to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table.

SA 3352. Mrs. CAPITO (for herself and Mr. KING) submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3353. Ms. WARREN (for herself and Mrs. CAPITO) submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3354. Mrs. GILLIBRAND (for herself and Mrs. CAPITO) submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3355. Mr. FLAKE submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3356. Mr. FLAKE submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3357. Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3358. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3359. Mr. CARDIN (for himself, Mr. BLUMENTHAL, and Mr. SANDERS) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3360. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3361. Mr. CARDIN (for himself and Mr. HELLER) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3362. Mrs. FEINSTEIN (for herself and Mr. GRASSLEY) submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3363. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3364. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3365. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3366. Mr. LANKFORD (for himself and Mr. HATCH) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3367. Mr. TOOMEY (for himself, Mr. BROWN, Mr. KAINE, and Mr. PORTMAN) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3368. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3369. Mr. CORNYN (for himself and Mr. ALEXANDER) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3370. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3371. Mr. SCHATZ (for himself and Mr. HATCH) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3372. Mr. HEINRICH (for himself and Mr. ENZI) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3373. Mrs. ERNST submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3374. Mr. DONNELLY (for himself and Mrs. CAPITO) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3375. Mr. REID (for Mrs. MCCASKILL (for herself and Mr. BLUNT)) submitted an amendment intended to be proposed by Mr. REID, of NV to the bill S. 524, supra; which was ordered to lie on the table.

SA 3376. Mr. KAINE (for himself and Mrs. CAPITO) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3377. Mr. KING submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3378. Mr. GRASSLEY (for himself, Mr. LEAHY, Mr. WHITEHOUSE, Mr. PORTMAN, Ms. KLOBUCHAR, Ms. AYOTTE, Mr. GRAHAM, Mr. COONS, Mr. CORNYN, and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3379. Ms. BALDWIN (for herself, Mr. MARKEY, and Mr. MENENDEZ) submitted an amendment intended to be proposed by her to the bill S. 524, supra; which was ordered to lie on the table.

SA 3380. Mr. TESTER submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3381. Mr. MARKEY (for himself and Mr. PAUL) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3382. Mr. MARKEY (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3383. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3384. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

SA 3385. Mr. DAINES (for himself and Mr. PETERS) submitted an amendment intended to be proposed by him to the bill S. 524, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3351. Mr. HELLER submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 48, line 19, insert after ''community organizations'' the following: '', and nonprofit organizations that demonstrate the capacity to provide recovery services to veterans,''.

SA 3352. Mrs. CAPITO (for herself and Mr. KING) submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title VII, add the following:

SEC. 705. MEDICAID PROVIDER PARTICIPATION CERTIFICATION FOR FACILITIES TREATING INFANTS UNDER 1 YEAR OF AGE WITH NEONATAL ABSTINENCE SYNDROME.

(a) GUIDELINES FOR CERTIFICATION FOR PARTICIPATION UNDER MEDICAID STATE PLANS OF CERTAIN FACILITIES TREATING INFANTS UNDER 1 YEAR OF AGE WITH NEONATAL ABSTINENCE SYNDROME.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary of Health and Human Services shall establish guidelines, in accordance with paragraph (2), for State agencies and recognized national listing or accrediting bodies to follow for purposes of certifying a residential pediatric recovery center as qualifying for a provider agreement for participation under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). Notwithstanding any other provision of law, a residential pediatric recovery center may satisfy the requirements set forth in such guidelines, in lieu of any comparable requirements otherwise applicable to such a center for purposes of certification for participation under such a State plan.

(2) GUIDELINES DESCRIBED.—The guidelines established under paragraph (1) shall—

(A) provide for physical environment requirements and other necessary requirements specifically applicable to treating individuals who are under 1 year of age with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors; and

(B) take into account that certain physical environment requirements, and any other requirements, needed for centers or facilities treating adults may not be necessary for centers or facilities treating individuals described in subparagraph (A).

(3) RESIDENTIAL PEDIATRIC RECOVERY CENTER.—For purposes of this section, the term ''residential pediatric recovery center'' means a center or facility that furnishes items and services to infants who are under 1 year of age with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors and mothers of such infants.

(b) STATE LAW LICENSURE OF CERTAIN FACILITIES SATISFIES CERTIFICATION REQUIREMENTS.—Notwithstanding any other provision of law, in the case of a State that recognizes and licenses residential pediatric recovery centers (as defined in subsection (a)(3)), such a center that is licensed, in accordance with such State law, shall be treated as satisfying any comparable requirements otherwise applicable to such a center for purposes of certification for participation under the State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(c) SENSE OF CONGRESS.—It is the sense of Congress that residential pediatric recovery centers (as defined in subsection (a)(3)) should offer counseling and other services to mothers (and other appropriate family members and caretakers) of infants receiving treatment at such centers. Such services may include the following:

(1) Counseling or referrals for services.

(2) Activities to encourage mother-infant bonding.

(3) Training on caring for such infants.

(4) Activities to encourage transparency of relevant State mandatory reporting requirements.

SA 3353. Ms. WARREN (for herself and Mrs. CAPITO) submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. PRESCRIPTIONS.

Section 309(a) of the Controlled Substances Act (21 U.S.C. 829(a)) is amended—

(1) by inserting ''(1) IN GENERAL.—'' before ''Except''; and

(2) by adding at the end the following:

''(2) PARTIAL FILLING OF PRESCRIPTIONS.—

''(A) IN GENERAL.—A prescription for a controlled substance in schedule II may be partially filled if—

''(i) it is requested by—

''(I) the practitioner that wrote the prescription by making a notation on the face of the written prescription, in the written record of the emergency oral prescription, or in the electronic prescription record; or

''(II) the patient;

''(ii) the pharmacist partially filling the prescription makes a notation of the partial filling and records it in the same manner as a filling of the prescription, in accordance with regulations prescribed by the Attorney General;

''(iii) the pharmacist partially filling the prescription updates the record each time the prescription is partially filled;

''(iv) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed; and

''(v) the partial filling is not prohibited under the law of the State in which it occurs.

''(B) REMAINING PORTIONS.—Remaining portions of a partially filled prescription—

''(i) may be filled; and

''(ii) must be exhausted not later than 30 days after the date on which the prescription is issued, except in the case of a partially filled emergency prescription, the remaining portions of which must be exhausted not later than 72 hours after the prescription is issued.''.

SA 3354. Mrs. GILLIBRAND (for herself and Mrs. CAPITO) submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. OPIOID PRESCRIPTION GUIDELINES.

Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall issue guidelines for the safe prescribing of opioids for the treatment of acute pain.

SA 3355. Mr. FLAKE submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title VII, add the following:

SEC. 705. COMPTROLLER GENERAL OF THE UNITED STATES STUDY ON VETERANS TREATMENT COURTS AND VETERANS JUSTICE OUTREACH PROGRAM.

(a) STUDY AND REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall—

(1) complete a study on the effectiveness of Veterans Treatment Courts and the Veterans Justice Outreach Program of the Department of Veterans Affairs; and

(2) submit to Congress a report on the findings of the Comptroller General with respect to the study completed under paragraph (1).

(b) ELEMENTS.—As part of the study required by subsection (a), the Comptroller General shall assess the following:

(1) The extent to which Veterans Treatment Courts—

(A) provide a benefit to veterans with a mental illness or substance abuse problem; and

(B) provide timely access to services furnished by the Veterans Health Administration.

(2) The number of Veterans Treatment Courts in operation.

(3) The number of Veterans Treatment Courts in the process of being established.

(4) Whether there are sufficient numbers of Veterans Justice Outreach Specialists assigned, under the Veterans Justice Outreach Program of the Department of Veterans Affairs, to Veterans Treatment Courts.

(5) The number of veterans assigned to each Veterans Justice Outreach Specialist that is assigned to a Veterans Treatment Court.

(6) Whether having additional Veterans Justice Outreach Specialists will allow veterans to better access services furnished by the Veterans Health Administration and will allow for the establishment of additional Veterans Treatment Courts.

SA 3356. Mr. FLAKE submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. STUDY ON DRUG TRAFFICKING.

Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study and submit a report to Congress on the impact that the trafficking of narcotics, specifically opioids and methamphetamine, through States that border Mexico has on substance abuse of narcotics by the residents of such States.

SA 3357. Mrs. SHAHEEN submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. CONTROLLED SUBSTANCE MONITORING PROGRAM.

(a) AMENDMENT TO NATIONAL ALL SCHEDULE PRESCRIPTION REPORTING ACT OF 2005.—Paragraph (1) of section 2 of the National All Schedules Prescription Electronic Reporting Act of 2005 (Public Law 109–60) is amended to read as follows:

''(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that—

''(A) health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

''(B) appropriate law enforcement, regulatory, and State professional licensing authorities have access to prescription history information for the purposes of investigating drug diversion and prescribing and dispensing practices of errant prescribers or pharmacists; and''.

(b) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—Section 399O of the Public Health Service Act (42 U.S.C. 280g–3) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking ''or'';

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

(C) by adding at the end the following:

''(C) to maintain and operate an existing State-controlled substance monitoring program.'';

(2) by amending subsection (b) to read as follows:

''(b) MINIMUM REQUIREMENTS.—The Secretary shall maintain and, as appropriate, supplement or revise (after publishing proposed additions and revisions in the Federal Register and receiving public comments thereon) minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).'';

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in the matter preceding clause (i), by striking ''(a)(1)(B)'' and inserting ''(a)(1)(B) or (a)(1)(C)'';

(ii) in clause (i), by striking ''program to be improved'' and inserting ''program to be improved or maintained'';

(iii) by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively;

(iv) by inserting after clause (ii), the following:

''(iii) a plan to apply the latest advances in health information technology in order to incorporate prescription drug monitoring program data directly into the workflow of prescribers and dispensers to ensure timely access to patients' controlled prescription drug history;'';

(v) in clause (iv) (as so redesignated), by inserting before the semicolon the following: ''and at least one health information technology system such as electronic health records, health information exchanges, and e-prescribing systems''; and

(vi) in clause (v) (as so redesignated), by striking ''public health'' and inserting ''public health or public safety'';

(B) in paragraph (3)—

(i) by striking ''If a State that submits'' and inserting the following:

''(A) IN GENERAL.—If a State that submits'';

(ii) by inserting before the period at the end ''and include timelines for full implementation of such interoperability. The State shall also describe the manner in which it will achieve interoperability between its monitoring program and health information technology systems, as allowable under State law, and include timelines for the implementation of such interoperability''; and

(iii) by adding at the end the following:

''(B) MONITORING OF EFFORTS.—The Secretary shall monitor State efforts to achieve interoperability, as described in subparagraph (A).''; and

(C) in paragraph (5)—

(i) by striking ''implement or improve'' and inserting ''establish, improve, or maintain''; and

(ii) by adding at the end the following: ''The Secretary shall redistribute any funds that are so returned among the remaining grantees under this section in accordance with the formula described in subsection (a)(2)(B).'';

(4) in subsection (d)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''In implementing or improving'' and all that follows through ''(a)(1)(B)'' and inserting ''In establishing, improving, or maintaining a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subparagraph (B) or (C) of subsection (a)(1)''; and

(ii) by striking ''public health'' and inserting ''public health or public safety''; and

(B) by adding at the end the following:

''(5) The State shall report on interoperability with the controlled substance monitoring program of Federal agencies, where appropriate, 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, real-time or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.'';

(5) in subsections (e), (f)(1), and (g), by striking ''implementing or improving'' each place it appears and inserting ''establishing, improving, or maintaining'';

(6) in subsection (f)—

(A) in paragraph (1)(B) by striking ''misuse of a schedule II, III, or IV substance'' and inserting ''misuse of a controlled substance included in schedule II, III, or IV of section 202(c) of the Controlled Substances Act''; and

(B) by adding at the end the following:

''(3) EVALUATION AND REPORTING.—Subject to subsection (g), a State receiving a grant under subsection (a) shall provide the Secretary with aggregate data and other information determined by the Secretary to be necessary to enable the Secretary—

''(A) to evaluate the success of the State's program in achieving its purposes; or

''(B) to prepare and submit the report to Congress required by subsection (k)(2).

''(4) RESEARCH BY OTHER ENTITIES.—A department, program, or administration receiving nonidentifiable information under paragraph (1)(D) may make such information available to other entities for research purposes.'';

(7) by striking subsection (k);

(8) by redesignating subsections (h) through (j) as subsections (i) through (k), respectively;

(9) in subsections (c)(1)(A)(iv) and (d)(4), by striking ''subsection (h)'' each place it appears and inserting ''subsection (i)'';

(10) by inserting after subsection (g) the following:

''(h) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving a grant under subsection (a) shall take steps to—

''(1) facilitate prescriber and dispenser use of the State's controlled substance monitoring system; and

''(2) educate prescribers and dispenser on the benefits of the system both to them and society.'';

(11) in subsection (k)(2)(A), as redesignated—

(A) in clause (ii), by striking ''or affected'' and inserting '', established or strengthened initiatives to ensure linkages to substance use disorder services, or affected''; and

(B) in clause (iii), by striking ''including an assessment'' and inserting ''between controlled substance monitoring programs and health information technology systems, and including an assessment'';

(12) in subsection (l)(1), by striking ''establishment, implementation, or improvement'' and inserting ''establishment, improvement, or maintenance'';

(13) in subsection (m)(8), by striking ''and the District of Columbia'' and inserting '', the District of Columbia, and any commonwealth or territory of the United States''; and

(14) by amending subsection (n), to read as follows:

''(n) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $7,000,000 for each of fiscal years 2016 through 2020.''.

SA 3358. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 38, line 19, strike ''other clinically appropriate services,'' and insert ''other clinically appropriate services and through the establishment of treatment centers that operate 24 hours a day, 7 days a week, to provide access to behavioral health treatment,''.

SA 3359. Mr. CARDIN (for himself, Mr. BLUMENTHAL, and Mr. SANDERS) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. _____. GAO REPORT REGARDING NALOXONE.

Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on—

(1) the increase in the price of naloxone over the 5 years preceding the date of enactment of this Act; and

(2) the impact of such price increase on the ability of States and local health departments to reduce the number of deaths due to opioid overdose.

SA 3360. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE ____—DEMOCRACY RESTORATION ACT

SEC. ____1. SHORT TITLE.

This title may be cited as the ''Democracy Restoration Act of 2016''.

SEC. ____2. FINDINGS.

Congress makes the following findings:

(1) The right to vote is the most basic constitutive act of citizenship. Regaining the right to vote reintegrates individuals with criminal convictions into free society, helping to enhance public safety.

(2) Article I, section 4, of the Constitution grants Congress ultimate supervisory power over Federal elections, an authority which has repeatedly been upheld by the United States Supreme Court.

(3) Basic constitutional principles of fairness and equal protection require an equal opportunity for citizens of the United States to vote in Federal elections. The right to vote may not be abridged or denied by the United States or by any State on account of race, color, gender, or previous condition of servitude. The 13th, 14th, 15th, 19th, 24th, and 26th Amendments to the Constitution empower Congress to enact measures to protect the right to vote in Federal elections. The 8th Amendment to the Constitution provides for no excessive bail to be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

(4) There are 3 areas where discrepancies in State laws regarding criminal convictions lead to unfairness in Federal elections—

(A) the lack of a uniform standard for voting in Federal elections leads to an unfair disparity and unequal participation in Federal elections based solely on where a person lives;

(B) laws governing the restoration of voting rights after a criminal conviction vary throughout the country and persons in some States can easily regain their voting rights while in other States persons effectively lose their right to vote permanently; and

(C) State disenfranchisement laws disproportionately impact racial and ethnic minorities.

(5) Two States do not disenfranchise individuals with criminal convictions at all (Maine and Vermont), but 48 States and the District of Columbia have laws that deny convicted individuals the right to vote while they are in prison.

(6) In some States disenfranchisement results from varying State laws that restrict voting while individuals are under the supervision of the criminal justice system or after they have completed a criminal sentence. In 35 States, convicted individuals may not vote while they are on parole and 31 of those States disenfranchise individuals on felony probation as well. In 11 States, a conviction can result in lifetime disenfranchisement.

(7) Several States deny the right to vote to individuals convicted of certain misdemeanors.

(8) An estimated 5,850,000 citizens of the United States, or about 1 in 40 adults in the United States, currently cannot vote as a result of a felony conviction. Of the 5,850,000 citizens barred from voting, only 25 percent are in prison. By contrast, 75 percent of the disenfranchised reside in their communities while on probation or parole or after having completed their sentences. Approximately 2,600,000 citizens who have completed their sentences remain disenfranchised due to restrictive State laws. In 6 States—Alabama, Florida, Kentucky, Mississippi, Tennessee, and Virginia—more than 7 percent of the total population is disenfranchised.

(9) In those States that disenfranchise individuals post-sentence, the right to vote can be regained in theory, but in practice this possibility is often granted in a non-uniform and potentially discriminatory manner. Disenfranchised individuals must either obtain a pardon or an order from the Governor or an action by the parole or pardon board, depending on the offense and State. Individuals convicted of a Federal offense often have additional barriers to regaining voting rights.

(10) State disenfranchisement laws disproportionately impact racial and ethnic minorities. Eight percent of the African-American population, or 2,000,000 African-Americans, are disenfranchised. Given current rates of incarceration, approximately 1 in 3 of the next generation of African-American men will be disenfranchised at some point

during their lifetime. Currently, 1 of every 13 African-Americans are rendered unable to vote because of felony disenfranchisement, which is a rate 4 times greater than non African-Americans. 7.7 percent of African-Americans are disenfranchised whereas only 1.8 percent of non African-Americans are. In 3 States—Florida (23 percent), Kentucky (22 percent), and Virginia (20 percent)—more than 1 in 5 African-Americans are unable to vote because of prior convictions.

(11) Latino citizens are disproportionately disenfranchised based upon their disproportionate representation in the criminal justice system. If current incarceration trends hold, 17 percent of Latino men will be incarcerated during their lifetimes, in contrast to less than 6 percent of non-Latino White men. When analyzing the data across 10 States, Latinos generally have disproportionately higher rates of disenfranchisement compared to their presence in the voting age population. In 6 out of 10 States studied in 2003, Latinos constitute more than 10 percent of the total number of persons disenfranchised by State felony laws. In 4 States (California, 37 percent; New York, 34 percent; Texas, 30 percent; and Arizona, 27 percent), Latinos were disenfranchised by a rate of more than 25 percent.

(12) Disenfranchising citizens who have been convicted of a criminal offense and who are living and working in the community serves no compelling State interest and hinders their rehabilitation and reintegration into society.

(13) State disenfranchisement laws can suppress electoral participation among eligible voters by discouraging voting among family and community members of disenfranchised persons. Future electoral participation by the children of disenfranchised parents may be impacted as well.

(14) The United States is the only Western democracy that permits the permanent denial of voting rights for individuals with felony convictions.

SEC. ___3. RIGHTS OF CITIZENS.

The right of an individual who is a citizen of the United States to vote in any election for Federal office shall not be denied or abridged because that individual has been convicted of a criminal offense unless such individual is serving a felony sentence in a correctional institution or facility at the time of the election.

SEC. ___4. ENFORCEMENT.

(a) ATTORNEY GENERAL.—The Attorney General may, in a civil action, obtain such declaratory or injunctive relief as is necessary to remedy a violation of this title.

(b) PRIVATE RIGHT OF ACTION.—

(1) IN GENERAL.—A person who is aggrieved by a violation of this title may provide written notice of the violation to the chief election official of the State involved.

(2) RELIEF.—Except as provided in paragraph (3), if the violation is not corrected within 90 days after receipt of a notice under paragraph (1), or within 20 days after receipt of the notice if the violation occurred within 120 days before the date of an election for Federal office, the aggrieved person may, in a civil action, obtain declaratory or injunctive relief with respect to the violation.

(3) EXCEPTION.—If the violation occurred within 30 days before the date of an election for Federal office, the aggrieved person need not provide notice to the chief election official of the State under paragraph (1) before bringing a civil action to obtain declaratory or injunctive relief with respect to the violation.

SEC. ___5. NOTIFICATION OF RESTORATION OF VOTING RIGHTS.

(a) STATE NOTIFICATION.—

(1) NOTIFICATION.—On the date determined under paragraph (2), each State shall notify in writing any individual who has been convicted of a criminal offense under the law of that State that such individual has the right to vote in an election for Federal office pursuant to the Democracy Restoration Act of 2016 and may register to vote in any such election.

(2) DATE OF NOTIFICATION.—

(A) FELONY CONVICTION.—In the case of such an individual who has been convicted of a felony, the notification required under paragraph (1) shall be given on the date on which the individual—

(i) is sentenced to serve only a term of probation; or

(ii) is released from the custody of that State (other than to the custody of another State or the Federal Government to serve a term of imprisonment for a felony conviction).

(B) MISDEMEANOR CONVICTION.—In the case of such an individual who has been convicted of a misdemeanor, the notification required under paragraph (1) shall be given on the date on which such individual is sentenced by a State court.

(b) FEDERAL NOTIFICATION.—

(1) NOTIFICATION.—Any individual who has been convicted of a criminal offense under Federal law shall be notified in accordance with paragraph (2) that such individual has the right to vote in an election for Federal office pursuant to the Democracy Restoration Act of 2016 and may register to vote in any such election.

(2) DATE OF NOTIFICATION.—

(A) FELONY CONVICTION.—In the case of such an individual who has been convicted of a felony, the notification required under paragraph (1) shall be given—

(i) in the case of an individual who is sentenced to serve only a term of probation, by the Assistant Director for the Office of Probation and Pretrial Services of the Administrative Office of the United States Courts on the date on which the individual is sentenced; or

(ii) in the case of any individual committed to the custody of the Bureau of Prisons, by the Director of the Bureau of Prisons, during the period beginning on the date that is 6 months before such individual is released and ending on the date such individual is released from the custody of the Bureau of Prisons.

(B) MISDEMEANOR CONVICTION.—In the case of such an individual who has been convicted of a misdemeanor, the notification required under paragraph (1) shall be given on the date on which such individual is sentenced by a court established by an Act of Congress.

SEC. ___6. DEFINITIONS.

For purposes of this title:

(1) CORRECTIONAL INSTITUTION OR FACILITY.—The term ''correctional institution or facility'' means any prison, penitentiary, jail, or other institution or facility for the confinement of individuals convicted of criminal offenses, whether publicly or privately operated, except that such term does not include any residential community treatment center (or similar public or private facility).

(2) ELECTION.—The term ''election'' means—

(A) a general, special, primary, or runoff election;

(B) a convention or caucus of a political party held to nominate a candidate;

(C) a primary election held for the selection of delegates to a national nominating convention of a political party; or

(D) a primary election held for the expression of a preference for the nomination of persons for election to the office of President.

(3) FEDERAL OFFICE.—The term ''Federal office'' means the office of President or Vice President of the United States, or of Senator or Representative in, or Delegate or Resident Commissioner to, the Congress of the United States.

(4) PROBATION.—The term ''probation'' means probation, imposed by a Federal, State, or local court, with or without a condition on the individual involved concerning—

(A) the individual's freedom of movement;

(B) the payment of damages by the individual;

(C) periodic reporting by the individual to an officer of the court; or

(D) supervision of the individual by an officer of the court.

SEC. ___7. RELATION TO OTHER LAWS.

(a) STATE LAWS RELATING TO VOTING RIGHTS.—Nothing in this title shall be construed to prohibit the States from enacting any State law which affords the right to vote in any election for Federal office on terms less restrictive than those established by this title.

(b) CERTAIN FEDERAL ACTS.—The rights and remedies established by this title are in addition to all other rights and remedies provided by law, and neither rights and remedies established by this title shall supersede, restrict, or limit the application of the Voting Rights Act of 1965 (42 U.S.C. 1973 et seq.) or the National Voter Registration Act (42 U.S.C. 1973–gg).

SEC. ___8. FEDERAL PRISON FUNDS.

No State, unit of local government, or other person may receive or use, to construct or otherwise improve a prison, jail, or other place of incarceration, any Federal funds unless that person has in effect a program under which each individual incarcerated in that person's jurisdiction who is a citizen of the United States is notified, upon release from such incarceration, of that individual's rights under section ___3.

SEC. ___9. EFFECTIVE DATE.

This title shall apply to citizens of the United States voting in any election for Federal office held after the date of the enactment of this title.

SA 3361. Mr. CARDIN (for himself and Mr. HELLER) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEDICARE PAYMENT FOR THERAPY SERVICES.

(a) REPEAL OF THERAPY CAP AND 1-YEAR EXTENSION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (4)—

(A) by striking ''This subsection'' and inserting ''Except as provided in paragraph (5)(C)(iii), this subsection''; and

(B) by inserting the following before the period at the end: ''or with respect to services furnished on or after the date of enactment of subsection (aa)''; and

(2) in paragraph (5)—

(A) in subparagraph (A), in the first sentence, by striking ''December 31, 2017'' and inserting ''the date of enactment of the Comprehensive Addiction and Recovery Act of 2016''; and

(B) in subparagraph (C), by adding at the end the following new clause:

''(iii) Beginning on the date of enactment of subsection (aa) and ending on the day before the date of the implementation of such subsection, the manual medical review process described in clause (i), subject to subparagraph (E), shall apply with respect to expenses incurred in a year for services described in paragraphs (1) and (3) (including services described in subsection (a)(8)(B)) that exceed the threshold described in clause (ii) for the year.''; and

(3) in paragraph (6)(A)—

(A) by striking ''December 31, 2017'' and inserting ''the date of enactment of the Comprehensive Addiction and Recovery Act of 2016''; and

(B) by striking ''2012 through 2017'' and inserting ''the period beginning on January 1, 2012, and ending on such date of enactment''.

(b) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—

(1) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is amended by adding at the end the following new subsection:

''(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—

''(1) IN GENERAL.—

''(A) PROCESS FOR MEDICAL REVIEW.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of outpatient therapy services (as defined in paragraph (10)) and, subject to paragraph (12), apply such process to such services furnished on or after the date that is 12 months after the date of enactment of this subsection, focusing on services identified under subparagraph (B).

''(B) IDENTIFICATION OF SERVICES FOR REVIEW.—Under the process, the Secretary shall identify services for medical review, using such factors as the Secretary determines appropriate, which may include the following:

''(i) Services furnished by a therapy provider (as defined in paragraph (10)) who, in a prior period, has had a high claims denial percentage or is less compliant with other applicable requirements under this title.

''(ii) Services furnished by a therapy provider whose pattern of billing is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day.

''(iii) Services furnished by a therapy provider that is newly enrolled under this title or has not previously furnished therapy services under this part.

''(iv) Services furnished to treat a type of medical condition.

''(v) Services identified by use of the standardized data elements required to be reported under section 1834(t).

''(vi) Services furnished by a therapy provider who is part of a group that includes a therapy provider identified by factors described in this subparagraph.

''(vii) Other services as determined appropriate by the Secretary.

''(2) MEDICAL REVIEW.—

''(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

''(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the Secretary shall use prior authorization medical review for outpatient therapy services furnished to an individual above one or more thresholds established by the Secretary, such as a dollar threshold or a threshold based on other factors.

''(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION FOR A THERAPY PROVIDER.—The Secretary shall end the application of prior authorization medical review to outpatient therapy services furnished by a therapy provider if the Secretary determines that the provider has a low denial rate under such prior authorization. The Secretary may subsequently reapply prior authorization medical review to such therapy provider if the Secretary determines it to be appropriate.

''(iii) PRIOR AUTHORIZATION OF MULTIPLE SERVICES.—The Secretary shall, where practicable, provide for prior authorization medical review for multiple services at a single time, such as services in a therapy plan of care described in section 1861(p)(2).

''(B) OTHER TYPES OF MEDICAL REVIEW.—The Secretary may use pre-payment review or post-payment review for services identified under paragraph (1)(B) that are not subject to prior authorization medical review under subparagraph (A).

''(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

''(3) REVIEW CONTRACTORS.—The Secretary shall conduct prior authorization medical review of outpatient therapy services under this subsection using medicare administrative contractors (as described in section 1874A) or other review contractors (other than contractors under section 1893(h) or other contractors paid on a contingent basis).

''(4) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to an outpatient therapy service for which prior authorization medical review under this subsection applies, the following shall apply:

''(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

''(B) DENIAL OF PAYMENT.—Subject to paragraph (6), no payment shall be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section.

''(5) SUBMISSION OF INFORMATION.—A therapy provider may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable, but not later than 24 months after the date of enactment of this subsection.

''(6) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (4)(A) within 10 business days of the date of the Secretary's receipt of medical documentation needed to make such determination, paragraph (4)(B) shall not apply.

''(7) CONSTRUCTION.—With respect to an outpatient therapy service that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act or any other provision of law.

''(8) BENEFICIARY PROTECTIONS.—In the case where payment may not be made as a result of application of medical review under this subsection, section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

''(9) IMPLEMENTATION.—

''(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

''(C) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the identification of services for medical review or the process for medical review under this subsection.

''(10) DEFINITIONS.—For purposes of this subsection:

''(A) OUTPATIENT THERAPY SERVICES.—The term 'outpatient therapy services' means the following services for which payment is made under section 1848, 1834(g), or 1834(k):

''(i) Physical therapy services of the type described in section 1861(p).

''(ii) Speech-language pathology services of the type described in such section though the application of section 1861(ll)(2).

''(iii) Occupational therapy services of the type described in section 1861(p) through the operation of section 1861(g).

''(B) THERAPY PROVIDER.—The term 'therapy provider' means a provider of services (as defined in section 1861(u)) or a supplier (as defined in section 1861(d)) who submits a claim for outpatient therapy services.

''(11) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year (beginning with fiscal year 2016). Amounts transferred under this paragraph shall remain available until expended.

''(12) SCALING BACK.—

''(A) PERIODIC DETERMINATIONS.—Beginning with 2020, and every two years thereafter, the Secretary shall—

''(i) make a determination of the improper payment rate for outpatient therapy services for a 12-month period; and

''(ii) make such determination publicly available.

''(B) SCALING BACK.—If the improper payment rate for outpatient therapy services determined for a 12-month period under subparagraph (A) is 50 percent or less of the Medicare fee-for-service improper payment rate for such period, the Secretary shall—

''(i) reduce the amount and extent of medical review conducted for a prospective year under the process established in this subsection; and

''(ii) return an appropriate portion of the funding provided for such year under paragraph (11).''.

(2) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of medical review of outpatient therapy services under section 1833(aa) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of—

(i) aggregate data on—

(I) the number of individuals, therapy providers, and claims subject to such review; and

(II) the number of reviews conducted under such section; and

(ii) the outcomes of such reviews.

(B) REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—

(1) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(t) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—

''(1) STANDARDIZED DATA ELEMENTS.—

''(A) IN GENERAL.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of standardized data elements for individuals receiving outpatient therapy services.

''(B) CATEGORIES.—

''(i) IN GENERAL.—Such standardized data elements shall include information with respect to the following categories, as determined appropriate by the Secretary:

''(I) Functional status.

''(II) Demographic information.

''(III) Diagnosis.

''(IV) Severity.

''(V) Affected body structures and functions.

''(VI) Limitations with activities of daily living and participation.

''(VII) Other categories determined to be appropriate by the Secretary.

''(ii) ALIGNMENT WITH CATEGORIES FOR REPORTING OF ASSESSMENT DATA UNDER IMPACT.—The Secretary shall, as appropriate, align the functional status category under subclause (I) of clause (i) and the other categories under subclauses (II) through (VII) of such clause with the categories described in clauses (i) through (vi) of section 1899B(b)(1)(B).

''(C) SOLICITATION OF INPUT.—The Secretary shall accept input from stakeholders through the date that is 60 days after the date the Secretary posts the draft list of standardized data elements pursuant to subparagraph (A). In seeking such input, the Secretary shall use one or more mechanisms to solicit input from stakeholders that may include use of open door forums, town hall meetings, requests for information, or other mechanisms determined appropriate by the Secretary.

''(D) OPERATIONAL LIST OF STANDARDIZED DATA ELEMENTS.—Not later than 120 days after the end of the period for accepting input described in subparagraph (C), the Secretary, taking into account such input, shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of standardized data elements.

''(E) SUBSEQUENT REVISIONS.—Subsequent revisions to the operational list of standardized data elements shall be made through rulemaking. Such revisions may be based on experience and input from stakeholders.

''(2) SYSTEM TO REPORT STANDARDIZED DATA ELEMENTS.—

''(A) IN GENERAL.—Not later than 18 months after the date the Secretary posts the operational list of standardized data elements pursuant to paragraph (1)(D), the Secretary shall develop and implement an electronic system (which may be a web portal) for therapy providers to report the standardized data elements for individuals with respect to outpatient therapy services.

''(B) STAKEHOLDER INPUT.—The Secretary shall seek input from stakeholders regarding the best way to report the standardized data elements under this subsection.

''(3) REPORTING.—

''(A) FREQUENCY OF REPORTING.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the Secretary shall specify the frequency of reporting standardized data elements under this subsection.

''(ii) STAKEHOLDER INPUT.—The Secretary shall seek input from stakeholders regarding the frequency of the reporting of such data elements.

''(iii) ALIGNMENT WITH FREQUENCY FOR REPORTING OF ASSESSMENT DATA UNDER IMPACT.—The Secretary shall, as appropriate, align the frequency of the reporting of such data elements with respect to an individual under this subsection with the frequency in which data is required to be submitted with respect to an individual under the second sentence of section 1899B(b)(1)(A).

''(B) REPORTING REQUIREMENT.—Beginning on the date the system to report standardized data elements under this subsection is operational, no payment shall be made under this part for outpatient therapy services furnished to an individual unless a therapy provider reports the standardized data elements for such individual.

''(4) REPORT ON NEW PAYMENT SYSTEM FOR OUTPATIENT THERAPY SERVICES.—

''(A) IN GENERAL.—Not later than 24 months after the date described in paragraph (3)(B), the Secretary shall submit to Congress a report on the design of a new payment system for outpatient therapy services. The report shall include an analysis of the standardized data elements collected and other appropriate data and information.

''(B) FEATURES.—Such report shall consider—

''(i) appropriate adjustments to payment (such as case mix and outliers);

''(ii) payments on an episode of care basis; and

''(iii) reduced payment for multiple episodes.

''(C) CONSULTATION.—The Secretary shall consult with stakeholders regarding the design of such a new payment system.

''(5) IMPLEMENTATION.—

''(A) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $7,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph shall remain available until expended.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to specification of the standardized data elements and implementation of the system to report such standardized data elements under this subsection.

''(C) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the specification of standardized data elements required under this subsection or the system to report such standardized data elements.

''(D) DEFINITION OF OUTPATIENT THERAPY SERVICES AND THERAPY PROVIDER.—In this subsection, the terms 'outpatient therapy services' and 'therapy provider' have the meaning given those terms in section 1833(aa).''.

(2) SUNSET OF CURRENT CLAIMS-BASED COLLECTION OF THERAPY DATA.—Section 3005(g)(1) of the Middle Class Tax Extension and Job Creation Act of 2012 (42 U.S.C. 1395l note) is amended, in the first sentence, by inserting ''and ending on the date the system to report standardized data elements under section 1834(t) of the Social Security Act (42 U.S.C. 1395m(t)) is implemented,'' after ''January 1, 2013,''.

(d) REPORTING OF CERTAIN INFORMATION.—Section 1842(t) of the Social Security Act (42 U.S.C. 1395u(t)) is amended by adding at the end the following new paragraph:

''(3) Each request for payment, or bill submitted, by a therapy provider (as defined in section 1833(aa)(10)) for an outpatient therapy service (as defined in such section) furnished by a therapy assistant on or after January 1, 2018, shall include (in a form and manner specified by the Secretary) an indication that the service was furnished by a therapy assistant.''.

SA 3362. Mrs. FEINSTEIN (for herself and Mr. GRASSLEY) submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE ____—TRANSNATIONAL DRUG TRAFFICKING ACT

SEC. 01. SHORT TITLE.

This title may be cited as the ''Transnational Drug Trafficking Act of 2015''.

SEC. __02. POSSESSION, MANUFACTURE OR DISTRIBUTION FOR PURPOSES OF UNLAWFUL IMPORTATIONS.

Section 1009 of the Controlled Substances Import and Export Act (21 U.S.C. 959) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively; and

(2) in subsection (a), by striking ''It shall'' and all that follows and inserting the following: ''It shall be unlawful for any person to manufacture or distribute a controlled substance in schedule I or II or flunitrazepam or a listed chemical intending, knowing, or having reasonable cause to believe that such substance or chemical will be unlawfully imported into the United States or into waters within a distance of 12 miles of the coast of the United States.

''(b) It shall be unlawful for any person to manufacture or distribute a listed chemical—

''(1) intending or knowing that the listed chemical will be used to manufacture a controlled substance; and

''(2) intending, knowing, or having reasonable cause to believe that the controlled substance will be unlawfully imported into the United States.''.

SEC. __03. TRAFFICKING IN COUNTERFEIT GOODS OR SERVICES.

Chapter 113 of title 18, United States Code, is amended—

(1) in section 2318(b)(2), by striking ''section 2320(e)'' and inserting ''section 2320(f)''; and

(2) in section 2320—

(A) in subsection (a), by striking paragraph (4) and inserting the following:

''(4) traffics in a drug and knowingly uses a counterfeit mark on or in connection with such drug,'';

(B) in subsection (b)(3), in the matter preceding subparagraph (A), by striking ''counterfeit drug'' and inserting ''drug that uses a counterfeit mark on or in connection with the drug''; and

(C) in subsection (f), by striking paragraph (6) and inserting the following:

''(6) the term 'drug' means a drug, as defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321).''.

SA 3363. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. _____. GUIDANCE REGARDING GENERIC DRUGS WITH ABUSE-DETERRENT PROPERTIES.

Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall issue guidance regarding the development and testing of drugs that have abuse-deterrent properties and may be submitted for approval under section 505(j) of the Federal

Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SA 3364. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. SAFE STORAGE OF PRESCRIPTION MEDICINES.

(a) GUIDELINES.—The Director of the Centers for Disease Control and Prevention shall issue guidelines for health care providers regarding the safe storage of prescription medications in the home.

(b) STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on how individuals who seek treatment, through Federal programs, for opioid abuse or overdose obtain prescription medications.

(2) REPORT.—The Comptroller General shall submit a report containing the results of the study to Congress.

SA 3365. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

In section 101, strike subsection (c)(5) and all that follows through the end of the section, and insert the following:

(5) representatives of hospitals;

(6) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment community;

(D) pain advocacy groups;

(E) groups with expertise around overdose reversal;

(F) State agencies that manage State prescription drug monitoring programs; and

(G) State agencies that administer grants under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.); and

(7) other stakeholders, as the Secretary determines appropriate.

(d) DUTIES.—The task force shall—

(1) not later than 180 days after the date on which the task force is convened under subsection (b), review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication, taking into consideration—

(A) existing pain management research;

(B) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(C) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of alternatives to opioids to reduce opioid monotherapy in appropriate cases;

(D) the management of high-risk populations, other than populations who suffer pain, who—

(i) may use or be prescribed benzodiazepines, alcohol, and diverted opioids; or

(ii) receive opioids in the course of medical care;

(E) whether the State prescription drug monitoring programs are sufficiently available, functional, and useful to be integrated into the process for prescribing pain medication; and

(F) the Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (80 Fed. Reg. 77351 (December 14, 2015)) and any final guidelines issued by the Centers for Disease Control and Prevention;

(2) solicit and take into consideration public comment on the practices developed under paragraph (1), amending such best practices if appropriate; and

(3) develop a strategy for disseminating information about the best practices to stakeholders, as appropriate.

(e) LIMITATION.—The task force shall not have rulemaking authority.

(f) REPORT.—Not later than 270 days after the date on which the task force is convened under subsection (b), the task force shall submit to Congress a report that includes—

(1) the strategy for disseminating best practices for pain management (including chronic and acute pain) and prescribing pain medication, as reviewed, modified, or updated under subsection (d);

(2) the results of a feasibility study on linking the best practices described in paragraph (1) to receiving and renewing registrations under section 303(f) of the Controlled Substances Act (21 U.S.C. 823(f)); and

(3) recommendations for effectively applying the best practices described in paragraph (1) to improve prescribing practices at medical facilities, including medical facilities of the Veterans Health Administration.

(g) GAO REPORT ON STATE PRESCRIPTION DRUG MONITORING PROGRAMS.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit to Congress a report examining the variations that exist across State prescription drug monitoring programs. In preparing the report, the Comptroller General shall determine best practices among State prescription drug monitoring programs, and examine State strategies to increase queries to such programs by health care providers. The Comptroller General shall include in the report recommendations about how the best practices may be replicated in other State prescription drug monitoring programs and whether there should be Federal minimum standards in place to facilitate access to, requests for data to, data transmission from, and information exchange among the programs.

SA 3366. Mr. LANKFORD (for himself and Mr. HATCH) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 4, line 20, after the period insert the following: ''As such, in order to stem the tide of heroin coming into the United States, interdiction at the Mexican border must be a priority.''.

SA 3367. Mr. TOOMEY (for himself, Mr. BROWN, Mr. KAINE, and Mr. PORTMAN) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER THE MEDICARE PROGRAM.

(a) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

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

''(5) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

''(A) AUTHORITY TO ESTABLISH.—A PDP sponsor may establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary's access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by a prescriber (or prescribers) selected under subparagraph (D), and dispensed for such beneficiary by a pharmacy (or pharmacies) selected under such subparagraph.

''(B) REQUIREMENT FOR NOTICES.—

''(i) IN GENERAL.—A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

''(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

''(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse, as described in subparagraph (C)(iv).

''(ii) INITIAL NOTICE.—An initial written notice described in this clause is a notice that provides to the beneficiary—

''(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

''(II) information, when possible, describing State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary may have access, including substance use disorder treatment services, addiction treatment services, mental health services, and other counseling services;

''(III) a request for the beneficiary to submit to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

''(IV) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

''(V) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor;

''(VI) contact information for other organizations that can provide the beneficiary with information regarding drug management program for at-risk beneficiaries (similar to the information provided by the Secretary in other standardized notices to part D eligible individuals enrolled in prescription drug plans under this part); and

''(VII) notice that the beneficiary has a right to an appeal pursuant to subparagraph (E).

''(iii) SECOND NOTICE.—A second written notice described in this clause is a notice that provides to the beneficiary notice—

''(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

''(II) that such beneficiary has been sent, or informed of, such identification in the initial notice and is now subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

''(III) of the prescriber and pharmacy selected for such individual under subparagraph (D);

''(IV) of, and information about, the right of the beneficiary to a reconsideration and an appeal under subsection (h) of such identification and the prescribers and pharmacies selected;

''(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subparagraph (D), submit such preferences to the PDP sponsor; and

''(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (V).

''(iv) TIMING OF NOTICES.—

''(I) IN GENERAL.—Subject to subclause (II), a second written notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 30 days after an initial notice described in clause (ii) is provided to the beneficiary.

''(II) EXCEPTION.—In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rulemaking by the Secretary regarding the health or safety of the beneficiary or regarding significant drug diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (II), the PDP sponsor may provide such second notice on such earlier date.

''(III) FORM OF NOTICE.—The written notices under clauses (ii) and (iii) shall be in a format determined appropriate by the Secretary, taking into account beneficiary preferences.

''(C) AT-RISK BENEFICIARY FOR PRESCRIPTION DRUG ABUSE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'at-risk beneficiary for prescription drug abuse' means a part D eligible individual who is not an exempted individual described in clause (ii) and—

''(I) who is identified through criteria developed by the Secretary in consultation with PDP sponsors and other stakeholders described in subsection section ____(g)(2)(A) of the Comprehensive Addiction and Recovery Act of 2016 based on clinical factors indicating misuse or abuse of prescription drugs described in subparagraph (G), including dosage, quantity, duration of use, number of and reasonable access to prescribers, and number of and reasonable access to pharmacies used to obtain such drug; or

''(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under a prescription drug plan in which such individual was previously enrolled and such identification has not been terminated under subparagraph (F).

''(ii) EXEMPTED INDIVIDUAL DESCRIBED.—An exempted individual described in this clause is an individual who—

''(I) receives hospice care under this title;

''(II) resides in a long-term care facility, a facility described in section 1905(d), or other facility under contract with a single pharmacy; or

''(III) the Secretary elects to treat as an exempted individual for purposes of clause (i).

''(iii) PROGRAM SIZE.—The Secretary shall establish policies, including the criteria developed under clause (i)(I) and the exemptions under clause (ii)(III), to ensure that the population of enrollees in a drug management program for at-risk beneficiaries operated by a prescription drug plan can be effectively managed by such plans.

''(iv) CLINICAL CONTACT.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by a PDP sponsor, the PDP sponsor shall contact the beneficiary's providers who have prescribed frequently abused drugs regarding whether prescribed medications are appropriate for such beneficiary's medical conditions.

''(D) SELECTION OF PRESCRIBERS.—

''(i) IN GENERAL.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(III) and (iii)(V) of subparagraph (B) if applicable, select—

''(I) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, individual who is authorized to prescribe frequently abused drugs (referred to in this paragraph as a 'prescriber') who may write prescriptions for such drugs for such beneficiary; and

''(II) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, pharmacy that may dispense such drugs to such beneficiary.

''(ii) REASONABLE ACCESS.—In making the selection under this subparagraph, a PDP sponsor shall ensure, taking into account geographic location, beneficiary preference, impact on cost-sharing, and reasonable travel time, that the beneficiary continues to have reasonable access to drugs described in subparagraph (G), including—

''(I) for individuals with multiple residences; and

''(II) in the case of natural disasters and similar emergency situations.

''(iii) BENEFICIARY PREFERENCES.—

''(I) IN GENERAL.—If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

''(aa) review such preferences;

''(bb) select or change the selection of a prescriber or pharmacy for the beneficiary based on such preferences; and

''(cc) inform the beneficiary of such selection or change of selection.

''(II) EXCEPTION.—In the case that the PDP sponsor determines that a change to the selection of a prescriber or pharmacy under item (bb) by the PDP sponsor is contributing or would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of a prescriber or pharmacy for the beneficiary. If the PDP sponsor changes the selection pursuant to the preceding sentence, the PDP sponsor shall provide the beneficiary with—

''(aa) at least 30 days written notice of the change of selection; and

''(bb) a rationale for the change.

''(III) TIMING.—An at-risk beneficiary for prescription drug abuse may choose to express their prescriber and pharmacy preference and communicate such preference to their PDP sponsor at any date while enrolled in the program, including after a second notice under subparagraph (B)(iii) has been provided.

''(iv) CONFIRMATION.—Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must notify the prescriber and pharmacy that the beneficiary involved has been identified for inclusion in the drug management program for at-risk beneficiaries and that the prescriber and pharmacy has been selected as the beneficiary's designated prescriber and pharmacy.

''(E) APPEALS.—The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, and the selection of a prescriber or pharmacy under subparagraph (D) with respect to such individual shall be subject to an expedited reconsideration and appeal pursuant to subsection (h).

''(F) TERMINATION OF IDENTIFICATION.—

''(i) IN GENERAL.—The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such standards such identification shall terminate as of the earlier of—

''(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); or

''(II) the end of such maximum period of identification as the Secretary may specify.

''(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph (C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

''(G) FREQUENTLY ABUSED DRUG.—For purposes of this subsection, the term 'frequently abused drug' means a drug that is determined by the Secretary to be frequently abused or diverted and that is—

''(i) a Controlled Drug Substance in Schedule CII; or

''(ii) within the same class or category of drugs as a Controlled Drug Substance in Schedule CII, as determined through notice and comment rulemaking.

''(H) DATA DISCLOSURE.—

''(i) DATA ON DECISION TO IMPOSE LIMITATION.—In the case of an at-risk beneficiary for prescription drug abuse (or an individual who is a potentially at-risk beneficiary for prescription drug abuse) whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, the Secretary shall establish rules and procedures to require such PDP sponsor to disclose data, including necessary individually identifiable health information, about the decision to impose such limitations and the limitations imposed by the PDP sponsor under this part.

''(ii) DATA TO REDUCE FRAUD, ABUSE, AND WASTE.—The Secretary shall establish rules and procedures to require PDP sponsors operating a drug management program for at-risk beneficiaries under this paragraph to provide the Secretary with such data as the Secretary determines appropriate for purposes of identifying patterns of prescription drug utilization for plan enrollees that are

outside normal patterns and that may indicate fraudulent, medically unnecessary, or unsafe use.

''(I) SHARING OF INFORMATION FOR SUBSEQUENT PLAN ENROLLMENTS.—The Secretary shall establish procedures under which PDP sponsors who offer prescription drug plans shall share information with respect to individuals who are at-risk beneficiaries for prescription drug abuse (or individuals who are potentially at-risk beneficiaries for prescription drug abuse) and enrolled in a prescription drug plan and who subsequently disenroll from such plan and enroll in another prescription drug plan offered by another PDP sponsor.

''(J) PRIVACY ISSUES.—Prior to the implementation of the rules and procedures under this paragraph, the Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subparagraphs (H) and (I) by PDP sponsors. Such clarification shall provide that the sharing of such data shall be considered to be protected health information in accordance with the requirements of the regulations promulgated pursuant to such section 264(c).

''(K) EDUCATION.—The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

''(i) provided through the improper payment outreach and education program described in section 1874A(h); and

''(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.

''(L) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that existing plan sponsor compliance reviews and audit processes include the drug management programs for at-risk beneficiaries under this paragraph, including appeals processes under such programs.''.

(2) INFORMATION FOR CONSUMERS.—Section 1860D–4(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–104(a)(1)(B)) is amended by adding at the end the following:

''(v) The drug management program for at-risk beneficiaries under subsection (c)(5).''.

(3) DUAL ELIGIBLES.—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended by inserting '', subject to such limits as the Secretary may establish for individuals identified pursuant to section 1860D–4(c)(5)'' after ''the Secretary''.

(b) UTILIZATION MANAGEMENT PROGRAMS.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)), as amended by subsection (a)(1), is amended—

(1) in paragraph (1), by inserting after subparagraph (D) the following new subparagraph:

''(E) A utilization management tool to prevent drug abuse (as described in paragraph (5)(A)).''; and

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

''(6) UTILIZATION MANAGEMENT TOOL TO PREVENT DRUG ABUSE.—

''(A) IN GENERAL.—A tool described in this paragraph is any of the following:

''(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

''(ii) Retrospective utilization review to identify—

''(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

''(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

''(iii) Consultation with the contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

''(B) REPORTING.—A PDP sponsor offering a prescription drug plan in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1893 with respect to such State a report, on a monthly basis, containing information on—

''(i) any provider of services or supplier described in subparagraph (A)(ii)(II) that is identified by such plan sponsor during the 30-day period before such report is submitted; and

''(ii) the name and prescription records of individuals described in paragraph (5)(C).

''(C) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that plan sponsor annual compliance reviews and program audits include a certification that utilization management tools under this paragraph are in compliance with the requirements for such tools.''.

(c) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—Section 1860D–42 of the Social Security Act (42 U.S.C. 1395w–152) is amended by adding at the end the following new subsection:

''(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.''.

(d) SENSE OF CONGRESS REGARDING USE OF TECHNOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of Congress that MA organizations and PDP sponsors should consider using e-prescribing and other health information technology tools to support combating fraud under MA-PD plans and prescription drug plans under parts C and D of the Medicare Program.

(e) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the implementation of the amendments made by this section, including the effectiveness of the at-risk beneficiaries for prescription drug abuse drug management programs authorized by section 1860D–4(c)(5) of the Social Security Act (42 U.S.C. 1395w–10(c)(5)), as added by subsection (a)(1). Such study shall include an analysis of—

(A) the impediments, if any, that impair the ability of individuals described in subparagraph (C) of such section 1860D–4(c)(5) to access clinically appropriate levels of prescription drugs;

(B) the effectiveness of the reasonable access protections under subparagraph (D)(ii) of such section 1860D–4(c)(5), including the impact on beneficiary access and health;

(C) how best to define the term ''designated pharmacy'', including whether the definition of such term should include an entity that is comprised of a number of locations that are under common ownership and that electronically share a real-time, online database and whether such a definition would help to protect and improve beneficiary access;

(D) the types of—

(i) individuals who, in the implementation of such section, are determined to be individuals described in such subparagraph; and

(ii) prescribers and pharmacies that are selected under subparagraph (D) of such section;

(E) the extent of prescription drug abuse beyond Controlled Drug Substances in Schedule CII in parts C and D of the Medicare program; and

(F) other areas determined appropriate by the Comptroller General.

(2) REPORT.—Not later than July 1, 2019, the Comptroller General of the United States shall submit to the appropriate committees of jurisdiction of Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines to be appropriate.

(f) REPORT BY SECRETARY.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of Congress a report on ways to improve upon the appeals process for Medicare beneficiaries with respect to prescription drug coverage under part D of title XVIII of the Social Security Act. Such report shall include an analysis comparing appeals processes under parts C and D of such title XVIII.

(2) FEEDBACK.—In development of the report described in paragraph (1), the Secretary of Health and Human Services shall solicit feedback on the current appeals process from stakeholders, such as beneficiaries, consumer advocates, plan sponsors, pharmacy benefit managers, pharmacists, providers, independent review entity evaluators, and pharmaceutical manufacturers.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in subsection (d)(2), the amendments made by this section shall apply to prescription drug plans for plan years beginning on or after January 1, 2018.

(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

(A) IN GENERAL.—Not later than January 1, 2017, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title of such Act, advocacy groups representing such individuals, clinicians, plan sponsors, pharmacists, retail pharmacies, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B). The input described in the preceding sentence shall be provided to the Secretary in sufficient time in order for the Secretary to take such input into account in promulgating the regulations pursuant to subparagraph (C).

(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

(i) the impact on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors who are at-risk beneficiaries for prescription drug abuse (as defined in paragraph (5)(C) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–10(c)));

(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under

such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act);

(iii) the types of enrollees that should be treated as exempted individuals, as described in clause (ii) of such paragraph;

(iv) the manner in which terms and definitions in paragraph (5) of such section 1860D–4(c) should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph (5);

(v) the information to be included in the notices described in subparagraph (B) of such section and the standardization of such notices;

(vi) with respect to a PDP sponsor that establishes a drug management program for at-risk beneficiaries under such paragraph (5), the responsibilities of such PDP sponsor with respect to the implementation of such program;

(vii) notices for plan enrollees at the point of sale that would explain why an at-risk beneficiary has been prohibited from receiving a prescription at a location outside of the designated pharmacy;

(viii) evidence-based prescribing guidelines for opiates; and

(ix) the sharing of claims data under parts A and B with PDP sponsors.

(C) RULEMAKING.—The Secretary of Health and Human Services shall, taking into account the input gathered pursuant to subparagraph (A) and after providing notice and an opportunity to comment, promulgate regulations to carry out the provisions of, and amendments made by subsections (a) and (b).

SA 3368. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title VII, add the following:

SEC. 705. RELATIVE DRUG INTERDICTION NEEDS AS PRIMARY FACTOR IN ALLOCATION TO STATES OF FUNDS FOR NATIONAL GUARD DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES.

Section 112 of title 32, United States Code, is amended—

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

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

''(f) PROVISION OF FUNDS TO STATES BASED ON RELATIVE DRUG INTERDICTION NEEDS.—In providing funds to States under this section, the Secretary shall use as a primary factor in allocating such funds the relative drug interdiction needs of the States (as reflected in the State drug interdiction and counter-drug activities plans of the States under subsection (c)).''.

SA 3369. Mr. CORNYN (for himself and Mr. ALEXANDER) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE VIII—MENTAL HEALTH AND SUBSTANCE ABUSE REFORM ACT

SEC. 801. SHORT TITLE.

This title may be cited as the ''Mental Health and Substance Abuse Reform Act of 2016''.

SEC. 802. ASSISTANCE FOR INDIVIDUALS TRANSITIONING OUT OF SYSTEMS.

Section 2976(f) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797w(f)) is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(7) provide mental health treatment and transitional services for those with mental illnesses or with co-occurring disorders, including housing placement or assistance.''.

SEC. 803. CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH CHALLENGES IN DRUG COURTS.

Part EE of title I of Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797u et seq.) is amended—

(1) in section 2951(a)(1) (42 U.S.C. 3797u(a)(1)), by inserting '', including co-occurring substance abuse and mental health problems,'' after ''problems''; and

(2) in section 2959(a) (42 U.S.C. 3797u–8(a)), by inserting '', including training for drug court personnel and officials on identifying and addressing co-occurring substance abuse and mental health problems'' after ''part''.

SEC. 804. CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH CHALLENGES IN RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS.

Section 1901(a) of title I of Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff(a)) is amended—

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

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

(3) by adding at the end the following:

''(3) developing and implementing specialized residential substance abuse treatment programs that identify and provide appropriate treatment to inmates with co-occurring mental health and substance abuse disorders or challenges.''.

SA 3370. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title II, add the following:

SEC. 205. REQUIREMENT FOR 3-YEAR PLAN TO ACHIEVE 90-PERCENT RATE OF EFFECTIVE DRUG INTERDICTION.

(a) DEFINITION OF TRANSIT ZONE.—In this section, the term ''Transit Zone'' means the sea corridors of the western Atlantic Ocean, the Gulf of Mexico, the Caribbean Sea, and the eastern Pacific Ocean through which illicit drugs transit, either directly or indirectly, to the United States.

(b) PLAN REQUIRED.—Not later than 180 days after the date of enactment of this Act, the President shall submit to the relevant congressional committees a report setting forth a comprehensive interagency plan for achieving within 3 years a 90-percent rate of effective interdiction of all illegal drugs that would otherwise—

(1) pass through the Transit Zone en route to the United States; or

(2) enter the United States across the Southwest border.

(c) INTERAGENCY INTEGRATION AND COORDINATION.—The plan required under subsection (b) shall describe the integration and coordination of efforts by all relevant Federal agencies, including the Department of Homeland Security, the Department of Justice, and the Department of Defense, necessary to achieve the objective stated in subsection (b).

(d) ELEMENTS.—The plan required under subsection (b) shall include—

(1) a detailed description of the manner in which the stated objective will be accomplished;

(2) a determination of which official will lead the effort and be accountable for its results;

(3) the specific roles and functions that will be carried out by each agency;

(4) the means that will be required, in terms of personnel, equipment, and other resources;

(5) a detailed budget plan describing the funding that will be needed, broken down by agency;

(6) an explanation of any new or different legal authorities that will be required; and

(7) a specific target date on which the stated objective will be achieved.

SA 3371. Mr. SCHATZ (for himself and Mr. HATCH) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title I of the bill, add the following:

SEC. 104. ENHANCING BASIC AND APPLIED RESEARCH ON PAIN TO DISCOVER THERAPIES TO REDUCE THE CURRENT OVER-PRESCRIBING OF OPIOIDS.

(a) IN GENERAL.—Out of any money appropriated to the National Institutes of Health not otherwise obligated, the Director of the National Institutes of Health may intensify and coordinate fundamental, translational, and clinical research of the National Institutes of Health (referred to in this section as the ''NIH'') with respect to the understanding of pain and the discovery and development of therapies for chronic pain.

(b) PRIORITY AND DIRECTION.—The prioritization and direction of the Federally funded portfolio of pain research studies shall consider recommendations made by the Interagency Pain Research Coordinating Committee in concert with the Pain Management Best Practices Inter-Agency Task Force, and in accordance with the National Pain Strategy, the Federal Pain Research Strategy, and the NIH-Wide Strategic Plan for Fiscal Years 2016-2020, the latter which calls for the relative burdens of individual diseases and medical disorders to be regarded as crucial considerations in balancing the priorities of the Federal research portfolio.

SA 3372. Mr. HEINRICH (for himself and Mr. ENZI) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 11, line 9, strike ''and''.

On page 11, between lines 9 and 10, insert the following:

(6) rural community health professionals; and

On page 11, line 10, strike ''(6)'' and insert ''(7)''.

SA 3373. Mrs. ERNST submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of section 203, add the following:

(c) GAO REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall—

(1) review the prescription drug take back program authorized under subsection (b), including participation rates and stakeholder concerns, in order to catalogue the most significant regulatory barriers for voluntary participation by retail pharmacies; and

(2) submit to Congress a report that includes recommendations on how the Drug Enforcement Administration and Congress can address existing regulatory barriers in order to expand voluntary participation by retail pharmacies in the program.

SA 3374. Mr. DONNELLY (for himself and Mrs. CAPITO) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 33, line 5, strike the period and insert ", which may include an outreach coordinator or team to connect individuals receiving opioid overdose reversal drugs to follow-up services.".

SA 3375. Mr. REID (for Mrs. MCCASKILL (for herself and Mr. BLUNT)) submitted an amendment intended to be proposed by Mr. REID of NV to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

In section 601(b), add at the end the following:

(6) STATES WITHOUT PRESCRIPTION DRUG MONITORING PROGRAMS.—In the case of a State that does not have a prescription drug monitoring program, a county or other unit of local government within the State that has a prescription drug monitoring program shall be treated as a State for purposes of this section, including for purposes of eligibility for grants under paragraph (1).

SA 3376. Mr. KAINE (for himself and Mrs. CAPITO) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 67, line 24, insert "including best practices on the co-prescribing of naloxone" after "guidelines".

On page 77, between lines 5 and 6, insert the following:

SEC. ___. NALOXONE CO-PRESCRIBING IN FEDERAL HEALTH CARE AND MEDICAL FACILITIES.

(a) NALOXONE CO-PRESCRIBING GUIDELINES.—Not later than 180 days after the date of enactment of this Act:

(1) The Secretary of Health and Human Services shall, as appropriate, provide information to prescribers within Federally qualified health centers (as defined in paragraph (4) of section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), and the health care facilities of the Indian Health Service, on best practices for co-prescribing naloxone for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(2) The Secretary of Defense shall, as appropriate, provide information to prescribers within Department of Defense medical facilities on best practices for co-prescribing naloxone for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(3) The Secretary of Veterans Affairs shall, as appropriate, provide information to prescribers within Department of Veterans Affairs medical facilities on best practices for co-prescribing naloxone for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(b) DEFINITIONS.—In this section:

(1) CO-PRESCRIBING.—The term "co-prescribing" means, with respect to an opioid overdose reversal drug, the practice of prescribing such drug in conjunction with an opioid prescription for patients at an elevated risk of overdose, or in conjunction with an opioid agonist approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for the treatment of opioid use disorders, or in other circumstances in which a provider identifies a patient at an elevated risk for an intentional or unintentional drug overdose from heroin or prescription opioid therapies.

(2) ELEVATED RISK OF OVERDOSE.—The term "elevated risk of overdose" has the meaning given such term by the Secretary of Health and Human Services, which—

(A) may be based on the criteria provided in the Opioid Overdose Toolkit published by the Substance Abuse and Mental Health Services Administration; and

(B) may include patients on a first course opioid treatment, patients using extended-release and long-acting opioid analgesic, and patients with a respiratory disease or other co-morbidities.

SA 3377. Mr. KING submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE VIII—PHARMACEUTICAL STEWARDSHIP ACT

SEC. 801. SHORT TITLE.

This title may be cited as the "Pharmaceutical Stewardship Act of 2016".

SEC. 802. NATIONAL PHARMACEUTICAL STEWARDSHIP PROGRAMS.

(a) DEFINITIONS.—In this section:

(1) The term "board of directors" means the board of directors of the organization.

(2) The term "producer", with respect to a covered drug, means the holder of an approved application for the covered drug under subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355).

(3) The term "certified national pharmaceutical stewardship program" means a national pharmaceutical stewardship program with a certification in effect under subsection (g) or (h).

(4) The term "controlled substance" means a controlled substance (as such term is defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) in schedule II, III, IV, or V under section 202 of such Act (21 U.S.C. 812).

(5) The term "covered drug" means a drug (as such term is defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) that is marketed in the United States other than—

(A) a drug for which a take-back program is in effect pursuant to a risk evaluation and mitigation strategy under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1);

(B) a vitamin or dietary supplement (as such term is defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321));

(C) an herbal-based remedy or homeopathic drug, product, or remedy;

(D) a soap (with or without germicidal agents), laundry detergent, bleach, household cleaning product, shampoo, sunscreen, toothpaste, lip balm, antiperspirant, or other product that is regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) exclusively as a cosmetic;

(E) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262)); or

(F) a pesticide (as defined in section 2 of the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136)) that is contained in a collar, powder, shampoo, topical application, or other system for delivery or application to a pet.

(6) The term "organization" means the National Pharmaceutical Stewardship Organization established in accordance with subsection (c).

(7) The term "Secretary" means the Secretary of Health and Human Services.

(8) The term "ultimate user" has the meaning given to such term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(b) REQUIRED PARTICIPATION.—Each producer of a covered drug shall participate in—

(1) the certified national pharmaceutical stewardship program of the National Pharmaceutical Stewardship Organization; or

(2) another certified national pharmaceutical stewardship program.

(c) NATIONAL PHARMACEUTICAL STEWARDSHIP ORGANIZATION.—

(1) ESTABLISHMENT.—There shall be established in accordance with this section a nonprofit private corporation to be known as the National Pharmaceutical Stewardship Organization. The organization shall not be an agency or instrumentality of the Federal Government, and officers, employees, and members of the board of the organization shall not, by virtue of such service, be considered officers or employees of the Federal Government.

(2) PURPOSE.—The purpose of the organization shall be to establish and, beginning not later than 2 years after the date of enactment of this title, implement a certified national pharmaceutical stewardship program.

(3) BOARD OF DIRECTORS.—

(A) REPRESENTATION.—The organization shall have a board of directors with balanced representation of each of the following:

(i) Producers of covered drugs.

(ii) Public health, pharmacy, law enforcement, and substance use disorder treatment professionals.

(iii) Water quality and waste management stakeholders.

(B) INITIAL MEMBERS.—The Secretary shall appoint the initial members of the board of directors.

(4) POWERS.—

(A) IN GENERAL.—The organization may—

(i) adopt and amend a constitution and bylaws for the management of its property and the regulation of its affairs;

(ii) adopt and alter a corporate seal;

(iii) choose officers, managers, agents, and employees as the activities of the organization require;

(iv) make contracts;

(v) acquire, own, lease, encumber, and transfer property as necessary to carry out the purposes of the organization;

(vi) borrow money, issue instruments of indebtedness, and secure its obligations by granting security interests in its property;

(vii) sue and be sued; and

(viii) do any other act necessary and proper to carry out the purpose of the organization.

(B) BYLAWS.—The board of directors shall establish the general policies of the organization for carrying out the purpose described in paragraph (2), including the establishment of the bylaws of the organization, which shall include bylaws for the following:

(i) Entering into contracts and agreements with service providers and entities as necessary, useful, or convenient to provide all or portions of the national pharmaceutical stewardship program of the organization.

(ii) Taking any legal action necessary or proper for the recovery of an assessment for, on behalf of, or against producers of a covered drug participating in such program.

(iii) Performing other such functions as may be necessary or proper to carry out the purpose described in paragraph (2).

(iv) Ensuring that the members of the board of directors serve without compensation, but are entitled to reimbursement (solely from the funds of the organization) for expenses incurred in the discharge of their duties as members of the board of directors.

(v) Ensuring that the organization does not use any Federal, State, or local government funds to carry out the purpose described in paragraph (2).

(vi) Allowing the Secretary—

(I) to audit the activities of the organization as the Secretary deems necessary; and

(II) to access any facilities or property of the organization as the Secretary deems necessary to conduct inspections or investigate complaints.

(5) NONPROFIT STATUS.—In carrying out the purpose described in paragraph (2), the board of directors shall establish such policies and bylaws under paragraph (4)(B) as may be necessary to ensure that the organization maintains its status as an organization that—

(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986; and

(B) is, under subsection (a) of such section, exempt from taxation.

(6) CONTRIBUTIONS TO NATIONAL PHARMACEUTICAL STEWARDSHIP ORGANIZATION NOT TREATED AS CHARITABLE CONTRIBUTIONS.—A contribution (including any payment or fee) by a producer of a covered drug to the organization or the organization's national pharmaceutical stewardship program shall not be treated as a charitable contribution for purposes of section 170 of the Internal Revenue Code of 1986.

(7) ARTICLES OF INCORPORATION.—The Secretary shall ensure that the initial articles of incorporation of the organization are properly filed not later than 60 days after the date of enactment of this title.

(d) PROGRAM REQUIREMENTS.—To be certified (and maintain certification) under subsection (g) or (h), a national pharmaceutical stewardship program (referred to in this section as a ''program'') shall meet each of the following requirements:

(1) The program is operated pursuant to an agreement among the producers of covered drugs participating in the program.

(2) Subject to subsection (e), the costs of the program are fully paid by such producers.

(3) The program shall not impose any fee on individuals, wholesalers, or retailers for transport and disposal of a covered drug through the program, except to the extent an individual, wholesaler, or retailer is acting as a producer of a covered drug.

(4) The program is developed with input from the public, including an opportunity for public comment and public hearings.

(5) The program provides a system to facilitate the collection and disposal of any covered drug that—

(A) is delivered to the program by the ultimate user of the covered drug in the United States; and

(B) is household waste as defined under the implementing regulations of subtitle C of title II of the Solid Waste Disposal Act (42 U.S.C. 6901 et seq.; commonly referred to as the ''Resource Conservation and Recovery Act'').

(6) Collection and disposal of a covered drug through the program's system (described in paragraph (5)) occurs only in a manner that—

(A) is safe and secure;

(B) results in the covered drug being rendered unrecoverable in accordance with the requirements for nonretrievable disposal of controlled substances under part 1300 of title 21, Code of Federal Regulations (or any successor regulations);

(C) protects patient information;

(D) is accessible in every State, county, and city or town, by including—

(i) at least one collection site that is accessible on an ongoing, year-round basis in every county of every State and at least one additional such collection site for every 30,000 county residents, giving preference to retail pharmacies that—

(I) operate secure collection receptacles in accordance with applicable regulations of the Drug Enforcement Administration; and

(II) are geographically distributed to provide reasonably convenient and equitable access;

(ii) if ongoing, year-round collection is not feasible in a specific county or city (as determined by the Secretary)—

(I) periodic collection events; or

(II) the provision of prepaid mailing envelopes or deactivation technologies to individuals in such county or city; and

(iii) prepaid mailing envelopes or deactivation technologies made available to individuals with disabilities and home-bound residents upon request through the program's toll-free telephone number and website under paragraph (8); and

(E) in the case of a controlled substance, is consistent with section 302(g) of the Controlled Substances Act (21 U.S.C. 822(g)).

(7) The program—

(A) promotes the collection and disposal of covered drugs through the program; and

(B) to the extent feasible, works with local recycling facilities and officials to collect and recycle covered drug packaging at collection locations.

(8) The program ensures that options for collection and disposal of covered drugs through the program are widely understood by customers, pharmacists, retailers, and health care practitioners including doctors and other prescribers, including by—

(A) maintaining a toll-free telephone number, a website optimized for mobile platforms, and a free mobile application that—

(i) publicize all currently available collection and disposal options, updated within 30 days of any change; and

(ii) provide substance use disorder treatment and referral information;

(B) preparing educational and outreach materials that—

(i) clearly explain what ''covered drugs'' are collected at each collection site;

(ii) describe where and how to dispose of covered drugs through the program;

(iii) address the risks of diversion of covered drugs, including accidental overdose, accidental poisoning, and environmental contamination;

(iv) raise awareness about the importance of safe storage and disposal; and

(v) utilize plain language and explanatory images readily understandable by all residents, including individuals with limited English proficiency; and

(C) providing such materials to pharmacies, health care facilities, and other interested parties for dissemination.

(9) Every 4 years, the program, using an independent evaluator at the expense of the program, evaluates the effectiveness of its educational and outreach activities under paragraph (8), including with respect to—

(A) the percentage of residents of the United States who are aware of the program;

(B) the percentage of residents of the United States who report having access to a collection site, prepaid mail-back envelope, or deactivation system; and

(C) the extent to which residents of the United States find the program to be convenient.

(10) Annually, the program, using an independent auditor at the expense of the program, audits relevant information provided in the program's report to the Secretary, including—

(A) the amount, by weight, of covered drugs collected and disposed of in each State by drop-off site and, if applicable, the total amount by weight collected by mail-back method and disposed of; and

(B) the income and expenditures of the program.

(e) MECHANISM FOR TRANSFER OF COSTS AMONG PRODUCERS.—To be certified (and maintain certification) under subsection (g) or (h), a program shall include a mechanism that—

(1) provides for receiving and transferring of funds among all national pharmaceutical stewardship programs that are so certified in such amounts as may be necessary, to be adjusted on at least an annual basis, to ensure that the producers of covered drugs participating in such programs bear the costs of such programs in a manner that provides for a fair and reasonable allocation of such costs across such participants; and

(2) is specified in a written agreement among all producers of covered drugs.

(f) PROGRAM REPORTING REQUIREMENTS.—

(1) IN GENERAL.—To be certified (and maintain certification) under subsection (g) or (h), a program shall agree to submit a report to the Secretary within one year following such certification, and annually thereafter.

(2) CONTENTS.—Each report submitted by a program under paragraph (1) shall describe the program's activities during the preceding calendar year, including at a minimum—

(A) a list of producers participating in the program;

(B) a specification of the amount, by weight, of covered drugs collected and disposed of in each State—

(i) by drop-off site; and

(ii) if applicable, by mail-back method;

(C) a description of the collection system in each State, including the location of each collection site and, if applicable, locations where envelopes for mail-back or deactivation technologies are provided;

(D) an identification of any safety or security problems which occurred during collection, transportation, or disposal of covered drugs during the preceding calendar year and, with respect to any such problems, a description of the changes which have or will be made to policies, procedures, or tracking mechanisms to alleviate any such problems

and to improve safety and security in the future;

(E) a description of the educational and outreach activities under subsection (d)(8) and the methodology used to evaluate such activities under subsection (d)(9);

(F) a description of how collected packaging was recycled to the extent feasible, including the recycling facility or facilities used; and

(G) the total expenditures of the program.

(3) PROCEDURES.—The Secretary shall establish procedures for reporting under this subsection not later than the date that is one year after the date of the enactment of this title.

(4) PUBLIC AVAILABILITY.—The Secretary shall make each report submitted under this subsection available to the public.

(g) CERTIFICATION OF NATIONAL PHARMACEUTICAL STEWARDSHIP ORGANIZATION'S PROGRAM.—

(1) PROGRAM PLAN.—To seek certification of its program, the organization shall submit a plan to the Secretary containing such information as the Secretary may require.

(2) CONSIDERATION BY SECRETARY.—Upon receipt of a plan under paragraph (1), the Secretary—

(A) shall consult with the Administrator of the Drug Enforcement Administration on the adequacy of the proposed program's security measures for collection, transportation, and disposal of covered drugs, disposal systems, and mechanisms for secure tracking and handling;

(B) shall consult with the Administrator of the Environmental Protection Agency on the adequacy of the program's disposal methods and compliance with environmental requirements;

(C) shall consult with the Secretary of Transportation on the adequacy of the program's compliance with respect to requirements for transport of covered drugs; and

(D) within 90 days after receipt of the plan, shall—

(i) certify the program if the Secretary determines it meets the requirements of this section; or

(ii) reject the proposed program and provide a written explanation of the reasons for such rejection.

(3) RESPONSE TO REJECTION OF PROPOSED PROGRAM.—If the Secretary rejects the organization's proposed program under paragraph (2)(D)(ii), the rejection shall be treated as final agency action, and the organization may—

(A) revise its proposed program and submit a new plan under paragraph (1); or

(B) seek judicial review of the rejection not later than 60 days after receiving notice of the rejection.

(4) TERM OF CERTIFICATION; RECERTIFICATION.—The term of a certification (including a recertification) under paragraph (2)(D)(i) shall be not more than 2 years. To have its program recertified, the organization shall submit a new plan under paragraph (1), including any relevant updates, for approval under paragraph (2)(D)(i).

(5) CHANGES TO CERTIFIED PROGRAM.—Before making any significant change to its certified national pharmaceutical stewardship program, the organization shall seek and obtain approval for the change from the Secretary. Not later than 15 days after submission of a request for a change under the preceding sentence, the Secretary shall approve the change or reject the change and provide a written explanation of the reasons for the rejection.

(6) SUBMISSION REQUIREMENTS.—

(A) PUBLICATION.—Not later than 6 months after the date of the enactment of this title, the Secretary shall publish requirements for the submission of program plans under paragraph (1) and requests for changes under paragraph (5), including requirements for the contents of such submissions.

(B) FAILURE TO PUBLISH.—If the Secretary fails to publish such requirements by the deadline specified in subparagraph (A), the requirements of this section applicable to producers of covered drugs shall nonetheless apply.

(h) CERTIFICATION OF OTHER PROGRAMS.—

(1) APPLICATION.—In lieu of participating in the certified national pharmaceutical stewardship program of the organization, one or more producers of a covered drug may submit a stewardship plan to the Secretary seeking certification of a separate national pharmaceutical stewardship program.

(2) GOVERNING PROVISIONS.—The provisions of subsection (g) shall apply with respect to a stewardship plan for certification of a program under paragraph (1) to the same extent and in the same manner as such provisions apply to a program plan for certification of a program by the organization under subsection (g), except as follows:

(A) The reference to 90 days in subsection (g)(2)(D) (relating to the period of the Secretary's review of a program plan) shall be treated as a reference to 120 days.

(B) If the Secretary rejects the proposed stewardship plan, in lieu of submitting a new stewardship plan under paragraph (1) or seeking judicial review of the rejection, the producers may choose to participate in the certified national pharmaceutical stewardship program of the organization.

(C) The reference to 2 years in subsection (g)(4) (relating to the term of certification) shall be treated as references to 1 year.

(i) SOLICITATION OF PUBLIC COMMENT TO INFORM PROGRAM UPDATES.—

(1) IN GENERAL.—A certified national product stewardship program shall—

(A) annually invite comments from stakeholders on their satisfaction with the services provided by the program, including representatives of health care facilities, prescribers, pharmacies and pharmacists, State and local government officials, law enforcement personnel, public health organizations, substance use disorder professionals, waste management stakeholders, environmental organizations, and consumers;

(B) compile and submit the information received through such comments to the Secretary; and

(C) use such information in developing updates and changes to the program.

(2) USE BY SECRETARY.—The Secretary shall use information submitted under paragraph (1)(B) in reviewing proposed updates and revisions to certified national pharmaceutical stewardship program plans.

(3) GUIDANCE.—The Secretary shall issue guidance on the process for complying with this subsection.

(j) SUSPENSION OF PROGRAM.—

(1) IMMINENT DANGER.—The Secretary may suspend, in whole or in part, the certification of any national pharmaceutical stewardship program under this section if the Secretary determines that such action is necessary to protect the public from imminent danger.

(2) FAILURE TO COMPLY.—If the Secretary determines that a national pharmaceutical stewardship is in violation of the requirements of this section, the Secretary—

(A) within 30 days of learning of the violation, may issue a written warning to the program stating that the program is in violation of this section; and

(B) if the program has not rectified each violation identified in such warning within 30 days of receipt of such warning, may suspend, in whole or in part, the certification of the program.

(k) CIVIL PENALTIES.—Beginning on the date that is 2 years after the date of enactment of this title, a producer of a covered drug shall be liable for a civil penalty of not more than $50,000 for each calendar day on which, as determined by the Secretary, the producer—

(1) is not participating in a certified national pharmaceutical program; or

(2) is in violation of its obligation to contribute to the costs of such a program under subsection (d)(2).

(l) REGULATORY POWER.—The Secretary may adopt rules or guidance necessary to implement, administer, and enforce this section. The Secretary, in consultation with the Administrator of the Environmental Protection Agency, the Administrator of the Drug Enforcement Administration, the Director of National Drug Control Policy, the Secretary of Transportation, and the Commissioner of Food and Drugs, may include in such regulations or guidance any performance standards determined appropriate for implementing the program requirements specified in this section.

(m) STATE, TRIBAL, AND LOCAL REGULATION.—Nothing in this title prohibits a State, tribal, or local government from imposing any requirements relating to the safe and secure disposal of covered drugs that are more stringent than the requirements of this title.

(n) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this title, the Secretary shall report to the appropriate committees of the Congress concerning the status of the national pharmaceutical stewardship programs under this section, including any recommendations for changes to this section.

(o) SEVERABILITY.—If any provision of this section or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this section, and the application of the provisions of such remainder to any person or circumstance, shall not be affected thereby.

(p) EVALUATION.—

(1) IN GENERAL.—Not later than 2 years after the date of the enactment of this title, and annually thereafter, the Director of the Office of the National Drug Control Policy, in consultation with the Secretary of Health and Human Services, the Attorney General, and the Administrator of the Drug Enforcement Administration, shall—

(A) conduct an evaluation of the effectiveness of the national pharmaceutical stewardship programs under this section; and

(B) submit a report to the Congress on the results of each such evaluation, including recommendations for improving the programs.

(2) METRICS.—The evaluation under paragraph (1) shall address each of the following:

(A) Public access to national pharmaceutical stewardship programs under this section.

(B) Public awareness of such programs, including awareness of the risks of diversion of drugs and awareness of the importance of safe storage and safe disposal of pharmaceuticals.

(C) Impact of the programs on prescription drug abuse, including analysis of hospital admissions for prescription drug overdoses, per capita deaths due to prescription drug overdoses, and arrests for illegal possession of controlled substances in schedule II, III, IV, or V.

(q) ANNUAL FEES.—The Secretary may assess, collect, and use, without further appropriation, annual fees from producers of covered drugs to pay the administrative costs of carrying out this section and section 803.

(r) DELAYED APPLICABILITY.—In the case of producer that first offers a covered drug for

sale in interstate commerce (including by importing the covered drug) after the date of enactment of this title, the requirements of this title apply with respect to such producer beginning on the date that is 180 days after the date on which the producer first offers the covered drug for sale in interstate commerce.

SEC. 803. COORDINATED EDUCATION CAMPAIGN ON DRUG DISPOSAL.

Not later than 18 months after the date of the enactment of this title, the Director of the Office of National Drug Control Policy, in consultation with the Secretary of Health and Human Services and the Administrator of the Environmental Protection Agency, shall establish and begin implementation of a coordinated education and outreach campaign—

(1) to increase awareness among members of the public regarding how drugs may be safely and securely disposed consistent with public safety, public health, and environmental protection through national pharmaceutical stewardship programs established under section 802 and by other appropriate means; and

(2) to link members of the public to the national and local educational and outreach activities conducted by such programs.

SA 3378. Mr. GRASSLEY (for himself, Mr. LEAHY, Mr. WHITEHOUSE, Mr. PORTMAN, Ms. KLOBUCHAR, Ms. AYOTTE, Mr. GRAHAM, Mr. COONS, Mr. CORNYN, and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; 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 ''Comprehensive Addiction and Recovery Act of 2016''.

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

SEC. 2. FINDINGS.

Congress finds the following:

(1) The abuse of heroin and prescription opioid painkillers is having a devastating effect on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention, drug overdose deaths now surpass traffic accidents in the number of deaths caused by injury in the United States. In 2014, an average of more than 120 people in the United States died from drug overdoses every day.

(2) According to the National Institute on Drug Abuse (commonly known as ''NIDA''), the number of prescriptions for opioids increased from approximately 76,000,000 in 1991 to nearly 207,000,000 in 2013, and the United States is the biggest consumer of opioids globally, accounting for almost 100 percent of the world total for hydrocodone and 81 percent for oxycodone.

(3) Opioid pain relievers are the most widely misused or abused controlled prescription drugs (commonly referred to as ''CPDs'') and are involved in most CPD-related overdose incidents. According to the Drug Abuse Warning Network (commonly known as ''DAWN''), the estimated number of emergency department visits involving nonmedical use of prescription opiates or opioids increased by 112 percent between 2006 and 2010, from 84,671 to 179,787.

(4) The use of heroin in the United States has also spiked sharply in recent years. According to the most recent National Survey on Drug Use and Health, more than 900,000 people in the United States reported using heroin in 2014, nearly a 35 percent increase from the previous year. Heroin overdose deaths more than tripled from 2010 to 2014.

(5) The supply of cheap heroin available in the United States has increased dramatically as well, largely due to the activity of Mexican drug trafficking organizations. The Drug Enforcement Administration (commonly known as the ''DEA'') estimates that heroin seizures at the Mexican border have more than doubled since 2010, and heroin production in Mexico increased 62 percent from 2013 to 2014. While only 8 percent of State and local law enforcement officials across the United States identified heroin as the greatest drug threat in their area in 2008, that number rose to 38 percent in 2015.

(6) Law enforcement officials and treatment experts throughout the country report that many people who have misused prescription opioids have turned to heroin as a cheaper or more easily obtained alternative to prescription opioids.

(7) According to a report by the National Association of State Alcohol and Drug Abuse Directors (commonly referred to as ''NASADAD''), 37 States reported an increase in admissions to treatment for heroin use during the past 2 years, while admissions to treatment for prescription opiates increased 500 percent from 2000 to 2012.

(8) Research indicates that combating the opioid crisis, including abuse of prescription painkillers and, increasingly, heroin, requires a multipronged approach that involves prevention, education, monitoring, law enforcement initiatives, reducing drug diversion and the supply of illicit drugs, expanding delivery of existing treatments (including medication assisted treatments), expanding access to overdose medications and interventions, and the development of new medications for pain that can augment the existing treatment arsenal.

(9) Substance use disorders are a treatable disease. Discoveries in the science of addiction have led to advances in the treatment of substance use disorders that help people stop abusing drugs and prescription medications and resume their productive lives.

(10) According to the National Survey on Drug Use and Health, approximately 22,700,000 people in the United States needed substance use disorder treatment in 2013, but only 2,500,000 people received it. Furthermore, current treatment services are not adequate to meet demand. According to a report commissioned by the Substance Abuse and Mental Health Services Administration (commonly known as ''SAMHSA''), there are approximately 32 providers for every 1,000 individuals needing substance use disorder treatment. In some States, the ratio is much lower.

(11) The overall cost of drug abuse, from health care- and criminal justice-related costs to lost productivity, is steep, totaling more than $700,000,000,000 a year, according to NIDA. Effective substance abuse prevention can yield major economic dividends.

(12) According to NIDA, when schools and communities properly implement science-validated substance abuse prevention programs, abuse of alcohol, tobacco, and illicit drugs is reduced. Such programs help teachers, parents, and healthcare professionals shape the perceptions of youths about the risks of drug abuse.

(13) Diverting certain individuals with substance use disorders from criminal justice systems into community-based treatment can save billions of dollars and prevent sizeable numbers of crimes, arrests, and re-incarcerations over the course of those individuals' lives.

(14) According to the DEA, more than 2,700 tons of expired, unwanted prescription medications have been collected since the enactment of the Secure and Responsible Drug Disposal Act of 2010 (Public Law 111–273; 124 Stat. 2858).

(15) Faith-based, holistic, or drug-free models can provide a critical path to successful recovery for a number of people in the United States. The 2015 membership survey conducted by Alcoholics Anonymous (commonly known as ''AA'') found that 73 percent of AA members were sober longer than 1 year and attended 2.5 meetings per week.

(16) Research shows that combining treatment medications with behavioral therapy is an effective way to facilitate success for some patients. Treatment approaches must be tailored to address the drug abuse patterns and drug-related medical, psychiatric, and social problems of each individual. Different types of medications may be useful at different stages of treatment or recovery to help a patient stop using drugs, stay in treatment, and avoid relapse. Patients have a range of options regarding their path to recovery and many have also successfully addressed drug abuse through the use of faith-based, holistic, or drug-free models.

(17) Individuals with mental illness, especially severe mental illness, are at considerably higher risk for substance abuse than the general population, and the presence of a mental illness complicates recovery from substance abuse.

(18) Rural communities are especially susceptible to heroin and opioid abuse. Individuals in rural counties have higher rates of drug poisoning deaths, including deaths from opioids. According to the American Journal of Public Health, ''[O]pioid poisonings in nonmetropolitan counties have increased at a rate greater than threefold the increase in metropolitan counties.'' According to a February 19, 2016, report from the Maine Rural Health Research Center, ''[M]ultiple studies document a higher prevalence [of abuse] among specific vulnerable rural populations, particularly among youth, women who are pregnant or experiencing partner violence, and persons with co-occurring disorders.''

SEC. 3. DEFINITIONS.

In this Act—

(1) the term ''first responder'' includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of professional duties, responds to fire, medical, hazardous material, or other similar emergencies;

(2) the term ''medication assisted treatment'' means the use, for problems relating to heroin and other opioids, of medications approved by the Food and Drug Administration in combination with counseling and behavioral therapies;

(3) the term ''opioid'' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability; and

(4) the term ''State'' means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and any territory or possession of the United States.

TITLE I—PREVENTION AND EDUCATION

SEC. 101. DEVELOPMENT OF BEST PRACTICES FOR THE PRESCRIBING OF PRESCRIPTION OPIOIDS.

(a) DEFINITIONS.—In this section—

(1) the term ''Secretary'' means the Secretary of Health and Human Services; and

(2) the term ''task force'' means the Pain Management Best Practices Interagency Task Force convened under subsection (b).

(b) INTERAGENCY TASK FORCE.—Not later than December 14, 2018, the Secretary, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administrator of the Drug Enforcement Administration, shall convene a Pain Management Best Practices Interagency Task Force to review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication.

(c) MEMBERSHIP.—The task force shall be comprised of—

(1) representatives of—

(A) the Department of Health and Human Services;

(B) the Department of Veterans Affairs;

(C) the Food and Drug Administration;

(D) the Department of Defense;

(E) the Drug Enforcement Administration;

(F) the Centers for Disease Control and Prevention;

(G) the National Academy of Medicine;

(H) the National Institutes of Health;

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

(J) the Office of Rural Health Policy of the Department of Health and Human Services;

(2) physicians, dentists, and nonphysician prescribers;

(3) pharmacists;

(4) experts in the fields of pain research and addiction research;

(5) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment community;

(D) pain advocacy groups; and

(E) groups with expertise around overdose reversal; and

(6) other stakeholders, as the Secretary determines appropriate.

(d) DUTIES.—The task force shall—

(1) not later than 180 days after the date on which the task force is convened under subsection (b), review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication, taking into consideration—

(A) existing pain management research;

(B) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(C) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of alternatives to opioids to reduce opioid monotherapy in appropriate cases;

(D) the management of high-risk populations, other than populations who suffer pain, who—

(i) may use or be prescribed benzodiazepines, alcohol, and diverted opioids; or

(ii) receive opioids in the course of medical care; and

(E) the Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (80 Fed. Reg. 77351 (December 14, 2015)) and any final guidelines issued by the Centers for Disease Control and Prevention;

(2) solicit and take into consideration public comment on the practices developed under paragraph (1), amending such best practices if appropriate; and

(3) develop a strategy for disseminating information about the best practices to stakeholders, as appropriate.

(e) LIMITATION.—The task force shall not have rulemaking authority.

(f) REPORT.—Not later than 270 days after the date on which the task force is convened under subsection (b), the task force shall submit to Congress a report that includes—

(1) the strategy for disseminating best practices for pain management (including chronic and acute pain) and prescribing pain medication, as reviewed, modified, or updated under subsection (d); and

(2) recommendations for effectively applying the best practices described in paragraph (1) to improve prescribing practices at medical facilities, including medical facilities of the Veterans Health Administration.

SEC. 102. AWARENESS CAMPAIGNS.

(a) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the Attorney General, shall advance the education and awareness of the public, providers, patients, and other appropriate entities regarding the risk of abuse of prescription opioid drugs if such products are not taken as prescribed.

(b) DRUG-FREE MEDIA CAMPAIGN.—

(1) IN GENERAL.—The Office of National Drug Control Policy, in coordination with the Secretary of Health and Human Services and the Attorney General, shall establish a national drug awareness campaign.

(2) REQUIREMENTS.—The national drug awareness campaign required under paragraph (1) shall—

(A) take into account the association between prescription opioid abuse and heroin use;

(B) emphasize the similarities between heroin and prescription opioids and the effects of heroin and prescription opioids on the human body; and

(C) bring greater public awareness to the dangerous effects of fentanyl when mixed with heroin or abused in a similar manner.

SEC. 103. COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO ADDRESS LOCAL DRUG CRISES.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.) is amended by striking section 2997 and inserting the following:

''SEC. 2997. COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO ADDRESS LOCAL DRUG CRISES.

''(a) DEFINITIONS.—In this section—

''(1) the term 'Drug-Free Communities Act of 1997' means chapter 2 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1521 et seq.);

''(2) the term 'eligible entity' means an organization that—

''(A) on or before the date of submitting an application for a grant under this section, receives or has received a grant under the Drug-Free Communities Act of 1997; and

''(B) has documented, using local data, rates of abuse of opioids or methamphetamines at levels that are—

''(i) significantly higher than the national average as determined by the Secretary (including appropriate consideration of the results of the Monitoring the Future Survey published by the National Institute on Drug Abuse and the National Survey on Drug Use and Health published by the Substance Abuse and Mental Health Services Administration); or

''(ii) higher than the national average, as determined by the Secretary (including appropriate consideration of the results of the surveys described in clause (i)), over a sustained period of time;

''(3) the term 'local drug crisis' means, with respect to the area served by an eligible entity—

''(A) a sudden increase in the abuse of opioids or methamphetamines, as documented by local data; or

''(B) the abuse of prescription medications, specifically opioids or methamphetamines, that is significantly higher than the national average, over a sustained period of time, as documented by local data;

''(4) the term 'opioid' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability; and

''(5) the term 'Secretary' means the Secretary of Health and Human Services.

''(b) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Office of National Drug Control Policy, may make grants to eligible entities to implement comprehensive community-wide strategies that address local drug crises within the area served by the eligible entity.

''(c) APPLICATION.—

''(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(2) CRITERIA.—As part of an application for a grant under this section, the Secretary shall require an eligible entity to submit a detailed, comprehensive, multisector plan for addressing the local drug crisis within the area served by the eligible entity.

''(d) USE OF FUNDS.—An eligible entity shall use a grant received under this section—

''(1) for programs designed to implement comprehensive community-wide prevention strategies to address the local drug crisis in the area served by the eligible entity, in accordance with the plan submitted under subsection (c)(2); and

''(2) to obtain specialized training and technical assistance from the organization funded under section 4 of Public Law 107–82 (21 U.S.C. 1521 note).

''(e) SUPPLEMENT NOT SUPPLANT.—An eligible entity shall use Federal funds received under this section only to supplement the funds that would, in the absence of those Federal funds, be made available from other Federal and non-Federal sources for the activities described in this section, and not to supplant those funds.

''(f) EVALUATION.—A grant under this section shall be subject to the same evaluation requirements and procedures as the evaluation requirements and procedures imposed on the recipient of a grant under the Drug-Free Communities Act of 1997.

''(g) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 8 percent of the amounts made available to carry out this section for a fiscal year may be used by the Secretary to pay for administrative expenses.''.

TITLE II—LAW ENFORCEMENT AND TREATMENT

SEC. 201. TREATMENT ALTERNATIVE TO INCARCERATION PROGRAMS.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State, unit of local government, Indian tribe, or nonprofit organization.

(2) ELIGIBLE PARTICIPANT.—The term ''eligible participant'' means an individual who—

(A) comes into contact with the juvenile justice system or criminal justice system or is arrested or charged with an offense that is not—

(i) a crime of violence, as defined under applicable State law or section 3156 of title 18, United States Code; or

(ii) a serious drug offense, as defined under section 924(e)(2)(A) of title 18, United States Code;

(B) has been screened by a qualified mental health professional and determined to suffer from a substance use disorder, or co-occurring mental illness and substance use disorder, that there is a reasonable basis to believe is related to the commission of the offense; and

(C) has been, after consideration of any potential risk of violence to any person in the program or the public if the individual were selected to participate in the program, unanimously approved for participation in a program funded under this section by, as applicable depending on the stage of the criminal justice process—

(i) the relevant law enforcement agency;

(ii) the prosecuting attorney;

(iii) the defense attorney;

(iv) the pretrial, probation, or correctional officer;

(v) the judge; and

(vi) a representative from the relevant mental health or substance abuse agency.

(b) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services, in coordination with the Attorney General, may make grants to eligible entities to—

(1) develop, implement, or expand a treatment alternative to incarceration program for eligible participants, including—

(A) pre-booking, including pre-arrest, treatment alternative to incarceration programs, including—

(i) law enforcement training on substance use disorders and co-occurring mental illness and substance use disorders;

(ii) receiving centers as alternatives to incarceration of eligible participants;

(iii) specialized response units for calls related to substance use disorders and co-occurring mental illness and substance use disorders; and

(iv) other pre-arrest or pre-booking treatment alternative to incarceration models; and

(B) post-booking treatment alternative to incarceration programs, including—

(i) specialized clinical case management;

(ii) pretrial services related to substance use disorders and co-occurring mental illness and substance use disorders;

(iii) prosecutor and defender based programs;

(iv) specialized probation;

(v) programs utilizing the American Society of Addiction Medicine patient placement criteria;

(vi) treatment and rehabilitation programs and recovery support services; and

(vii) drug courts, DWI courts, and veterans treatment courts; and

(2) facilitate or enhance planning and collaboration between State criminal justice systems and State substance abuse systems in order to more efficiently and effectively carry out programs described in paragraph (1) that address problems related to the use of heroin and misuse of prescription drugs among eligible participants.

(c) APPLICATION.—

(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Secretary of Health and Human Services—

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

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

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

(A) provide extensive evidence of collaboration with State and local government agencies overseeing health, community corrections, courts, prosecution, substance abuse, mental health, victims services, and employment services, and with local law enforcement agencies;

(B) demonstrate consultation with the Single State Authority for Substance Abuse (as defined in section 201(e) of the Second Chance Act of 2007 (42 U.S.C. 17521(e)));

(C) demonstrate consultation with the Single State criminal justice planning agency;

(D) demonstrate that evidence-based treatment practices, including if applicable the use of medication assisted treatment, will be utilized; and

(E) demonstrate that evidenced-based screening and assessment tools will be utilized to place participants in the treatment alternative to incarceration program.

(d) REQUIREMENTS.—Each eligible entity awarded a grant for a treatment alternative to incarceration program under this section shall—

(1) determine the terms and conditions of participation in the program by eligible participants, taking into consideration the collateral consequences of an arrest, prosecution, or criminal conviction;

(2) ensure that each substance abuse and mental health treatment component is licensed and qualified by the relevant jurisdiction;

(3) for programs described in subsection (b)(2), organize an enforcement unit comprised of appropriately trained law enforcement professionals under the supervision of the State, tribal, or local criminal justice agency involved, the duties of which shall include—

(A) the verification of addresses and other contacts of each eligible participant who participates or desires to participate in the program; and

(B) if necessary, the location, apprehension, arrest, and return to court of an eligible participant in the program who has absconded from the facility of a treatment provider or has otherwise violated the terms and conditions of the program, consistent with Federal and State confidentiality requirements;

(4) notify the relevant criminal justice entity if any eligible participant in the program absconds from the facility of the treatment provider or otherwise violates the terms and conditions of the program, consistent with Federal and State confidentiality requirements;

(5) submit periodic reports on the progress of treatment or other measured outcomes from participation in the program of each eligible participant in the program to the relevant State, tribal, or local criminal justice agency;

(6) describe the evidence-based methodology and outcome measurements that will be used to evaluate the program, and specifically explain how such measurements will provide valid measures of the impact of the program; and

(7) describe how the program could be broadly replicated if demonstrated to be effective.

(e) USE OF FUNDS.—An eligible entity shall use a grant received under this section for expenses of a treatment alternative to incarceration program, including—

(1) salaries, personnel costs, equipment costs, and other costs directly related to the operation of the program, including the enforcement unit;

(2) payments for treatment providers that are approved by the relevant State or tribal

jurisdiction and licensed, if necessary, to provide needed treatment to eligible participants in the program, including medication assisted treatment, aftercare supervision, vocational training, education, and job placement;

(3) payments to public and nonprofit private entities that are approved by the State or tribal jurisdiction and licensed, if necessary, to provide alcohol and drug addiction treatment and mental health treatment to eligible participants in the program; and

(4) salaries, personnel costs, and other costs related to strategic planning among State and local government agencies.

(f) SUPPLEMENT NOT SUPPLANT.—An eligible entity shall use Federal funds received under this section only to supplement the funds that would, in the absence of those Federal funds, be made available from other Federal and non-Federal sources for the activities described in this section, and not to supplant those funds.

(g) GEOGRAPHIC DISTRIBUTION.—The Secretary of Health and Human Services shall ensure that, to the extent practicable, the geographical distribution of grants under this section is equitable and includes a grant to an eligible entity in—

(1) each State;

(2) rural, suburban, and urban areas; and

(3) tribal jurisdictions.

(h) PRIORITY CONSIDERATION WITH RESPECT TO STATES.—In awarding grants to States under this section, the Secretary of Health and Human Services shall give priority to—

(1) a State that submits a joint application from the substance abuse agencies and criminal justice agencies of the State that proposes to use grant funds to facilitate or enhance planning and collaboration between the agencies, including coordination to better address the needs of incarcerated populations; and

(2) a State that—

(A) provides civil liability protection for first responders, health professionals, and family members who have received appropriate training in the administration of naloxone in administering naloxone to counteract opioid overdoses; and

(B) submits to the Secretary a certification by the attorney general of the State that the attorney general has—

(i) reviewed any applicable civil liability protection law to determine the applicability of the law with respect to first responders, health care professionals, family members, and other individuals who—

(I) have received appropriate training in the administration of naloxone; and

(II) may administer naloxone to individuals reasonably believed to be suffering from opioid overdose; and

(ii) concluded that the law described in subparagraph (A) provides adequate civil liability protection applicable to such persons.

(i) REPORTS AND EVALUATIONS.—

(1) IN GENERAL.—Each fiscal year, each recipient of a grant under this section during that fiscal year shall submit to the Secretary of Health and Human Services a report on the outcomes of activities carried out using that grant in such form, containing such information, and on such dates as the Secretary of Health and Human Services shall specify.

(2) CONTENTS.—A report submitted under paragraph (1) shall—

(A) describe best practices for treatment alternatives; and

(B) identify training requirements for law enforcement officers who participate in treatment alternative to incarceration programs.

(j) FUNDING.—During the 5-year period beginning on the date of enactment of this Act, the Secretary of Health and Human Services may carry out this section using not more than $5,000,000 each fiscal year of amounts appropriated to the Substance Abuse and Mental Health Services Administration for Criminal Justice Activities. No additional funds are authorized to be appropriated to carry out this section.

SEC. 202. FIRST RESPONDER TRAINING FOR THE USE OF DRUGS AND DEVICES THAT RAPIDLY REVERSE THE EFFECTS OF OPIOIDS.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 103, is amended by adding at the end the following:

"SEC. 2998. FIRST RESPONDER TRAINING FOR THE USE OF DRUGS AND DEVICES THAT RAPIDLY REVERSE THE EFFECTS OF OPIOIDS.

''(a) DEFINITION.—In this section—

''(1) the terms 'drug' and 'device' have the meanings given those terms in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321);

''(2) the term 'eligible entity' means a State, a unit of local government, or an Indian tribal government;

''(3) the term 'first responder' includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of professional duties, responds to fire, medical, hazardous material, or other similar emergencies;

''(4) the term 'opioid' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability; and

''(5) the term 'Secretary' means the Secretary of Health and Human Services.

''(b) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Attorney General, may make grants to eligible entities to allow appropriately trained first responders to administer an opioid overdose reversal drug to an individual who has—

''(1) experienced a prescription opioid or heroin overdose; or

''(2) been determined to have likely experienced a prescription opioid or heroin overdose.

''(c) APPLICATION.—

''(1) IN GENERAL.—An eligible 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 eligible 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 that the program will coordinate; and

''(D) describe how 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.

''(d) USE OF FUNDS.—An eligible entity shall use a grant received under this section to—

''(1) make such opioid overdose reversal drugs or devices that are approved by the Food and Drug Administration, such as naloxone, available to be carried and administered by first responders;

''(2) train and provide resources for first responders on carrying an opioid overdose reversal drug or device approved by the Food and Drug Administration, such as naloxone, and administering the drug or device to an individual who has experienced, or has been determined to have likely experienced, a prescription opioid or heroin overdose; and

''(3) establish processes, protocols, and mechanisms for referral to appropriate treatment.

''(e) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall make a grant for the purpose of providing technical assistance and training on the use of an opioid overdose reversal drug, such as naloxone, to respond to an individual who has experienced, or has been determined to have likely experienced, a prescription opioid or heroin overdose, and mechanisms for referral to appropriate treatment for an eligible entity receiving a grant under this section.

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

''(1) the number of first responders equipped with naloxone, or another opioid overdose reversal drug, for the prevention of fatal opioid and heroin overdose;

''(2) the number of opioid and heroin overdoses reversed by first responders receiving training and supplies of naloxone, or another opioid overdose reversal drug, through a grant received under this section;

''(3) the number of calls for service related 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 research, training, and naloxone, or another opioid overdose reversal drug, supply needs of first responder agencies, including those agencies that are not receiving grants under this section.

''(g) RURAL AREAS WITH LIMITED ACCESS TO EMERGENCY MEDICAL SERVICES.—In making grants under this section, the Secretary shall ensure that not less than 25 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.''.

SEC. 203. PRESCRIPTION DRUG TAKE BACK EXPANSION.

(a) DEFINITION OF COVERED ENTITY.—In this section, the term ''covered entity'' means—

(1) a State, local, or tribal law enforcement agency;

(2) a manufacturer, distributor, or reverse distributor of prescription medications;

(3) a retail pharmacy;

(4) a registered narcotic treatment program;

(5) a hospital or clinic with an onsite pharmacy;

(6) an eligible long-term care facility; or

(7) any other entity authorized by the Drug Enforcement Administration to dispose of prescription medications.

(b) PROGRAM AUTHORIZED.—The Attorney General, in coordination with the Administrator of the Drug Enforcement Administration, the Secretary of Health and Human Services, and the Director of the Office of National Drug Control Policy, shall coordinate with covered entities in expanding or making available disposal sites for unwanted prescription medications.

SEC. 204. HEROIN AND METHAMPHETAMINE TASK FORCES.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 202, is amended by adding at the end the following:

''SEC. 2999. HEROIN AND METHAMPHETAMINE TASK FORCES.

''(a) DEFINITION OF OPIOID.—In this section, the term 'opioid' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

''(b) AUTHORITY.—The Attorney General may make grants to State law enforcement agencies for investigative purposes—

''(1) to locate or investigate illicit activities through statewide collaboration, including activities related to—

''(A) the distribution of heroin or fentanyl, or the unlawful distribution of prescription opioids; or

''(B) unlawful heroin, fentanyl, and prescription opioid traffickers; and

''(2) to locate or investigate illicit activities, including precursor diversion, laboratories, or methamphetamine traffickers.''.

TITLE III—TREATMENT AND RECOVERY

SEC. 301. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 204, is amended by adding at the end the following:

''SEC. 2999A. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

''(a) DEFINITIONS.—In this section—

''(1) the terms 'Indian tribe' and 'tribal organization' have the meaning given those terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603));

''(2) the term 'medication assisted treatment' means the use, for problems relating to heroin and other opioids, of medications approved by the Food and Drug Administration in combination with counseling and behavioral therapies;

''(3) the term 'opioid' means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability;

''(4) the term 'Secretary' means the Secretary of Health and Human Services; and

''(5) the term 'State substance abuse agency' means the agency of a State responsible for the State prevention, treatment, and recovery system, including management of the Substance Abuse Prevention and Treatment Block Grant under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

''(b) GRANTS.—

''(1) AUTHORITY TO MAKE GRANTS.—The Secretary, acting through the Director of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, and in coordination with the Attorney General and other departments or agencies, as appropriate, may award grants to State substance abuse agencies, units of local government, nonprofit organizations, and Indian tribes or tribal organizations that have a high rate, or have had a rapid increase, in the use of heroin or other opioids, in order to permit such entities to expand activities, including an expansion in the availability of medication assisted treatment and other clinically appropriate services, with respect to the treatment of addiction in the specific geographical areas of such entities where there is a high rate or rapid increase in the use of heroin or other opioids.

''(2) NATURE OF ACTIVITIES.—The grant funds awarded under paragraph (1) shall be used for activities that are based on reliable scientific evidence of efficacy in the treatment of problems related to heroin or other opioids.

''(c) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that grants awarded under subsection (b) are distributed equitably among the various regions of the United States and among rural, urban, and suburban areas that are affected by the use of heroin or other opioids.

''(d) ADDITIONAL ACTIVITIES.—In administering grants under subsection (b), the Secretary shall—

''(1) evaluate the activities supported by grants awarded under subsection (b);

''(2) disseminate information, as appropriate, derived from the evaluation as the Secretary considers appropriate;

''(3) provide States, Indian tribes and tribal organizations, and providers with technical assistance in connection with the provision of treatment of problems related to heroin and other opioids; and

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

SEC. 302. CRIMINAL JUSTICE MEDICATION ASSISTED TREATMENT AND INTERVENTIONS DEMONSTRATION.

(a) DEFINITIONS.—In this section—

(1) the term ''criminal justice agency'' means a State, local, or tribal—

(A) court;

(B) prison;

(C) jail; or

(D) other agency that performs the administration of criminal justice, including prosecution, pretrial services, and community supervision;

(2) the term ''eligible entity'' means a State, unit of local government, or Indian tribe; and

(3) the term ''Secretary'' means the Secretary of Health and Human Services.

(b) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Attorney General, may make grants to eligible entities to implement medication assisted treatment programs through criminal justice agencies.

(c) APPLICATION.—

(1) IN GENERAL.—An eligible 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 eligible entity, in submitting an application under paragraph (1), shall—

(A) certify that each medication assisted treatment program funded with a grant under this section has been developed in consultation with the Single State Authority for Substance Abuse (as defined in section 201(e) of the Second Chance Act of 2007 (42 U.S.C. 17521(e))); and

(B) describe how data will be collected and analyzed to determine the effectiveness of the program described in subparagraph (A).

(d) USE OF FUNDS.—An eligible entity shall use a grant received under this section for expenses of—

(1) a medication assisted treatment program, including the expenses of prescribing medications recognized by the Food and Drug Administration for opioid treatment in conjunction with psychological and behavioral therapy;

(2) training criminal justice agency personnel and treatment providers on medication assisted treatment;

(3) cross-training personnel providing behavioral health and health services, administration of medicines, and other administrative expenses, including required reports; and

(4) the provision of recovery coaches who are responsible for providing mentorship and transition plans to individuals reentering society following incarceration or alternatives to incarceration.

(e) PRIORITY CONSIDERATION WITH RESPECT TO STATES.—In awarding grants to States under this section, the Secretary shall give priority to a State that—

(1) provides civil liability protection for first responders, health professionals, and family members who have received appropriate training in the administration of naloxone in administering naloxone to counteract opioid overdoses; and

(2) submits to the Secretary a certification by the attorney general of the State that the attorney general has—

(A) reviewed any applicable civil liability protection law to determine the applicability of the law with respect to first responders, health care professionals, family members, and other individuals who—

(i) have received appropriate training in the administration of naloxone; and

(ii) may administer naloxone to individuals reasonably believed to be suffering from opioid overdose; and

(B) concluded that the law described in subparagraph (A) provides adequate civil liability protection applicable to such persons.

(f) TECHNICAL ASSISTANCE.—The Secretary, in coordination with the Director of the National Institute on Drug Abuse and the Attorney General, shall provide technical assistance and training for an eligible entity receiving a grant under this section.

(g) REPORTS.—

(1) IN GENERAL.—An eligible entity receiving a grant under this section shall submit a report to the Secretary on the outcomes of each grant received under this section for individuals receiving medication assisted treatment, based on—

(A) the recidivism of the individuals;

(B) the treatment outcomes of the individuals, including maintaining abstinence from illegal, unauthorized, and unprescribed or undispensed opioids and heroin;

(C) a comparison of the cost of providing medication assisted treatment to the cost of incarceration or other participation in the criminal justice system;

(D) the housing status of the individuals; and

(E) the employment status of the individuals.

(2) CONTENTS AND TIMING.—Each report described in paragraph (1) shall be submitted annually in such form, containing such information, and on such dates as the Secretary shall specify.

(h) FUNDING.—During the 5-year period beginning on the date of enactment of this Act, the Secretary may carry out this section using not more than $5,000,000 each fiscal year of amounts appropriated to the Substance Abuse and Mental Health Services Administration for Criminal Justice Activities. No additional funds are authorized to be appropriated to carry out this section.

SEC. 303. NATIONAL YOUTH RECOVERY INITIATIVE.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 301, is amended by adding at the end the following:

''SEC. 2999B. NATIONAL YOUTH RECOVERY INITIATIVE.

''(a) DEFINITIONS.—In this section:

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

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

''(B) an accredited high school that is seeking to establish or expand recovery support services;

''(C) an institution of higher education;

''(D) a recovery program at a nonprofit collegiate institution; or

''(E) a nonprofit organization.

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

''(3) RECOVERY PROGRAM.—The term 'recovery program'—

''(A) means a program to help individuals who are recovering from substance use disorders to initiate, stabilize, and maintain healthy and productive lives in the community; and

''(B) includes peer-to-peer support and communal activities to build recovery skills and supportive social networks.

''(b) GRANTS AUTHORIZED.—The Secretary of Health and Human Services, in coordination with the Secretary of Education, may award grants to eligible entities to enable the entities to—

''(1) provide substance use disorder recovery support services to young people in high school and enrolled in institutions of higher education;

''(2) help build communities of support for young people in recovery through a spectrum of activities such as counseling and health- and wellness-oriented social activities; and

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

''(c) USE OF FUNDS.—Grants awarded under subsection (b) may be used for activities to develop, support, and maintain youth recovery support services, including—

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

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

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

''(4) establishment of recovery high schools;

''(5) coordination of recovery programs with—

''(A) substance use disorder treatment programs and systems;

''(B) providers of mental health services;

''(C) primary care providers and physicians;

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

''(E) employers;

''(F) housing services;

''(G) child welfare services;

''(H) high schools and institutions of higher education; and

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

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

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

SEC. 304. BUILDING COMMUNITIES OF RECOVERY.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 303, is amended by adding at the end the following:

''SEC. 2999C. 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 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 of Health and Human Services may 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 50 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) advocate for individuals in recovery from substance use disorders;

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

''(i) substance use disorder treatment programs and systems;

''(ii) providers of mental health services;

''(iii) primary care providers and physicians;

''(iv) the criminal justice system;

''(v) employers;

''(vi) housing services;

''(vii) child welfare agencies; and

''(viii) other recovery support services that facilitate recovery from substance use disorders;

''(C) reduce the stigma associated with substance use disorders;

''(D) conduct public education and outreach on issues relating to substance use disorders and recovery, including—

''(i) how to identify the signs of addiction;

''(ii) the resources that are available to individuals struggling with addiction and families who have a family member struggling with or being treated for addiction, including programs that mentor and provide support services to children;

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

''(iv) information on the medical consequences of substance use disorders, including neonatal abstinence syndrome and potential infection with human immunodeficiency virus and viral hepatitis; and

''(E) carry out other activities that strengthen the network of community support for individuals in recovery.''.

TITLE IV—ADDRESSING COLLATERAL CONSEQUENCES

SEC. 401. CORRECTIONAL EDUCATION DEMONSTRATION GRANT PROGRAM.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 304, is amended by adding at the end the following:

''SEC. 2999D. CORRECTIONAL EDUCATION DEMONSTRATION GRANT PROGRAM.

''(a) DEFINITION.—In this section, the term 'eligible entity' means a State, unit of local government, nonprofit organization, or Indian tribe.

''(b) GRANT PROGRAM AUTHORIZED.—The Attorney General may make grants to eligible entities to design, implement, and expand educational programs for offenders in prisons, jails, and juvenile facilities, including to pay for—

''(1) basic education, secondary level academic education, high school equivalency examination preparation, career technical education, and English language learner instruction at the basic, secondary, or post-secondary levels, for adult and juvenile populations;

''(2) screening and assessment of inmates to assess education level and needs, occupational interest or aptitude, risk level, and other needs, and case management services;

''(3) hiring and training of instructors and aides, reimbursement of non-corrections staff and experts, reimbursement of stipends paid to inmate tutors or aides, and the costs of training inmate tutors and aides;

''(4) instructional supplies and equipment, including occupational program supplies and equipment to the extent that the supplies and equipment are used for instructional purposes;

''(5) partnerships and agreements with community colleges, universities, and career technology education program providers;

''(6) certification programs providing recognized high school equivalency certificates and industry recognized credentials; and

''(7) technology solutions to—

''(A) meet the instructional, assessment, and information needs of correctional populations; and

''(B) facilitate the continued participation of incarcerated students in community-based education programs after the students are released from incarceration.

''(c) APPLICATION.—An eligible entity seeking a grant under this section shall submit to the Attorney General an application in such form and manner, at such time, and accompanied by such information as the Attorney General specifies.

''(d) PRIORITY CONSIDERATIONS.—In awarding grants under this section, the Attorney General shall give priority to applicants that—

''(1) assess the level of risk and need of inmates, including by—

''(A) assessing the need for English language learner instruction;

''(B) conducting educational assessments; and

''(C) assessing occupational interests and aptitudes;

''(2) target educational services to assessed needs, including academic and occupational at the basic, secondary, or post-secondary level;

''(3) target career and technology education programs to—

''(A) areas of identified occupational demand; and

''(B) employment opportunities in the communities in which students are reasonably expected to reside post-release;

''(4) include a range of appropriate educational opportunities at the basic, secondary, and post-secondary levels;

''(5) include opportunities for students to attain industry recognized credentials;

''(6) include partnership or articulation agreements linking institutional education programs with community sited programs provided by adult education program providers and accredited institutions of higher education, community colleges, and vocational training institutions; and

''(7) explicitly include career pathways models offering opportunities for incarcerated students to develop academic skills, in-demand occupational skills and credentials, occupational experience in institutional work programs or work release programs, and linkages with employers in the community, so that incarcerated students have opportunities to embark on careers with strong prospects for both post-release employment and advancement in a career ladder over time.

''(e) REQUIREMENTS.—An eligible entity seeking a grant under this section shall—

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

''(2) describe how each program described in paragraph (1) could be broadly replicated if demonstrated to be effective.

''(f) CONTROL OF INTERNET ACCESS.—An entity that receives a grant under this section may restrict access to the Internet by prisoners, as appropriate and in accordance with Federal and State law, to ensure public safety.''.

SEC. 402. NATIONAL TASK FORCE ON RECOVERY AND COLLATERAL CONSEQUENCES.

(a) DEFINITION.—In this section, the term ''collateral consequence'' means a penalty, disability, or disadvantage imposed on an individual who is in recovery for a substance use disorder (including by an administrative agency, official, or civil court) as a result of a Federal or State conviction for a drug-related offense but not as part of the judgment of the court that imposes the conviction.

(b) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Attorney General shall establish a bipartisan task force to be known as the Task Force on Recovery and Collateral Consequences (in this section referred to as the ''Task Force'').

(2) MEMBERSHIP.—

(A) TOTAL NUMBER OF MEMBERS.—The Task Force shall include 10 members, who shall be appointed by the Attorney General in accordance with subparagraphs (B) and (C).

(B) MEMBERS OF THE TASK FORCE.—The Task Force shall include—

(i) members who have national recognition and significant expertise in areas such as health care, housing, employment, substance use disorders, mental health, law enforcement, and law;

(ii) not fewer than 2 members—

(I) who have personally experienced a substance abuse disorder or addiction and are in recovery; and

(II) not fewer than 1 of whom has benefitted from medication assisted treatment; and

(iii) to the extent practicable, members who formerly served as elected officials at the State and Federal levels.

(C) TIMING.—The Attorney General shall appoint the members of the Task Force not later than 60 days after the date on which the Task Force is established under paragraph (1).

(3) CHAIRPERSON.—The Task Force shall select a chairperson or co-chairpersons from among the members of the Task Force.

(c) DUTIES OF THE TASK FORCE.—

(1) IN GENERAL.—The Task Force shall—

(A) identify collateral consequences for individuals with Federal or State convictions for drug-related offenses who are in recovery for substance use disorder; and

(B) examine any policy basis for the imposition of collateral consequences identified under subparagraph (A) and the effect of the collateral consequences on individuals in recovery in resuming their personal and professional activities.

(2) RECOMMENDATIONS.—Not later than 180 days after the date of the first meeting of the Task Force, the Task Force shall develop recommendations, as it considers appropriate, for proposed legislative and regulatory changes related to the collateral consequences identified under paragraph (1).

(3) COLLECTION OF INFORMATION.—The Task Force shall hold hearings, require the testimony and attendance of witnesses, and secure information from any department or agency of the United States in performing the duties under paragraphs (1) and (2).

(4) REPORT.—

(A) SUBMISSION TO EXECUTIVE BRANCH.—Not later than 1 year after the date of the first meeting of the Task Force, the Task Force shall submit a report detailing the findings and recommendations of the Task Force to—

(i) the head of each relevant department or agency of the United States;

(ii) the President; and

(iii) the Vice President.

(B) SUBMISSION TO CONGRESS.—The individuals who receive the report under subparagraph (A) shall submit to Congress such legislative recommendations, if any, as those individuals consider appropriate based on the report.

TITLE V—ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

SEC. 501. IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN.

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

(1) in subsection (a), by inserting ''(referred to in this section as the 'Director')'' after ''Director of the Center for Substance Abuse Treatment''; and

(2) in subsection (p), in the first sentence—

(A) by striking ''Committee on Labor and Human Resources'' and inserting ''Committee on Health, Education, Labor, and Pensions''; and

(B) by inserting ''(other than subsection (r))'' after ''this section''.

(b) PILOT PROGRAM GRANTS FOR STATE SUBSTANCE ABUSE AGENCIES.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended—

(1) by striking subsection (r); and

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

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

''(1) IN GENERAL.—The Director shall carry out a pilot program under which the Director makes competitive grants to State substance abuse agencies to—

''(A) 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) 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) promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery that are evidence-based, including effective family-based programs for women involved with the criminal justice system.

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

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

''(C) shall 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) notwithstanding subsection (a)(1), shall not require that services furnished through such a grant be provided solely to women that reside in facilities; and

''(E) shall not require that grant recipients under the program make available all services described in subsection (d).

''(3) REQUIRED SERVICES.—

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

''(i) shall include the requirements described in subsection (c);

''(ii) may include any of the services described in subsection (d);

''(iii) may include other services, as appropriate; and

''(iv) shall be based on the recommendations submitted under subparagraph (B)

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

''(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

''(5) EVALUATION AND REPORT TO CONGRESS.—

''(A) IN GENERAL.—Out of amounts made available to the Center for Behavioral Health Statistics and Quality, the Director of the Center for Behavioral Health Statistics and Quality, in cooperation with the recipients of grants under this subsection, shall conduct an evaluation of the pilot program under this subsection, beginning 1 year after the date on which a grant is first awarded under this subsection. The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment, not later than 120 days after completion of such evaluation, shall submit to the relevant Committees of the Senate and the House of Representatives a report on such evaluation.

''(B) CONTENTS.—The report to Congress under subparagraph (A) shall include, at a minimum, outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs, engagement in treatment services, retention in the appropriate level and duration of services, increased access to the use of drugs approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling, and other appropriate measures.

''(6) DEFINITION OF STATE SUBSTANCE ABUSE AGENCY.—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 program under part B of title XIX.

''(s) FUNDING.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there are authorized to be appropriated $15,900,000 for each of fiscal years 2016 through 2020.

''(2) LIMITATION.—Of the amounts made available under paragraph (1) to carry out this section, not more than 25 percent may be used each fiscal year to carry out subsection (r).''.

SEC. 502. REPORT ON GRANTS FOR FAMILY-BASED SUBSTANCE ABUSE TREATMENT.

Section 2925 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797s–4) is amended—

(1) by striking ''An entity'' and inserting ''(a) ENTITY REPORTS.—An entity''; and

(2) by adding at the end the following:

''(b) ATTORNEY GENERAL REPORT ON FAMILY-BASED SUBSTANCE ABUSE TREATMENT.—The Attorney General shall submit to Congress an annual report that describes the number of grants awarded under section 2921(1) and how such grants are used by the recipients for family-based substance abuse treatment programs that serve as alternatives to incarceration for custodial parents to receive treatment and services as a family.''.

SEC. 503. VETERANS' TREATMENT COURTS.

Section 2991(j)(1)(B)(ii) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(j)(1)(B)(ii)), as amended by the Comprehensive Justice and Mental Health Act of 2015 (S. 993, 114th Congress), is amended—

(1) by inserting ''(I)'' after ''(ii)'';

(2) in subclause (I), as so designated, by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(II) was discharged or released from such service under dishonorable conditions, if the reason for that discharge or release, if known, is attributable to a substance use disorder.''.

TITLE VI—INCENTIVIZING STATE COMPREHENSIVE INITIATIVES TO ADDRESS PRESCRIPTION OPIOID AND HEROIN ABUSE

SEC. 601. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.

(a) DEFINITIONS.—In this section—

(1) the term ''dispenser'' has the meaning given the term in section 102 of the Controlled Substances Act (21 U.S.C. 802);

(2) the term ''prescriber'' means a dispenser who prescribes a controlled substance, or the agent of such a dispenser;

(3) the term ''prescriber of a schedule II, III, or IV controlled substance'' does not include a prescriber of a schedule II, III, or IV controlled substance that dispenses the substance—

(A) for use on the premises on which the substance is dispensed;

(B) in a hospital emergency room, when the substance is in short supply;

(C) for a certified opioid treatment program; or

(D) in other situations as the Attorney General may reasonably determine; and

(4) the term ''schedule II, III, or IV controlled substance'' means a controlled substance that is listed on schedule II, schedule III, or schedule IV of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)).

(b) PLANNING AND IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Attorney General, in coordination with the Secretary of Health and Human Services and in consultation with the Director of the Office of National Drug Control Policy, may award grants to States, and combinations thereof, to prepare a comprehensive plan for and implement an integrated opioid abuse response initiative.

(2) PURPOSES.—A State receiving a grant under this section shall establish a comprehensive response to opioid abuse, which shall include—

(A) prevention and education efforts around heroin and opioid use, treatment, and recovery, including education of residents, medical students, and physicians and other prescribers of schedule II, III, or IV controlled substances on relevant prescribing guidelines and the prescription drug monitoring program of the State;

(B) a comprehensive prescription drug monitoring program to track dispensing of schedule II, III, or IV controlled substances, which shall—

(i) provide for data sharing with other States by statute, regulation, or interstate agreement; and

(ii) allow for access to all individuals authorized by the State to write prescriptions for schedule II, III, or IV controlled substances on the prescription drug monitoring program of the State;

(C) developing, implementing, or expanding prescription drug and opioid addiction treatment programs by—

(i) expanding programs for medication assisted treatment of prescription drug and opioid addiction, including training for treatment and recovery support providers;

(ii) developing, implementing, or expanding programs for behavioral health therapy for individuals who are in treatment for prescription drug and opioid addiction;

(iii) developing, implementing, or expanding programs to screen individuals who are in treatment for prescription drug and opioid addiction for hepatitis C and HIV, and provide treatment for those individuals if clinically appropriate; or

(iv) developing, implementing, or expanding programs that provide screening, early intervention, and referral to treatment (commonly known as ''SBIRT'') to teenagers and young adults in primary care, middle schools, high schools, universities, school-based health centers, and other community-based health care settings frequently accessed by teenagers or young adults; and

(D) developing, implementing, and expanding programs to prevent overdose death from prescription medications and opioids.

(3) PLANNING GRANT APPLICATIONS.—

(A) APPLICATION.—

(i) IN GENERAL.—A State seeking a planning grant under this section to prepare a comprehensive plan for an integrated opioid abuse response initiative shall submit to the Attorney General an application in such form, and containing such information, as the Attorney General may require.

(ii) REQUIREMENTS.—An application for a planning grant under this section shall, at a minimum, include—

(I) a budget and a budget justification for the activities to be carried out using the grant;

(II) a description of the activities proposed to be carried out using the grant, including a schedule for completion of such activities;

(III) outcome measures that will be used to measure the effectiveness of the programs and initiatives to address opioids; and

(IV) a description of the personnel necessary to complete such activities.

(B) PERIOD; NONRENEWABILITY.—A planning grant under this section shall be for a period of 1 year. A State may not receive more than 1 planning grant under this section.

(C) STRATEGIC PLAN AND PROGRAM IMPLEMENTATION PLAN.—A State receiving a planning grant under this section shall develop a strategic plan and a program implementation plan.

(4) IMPLEMENTATION GRANTS.—

(A) APPLICATION.—A State seeking an implementation grant under this section to implement a comprehensive strategy for addressing opioid abuse shall submit to the Attorney General an application in such form, and containing such information, as the Attorney General may require.

(B) USE OF FUNDS.—A State that receives an implementation grant under this section shall use the grant for the cost of carrying out an integrated opioid abuse response program in accordance with this section, including for technical assistance, training, and administrative expenses.

(C) REQUIREMENTS.—An integrated opioid abuse response program carried out using an implementation grant under this section shall—

(i) require that each prescriber of a schedule II, III, or IV controlled substance in the State—

(I) registers with the prescription drug monitoring program of the State; and

(II) consults the prescription drug monitoring program database of the State before prescribing a schedule II, III, or IV controlled substance;

(ii) require that each dispenser of a schedule II, III, or IV controlled substance in the State—

(I) registers with the prescription drug monitoring program of the State;

(II) consults the prescription drug monitoring program database of the State before dispensing a schedule II, III, or IV controlled substance; and

(III) reports to the prescription drug monitoring program of the State, at a minimum, each instance in which a schedule II, III, or IV controlled substance is dispensed, with limited exceptions, as defined by the State, which shall indicate the prescriber by name and National Provider Identifier;

(iii) require that, not fewer than 4 times each year, the State agency or agencies that administer the prescription drug monitoring program of the State prepare and provide to each prescriber of a schedule II, III, or IV controlled substance an informational report that shows how the prescribing patterns of the prescriber compare to prescribing practices of the peers of the prescriber and expected norms;

(iv) if informational reports provided to a prescriber under clause (iii) indicate that the prescriber is repeatedly falling outside of expected norms or standard practices for the prescriber's field, direct the prescriber to educational resources on appropriate prescribing of controlled substances;

(v) ensure that the prescriber licensing board of the State receives a report describing any prescribers that repeatedly fall outside of expected norms or standard practices for the prescriber's field, as described in clause (iii);

(vi) require consultation with the Single State Authority for Substance Abuse (as defined in section 201(e) of the Second Chance Act of 2007 (42 U.S.C. 17521(e))); and

(vii) establish requirements for how data will be collected and analyzed to determine the effectiveness of the program.

(D) PERIOD.—An implementation grant under this section shall be for a period of 2 years.

(5) PRIORITY CONSIDERATIONS.—In awarding planning and implementation grants under this section, the Attorney General shall give priority to a State that—

(A)(i) provides civil liability protection for first responders, health professionals, and family members who have received appropriate training in the administration of naloxone in administering naloxone to counteract opioid overdoses; and

(ii) submits to the Attorney General a certification by the attorney general of the State that the attorney general has—

(I) reviewed any applicable civil liability protection law to determine the applicability of the law with respect to first responders, health care professionals, family members, and other individuals who—

(aa) have received appropriate training in the administration of naloxone; and

(bb) may administer naloxone to individuals reasonably believed to be suffering from opioid overdose; and

(II) concluded that the law described in subclause (I) provides adequate civil liability protection applicable to such persons;

(B) has in effect legislation or implements a policy under which the State shall not terminate, but may suspend, enrollment under the State plan for medical assistance under

title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for an individual who is incarcerated for a period of fewer than 2 years;

(C) has a process for enrollment in services and benefits necessary by criminal justice agencies to initiate or continue treatment in the community, under which an individual who is incarcerated may, while incarcerated, enroll in services and benefits that are necessary for the individual to continue treatment upon release from incarceration;

(D) ensures the capability of data sharing with other States, such as by making data available to a prescription monitoring hub;

(E) ensures that data recorded in the prescription drug monitoring program database of the State is available within 24 hours, to the extent possible; and

(F) ensures that the prescription drug monitoring program of the State notifies prescribers and dispensers of schedule II, III, or IV controlled substances when overuse or misuse of such controlled substances by patients is suspected.

(c) AUTHORIZATION OF FUNDING.—For each of fiscal years 2016 through 2020, the Attorney General may use, from any unobligated balances made available under the heading ''GENERAL ADMINISTRATION'' to the Department of Justice in an appropriation Act, such amounts as are necessary to carry out this section, not to exceed $5,000,000 per fiscal year.

TITLE VII—MISCELLANEOUS

SEC. 701. GAO REPORT ON IMD EXCLUSION.

(a) DEFINITION.—In this section, the term ''Medicaid Institutions for Mental Disease exclusion'' means the prohibition on Federal matching payments under Medicaid for patients who have attained age 22, but have not attained age 65, in an institution for mental diseases under subparagraph (B) of the matter following subsection (a) of section 1905 of the Social Security Act (42 U.S.C. 1396d) and subsection (i) of such section.

(b) REPORT REQUIRED.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the impact that the Medicaid Institutions for Mental Disease exclusion has on access to treatment for individuals with a substance use disorder.

(c) ELEMENTS.—The report required under subsection (b) shall include a review of what is known regarding—

(1) Medicaid beneficiary access to substance use disorder treatments in institutions for mental disease; and

(2) the quality of care provided to Medicaid beneficiaries treated in and outside of institutions for mental disease for substance use disorders.

SEC. 702. FUNDING.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.), as amended by section 401, is amended by adding at the end the following:

''SEC. 2999E. FUNDING.

''There are authorized to be appropriated to the Attorney General and the Secretary of Health and Human Services to carry out this part $62,000,000 for each of fiscal years 2016 through 2020.''.

SEC. 703. CONFORMING AMENDMENTS.

Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.) is amended—

(1) in the part heading, by striking ''**CONFRONTING USE OF METHAMPHETAMINE**'' and inserting ''**COMPREHENSIVE ADDICTION AND RECOVERY**''; and

(2) in section 2996(a)(1), by striking ''this part'' and inserting ''this section''.

SEC. 704. GRANT ACCOUNTABILITY.

(a) GRANTS UNDER PART II OF TITLE I OF THE OMNIBUS CRIME CONTROL AND SAFE STREETS ACT OF 1968.—Part II of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc et seq.); as amended by section 702, is amended by adding at the end the following:

''SEC. 2999F. GRANT ACCOUNTABILITY.

''(a) DEFINITIONS.—In this section—

''(1) the term 'applicable committees'—

''(A) with respect to the Attorney General and any other official of the Department of Justice, means—

''(i) the Committee on the Judiciary of the Senate; and

''(ii) the Committee on the Judiciary of the House of Representatives; and

''(B) with respect to the Secretary of Health and Human Services and any other official of the Department of Health and Human Services, means—

''(i) the Committee on Health, Education, Labor, and Pensions of the Senate; and

''(ii) the Committee on Energy and Commerce of the House of Representatives;

''(2) the term 'covered agency' means—

''(A) the Department of Justice; and

''(B) the Department of Health and Human Services; and

''(3) the term 'covered official' means—

''(A) the Attorney General; and

''(B) the Secretary of Health and Human Services.

''(b) ACCOUNTABILITY.—All grants awarded by a covered official under this part shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of a covered agency that the audited grantee has utilized grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months after the date on which the final audit report is issued.

''(B) AUDIT.—Beginning in the first fiscal year beginning after the date of enactment of this section, and in each fiscal year thereafter, the Inspector General of a covered agency shall conduct audits of recipients of grants awarded by the applicable covered official under this part to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) MANDATORY EXCLUSION.—A recipient of grant funds under this part that is found to have an unresolved audit finding shall not be eligible to receive grant funds under this part during the first 2 fiscal years beginning after the end of the 12-month period described in subparagraph (A).

''(D) PRIORITY.—In awarding grants under this part, a covered official shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this part.

''(E) REIMBURSEMENT.—If an entity is awarded grant funds under this part during the 2-fiscal-year period during which the entity is barred from receiving grants under subparagraph (C), the covered official that awarded the grant funds shall—

''(i) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

''(2) NONPROFIT ORGANIZATION REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant programs under this part, the term 'nonprofit organization' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

''(B) PROHIBITION.—A covered official may not award a grant under this part to a nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986.

''(C) DISCLOSURE.—Each nonprofit organization that is awarded a grant under this part and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the applicable covered official, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, a covered official shall make the information disclosed under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—No amounts made available to a covered official under this part may be used by the covered official, or by any individual or entity awarded discretionary funds through a cooperative agreement under this part, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the covered official, unless the covered official provides prior written authorization that the funds may be expended to host the conference.

''(B) WRITTEN AUTHORIZATION.—Written authorization under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—

''(i) DEPARTMENT OF JUSTICE.—The Deputy Attorney General shall submit to the applicable committees an annual report on all conference expenditures approved by the Attorney General under this paragraph.

''(ii) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Deputy Secretary of Health and Human Services shall submit to the applicable committees an annual report on all conference expenditures approved by the Secretary of Health and Human Services under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this section, each covered official shall submit to the applicable committees an annual certification—

''(A) indicating whether—

''(i) all audits issued by the Office of the Inspector General of the applicable agency under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director, or the appropriate official of the Department of Health and Human Services, as applicable;

''(ii) all mandatory exclusions required under paragraph (1)(C) have been issued; and

''(iii) all reimbursements required under paragraph (1)(E) have been made; and

''(B) that includes a list of any grant recipients excluded under paragraph (1) from the previous year.

''(c) PREVENTING DUPLICATIVE GRANTS.—

''(1) IN GENERAL.—Before a covered official awards a grant to an applicant under this part, the covered official shall compare potential grant awards with other grants

awarded under this part by the covered official to determine if duplicate grant awards are awarded for the same purpose.

''(2) REPORT.—If a covered official awards duplicate grants to the same applicant for the same purpose, the covered official shall submit to the applicable committees a report that includes—

''(A) a list of all duplicate grants awarded, including the total dollar amount of any duplicate grants awarded; and

''(B) the reason the covered official awarded the duplicate grants.''.

(b) OTHER GRANTS.—

(1) DEFINITIONS.—In this subsection—

(A) the term ''applicable committees''—

(i) with respect to the Attorney General and any other official of the Department of Justice, means—

(I) the Committee on the Judiciary of the Senate; and

(II) the Committee on the Judiciary of the House of Representatives; and

(ii) with respect to the Secretary of Health and Human Services and any other official of the Department of Health and Human Services, means—

(I) the Committee on Health, Education, Labor, and Pensions of the Senate; and

(II) the Committee on Energy and Commerce of the House of Representatives;

(B) the term ''covered agency'' means—

(i) the Department of Justice; and

(ii) the Department of Health and Human Services;

(C) the term ''covered grant'' means a grant under section 201, 302, or 601 of this Act or section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) (as amended by section 501 of this Act); and

(D) the term ''covered official'' means—

(i) the Attorney General; and

(ii) the Secretary of Health and Human Services.

(2) ACCOUNTABILITY.—All covered grants awarded by a covered official shall be subject to the following accountability provisions:

(A) AUDIT REQUIREMENT.—

(i) DEFINITION.—In this subparagraph, the term ''unresolved audit finding'' means a finding in the final audit report of the Inspector General of a covered agency that the audited grantee has utilized grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months after the date on which the final audit report is issued.

(ii) AUDIT.—Beginning in the first fiscal year beginning after the date of enactment of this Act, and in each fiscal year thereafter, the Inspector General of a covered agency shall conduct audits of recipients of covered grants awarded by the applicable covered official to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

(iii) MANDATORY EXCLUSION.—A recipient of covered grant funds that is found to have an unresolved audit finding shall not be eligible to receive covered grant funds during the first 2 fiscal years beginning after the end of the 12-month period described in clause (i).

(iv) PRIORITY.—In awarding covered grants, a covered official shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a covered grant.

(v) REIMBURSEMENT.—If an entity is awarded covered grant funds during the 2-fiscal-year period during which the entity is barred from receiving grants under clause (iii), the covered official that awarded the funds shall—

(I) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

(II) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

(B) NONPROFIT ORGANIZATION REQUIREMENTS.—

(i) DEFINITION.—For purposes of this subparagraph and the covered grant programs, the term ''nonprofit organization'' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

(ii) PROHIBITION.—A covered official may not award a covered grant to a nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986.

(iii) DISCLOSURE.—Each nonprofit organization that is awarded a covered grant and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the applicable covered official, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, a covered official shall make the information disclosed under this clause available for public inspection.

(C) CONFERENCE EXPENDITURES.—

(i) LIMITATION.—No amounts made available to a covered official under a covered grant program may be used by the covered official, or by any individual or entity awarded discretionary funds through a cooperative agreement under a covered grant program, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the covered official, unless the covered official provides prior written authorization that the funds may be expended to host the conference.

(ii) WRITTEN AUTHORIZATION.—Written authorization under clause (i) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

(iii) REPORT.—

(I) DEPARTMENT OF JUSTICE.—The Deputy Attorney General shall submit to the applicable committees an annual report on all conference expenditures approved by the Attorney General under this subparagraph.

(II) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Deputy Secretary of Health and Human Services shall submit to the applicable committees an annual report on all conference expenditures approved by the Secretary of Health and Human Services under this subparagraph.

(D) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this Act, each covered official shall submit to the applicable committees an annual certification—

(i) indicating whether—

(I) all audits issued by the Office of the Inspector General of the applicable agency under subparagraph (A) have been completed and reviewed by the appropriate Assistant Attorney General or Director, or the appropriate official of the Department of Health and Human Services, as applicable;

(II) all mandatory exclusions required under subparagraph (A)(iii) have been issued; and

(III) all reimbursements required under subparagraph (A)(v) have been made; and

(ii) that includes a list of any grant recipients excluded under subparagraph (A) from the previous year.

(3) PREVENTING DUPLICATIVE GRANTS.—

(A) IN GENERAL.—Before a covered official awards a covered grant to an applicant, the covered official shall compare potential grant awards with other covered grants awarded by the covered official to determine if duplicate grant awards are awarded for the same purpose.

(B) REPORT.—If a covered official awards duplicate grants to the same applicant for the same purpose, the covered official shall submit to the applicable committees a report that includes—

(i) a list of all duplicate grants awarded, including the total dollar amount of any duplicate grants awarded; and

(ii) the reason the covered official awarded the duplicate grants.

SA 3379. Ms. BALDWIN (for herself, Mr. MARKEY, and Mr. MENENDEZ) submitted an amendment intended to be proposed by her to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. FUNDING FOR OPIOID AND HEROIN ABUSE PREVENTION AND TREATMENT.

(a) SHORT TITLE.—This section may be cited as the ''Opioid and Heroin Abuse Crisis Investment Act''.

(b) FUNDING.—There are authorized to be appropriated, and are appropriated, out of monies in the Treasury not otherwise obligated, $1,164,600,000 for the period of fiscal years 2017 and 2018, to improve opioid prescribing practices to reduce opioid use disorders and overdose, to be made available in accordance with this section.

(c) STATE TARGETED RESPONSE COOPERATIVE AGREEMENTS.—Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 509 the following:

''SEC. 510. STATE TARGETED RESPONSE COOPERATIVE AGREEMENTS.

''(a) IN GENERAL.—The Secretary shall enter into additional targeted response cooperative agreements with States under this title to expand opioid treatment capacity and make services more affordable to those who cannot afford such services.

''(b) AWARDING OF FUNDING.—The Secretary shall allocate funding to States under this section based on—

''(1) the severity of the opioid epidemic in the State; and

''(2) the strength of the strategy of the State to respond to such epidemic.

''(c) USE OF FUNDS.—Amounts received by a State under this section shall be used to expand treatment capacity and make services more affordable to those who cannot afford such services and to help individuals seek treatment, successfully complete treatment, and sustain recovery.

''(d) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this section, $460,000,000 for each of fiscal years 2017 and 2018.''.

(d) TREATMENT FOR PRESCRIPTION DRUG ABUSE AND HEROIN USE.—Section 331(b) of the Public Health Service Act (42 U.S.C. 254d(b)) is amended by adding at the end the following:

''(3)(A) The Secretary shall use amounts made available under subparagraph (B) to

support enhanced loan repayment awards to increase the number of clinicians in the Corps with medication assisted treatment training to treat individuals with opioid use disorders through loan repayments to clinicians.

''(B) From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this paragraph, $25,000,000 for each of fiscal years 2017 and 2018.''.

(e) EVALUATION OF MEDICATION-ASSISTED TREATMENT.—Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 510, as added by subsection (c)) the following:

''SEC. 511. EVALUATION OF MEDICATION-ASSISTED TREATMENT.

''(a) IN GENERAL.—In order to assess the treatment outcomes of patients with opioid addiction receiving medication-assisted treatment, the Secretary shall evaluate the short, medium, and long-term outcomes of such substance abuse treatment programs in order to increase effectiveness in reducing opioid use disorders, overdose, and death.

''(b) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this section, $15,000,000 for each of fiscal years 2017 and 2018.''.

(f) MEDICATION-ASSISTED TREATMENT FOR PRESCRIPTION DRUG AND OPIOID ADDICTION.—Section 509 of the Public Health Service Act (42 U.S.C. 290bb-2) is amended—

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

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

''(f) MEDICATION-ASSISTED TREATMENT FOR PRESCRIPTION DRUG AND OPIOID ADDICTION.—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall use amounts made available under paragraph (3) to award grants to States to expand or enhance medication assisted treatment utilizing medications approved by the Food and Drug Administration in combination with psychosocial services, recovery support services, and coordination with HIV or hepatitis C direct services.

''(2) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $50,100,000 for fiscal year 2017.''.

(g) BUPRENORPHINE-PRESCRIBING AUTHORITY DEMONSTRATION.—

(1) IN GENERAL.—To increase the availability of medication-assisted treatment services for prescription drug and opioid addiction, the Secretary of Health and Human Services shall use amounts made available under paragraph (3) to establish a demonstration project to test the safety and effectiveness of allowing the prescribing of buprenorphine by non-physician advance practice providers in accordance with the providers' prescribing authority under applicable State law.

(2) TARGETING.—In carrying out the demonstration project under paragraph (1), the Secretary of Health and Human Services shall target populations and geographic areas that are most affected by both high-need and limited access to physicians authorized to prescribe buprenorphine.

(3) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $10,000,000 for fiscal year 2017.

(4) DEMONSTRATION PROJECT.—

(A) IN GENERAL.—Notwithstanding subparagraph (B)(i) of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(B)(i)), the Secretary of Health and Human Services may, using amounts made available in this Act to carry out title V of the Public Health Service Act, establish and carry out a demonstration project through fiscal year 2021 in which, for purposes of prescribing buprenorphine under such section 303(g)(2), the term ''practitioner'' shall be deemed to include non-physician providers authorized to prescribe buprenorphine by the jurisdiction in which the provider is licensed and who meet such criteria as determined appropriate by the Secretary, in consultation with the Attorney General, for participation in the project.

(B) LIMITATION.—In implementing the demonstration project under subparagraph (A), the Secretary of Health and Human Services and the Attorney General shall not be subject to the requirements of section 553 of title 5, United States Code.

(C) GRANTS.—The Secretary of Health and Human Services may enter into grants, contracts, or cooperative agreements with one or more research institutions, and public and nonprofit entities to assist in carrying out the demonstration project under subparagraph (A). Amounts available for fiscal year 2016 to the Attorney General for carrying out such section 303 of the Controlled Substances Act shall also be available to the Attorney General to facilitate and support the efficient operation of the demonstration project under this paragraph.

(D) TERMINATION OF AUTHORITY.—Any authority provided under this paragraph for a provider to prescribe buprenorphine shall end not later than the date on which such provider ceases to participate in the demonstration project under this paragraph.

(h) DISSEMINATION OF GUIDELINES FOR PREVENTING PRESCRIPTION DRUG OVERDOSE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

''(n) DISSEMINATION OF GUIDELINES FOR PREVENTING PRESCRIPTION DRUG OVERDOSE.—

''(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall disseminate guidelines to improve opioid prescribing practices to reduce opioid use disorders and overdose.

''(2) USE OF FUNDS.—In carrying out this subsection, the Director of the Centers for Disease Control and Prevention shall use amounts made available under paragraph (3) to—

''(A) pilot test, evaluate, and adapt comprehensive tools and dissemination strategies to convey opioid prescribing guidelines of the Centers for Disease Control and Prevention in succinct, usable formats accessible to health care providers;

''(B) develop, evaluate, and publicly disseminate clinical decision support tools derived from the opioid prescribing guidelines of the Centers for Disease Control and Prevention;

''(C) establish training modules in partnership with professional societies and health systems, including online modules available for continuing medical education credits and maintenance of certification; and

''(D) coordinate with Office of the National Coordinator for Health Information Technology to ensure that guidelines developed under this subsection are effectively disseminated and translated into clinical support tools for integration into clinical workflow.

''(3) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $10,000,000 for fiscal year 2017.''.

(i) RURAL OPIOID OVERDOSE REVERSAL GRANT PROGRAM.—Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended—

(1) by redesignating subsection (j) as subsection (k); and

(2) by inserting after subsection (i), the following:

''(j) RURAL OPIOID OVERDOSE REVERSAL GRANT PROGRAM.—

''(1) IN GENERAL.—The Director may award grants to eligible entities to implement activities for the prevention, intervention, and treatment of opioid misuse and overdose.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

''(A) shall be a rural public or rural nonprofit private entity; and

''(B) shall represent a network composed of participants—

''(i) that include 3 or more health care providers; and

''(ii) that may be nonprofit or for-profit entities.

''(3) USE OF FUNDS.—Amounts awarded under a grant under this subsection shall be used—

''(A) to provide opioid misuse education and prevention services;

''(B) to provide training to licensed health care professionals and first responders in the recognition of the signs of opioid overdose and learn the appropriate way to administer naloxone;

''(C) to provide appropriate transportation services to a hospital or clinic for continued care after administration;

''(D) to refer those individuals with a drug dependency to an appropriate substance use disorder treatment centers where care coordination is provided by a team of providers; and

''(E) to purchase naloxone and opioid overdose reversal devices.

''(4) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $10,000,000 for fiscal year 2017.''.

(j) PRESCRIPTION DRUG OVERDOSE INITIATIVE.—Section 3001(c) of the Public Health Service Act (42 U.S.C. 300jj-11(c)) is amended by adding at the end the following:

''(9) PRESCRIPTION DRUG OVERDOSE INITIATIVE.—

''(A) IN GENERAL.—The Secretary, acting through the National Coordinator, shall use amounts made available under subparagraph (B) to expand efforts to harmonize technical standards to support prescription drug monitoring programs and health information technology interoperability.

''(B) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $5,000,000 for fiscal year 2017.''.

(k) BUREAU OF PRISONS TREATMENT PROGRAMS.—Section 4042 of title 18, United States Code, is amended by adding at the end the following:

''(e) TREATMENT PROGRAMS.—

''(1) IN GENERAL.—The Director of the Bureau of Prisons shall use amounts made available under paragraph (2) to support drug treatment programs within the Bureau of Prisons, including expanding the medication-assisted treatment pilot.

''(2) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $3,000,000 for fiscal year 2017.''.

(l) SECOND CHANCE ACT OF 2007.—Section 201 of the Second Chance Act of 2007 (42 U.S.C. 17521) is amended—

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

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

''(f) COMMUNITY REINTEGRATION.—

''(1) IN GENERAL.—The Attorney General shall use amounts made available under paragraph (2) to carry out activities to reduce recidivism and increase public safety by helping justice-involved individuals successfully reintegrate into the community, including by carrying out activities including providing treatment for co-occurring disorders and providing family-based substance abuse treatment.

''(2) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $50,000,000 for fiscal year 2017.''.

(m) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Section 503 of the Controlled Substances Act (21 U.S.C. 873) is amended by adding at the end the following:

''(e)(1) In carrying out this section, the Attorney General may use amounts made available under paragraph (2) to provide support for State, local, and tribal governments in the development of residential and aftercare services for substance-involved inmates.

''(2) From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this subsection, $14,000,000 for fiscal year 2017.''.

(n) HEROIN ENFORCEMENT GROUPS.—Part E of the Controlled Substances Act (21 U.S.C. 871 et seq.) is amended by adding at the end the following:

''SEC. 521. HEROIN ENFORCEMENT GROUPS.

''(a) IN GENERAL.—The Attorney General shall use amounts made available under subsection (b) to establish new heroin enforcement groups with the Drug Enforcement Administration to target, disrupt, and dismantle heroin trafficking organizations.

''(b) FUNDING.—From amounts appropriated under subsection (b) of the Opioid and Heroin Abuse Crisis Investment Act, there shall be made available to carry out this section, $12,500,000 for fiscal year 2017.''.

(o) EMERGENCY DESIGNATIONS.—

(1) IN GENERAL.—This section is designated as an emergency requirement pursuant to section 4(g) of the Statutory Pay-As-You-Go Act of 2010 (2 U.S.C. 933(g)).

(2) DESIGNATION IN SENATE.—In the Senate, this section is designated as an emergency requirement pursuant to section 403(a) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SA 3380. Mr. TESTER submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. GRANTS FOR DEVELOPING ALTERNATIVES TO OPIOID DRUGS.

Section 409J of the Public Health Service Act (42 U.S.C. 284q) is amended by adding at the end the following:

''(c) GRANTS FOR DEVELOPING ALTERNATIVES TO OPIOID DRUGS.—The Director of NIH may award grants in collaboration with the Pain Consortium for increasing research and development opportunities to accelerate the development of drugs that are alternatives to opioids for effective pain treatments.''.

SA 3381. Mr. MARKEY (for himself and Mr. PAUL) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE VIII—TREAT ACT

SEC. 801. SHORT TITLE.

This title may be cited as the ''Recovery Enhancement for Addiction Treatment Act'' or the ''TREAT Act''.

SEC. 802. FINDINGS.

Congress finds the following:

(1) Overdoses from opioids have increased dramatically in the United States.

(2) Deaths from drug overdose, largely from prescription pain relievers, have tripled among men and increased five-fold among women over the past decade.

(3) Nationwide, drug overdoses now claim more lives than car accidents.

(4) Opioid addiction is a chronic disease that, untreated, places a large burden on the healthcare system. Roughly 475,000 emergency room visits each year are attributable to the misuse and abuse of opioid pain medication.

(5) Effective medication-assisted treatment for opioid addiction, in combination with counseling and behavioral therapies, can decrease overdose deaths, be cost-effective, reduce transmissions of HIV and viral hepatitis, and reduce other social harms such as criminal activity.

(6) Effective medication-assisted treatment programs for opioid addiction should include multiple components, including medications, cognitive and behavioral supports and interventions, and drug testing.

(7) Effective medication-assisted treatment programs for opioid addiction may use a team of staff members, in addition to a prescribing provider, to deliver comprehensive care.

(8) Access to medication-assisted treatments, including office-based buprenorphine opioid treatment, remains limited in part due to current practice regulations and an insufficient number of providers.

(9) More than 10 years of experience in the United States with office-based buprenorphine opioid treatment has informed best practices for delivering successful, high quality care.

SEC. 803. EXPANSION OF PATIENT LIMITS UNDER WAIVER.

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

(1) in clause (i), by striking ''physician'' and inserting ''practitioner'';

(2) in clause (iii)—

(A) by striking ''30'' and inserting ''100''; and

(B) by striking '', unless, not sooner'' and all that follows through the end and inserting a period; and

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

''(iv) Not earlier than 1 year after the date on which a qualifying practitioner obtained an initial waiver pursuant to clause (iii), the qualifying practitioner may submit a second notification to the Secretary of the need and intent of the qualifying practitioner to treat an unlimited number of patients, if the qualifying practitioner—

''(I)(aa) satisfies the requirements of item (aa), (bb), (cc), or (dd) of subparagraph (G)(ii)(I); and

''(bb) agrees to fully participate in the Prescription Drug Monitoring Program of the State in which the qualifying practitioner is licensed, pursuant to applicable State guidelines; or

''(II)(aa) satisfies the requirements of item (ee), (ff), or (gg) of subparagraph (G)(ii)(I);

''(bb) agrees to fully participate in the Prescription Drug Monitoring Program of the State in which the qualifying practitioner is licensed, pursuant to applicable State guidelines;

''(cc) practices in a qualified practice setting; and

''(dd) has completed not less than 24 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) with respect to the treatment and management of opiate-dependent patients 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.''.

SEC. 804. DEFINITIONS.

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

(1) by striking clause (ii) and inserting the following:

''(ii) The term 'qualifying practitioner' means the following:

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

''(aa) The physician holds a board certification in addiction psychiatry from the American Board of Medical Specialties.

''(bb) The physician holds an addiction certification from the American Society of Addiction Medicine.

''(cc) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

''(dd) The physician holds a board certification from the American Board of Addiction Medicine.

''(ee) The physician has completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) with respect to the treatment and management of opiate-dependent patients 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.

''(ff) The physician has participated as an investigator in 1 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 this sponsor of such approved drug.

''(gg) The physician has such other training or experience as the Secretary determines will demonstrate the ability of the physician to treat and manage opiate-dependent patients.

''(II) A nurse practitioner or physician assistant who is licensed under State law and meets all of the following conditions:

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

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

''(AA) Has completed not fewer than 24 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) with respect to the treatment and

management of opiate-dependent patients 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.

''(BB) Has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

''(cc) The nurse practitioner or physician assistant practices under the supervision of a licensed physician who holds an active waiver to prescribe schedule III, IV, or V narcotic medications for opioid addiction therapy, and—

''(AA) the supervising physician satisfies the conditions of item (aa), (bb), (cc), or (dd) of subclause (I); or

''(BB) both the supervising physician and the nurse practitioner or physician assistant practice in a qualified practice setting.

''(III) A nurse practitioner who is licensed under State law and meets all of the following conditions:

''(aa) The nurse practitioner is licensed under State law to prescribe schedule III, IV, or V medications for pain.

''(bb) The nurse practitioner has training or experience that the Secretary determines demonstrates specialization in the ability to treat opiate-dependent patients, such as a certification in addiction specialty accredited by the American Board of Nursing Specialties or the National Commission for Certifying Agencies, or a certification in addiction nursing as a Certified Addiction Registered Nurse—Advanced Practice.

''(cc) In accordance with State law, the nurse practitioner prescribes opioid addiction therapy in collaboration with a physician who holds an active waiver to prescribe schedule III, IV, or V narcotic medications for opioid addiction therapy.

''(dd) The nurse practitioner practices in a qualified practice setting.''; and

(2) by adding at the end the following:

''(iii) The term 'qualified practice setting' means 1 or more of the following treatment settings:

''(I) A National Committee for Quality Assurance-recognized Patient-Centered Medical Home or Patient-Centered Specialty Practice.

''(II) A Centers for Medicaid & Medicare Services-recognized Accountable Care Organization.

''(III) A clinical facility administered by the Department of Veterans Affairs, Department of Defense, or Indian Health Service.

''(IV) A Behavioral Health Home accredited by the Joint Commission.

''(V) A Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))) or a Federally-qualified health center look-alike.

''(VI) A Substance Abuse and Mental Health Services-certified Opioid Treatment Program.

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

''(VIII) A clinic that demonstrates compliance with the Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office issued by the Federation of State Medical Boards.

''(IX) A treatment setting that is part of an Accreditation Council for Graduate Medical Education, American Association of Colleges of Osteopathic Medicine, or American Osteopathic Association-accredited residency or fellowship training program.

''(X) Any other practice setting approved by a State regulatory board or State Medicaid Plan to provide addiction treatment services.

''(XI) Any other practice setting approved by the Secretary.''.

SEC. 805. GAO EVALUATION.

Two years after the date on which the first notification under clause (iv) of section 303(g)(2)(B) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(B)), as added by this title, is received by the Secretary of Health and Human Services, the Comptroller General of the United States shall initiate an evaluation of the effectiveness of the amendments made by this title, 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;

(3) the integration of medication-assisted treatment with routine healthcare services;

(4) diversion of opioid addiction treatment medication;

(5) changes in State or local policies and legislation relating to opioid addiction treatment;

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

(7) the use of Prescription Drug Monitoring Programs by waived practitioners to maximize safety of patient care and prevent diversion of opioid addiction medication;

(8) the findings of Drug Enforcement Administration inspections of waived practitioners, including the frequency with which the Drug Enforcement Administration finds no documentation of access to behavioral health services; and

(9) the effectiveness of cross-agency collaboration between Department of Health and Human Services and the Drug Enforcement Administration for expanding effective opioid addiction treatment.

SA 3382. Mr. MARKEY (for himself and Mr. BLUMENTHAL) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. CONTINUING EDUCATION REQUIREMENTS FOR CERTAIN PRACTITIONERS PRESCRIBING CONTROLLED SUBSTANCES.

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

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

(2) by adding at the end the following:

''(j)(1) In this subsection, the term 'covered practitioner' means a practitioner that is not a hospital, pharmacy, or veterinarian.

''(2)(A) Except as provided in subparagraph (B), as a condition of granting or renewing the registration of a covered practitioner under this part to dispense, or conduct research with, controlled substances in schedule II, III, IV, or V, the Attorney General shall require, before each such grant or renewal of registration, that the covered practitioner complete training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that the Secretary of Health and Human Services determines meets the requirements under paragraph (3).

''(B) Subparagraph (A) shall not apply to the granting or renewal of a registration described in subparagraph (A) if the registration is solely for dispensing non-narcotic controlled substances or substances on schedule IV or V.

''(3) The training provided for purposes of paragraph (2) shall, at a minimum, expose covered practitioners to—

''(A) best practices for pain management, including alternatives to prescribing controlled substances and other alternative therapies to decrease the use of opioids;

''(B) responsible prescribing of pain medications, as described in Federal prescriber guidelines for nonmalignant pain;

''(C) methods for diagnosing, treating, and managing a substance use disorder, including the use of medications approved by the Food and Drug Administration and evidence-based nonpharmacological therapies;

''(D) linking patients to evidence-based treatment for substance use disorders; and

''(E) tools to manage adherence and diversion of controlled substances, including prescription drug monitoring programs, drug screening, informed consent, overdose education, and the use of opioid overdose antagonists.

''(4) The Substance Abuse and Mental Health Services Administration shall establish or support the establishment of not less than 1 training module that meets the requirements under paragraph (3) that is provided—

''(A) to any covered practitioner registered or applying for a registration under this part to dispense, or conduct research with, controlled substances in schedule II, III, IV, or V;

''(B) online; and

''(C) free of charge.

''(5) The Secretary of Health and Human Services shall establish, maintain, and periodically update a publically available database providing information relating to training modules that meet the requirements under paragraph (3).

''(6) Not later than 5 years after the date of enactment of this subsection, the Secretary of Health and Human Services shall evaluate and make publically available a report describing how exposure to the training required under this subsection has changed prescribing patterns of controlled substances.''.

SA 3383. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end of title VII, add the following:

SEC. ___. SUSPENSION OF MEDICAID BENEFITS FOR INMATES OF PUBLIC INSTITUTIONS.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide that the State shall not terminate (but may suspend) enrollment under a State plan for medical assistance for an individual who is an inmate of a public institution and was enrolled for medical assistance under the State plan immediately before becoming an inmate of such a public institution or who becomes eligible to enroll for such medical assistance while an inmate of a public institution;''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to the eligibility and enrollment of individuals who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act.

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

SA 3384. Mr. MARKEY submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. 705. ADVISORY COMMITTEE FOR APPROVAL OF NEW OPIOID DRUGS.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by adding at the end the following:

''(y) ADVISORY COMMITTEE REGARDING OPIOID DRUGS.—Notwithstanding any other provision of this Act, the Secretary shall convene a panel of experts, which shall expressly consider the issues of addiction, abuse, and dependence—

''(1) to review an application submitted under subsection (b) or (j) for a new drug that is an opioid before the Secretary may approve such application; and

''(2) to review a supplement to an application approved under this section for a drug that is an opioid before the Secretary may approve such supplement.''.

SA 3385. Mr. DAINES (for himself and Mr. PETERS) submitted an amendment intended to be proposed by him to the bill S. 524, to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use; which was ordered to lie on the table; as follows:

On page 65, strike line 23 and insert the following:

disorder, service-connected post-traumatic stress disorder, military sexual trauma, or a service-connected traumatic brain injury, as determined on a case-by-case basis.''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. THUNE. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on March 1, 2016, at 10 a.m., in room 328A of the Russell Senate Office Building, to conduct a hearing entitled ''Business Meeting: To consider the Chairman's Mark on Biotechnology Labeling Solutions.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. THUNE. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on March 1, 2016, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. THUNE. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on March 1, 2016, at 10:30 a.m., in room SD–215 of the Dirksen Senate Office Building, to conduct a hearing entitled ''The Multiemployer Pension Plan System: Recent Reforms and Current Challenges.''

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. THUNE. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on March 1, 2016, at 2:30 p.m., in room SH–219 of the Hart Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTE ON AIRLAND

Mr. THUNE. Mr. President, I ask unanimous consent that the Subcommittee on Airland of the Committee on Armed Services be authorized to meet during the session of the Senate on March 1, 2016, at 3 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON STATE DEPARTMENT AND USAID MANAGEMENT, INTERNATIONAL OPERATIONS, AND BILATERAL INTERNATIONAL DEVELOPMENT

Mr. THUNE. Mr. President, I ask unanimous consent that the Subcommittee on State Department and USAID Management, International Operations, and Bilateral International Development be authorized to meet during the session of the Senate on March 1, 2016, at 2:30 p.m., to conduct a hearing entitled ''A Review of the FY 2017 State and USAID Budget Request.''

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS CONSENT AGREEMENT—S. 524

Mr. MCCONNELL. Mr. President, I ask unanimous consent that following leader remarks on Wednesday, March 2, the motion to proceed to Calendar No. 369, S. 524, be agreed to, that the committee-reported substitute amendment be withdrawn, that Senator GRASSLEY or his designee be recognized to offer a substitute amendment, No. 3378, and that the first three first-degree amendments in order be the following: 3362, which is a Feinstein-Grassley amendment; 3345, Shaheen; 3367, Toomey; and that Senator GRASSLEY or his designee be permitted to offer a side-by-side amendment to the Shaheen amendment and that Senator LEAHY or his designee be permitted to offer a side-by-side amendment to the Toomey amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

RARE DISEASE DAY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged and the Senate proceed to the immediate consideration of S. Res. 380.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 380) designating February 29, 2016 as ''Rare Disease Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. MCCONNELL. Mr. President, I know of no further debate on the resolution.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to the resolution.

The resolution (S. Res. 380) was agreed to.

Mr. MCCONNELL. Mr. President, I finally ask unanimous consent that the preamble be agreed to and the motions to reconsider be considered made and laid upon the table with no intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The preamble was agreed to.

(The resolution, with its preamble, is printed in the RECORD of February 29, 2016, under ''Submitted Resolutions.'')

CONGRATULATING THE COMMUNITY COLLEGES OF IOWA

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of S. Res. 382, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 382) congratulating the community colleges of Iowa for 50 years of outstanding service to the State of Iowa, the United States, and the world.

There being no objection, the Senate proceeded to consider the resolution.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be considered made and laid upon