

114TH CONGRESS
2D SESSION

S. 2562

To support a comprehensive public health response to the heroin and prescription drug abuse crisis.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 22, 2016

Mr. BROWN (for himself and Ms. BALDWIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To support a comprehensive public health response to the heroin and prescription drug abuse crisis.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Heroin and Prescription Drug Abuse Prevention and Re-
6 duction Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PREVENTION

- Sec. 101. Practitioner education.
- Sec. 102. Co-prescribing opioid overdose reversal drugs grant program.
- Sec. 103. Opioid overdose reversal co-prescribing guidelines.
- Sec. 104. Surveillance capacity building.

TITLE II—CRISIS

- Sec. 201. Grants to support syringe exchange programs.
- Sec. 202. Grant program to reduce drug overdose deaths.

TITLE III—TREATMENT

- Sec. 301. Expansion of patient limits under waiver.
- Sec. 302. Definitions.
- Sec. 303. Evaluation by assistant Secretary for planning and evaluation.
- Sec. 304. Reauthorization of residential treatment programs for pregnant and postpartum women.
- Sec. 305. Pilot program grants for State substance abuse agencies.
- Sec. 306. Evidence-based opioid and heroin treatment and interventions demonstration.
- Sec. 307. Grants to improve access to treatment and recovery for adolescents.
- Sec. 308. Strengthening parity in mental health and substance use disorder benefits.
- Sec. 309. Study on treatment infrastructure.
- Sec. 310. Substance use disorder professional loan repayment program.

TITLE IV—RECOVERY

- Sec. 401. National youth recovery initiative.
- Sec. 402. Grants to enhance and expand recovery support services.

1 **TITLE I—PREVENTION**

2 **SEC. 101. PRACTITIONER EDUCATION.**

3 (a) EDUCATION REQUIREMENTS.—

4 (1) REGISTRATION CONSIDERATION.—Section
 5 303(f) of the Controlled Substances Act (21 U.S.C.
 6 823(f)) is amended by inserting after paragraph (5)
 7 the following:

8 “(6) The applicant’s compliance with the train-
 9 ing requirements described in subsection (g)(3) dur-
 10 ing any previous period in which the applicant has
 11 been subject to such training requirements.”.

1 (2) TRAINING REQUIREMENTS.—Section 303(g)
2 of the Controlled Substances Act (21 U.S.C. 823(g))
3 is amended by adding at the end the following:

4 “(3)(A) To be registered to prescribe or otherwise
5 dispense opioids for the treatment of pain, or pain man-
6 agement, a practitioner described in paragraph (1) shall
7 comply with the 12-hour training requirement of subpara-
8 graph (B) at least once during each 3-year period or the
9 requirements of a State training program approved by the
10 Secretary of Health and Human Services under subpara-
11 graph (C).

12 “(B) The training requirement of this subparagraph
13 is that the practitioner has completed not less than 12
14 hours of training (through classroom situations, seminars
15 at professional society meetings, electronic communica-
16 tions, or otherwise) with respect to—

17 “(i) the treatment and management of opioid-
18 dependent patients;

19 “(ii) pain management treatment guidelines;
20 and

21 “(iii) early detection of opioid addiction, includ-
22 ing through such methods as Screening, Brief Inter-
23 vention, and Referral to Treatment (SBIRT),

24 that is provided by the American Society of Addiction
25 Medicine, the American Academy of Addiction Psychiatry,

1 the American Medical Association, the American Osteo-
2 pathic Association, the American Psychiatric Association,
3 the American Academy of Pain Management, the Amer-
4 ican Pain Society, the American Academy of Pain Medi-
5 cine, the American Board of Pain Medicine, the American
6 Society of Interventional Pain Physicians, or any other or-
7 ganization that the Secretary determines is appropriate
8 for purposes of this subparagraph.

9 “(C) The Secretary of Health and Human Services
10 may approve a State training program that practitioners
11 described in paragraph (1) may comply with in lieu of
12 compliance with the training program provided for in sub-
13 paragraph (B).”.

14 (b) FUNDING.—The Drug Enforcement Administra-
15 tion shall fund the enforcement of the requirements speci-
16 fied in section 303(g)(3) of the Controlled Substances Act
17 (as added by subsection (a)) through the use of a portion
18 of the licensing fees paid by controlled substance pre-
19 scribers under the Controlled Substances Act (21 U.S.C.
20 801 et seq.).

21 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section
23 \$1,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 102. CO-PRESCRIBING OPIOID OVERDOSE REVERSAL**
2 **DRUGS GRANT PROGRAM.**

3 (a) ESTABLISHMENT.—

4 (1) IN GENERAL.—Not later than six months
5 after the date of the enactment of this Act, the Sec-
6 retary of Health and Human Services shall estab-
7 lish, in accordance with this section, a four-year co-
8 prescribing opioid overdose reversal drugs grant pro-
9 gram (in this title referred to as the “grant pro-
10 gram”) under which the Secretary shall provide not
11 more than a total of 12 grants to eligible entities to
12 carry out the activities described in subsection (c).

13 (2) ELIGIBLE ENTITY.—For purposes of this
14 section, the term “eligible entity” means a federally
15 qualified health center (as defined in section
16 1861(aa) of the Social Security Act (42 U.S.C.
17 1395x(aa))), an opioid treatment program under
18 part 8 of title 42, Code of Federal Regulations, or
19 section 303(g) of the Controlled Substances Act (21
20 U.S.C. 823(g)), a program approved by a State sub-
21 stance abuse agency, or any other entity that the
22 Secretary deems appropriate.

23 (3) CO-PRESCRIBING.—For purposes of this
24 title, the term “co-prescribing” means, with respect
25 to an opioid overdose reversal drug, the practice of
26 prescribing such drug in conjunction with an opioid

1 prescription for patients at an elevated risk of over-
2 dose, or in conjunction with an opioid agonist ap-
3 proved under section 505 of the Federal Food,
4 Drug, and Cosmetic Act (21 U.S.C. 355) for the
5 treatment of opioid abuse disorders, or in other cir-
6 cumstances in which a provider identifies a patient
7 at an elevated risk for an intentional or uninten-
8 tional drug overdose from heroin or prescription
9 opioid therapies. For purposes of the previous sen-
10 tence, a patient may be at an elevated risk of over-
11 dose if the patient meets the criteria under the exist-
12 ing co-prescribing guidelines that the Secretary
13 deems appropriate, such as the criteria provided in
14 the Opioid Overdose Toolkit published by the Sub-
15 stance Abuse and Mental Health Services Adminis-
16 tration.

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

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

1 (2) the criteria that will be used to identify eli-
2 gible patients to participate in such program; and

3 (3) how such program will work to try to iden-
4 tify State, local, or private funding to continue the
5 program after expiration of the grant.

6 (c) USE OF FUNDS.—An eligible entity receiving a
7 grant under this section may use the grant for any of the
8 following activities:

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

11 (2) To train and provide resources for health
12 care providers and pharmacists on the co-prescribing
13 of opioid overdose reversal drugs.

14 (3) To establish mechanisms and processes,
15 consistent with applicable Federal and State privacy
16 rules, for tracking patients participating in the pro-
17 gram described in paragraph (1) and the health out-
18 comes of such patients.

19 (4) To purchase opioid overdose reversal drugs
20 for distribution under the program described in
21 paragraph (1).

22 (5) To offset the co-pays and other cost sharing
23 associated with opioid overdose reversal drugs to en-
24 sure that cost is not a limiting factor for eligible pa-
25 tients.

1 (6) To conduct community outreach, in con-
2 junction with community-based organizations, de-
3 signed to raise awareness of co-prescribing practices,
4 and the availability of opioid overdose reversal
5 drugs.

6 (7) To establish protocols to connect patients
7 who have experienced a drug overdose with appro-
8 priate treatment, including medication assisted
9 treatment and appropriate counseling and behavioral
10 therapies.

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

18 (1) the number of prescribers trained;

19 (2) the number of prescribers who have co-pre-
20 scribed an opioid overdose reversal drug to at least
21 one patient;

22 (3) the total number of prescriptions written for
23 opioid overdose reversal drugs;

1 (4) the percentage of patients at elevated risk
2 who received a prescription for an opioid overdose
3 reversal drug;

4 (5) the number of patients reporting use of an
5 opioid overdose reversal drug; and

6 (6) any other outcome measures that the Sec-
7 retary deems appropriate.

8 (e) REPORTS BY SECRETARY.—For each year of the
9 grant program under this section, the Secretary of Health
10 and Human Services shall submit to the appropriate com-
11 mittees of the House of Representatives and of the Senate
12 a report aggregating the information received from the
13 grant recipients for such year under subsection (d) and
14 evaluating the outcomes achieved by the programs funded
15 by grants made under this section.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to carry out this section and
18 section 103 \$4,000,000 for each of fiscal years 2017
19 through 2021.

20 **SEC. 103. OPIOID OVERDOSE REVERSAL CO-PRESCRIBING**
21 **GUIDELINES.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services shall establish a grant program under
24 which the Secretary shall award grants to eligible State

1 entities to develop opioid overdose reversal co-prescribing
2 guidelines.

3 (b) ELIGIBLE STATE ENTITIES.—For purposes of
4 subsection (a), eligible State entities are State depart-
5 ments of health in conjunction with State medical boards;
6 city, county, and local health departments; and community
7 stakeholder groups involved in reducing opioid overdose
8 deaths.

9 (c) ADMINISTRATIVE PROVISIONS.—

10 (1) GRANT AMOUNTS.—A grant made under
11 this section may not be for more than \$200,000 per
12 grant.

13 (2) PRIORITIZATION.—In awarding grants
14 under this section, the Secretary shall give priority
15 to eligible State entities which propose to base their
16 guidelines on existing guidelines on co-prescribing to
17 speed enactment, including guidelines of—

18 (A) the Department of Veterans Affairs;

19 (B) nationwide medical societies, such as
20 the American Society of Addiction Medicine or
21 the American Medical Association; and

22 (C) the Centers for Disease Control and
23 Prevention.

1 **SEC. 104. SURVEILLANCE CAPACITY BUILDING.**

2 (a) PROGRAM AUTHORIZED.—The Secretary of
3 Health and Human Services, acting through the Director
4 of the Centers for Disease Control and Prevention, shall
5 award cooperative agreements or grants to eligible entities
6 to improve fatal and nonfatal drug overdose surveillance
7 and reporting capabilities, including—

8 (1) providing training to improve identification
9 of drug overdose as the cause of death by coroners
10 and medical examiners;

11 (2) establishing, in cooperation with the Na-
12 tional Poison Data System, coroners, and medical
13 examiners, a comprehensive national program for
14 surveillance of, and reporting to an electronic data-
15 base on, drug overdose deaths in the United States;
16 and

17 (3) establishing, in cooperation with the Na-
18 tional Poison Data System, a comprehensive na-
19 tional program for surveillance of, and reporting to
20 an electronic database on, fatal and nonfatal drug
21 overdose occurrences, including epidemiological and
22 toxicologic analysis and trends.

23 (b) ELIGIBLE ENTITY.—To be eligible to receive a
24 grant or cooperative agreement under this section, an enti-
25 ty shall be—

26 (1) a State, local, or tribal government; or

1 (2) the National Poison Data System working
2 in conjunction with a State, local, or tribal govern-
3 ment.

4 (c) APPLICATION.—

5 (1) IN GENERAL.—An eligible entity desiring a
6 grant or cooperative agreement under this section
7 shall submit to the Secretary an application at such
8 time, in such manner, and containing such informa-
9 tion as the Secretary may require.

10 (2) CONTENTS.—An application described in
11 paragraph (1) shall include—

12 (A) a description of the activities to be
13 funded through the grant or cooperative agree-
14 ment; and

15 (B) evidence that the eligible entity has the
16 capacity to carry out such activities.

17 (d) REPORT.—As a condition of receipt of a grant
18 or cooperative agreement under this section, an eligible en-
19 tity shall agree to prepare and submit, not later than 90
20 days after the end of the grant or cooperative agreement
21 period, a report to the Secretary describing the results of
22 the activities supported through the grant or cooperative
23 agreement.

24 (e) NATIONAL POISON DATA SYSTEM.—In this sec-
25 tion, the term “National Poison Data System” means the

1 system operated by the American Association of Poison
 2 Control Centers, in partnership with the Centers for Dis-
 3 ease Control and Prevention, for real-time local, State,
 4 and national electronic reporting, and the corresponding
 5 database network.

6 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
 7 authorized to be appropriated to carry out this section
 8 \$5,000,000 for each of the fiscal years 2017 through
 9 2021.

10 **TITLE II—CRISIS**

11 **SEC. 201. GRANTS TO SUPPORT SYRINGE EXCHANGE PRO-** 12 **GRAMS.**

13 (a) IN GENERAL.—The Secretary of Health and
 14 Human Services may award grants to State, local, and
 15 tribal governments and community organizations to sup-
 16 port syringe exchange programs.

17 (b) USE OF FUNDS.—Grants under subsection (a)
 18 may be used to support carrying out syringe exchange pro-
 19 grams, including through—

20 (1) providing outreach, counseling, health edu-
 21 cation, case management, syringe disposal, and
 22 other services as determined appropriate by the Sec-
 23 retary of Health and Human Services; and

24 (2) providing technical assistance, including
 25 training and capacity building, to assist the develop-

1 ment and implementation of syringe exchange pro-
2 grams.

3 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated \$15,000,000 for each of fis-
5 cal years 2017 through 2021 to carry out this section, of
6 which—

7 (1) at least 15 percent shall be for syringe ex-
8 change programs that have been in operation for
9 less than 3 years; and

10 (2) 5 percent shall be for technical assistance
11 under subsection (b)(2).

12 **SEC. 202. GRANT PROGRAM TO REDUCE DRUG OVERDOSE**
13 **DEATHS.**

14 (a) PROGRAM AUTHORIZED.—The Secretary of
15 Health and Human Services, acting through the Adminis-
16 trator of the Substance Abuse and Mental Health Services
17 Administration, shall award grants or enter into coopera-
18 tive agreements with eligible entities to enable the eligible
19 entities to reduce deaths occurring from overdoses of
20 drugs.

21 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
22 grant or cooperative agreement under this section, an enti-
23 ty shall be a partnership between any of the following: a
24 State, local, or tribal government, a correctional institu-
25 tion, a law enforcement agency, a community agency, a

1 professional organization in the field of poison control and
2 surveillance, or a private nonprofit organization.

3 (c) APPLICATION.—

4 (1) IN GENERAL.—An eligible entity desiring a
5 grant or cooperative agreement under this section
6 shall submit to the Secretary of Health and Human
7 Services an application at such time, in such man-
8 ner, and containing such information as the Sec-
9 retary may require.

10 (2) CONTENTS.—An application under para-
11 graph (1) shall include—

12 (A) a description of the activities to be
13 funded through the grant or cooperative agree-
14 ment; and

15 (B) evidence that the eligible entity has the
16 capacity to carry out such activities.

17 (d) PRIORITY.—In entering into grants and coopera-
18 tive agreements under subsection (a), the Secretary of
19 Health and Human Services shall give priority to eligible
20 entities that—

21 (1) include a public health agency or commu-
22 nity-based organization; and

23 (2) have expertise in preventing deaths occur-
24 ring from overdoses of drugs in populations at high
25 risk of such deaths.

1 (e) ELIGIBLE ACTIVITIES.—As a condition of receipt
2 of a grant or cooperative agreement under this section,
3 an eligible entity shall agree to use the grant or coopera-
4 tive agreement to do each of the following:

5 (1) Purchase and distribute the drug naloxone
6 or a similarly effective medication.

7 (2) Carry out one or more of the following ac-
8 tivities:

9 (A) Educating prescribers and pharmacists
10 about overdose prevention and naloxone pre-
11 scription, or prescriptions of a similarly effec-
12 tive medication.

13 (B) Training first responders, other indi-
14 viduals in a position to respond to an overdose,
15 and law enforcement and corrections officials on
16 the effective response to individuals who have
17 overdosed on drugs. Training pursuant to this
18 subparagraph may include any activity that is
19 educational, instructional, or consultative in na-
20 ture, and may include volunteer training,
21 awareness building exercises, outreach to indi-
22 viduals who are at risk of a drug overdose, and
23 distribution of educational materials.

24 (C) Implementing and enhancing programs
25 to provide overdose prevention, recognition,

1 treatment, and response to individuals in need
2 of such services.

3 (D) Educating the public and providing
4 outreach to the public about overdose preven-
5 tion and naloxone prescriptions, or prescriptions
6 of other similarly effective medications.

7 (f) COORDINATING CENTER.—

8 (1) ESTABLISHMENT.—The Secretary of Health
9 and Human Services shall establish and provide for
10 the operation of a coordinating center responsible
11 for—

12 (A) collecting, compiling, and dissemi-
13 nating data on the programs and activities
14 under this section, including tracking and eval-
15 uating the distribution and use of naloxone and
16 other similarly effective medication;

17 (B) evaluating such data and, based on
18 such evaluation, developing best practices for
19 preventing deaths occurring from drug
20 overdoses;

21 (C) making such best practices specific to
22 the type of community involved;

23 (D) coordinating and harmonizing data
24 collection measures;

1 (E) evaluating the effects of the program
2 on overdose rates; and

3 (F) education and outreach to the public
4 about overdose prevention and prescription of
5 naloxone and other similarly effective medica-
6 tion.

7 (2) REPORTS TO CENTER.—As a condition on
8 receipt of a grant or cooperative agreement under
9 this section, an eligible entity shall agree to prepare
10 and submit, not later than 90 days after the end of
11 the award period, a report to such coordinating cen-
12 ter and the Secretary of Health and Human Services
13 describing the results of the activities supported
14 through the grant or cooperative agreement.

15 (g) DURATION.—The period of a grant or cooperative
16 agreement under this section shall be 4 years.

17 (h) DEFINITION.—In this part, the term “drug”—

18 (1) means a drug, as defined in section 201 of
19 the Federal Food, Drug, and Cosmetic Act (21
20 U.S.C. 321); and

21 (2) includes controlled substances, as defined in
22 section 102 of the Controlled Substances Act (21
23 U.S.C. 802).

24 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
25 authorized to be appropriated \$20,000,000 to carry out

1 this section for each of the fiscal years 2017 through
 2 2021.

3 **TITLE III—TREATMENT**

4 **SEC. 301. EXPANSION OF PATIENT LIMITS UNDER WAIVER.**

5 Section 303(g)(2)(B) of the Controlled Substances
 6 Act (21 U.S.C. 823(g)(2)(B)) is amended—

7 (1) in clause (i), by striking “physician” and in-
 8 serting “practitioner”;

9 (2) in clause (iii)—

10 (A) by striking “30” and inserting “100”;

11 and

12 (B) by striking “, unless, not sooner” and
 13 all that follows through the end and inserting a
 14 period; and

15 (3) by inserting at the end the following new
 16 clause:

17 “(iv) Not earlier than 1 year after the date
 18 on which a qualifying practitioner obtained an
 19 initial waiver pursuant to clause (iii), the quali-
 20 fying practitioner may submit a second notifica-
 21 tion to the Secretary of the need and intent of
 22 the qualifying practitioner to treat an unlimited
 23 number of patients, if the qualifying practi-
 24 tioner—

1 “(I)(aa) satisfies the requirements of
2 item (aa), (bb), (cc), or (dd) of subpara-
3 graph (G)(ii)(I); and

4 “(bb) agrees to fully participate in the
5 Prescription Drug Monitoring Program of
6 the State in which the qualifying practi-
7 tioner is licensed, pursuant to applicable
8 State guidelines; or

9 “(II)(aa) satisfies the requirements of
10 item (ee), (ff), or (gg) of subparagraph
11 (G)(ii)(I);

12 “(bb) agrees to fully participate in the
13 Prescription Drug Monitoring Program of
14 the State in which the qualifying practi-
15 tioner is licensed, pursuant to applicable
16 State guidelines;

17 “(cc) practices in a qualified practice
18 setting; and

19 “(dd) has completed not less than 24
20 hours of training (through classroom situa-
21 tions, seminars at professional society
22 meetings, electronic communications, or
23 otherwise) with respect to the treatment
24 and management of opiate-dependent pa-
25 tients for substance use disorders 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.”.

9 SEC. 302. DEFINITIONS.

10 Section 303(g)(2)(G) of the Controlled Substances
11 Act (21 U.S.C. 823(g)(2)(G)) is amended—

12 (1) by striking clause (ii) and inserting the fol-
13 lowing:

14 “(ii) The term ‘qualifying practitioner’
15 means the following:

16 “(I) A physician who is licensed under
17 State law and who meets 1 or more of the
18 following conditions:

19 “(aa) The physician holds a
20 board certification in addiction psychi-
21 atry from the American Board of
22 Medical Specialties.

23 “(bb) The physician holds an ad-
24 diction certification from the Amer-
25 ican Society of Addiction Medicine.

1 “(cc) The physician holds a
2 board certification in addiction medi-
3 cine from the American Osteopathic
4 Association.

5 “(dd) The physician holds a
6 board certification from the American
7 Board of Addiction Medicine.

8 “(ee) The physician has com-
9 pleted not less than 8 hours of train-
10 ing (through classroom situations,
11 seminar at professional society meet-
12 ings, electronic communications, or
13 otherwise) with respect to the treat-
14 ment and management of opiate-de-
15 pendent patients for substance use
16 disorders provided by the American
17 Society of Addiction Medicine, the
18 American Academy of Addiction Psy-
19 chiatry, the American Medical Asso-
20 ciation, the American Osteopathic As-
21 sociation, the American Psychiatric
22 Association, or any other organization
23 that the Secretary determines is ap-
24 propriate for purposes of this sub-
25 clause.

1 “(ff) The physician has partici-
2 pated as an investigator in 1 or more
3 clinical trials leading to the approval
4 of a narcotic drug in schedule III, IV,
5 or V for maintenance or detoxification
6 treatment, as demonstrated by a
7 statement submitted to the Secretary
8 by this sponsor of such approved
9 drug.

10 “(gg) The physician has such
11 other training or experience as the
12 Secretary determines will demonstrate
13 the ability of the physician to treat
14 and manage opiate-dependent pa-
15 tients.

16 “(II) A nurse practitioner or physi-
17 cian assistant who is licensed under State
18 law and meets all of the following condi-
19 tions:

20 “(aa) The nurse practitioner or
21 physician assistant is licensed under
22 State law to prescribe schedule III,
23 IV, or V medications for pain.

1 “(bb) The nurse practitioner or
2 physician assistant satisfies 1 or more
3 of the following:

4 “(AA) Has completed not
5 fewer than 24 hours of training
6 (through classroom situations,
7 seminar at professional society
8 meetings, electronic communica-
9 tions, or otherwise) with respect
10 to the treatment and manage-
11 ment of opiate-dependent pa-
12 tients for substance use disorders
13 provided by the American Society
14 of Addiction Medicine, the Amer-
15 ican Academy of Addiction Psy-
16 chiatry, the American Medical
17 Association, the American Osteo-
18 pathic Association, the American
19 Psychiatric Association, or any
20 other organization that the Sec-
21 retary determines is appropriate
22 for purposes of this subclause.

23 “(BB) Has such other train-
24 ing or experience as the Sec-
25 retary determines will dem-

1 onstrate the ability of the nurse
 2 practitioner or physician assist-
 3 ant to treat and manage opiate-
 4 dependent patients.

5 “(cc) The nurse practitioner or
 6 physician assistant practices within
 7 the scope of their State license, in-
 8 cluding compliance with any super-
 9 vision or collaboration requirements
 10 under State law.

11 “(dd) The nurse practitioner or
 12 physician assistant practice in a quali-
 13 fied practice setting.”; and

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

15 “(iii) The term ‘qualified practice setting’
 16 means 1 or more of the following treatment set-
 17 tings:

18 “(I) A National Committee for Qual-
 19 ity Assurance-recognized Patient-Centered
 20 Medical Home or Patient-Centered Spe-
 21 cialty Practice.

22 “(II) A Centers for Medicaid & Medi-
 23 care Services-recognized Accountable Care
 24 Organization.

1 “(III) A clinical facility administered
2 by the Department of Veterans Affairs,
3 Department of Defense, or Indian Health
4 Service.

5 “(IV) A Behavioral Health Home ac-
6 credited by the Joint Commission.

7 “(V) A Federally-qualified health cen-
8 ter (as defined in section 1905(l)(2)(B) of
9 the Social Security Act (42 U.S.C.
10 1396d(l)(2)(B))) or a Federally-qualified
11 health center look-alike.

12 “(VI) A Substance Abuse and Mental
13 Health Services-certified Opioid Treatment
14 Program.

15 “(VII) A clinical program of a State
16 or Federal jail, prison, or other facility
17 where individuals are incarcerated.

18 “(VIII) A clinic that demonstrates
19 compliance with the Model Policy on
20 DATA 2000 and Treatment of Opioid Ad-
21 diction in the Medical Office issued by the
22 Federation of State Medical Boards.

23 “(IX) A treatment setting that is part
24 of an Accreditation Council for Graduate
25 Medical Education, American Association

of Colleges of Osteopathic Medicine, or
 American Osteopathic Association-accred-
 ited residency or fellowship training pro-
 gram.

“(X) Any other practice setting ap-
 proved by a State regulatory board, State
 substance abuse agency, or State Medicaid
 Plan to provide addiction treatment serv-
 ices.

“(XI) Any other practice setting ap-
 proved by the Secretary.”.

**SEC. 303. EVALUATION BY ASSISTANT SECRETARY FOR
 PLANNING AND EVALUATION.**

Two years after the date on which the first notifica-
 tion under clause (iv) of section 303(g)(2)(B) of the Con-
 trolled Substances Act (21 U.S.C. 823(g)(2)(B)), as added
 by section 301, is received by the Secretary of Health and
 Human Services, the Assistant Secretary for Planning and
 Evaluation shall initiate an evaluation of the effectiveness
 of the amendments made by sections 301 and 302, which
 shall include an evaluation of—

- (1) any changes in the availability and use of
 medication-assisted treatment for opioid addiction;
- (2) the quality of medication-assisted treatment
 programs;

1 (3) the integration of medication-assisted treat-
2 ment with routine healthcare services;

3 (4) diversion of opioid addiction treatment
4 medication;

5 (5) changes in State or local policies and legis-
6 lation relating to opioid addiction treatment;

7 (6) the use of nurse practitioners and physician
8 assistants who prescribe opioid addiction medication;

9 (7) the use of Prescription Drug Monitoring
10 Programs by waived practitioners to maximize safety
11 of patient care and prevent diversion of opioid addic-
12 tion medication;

13 (8) the findings of the Drug Enforcement Ad-
14 ministration inspections of waived practitioners, in-
15 cluding the frequency with which the Drug Enforce-
16 ment Administration finds no documentation of ac-
17 cess to behavioral health services; and

18 (9) the effectiveness of cross-agency collabora-
19 tion between the Department of Health and Human
20 Services and the Drug Enforcement Administration
21 for expanding effective opioid addiction treatment.

1 **SEC. 304. REAUTHORIZATION OF RESIDENTIAL TREAT-**
 2 **MENT PROGRAMS FOR PREGNANT AND**
 3 **POSTPARTUM WOMEN.**

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

6 (1) in subsection (p), by inserting “(other than
 7 subsection (r))” after “section”; and

8 (2) in subsection (r), by striking “such sums”
 9 and all that follows through “2003” and inserting
 10 “\$40,000,000 for each of fiscal years 2017 through
 11 2021”.

12 **SEC. 305. PILOT PROGRAM GRANTS FOR STATE SUBSTANCE**
 13 **ABUSE AGENCIES.**

14 (a) IN GENERAL.—From amounts made available
 15 under section 508(s) of the Public Health Service Act (42
 16 U.S.C. 290bb–1), the Secretary of Health and Human
 17 Services (referred to in this section as the “Secretary”)
 18 shall carry out a pilot program under which competitive
 19 grants are made by the Secretary to State substance abuse
 20 agencies to—

21 (1) enhance flexibility in the use of funds de-
 22 signed to support family-based services for pregnant
 23 and postpartum women with a primary diagnosis of
 24 a substance use disorder, including opioid use dis-
 25 orders;

1 (2) help State substance abuse agencies address
2 identified gaps in services furnished to such women
3 along the continuum of care, including services pro-
4 vided to women in nonresidential-based settings; and

5 (3) promote a coordinated, effective, and effi-
6 cient State system managed by State substance
7 abuse agencies by encouraging new approaches and
8 models of service delivery.

9 (b) REQUIREMENTS.—In carrying out the pilot pro-
10 gram under this section, the Secretary shall—

11 (1) require State substance abuse agencies to
12 submit to the Secretary applications, in such form
13 and manner and containing such information as
14 specified by the Secretary, to be eligible to receive a
15 grant under the program;

16 (2) identify, based on such submitted applica-
17 tions, State substance abuse agencies that are eligi-
18 ble for such grants;

19 (3) require services proposed to be furnished
20 through such a grant to support family-based treat-
21 ment and other services for pregnant and
22 postpartum women with a primary diagnosis of a
23 substance use disorder, including opioid use dis-
24 orders; and

1 (4) not require that services furnished through
 2 such a grant be provided solely to women that reside
 3 in facilities.

4 (c) REQUIRED SERVICES.—

5 (1) IN GENERAL.—The Secretary shall specify a
 6 minimum set of services required to be made avail-
 7 able to eligible women through a grant awarded
 8 under the pilot program under this section. Such
 9 minimum set—

10 (A) shall include requirements described in
 11 section 508(c) of the Public Health Service Act
 12 and be based on the recommendations sub-
 13 mitted under paragraph (2); and

14 (B) may be selected from among the serv-
 15 ices described in section 508(d) of such Act and
 16 include other services as appropriate.

17 (2) STAKEHOLDER INPUT.—The Secretary shall
 18 convene and solicit recommendations from stake-
 19 holders, including State substance abuse agencies,
 20 health care providers, persons in recovery from sub-
 21 stance abuse, and other appropriate individuals, for
 22 the minimum set of services described in paragraph
 23 (1).

24 (d) DURATION.—The pilot program under this sec-
 25 tion shall not exceed 5 years.

1 (e) EVALUATION AND REPORT TO CONGRESS.—The
 2 Director of the Center for Behavioral Health Statistics
 3 and Quality shall fund an evaluation of the pilot program
 4 at the conclusion of the first grant cycle funded by the
 5 pilot program. The Director of the Center for Behavioral
 6 Health Statistics and Quality, in coordination with the
 7 Secretary shall submit to the relevant committees of juris-
 8 diction of the House of Representatives and the Senate
 9 a report on such evaluation. The report shall include at
 10 a minimum outcomes information from the pilot program,
 11 including any resulting reductions in the use of alcohol
 12 and other drugs; engagement in treatment services; reten-
 13 tion in the appropriate level and duration of services; in-
 14 creased access to the use of medications approved by the
 15 Food and Drug Administration for the treatment of sub-
 16 stance use disorders in combination with counseling; and
 17 other appropriate measures.

18 (f) STATE SUBSTANCE ABUSE AGENCIES DE-
 19 FINED.—For purposes of this section, the term “State
 20 substance abuse agency” means, with respect to a State,
 21 the agency in such State that manages the Substance
 22 Abuse Prevention and Treatment Block Grant under part
 23 B of title XIX of the Public Health Service Act.

24 (g) FUNDING.—Subsection (s) of section 508 of the
 25 Public Health Service Act (42 U.S.C. 290bb–1), is amend-

1 ed by adding at the end the following new sentence: “Of
 2 the amounts made available for a year pursuant to the
 3 previous sentence to carry out this section, not more than
 4 25 percent of such amounts shall be made available for
 5 such year to carry out section 305 of the Heroin and Pre-
 6 scription Drug Abuse Prevention and Reduction Act, other
 7 than subsection (e) of such section.”.

8 **SEC. 306. EVIDENCE-BASED OPIOID AND HEROIN TREAT-**
 9 **MENT AND INTERVENTIONS DEMONSTRA-**
 10 **TION.**

11 (a) GRANTS.—

12 (1) AUTHORITY TO MAKE GRANTS.—The Sec-
 13 retary of Health and Human Services (referred to in
 14 this section as the “Secretary”) shall award grants
 15 to State substance abuse agencies, units of local gov-
 16 ernment, nonprofit organizations, and Indian tribes
 17 or tribal organizations (as defined in section 4 of the
 18 Indian Health Care Improvement Act (25 U.S.C.
 19 1603)) that have a high rate, or have had a rapid
 20 increase, in the use of heroin or other opioids, in
 21 order to permit such entities to expand activities, in-
 22 cluding an expansion in the availability of medica-
 23 tion assisted treatment, evidence-based counseling,
 24 or behavioral therapies with respect to the treatment
 25 of addiction in the specific geographical areas of

1 such entities where there is a rate or rapid increase
2 in the use of heroin or other opioids.

3 (2) RECIPIENTS.—The entities receiving grants
4 under paragraph (1) shall be selected by the Sec-
5 retary.

6 (3) NATURE OF ACTIVITIES.—The grant funds
7 awarded under paragraph (1) shall be used for ac-
8 tivities that are based on reliable scientific evidence
9 of efficacy in the treatment of problems related to
10 heroin or other opioids.

11 (b) GEOGRAPHIC DISTRIBUTION.—The Secretary
12 shall ensure that grants awarded under subsection (a) are
13 distributed equitably among the various regions of the Na-
14 tion and among rural, urban, and suburban areas that are
15 affected by the use of heroin or other opioids.

16 (c) ADDITIONAL ACTIVITIES.—The Secretary shall—

17 (1) evaluate the activities supported by grants
18 awarded under subsection (a);

19 (2) disseminate widely such significant informa-
20 tion derived from the evaluation as the Secretary
21 considers appropriate;

22 (3) provide States, Indian tribes and tribal or-
23 ganizations, and providers with technical assistance
24 in connection with the provision of treatment of
25 problems related to heroin and other opioids; and

1 (4) fund only those applications that specifically
 2 support recovery services as a critical component of
 3 the grant program.

4 (d) DEFINITION.—In this section, the term “medica-
 5 tion assisted treatment” means the use, for problems re-
 6 lating to heroin and other opioids, of medications approved
 7 by the Food and Drug Administration in combination with
 8 counseling and behavioral therapies.

9 (e) AUTHORIZATION OF APPROPRIATIONS.—

10 (1) IN GENERAL.—There is authorized to be
 11 appropriated to carry out this section \$300,000,000
 12 for each of fiscal years 2017 through 2021.

13 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
 14 propriated to carry out this section in any fiscal
 15 year, not more than 5 percent of such funds shall
 16 be available to the Secretary for purposes of car-
 17 rying out subsection (c).

18 **SEC. 307. GRANTS TO IMPROVE ACCESS TO TREATMENT**

19 **AND RECOVERY FOR ADOLESCENTS.**

20 (a) IN GENERAL.—The Secretary of Health and
 21 Human Services (referred to in this section as the “Sec-
 22 retary”) shall award grants, contracts, or cooperative
 23 agreements to eligible State substance abuse agencies and
 24 other entities determined appropriate by the Secretary for

1 the purpose of increasing the capacity of substance use
2 disorder treatment and recovery services for adolescents.

3 (b) ELIGIBILITY.—To be eligible to receive a grant,
4 contract, or cooperative agreement under subsection (a)
5 an entity shall—

6 (1) prepare and submit to the Secretary an ap-
7 plication at such time, in such manner, and contain
8 such information as the Secretary may require, in-
9 cluding a plan for the evaluation of any activities
10 carried out with the funds provided under this sec-
11 tion;

12 (2) ensure that all entities receiving support
13 under the grant, contract, or cooperative agreement
14 comply with all applicable State licensure or certifi-
15 cation requirements regarding the provision of the
16 services involved; and

17 (3) provide the Secretary with periodic evalua-
18 tions of the progress of the activities funded under
19 this section and an evaluation at the completion of
20 such activities, as the Secretary determines to be ap-
21 propriate.

22 (c) PRIORITY.—In awarding grants, contracts, and
23 cooperative agreements under subsection (a), the Sec-
24 retary shall give priority to applicants who propose to fill

1 a demonstrated geographic need for adolescent specific
2 residential treatment services.

3 (d) USE OF FUNDS.—Amounts awarded under
4 grants, contracts, or cooperative agreements under this
5 section may be used to enable health care providers or fa-
6 cilities that provide treatment and recovery assistance for
7 adolescents with a substance use disorder to provide the
8 following services:

9 (1) Individualized patient centered care that is
10 specific to circumstances of the individual patient.

11 (2) Clinically appropriate, trauma-informed,
12 gender-specific and age appropriate treatment serv-
13 ices that are based on reliable scientific evidence of
14 efficacy in the treatment of problems related to sub-
15 stance use disorders.

16 (3) Clinically appropriate care to address treat-
17 ment for substance use and any co-occurring phys-
18 ical and mental health disorders at the same loca-
19 tion, and through access to primary care services.

20 (4) Coordination of treatment services with re-
21 covery and other social support, including edu-
22 cational, vocational training, assistance with the ju-
23 venile justice system, child welfare, and mental
24 health agencies.

1 (5) Aftercare and long-term recovery support,
2 including peer support services.

3 (e) DURATION OF ASSISTANCE.—Grants, contracts,
4 and cooperative agreements awarded under subsection (a)
5 shall be for a period not to exceed 5 years.

6 (f) ADDITIONAL ACTIVITIES.—The Secretary shall—

7 (1) collect and evaluate the activities carried
8 out with amounts received under subsection (a);

9 (2) disseminate widely such significant informa-
10 tion derived from the evaluation as the Secretary
11 considers appropriate; and

12 (3) provide States, Indian tribes and tribal or-
13 ganizations, and providers with technical assistance
14 in connection with the provision of treatment and re-
15 covery services funded through this section to ado-
16 lescents related to the abuse of heroin and other
17 opioids.

18 (g) AUTHORIZATION OF APPROPRIATIONS.—

19 (1) IN GENERAL.—There is authorized to be
20 appropriated to carry out this section, \$25,000,000
21 for each of fiscal years 2017 through 2021.

22 (2) USE OF CERTAIN FUNDS.—Of the funds ap-
23 propriated to carry out this section in any fiscal
24 year, not more than 5 percent of such funds shall

1 be available to the Secretary for purposes of car-
 2 rying out subsection (f).

3 **SEC. 308. STRENGTHENING PARITY IN MENTAL HEALTH**
 4 **AND SUBSTANCE USE DISORDER BENEFITS.**

5 (a) PUBLIC HEALTH SERVICE ACT.—Section
 6 2726(a) of the Public Health Service Act (42 U.S.C.
 7 300gg–26(a)) is amended by adding at the end the fol-
 8 lowing new paragraphs:

9 “(6) DISCLOSURE AND ENFORCEMENT RE-
 10 QUIREMENTS.—

11 “(A) DISCLOSURE REQUIREMENTS.—

12 “(i) REGULATIONS.—Not later than
 13 December 31, 2016, the Secretary, in co-
 14 operation with the Secretaries of Labor
 15 and the Treasury, as appropriate, shall
 16 issue additional regulations for carrying
 17 out this section, including an explanation
 18 of documents that must be disclosed by
 19 plans and issuers, the process governing
 20 such disclosures by plans and issuers, and
 21 analyses that must be conducted by plans
 22 and issuers by a group health plan or
 23 health insurance issuer offering health in-
 24 surance coverage in the group or individual
 25 market in order for such plan or issuer to

demonstrate compliance with the provisions of this section.

“(ii) DISCLOSURE REQUIREMENTS.— Documents required to be disclosed by a group health plan or health insurance issuer offering health insurance coverage in the group or individual market under clause (i) shall include an annual report that details the specific analyses performed to ensure compliance of such plan or coverage with the law and regulations. At a minimum, with respect to the application of non-quantitative treatment limitations (in this paragraph referred to as NQTLs) to benefits under the plan or coverage, such report shall—

“(I) identify the specific factors the plan or coverage used in performing its NQTL analysis;

“(II) identify and define the specific evidentiary standards relied on to evaluate the factors;

“(III) describe how the evidentiary standards are applied to each service category for mental health,

1 substance use disorders, medical bene-
2 fits, and surgical benefits;

3 “(IV) disclose the results of the
4 analyses of the specific evidentiary
5 standards in each service category;
6 and

7 “(V) disclose the specific findings
8 of the plan or coverage in each service
9 category and the conclusions reached
10 with respect to whether the processes,
11 strategies, evidentiary standards, or
12 other factors used in applying the
13 NQTL to mental health or substance
14 use disorder benefits are comparable
15 to, and applied no more stringently
16 than, the processes, strategies, evi-
17 dentiary standards, or other factors
18 used in applying the limitation with
19 respect to medical and surgical bene-
20 fits in the same classification.

21 “(iii) GUIDANCE.—The Secretary, in
22 cooperation with the Secretaries of Labor
23 and the Treasury, as appropriate, shall
24 issue guidance to group health plans and
25 health insurance issuers offering health in-

1 surance coverage in the group or individual
2 markets on how to satisfy the requirements
3 of this section with respect to making in-
4 formation available to current and poten-
5 tial participants and beneficiaries. Such in-
6 formation shall include certificate of cov-
7 erage documents and instruments under
8 which the plan or coverage involved is ad-
9 ministered and operated that specify, in-
10 clude, or refer to procedures, formulas, and
11 methodologies applied to determine a par-
12 ticipant or beneficiary's benefit under the
13 plan or coverage, regardless of whether
14 such information is contained in a docu-
15 ment designated as the 'plan document'.
16 Such guidance shall include a disclosure of
17 how the plan or coverage involved has pro-
18 vided that processes, strategies, evidentiary
19 standards, and other factors used in apply-
20 ing the NQTL to mental health or sub-
21 stance use disorder benefits are com-
22 parable to, and applied no more stringently
23 than, the processes, strategies, evidentiary
24 standards, or other factors used in apply-
25 ing the limitation with respect to medical

1 and surgical benefits in the same classi-
 2 fication.

3 “(iv) DEFINITIONS.—In this para-
 4 graph and paragraph (7), the terms ‘non-
 5 quantitative treatment limitations’, ‘com-
 6 parable to’, and ‘applied no more strin-
 7 gently than’ have the meanings given such
 8 terms in sections 146 and 147 of title 45,
 9 Code of Federal Regulations (or any suc-
 10 cessor regulation).

11 “(B) ENFORCEMENT.—

12 “(i) PROCESS FOR COMPLAINTS.—The
 13 Secretary, in cooperation with the Secre-
 14 taries of Labor and the Treasury, as ap-
 15 propriate, shall, with respect to group
 16 health plans and health insurance issuers
 17 offering health insurance coverage in the
 18 group or individual market, issue guidance
 19 to clarify the process and timeline for cur-
 20 rent and potential participants and bene-
 21 ficiaries (and authorized representatives
 22 and health care providers of such partici-
 23 pants and beneficiaries) with respect to
 24 such plans and coverage to file formal
 25 complaints of such plans or issuers being

1 in violation of this section, including guid-
2 ance, by plan type, on the relevant State,
3 regional, and national offices with which
4 such complaints should be filed.

5 “(ii) AUTHORITY FOR PUBLIC EN-
6 FORCEMENT.—The Secretary, in consulta-
7 tion with the Secretaries of Labor and the
8 Treasury, shall make available to the pub-
9 lic on the Consumer Parity Portal website
10 established under paragraph (7) de-identi-
11 fied information on audits and investiga-
12 tions of group health plans and health in-
13 surance issuers conducted under this sec-
14 tion.

15 “(iii) AUDITS.—

16 “(I) RANDOMIZED AUDITS.—The
17 Secretary in cooperation with the Sec-
18 retaries of Labor and the Treasury, is
19 authorized to conduct randomized au-
20 dits of group health plans and health
21 insurance issuers offering health in-
22 surance coverage in the group or indi-
23 vidual market to determine compli-
24 ance with this section. Such audits
25 shall be conducted on no fewer than

1 twelve plans and issuers per plan
2 year. Information from such audits
3 shall be made plainly available on the
4 Consumer Parity Portal website es-
5 tablished under paragraph (7).

6 “(II) ADDITIONAL AUDITS.—In
7 the case of a group health plan or
8 health insurance issuer offering health
9 insurance coverage in the group or in-
10 dividual market with respect to which
11 any claim has been filed during a plan
12 year, the Secretary may audit the
13 books and records of such plan or
14 issuer to determine compliance with
15 this section. Information detailing the
16 results of the audit shall be made
17 available on the Consumer Parity Por-
18 tal website established under para-
19 graph (7).

20 “(iv) DENIAL RATES.—The Secretary
21 shall collect information on the rates of
22 and reasons for denial by group health
23 plans and health insurance issuers offering
24 health insurance coverage in the group or
25 individual market of claims for outpatient

1 and inpatient mental health and substance
 2 use disorder services compared to the rates
 3 of and reasons for denial of claims for
 4 medical and surgical services. For the first
 5 plan year beginning at least two years
 6 after the date of the enactment of this
 7 paragraph and each subsequent plan year,
 8 the Secretary shall submit to the Com-
 9 mittee on Energy and Commerce of the
 10 House of Representatives and the Com-
 11 mittee on Health, Education, Labor, and
 12 Pensions of the Senate, and make plainly
 13 available on the Consumer Parity Portal
 14 website under paragraph (7), the informa-
 15 tion collected under the previous sentence
 16 with respect to the previous plan year.

17 “(7) CONSUMER PARITY PORTAL WEBSITE.—

18 The Secretary, in consultation with the Secretaries
 19 of Labor and the Treasury, shall establish a one-
 20 stop Internet website portal for—

21 “(A) submitting complaints and violations
 22 relating to this section, section 712 of the Em-
 23 ployee Retirement Income Security Act of 1974,
 24 and section 9812 of the Internal Revenue Code
 25 of 1986; and

1 “(B) for each of such Secretaries to submit
 2 information in order to provide such informa-
 3 tion to health care consumers pursuant to para-
 4 graph (6), section 712(a)(6) of the Employee
 5 Retirement Income Security Act of 1974, and
 6 section 9812(a)(6) of the Internal Revenue
 7 Code of 1986.

8 Such portal shall have the ability to take basic infor-
 9 mation related to the complaint, including name,
 10 contact information, and brief narrative, and trans-
 11 mit such information in a timely fashion to the ap-
 12 propriate State or Federal enforcement agency. Once
 13 the consumer information is submitted, such portal
 14 shall provide the consumer with contact information
 15 for the appropriate enforcement agency to follow-up
 16 on the complaint.”.

17 (b) EMPLOYEE RETIREMENT INCOME SECURITY ACT
 18 OF 1974.—Section 712(a) of the Employee Retirement In-
 19 come Security Act of 1974 (29 U.S.C. 1185a(a)) is
 20 amended by adding at the end the following new para-
 21 graph:

22 “(6) DISCLOSURE AND ENFORCEMENT RE-
 23 QUIREMENTS.—

24 “(A) DISCLOSURE REQUIREMENTS.—

1 “(i) REGULATIONS.—Not later than
2 December 31, 2016, the Secretary, in co-
3 operation with the Secretaries of Health
4 and Human Services and the Treasury, as
5 appropriate, shall issue additional regula-
6 tions for carrying out this section, includ-
7 ing an explanation of documents that must
8 be disclosed by plans and issuers, the proc-
9 ess governing such disclosures by plans
10 and issuers, and analyses that must be
11 conducted by plans and issuers by a group
12 health plan (or health insurance coverage
13 offered in connection with such a plan) in
14 order for such plan or issuer to dem-
15 onstrate compliance with the provisions of
16 this section.

17 “(ii) DISCLOSURE REQUIREMENTS.—
18 Documents required to be disclosed by a
19 group health plan (or health insurance cov-
20 erage offered in connection with such a
21 plan) under clause (i) shall include an an-
22 nual report that details the specific anal-
23 yses performed to ensure compliance of
24 such plan or coverage with the law or regu-
25 lations. At a minimum, with respect to the

1 application of non-quantitative treatment
2 limitations (in this paragraph referred to
3 as NQTLs) to benefits under the plan or
4 coverage, such report shall—

5 “(I) identify the specific factors
6 the plan or coverage used in per-
7 forming its NQTL analysis;

8 “(II) identify and define the spe-
9 cific evidentiary standards relied on to
10 evaluate the factors;

11 “(III) describe how the evi-
12 dentiary standards are applied to each
13 service category for mental health,
14 substance use disorders, medical bene-
15 fits, and surgical benefits;

16 “(IV) disclose the results of the
17 analyses of the specific evidentiary
18 standards in each service category;
19 and

20 “(V) disclose the specific findings
21 of the plan or coverage in each service
22 category and the conclusions reached
23 with respect to whether the processes,
24 strategies, evidentiary standards, or
25 other factors used in applying the

1 NQTL to mental health or substance
2 use disorder benefits are comparable
3 to, and applied no more stringently
4 than, the processes, strategies, evi-
5 dentiary standards, or other factors
6 used in applying the limitation with
7 respect to medical and surgical bene-
8 fits in the same classification.

9 “(iii) GUIDANCE.—The Secretary, in
10 cooperation with the Secretaries of Health
11 and Human Services and the Treasury, as
12 appropriate, shall issue guidance to group
13 health plans (and health insurance cov-
14 erage offered in connection with such a
15 plan) on how to satisfy the requirements of
16 this section with respect to making infor-
17 mation available to current and potential
18 participants and beneficiaries. Such infor-
19 mation shall include certificate of coverage
20 documents and instruments under which
21 the plan or coverage involved is adminis-
22 tered and operated that specify, include, or
23 refer to procedures, formulas, and meth-
24 odologies applied to determine a partici-
25 pant or beneficiary’s benefit under the plan

1 or coverage, regardless of whether such in-
 2 formation is contained in a document des-
 3 ignated as the ‘plan document’. Such guid-
 4 ance shall include a disclosure of how the
 5 plan or coverage involved has provided that
 6 processes, strategies, evidentiary stand-
 7 ards, and other factors used in applying
 8 the NQTL to mental health or substance
 9 use disorder benefits are comparable to,
 10 and applied no more stringently than, the
 11 processes, strategies, evidentiary stand-
 12 ards, or other factors used in applying the
 13 limitation with respect to medical and sur-
 14 gical benefits in the same classification.

15 “(iv) DEFINITIONS.—In this para-
 16 graph, the terms ‘non-quantitative treat-
 17 ment limitations’, ‘comparable to’, and ‘ap-
 18 plied no more stringently than’ have the
 19 meanings given such terms in sections 146
 20 and 147 of title 45, Code of Federal Regu-
 21 lations (or any successor regulation).

22 “(B) ENFORCEMENT.—

23 “(i) PROCESS FOR COMPLAINTS.—The
 24 Secretary, in cooperation with the Secre-
 25 taries of Health and Human Services and

1 the Treasury, as appropriate, shall, with
2 respect to group health plans (and health
3 insurance coverage offered in connection
4 with such a plan), issue guidance to clarify
5 the process and timeline for current and
6 potential participants and beneficiaries
7 (and authorized representatives and health
8 care providers of such participants and
9 beneficiaries) with respect to such plans
10 (and coverage) to file formal complaints of
11 such plans (or coverage) being in violation
12 of this section, including guidance, by plan
13 type, on the relevant State, regional, and
14 national offices with which such complaints
15 should be filed.

16 “(ii) AUTHORITY FOR PUBLIC EN-
17 FORCEMENT.—The Secretary, in consulta-
18 tion with the Secretaries of Labor and the
19 Treasury, shall make available to the pub-
20 lic on the Consumer Parity Portal website
21 established under section 2726(a)(7) of the
22 Public Health Service Act de-identified in-
23 formation on audits and investigations of
24 group health plans (and health insurance

1 coverage offered in connection with such a
2 plan) conducted under this section.

3 “(iii) AUDITS.—

4 “(I) RANDOMIZED AUDITS.—The
5 Secretary in cooperation with the Sec-
6 retaries of Health and Human Serv-
7 ices and the Treasury, is authorized
8 to conduct randomized audits of
9 group health plans (and health insur-
10 ance coverage offered in connection
11 with such a plan) to determine com-
12 pliance with this section. Such audits
13 shall be conducted on no fewer than
14 twelve plans and coverage per plan
15 year. Information from such audits
16 shall be made plainly available on the
17 Consumer Parity Portal website es-
18 tablished under section 2726(a)(7) of
19 the Public Health Service Act.

20 “(II) ADDITIONAL AUDITS.—In
21 the case of a group health plan (or
22 health insurance coverage offered in
23 connection with such a plan) with re-
24 spect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan (or coverage) to determine
3 compliance with this section. Informa-
4 tion detailing the results of the audit
5 shall be made available on the Con-
6 sumer Parity Portal website estab-
7 lished under section 2726(a)(7) of the
8 Public Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans (and health insurance coverage of-
13 fered in connection with such a plan) of
14 claims for outpatient and inpatient mental
15 health and substance use disorder services
16 compared to the rates of and reasons for
17 denial of claims for medical and surgical
18 services. For the first plan year beginning
19 at least two years after the date of the en-
20 actment of this paragraph and each subse-
21 quent plan year, the Secretary shall submit
22 to the Committee on Energy and Com-
23 merce of the House of Representatives and
24 the Committee on Health, Education,
25 Labor, and Pensions of the Senate, and

1 make plainly available on the Consumer
 2 Parity Portal website under section
 3 2726(a)(7) of the Public Health Service
 4 Act, the information collected under the
 5 previous sentence with respect to the pre-
 6 vious plan year.”.

7 (c) INTERNAL REVENUE CODE OF 1986.—Section
 8 9812(a) of the Internal Revenue Code of 1986 is amended
 9 by adding at the end the following new paragraph:

10 “(6) DISCLOSURE AND ENFORCEMENT RE-
 11 QUIREMENTS.—

12 “(A) DISCLOSURE REQUIREMENTS.—

13 “(i) REGULATIONS.—Not later than
 14 December 31, 2016, the Secretary, in co-
 15 operation with the Secretaries of Health
 16 and Human Services and Labor, as appro-
 17 priate, shall issue additional regulations for
 18 carrying out this section, including an ex-
 19 planation of documents that must be dis-
 20 closed by plans and issuers, the process
 21 governing such disclosures by plans and
 22 issuers, and analyses that must be con-
 23 ducted by plans and issuers by a group
 24 health plan in order for such plan to dem-

1 onstrate compliance with the provisions of
2 this section.

3 “(ii) DISCLOSURE REQUIREMENTS.—
4 Documents required to be disclosed by a
5 group health plan under clause (i) shall in-
6 clude an annual report that details the spe-
7 cific analyses performed to ensure compli-
8 ance of such plan with the law and regula-
9 tions. At a minimum, with respect to the
10 application of non-quantitative treatment
11 limitations (in this paragraph referred to
12 as NQTLs) to benefits under the plan or
13 coverage, such report shall—

14 “(I) identify the specific factors
15 the plan or coverage used in per-
16 forming its NQTL analysis;

17 “(II) identify and define the spe-
18 cific evidentiary standards relied on to
19 evaluate the factors;

20 “(III) describe how the evi-
21 dentiary standards are applied to each
22 service category for mental health,
23 substance use disorders, medical bene-
24 fits, and surgical benefits;

1 “(IV) disclose the results of the
2 analyses of the specific evidentiary
3 standards in each service category;
4 and

5 “(V) disclose the specific findings
6 of the plan in each service category
7 and the conclusions reached with re-
8 spect to whether the processes, strate-
9 gies, evidentiary standards, or other
10 factors used in applying the NQTL to
11 mental health or substance use dis-
12 order benefits are comparable to, and
13 applied no more stringently than, the
14 processes, strategies, evidentiary
15 standards, or other factors used in ap-
16 plying the limitation with respect to
17 medical and surgical benefits in the
18 same classification.

19 “(iii) GUIDANCE.—The Secretary, in
20 cooperation with the Secretaries of Health
21 and Human Services and Labor, as appro-
22 priate, shall issue guidance to group health
23 plans on how to satisfy the requirements of
24 this section with respect to making infor-
25 mation available to current and potential

1 participants and beneficiaries. Such infor-
2 mation shall include certificate of coverage
3 documents and instruments under which
4 the plan involved is administered and oper-
5 ated that specify, include, or refer to pro-
6 cedures, formulas, and methodologies ap-
7 plied to determine a participant or bene-
8 ficiary's benefit under the plan, regardless
9 of whether such information is contained
10 in a document designated as the 'plan doc-
11 ument'. Such guidance shall include a dis-
12 closure of how the plan involved has pro-
13 vided that processes, strategies, evidentiary
14 standards, and other factors used in apply-
15 ing the NQTL to mental health or sub-
16 stance use disorder benefits are com-
17 parable to, and applied no more stringently
18 than, the processes, strategies, evidentiary
19 standards, or other factors used in apply-
20 ing the limitation with respect to medical
21 and surgical benefits in the same classi-
22 fication.

23 “(iv) DEFINITIONS.—In this para-
24 graph, the terms ‘non-quantitative treat-
25 ment limitations’, ‘comparable to’, and ‘ap-

1 plied no more stringently than' have the
2 meanings given such terms in sections 146
3 and 147 of title 45, Code of Federal Regu-
4 lations (or any successor regulation).

5 “(B) ENFORCEMENT.—

6 “(i) PROCESS FOR COMPLAINTS.—The
7 Secretary, in cooperation with the Secre-
8 taries of Health and Human Services and
9 Labor, as appropriate, shall, with respect
10 to group health plans, issue guidance to
11 clarify the process and timeline for current
12 and potential participants and beneficiaries
13 (and authorized representatives and health
14 care providers of such participants and
15 beneficiaries) with respect to such plans
16 (and coverage) to file formal complaints of
17 such plans being in violation of this sec-
18 tion, including guidance, by plan type, on
19 the relevant State, regional, and national
20 offices with which such complaints should
21 be filed.

22 “(ii) AUTHORITY FOR PUBLIC EN-
23 FORCEMENT.—The Secretary, in consulta-
24 tion with the Secretaries of Labor and the
25 Treasury, shall make available to the pub-

1 lic on the Consumer Parity Portal website
2 established under section 2726(a)(7) of the
3 Public Health Service Act de-identified in-
4 formation on audits and investigations of
5 group health plans conducted under this
6 section.

7 “(iii) AUDITS.—

8 “(I) RANDOMIZED AUDITS.—The
9 Secretary in cooperation with the Sec-
10 retaries of Health and Human Serv-
11 ices and Labor, is authorized to con-
12 duct randomized audits of group
13 health plans to determine compliance
14 with this section. Such audits shall be
15 conducted on no fewer than twelve
16 plans per plan year. Information from
17 such audits shall be made plainly
18 available on the Consumer Parity Por-
19 tal website established under section
20 2726(a)(7) of the Public Health Serv-
21 ice Act.

22 “(II) ADDITIONAL AUDITS.—In
23 the case of a group health plan with
24 respect to which any claim has been
25 filed during a plan year, the Secretary

1 may audit the books and records of
2 such plan to determine compliance
3 with this section. Information detail-
4 ing the results of the audit shall be
5 made available on the Consumer Par-
6 ity Portal website established under
7 section 2726(a)(7) of the Public
8 Health Service Act.

9 “(iv) DENIAL RATES.—The Secretary
10 shall collect information on the rates of
11 and reasons for denial by group health
12 plans of claims for outpatient and inpa-
13 tient mental health and substance use dis-
14 order services compared to the rates of and
15 reasons for denial of claims for medical
16 and surgical services. For the first plan
17 year beginning at least two years after the
18 date of the enactment of this paragraph
19 and each subsequent plan year, the Sec-
20 retary shall submit to the Committee on
21 Energy and Commerce of the House of
22 Representatives and the Committee on
23 Health, Education, Labor, and Pensions of
24 the Senate, and make plainly available on
25 the Consumer Parity Portal website under

1 section 2726(a)(7) of the Public Health
2 Service Act, the information collected
3 under the previous sentence with respect to
4 the previous plan year.”.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated \$2,000,000 for each of fis-
7 cal years 2017 through 2021 to carry out this section, in-
8 cluding the amendments made by this section.

9 **SEC. 309. STUDY ON TREATMENT INFRASTRUCTURE.**

10 Not later than 24 months after the date of enactment
11 of this Act, the Comptroller General of the United States
12 shall initiate an evaluation, and submit to Congress a re-
13 port, of the inpatient and outpatient treatment capacity,
14 availability, and needs of the United States, which shall
15 include, to the extent data is available—

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

18 (2) the capacity of inpatient clinical stabiliza-
19 tion programs, transitional residential support serv-
20 ices, and residential rehabilitation programs;

21 (3) the capacity of demographic specific resi-
22 dential or inpatient treatment programs, such as
23 those designed for pregnant women or adolescents;

24 (4) geographical differences of the availability
25 of residential and outpatient treatment and recovery

1 options for substance use disorders across the con-
 2 tinuum of care;

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

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

13 (7) an assessment of the need for residential
 14 and outpatient treatment for substance use disorders
 15 across the continuum of care.

16 **SEC. 310. SUBSTANCE USE DISORDER PROFESSIONAL LOAN**
 17 **REPAYMENT PROGRAM.**

18 Subpart 3 of part E of title VII of the Public Health
 19 Service Act (42 U.S.C. 295f et seq.) is amended by adding
 20 at the end the following:

21 **“SEC. 779. SUBSTANCE USE DISORDER PROFESSIONAL**
 22 **LOAN REPAYMENT PROGRAM.**

23 “(a) ESTABLISHMENT.—The Secretary shall estab-
 24 lish and carry out a substance use disorder health profes-
 25 sional loan repayment program under which qualified

1 health professionals agree to be employed full-time for a
2 specified period (which shall be not less than 2 years) in
3 providing substance use disorder prevention and treatment
4 services.

5 “(b) PROGRAM ADMINISTRATION.—Through the pro-
6 gram established under this section, the Secretary shall
7 enter into contracts with qualified health professionals
8 under which—

9 “(1) a qualified health professional agrees to
10 provide substance use disorder prevention and treat-
11 ment services with respect to an area or population
12 that (as determined by the Secretary)—

13 “(A) has a shortage of such services (as
14 defined by the Secretary); and

15 “(B) has a sufficient population of individ-
16 uals with a substance use disorder to support
17 the provision of such services; and

18 “(2) the Secretary agrees to make payments on
19 the principal and interest of undergraduate, or grad-
20 uate education loans of the qualified health profes-
21 sional—

22 “(A) of not more than \$35,000 for each
23 year of service described in paragraph (1); and

24 “(B) for not more than 3 years.

1 “(c) QUALIFIED HEALTH PROFESSIONAL DE-
 2 FINED.—In this section, the term ‘qualified health profes-
 3 sional’ means an individual who is (or will be upon the
 4 completion of the individual’s graduate education) a psy-
 5 chiatrist, psychologist, nurse practitioner, physician assist-
 6 ant, clinical social worker, substance abuse counselor, or
 7 other substance use disorder health professional.

8 “(d) PRIORITY.—In entering into agreements under
 9 this section, the Secretary shall give priority to applicants
 10 who—

11 “(1) have familiarity with evidence-based meth-
 12 ods and culturally and linguistically competent
 13 health care services; and

14 “(2) demonstrate financial need.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 16 is authorized to be appropriated \$20,000,000 for each of
 17 fiscal years 2017 through 2021 to carry out this section.”.

18 **TITLE IV—RECOVERY**

19 **SEC. 401. NATIONAL YOUTH RECOVERY INITIATIVE.**

20 (a) DEFINITIONS.—In this section:

21 (1) ELIGIBLE ENTITY.—The term “eligible enti-
 22 ty” means—

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

1 (B) an accredited high school that is seek-
2 ing to establish or expand recovery support
3 services;

4 (C) an institution of higher education;

5 (D) a recovery program at a nonprofit col-
6 legiate institution; or

7 (E) a nonprofit organization.

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

12 (3) RECOVERY PROGRAM.—The term “recovery
13 program”—

14 (A) means a program to help individuals
15 who are recovering from substance use dis-
16 orders to initiate, stabilize, and maintain
17 healthy and productive lives in the community;
18 and

19 (B) includes peer-to-peer support and com-
20 munal activities to build recovery skills and
21 supportive social networks.

22 (4) SECRETARY.—The term “Secretary” means
23 the Secretary of Health and Human Services.

1 (b) GRANTS AUTHORIZED.—The Secretary, in con-
2 sultation with the Secretary of Education, may award
3 grants to eligible entities to enable the entities to—

4 (1) provide substance use recovery support serv-
5 ices to young people in high school and enrolled in
6 institutions of higher education;

7 (2) help build communities of support for young
8 people in recovery through a spectrum of activities
9 such as counseling and healthy and wellness-oriented
10 social activities; and

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

14 (c) USE OF FUNDS.—Grants awarded under sub-
15 section (b) may be used for activities to develop, support,
16 and maintain youth recovery support services, including—

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

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

21 (3) healthy and wellness-oriented social activi-
22 ties and community engagement;

23 (4) establishment of recovery high schools;

24 (5) coordination of recovery programs with—

1 (A) substance use disorder treatment pro-
2 grams and systems;

3 (B) providers of mental health services;

4 (C) primary care providers;

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

7 (E) employers;

8 (F) housing services;

9 (G) child welfare services;

10 (H) institutions of secondary higher edu-
11 cation and institutions of higher education; and

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

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

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

20 (d) TECHNICAL SUPPORT.—The Secretary shall pro-
21 vide technical support to recipients of grants under this
22 section.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
24 authorized to be appropriated to carry out this section
25 \$30,000,000 for each of fiscal years 2017 through 2021.

1 **SEC. 402. GRANTS TO ENHANCE AND EXPAND RECOVERY**
2 **SUPPORT SERVICES.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the “Sec-
5 retary”) shall award grants to State substance abuse
6 agencies and nonprofit organizations to develop, expand,
7 and enhance recovery support services for individuals with
8 substance use disorders.

9 (b) ELIGIBLE ENTITIES.—In the case of an applicant
10 that is not a State substance abuse agency, to be eligible
11 to receive a grant under this section, the entity shall—

12 (1) prepare and submit to the Secretary an ap-
13 plication at such time, in such manner, and contain
14 such information as the Secretary may require, in-
15 cluding a plan for the evaluation of any activities
16 carried out with the funds provided under this sec-
17 tion;

18 (2) demonstrate the inclusion of individuals in
19 recovery from a substance use disorder in leadership
20 levels or governing bodies of the entity;

21 (3) have as a primary mission the provision of
22 long-term recovery support for substance use dis-
23 orders; and

24 (4) be accredited by the Council on the Accredi-
25 tation of Peer Recovery Support Services or meet
26 any applicable State certification requirements re-

1 garding the provision of the recovery services in-
2 volved.

3 (c) USE OF FUNDS.—Amounts awarded under a
4 grant under this section shall be used to provide for the
5 following activities:

6 (1) Educating and mentoring that assists indi-
7 viduals and families with substance use disorders in
8 navigating systems of care.

9 (2) Peer recovery support services which include
10 peer coaching and mentoring.

11 (3) Recovery-focused community education and
12 outreach programs, including training on the use of
13 all forms of opioid overdose antagonists used to
14 counter the effects of an overdose.

15 (4) Training, mentoring, and education to de-
16 velop and enhance peer mentoring and coaching.

17 (5) Programs aimed at identifying and reducing
18 stigma and discriminatory practices that serve as
19 barriers to substance use disorder recovery and
20 treatment of these disorders.

21 (6) Developing partnerships between networks
22 that support recovery and other community organi-
23 zations and services, including—

24 (A) public and private substance use dis-
25 order treatment programs and systems;

1 (B) health care providers;

2 (C) recovery-focused addiction and recovery professionals;

3 (D) faith-based organizations;

4 (E) organizations focused on criminal justice reform;

5 (F) schools; and

6 (G) social service agencies in the community, including educational, juvenile justice, child welfare, housing, and mental health agencies.

7 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
8 authorized to be appropriated to carry out this section,
9 \$100,000,000 for each of fiscal years 2017 through 2021.

10 ○