. The funding was already obligated to states and rescinding it has only undermined States’ ability to address the overdose crisis.

On April 16, 2025, an internal budget document revealed the Trump Administration’s plans for drastic cuts across the Department of Health and Human Services (HHS).<sup>8</sup> The document listed out specific programs that are poised to be eliminated, including 40 different mental health and substance use programs. Among these programs were eight programs reauthorized by H.R. 2483, including programs that train first responders for overdose response, provide residential treatment for pregnant and postpartum women, a task force on best practices for trauma-informed care, support the full spectrum of recovery services, target youth substance use disorder prevention, and help individuals in recovery reenter the workforce.<sup>9</sup>

Congressional Republicans have stood silently by while the Trump Administration decimates our mental health and substance use prevention, treatment, and recovery landscape. It is Congress’ job to ensure that agencies can continue their critical work and that authorized programs are not arbitrarily and illegally slashed. Without proper Congressional oversight, there is little evidence to inspire confidence that H.R. 2438 will be faithfully implemented, or that we can make meaningful progress to combat the opioid crisis or improve the mental health and well being of all Americans.

FRANK PALLONE, Jr.,  
*Ranking Member.*

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<sup>8</sup>*Internal Budget Document Reveals Extent of Trump’s Proposed Health Cuts*, The Washington Post (Apr. 16, 2025).

<sup>9</sup>*The Leaked OMB Passback Document: What It Is and Isn’t*, McDermott+ (Apr. 24, 2025).

## EXCHANGE OF LETTERS WITH ADDITIONAL COMMITTEES OF REFERRAL

JIM JORDAN, Ohio  
CHAIRMANJAMIE RASKIN, Maryland  
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

**Congress of the United States**  
**House of Representatives**

COMMITTEE ON THE JUDICIARY

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May 28, 2025

The Honorable Brett Guthrie  
Chairman  
Committee on Energy and Commerce  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Guthrie:

I write regarding H.R. 2483, the SUPPORT for Patients and Communities Reauthorization Act of 2025. Provisions of this bill fall within the Judiciary Committee's Rule X jurisdiction, and I appreciate that you consulted with us on those provisions. The Judiciary Committee agrees that it shall be discharged from further consideration of the bill so that it may proceed expeditiously to the House floor.

The Committee takes this action with the understanding that forgoing further consideration of this measure does not in any way alter the Committee's jurisdiction or waive any future jurisdictional claim over these provisions or their subject matter. We also reserve the right to seek appointment of an appropriate number of conferees in the event of a conference with the Senate involving this measure or similar legislation.

I ask that you please include this letter in your committee's report to accompany this legislation or insert this letter in the *Congressional Record* during consideration of H.R. 2483 on the House floor. I appreciate the cooperative manner in which our committees have worked on this matter, and I look forward to working collaboratively in the future on matters of shared jurisdiction. Thank you for your attention to this matter.

Sincerely,

  
 Jim Jordan  
 Chairman

cc The Honorable Jamie Raskin, Ranking Member, Committee on the Judiciary  
 The Honorable Frank Pallone, Ranking Member, Committee on Energy and Commerce  
 The Honorable Jason Smith, Parliamentarian



COMMITTEE ON  
EDUCATION AND WORKFORCE  
U S HOUSE OF REPRESENTATIVES  
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May 29, 2025

The Honorable Brett Guthrie  
Chair, Energy and Commerce Committee  
U S House of Representatives  
2125 Rayburn House Office Building  
Washington, D C. 20515

Dear Chair Guthrie

I write regarding H.R. 2483, the "SUPPORT for Patients and Communities Reauthorization Act of 2025." While there are provisions of the legislation that fall within the Rule X jurisdiction of the Committee on Education and Workforce, I wanted to notify you that the Committee will forgo action on the bill so that it may proceed expeditiously to the House floor for consideration.

This is done with the understanding that the Committee's jurisdictional interests over this, and similar legislation, are in no way diminished or altered. In addition, the Committee reserves the right to seek conferees on H.R. 2483 and asks for your support when such a request is made.

Finally, I respectfully request your response confirming this understanding with respect to H.R. 2483 and ask that a copy of our exchange of letters on this matter be included in the committee report or the bill or in the *Congressional Record* during consideration of the bill on the House floor.

Sincerely,

Tim Walberg  
Chairman  
Committee on Education and Workforce

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