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Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act

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SUMMARY

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Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act

On October 24, 2018, President Donald J. Trump signed into law H.R. 6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271; the SUPPORT for Patients and Communities Act, or the SUPPORT Act).

The SUPPORT Act is a sweeping measure designed to address widespread overprescribing and abuse of opioids in the United States. The act includes provisions involving law enforcement, public health, and health care financing and coverage. Broadly, the legislation imposes tighter oversight of opioid production and distribution; imposes additional reporting and safeguards to address fraud; and limits coverage of prescription opioids, while expanding coverage of and access to opioid addiction treatment services. The law also authorizes a number of programs that seek to expand consumer education on opioid use and train additional providers to treat individuals with opioid use disorders.

The SUPPORT Act builds on recent efforts by the federal government to address the opioid epidemic, including the Comprehensive Addiction and Recovery Act of 2016 (CARA; P.L. 114-198) and the 21st Century Cures Act (Cures Act; P.L. 114-255). CARA addressed substance use issues broadly, targeting the opioid crisis predominantly through public health and law enforcement strategies. The Cures Act, enacted that same year, largely focused on medical innovation, but it also authorized additional funding to combat opioid addiction and included provisions addressing various mental health and substance use activities.

CRS is publishing a series of reports on the SUPPORT Act, which consists of eight titles. This report summarizes the provisions in Title VII and VIII of the SUPPORT Act. Title VII, Public Health Provisions, includes a number of provisions that seek to improve the information collected about opioid abuse and increase access to treatment by supporting treatment programs and providers, among other things. Title VIII, Miscellaneous, includes, among others, provisions related to child welfare, the Department of Justice (DOJ), and drug testing required by the Department of Transportation (DOT). It also includes several revenue-related provisions and the budget effects of this act and also describes Section 4003, an offset included in Title IV related to individuals who seek a religious exemption from the requirement to maintain health insurance coverage.

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Introduction

On October 24, 2018, President Donald J. Trump signed into law H.R. 6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271; SUPPORT for Patients and Communities Act, or the SUPPORT Act). The final agreement on the bill was approved by the House 393-8 on September 28, 2018, and cleared by the Senate by a vote of 98-1 on October 3, 2018.[1]

Over the past several years, there has been growing concern among the public and lawmakers in the United States about rising drug overdose deaths. Opioid overdose deaths, in particular, have increased significantly in the past 15 years. In 2015, an estimated 33,091 Americans died of opioid-related overdoses.[2] Provisional data for 2017 estimate 49,068 deaths involving opioids, representing a fourfold increase over 2002 during the beginning of the epidemic.[3] In October of 2017, President Trump declared the opioid epidemic a national public health emergency.[4]

The SUPPORT Act is a sweeping measure designed to address widespread overprescribing and abuse of opioids in the United States. The act includes provisions involving law enforcement, public health, and health care financing and insurance coverage. Broadly, the legislation imposes tighter oversight of opioid production and distribution; imposes additional reporting and safeguards to address fraud; and limits coverage of prescription opioids, while expanding coverage of and access to opioid addiction treatment services. The bill also authorizes a number of programs that seek to expand consumer education on opioid use and train additional providers to treat individuals with opioid use disorders.

Budgetary Impact

The SUPPORT Act includes a number of legislative changes that affect direct spending and revenues. The purpose of this report is not to summarize the budgetary effect of every provision in Title VII and VIII of the SUPPORT Act. As such, this report does not discuss the budgetary impact of individual provisions in the law, with the exception of Section 4003 (see "Section 4003: Additional Religious Exemption from Health Coverage Responsibility Requirement"). Overall, the Congressional Budget Office (CBO) estimated that the SUPPORT Act would increase the on-budget deficit by $1,001 million over five years (FY2019-FY2023), but would reduce the on-budget deficit by $52 million over 10 years (FY2019-FY2028).[5] Generally, pay-as-you-go

[1] A different version of H.R. 6 passed the House on June 22, 2018, by a vote of 396-14, and an amended version of the bill was passed by the Senate on September 17, 2018, by a vote of 99-1. On September 28, 2018, the House passed a final agreement on H.R. 6 by a vote of 393-8, and on October 3, the Senate passed the final version of H.R. 6 by a vote of 98-1. See Energy and Commerce Committee, "Opioid Legislation," October 24, 2018, https://energycommerce.house.gov/opioids-legislation/.

[2] U.S. Department of Health and Human Services (HHS), National Institutes of Health (NIH), National Institute on Drug Abuse (NIDA), *Overdose Death Rates*, updated September 2017, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

[3] HHS, CDC, National Center for Health Statistics, *Provisional Drug Overdose Death Counts*, NVSS Vital Statistics Rapid Release, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Last updated November 14, 2018; and HHS, NIH, NIDA, *Overdose Death Rates*, Updated August 2018, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

[4] White House, "President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis," October 26, 2017, https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-action-drug-addiction-opioid-crisis/.

[5] CBO, Estimated Direct Spending and Revenue Effects of H.R. 6, Substance Use–Disorder Prevention that Promotes

(PAYGO) scorecards record the effects resulting from legislative changes affecting direct spending and revenues; however, Section 8231 of the SUPPORT ACT excludes such budgetary effects from PAYGO scorecards, thus precluding any possible sequestration as a result of the enactment of the legislation.[6]

Related Prior Laws

The SUPPORT Act builds on recent efforts by the federal government to address the opioid epidemic, including the Comprehensive Addiction and Recovery Act of 2016 (CARA; P.L. 114-198) and the 21st Century Cures Act (Cures Act; P.L. 114-255). CARA addressed substance use issues broadly, targeting the opioid crisis predominantly through public health and law enforcement strategies.[7] The Cures Act, enacted that same year as CARA, largely focused on medical innovation, amending the Food and Drug Administration (FDA) pathways for medical product development and review and authorizing new funding for biomedical research. The Cures Act also authorized additional funding to combat opioid addiction and included provisions addressing various mental health and substance use activities in the Cures Act Title B, the Helping Families in Mental Health Crisis Reform Act. Title B in the Cures Act made a number of changes to authorities and programs of the Substance Abuse and Mental Health Services Administration (SAMHSA), the primary agency within the Department of Health and Human Services (HHS) tasked with increasing access to community-based services to prevent and treat mental disorders and substance use disorders (SUDs).[8]

SUPPORT ACT Organization

The SUPPORT Act consists of eight titles:

- Title I – Medicaid Provisions to Address the Opioid Crisis
- Title II – Medicare Provisions to Address the Opioid Crisis
- Title III – FDA and Controlled Substance Provisions
- Title IV – Offsets
- Title V – Other Medicaid Provisions
- Title VI – Other Medicare Provisions
- Title VII – Public Health Provisions
- Title VIII – Miscellaneous

CRS has published a series of reports on this law, organized by title. This report summarizes the provisions in Title VII and Title VIII of the SUPPORT Act. Title VII, Public Health Provisions, includes provisions that seek to improve the information collected about opioid abuse and increase access to treatment by supporting treatment programs and providers, among other things. Title VIII, Miscellaneous, includes provisions related to child welfare, the Department of Justice

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Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, September 27, 2018, https://www.cbo.gov/system/files?file=2018-09/H.R. 6 ConferenceSept27.pdf.

[6] For more information on the PAYGO scorecards, see CRS Report R41157, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, and CRS Report RL31943, *Budget Enforcement Procedures: The Senate Pay-As-You-Go (PAYGO) Rule*.

[7] For more information, see CRS Report R44493, *The Comprehensive Addiction and Recovery Act of 2016 (S. 524): Comparison of Senate- and House-Passed Versions*.

[8] For more information, see CRS Report R44720, *The 21st Century Cures Act (Division A of P.L. 114-255)* and CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

(DOJ), and drug testing required by the Department of Transportation (DOT), among others. This report summarizes the budget effects of this act and also describes Section 4003, an offset included in Title IV related to individuals who seek a religious exemption from the requirement to maintain health insurance coverage.

The report describes each section in Title VII and Title VIII in order. Relevant background is provided for context. The report concludes with an appendix that catalogues deadlines, effective dates, and reporting requirements included in Title VII and VIII provisions. This report is intended to reflect the SUPPORT Act at enactment (i.e., October 24, 2018). It does not track the law's implementation or funding and will not be updated.

Throughout this report, unless otherwise stated, the "Secretary" means the Secretary of the Department of Health and Human Services (HHS). In addition, "this section" refers to matters addressed under that specific section of the act. This report uses a number of acronyms, which are listed below.

Abbreviations Used in This Report

Abbreviation	Definition
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ACEs	Adverse Childhood Experiences
ACF	Administration for Children and Families
ASMHSU	Assistant Secretary for Mental Health and Substance Use
ATI	Above the Influence
BCOR	Building Communities of Recovery
BHWET	Behavioral Health Workforce Education and Training
BJA	Bureau of Justice Assistance
BRFSS	Behavioral Risk Factor Surveillance System
CARA	Comprehensive Addiction and Recovery Act of 2016 (CARA, P.L. 114-198, as amended)
CAPTA	Child Abuse Prevention and Treatment Act (P.L. 93-274, as amended)
CBO	Congressional Budget Office
CBHSQ	Center for Behavioral Health Statistics and Quality
CBP	Customs and Border Protection
CDBG	Community Development Block Grant
CDC	Centers for Disease Control and Prevention
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COAP	Comprehensive Opioid Abuse Grant Program
COPS	Community Oriented Policing Services
CPS	Child Protective Services
CSA	Controlled Substances Act
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CTAC	Counter-Narcotics Technology Center

Abbreviation	Definition
Cures	21st Century Cures Act (P.L. 114-255)
DEA	Drug Enforcement Agency
DFC	Drug Free Communities
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Transportation
DWG	Dislocated Worker Grants
eATF	electronic alcohol testing form
EBP KIT	Evidence-Based Practices Knowledge Informing Transformation
EBSA	Employee Benefits Security Administration
EMS	Inbound Express Mail
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
FRA	Federal Railroad Administration
FTC	Federal Trade Commission
FY	Fiscal Year
GAO	Government Accountability Office
HIDTA	High Intensity Drug Trafficking Areas
HEAL	Helping to End Addiction Long-term
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act (P.L. 104-191, as amended)
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IDEA	Individuals with Disabilities Education Act (P.L. 101-476, as amended)
IHS	Indian Health Service
IMPC	international mail processing centers
IPRCC	Interagency Pain Research Coordinating Committee
IRC	Internal Revenue Code
LEA	Local Education Agency
MAP-21	Moving Ahead for Progress in the 21st Century Act
MAT	Medication-Assisted Treatment
NAS	Neonatal Abstinence Syndrome
NASPER	National All Schedules Prescription Electronic Reporting

Abbreviation	Definition
NCI	National Community Antidrug Coalition Institute
NCSACW	National Center on Substance Abuse and Child Welfare
NCTSI	National Child Traumatic Stress Initiative
NHSC	National Health Service Corps
NIH	National Institutes of Health
OCR	Office for Civil Rights (within the Department of Health and Human Services)
OIG	Office of Inspector General
OJP	Office of Justice Programs
ONDCP	Office of National Drug Control Policy
OT	Other Transaction
OTETA	Omnibus Transportation Employee Testing Act
OUD	Opioid Use Disorder
PAYGO	Pay-As-You-Go
PDMP	Prescription Drug Monitoring Program
PHI	Private Health Information
PHSA	Public Health Service Act
PPW	Pregnant and postpartum women
Project AWARE	Advancing Wellness and Resilience in Education
PSSF	Promoting Safe and Stable Families Program
PTSD	Post-traumatic Stress Disorder
R&D	Research and Development
ReCAST	Resilience in Communities After Stress and Trauma Program
REGROUP	Reauthorizing and Extending Grants for Recovery From Opioid Use Programs
RPG	Regional Partnership Grants
SAMHSA	Substance Abuse and Mental Health Services Administration
SEA	State Education Agency
SSA	Social Security Act
START	Sobriety Treatment and Recovery Teams
STOP	The Synthetics Trafficking and Overdose Prevention Act of 2018
SUD	Substance Use Disorder
SUPPORT	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act
STR	State Targeted Response Grants
TTA	Training and Technical Assistance
UPU	Universal Postal Union
U.S.C.	United States Code
USPS	United States Postal Service
VA	Department of Veterans Affairs

Abbreviation	Definition
VHA	Veterans Health Administration
WDB	Workforce Development Boards
WIOA	Workforce Innovation and Opportunity Act
YRBSS	Youth Behavioral Surveillance System

Title VII – Public Health Provisions

Subtitle A: Awareness and Training

Section 7001: Report on Effects on Public Health of Synthetic Drug Use

Background

Led by fentanyl, a synthetic opioid 50-100 times more potent than morphine, synthetic opioids emerged as the leading cause of opioid-related overdose deaths in 2016.[9] Currently, two types of fentanyl exist: (1) pharmaceutical fentanyl used to treat pain and (2) illicit, nonpharmaceutical fentanyl used illegally as a recreational drug. Pharmaceutical fentanyl is a Schedule II narcotic[10] approved by the FDA as an analgesic for severe pain. While some pharmaceutical fentanyl is diverted from legitimate use, most fentanyl-related overdoses are associated with illicit, nonpharmaceutical fentanyl.[11] Illicit fentanyl comes in many chemical formulations, known as *analogues*.[12]

Provision

Section 7001 requires the Secretary, in coordination with the U.S. Surgeon General, to submit a report on the health effects of new psychoactive substances, including synthetic drugs (i.e., analogues) used by adolescents and young adults. The report is to be submitted to specified committees of jurisdiction in the House and Senate no later than three years after enactment. The provision defines the term "new psychoactive substance" to mean a "controlled substance analogue" as defined under the Controlled Substances Act,[13] which means a substance with a substantially similar structure of a controlled substance in the Drug Enforcement Administration's (DEA) Schedule I or II drug classification system that has a similar stimulant, depressant, or hallucinogenic effect on the central nervous system.

[9] Christopher Jones, Emily Einstein, and Wilson Compton, "“Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States,,” 2010-2016," *JAMA*, vol. 319, no. 17 (May 1, 2018).

[10] The Drug Enforcement Administration's (DEA) drug classification system described in 21 C.F.R. §§1308.11-1308.15. Under this system, substances are classified under five schedules based on medical use, potential for abuse, and risk to public health, among other factors—with Schedule 1 being the most restrictive.

[11] Centers for Disease Control and Prevention (CDC), *Opioid Overdose: Reported Law Enforcement Testing Positive for Fentanyl Increase Across US*, Atlanta, GA, August 24, 2016, https://www.cdc.gov/drugoverdose/data/fentanyl-le-reports.html.

[12] For more information on synthetic drugs, see CRS Report R42066, *Synthetic Drugs: Overview and Issues for Congress*.

[13] 21 U.S.C. §802(32).

Section 7002: First Responder Training

Background

PHSA Section 546 requires the Secretary to award grants to states, local government entities, Indian Tribes and tribal organizations to train and provide resources to first responders and others to administer FDA approved or cleared drugs or devices for emergency treatment in cases of a known or suspected opioid overdose. The section also includes grants for technical assistance and training on the use of these approved drugs, requires that grants be awarded to entities in both urban and rural areas, and requires a program evaluation as specified. The section had authorized an appropriation of $12 million for each of FY2017-FY2021. In FY2017, SAMHSA awarded 21 four-year cooperative agreements for up to $11.2 million each year. No new agreements were made in FY2018.[14]

Provision

Section 7002 amends PHSA Section 546 to permit grant funds to be used to provide training and resources to first responders and other "key community sectors," as defined, about safety around fentanyl, carfentanil, and other dangerous licit and illicit drugs. Grants may also be used to provide technical assistance about how first responders and other "key community sectors" can better protect themselves in the event of exposure to such drugs. The provision defines "key community sectors" as SUD treatment providers and emergency medical service agencies, among others. The section extends and increases the annual authorization of appropriations. Specifically, it increases the amount of the program's appropriation from $12 million annually to $36 million annually and makes this new amount effective for each of FY2019 through FY2023.

Subtitle B: Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids

Section 7011: Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids

Background

Public health and law enforcement agencies at the federal, state, and local levels operate laboratories for different purposes. Public health laboratories are primarily responsible for monitoring and detecting health threats such as infectious diseases, contaminants, and bioterrorism agents, and may also receive specimens from health care facilities for analysis.[15] Laboratories run by law enforcement agencies—forensic laboratories—conduct analyses to assist with crime investigations, such as for suspected controlled substances or crime scene investigation.[16] Federal agencies such as the Centers for Disease Control and Prevention (CDC)

[14] HHS, SAMHSA, "First Responders—Comprehensive Addiction and Recovery Act Cooperative Agreements," https://www.samhsa.gov/grants/grant-announcements/sp-17-005.

[15] Association of Public Health Laboratories, "About Public Health Laboratories," at https://www.aphl.org/aboutAPHL/pages/aboutphls.aspx.

[16] United States Drug Enforcement Administration, "Laboratories," at https://www.dea.gov/laboratories.

and the DEA provide scientific, technical, and administrative support to laboratories at the state and local levels.[17]

Provision

Section 7011 requires the Secretary to award grants to federal, state, and local agencies to coordinate public health laboratories and laboratories operated by law enforcement agencies—such as Customs and Border Protection (CBP) and DEA—to improve the detection of synthetic opioids. The Secretary must, in consultation with other specified federal agencies, develop or identify (1) best practices for the safety and quality of synthetic opioid testing, with respect to reference materials, instrument calibration, and quality control protocols; (2) reference materials and quality control standards to enhance clinical diagnostics, postmortem data collection, and portable testing equipment; and (3) procedures for identifying and reporting new and emerging synthetic opioid formulations. Laboratories receiving grants must follow these best practices and cooperate with law enforcement and public health authorities in diagnostic testing, investigations, tracking of trends, and related activities. Section 7011 authorizes to be appropriated $15 million for each of FY2019 through FY2023 to carry out this section.

Subtitle C: Indexing Narcotics, Fentanyl, and Opioids

Section 7021: Establishment of Substance Use Disorder Information Dashboard

Background

Several federal agencies within HHS provide information on substance use disorder prevention, treatment, and recovery—including guidelines, best practices, and resources on evidence-based interventions.[18] SAMHSA, for instance, makes information it collects and develops publicly available through, among other things, public health campaigns that provide information on behavioral health issues including specific SUDs.[19] However, no centralized public location for consumers and professionals to comprehensively access such information currently exists.

Provision

Section 7021 creates a new PHSA Section 1711 entitled "Establishment of Substance Use Disorder Information Dashboard." The new section requires the Secretary, in consultation with the Director of the Office of National Drug Control Policy (ONDCP), to establish, make available on the HHS website, and periodically update a public information dashboard that coordinates HHS actions on prevention and treatment strategies related to reducing opioid and other substance use disorders. The dashboard is to include (1) links to HHS substance use disorder programs; (2) access to data from multiple specified sources regarding substance use disorder prevention, treatment, and recovery; (3) data on prevention and treatment strategies in different regions of the United States, as specified; (4) information on alternatives to controlled substances for pain management; and (5) guidelines and best practices for health care providers in the

[17] Several CDC components provide public health laboratory support, including the Division of Laboratory Systems, https://www.cdc.gov/ophss/csels/dls/about-us.html. For information on DEA support to forensic laboratories see https://www.dea.gov/forensic-sciences.

[18] For example, CDC, NIH including the National Institute on Drug Abuse (NIDA), the FDA, and SAMHSA.

[19] For example, see HHS, SAMHSA, "Programs and Campaigns," https://www.samhsa.gov/programs-campaigns.

treatment of substance use disorders. The provision requires the Secretary to establish the dashboard no later than six months after the date of enactment.

Section 7022: Interdepartmental Substance Use Disorders Coordinating Committee

Background

Although many federal departments and agencies, both within and beyond HHS, provide substance use disorder prevention, treatment, and recovery services, no formalized interagency body to coordinate these federal activities currently exists.

CARA established the Pain Management Best Practices Inter-Agency Task Force, which is tasked with identifying, reviewing, and determining gaps or inconsistencies between best practices for pain management developed or adopted by federal agencies.[20] While the task force is required to include representatives of the addiction treatment community, including individuals in recovery from a SUD, its mandated duties focus on best practices for pain management, rather than SUDs more broadly.

Provision

Section 7022 requires the Secretary, in coordination with the Director of National Drug Control Policy, to establish an interagency SUD coordinating committee (the Interdepartmental Substance Use Disorder Coordinating Committee) within three months of enactment. The committee must meet not less than biannually and has certain specified duties related to identifying areas for improved coordinating and making recommendations for improving SUD-related federal programs and activities.

The section specifies that the Secretary is the committee's chair and that its members include both federal members and at least 15 nonfederal members. Its federal members include a number of Cabinet level officials, the Commissioner of the Social Security Administration, the Assistant Secretary for Mental Health and Substance Use (ASMHSU), the Director of National Drug Control Policy, and representatives from other federal agencies that support or conduct programs related to SUDs. The committee's nonfederal members include a number of public representatives, including individuals who have been treated for opioid and other SUDs; directors of state substance abuse agencies, research, and advocacy groups; SUD treatment professionals with certain specified experiences; a drug court judge; and public safety personnel. The section specifies that nonfederal committee members will serve three-year terms and may be reappointed. It also specifies the procedures used to fill nonfederal committee vacancies. The section requires the committee to publish, on the HHS website, an annual report not later than one year after enactment and annually thereafter for the committee's duration. The report must include a summary of the committee's activities including any findings. The section permits the committee to establish working groups and specifies that the committee would be subject to the Federal Advisory Committee Act and that the committee will terminate six years after it is established.

[20] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, "Charter: Pain Management Best Practices Inter-Agency Task Force," https://www.hhs.gov/ash/advisory-committees/pain/charter/index.html.

Section 7023: National Milestones to Measure Success in Curtailing the Opioid Crisis

Background

HHS's Office of Disease Prevention and Health Promotion develops HealthyPeople.gov, a set of 10-year national objectives that aim to improve the health of the U.S. population. The current version, *Healthy People 2020*,[21] includes measures to track and reduce substance use and rates of substance abuse as measured through progress on a number of objectives.[22] While reducing opioid use is a component of this objective, it is not the exclusive focus. SAMHSA also tracks its programs to measure its effectiveness relative to (1) a set of measures developed in accordance with the Government Performance and Results Modernization Act of 2010, and (2) goals included in HHS's strategic plan.[23] While SAMHSA measures the performance of some of the agency's opioid specific programs, opioid-specific measurement is not the focus.

More related to measuring progress on addressing opioid misuse and abuse is in the President's Commission on Combating Addiction and the Opioid Crisis, which noted that this task is challenging because opioid-specific measures are lacking, and because the component data that would be needed to develop such measures (e.g., overdose data) are not collected in a uniform manner. Among the commission's recommendations is to strengthen data collection activities. It did not recommend that specific benchmarks be used.[24] HHS flags improved data collection as one of the five points in its strategy to combat opioid abuse, misuse, and overdose.[25]

Provision

Section 7023 requires the Secretary, in coordination with the Administrator of the DEA and the Director of ONDCP, to develop national indicators ("milestones"), as specified, to measure success in curtailing the opioid epidemic. The milestones are to include no fewer than 10 indicators to measure progress in reversing the incidence and prevalence of opioid abuse and opioid-related morbidity and mortality in the United States. The provision requires the Secretary to identify these milestones no later than 180 days after the date of enactment. Indicators are to include the number of opioid overdoses, the number of opioid-related emergency department visits, the number of individuals receiving treatment for opioid use disorder (OUD), and the number of individuals in sustained recovery, among others.

The provision also requires the Secretary to identify a reasonable goal to achieve within five years following enactment that signifies progress. The provision permits an extension to the timeline for meeting the identified goals if the Secretary determines the goal will not be achieved within five years of the date of enactment. In this case, the Secretary is required to include a rationale for why additional time is needed and information on necessary changes to change the

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[21] HHS, Office of Disease Prevention and Health Promotion, "Healthy People 2020," https://www.healthypeople.gov/2020/About-Healthy-People.

[22] HHS, Office of Disease Prevention and Health Promotion, "Healthy People 2020: Substance Abuse," https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/objectives.

[23] HHS, Substance Abuse and Mental Health Services Administration, FY2019 Justification of Estimates for Congressional Committees, p. 5, https://www.samhsa.gov/sites/default/files/sites/default/files/samhsa-fy-2019-congressional-justification.pdf.

[24] The President's Commission on Combating Drug Addiction and the Opioid Crisis, Final Report, October 1, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

[25] HHS, *Strategy to Combat Opioid Abuse, Misuse, and Overdose: A Framework Based on the Five Point Strategy*, https://www.hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf, pp. 5-6.

goal. Finally, the provision requires the Secretary to make annual reports on the progress toward meeting these milestones, beginning not later than one year after enactment. These reports must be made publicly available through the HHS website and must be submitted to specified congressional committees of jurisdiction.

Section 7024: Study on Prescribing Limits

Background

Federal law does not specifically limit how much of any drug a provider may prescribe, although in certain cases, it may limit the number of prescriptions a provider can write for a patient at one time.[26] Some states have enacted laws establishing prescribing limits on opioids.[27]

Provision

Section 7024 requires the Secretary, in consultation with the Attorney General, to submit to Congress, within two years of enactment, a report on the impact of federal and state laws and regulations that limit the length, quantity, or dosage of opioid prescriptions, and the impacts of such limits on patients and prescribers, as specified.

Subtitle D: Ensuring Access to Quality Sober Living

Section 7031: National Recovery Housing Best Practices

Background

SAMHSA refers broadly to substance use recovery housing as "a sober, safe, and healthy living environment that promotes recovery from alcohol and other drug use and associated problems."[28] Models of recovery housing, and the effectiveness of services provided, vary substantially. Most regulation of recovery housing occurs on the state level. Currently, no federally recognized standards of practice for recovery housing exist.[29]

Provision

Section 7031 creates a new PHSA Section 550 entitled "National Recovery Housing Best Practices," which requires the Secretary to develop best practices for operating substance use

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[26] Pursuant to Section 309(a) of the Controlled Substances Act [21 U.S.C. §829(a)], a prescription for a Schedule II drug may not be refilled, and a new prescription would be required. Federal regulations at 21 C.F.R. §1306.12 allow a prescriber, under specified conditions, to write multiple prescriptions for a Schedule II drug to be filled sequentially, up to 90 days.

[27] National Conference on State Legislatures, "Prescribing Policies: States Confront Opioid Overdose Epidemic," April 5, 2018, http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx.

[28] National Association of Recovery Residences, *A Primer on Recovery Residences: Frequently Asked Questions*, Atlanta, GA, September 20, 2012, http://narronline.org/wp-content/uploads/2014/06/Primer-on-Recovery-Residences-09-20-2012a.pdf referenced at https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/recovery-homes-help-people.

[29] SAMHSA publishes an Evidence-Based Practices Knowledge Informing Transformation (EBP KIT) on Permanent Supportive Housing (https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510)), which outlines the essential components for supportive housing services for people living with mental health disorders, including co-occurring substance use disorders. SAMHSA also offers other Evidence-Based Practices KITs (available at https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs) in addition to an evidence-based practice resource center webpage (available at https://www.samhsa.gov/ebp-resource-center). These publications, however, do not comprehensively identify best practices for recovery housing.

recovery housing. The provision defines recovery housing to mean a "shared living environment free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders." In identifying these best practices, the Secretary is required to consult with other entities such as SAMHSA, CMS, the HUD Secretary, state health commissioners, health insurers, and individuals with a history of SUD, among others. The provision requires the Secretary, in consultation with the same specified entities and the Attorney General, as appropriate, to identify common indicators that could be used to identify potentially fraudulent recovery housing operators, as described.

The Secretary is required to disseminate the best practices and common indicators, as appropriate, to specified entities which include state agencies, tribal organizations, the Attorney General, recovery housing entities, and the public, among others.

In carrying out these activities, the Secretary is required to consult with specified entities and consider how recovery housing supports recovery, prevents relapse and overdose, and improves access to treatment, including medication-assisted treatment (MAT). This provision does not give the Secretary the authority to require states to adhere to minimum standards, though the best practices may include model laws for states to implement suggested minimum standards. The provision authorizes to be appropriated $3 million for the period of FY2019 through FY2021.

Subtitle E: Advancing Cutting Edge Research

Section 7041: Unique Research Initiatives

Background

The Cures Act authorized the NIH Director to fund "unique research initiatives" through transactions other than contracts, grants, or cooperative agreements, also known as Other Transaction (OT) authority (P.L. 114-255, Section 2036).[30] OT authority is a special vehicle used by certain federal agencies for obtaining or advancing research and development (R&D).[31] An OT is not a contract, grant, or cooperative agreement, and there is no statutory or regulatory definition of "other transaction." Only those agencies that have been provided OT authority may engage in these transactions. Generally, OT authority is created because the government needs to obtain leading-edge R&D from commercial sources, but some companies (and other entities) are unwilling or unable to comply with the government's procurement regulations and certain procurement statutes that govern contracts.

The Cures Act added OT authority under a new PHSA Section 402(n) and identified two unique research initiatives that could be funded by NIH via this new OT authority: (1) the Precision Medicine Initiative (under PHSA section 498E) and (2) other "important areas" of research requiring collaboration between the different NIH institutes and centers, or that would benefit from strategic coordination and planning (under PHSA Section 402[b][7]). Examples in the Cures Act of these other "important areas" include "emerging scientific opportunities, rising public health challenges, or knowledge gaps that deserve special emphasis." PHSA Section 402(n) requires internal NIH reporting on the use of this authority and requires the HHS Secretary,

[30] See CRS Report R44720, *The 21st Century Cures Act (Division A of P.L. 114-255)*, Section 2036. High-Risk, High-Reward Research.

[31] For further information, see U.S. Government Accountability Office, *DOD Research: Acquiring Research by Nontraditional Means*, GAO/NSIAD-96-11, March 29, 1996, https://www.gpo.gov/fdsys/pkg/GAOREPORTS-NSIAD-96-11/pdf/GAOREPORTS-NSIAD-96-11.pdf.

through the NIH Director, to submit a report to Congress evaluating the activities under this new subsection by September 30, 2020.[32]

Provision

Section 7041 adds a third "unique research initiative," allowing the Director of the NIH to use OT authority to carry out "high impact cutting-edge research that fosters scientific creativity and increases fundamental biological understanding leading to the prevention, diagnosis, or treatment of diseases and disorders, or research urgently required to respond to a public health threat" under PHSA Section 402(n).

Section 7042: Pain Research

Background

The Interagency Pain Research Coordinating Committee (IPRCC) was established in Section 4305 of the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended), which added a new PHSA Section 409J.[33] IPRCC is responsible for coordinating efforts within HHS and other federal agencies related to pain research. It consists of members from federal agencies that conduct pain care research and treatment, as well as nonfederal scientists, physicians, and other health professionals and representatives of "leading research, advocacy, and service organizations for individuals with pain-related conditions."

The IPRCC is required to meet no less than once a year, and is required to (1) summarize advances in pain care research supported by federal agencies, (2) identify critical gaps in research, (3) ensure there is not duplication of research activities at the NIH and other federal agencies, (4) make recommendations on how to best disseminate information on pain care, and (5) make recommendations on how to expand partnerships between public and private entities to expand collaborative, cross-cutting research.

Provision

Section 7042 amends the duties of the IPRCC under PHSA 409J(b). It requires the IPRCC to include in its summary of advances in pain care research the best practices for the utilization of alternative pain management therapies as specified. Section 7042 provides further details on the gaps in research that the IPRCC is required to identify, specifically gaps in research: (1) on relevant biomarkers and screening models for the epidemiology of acute and chronic pain; (2) on the diagnosis, treatment, and management of acute and chronic pain, including with respect to alternative pain management therapies as specified; and (3) on the risk factors for, and early warning signs of, substance use disorders in populations with acute and chronic pain.

Section 7042 clarifies that the IPRCC is required to make its recommendations to the NIH Director, including (1) how to best disseminate information on pain care and epidemiological data related to acute and chronic pain, (2) how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research, and (3) how to ensure the activities of the NIH and other federal agencies are free of duplication. Finally, Section 7042 requires the Secretary ensure that recommendations and actions taken by the NIH Director on the topics discussed in the IPRCC meetings are included in appropriate reports to Congress.

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[32] See CRS Report R44720, *The 21st Century Cures Act (Division A of P.L. 114-255)*, Section 2036. High-Risk, High-Reward Research.

[33] See CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*.

Subtitle F: Jessie's Law

Section 7051: Inclusion of Opioid Addiction History in Patient Records

Background

Federal law and regulations—specifically, 42 CFR Part 2, commonly referred to as the "Part 2 regulations"—explicitly protect the privacy of patient records at federally assisted alcohol and drug treatment programs.[34] Under Part 2, the disclosure of SUD treatment records requires a patient's written consent, unless the type of disclosure falls under one of a handful of specific statutory exceptions. For example, Part 2 generally requires consent to release information about a patient's substance use disorder history and treatment regimens to clinicians at another facility, except in the case of a medical emergency. This contrasts with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which permits clinicians to share patient information for treatment and payment purposes without patient consent or authorization.[35]

Provision

Section 7051 requires the Secretary, not later than one year after enactment, to identify or facilitate the development of best practices regarding the display of information about a patient's history of OUD, only at the patient's request, in the medical record; what constitutes a patient's request; and the process and methods for displaying this information. The Secretary is required to disseminate these best practices to health care providers and state agencies, and must consider numerous factors in the identification or development of the best practices, as specified, including all applicable federal and state laws and regulations.

Section 7052: Communication with Families during Emergencies

Background

The HIPAA Privacy Rule administered by the HHS Office for Civil Rights (OCR), permits a health care provider to disclose protected health information (PHI) to family, friends, or others directly involved in an individual's care (or payment related to that care) as long as the individual does not object to the disclosure or the provider reasonably infers, based on professional judgment, that the individual would not object.[36] If the individual objects, the provider is prohibited from sharing any PHI with the individual's caregivers.

The Privacy Rule also addresses situations in which the individual is not present, or the opportunity to agree or object "cannot practicably be provided because of the individual's incapacity or an emergency circumstance." Under such circumstances, a health care provider may share the individual's PHI with family, friends, or others directly involved in the individual's care if, based on professional judgment, the provider determines that disclosure is in the "best interests" of the individual.[37]

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[34] 42 C.F.R. Part 2, promulgated pursuant to PHSA Section 543. The term "federally assisted" is defined in the rule at 42 C.F.R. §2.12(b).

[35] Generally, 45 C.F.R. Part 164, Subpart E.

[36] 45 C.F.R. §164.510(b)(2).

[37] 45 C.F.R. §164.510(b)(3).

On February 20, 2014, HHS released a guidance document ("HIPAA Privacy Rule and Sharing Information Related to Mental Health") that provides answers to several frequently asked questions about the circumstances under which the Privacy Rule permits a health care provider to disclose a mentally ill individual's PHI. Pursuant to Cures Section 11003, OCR updated this document in December of 2017 and published new guidance on responding to the opioid crisis in October 2017 ("How HIPAA Allows Doctors to Respond to the Opioid Crisis").[38]

The Part 2 Rule protects the privacy of patient records at federally assisted alcohol and drug treatment programs. The Part 2 regulations restrict the use and disclosure of any patient information that directly identifies a patient as an alcohol or drug abuser, or that links the patient to the alcohol or drug treatment facility (or provider). Such information may not be disclosed without the patient's prior written consent, except in a few specified circumstances. On January 18, 2017, the Secretary published a final rule that amends the Part 2 Rule to try to better align the Part 2 Rule with HIPAA and facilitate exchange of information between Part 2 programs and other providers. In addition, SAMHSA published a supplemental final rule in January 2018 that makes additional changes to Part 2 to permit third parties in lawful possession of Part 2 data to disclose the information to their contractors, subcontractors, and legal representatives.[39] Cures Section 11004 requires the Secretary, not later than one year after enactment (i.e., December 13, 2017), to develop, disseminate, and periodically update model programs for training health care providers, lawyers, and patients and their families on the permitted uses and disclosures of PHI of individuals seeking or receiving treatment for mental health or substance use disorders, consistent with the HIPAA privacy and security standards.[40]

Provision

Section 7052 requires the Secretary to annually notify health care providers of permitted disclosures of certain health information under federal privacy law during an emergency to family, caregivers, and health care providers. In carrying out this notification, the Secretary is authorized to use the model training programs for SUD patient records developed under Section 7053, or the model training programs for training health care providers, lawyers, and patients and their families developed under Cures Section 11004.

Section 7053: Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records

Background

See background for "Section 7052: Communication with Families during Emergencies"

Provision

Section 7053 requires the Secretary, not later than one year after enactment, to identify model programs and materials, including those to train health care providers in the permitted uses and disclosures of information in compliance with 42 CFR Part 2 and those to educate families and

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[38] HHS, Information Related to Mental and Behavioral Health, including Opioid Overdose, https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html.

[39] 82 *Federal Register* 6052, January 18, 2017; 83 *Federal Register* 239, January 3, 2018.

[40] According the Office for Civil Rights, the implementation of this provision is in progress. See U.S. Department of U.S. Department of Health and Human Services, "HHS Highlights Office for Civil 'Rights' Ongoing Response to the Opioid Crisis, While Implementing the 21st Century Cures Act," press release, December 18, 2017, https://www.hhs.gov/about/news/2017/12/18/hhs-highlights-office-civil-rights-ongoing-response-opioid-crisis-implementing-21st-century.html.

patients on their rights to protect and obtain information under 42 CFR Part 2. The section requires that the model programs and materials be periodically updated and disseminated, and that the development, identification, and updating of the models and programs must include input from relevant stakeholders. The section authorizes to be appropriated $4 million for FY2019, $2 million for each of FY2020 and FY2021, and $1 million for each of FY2022 and FY2023.

Subtitle G: Protecting Pregnant Women and Infants

Section 7061: Report on Addressing Maternal and Infant Health in the Opioid Crisis

Background

Health care providers prescribe opioids to pregnant and postpartum women (PPW) with the goal of reducing their pain. Some pregnant women who use opioids become addicted to them. Opioid use disorder during pregnancy is linked to maternal mortality.[41] The prevalence of pregnant women with OUDs at the time of delivery has increased in the United States. The CDC reported that the U.S. rate of OUD cases among women who deliver in the hospital more than quadrupled, from 1.5 OUD cases per 1,000 hospital deliveries in 1999 to 6.5 OUD cases per 1,000 hospital deliveries in 2014.[42] The CDC has raised concern about this increasing rate because infants born to women with OUDs generally are born with neonatal abstinence syndrome (NAS). According to the CDC, NAS "occurs when newborn babies experience withdrawal after being exposed to drugs in the womb."[43]

Provision

Section 7061 requires the Secretary—in coordination with specified HHS agencies—to submit a report on opioid use during and after pregnancy to specified congressional committees not later than 18 months after enactment. This section does not authorize any additional appropriations for these activities.

Section 7062: Protecting Moms and Infants

Background

Section 2 of the Protecting Our Infants Act of 2015 (P.L. 114-91) required the Secretary to conduct a review of the HHS's planning and coordination activities related to prenatal opioid use, including NAS. In carrying out this review, the Secretary was required to develop a strategy to address gaps in research and duplication, overlap, and gaps in federal programs. Congress directed the Secretary to submit a report to specified congressional committees on the findings of the review and the related strategy, no later than November 25, 2016. Section 3 of P.L. 114-91 required the Secretary to conduct a separate study on, and develop recommendations for, preventing and treating prenatal OUDs, and to publish the recommendations on HHS's website

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[41] CDC, "Opioid Use Disorder Documented at Delivery Hospitalization-United States, 1999-2014," *Morbidity and Mortality Weekly Report*, August 10, 2018, https://www.cdc.gov/mmwr/volumes/67/wr/mm6731a1.htm?s_cid=mm6731a1_w.

[42] Ibid.

[43] CDC, "Primary Prevention and Public Health Strategies to Prevent Neonatal Abstinence Syndrome," August 16, 2016, https://www.cdc.gov/grand-rounds/pp/2016/20160816-neonatal-addiction.html.

no later than May 25, 2016. In response to the requirements in Section 2 and Section 3, the Secretary submitted a report in January 2017, *Protecting Our Infants Act: Report to Congress*, which discussed findings and outlined a strategy to address gaps, challenges, and recommendations related to prenatal opioid exposure and NAS.[44] After seeking public comment about this strategy, HHS released a follow-up report in June 2017, *Protecting Our Infants Act: Final Strategy* (*Final Strategy*). The *Final Strategy* report outlined the steps the department would take to address the findings and implement the recommendations in the *Protecting Our Infants Act: Report to Congress*.[45] The report also stated that HHS's ability to fully implement the recommendations is contingent upon funding.[46]

SAMHSA's Center for Substance Abuse Treatment (CSAT) is charged with promoting community-based treatment and recovery services for substance use disorder.[47] PHSA Section 508 requires the Director of CSAT to award grants and cooperative agreements or contracts to public and nonprofit entities through the Residential Treatment for Pregnant and Postpartum grant program.[48] This grant program provides support to grantees to provide medical services such as outpatient treatment for SUD, postpartum care, and pediatric care to PPW and to the infants and children of those women. PHSA Section 508 separately requires the Director of CSAT to award competitive grants to state substance abuse agencies under the Treatment for PPW state pilot grant program.[49] These competitive grants are intended for state substance abuse agencies to support family-based services, identify gaps in services, and promote a coordinated state system to deliver care to PPW who have an SUD. PHSA Section 508 authorizes $16.9 million for each of FY2017 through FY2021 to carry out these programs.[50] The program's FY2018 funding level was $29.9 million.[51]

Provision

Section 7062(a) requires the Secretary, within 60 days of enactment, to submit a report to specified congressional committees, and make that report publicly available on the HHS website, on implementing the strategy developed pursuant to Section 2 of P.L. 114-91. The section also requires the Secretary to provide the committees with periodic updates to the report.

Section 7062(b) amends PHSA Section 508(s)[52] to authorize $29.9 million for each of FY2019 through FY2023.

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[44] HHS, Behavioral Health Coordinating Council, *Protecting Our Infants Act: Report to Congress*, January 2017, https://www.samhsa.gov/sites/default/files/topics/specific_populations/protecting-our-infants-act-report-congress-2017.pdf.

[45] HHS, Behavioral Health Coordinating Council, *Protecting Our Infants: Final Strategy*, June 2017, https://www.samhsa.gov/sites/default/files/topics/specific_populations/final-strategy-protect-our-infants.pdf. (Hereinafter, HHS, Behavioral Health Coordinating Council, *Protecting Our Infants: Final Strategy)*.

[46] Ibid,., p. 2.

[47] CSAT, *[CSAT]: About Us*, https://www.samhsa.gov/about-us/who-we-are/offices-centers/csat.

[48] 42 U.S.C. §290bb-1(a).

[49] 42 U.S.C. §290bb-1(r).

[50] 42 U.S.C. §290bb-1(s).

[51] SAMHSA, *Operating Plan for FY2018*, https://www.samhsa.gov/sites/default/files/sites/default/files/fy_2018_samhsa_operating_plan.pdf.

[52] Ibid.

Section 7063: Early Interventions for Pregnant Women and Infants

Background

PHSA Section 515(b) provides the duties for the Director of the Center for Substance Abuse Prevention (CSAP) at SAMHSA. CSAP is charged with improving behavioral health through evidence-based prevention approaches.[53] PHSA Section 515(b) does not require the Director of CSAP to carry out activities explicitly for pregnant women and infants.

PHSA Section 507(b) provides the duties of the Director of CSAT at SAMHSA. This section requires the Director of CSAT to carry out activities explicitly for pregnant women and infants. The Director of CSAT is not required, however, to encourage education about SUDs for pregnant women and health care providers.

Provision

Section 7063(a) amends PHSA Section 515(b) (42 U.S.C. §290bb-21[b]) to require the Director of CSAP to develop educational materials about pain management and the prevention of SUDs during pregnancy, in collaboration with CDC and in consultation with relevant stakeholders.

Section 7063(b) amends PHSA Section 507(b) (42 U.S.C. §290bb[b]) to require the Director of CSAT, in cooperation with the Secretary, to implement the recommendations of the *Final Strategy*.[54] Section 7063(c) amends PHSA Section 507(b) (42 U.S.C. §290bb[b]) to require the Director of CSAT to encourage education, through relevant stakeholders and public-private partnerships, about SUDs to both pregnant women and health care providers who treat pregnant women and babies.

Section 7064: Prenatal and Postnatal Health

Background

PHSA Section 317L required the Secretary, acting through the CDC Director to collect and analyze data and to provide public information and education on smoking, drug, and alcohol cessation programs and prevention.

The section also authorized the Secretary to award grants or enter into contracts with states, local governments, and public and nonprofit entities such as scientific and academic institutions and federally qualified health centers (FQHCs). The Secretary may also provide technical and consultative assistance to awardees. Finally, the section authorized an appropriation of such sums as may be necessary for each of FY2001 through FY2005.[55] In FY2018, CDC's overall motherhood and infant health activities, of which this program is a component, were funded at $46.0 million.[56]

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[53] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, "*Center for Substance Abuse Prevention: About Us*, https://www.samhsa.gov/about-us/who-we-are/offices-centers/csap.

[54] The *Final Strategy* report outlined the steps the department would take to address the findings and implement the recommendations in the *Protecting Our Infants Act: Report to Congress*. See HHS, Behavioral Health Coordinating Council, *Protecting Our Infants: Final Strategy*.

[55] 42 U.S.C. §247b-13(c).

[56] CDC, *Operating Plan for FY2018*, https://www.cdc.gov/budget/documents/fy2018/fy-2018-cdc-operating-plan.pdf.

Provision

Section 7064 amends PHSA Section 317L[57] to require the CDC Director to also collect data on the incidence, prevalence, and implications of prenatal smoking, alcohol, and other substance misuse or abuse; the incidence and prevalence of NAS and other maternal and child health outcomes; and additional patient information that can inform data analyses. It also requires the CDC Director to examine the long-term outcomes associated with prenatal substance abuse and misuse, as part of conducting applied epidemiological research; to assess the effectiveness of treatment programs (in addition to educational and cessation programs); and to issue specified public reports. Section 7064 replaces the term, "illegal drug use" with "substance abuse and misuse" in Section 317L.

To carry out the above activities, the section authorizes the Secretary to provide technical assistance to program grantees; ensure data sharing between states, tribes, and the CDC; ensure that data collection conducted under this section is done in a manner consistent with applicable privacy laws; and coordinate with the Office of the National Coordinator for Health Information Technology to assist states and tribes with implementing systems that are interoperable with other health information technology systems. Section 7064 authorizes such sums as necessary for these activities for each of FY2019 through FY2023.

Section 7065: Plans of Safe Care

Background

The Child Abuse Prevention and Treatment Act (CAPTA) authorizes formula funding to states and territories to improve their child protective services and authorizes the Secretary to make competitive grants for related research, technical assistance, and demonstration projects.[58] Funding for these activities is authorized to be appropriated in Section 112 of CAPTA and is administered by the Children's Bureau within HHS's Administration for Children and Families (ACF).[59]

Among other things, states that receive CAPTA formula grant funding must have statewide policies and procedures in place regarding infants affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder (hereafter referred to as substance-exposed infants). Specifically, they must ensure that health care providers involved in the delivery or care of a substance-exposed infant provide notice to child protective services (CPS) and that a "plan of safe care" is developed for such an infant (Section 106(b)(2)(B)(ii) and (iii) of CAPTA). [60]

Following a rise in the incidence of opioid-exposed infants who experience NAS, and concerns that not all states appeared to develop plans of safe care for these infants, Congress revised and strengthened the requirement. CARA amended CAPTA to clarify that a plan of safe care is to ensure the safety and well-being of a substance-exposed infant after he or she leaves the care of

[57] Ibid.

[58] These authorizations are included in Title I of CAPTA.

[59] The authorization for appropriation to carry out CAPTA expired with FY2015, but annual funding has continued.

[60] The Keeping Children and Families Safe Act of 2003 (P.L. 108-36) first added this requirement to CAPTA with regard to "illegal" substances. In 2010, the CAPTA Reauthorization Act (P.L. 111-320) added the reference to infants affected by a Fetal Alcohol Spectrum Disorder. The 2016 CARA amendments struck the reference to "illegal" drug use, requiring notice without regard to whether exposure was to a legal or illegal substance.

health care providers, including by addressing the SUD treatment needs of the infant *and* the infant's affected family or caregiver. Further, it directed states to monitor the work of local entities to determine whether and how plans of safe care are carried out.

Initially many states had trouble assuring their compliance with these requirements. A January 2018 report from the U.S. Government Accountability Office (GAO) noted that while HHS had provided some guidance to states, most states sought additional guidance to address challenges in implementing plans of safe care.[61] Appropriations for each of FY2018 (P.L. 115-141) and FY2019 (P.L. 115-245) included $85 million for CAPTA state grants, up from $25 million in FY2017. The conference agreement accompanying the FY2019 appropriations act notes that, as was the case in FY2018, $60 million of this amount is intended to help states develop plans of safe care. The conference report also directs the Secretary to provide technical assistance on best practices and evidence-based interventions to help states address the health, safety, and SUD treatment needs of the child and family, and to evaluate their plans of safe care work.[62]

Provision

Section 7065(a) amends CAPTA to authorize the Secretary to make grants to states and territories to facilitate collaboration among agencies of public health, child welfare, social services, maternal and child health, mental health, and SUD treatment; hospitals with labor and delivery units; and medical staff in developing, implementing, and monitoring plans of safe care for substance-exposed infants. The section describes distribution of the funds (including a reservation of funds for tribes to carry out related work), application requirements, how the funds may be used, data and outcome reporting requirements for states, and related duties of the Secretary. Among the permissible uses of funds are those related to planning and developing safe care plans by improving state and local systems, coordinating and training health care and treatment providers, establishing interagency partnerships, and improving data collection systems. The section requires the Secretary to submit to certain congressional committees, annual reports based on state-reported data, as well as recommendations or observations on the challenges, successes, and lessons learned from implementing the plan of safe care grant program. The section requires that this report be prepared using funds reserved for technical assistance. No new funding is authorized for these grants, but HHS is permitted to use CAPTA appropriations for them. The section specifies that the Secretary's authority to award these grants sunsets on the last day of FY2023 (i.e., September 30, 2023).

Section 7065(b): [Repeal of the Abandoned Infants Assistance Act]

Background

The Abandoned Infants Assistance Act of 1988 (P.L. 100-505, as amended) responded to congressional concerns about the number of infants who remained in hospital care beyond their medical need to do so and who, often because of parental drug use, were born with exposure to both human immunodeficiency virus (HIV) and drugs. The act authorized funding for local

[61] U.S. Government Accountability Office (GAO), *Substance-Affected Infants: Additional Guidance Would Help States Better Implement Protections for Children,* https://www.gao.gov/products/GAO-18-196. For more information, see. CRS Report R45270, *Child Welfare Funding in FY2018*.

[62] U.S. Congress, 115th Cong., 2nd Sess., *Conference Report to Accompany H.R. 6157*, H.Rept. 115-952, p. 539, https://www.congress.gov/115/crpt/hrpt952/CRPT-115hrpt952.pdf.

demonstration projects to prevent and respond to the abandonment of such infants and young children. Congress last provided funding for this program ($11 million) in FY2015.[63]

Provision

Repeals the Abandoned Infants Assistance Act effective at enactment.

Subtitle H: Substance Use Disorder Treatment Workforce

Section 7071: Loan Repayment Program for Substance Use Disorder Treatment Workforce

Background

The federal government supports a number of health workforce programs that are administered by the HHS's Health Resources and Services Administration (HRSA). Among the largest of these programs is the National Health Service Corps (NHSC), which provides scholarships and loan repayment to health care providers—including those who treat behavioral health conditions—in exchange for a two-year or more service commitment in a health professional shortage area (HPSA).[64] The program permits the following behavioral health providers to participate: (1) psychiatrists are eligible for both scholarships and loan repayments; (2) nurse practitioners and physician assistants who focus on mental health and psychiatry are eligible for both scholarships and loan repayments; and (3) health service psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors are eligible for the loan repayment program only.

The NHSC typically provides scholarships that cover the cost of attendance and living expenses and loan repayment awards of $30,000 for a two-year commitment with $50,000 available for participants at sites located in severe shortage areas (as defined by HRSA). Beginning in the fall of 2018, the NHSC expanded its program to encompass more SUD provider types to include physician assistants (who are eligible to prescribe MAT) and SUD counselors. The program expansion will also provide higher repayment awards ($75,000 in exchange for three years of service).[65]

Provision

Section 7071 creates a new PHSA Section 781 entitled "Loan Repayment Program for Substance Use Disorder Treatment Workforce," which requires the Secretary, acting, through the HRSA Administrator, to create a new loan repayment program that makes loan repayment awards to SUD treatment providers (as defined) who provide care in a mental health HPSA or in a county or municipality with high rates of overdose deaths, as defined. The program makes eligible a wider range of behavioral health provider types beyond those who are currently eligible for the NHSC (e.g., SUD treatment providers who are paraprofessionals or completing fellowship training in clinical psychology) and permits clinicians to fulfill their required service commitment at health

[63] For additional information on the Abandon Infants Assistance Act, see "Abandoned Infants Assistance" in CRS Report R43458, *Child Welfare: An Overview of Federal Programs and Their Current Funding*.

[64] CRS Report R44970, *The National Health Service Corps*. For more information about health professional shortage areas (HPSAs), see U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, "Shortage Designation," https://bhw.hrsa.gov/shortage-designation.

[65] Health Resources and Services Administration, National Health Service Corps, "Determine Your Loan Repayment Eligibility," https://nhsc.hrsa.gov/loan-repayment/eligibility/index.html#nhsc-lrp.

care sites that are not eligible service sites under the NHSC (e.g., inpatient treatment centers). The program requires a minimum of a two-year service commitment and provides a loan repayment amount that is one-sixth of an individual's loan balance, for up to a six-year service commitment, with a maximum repayment amount of $250,000.

The section specifies a number of elements related to the loan repayment program, including the types of loans that are eligible to be repaid and the penalties associated with breaching a loan repayment agreement. It permits the Secretary to establish additional criteria and rules to carry out this program, as determined necessary. Finally, the section authorizes an appropriation of $25 million for each of FY2019 through FY2023 and requires the Secretary, not later than five years after enactment and biannually thereafter, to submit a report to Congress including certain specified elements.

Section 7072: Clarification Regarding Service in Schools and Other Community-Based Settings

Background

The National Health Service Corps (see description above in "Section 7071: Loan Repayment Program for Substance Use Disorder Treatment Workforce") permits providers to fulfill their service commitments in out-patient facilities including school-based health centers. It does not permit clinicians to count time practicing in a school that does not have a school-based health center.[66]

Provision

Section 7072 adds a new PHSA Section 338N "Clarification Regarding Service in Schools and Other Community-Based Settings," which specifies that NHSC scholarship and loan repayment recipients may provide services as behavioral or mental health providers at schools or other community-based settings provided that these sites are located in a HPSA. It further specifies that this time may count toward the participant's service commitment, but permits the Secretary to limit the number of hours in alternate settings that may count toward a participant's service commitment, provided that this limit is not less than 50% of total hours of obligated service required. Finally, the provision specifies that this change is notwithstanding other PHSA sections that authorize the NHSC.

Section 7073: Programs for Health Care Workforce

Background

PHSA Section 759 authorizes the Secretary to establish a program to train health professionals in pain care. The program authorized funding to health professions schools, hospices, and other entities for the development and implementation of education and training programs to health care professionals in pain care, including training on the following topics: (1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms; (2) applicable laws, regulations, rules, and policies on controlled substances; (3) interdisciplinary approaches to the delivery of pain care; (4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and (5) recent findings, developments, and improvements in the provision of pain care. Such sums as may be necessary were authorized from

[66] CRS Report R44970, *The National Health Service Corps*.

FY2010 through FY2012 to carry out the program. No funds were appropriated and the program was never implemented.

PHSA Section 756 authorizes the Behavioral Health Workforce Education and Training (BHWET) Program, which was codified in the Helping Families in Mental Health Crisis Reform Act of 2016, which was Division B of the Cures Act.[67] The program provides grants to support the training of the behavioral health workforce, including paraprofessionals. The program's appropriation was authorized from FY2018 through FY2022 at $50 million annually. The program received an appropriation of $75 million in each of FY2018 and FY2019.[68]

Provision

Section 7073 amends PHSA Section 759 to add tribal health programs to the entities authorized to receive pain care grants. It also requires that entities receiving grants include additional educational topics, including an emphasis on training in nonaddictive and nonpharmacological pain treatment methods, and issues related to understanding the dangers of opioid abuse and misuse and recognizing early warning signs of opioid use disorders. The section also authorizes such sums as may be necessary to carry out the program, from FY2019 to FY2023.

Section 7073 also amends PHSA Section 756, which authorizes the BHWET program, to insert language specifying that providers trained in trauma-informed care are eligible to participate. It extends the program's annual authorization of appropriations through FY2023.

Subtitle I: Preventing Overdoses While in Emergency Rooms

Section 7081: Program to Support Coordination and Continuation of Care for Drug Overdose Patients

Background

SAMHSA collects data on the number of patients who present to emergency departments with conditions related to substance use, including overdoses. Although it collects these data, it generally does not award funds related to developing treatment protocols. However, in 2018 SAMHSA made a grant announcement entitled "Improving Access to Overdose Treatment," which awarded funds to opioid treatment programs or other providers that have a waiver to prescribe buprenorphine.[69] The program aimed to expand access to FDA-approved drugs or devices for emergency treatment of known or suspected opioid overdose and to connect individuals who have experienced an overdose with appropriate treatment. As part of the program, grantees were required to partner with other community level providers to develop best practices for prescribing and co-prescribing FDA-approved overdose reversal drugs and to subsequently train other prescribers in the community.[70]

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[67] See CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

[68] For FY2019, this was included in Division B of P.L. 115-245 and FY2018 appropriations were provided by P.L. 115-141.

[69] For more information on buprenorphine and the waiver process, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*, by Johnathan H. Duff.

[70] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Improving Access to Overdose Treatment," https://www.samhsa.gov/grants/grant-announcements/sp-18-006.

Provision

Section 7081 requires the Secretary to award five-year competitive grants to develop best practices for (1) emergency treatment of known or suspected overdose; (2) the use of recovery coaches to encourage patients who experience nonfatal overdose to seek treatment; (3) the coordination and continuation of care and treatment through appropriate referrals of individuals after a nonfatal drug overdose; and (4) the provision or prescribing of overdose reversal medication. Entities eligible to apply for this grant include state substance abuse agencies, Indian Tribes or Tribal Organizations, and other entities (in conjunction with state substance abuse agencies) that offer voluntary treatment or other services in response to or follow drug overdose. The section specifies that applicants must apply to the Secretary for grant funds, the permissible use of grant funds, the granting preferences, and grantee reporting requirements.

The section requires the Secretary to submit a report to Congress not later than five years after enactment including certain specified elements. The section also specifies that federal and state privacy requirements apply to the grant program's data requirements and program oversight, and authorizes an appropriation of $10 million for each of FY2019 through FY2023 to carry out the section.

Subtitle J: Alternatives to Opioids in the Emergency Department

Section 7091: Emergency Department Alternatives to Opioids Demonstration Program

Background

The NIH is undertaking the Helping to End Addiction Long-term (HEAL) initiative, which supports research into a number of topics related to opioid use. These include research on nonaddictive pain treatment with an emphasis on making these alternatives available more quickly in clinical settings.[71] In FY2018, the NIH received funding for this initiative and allocated funding for research to develop pain management alternatives, among other things.[72]

Provision

Section 7091 requires the Secretary to carry out a demonstration program by awarding grants to hospitals and emergency departments (including freestanding emergency departments) to develop, implement, or study alternatives to opioids for pain management in hospital or emergency department settings. The section specifies the entities eligible for grants, the application procedures, permissible uses of funds, and grantee reporting requirements, which include certain specified program elements that are required to be developed in accordance with federal and state privacy requirements. The Secretary, when awarding grants, must ensure a geographic distribution of grantees. The section also permits the Secretary to carry out a similar demonstration program for acute care settings.

The section requires the Secretary to implement a process whereby grant recipients can share best practices and promote consultation with experts who have implemented successful opioid alternative programs in hospital or emergency department settings. The section requires the Secretary to identify or facilitate the development of best practices on opioid alternatives and to

[71] U.S. Department of Health and Human Services, National Institutes of Health, "HEAL Initiative Research Plan," https://www.nih.gov/research-training/medical-research-initiatives/heal-initiative/heal-initiative-research-plan#budget.

[72] Ibid.

provide technical assistance to hospitals and other acute care settings for certain specified purposes. The section also requires the Secretary to, not later than one year after the completion of the demonstration program, submit a report to Congress on the results of the demonstration program, as specified. Finally, the section authorizes an appropriation of $10 million for each of FY2019 through FY2021.

Subtitle K: Treatment, Education, and Community Help to Combat Addiction

Section 7101: Establishment of Regional Centers of Excellence in Substance Use Disorder Education

Background

HRSA has a number of programs that directly support the training of SUD treatment providers.[73] It also supports a Center of Excellence program that aims to increase the diversity of the health care workforce; no similar program exists for SUD providers. Generally these programs focus on directly supporting behavioral health provider training and not the development of curricula.[74]

Provision

Section 7101 creates a new PHSA Section 551 entitled "Regional Centers of Excellence in Substance Use Disorder Education," which requires the Secretary, in consultation with appropriate agencies, to award cooperative agreements to eligible entities that educate health professionals as Regional Centers of Excellence in Substance Use Disorder Education. These centers are required to improve health professional training resources in SUD prevention, treatment, and recovery by developing, evaluating, and distributing evidence-based resources, as specified. The Secretary is required to ensure a geographic distribution of centers, to evaluate the centers, and to disseminate the evaluation findings. The new PHSA section authorizes to be appropriated $4 million for each of FY2019 through FY2023.

Section 7102: Youth Prevention and Recovery

Background

Neither HHS nor the Department of Education operates a grant program that specifically targets SUD interventions in schools. Other grant programs, including several block grants, *may* support similar activities, but are not explicitly authorized to address substance use prevention and treatment efforts—including those specific to the opioid epidemic—for children, adolescents, and young adults in both educational and community-based settings.

PHSA Section 514 (42 U.S.C. § 290bb-7) establishes a grant program within SAMHSA's CSAT for SUD screening and treatment for children and adolescents, and related assistance to pregnant women and mothers. The language in PHSA Section 514 does not include "young adults," only "children and adolescents" regarding the included population for grants contained in the section.

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[73] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Behavioral Health," https://bhw.hrsa.gov/grants/mentalbehavioralhealth.

[74] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Centers of Excellence," https://bhw.hrsa.gov/fundingopportunities/?id=fabd901d-f6b1-45eb-913b-d491c1e6a747.

Provision

Section 7102(c) requires the Secretary, in consultation with the Secretary of Education, to administer a youth prevention and recovery initiative to "provide support for communities to support prevention of, treatment of, and recovery from" SUDs. This program requires the Secretary, in consultation with Department of Education, to award competitive three-year grants to educational or community-based entities to support evidence-based SUD prevention, treatment, and recovery programs for children, adolescents, and young adults. The provision specifies the program eligibility and application process. The provision requires the Secretary conduct an evaluation of each grant funded and provide technical assistance for grantees. Grantees must submit to the Secretary a report describing how they used grant funds and how the grant program has made an impact on the intended outcomes, such as student success, SUD prevalence, number of overdoses, and other indicators as the Secretary deems appropriate.

Section 7102(c)(3) requires the Secretary, in consultation with the Secretary of Education, to identify the development of evidence-based best practices for prevention of substance abuse by children, adolescents, and young adults—including for several specified populations. Best practices must address prevention, MAT, and effective communication for outreach such as use of social media. The Secretary is required to disseminate these best practices, as appropriate, to specified entities, including state education agencies (SEAs), local education agencies (LEAs), institutions of higher education, and nonprofit organizations, among others. The Secretary must submit a report to Congress no later than October 1, 2022, summarizing the effectiveness of the program. The provision authorizes to be appropriated $10 million for each of FY2019 through FY2023 to carry out Subsection (c).

Section 7102(b) requires the Secretary, in consultation with the Secretary of Education and other agencies such as SAMHSA and HRSA, to establish a resource center to provide technical support to grant recipients.

Section 7102(a) amends PHSA Section 514 (42 U.S.C. § 290bb-7) to add "young adults," in addition to children and adolescents, to the included population for grants contained in that section.

Subtitle L: Information from National Mental Health and Substance Use Policy Laboratory

Section 7111: Information from National Mental Health and Substance Use Policy Laboratory

Background

SAMHSA's National Mental Health and Substance Use Policy Laboratory (the Laboratory), authorized in PHSA Section 501A,[75] promotes innovation, dissemination, and adoption of evidence-based practices related to mental health and substance use disorders. The Laboratory's responsibilities include coordinating the implementation of policy changes likely to improve specified outcomes, collaborating with SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) to collect data and evaluate practices, identifying evidence-based practices, reviewing SAMHSA programs to identify duplicative programs or programs that are not evidence-based, and providing recommendations for improving SAMHSA programs. The

[75] Established in the 21st Century Cures Act (P.L. 114-255)

Laboratory also participates in other activities to encourage innovation and the dissemination of evidence-based practices. SAMHSA appointed its first Director of the National Mental Health and Substance Use Policy Laboratory in January 2018 and launched the Evidence-Based Practices Resource Center in April 2018.[76]

Provision

Section 7111 amends PHSA Section 501A(b)[77] to add a new responsibility to the National Mental Health and Substance Use Policy Laboratory, requiring the Laboratory to provide information to applicants for SAMHSA grants or cooperative agreements to (1) encourage the implementation and replication of evidence-based practices and (2) provide technical assistance to applicants for funding.

Subtitle M: Comprehensive Opioid Recovery Centers

Section 7121: Comprehensive Opioid Recovery Centers

Background

Substance use treatment facilities in the United States possess a wide variety of structural characteristics and offer a spectrum of services. Facilities may be public or privately owned, may be affiliated with a large medical center or independent, and may treat a variety of SUDs or specialize in a single substance of abuse. Some treatment facilities offer a comprehensive array of evidence-based treatment, recovery, and case management services with residential or outpatient options, while others operate using a single treatment model.[78] According to NIDA, the most effective treatments for substance use disorders are comprehensive in nature and provide a combination of therapies and other services to meet the needs of the individual patient.[79] Not all substance abuse treatment centers in the United States offer a comprehensive assortment of services, however. For example, 18% of substance use treatment facilities in the United States offered detoxification services, 60% of facilities provided outreach to the community, and 61% of opioid treatment programs offered all FDA approved MATs for OUD in 2016.[80]

Provision

Section 7121 creates a new PHSA Section 552, entitled "Comprehensive Opioid Recovery Centers," which establishes a grant program for the operation of comprehensive opioid recovery centers (which may be a single entity or an integrated delivery network). The new PHSA section requires the Secretary to award no fewer than 10 competitive grants with grant period, eligibility, priority, and preference specified. Each center is required, at a minimum, to carry out certain

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[76] SAMHSA, *SAMHSA Blog*, Leadership Announcement, January 9, 2018, https://blog.samhsa.gov/tag/policy and SAMHSA, *SAMHSA Launches Evidence-Based Practices Resource Center to Equip Clinicians, Strengthen Communities*, Press Announcements, April 5, 2018, https://www.samhsa.gov/newsroom/press-announcements/201804050230.

[77] 42 U.S.C. §290aa-0(b)).

[78] HHS, SAMHSA, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2016*, Data on Substance Abuse Treatment Facilities, Rockville, MD, July 2017, p. 19-28.

[79] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition)*, Components of Comprehensive Drug Abuse Treatment, Bethesda, MD, January 2018, https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-drug-addiction-treatment.

[80] HHS, SAMHSA, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2016*, Data on Substance Abuse Treatment Facilities, Rockville, MD, July 2017, p. 19-28.

specified activities, either directly, through referral, or through contractual arrangements. These activities include, among others, providing the full continuum of treatment services, which includes (1) all FDA approved MAT; (2) withdrawal management; (3) counseling by a licensed provider; (4) testing for infections commonly associated with drug use; (5) treatment for co-occurring substance use and mental disorders; (6) residential rehabilitation; (7) outpatient programs; (8) recovery housing; (9) peer recovery support services; and (10) job training and placement assistance. In addition, facilities must provide onsite access to medication, offer family support services such as child care and family counseling, and maintain an interoperable electronic health information system. New PHSA Section 552 also requires centers to conduct outreach activities, which may include training staff to work with specified community organizations, ensuring community awareness of center services, and disseminating evidence-based resources. Grantees are required to submit annual data regarding programs, activities, and outcomes, as specified. New PHSA Section 522(j) authorizes to be appropriated $10 million for each of FY2019 through FY2023 for carrying out the activities under the section.

Section 7121 requires the Secretary to submit a preliminary report to Congress no later than three years after the date of enactment, and a final report not later than two years after the preliminary report, with an evaluation of the effectiveness of the centers and further recommendations.

Subtitle N: Trauma-Informed Care

Section 7131: CDC Surveillance and Data Collection for Child, Youth, and Adult Trauma

Background

Adverse childhood experiences (ACEs) is a public health term to describe "all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18."[81] In 1998, a joint CDC and Kaiser Permanente study found a strong association between exposure to adverse childhood experiences and later adult chronic conditions and health risk behaviors, including illicit drug use.[82] Numerous subsequent studies have supported this association.[83] The Behavioral Risk Factor Surveillance System (BRFSS) is a national telephone survey, coordinated by CDC, on "health-related risk behaviors, chronic health conditions, and use of preventive services."[84] Since 2009, 32 states have added questions related to adverse childhood experiences to at least one year of their BRFSS survey.[85] Similarly, the Youth Risk Behavior Surveillance System (YRBSS) is a school-based survey conducted among high school students on youth health-related behaviors, including drug use.[86]

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[81] CDC, "Adverse Childhood Experiences: Looking at how ACEs affect our lives and society," https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html.

[82] Vincent J. Felitti, Robert F. Anda, and Dale Nordenberg, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences Study," *American Journal of Preventive Medicine*, vol. 14, no. 4 (May 1998), pp. 245-258.

[83] CDC, "Adverse Childhood Experiences Journal Articles by Topic Area," April 1, 2016, https://www.cdc.gov/violenceprevention/acestudy/journal.html.

[84] CDC, "Behavioral Risk Factor Surveillance System," September 4, 2018, https://www.cdc.gov/brfss/index.html.

[85] CDC, "About Behavioral Risk Factor Surveillance System ACE Data," https://www.cdc.gov/violenceprevention/acestudy/ace_brfss.html.

[86] CDC, "Youth Risk Behavior Surveillance System (YRBSS) Overview," https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm.

Provision

Section 7131 allows the CDC Director to collect and report biennial data on adverse childhood experiences through relevant public health surveys, including BRFSS and YRBSS, in cooperation with the states. The Director must encourage statistically reliable representation of rural areas among participating states, and may provide technical assistance to Indian Tribes for data collection and reporting. The provision authorizes to be appropriated $2 million for each of FY2019 through FY2023 to carry out this section.

Section 7132: Task Force to Develop Best Practices for Trauma-Informed Identification, Referral, and Support

Background

Multiple federal agencies, such as SAMHSA, HRSA, and ACF, provide trauma-informed programming, grants, and technical assistance to state and local governments, and other entities.[87] These activities primarily involve disseminating information to service organizations and practitioners; the agencies do not often provide explicit recommendations to other federal agencies.

Provision

Section 7132 establishes the Interagency Task Force on Trauma-Informed Care. This task force is required to make recommendations regarding best practices with respect to children and families who have experienced trauma and ways federal agencies can better coordinate responses to families affected by substance use disorders and trauma. Section 7132(b) specifies a minimum of 29 federal task force members, including representatives from several agencies within HHS, DOJ, VHA, HUD, and the Department of Education.

Specified duties of the task force include soliciting input from specified stakeholders and identifying and making recommendations to specified federal agencies and the general public regarding (1) evidence-based best practices for trauma-informed care; (2) a national strategy on how the task force and member agencies will collaborate to share data and improve federal efforts to support individuals experiencing substance use or related trauma; and (3) existing federal authorities at specified agencies and federal grant programs that disseminate best practices on, provide training in, or deliver services through trauma-informed practices. The information collected under the last activity must be disseminated to relevant program offices and to the general public through the task force's internet website.

The best practices identified and recommended by the task force must include (1) guidelines for professional development for specified front-line service providers in identifying early signs of trauma, in practices that mitigate the effects of trauma, and procedures for referring infants, children and their families to evidence-based trauma-informed support services; (2) recommendations for practices designed to avoid custody loss or criminal penalties for parents with children who have experienced trauma; and (3) opportunities for local and state-level partnerships designed to make referrals, utilize appropriate services, offer community-based

[87] For example, SAMHSA operates the *National Center for Trauma Informed Care*, which works to "further advance the knowledge base related to implementation of trauma-informed approaches" (more information is available at https://www.samhsa.gov/nctic). The authority for this center comes from 42 U.S.C. 290hh-1, which describes the National Child Traumatic Stress Initiative (NCTSI).

prevention activities to mitigate the effects of trauma, utilize local partnerships, prevent family separation, and support reunification of families.

The provision requires the task force hold its first meeting within 120 days of enactment. The task force must submit an operating plan to several specified federal agency leaders no later than two years after enactment. The operating plan must include a list of specific activities the task force plans to carry out, a plan for carrying out these activities, membership, an explanation of federal involvement in carrying out these activities, a budget, and other relevant information. The provision requires the task force submit to several specified federal agency leaders, Congress, and the general public a report containing all findings and recommendations required under this section no later than three years after the first meeting. In addition to this report, the task force must submit a report to Congress identifying recommendations requiring legislative authority to implement and a report to state governors describing opportunities for local and state-level partnerships and best practices. The task force will sunset 60 days after the submission of the final report but not later than September 30, 2023.

Section 7133: National Child Traumatic Stress Initiative

Background

Since its initial authorization in the Children's Health Act of 2000 (P.L. 106-310), the National Child Traumatic Stress Initiative (NCTSI) has raised awareness about the impact of trauma on children and adolescents (PHSA Section 582; 42 U.S.C. §290hh-1). PHSA Section 582 authorizes grants to support the continued operation of NCTSI and the development of evidence-based practices for treating disorders of children resulting from witnessing or experiencing a traumatic event.[88] It requires the NCTSI coordinating center to collect, analyze, and publish treatment and outcome data for children and families served by grantees. The provision also requires the coordinating center to facilitate training initiatives in trauma-informed, evidence-based practices, among other activities. PHSA Section 582(j) authorizes to be appropriated $46.9 million for each of FY2018 through FY2022.

Provision

Section 7133 amends PHSA Section 582(j) to reauthorize funding for the NCTSI (42 U.S.C. §290hh-1[j]). The provision authorizes to be appropriated $63.9 million for each of FY2019 through FY2023.

Section 7134: Grants to Improve Trauma Support Services and Mental Health Care for Children and Youth in Educational Settings

Background

PHSA Section 520 requires the Secretary to "address priority mental health needs of regional and national significance." Pursuant to this authority, SAMHSA operates the Project AWARE (Advancing Wellness and Resilience in Education) grant program. Project AWARE comprises three components: (1) Project AWARE State Education Agency (SEA) grants, which are awarded to SEAs to promote state efforts to make schools safer and increase access to mental health services; (2) Mental Health First Aid Grants, which support teachers and others who work with youth to help schools and communities recognize signs of mental health issues and/or substance abuse in youth; and (3) Resilience in Communities After Stress and Trauma Grants (ReCAST),

[88] The 21st Century Cures Act (P.L. 114-255), enacted in 2016, authorized the continued operation of the NCTSI.

which assist high-risk youth and families and promotes resilience in communities experiencing civil unrest through implementation of violence prevention programs and linkages to trauma-informed behavioral health services.[89] Grants are awarded to state and local educational agencies.[90] Although children who have experienced trauma may be served under Project AWARE grant-funded activities, this program does not explicitly focus on trauma support services.

Provision

Section 7134 authorizes the Secretary, in coordination with SAMHSA, to award grants to, or enter into contracts or cooperative agreements with, SEAs and LEAs to increase student access to evidence-based trauma support services and mental health care. Funds are to be used for evidence-based activities, including (1) collaborative efforts between school-based and trauma-informed support and mental health service systems; (2) school-wide behavioral interventions; (3) professional development for teachers, school leaders, mental health providers, and other professionals; (4) services at full-service community schools;[91] (5) engaging families to increase awareness of child and youth trauma; (6) technical assistance to school systems and mental health agencies; (7) program evaluation; and (8) partnerships with or subgrants to Head Start agencies and other entities to improve services to young children and their families.

Grants may be awarded for up to four years subject to eligibility and application requirements as specified. A grant recipient must establish a local interagency agreement among local educational agencies and others involved in the provision of services, with required terms of these agreements specified in the provision. The Secretary must ensure grants are equitably distributed among regions of the United States. Services provided through programs under this section should supplement, not supplant, any existing services. Section 7134 authorizes to be appropriated $50 million for each of FY2019 through FY2023. The provision permits the Secretary to reserve not more than 3% of the funding made available for each fiscal year to (1) conduct an evaluation of grant activities and (2) disseminate and promote the utilization of evidence-based trauma support and mental health practices.

Section 7135: Recognizing Early Childhood Trauma Related to Substance Abuse

Background

SAMHSA's NCTSI (42 U.S.C. §290hh-1) "improves treatment and services for children, adolescents, and families who have experienced traumatic events."[92] NCTSI raises awareness of the impact of trauma on children by providing information on the signs of child traumatic stress and resources on how caregivers can help. PHSA Section 582(e) requires NCTSI to disseminate "evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders" and to share NCTSI "expertise, evaluation data, and other activities, as

[89] SAMHSA FY2018 Justification of Estimates for Appropriations Committees, p. 35, https://www.samhsa.gov/sites/default/files/samhsa-fy-2018-congressional-justification.pdf.

[90] Of note, the authority for this program comes from Title V, Part B of the PHSA, not Title V, Part A. The authority for Section 7134 of the SUPPORT for Patients and Communities Act comes from Title V, Part A, hence its inclusion in the background here.

[91] Consistent with Section 4625 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7275).

[92] SAMHSA, *National Child Traumatic Stress Initiative*, Programs and Campaigns, updated January 7, 2016, https://www.samhsa.gov/child-trauma.

appropriate." NCTSI also provides technical assistance for professionals seeking training on child traumatic stress.

Provision

Section 7135 requires the Secretary to disseminate information, resources, and, if requested, technical assistance to professionals working with young children on ways to recognize trauma and respond appropriately. The stated goals of these activities are to (1) educate early childhood care and education providers on understanding and identifying early signs and risk factors of children affected by trauma, (2) suggest age-appropriate communication practices for trauma-informed care, (3) provide options for responding to children impacted by trauma including recommending resources and referrals for evidence-based services, and (4) promote whole-family and multigenerational approaches to keep families safely together. The provision requires the Secretary to coordinate with the task force established in Section 7132 in disseminating information, resources, and technical assistance. No additional funding is authorized.

Subtitle O: Eliminating Opioid Related Infectious Diseases

Section 7141: Reauthorization and Expansion of Program of Surveillance and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors

Background

PHSA Section 317N authorizes CDC to carry out programs or to award grants to improve the prevention, detection, treatment, and awareness of hepatitis C infections. CDC has noted that the current epidemic of injection opioid use has increased the incidence of hepatitis C and other viral and bacterial blood-borne infections, including HIV.[93]

Provision

Section 7141 replaces the previous text of PHSA Section 317N and expands authority to address opioid related infectious diseases by allowing CDC—directly or through grants to public and nonprofit private entities—to provide for programs to (1) cooperate with states and Indian Tribes to monitor infections commonly associated with illicit drug use; (2) identify, counsel, and offer testing to at-risk individuals; (3) provide appropriate referrals for counseling, testing, treatment, and follow-up services; (4) conduct public outreach; (5) educate health professionals; and (6) improve clinical laboratory procedures for the diagnosis of such infections. The section authorizes an appropriation of $40 million for each of FY2019 through FY2023.

Subtitle P: Peer Support Communities of Recovery

Section 7151: Building Communities of Recovery

Background

CARA established the Building Communities of Recovery (BCOR) grant program through a new PHSA Section 547 (42 U.S.C. §290ee-2) to help recovery community organizations, as defined,

[93] CDC, "Infectious Diseases, Opioids and Injection Drug Use," July 19, 2018, https://www.cdc.gov/pwid/opioid-use.html.

increase resources and enhance long-term recovery services, as specified. SAMHSA, through CSAT, awarded BCOR grants to support the development, enhancement, expansion, and delivery of recovery support services, and education about recovery. Of note, the federal share of the costs of a program funded by a BCOR grant could not exceed 50%. CARA authorized to be appropriated $1 million for each of FY2017 through FY2021.[94]

Provision

Section 7151 amends PHSA Section 547 to make adjustments to certain aspects of the BCOR grant program. The provision limits the federal share of the costs of a program funded by these grants to 85%, as opposed to the 50% previously specified. The provision amends allowable uses of funds to include building connections between recovery community organizations and peer support networks, as well as with educational and vocational schools and specified nonclinical community services, while removing the criminal justice system. The provision requires the Secretary to give "special consideration" to the unique needs of rural areas, including regions with higher than average age-adjusted rates of drug overdoses and areas with a shortage of prevention and treatment services. The provision increases the authorization of appropriations from $1 million to $5 million for each of FY2019 through FY2023.

Section 7152: Peer Support Technical Assistance Center

Background

The importance of peer support and peer-delivered services in substance use disorder recovery is well recognized.[95] The federal government supports these activities through grant programs such as SAMHSA's Recovery Community Services Program. The SUPPORT Act emphasizes, in several provisions (e.g., Section 7151), the importance of peer support activities in the recovery process. While SAMHSA publishes core competencies for peer support workers within behavioral health services, there are no comprehensive federally recognized best practices for peer recovery support organizations.[96]

Provision

Section 7152 adds a new PHSA Section 547A, entitled "Peer Support Technical Assistance Center," which establishes the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Services. The center is required to provide technical assistance and support, as specified, to recovery community organizations and peer support networks. This includes training on identifying signs of SUDs, resources to assist individuals with SUDs, and best practices for delivery of support services; data collection to support research; capacity building; and evaluation activities, among others. The provision also requires the center to periodically

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[94] According to SAMHSA's Operating Plans, the final amount appropriated in FY2017 for the Building Communities of Recovery grant program was $3 million and the amount in FY2018 was $5 million. According to the Conference Report accompanying the FY2019 appropriations act (H.Rept. 115-952), the amount appropriated for FY2019 was $6 million. SAMHSA's Operating Plans are available at https://www.samhsa.gov/about-us/budget.

[95] See, for example, Institute of Medicine of the National Academies, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Washington, DC, 2006.

[96] SAMHSA, *Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS): Core Competencies for Peer Workers*, Recovery Support Tools, September 5, 2017, https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers.

issue best practices for use by recovery community organizations and peer support networks. The provision authorizes to be appropriated $1 million for each of FY2019 through FY2023.

Subtitle Q: Creating Opportunities that Necessitate New and Enhanced Connections that Improve Opioid Navigation Strategies

Section 7161: Preventing Overdoses of Controlled Substances

Background

CDC conducts a variety of activities to address the opioid overdose epidemic, including (1) providing evidence-based tools, recommendations, and guidance for health care providers to improve opioid prescribing; (2) providing public education and awareness regarding the risks of prescription opioids; (3) providing funding, resources, and information to states to prevent opioid misuse, abuse, and overdose; (4) improving collaboration and communication between public health and public safety officials; and (5) collecting and analyzing data on opioid-related overdoses.[97]

Section 102 of CARA requires the Secretary, in coordination with other departments and agencies, to "advance the education and awareness of the public, providers, patients, consumers, and other appropriate entities" regarding the risk of prescription drug abuse through existing programs and activities.[98] The education and awareness campaigns are required to address (1) the dangers of opioid abuse; (2) the prevention of opioid abuse, as specified; and (3) the detection of early warning signs of addiction. The campaigns must take into account the relationship between prescription opioid abuse and heroin use, as specified.

Provision

Section 7161, subsection (a), adds a new PHSA Section 392A, entitled "Preventing Overdoses of Controlled Substances." It allows the CDC Director to conduct activities related to overdoses of controlled substances, such as prevention programs, surveillance and data collection activities, and education and awareness.

Subsection (a) of the new PHSA Section 392A allows the CDC Director to award grants and provide training and technical assistance to states, localities, and Indian tribes to carry out and expand evidence-based prevention activities, which may include (1) improving the efficiency and use of a prescription drug monitoring program (PDMP); (2) promoting community or health system interventions; (3) evaluating interventions to prevent controlled substance overdoses; and (4) implementing projects to advance an innovative prevention approach with respect to new and emerging public health crises. The provision specifies a number of PDMP purposes that may be funded, including, among others, registering all authorized users; enabling access to information in near-real-time; flagging potential opioid misuse and/or inappropriate prescribing; allowing access to de-identified data by other governmental partners; and enhancing interoperability between other state PDMPs and with HIT applications. The CDC Director may award additional grants for innovative projects for rapid response and any other evidence-based activity for preventing controlled substance misuse, abuse, and overdoses. Finally, subsection (a) allows the CDC Director to study substance use disorders and prevention approaches, in coordination with the ASMHSU.

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[97] CDC, "CDC's Role in the Opioid Epidemic," https://www.cdc.gov/drugoverdose/prevention/cdc-role.html.

[98] P.L. 114-198; 42 U.S.C. 290bb-25g.

Subsection (b) of the new PHSA Section 392A allows the CDC Director to conduct controlled substance overdose data collection activities, and to assist states and localities in doing so through grants, training, and technical assistance. It also allows the CDC Director to coordinate with the ASMHSU to collect data on emergency department visits resulting from alcohol or drug abuse. Subsection (c) of the new section provides definitions, and subsection (d) authorizes the appropriation of $496 million for each of FY2019 through FY2023 for new PHSA Section 392A, PHSA section 399O (as amended by Section 7162 of the SUPPORT Act, summarized below), and CARA Section 102 (as amended by Section 7161(b) of the SUPPORT Act, summarized below).

Section 7161, subsection (b), amends CARA Section 102, making changes to the authority for opioid abuse awareness campaigns as follows. Paragraph (b)(1) replaces the language of CARA subsection 102(a), making the following changes: it newly requires the Secretary to act specifically through the CDC Director; allows for the development of new programs; and specifies education and awareness topics for the public, providers, and other appropriate entities. Paragraph (b)(2) changes CARA subsection 102(b), replacing each use of "opioid abuse" with "opioid misuse and abuse," and adding "non-addictive treatment options" to the specified prevention topics to be included in the campaign.

Section 7162: Prescription Drug Monitoring Program

Background

PHSA Section 399O requires the Secretary, in consultation with SAMHSA and CDC, to award grants to each state that submits a proper application (as specified), in order to establish or improve state programs to monitor the dispensing of controlled substances. Awards are to be made according to a formula that includes a uniform "base" amount per applicant and an additional amount calculated according to the number of pharmacies in the applicant's state. Grantees must meet specified requirements to manage, protect, and share information from the monitoring program, including use of current technology and interoperability with monitoring programs in adjacent jurisdictions, and specified reporting requirements and privacy protections. As a condition of receipt of support, a state or locality must, by law or regulation, provide for the implementation of a monitoring program, with associated penalties for its misuse. The section authorizes or requires specified reports and formation of an advisory council, states rules of construction, and provides definitions. The section authorizes the appropriation of $10 million for each of FY2017 through FY2021.

The monitoring programs established by this language are now referred to as PDMPs.[99] They have incorporated an earlier HHS program, the National All Schedules Prescription Electronic Reporting (NASPER), which no longer operates under that name.

Provision

Section 7162 replaces PHSA Section 399O with new language, placing responsibility for assisting state controlled substance monitoring programs—now called PDMPs—with the CDC Director. The language refers to "receipt of support" and "grantees," but does not explicitly mention administration of a grant program, or include a formula. The language focuses on required or allowed PDMP attributes and activities, and other matters.

Subsection (a) of the amended PHSA Section 399O establishes the program, under the CDC Director, to support state and local PDMPs, including their implementation, maintenance, and improvement. Specified system attributes include timeliness of data, ease of use, and

[99] For an overview, see CRS Report R42593, *Prescription Drug Monitoring Programs*.

interoperability with other data systems such as electronic health records, pharmacy and Medicaid data, and worker's compensation claims records, among others. As a condition of receipt of support, a state or locality must, by law or regulation, provide for the implementation of a PDMP, with associated penalties for its misuse.

Subsection (b) of the amended PHSA Section 399O lists PDMP usage strategies that the Secretary must encourage, including, among others, reporting of dispensing to the PDMP within 24 hours, consultation of the PDMP by all prescribing practitioners before initiating treatment with or prescribing a controlled substance, and making nonidentifiable PDMP information available to CDC.

Subsection (c) of the amended PHSA Section 399O lists activities required or authorized by a state or locality receiving support. Such state or locality must establish notifications to practitioners and dispensers on the avoidance of unlawful diversion or misuse of controlled substances, and may access and analyze data from the PDMP and make notifications or queries to others, consistent with applicable state law, to avoid diversion and misuse.

In the amended PHSA Section 399O, subsection (d) specifies information that must be reported by entities receiving support (presumably to the CDC Director). It does not specify a deadline or time frame. Subsection (e) requires the entity receiving support provide aggregate nonidentifiable information from the PDMP to the Secretary for evaluation and reporting purposes. Subsection (f) requires entities receiving support provide education on PDMP access and use to prescribers and dispensers. Subsection (g) allows the Secretary to issue guidelines regarding reporting formats, disclosure of information, and other matters.

Subsection (h) of the amended PHSA Section 399O states that the section shall not be construed to (1) restrict law enforcement, narcotics control, licensure, disciplinary, or other controlled substance regulatory activity otherwise authorized by law; (2) preempt any state from imposing additional privacy protections; (3) supersede any federal privacy or confidentiality requirement; or (4) create a federal private cause of action.

In the amended PHSA Section 399O, Subsection (i) requires the Secretary, within three years of enactment, to study and report to Congress on the progress of states in implementing PDMPS (including their timeliness, privacy protections, and interoperability) and the effectiveness of PDMPs in addressing problems of inappropriate use, diversion, and overdose with controlled substances. The report may also address how the operation of PDMPs has established or strengthened linkages to substance use disorder treatment services, and has affected patient access to appropriate care. Subsection (j) requires states and localities to establish PDMP advisory councils. It prohibits their use of federal funds for this purpose. Finally, subsection (k) provides definitions.

As noted earlier, Section 7161 authorizes the appropriation of $496 million for each of FY2019 through FY2023 to implement this section and Section 7161.

Subtitle R: Review of Substance Use Disorder Treatment Providers Receiving Federal Funding

Section 7171: Review of Substance Use Disorder Treatment Providers Receiving Federal Funding

Background

SAMHSA has a number of programs that develop and disseminate information for behavioral health providers. The agency also provides information about providers to the public who are seeking to locate treatment services.[100] This information is not related to whether the providers receive payments from federal programs. Separately, HRSA analyzes the overall behavioral health workforce, in part, to identify the adequacy of the existing or future workforce in a given field.[101] This effort is about identifying the availability of providers and is not related to whether these providers have received federal support.

Provision

Section 7171 requires the Secretary to review entities that receive federal funding to provide SUD treatment services. The review is required to include certain specified elements about the entity's history, population served, and treatment capacity. The Secretary is required, within two years of enactment, to develop and submit a plan to Congress to direct appropriate resources to entities that provide SUD treatment services in order to address inadequacies in services or funding identified through the required review.

Subtitle S: Other Health Provisions

Section 7181: State Response to the Opioid Abuse Crisis

Background

Section 1003 of the Cures Act established the "Account for the State Response to the Opioid Abuse Crisis," to which $500 million was transferred for each of FY2017 and FY2018 (42 U.S.C. §290ee-3 note). Such amounts from the account were authorized to be appropriated to the Secretary for use as grants to states to support state responses to the opioid epidemic. The "Account for the State Response to the Opioid Abuse Crisis" resulted in the State Targeted Response to the Opioid Crisis (Opioid STR) grant program. While the funds were appropriated to HHS generally, the responsibility for administering these grants was delegated to SAMHSA.[102]

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[100] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Find Health and Treatment," https://www.samhsa.gov/.

[101] For examples, see U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Workforce, "Health Workforce Analysis, Research Finding," https://bhw.hrsa.gov/health-workforce-analysis/research.

[102] U.S. Congress, House Committee of the Whole House on the State of the Union, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2017*, To accompany H.R. 5926, 114th Cong., 2nd sess., July 22, 2016, 114-699, p. 4, available at https://www.gpo.gov/fdsys/pkg/CRPT-114hrpt699/pdf/CRPT-114hrpt699.pdf.

In both years of the program (FY2017 and FY2018), SAMHSA awarded formula grants to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, the Northern Marianas, Micronesia, Palau, and American Samoa.[103] The same amount was provided in both years of the grant. Per statute, this grant program supports states in addressing the opioid abuse crisis through activities that supplement opioid-related activities undertaken by the state agency that administers the Substance Abuse Block Grant distributed by SAMHSA.

Of note, Cures Act Section 1003(b)(3)(B) exempted the amounts appropriated for FY2017 and FY2018 from any cost estimates provided for purposes of budget controls. Effectively, the appropriations from the account were not counted against any spending limits, such as the statutory discretionary spending limits. Therefore, the amounts appropriated for the Opioid STR grant were considered outside those limits for FY2017 and FY2018.

Provision

Section 7181 reauthorizes the State and Tribal Response to the Opioid Abuse Crisis grant program.[104] Subsection (a) of Section 7181 requires the Secretary to award grants to Indian Tribes in addition to states and territories. The provision makes other changes, such as expanding the types of activities that grants may support to include the establishment of PDMPs and training for health care practitioners in preventing diversion of controlled substances.[105] It also emphasizes flexibility with use of funds by permitting resources to be directed "in accordance with local needs related to substance use disorders."

Subsection (a) of Section 7181 requires the Secretary to submit a report to specified congressional committees of jurisdiction summarizing reports from grantees, including the purposes for which grant funds are awarded and the activities of grant recipients. This provision further requires the Secretary, through SAMHSA, to provide state agencies with technical assistance concerning grant application and submission procedures, award management activities, and direct support to rural and underserved communities in addressing the opioid crisis.

Subsection (a) of Section 7181 authorizes to be appropriated $500 million for each of FY2019 through FY2021. This includes a 5% set-aside for Indian Tribes and up to a 15% set-aside for states with the highest age-adjusted drug overdose mortality rate based on CDC data.

Subsection (a) of Section 7181 removes the "Account for the State Response to the Opioid Abuse Crisis" language in Section 1003 of the Cures Act, which includes the transfer of funds from the Treasury to the account and the exemption from budget controls. Therefore, appropriations for this grant would be included in estimates for the purposes of budget controls, including the statutory discretionary spending limits. Subsection (b) of Section 7181 includes further technical corrections to remove obsolete provisions in the Cures Act.

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[103] HHS, SAMHSA, *FY2018 Justification of Estimates for Appropriations Committees*, p. 207 and HHS, SAMHSA, *FY2019 Justification of Estimates for Appropriations Committees*, p. 218.

[104] The provision amends the title of the opioid grant program from "State Response to the Opioid Abuse Crisis" to "State and Tribal Response to the Opioid Abuse Crisis."

[105] Prior to the enactment of the SUPPORT Act, Section 1003 of the Cures Act explicitly authorized the use of grants for "improving," but not "establishing," state prescription drug monitoring programs.

Section 7182: Report on Investigations Regarding Parity in Mental Health and Substance Use Disorder Benefits

Background

Section 13003 of the Cures Act required the Assistant Secretary of Labor of the Employee Benefits Security Administration (EBSA), in collaboration with the Administrator of CMS and the Secretary of the Treasury, to submit a report to specified congressional committees of jurisdiction summarizing federal investigations that found serious violations regarding compliance with federal requirements for parity in mental health and substance use disorder benefits over the preceding year.[106] Section 13003 requires the report to include the number of closed federal investigations conducted during the reporting period, the benefit classification examined by the investigation, the subject matter of the investigation, and a summary of the final decision rendered.

Provision

Section 7182 amends Cures Act Section 13003 so that the annual reports to Congress, beginning with the second report, summarize the results of investigations pertaining to compliance with mental health and substance use disorder parity requirements generally, rather than focusing exclusively on "serious violations." Reports are now to include the number of complaints received during the preceding 12 months in addition to the number of closed federal investigations. The provision also requires that reports include, for each investigation closed, which agency conducted the investigation, whether the health plan subject to the investigation is fully insured or not, a summary of any coordination between specified agencies, and references to any guidance provided by the agencies addressing the category of violation committed. The provision adds the Committee on Education and the Workforce to the specified congressional committees of jurisdiction required to receive the reports.

Section 7183: CAREER Act

Background

SAMHSA supports community-based mental health and substance abuse treatment and prevention services through formula grants to the states and U.S. territories and through competitive grant programs to states, territories, tribal entities, local communities, and private entities. SAMHSA also engages in a range of other activities that support substance abuse prevention and treatment, such as technical assistance, data collection, and health workforce development.[107] These activities may include efforts to connect individuals with the labor force, but generally SAMSHA programs are more health-focused. The Department of Labor (DOL) permits its National Dislocated Worker Grant Program disaster grants to be used to provide employment and training activities to populations affected by opioid use.[108] DOL funds can be

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[106] Mental health and substance abuse requirements under Section 2726 of the PHSA (42 U.S.C. 300gg-26, Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and Section 9812 of the Internal Revenue Code of 1986.

[107] CRS Report R44987, *The Opioid Epidemic and Federal Efforts to Address It: Frequently Asked Questions*.

[108] U.S. Department of Labor, Employment & Training Administration, "Training and Employment Guidance Letter No.4-18, National Health Emergency Phase 2: Disaster Recovery Dislocated Worker Demonstration Grants to Address the Opioid Crisis" https://wdr.doleta.gov/directives/corr_doc.cfm?DOCN=7230 and U.S. Department of Labor, Employment & Training Administration, Training and Employment Guidance Letter No.12-17, National Health

used for employment and training activities and for supportive services; they cannot be used for in-patient drug treatment and rehabilitation programs.

Provision

Section 7183 requires the Secretary, in consultation with the Secretary of Labor, to award competitive grants to treatment and recovery service providers for not more than five years to carry out evidence-based programs that continue or establish programs to support individuals in SUD treatment and recovery to live independently and participate in the workforce. Applicants must coordinate with one or more state or local stakeholders—employers, community development organizations, and Workforce Development Boards (WDB), Indian Tribes, or Tribal Organizations—and may use grant funds to hire personnel to provide treatment and recovery related services, to provide services using innovative technologies, and to provide workforce training activities, as specified. The provision specifies the application procedures, grantee reporting requirements, and the formula to be used when awarding grants, which takes into account the states' rates of drug overdose deaths, unemployment rate, and labor force participation rate. Finally, the provision requires the Secretary, not later than two years after the end of the first year of the grant period, to submit a report to Congress that includes certain specified elements and requires the Secretary to submit a final report to Congress not later than two years after the preliminary report was submitted that includes information on the use of grant funding and recommendations. The provision authorizes to be appropriated $5 million for each of FY2019 through FY2023.

Title VIII—Miscellaneous

Subtitle A: Synthetics Trafficking and Overdose Prevention

Section 8001. Short Title

Background

See Sections 8002-8007 below.

Provision

This section states that the subtitle (Section 8001-8009) may be cited as "The Synthetics Trafficking and Overdose Prevention Act of 2018" or "STOP Act of 2018."

Section 8002 Customs Fees

Background

Provisions in Subtitle A (The Synthetics Trafficking and Overdose Prevention Act of 2018 or "STOP Act of 2018") seek to prevent the entry of illegal drugs into the United States by requiring the U.S. Postal Service (USPS) to obtain advance electronic data on inbound packages before they enter the United States. Under prior law, private carriers such as FedEx and UPS were

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Emergency Dislocated Worker Demonstration Grants to Address the Opioid Crisis," https://wdr.doleta.gov/directives/corr_doc.cfm?DOCN=7468.

required to provide advance electronic data.[109] However, the USPS had been exempt from those requirements.

Provision

Section 8002 requires the assessment of a $1 per item fee on each Inbound Express Mail (EMS)[110] item sent to the United States through the international postal network. The proceeds from the fee are to be allocated equally between the USPS and the U.S. Customs and Border Protection (CBP) and may be used to directly reimburse for costs incurred in connection with the processing of Inbound EMS items.

Section 8003. Mandatory Advance Electronic Information for Postal Shipments

Background

Since its founding in 1874, the United States has been a member of the Universal Postal Union (UPU). The UPU is the primary forum for multilateral cooperation and negotiation of international postal issues amongst nations worldwide.[111] Since 2012, the UPU has noted that one of its goals is to increase postal integrity and security by working towards consistency, reliability, and predictability throughout the postal network including the exchange of advance electronic customs data. However, current UPU agreements do not require all member countries to provide the kind of advance electronic data that the SUPPORT Act requires. In addition, the UPU has repeatedly acknowledged that many of its member countries do not have an existing capability to gather, consistently format, or transmit advance electronic data. Prior to enactment of P.L. 115-271, the Secretary of the Treasury, in consultation with the Postmaster General, had discretion to determine whether to impose a requirement for reception of advance data on foreign mail entering the United States.

Provision

Section 8003 amends Section 343 of the Trade Act of 2002 (P.L. 107-210) to require the Secretary of the Treasury to issue regulations requiring the USPS to transmit select customs information to CBP for inbound international mail shipments, including those from foreign postal operators that are transported by private carrier. The section specifies that the regulations for mandatory advance electronic information for postal shipments may allow for phased implementation and incremental targets for the percentage of shipments for which advanced data are provided. The section also requires that the regulations for phased implementation are to take into consideration

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[109] The requirement for advance electronic data for private carriers is based on Section 343 of the Trade Act of 2002, P.L. 107-210, 19 U.S.C. §2071 note. The law provided that the U.S. Customs and Border Protection (CBP) must receive information pertaining to cargo before the cargo is either brought into or sent from the United States by any mode of commercial transportation (sea, air, rail, or truck). CBP amended 19 C.F.R. parts 4, 103, 113, 122, 123, 178, and 192 in order to implement the provision. Since FedEx, UPS, and other carriers use these commercial modes of transportation, they are required to provide these data. See Department of Homeland Security, Bureau of Customs and Border Protection, "Required Advance Electronic Presentation of Cargo Information. Final Rule." 68 *Federal Register* 68140, December 5, 2003.

[110] Express Mail Service (EMS) is an international service for express delivery of documents and merchandise worldwide by post. The EMS Cooperative includes a global network of 181 postal operators in over 175 countries. Universal Postal Union, "About EMS," at http://www.upu.int/en/activities/ems/about-ems.html. Also see the EMS Cooperative's website at https://www.ems.post/en.

[111] For additional information on the UPU, see CRS Insight IN10960, *Universal Postal Union to Convene an Extraordinary Congress*.

factors including (1) the risk posed by shipments, (2) the volume of incoming international mail from a particular country, and (3) the capability of a foreign postal operator to provide advance electronic data to the USPS.

Further, by December 31, 2018, the section requires the USPS to ensure transmission of advance electronic data of at least 70% of all inbound international mail and advance electronic data of 100% of inbound international mail from the People's Republic of China. By December 31, 2020, USPS is required to provide advance electronic data for 100% of inbound international mail shipments. A country may be excluded from the advance electronic data requirement if the Commissioner of CBP, in consultation with the Postmaster General, determines that (1) its shipments pose a low risk, (2) its shipments are of low volume and can be effectively screened through alternate means, and (3) its postal operators do not have the capability to collect and provide advance electronic data to the USPS. Further, Section 8003 requires that the Secretary of Homeland Security and the Postmaster General, in consultation with the Secretary of State, develop a Joint Strategic Plan to provide technical assistance, equipment, technology, and training to enhance the capacity of foreign postal operators to collect and transmit advance electronic customs data.

Section 8004. International Postal Agreements

Background

Generally, U.S. international postal policy is governed by *international postal arrangements*, which include bilateral and multilateral postal treaties, conventions, memoranda of agreement, and international postal agreements. As of January 1, 2018, the United States is a party to 314 bilateral international postal arrangements and 13 multilateral postal arrangements.[112] Of the bilateral postal arrangements, 167 involve Express Mail Services that will be subject to $1 per item fee under Section 8002.[113] Of the multilateral postal arrangements, 10 are with the UPU, while the remaining three are with a regional sub-union of the UPU.[114]

President Trump announced on October 17, 2018, that the United States intends to begin the one-year process to withdraw from the UPU.[115] The President stated that sufficient progress had not been made during the September 2018 UPU negotiations on several of the United States international postal priorities, including policies to ensure the collection of advance electronic customs data.[116]

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[112] Data on bilateral and multilateral international postal agreements obtained from the electronic edition of U.S. State Department, *Treaties in Force: A List of Treaties and Other International Agreements of the United States in Force on January 1, 2018*, at https://www.state.gov/documents/organization/282222.pdf. The electronic edition of *Treaties in Force* provides the most recent data available and includes "treaties and other agreements entered into by the United States which, as of the specified date, not expired by their own terms, been denounced by the parties, replaced or superseded by other agreements, or otherwise definitely terminated." (U.S. State Department, *Treaties in Force*, p. i).

[113] Ibid.

[114] Ibid.

[115] White House Press Secretary, "Statement from the Press Secretary," October 17, 2018, at https://www.whitehouse.gov/briefings-statements/statement-press-secretary-38/.

[116] U.S. President Donald J. Trump, "Presidential Memorandum for the Secretary of State, Secretary of the Treasury, Secretary of Homeland Security, Postmaster General, and Chairman of the Postal Regulatory Commission," August 23, 2018, at https://www.whitehouse.gov/presidential-actions/presidential-memorandum-secretary-state-secretary-treasury-secretary-homeland-security-postmaster-general-chairman-postal-regulatory-commission/.

Any member of the UPU may withdraw from the Union by submitting a notice of denunciation.[117] Withdrawal becomes effective one year from the date the notice is received.[118] On October 18, 2018, the UPU confirmed that it had received a notice of denunciation from the U.S. Secretary of State. Based on recommendations from the State Department, the Trump Administration stated that the U.S. would renegotiate its bilateral and multilateral postal arrangements as part of its UPU withdrawal process.[119]

Provision

Section 8004 prohibits the Secretary of State from committing the United States to any future international postal arrangements that are in conflict with the provisions in this subtitle. Further, to prevent the United States from violating its existing obligations, the section instructs the Secretary of State to renegotiate any existing postal treaties and arrangements that are in conflict with its provisions.

Section 8005. Cost Recoupment

Background

See Section 8002 above.

Provision

Section 8005 states that any other costs USPS incurs in connection with the requirements of this subtitle—costs not covered by revenues from the $1 per item EMS fee—are "to the extent practicable and otherwise recoverable by law," to be charged directly to foreign shippers or foreign postal operators.

Section 8006. Development of Technology to Detect Illicit Narcotics

Background

All incoming international mail arrives in the United States at one of the U.S. Postal Service's international mail processing centers (IMPCs).[120] While most mail originating outside the customs territory of the United States is subject to customs examination under USPS's *International Mail Manual*,[121] the screening processes used for incoming international mail differ by the type of post.

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[117] Universal Postal Union, Constitution, Chapter II, Article 11, "Accession or Admission to the Union: Procedures," at http://www.upu.int/uploads/tx_sbdownloader/actInForceIndefinitelyConstitutionEn.pdf#page=3.

[118] Ibid.

[119] White House Press Secretary, "Statement from the Press Secretary," October 17, 2018. As of January 1, 2018, the United States is a party to 314 bilateral international postal arrangements and 13 multilateral postal arrangements. Of the multilateral postal arrangements, 10 are with the UPU, while the remaining three are with a regional sub-union of the UPU.

[120] U.S. Customs and Border Protection, *Mail – Processing international mail: What is the process international mail goes through when it enters the U.S.?*, at https://help.cbp.gov/app/answers/detail/a_id/115/related/1/session/L2F2LzEvdGltZS8xNDgzNzI4NTgyL3NpZC84OUFPRCo3bg%3D%3D.

[121] U.S. Postal Service, International Mail Manual, §711.1, at http://pe.usps.com/text/imm/immc7_001.htm. The customs territory is defined by the IMM as the area outside the 50 states, the District of Columbia, and Puerto Rico (hereafter,

USPS takes initial delivery of all incoming international mail (letter and parcel post). In general, incoming international *letter* post is *not* subject to customs control and is screened by USPS, whereas incoming international *parcel* post *is* generally subject to customs control.[122] All international parcels USPS receives are sent to CBP to be screened and assessed for any potential customs duties owed. Once screened, parcels are returned to the USPS for delivery to customers.[123] Currently, both USPS (including the Postal Inspection Service) and CBP use technology to detect illicit narcotics and other hazardous materials contained in incoming international mail. For example, CBP uses handheld screening devices to analyze incoming international packages for narcotics and industrial chemicals.[124]

Provision

Section 8006 instructs the Postmaster General and the Commissioner of CBP, in coordination with the heads of other agencies as appropriate, to "identify and develop technology for the detection of illicit fentanyl, other synthetic opioids, and other narcotics and psychoactive substances entering the United States by mail." In addition, Section 8006 instructs the Postmaster General and the Commissioner to conduct outreach to the private sector regarding new technologies for the detection of fentanyl and other illicit narcotics.

Section 8007. Civil Penalties for Postal Shipments

Background

See Section 8003 above.

Provision

Section 8007 amends Section 436 of the Tariff Act of 1930[125] to make the USPS liable for civil penalties if it accepts a shipment that was found to have violated select requirements for clearance and reporting of incoming shipments under the Trade Act of 2002.[126]

Section 8008: Report on Violations of Arrival, Reporting, Entry, and Clearance Requirements and Falsity or Lack of Manifest

Background

See Sections 8002-8007 above.

USPS, IMM).

[122] Select types of international letter post (e.g., *small packets*) are subject to customs controls.

[123] U.S. Customs and Border Protection, *Mail – Processing international mail: What is the process international mail goes through when it enters the U.S.?*

[124] U.S. Customs and Border Protection, *O'Hare's CBP is first Line of Defense against Drugs*, March 28, 2018, at https://www.cbp.gov/newsroom/local-media-release/o-hare-s-cbp-first-line-defense-against-drugs.

[125] 19 U.S.C. §1436.

[126] P.L. 107-210; 19 U.S.C. §3801 note. Specifically, Section 8007 of the SUPPORT Act states "a civil penalty shall be imposed against the United States Postal Service if the Postal Service accepts a shipment in violation of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002."

Provision

Section 8008 requires the Commissioner of CBP to submit to the appropriate congressional committees an annual report that contains information on violations of section 436 of the Tariff Act of 1930 (19 U.S.C. §1436), as amended by Section 8007 of the SUPPORT Act, including (1) the name and address of the violator, (2) the violation committed, (3) the location or port of entry through which the items were transported, and (4) the location from which the items originated. For the purpose of Section 8007, the term "appropriate congressional committees" means (1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate, and (2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

Section 8009: Effective Date; Regulations

Background

See Sections 8002-8007 above.

Provision

With the exception of amendments made by section 8002, this subtitle took effect on the date of enactment (i.e., October 26, 2018). The section also requires that, not later than one year after the date of the enactment, such regulations as are necessary to carry out this subtitle and the amendments made by this subtitle be prescribed.

Subtitle B: Opioid Addiction Recovery Fraud Prevention

Sections 8021-8023: Opioid Addiction Recovery Fraud Prevention Act of 2018

Section 8023: Unfair or Deceptive Acts or Practices with Respect to Substance Use Disorder Treatment Service and Products

Background

According to SAMHSA, over 2 million people received substance use disorder treatment at a specialty facility in 2016.[127] In a report on the costs of the opioid crisis, the President's Council of Economic Advisers cited a study estimating that prescription opioid misuse increased health care and substance abuse treatment costs by almost $30 billion in 2013.[128] Due to the increased demand for opioid treatment, substance use treatment centers are a multibillion dollar industry.[129]

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[127] Eunice Park-Lee, Rachel Lipari, and Sarra Hedden, et al., *Receipt of Services for Substance Use and Mental Health Issues Among Adults: Results from the 2016 National Survey on Drug Use and Health*, SAMHSA, NSDUH Data Review, Rockville, MD, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016/NSDUH-DR-FFR2-2016.htm.

[128] Curtis Florence, Feijun Luo, and Likang Xu, et al., "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013," *Med Care*, vol. 54, no. 10 (October 2016), pp. 901-906, as cited in The Council of Economic Advisers, *The Underestimated Cost of the Opioid Crisis*, Executive Office of the President, November 2017, .https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf.

[129] HHS, SAMHSA, *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020*, HHS Publication No. SMA-14-4883, Rockville, MD, 2014, https://store.samhsa.gov/system/files/sma14-

Media outlets have reported cases of fraud and abuse in this industry, and multiple federal law enforcement agencies have conducted investigations uncovering violations. Investigations by the Federal Trade Commission (FTC), the Federal Bureau of Investigation (FBI) in DOJ, and the Department of Labor's Employee Benefits Security Administration (EBSA), for example, have all uncovered fraudulent acts regarding substance use treatment services and products.[130]

The FTC has responsibility with respect to the regulation of the truth or falsity of all advertising (other than labeling) of foods (including dietary supplements), cosmetics, devices, and drugs, with the exception of prescription drug advertising which is the responsibility of the FDA.[131] The FDA and FTC have sent joint warning letters to companies illegally marketing unapproved opioid cessations products claiming to treat opioid addiction and withdrawal.[132] Under the Federal Trade Commission Act (15 U.S.C. §§ 41 et seq.), the FTC has the authority to prohibit false or deceptive claims and may seek a judicial order levying civil penalties on violators.[133]

Provision

The Opioid Addiction Recovery Fraud Prevention Act (Sections 8021-8023) prohibits any unfair or deceptive acts regarding substance use disorder treatment services or products. The provision makes these practices unlawful under Section 18 of the Federal Trade Commission Act (15 U.S.C. §57a) and grants the FTC the jurisdiction, powers, and duties of enforcement, as though all applicable provisions of the Federal Trade Commission Act (15 U.S.C. §§ 41 et seq.) were incorporated into this section. Subsection (c) states that nothing in this subtitle should be construed to limit the authority of the FTC or the FDA. Section 8022 defines "substance use disorder treatment product" and "substance use disorder treatment service" for the purposes of the subtitle.

The provision effectively authorizes the FTC to seek civil penalties against opioid treatment programs and products that make false or deceptive claims regarding their cost, price, efficacy, performance, benefit, risk, or safety. The bill also authorizes state attorneys general, or other state officials, to bring civil actions for violations.[134]

4883.pdf.

[130] See, for example, U.S. Department of Labor, *Former Owners of Florida Substance Abuse Recovery Center's Sentenced to Prison and Ordered to pay $4,045,364 in Restitution for Healthcare Fraud*, News Release, May 17, 2018, https://www.dol.gov/newsroom/releases/ebsa/ebsa20180517, Federal Bureau of Investigation, *Sober Home and Drug Treatment Center Owner Sentenced*, News, Stories, February 21, 2018, https://www.fbi.gov/news/stories/florida-sober-home-owner-sentenced, and Federal Trade Commission, *FTC Brings Action to Stop Marketer from Making Deceptive Opiate Addiction and Withdrawal Treatment Claims*, Press Release, November 17, 2015, https://www.ftc.gov/news-events/press-releases/2015/11/ftc-brings-action-stop-marketer-making-deceptive-opiate-addiction.

[131] U.S. Food & Drug Administration, *Memorandum of Understanding Between The Federal Trade Commission and The Food and Drug Administration*, MOU 225-71-8003, May 14, 1971, https://www.fda.gov/AboutFDA/PartnershipsCollaborations/MemorandaofUnderstandingMOUs/DomesticMOUs/ucm115791.htm.

[132] FDA News Release, "FDA, FTC warn companies for selling illegal, unapproved opioid cessation products using deceptive claims" January 24, 2018, https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm593602.htm.

[133] See Federal Trade Commission, *A Brief Overview of the Federal Trade Commission's Investigative and Law Enforcement Authority*, What We Do, Washington, DC, July 2008, https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority for additional details.

[134] U.S. Congress, Senate Committee on Commerce, Science, and Transportation, *Opioid Addiction Recovery Fraud Prevention Act of 2018*, Report to accompany S. 2842, 115th Cong., 2nd sess., June 27, 2018, S.Rept. 115-285 (Washington: GPO, 2018).

Subtitle C: Addressing Economic and Workforce Impacts of the Opioid Crisis

Section 8041: Addressing Economic and Workforce Impacts of the Opioid Crisis

Background

SAMHSA supports community-based mental health and substance abuse treatment and prevention services through formula grants to the states and U.S. territories and through competitive grant programs to states, territories, tribal entities, local communities, and private entities. SAMHSA also engages in a range of other activities that support substance abuse prevention and treatment, such as technical assistance, data collection, and health workforce development. These activities may include efforts to connect individuals with the labor force, but generally SAMSHA programs are more health-focused.

DOL does provide some funding for employment and training activities to populations affected by opioid use. Specifically, the Workforce Innovation and Opportunity Act (WIOA) Dislocated Worker Grants (DWGs) are funded out the Dislocated Worker National Reserve, which is a set-aside from the WIOA Dislocated Worker Employment and Training Activities grant program. In 2018, DOL has made available funding from the National DWG Program to be used to provide employment and training activities to populations affected by opioid use. DOL funds from the National Reserve can be used for employment and training activities and for supportive services, but they cannot be used for in-patient drug treatment and rehabilitation programs.

Provision

Section 8041 requires the Secretary of Labor, in consultation with the Secretary, to carry out a pilot program by awarding competitive grants to state workforce agencies, outlying areas, or a tribal entity (i.e., eligible entities), which would then make subgrants to local Workforce Development Boards (WDBs) to provide a range of employment and related supportive services to individuals in communities with significant impacts from opioid and other SUDs.

The section requires an eligible entity applicant to provide information on two main impacts of opioids and SUDs. First, the entity must document a significant impact on the community of opioid and SUD-related problems. Such information might include data on the incidence of SUDs or arrest data showing increased substance use. Second, the eligible entity must provide information demonstrating that a high rate of substance use has contributed to economic or employment problems in the community. Relevant information might include data showing employers having difficulty filling vacancies because skilled workers are unable to pass a drug test and documentation of decreased economic activity due to SUDs. The section limits the amount of demonstration grants to be not less than $500,000, but not more than $5 million in a fiscal year. It requires eligible entities that receive a demonstration grant to make subgrants to local WDBs, as specified. WDBs receiving a subgrant must provide a variety of services and activities through a participating partnership, which may include a treatment provider, an employer, an education provider, a law enforcement agency, or other similar entities. The participating partnership must provide one or more specified services to workers directly or indirectly affected by a high rate of SUDs or workers seeking a transition to professions that support individuals with SUDs. Required services include those that seek to engage employers to connect program participants with employment opportunities, those that screen participants for

substance use and work readiness, and those that provide case management, treatment, supportive services, and job training to participants.

Of the grant amount received under this section, a participating partnership grantee may not use more than 10% for administrative costs, not more than 10% for treatment and recovery services, and not more than 10% for supportive services. The section also requires grantees to submit quarterly reports and the Secretary of Labor to evaluate the program, as specified. Finally, this section authorizes the Secretary of Labor to use up to $100 million, for the fiscal years of FY2019 through FY2023, of the funds from the National Dislocated Worker Grant program authorized by WIOA Section 170.

Subtitle D: Peer Support Counseling Program for Women Veterans

Section 8051: Peer Support Counseling Program for Women Veterans

Background

Among other things, the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) required the Secretary of the Department of Veterans Affairs (VA) to establish a peer support counseling program as part of a comprehensive program for suicide prevention among veterans.[135] The goal of the peer support counseling program is for volunteer veteran-peer support counselors to assist fellow veterans with issues related to mental health and readjustment, and to conduct outreach to veterans and their families.[136] However, under P.L. 111-163, the VA Secretary was not required to pursue the recruitment of women veteran-peer support counselors to provide gender-specific services to other women veterans. With the growing number of women veterans and since military service may affect women differently than men, policymakers believe that having peer counselors who are women would help women veterans with their reintegration and reduce stigma.[137]

Provision

Section 8051 amends 38 U.S.C.§1720F(j) and adds a new paragraph that requires the VA Secretary to pursue the recruitment of women peer support counselors with expertise in fields such as gender-specific issues and employment mentoring. In addition, to the extent practicable, the VA Secretary is required to emphasize the availability of peer counseling for women veterans who have experienced sexual trauma, have post-traumatic stress disorder (PTSD) or another mental health condition, are homeless or at risk of becoming homeless, or are at increased risk of suicide. Moreover, it stipulates that the VA Secretary conduct outreach to women veterans about the availability of peer counseling services; coordinate these efforts with community organizations, state and local governments, institutions of higher education, and other relevant stakeholders; and provide adequate training for peer support counselors.

This section does not authorize any additional appropriations for implementing this program, and it requires the VA Secretary to use funds allocated for the existing Peer Support Counseling Program. Lastly, this section requires the VA Secretary to submit a report to the Senate and House Veterans' Affairs Committees, no later than two years after the date of the enactment of this act,

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[135] 38 U.S.C. §1720F(j); 38 U.S.C. §1712A; and 38 U.S.C. §1720F.

[136] 38 U.S.C. §1720F(j).

[137] U.S. Congress, House Committee on Veterans' Affairs, To Direct the Secretary of Veterans Affairs to Increase the Number of Peer-To-Peer Counselors Providing Counseling for Women Veterans, And For Other Purposes, report to accompany H.R. 4635, 115th Cong., 2nd sess., May 18, 2018, H.Rept. 115-687, p. 4.

on the amended Peer Support Counseling Program that includes the number of peer support counselors in the program, an assessment of its effectiveness, and oversight of the program.

Subtitle E: Treating Barriers to Prosperity

Section 8061: Short Title

Background

See Section 8062 below.

Provision

This section states that the subtitle (Section 8062-8062) may be cited as the "Treating Barriers to Prosperity of 2018."

Section 8062: Drug Abuse Mitigation Initiative

Background

The Appalachian Regional Commission is a federally chartered entity created by Congress to address development and related issues affecting the multistate region and substate area experiencing long-term economic distress and isolation.[138] The commission does so through supporting projects that seek to improve the region's economic competitiveness. Among the current funding priority areas are projects that seek to improve the region's health.[139] In particular, the region is attempting to address its high rates of opioid use.[140]

Provision

Section 8062 amends 40 U.S.C. Chapter 145 to add a new 40 U.S.C. §14510, which permits the Appalachian Regional Commission to provide technical assistance, make grants, enter contracts with, or otherwise provide amounts to individuals or entities in the Appalachian region for projects and activities to address drug abuse (including opioid abuse). The new section specifies the types of projects and activities that could be developed and requires that only 50% of the cost of the activity may be provided from amounts appropriated to carry out this section. This limit does not apply to a county that has been designated as "distressed" under 40 U.S.C. §14526 (where the limit would be 80%) or to counties designated as "at risk" under that section (where the limit is 70%). Grants made under this section may be made from amounts provided under any other program and from any other source. Amounts made available to carry out this section may be used to increase the federal share as the Appalachian Regional Commission determines appropriate.

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[138] The Appalachian Regional Commission focuses on the area that borders the Appalachian Mountains, which includes part or all of 13 states. Specifically, it includes all of West Virginia and parts of 12 other states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. See Appalachian Regional Commission, "The Appalachian Region, https://www.arc.gov/appalachian_region/TheAppalachianRegion.asp.

[139] Appalachian Regional Commission, "Health," https://www.arc.gov/program_areas/index.asp?PROGRAM_AREA_ID=16.

[140] Appalachian Regional Commission, "The Appalachian Regional Commission at Work," http://www.arc.gov/images/appregion/fact_sheets/ARCatWork3-2017/ARC_at_Work_3-2017.pdf.

Subtitle F: Pilot Program to Help Individuals in Recovery from a Substance Use Disorder Become Stably Housed

Section 8071: Pilot Program to Help Individuals in Recovery from a Substance Use Disorder Become Stably Housed

Background

No federal grant program is explicitly and solely designed to provide temporary housing for individuals in recovery for SUDs. The majority of federal housing funding supports permanent housing for individuals and families, not temporary or "transitional" housing (the term often used in federal programs to describe housing assistance that does not exceed 24 months). Unlike transitional housing, permanent housing is not time-limited. Among the programs providing permanent housing assistance are HUD's Public Housing and Section 8 programs.

To the extent it is available, transitional housing funding is targeted to assist people who are experiencing homelessness.[141] Among the programs that can be used to fund transitional housing for homeless individuals and families are HUD's Continuum of Care and Community Development Block Grant (CDBG) programs and the Low Income Housing Tax Credit program, administered by the Treasury Department. Each of these programs has a broader set of purposes and uses than providing transitional housing for persons in recovery from substance abuse disorders; further, in some cases, there are limits on the use of program funds for transitional housing.[142]

Provision

Section 8071 authorizes a new grant program for states to provide individuals in recovery with stable, temporary housing. Temporary housing provided under this grant may be for no more than two years or until the individual secures permanent housing, whichever is earlier. States are eligible to receive assistance if they have a drug overdose mortality rate above the national average. The amounts made available to the states are to be allocated based on a funding formula established by the HUD Secretary. The provision requires the funding formula to prioritize states based on the greatest need, using the following factors and weights: (1) highest average rate of unemployment[143] (weighted at 15%), (2) lowest average labor force participation rates[144] (weighted at 15%), and (3) highest age-adjusted rates of drug overdose deaths[145] (weighted at 70%). Amounts available for the grant must be distributed according to the formula within 30 days after the formula is established. States are not required to contribute matching funds in order to receive a grant.

Grants are to be treated as though they were CDBG funds under Title I of the Housing and Community Development Act of 1974 (42 U.S.C. §§5301 et seq.). The provision permits the HUD Secretary to waive or alter requirements under Title I of this act, with some exceptions, provided the HUD Secretary provides written notice to specified congressional committees and to

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[141] Some transitional housing programs are targeted to specific populations, such as runaway and homeless youth, victims of domestic violence, and veterans.

[142] For example, transitional housing is considered a "public services" use of CDBG funding and grantees may use no more than 15% of their total CDBG grant funding for public services.

[143] Based on data provided by the Bureau of Labor Statistics for calendar years 2013 through 2017.

[144] Ibid.

[145] Based on data from the Centers for Disease Control and Prevention.

the public via notice at least 15 days before exercising that authority. In addition, states must expend at least 30% of funds within one year of receipt and may use up to 5% of the grant for administrative costs. During the first two years following enactment, the Secretary may use not more than 2% of funds made available under this section for technical assistance to grantees. The provision authorizes to be appropriated such sums as necessary for FY2019 through FY2023.

Subtitle G: Human Services

Subtitle G addresses policies relating to SUD treatment services for pregnant women, children and families, including residential treatment services or others that enable children and parents to remain safely together. Each of the sections in Subtitle G reference changes made by the Family First Prevention Services Act (Title VII, Division E of P.L. 115-123)[146] to the Foster Care, Prevention, and Permanency program (under Title IV-E of the SSA). Those changes permit (or will permit beginning in FY2020) Title IV-E funding to be used to provide certain SUD treatment and related services for child-welfare involved families.

Section 8081: Supporting Family-Focused Residential Treatment

Background

The Foster Care, Prevention, and Permanency program (Title IV-E of the SSA, also known as the Title IV-E program) is a joint federal-state program that funds assistance, including certain case management activities, for eligible children who are removed from their parents and placed in foster care (for their safety), as well as ongoing assistance to eligible children leaving foster care for new permanent homes via adoption or legal guardianship. The program is administered by ACF.

As amended by the Family First Prevention Services Act, Title IV-E support may also be used (as of FY2019) to make room and board payments for up to 12 months on behalf of children in foster care who are placed with their parents in a licensed family-based residential treatment center that provides trauma-informed SUD treatment, parenting skills training, parent education, and individual and family counseling (Section 472(j) of the SSA).

Separately, effective beginning with FY2020, states may elect to use Title IV-E program funds to provide 12 months of foster care prevention services to children at imminent risk of entering foster care, pregnant or parenting youth in foster care, and to the parents or kin caregivers of such children and youth. Prevention services that may be supported under this program option are trauma-informed and evidence-based SUD and mental health treatment services, as well as skills-based programs for parents living with their children, including parent education, parenting skills training, and individual and family counseling (Section 471(e) and Section 474(a)(6) of the SSA).

Medicaid is a joint federal-state program that finances the delivery of medical services, which may include substance use disorder treatment, case management, and certain other services, to a diverse low-income population, including children, pregnant women, and other adults. The federal government requires states to cover certain mandatory populations and benefits under their Medicaid programs but allows states to cover other optional populations and services. In addition, several waiver authorities allow states to operate their Medicaid programs outside of

[146] As enacted, P.L. 115-123 gives the short title of Title VII of its Division E as the "Bipartisan Budget Act." This is also the title of the overall act and is considered an inadvertent error. Here and throughout this report, Title VII, Division E of P.L. 115-123, is referred to by the heading given in the law to Title VII—"Family First Prevention Services Act" or by a shortened version of that language, "Family First"—rather than by its formal short title.

certain federal rules. As a result of these flexibilities, state programs may vary with regard to benefits provided and individuals served.

Additional federal programs administered by HHS agencies and that support SUD treatment for children and families may be many, but include, for example, SAMHSA's Residential Treatment Programs for Pregnant and Postpartum Women (PHSA Section 508) and Regional Partnership Grants (RPGs) to improve outcome for child and families affected by SUD (Section 437(f) of the SSA), administered by ACF.

Provision

Section 8081 requires the Secretary, after consulting with its divisions that administer SUD or child welfare programs, as well as with certain experts and stakeholders, to issue guidance to states on identifying opportunities to support family-focused residential treatment programs and related services, including MAT, counseling, parenting training, nonemergency transportation for care of children residing in the program, transitional services for families leaving the program, and others.

The guidance must be issued within 180 days of enactment and must specifically address opportunities to employ and coordinate funding available under Medicaid, including Medicaid waivers; the Title IV-E program, as amended by the Family First Prevention Services Act; and other programs administered by HHS.

For purposes of this section, "family-focused residential treatment," is defined as a "trauma-informed residential program" primarily for substance use disorder treatment of pregnant and postpartum women, parents, and guardians that allows, as "appropriate and applicable," children to reside with their parents or their guardians who are in such treatment.

Section 8082(a): Improving Recovery and Reunifying Families

Background

Some research conducted among child welfare-involved families with SUD, indicates that while timely assessment of services needs are important, it is associated with positive outcomes for those families only when paired with a specialized caseworker—a professional similar to a recovery coach—who is focused on ensuring the parent has access to treatment and is engaged in completing that treatment.[147]

The Promoting Safe and Stable Families Program (PSSF, Title IV-B Subpart 1, of the SSA) supports provision of child welfare services that strengthen families, keep children safely at home with their parents, and, when children are removed for their safety, aid in reuniting them with families whenever possible. Under SSA Section 435, the Secretary is required to conduct evaluations of programs supported under the PSSF program and may conduct evaluations of other state, local, or federally funded programs designed to achieve the same purposes as the PSSF program.

Provision

Section 8082(a) amends SSA Section 435 to include a one-time mandatory appropriation of $15 million (to remain available across eight years, FY2019-FY2026) for support of a family recovery

[147] For example, see Joseph P. Ryan, et al., "Timing Matters: A Randomized Control Trial of Recovery Coaches in Foster Care," *Journal of Substance Abuse Treatment,* v. 77 (2017), pp. 178-184.

and reunification program designed and carried out in a manner to support replication as appropriate.

With these funds, the Secretary must award a contract or grant to one or more eligible entities to conduct an evaluation of a family recovery and reunification program. The program must use a recovery coach model and is intended to enable parents or guardians with a SUD (who have temporarily lost custody of their children) to receive treatment and other services that will support their recovery and help them to be reunited with their children.

Further, the Secretary must ensure the program impacts are evaluated via a random assignment experiment that measures (for a minimum of five years) multiple relevant indicators (e.g., time to recovery, safety of reunifications, parental substance use, persistence of parental treatment engagement and recovery, costs, and others).

Finally, in addition to reports on the pilot phase, an impact study, and implementation of the family recovery and reunification program, the Secretary is required to publish (on an HHS-maintained website) a report that analyzes the program's impacts, and if warranted, includes a replication plan with any recommendations for legislative and administrative actions he determines appropriate.

Section 8082(b) and (c): Clarification of Payer of Last Resort Application to Child Welfare Prevention and Family Services; Effective Date

Background

As amended by the Family First Prevention Services Act (Title VII, Division E of P.L. 115-123), beginning with FY2020, states may elect to use funding under the Title IV-E program to support certain SUD and mental health treatment services, as well as skills-based programs for in-home parents. These services and programs may be provided to children at imminent risk of entering foster care, youth in foster care who are pregnant and parenting, and to the parents or kin caregivers of such children and youth. Prior to this amendment by Family First, Title IV-E, funding was not available for these services to child-welfare involved families.

A variety of previously authorized federal programs may also be used to provide SUD and mental health treatment, as well as in-home parent skills-based programs for some of these same child-welfare involved families. This includes the Medicaid program. If the services are available under the Medicaid state plan (or waiver), they may be provided to a Medicaid-eligible child or adult. However, in most cases under Medicaid's legally liable third-party rules, the Medicaid program must be considered the payer of last resort if another public or private source of funding is available for a service.

Provision

Section 8082(b) and(c) seeks to address circumstances in which a child or adult may be eligible for a service under more than one program. It amends the Title IV-E program to stipulate that provision of Title IV-E prevention services and programs is not intended to reduce medical or other assistance that would otherwise be available to an individual under another program. It further provides that a state child welfare agency must not be considered a legally liable third party for purposes of paying the costs of such services or programs if that cost would have been paid by another private or public source but for the enactment of the Title IV-E prevention support in P.L. 115-123. At the same time, it provides that Title IV-E may be used to pay such costs if this is necessary to prevent delay of service provision, pending reimbursement from the

private or public source with ultimate responsibility. Finally, this provision is made effective with the date of enactment of the Family First Act (February 9, 2018).

Section 8083: Building Capacity for Family-Focused Residential Treatment

Background

As amended by the Family First Prevention Services Act (Title VII, Division E of P.L. 115-123) and effective beginning with FY2020, states may elect to use the Foster Care, Prevention, and Permanency program (under Title IV-E of the SSA) to provide 12 months of specified foster care prevention services to children at imminent risk of entering foster care, pregnant or parenting teens in foster care, and the parents or kin caregivers of those children and youth. However, to be eligible for Title IV-E funding, the prevention services and programs offered must be offered on a trauma-informed basis and must meet certain criteria that defines them as "promising," "supported," or "well-supported" practices. Further, Title IV-E support for prevention services and programs will be available only to the extent that at least 50% of the total (state and federal) prevention spending for these activities meets the highest evidence standard (i.e., "well-supported").

Provision

Section 8083 requires the Secretary to make grants to eligible public and private entities (including state, county, local or tribal health or child welfare agencies; private nonprofits; research organizations; treatment service providers; and institutions of higher education) to develop, enhance, or evaluate family-focused residential treatment programs and in order to increase the availability of programs that meet the evidence-based practice criteria for Title IV-E prevention services.

It authorizes a one-time discretionary appropriation of $20 million (to remain available across five years, FY2019-FY2023) and requires any evaluation funded (in whole or in part with these dollars) to be designed to help determine if the family-focused residential treatment program being carried out would qualify as "promising," "supported," or "well-supported" under the Title IV-E program.

For purposes of this section, "family-focused residential treatment," is defined as a "trauma-informed residential program" primarily for substance use disorder treatment of pregnant and postpartum women, parents, and guardians that allows, as "appropriate and applicable," children to reside with their parents or their guardians who are in such treatment.

Subtitle H: Reauthorizing and Extending Grants for Recovery from Opioid Use Programs

Section 8091: Short Title

Background

See Section 8092 below.

Provision

This section states that the subtitle (Section 8091-8092) may be cited as the "Reauthorizing and Extending Grants for Recovery from Opioid Use Programs" or the "REGROUP Act of 2018."

Section 8092: Reauthorization of the Comprehensive Opioid Abuse Grant Program

Background

Section 201 of CARA amended Title I of the Omnibus Crime Control and Safe Streets Act of 1968 to authorize the Comprehensive Opioid Abuse Grant Program (COAP) for states, units of local government, and Indian Tribes.[148] These grants support projects primarily relating to opioid abuse, including (1) diversion and alternatives to incarceration projects; (2) collaboration between criminal justice, social service, and substance abuse agencies; (3) overdose outreach projects, including law enforcement training related to overdoses; (4) strategies to support those with a history of opioid misuse, including justice-involved individuals; (5) prescription drug monitoring programs;[149] (6) the development of interventions based on a public health and public safety understanding of opioid abuse; and (7) the planning and implementation of comprehensive strategies in response to the growing opioid epidemic.

The Bureau of Justice Assistance (BJA) in DOJ administers this grant program. Section 201 of CARA initially authorized $103 million for each of FY2017 through FY2021 for COAP.[150]

Provision

The Reauthorizing and Extending Grants for Recovery From Opioid Use Programs (REGROUP) Act of 2018 (Sections 8091-8092) amends Section 1001(a)(27) of the Omnibus Crime Control and Safe Streets Act of 1968 to reauthorize funding for COAP.[151] The provision authorizes to be appropriated $330 million for each of FY2019 through FY2023.

Subtitle I: Fighting Opioid Abuse in Transportation

Section 8101. Short Title

Background

Opioid use among the general population has increased in recent years. There is concern about the public safety impact of opioid use by transportation workers. There are also perceived opportunities for improvement in the federal Department of Transportation's (DOT)'s current drug and alcohol testing requirements for transportation workers.

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[148] 34 U.S.C. 10701 et seq.

[149] Of note, the Harold Rogers Prescription Drug Monitoring Program (PDMP) was incorporated into the Comprehensive Opioid Abuse Grant Program. The Harold Rogers PDMP is a discretionary, competitive grant program administered by BJA. It was created to help law enforcement, regulatory entities, and public health officials analyze data on prescriptions for controlled substances. Law enforcement uses of PDMP data include (but are not limited to) investigations of physicians who prescribe controlled substances for drug dealers or abusers, pharmacists who falsify records in order to sell controlled substances, and people who forge prescriptions.

[150] 34 U.S.C. §10261(a)(27)

[151] Ibid.

Provision

This section states that the subtitle (Section 8101-8109) may be cited as the "Fighting Opioid Abuse in Transportation Act."

Section 8102: Alcohol and Controlled Substance Testing of Mechanical Employees

Background

The Federal Railroad Administration's (FRA) drug and alcohol testing program requires that railroad workers in "safety-sensitive" positions be subject to drug and alcohol testing. FRA's definition of "safety-sensitive" positions does not include mechanical workers. The drug and alcohol testing programs of the Federal Aviation Administration and the Federal Transit Administration do include mechanics among the workers subject to federal drug and alcohol testing requirements.

Provision

This section requires the Secretary of Transportation to publish a rule in the *Federal Register* that revises the regulations promulgated under 49 U.S.C. §20140 to cover all railroad employees who perform "mechanical activities," which the Secretary will be required to define in the new regulation.

Section 8103: Department of Transportation Public Drug and Alcohol Testing Database

Background

DOT requires drug and alcohol testing for several types of transportation workers (generally defined as workers in "safety-sensitive" positions) across several transportation modes. However, the results of these testing programs, which would provide information on trends of drug and alcohol violations across several categories of employees (e.g., new employees, randomly tested employees) among the transportation modes, are not readily available to Congress or to the general public.

Provision

This section requires the Secretary of Transportation to, not later than March 31, 2019, establish and make publicly available on the DOT website a database of drug and alcohol testing data reported by employers for each mode of transportation. The section requires that the database be updated annually and that it include certain specified elements related to testing. The section prohibits DOT from releasing commercially sensitive data or personally identifiable data.

Section 8104: GAO Report on Department of Transportation's Collection and Use of Drug and Alcohol Testing Data

Background

Employers subject to DOT drug and alcohol testing requirements are required to submit their drug and alcohol testing data to DOT through the DOT Drug and Alcohol Testing Management Information System. Reporting requirements vary across modes and do not include results of tests which employers require but that are not required by DOT; but the results of this test could

provide valuable additional information to DOT about trends in drug use by transportation workers.

Provision

This section requires that, within two years after DOT establishes the database required in section 8103 that will make public the results of DOT-required drug and alcohol tests, GAO review the DOT's Drug and Alcohol Testing Management Information System and the public drug and alcohol testing results database required in Section 8103. The section permits GAO to make recommendations about how DOT could make better use of the testing data, whether improvements can be made in the testing process, and whether improvements can be made in the public testing results database.

Section 8105: Transportation Workplace Drug and Alcohol Testing Program; Addition of Fentanyl and Other Substances

Background

Prior to 2018, DOT drug testing was limited to five categories of drugs: marijuana, cocaine, amphetamines, opiates (not opioids), and PCP. As of 2018, four opioids (hydrocodone, hydromorphone, oxymorphone, and oxycodone) were added to the list of drugs for which DOT requires testing. But other drugs that are widely used could pose a public safety hazard if safety-sensitive transportation workers were under the influence of these drugs while at work. One such drug is fentanyl.

Provision

This section requires the Secretary to determine, not later than 180 days after enactment, whether it is justified based on the reliability and cost-effectiveness of testing to revise the "Mandatory Guidelines for Federal Workplace Drug Testing Programs" to include fentanyl and to consider whether to include any other drugs or other substances listed in schedule I and II of CSA Section 202. If the Secretary determines that the guidelines should be revised, the rulemaking to implement that determination must be completed within 18 months of making that determination. The Secretary must also notify specified congressional committees. If the list of tested substances is expanded, the DOT Secretary is required to add the new substances to the DOT's drug-testing panel not later than 18 months after the final rule required by this section is published. Finally, the section specifies that nothing in this section delays the publication of notices required by SUPPORT Act Sections 8106 and 8107 until the HHS Secretary makes a determination about the list being expanded, and that nothing in this section limits the authority of the Secretaries of HHS or DOT to expand the list to include additional substances.

Section 8106: Status Reports on Hair Testing Guidelines

Background

The Fixing America's Surface Transportation Act (P.L. 114-94, enacted December 4, 2015), among other things, added a new subsection to 49 U.S.C. §31306 to permit motor carriers to conduct preemployment testing of commercial motor vehicle operators for the use of alcohol and controlled substances and to use hair testing as an alternative to urine testing, but permits an exemption for commercial motor vehicle operators with established religious beliefs that prohibit the cutting or removal of hair. It also required the Secretary, not later than one year after enactment (i.e., December 4, 2016) to issue scientific and technical guidelines for hair testing as a

method of detecting the use of a controlled substances. As of the publication date of this CRS report, the guidelines have not been published.

Provision

This section requires the Secretary to report to Congress, not later than 60 days after enactment and annually thereafter until the Secretary publishes in the *Federal Register* a final notice of scientific and technical guidelines for hair testing in accordance with Section 5402(b) of the Fixing America's Surface Transportation Act (P.L. 114-94), on the status of the hair testing guidelines. The report is required to include reasons for their delay and an estimated date for when the guidelines will be completed. The section also requires, to the extent practicable and consistent with the objective of the hair testing, that the scientific and technical guidelines included in final notice eliminate the risk of positive test results that are caused by exposure to the drug use of others.

Section 8107: Mandatory Guidelines for Federal Workplace Drug Testing Programs Using Oral Fluid

Background

On May 15, 2015 (94 FR 28054), SAMHSA issued a "Notice of Proposed Mandatory Guidelines for Federal Workplace Drug Testing Programs – Oral Fluid," for public comment.[152] More than 100 public comments were received by July 14, 2015, when the public comment period closed.[153]

The Omnibus Transportation Employee Testing Act of 1991 (OTETA; P.L. 102-143) requires DOT to follow HHS guidelines for testing for the drugs for which DOT requires transportation employers to test safety-sensitive employees. The SAMHSA proposed guidelines for drug testing using oral fluids (e.g., saliva) conflict with OTETA requirements on a couple of points. One is that OTETA allows only testing that will determine use of a drug, not exposure, while SAMHSA's proposed guidelines include testing procedures for which exposure to a drug would result in a positive result.[154]

Provision

Not later than December 31, 2018, the Secretary is required to publish in the *Federal Register* a final notice of "Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid," based on the notice of proposed mandatory guidelines published in the *Federal Register* on May 15, 2015 (94 FR 28054). The section also requires, to the extent practicable and consistent with the objective of the oral fluid testing, that the scientific and technical guidelines included in final notice eliminate the risk of positive test results that are caused by exposure to the drug use of others. Finally, the section specifies that nothing in this section requires the Secretary to reissue a notice proposing these scientific and technical guidelines.

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[152] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Notice of Proposed Mandatory Guidelines for Federal Workplace Drug Testing Programs – Oral Fluid," 94 *Federal Register* 28054, May 15, 2015.

[153] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Comments on Proposed Mandatory Guidelines for Federal Workplace Drug Testing Programs – Oral Fluid," 94 *Federal Register* 28054, July 14, 2015, https://www.regulations.gov/docketBrowser?rpp=25&po=0&dct=PS&D=SAMHSA-2015-0001.

[154] Department of Transportation, *Office of Drug and Alcohol Policy and Compliance (ODAPC) Top Policy Issues: Rulemaking – Oral Fluid Drug Testing*, https://www.transportation.gov/transition/odapc-top-policy-issues.

Section 8108: Electronic Recordkeeping.

Background

DOT's required procedures for conducting workplace drug and alcohol testing for the federally regulated transportation industry are specified in 49 CFR Part 40. The procedures require, among other things, the use of the Federal Drug Testing Custody and Control Form to document every urine collection required by the DOT's drug testing program (49 C.F.R. §40.45). The rule specifies the elements that must be included in the form, that there is an electronic version of the form, and that laboratories may submit results electronically, provided that they take steps to ensure that the data is adequately protected.

DOT's Office of Drug and Alcohol Policy and Compliance plans to allow an electronic alcohol testing form (eATF) along with electronic signatures. This form and the use of electronic signatures for it have not yet been approved by the agency. The issue of signing documents electronically is particular challenging, due to the legal, security, and technological ramifications involved with digitization.

Provision

The section requires the Secretary, not later than one year after enactment, to ensure that each certified laboratory that requests approval for the use of completely paperless electronic Federal Drug Testing Custody and Control Forms from the National Laboratory Certification Program's Electronic Custody and Control Form systems receives approval for those electronic forms. It also requires the Secretary to establish a deadline by which a certified laboratory must submit their request for approval. The section specifies that nothing in this section can be construed as limiting the Secretary's authority to grant approval for certified laboratories to use paperless electronic Federal Drug Testing Custody and Control forms.

Finally, the section requires the DOT Secretary, not later than 18 months after the deadline for certified laboratories to request approval for electronic forms, to issue a final rule that revises 49 CFR Part 40 to permit, to the extent practicable, the use of electronic or digital signatures on electronic forms rather than handwritten signatures on paper forms.

Section 8109: Status Reports on Commercial Driver's License Drug and Alcohol Clearinghouse

Background

In 2012, in the Moving Ahead for Progress in the 21st Century Act (MAP-21, P.L. 112-141, Section 32402), Congress directed DOT to establish a national clearinghouse for records of commercial drivers' violations of the Federal Motor Carrier Safety Administration's drug and alcohol testing. The final rule implementing this directive was issued on December 5, 2016 (81 FR 87686), with an effective date of January 4, 2017, and a compliance date of January 6, 2020.

Provision

The section requires that, not later than 60 days after enactment and annually thereafter until the compliance date, as specified, the Administrator of the Federal Motor Carrier Safety Administration is required to submit to specified congressional committees a status report on the implementation of the final rule for the Commercial Driver's License Drug and Alcohol Clearinghouse (81 FR 25 87686). The report is required to include certain specified elements, and

the section defines the compliance date as the earlier of January 6, 2020, or the date that the national clearinghouse required under 49 U.S.C. §31306a is operational.

Subtitle J: Eliminating Kickbacks in Recovery

Section 8121: Short Title

Background

See Section 8121 below.

Provision

This section states that the subtitle (Section 8122-8122) may be cited as the "Eliminating Kickbacks in Recovery Act of 2018."

Section 8122: Criminal Penalties

Background

Congress created the federal anti-kickback statute in an effort to restrict improper influences on health care provider decision making and prevent overutilization in federal health care programs.[155] This statute establishes criminal penalties for persons who knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration") in return for a patient referral or other generation of business reimbursable under a federal health care program.[156] Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $100,000 and may be imprisoned for up to 10 years.[157] For purposes of the anti-kickback statute, a "federal health care program" includes programs such as Medicare and Medicaid but does not include private health insurance.[158]

In connection with high demand for treatment and recovery housing for individuals with SUDs, there have been reports of abusive payment arrangements involving recovery home operators and SUD treatment facilities.[159] These reports describe certain patient brokering arrangements in which a person received payment in exchange for recruiting and referring patients to particular treatment providers or recovery homes.[160] Reports have also detailed instances of alleged excessive billing for drug urine testing by laboratories and other entities.[161]

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[155] *See* 42 U.S.C. § 1320a-7b(b). *See also* 83 Fed. Reg. 43607, 43608 (August 27, 2018); 63 Fed. Reg. 1659, 1662 (January 9, 1998).

[156] 42 U.S.C. § 1320a-7b(b).

[157] *Id*. § 1320a-7b(b)(1)(B) and (b)(2)(B).

[158] *Id*. § 1320a-7b(f).

[159] *See, e.g.*,Anuradha Rao-Patel, Michael Adelberg, Samantha Arsenault, Andrew Kessler, *Fraud's Newest Hot Spot: The Opioid Epidemic And The Corresponding Rise Of Unethical Addiction Treatment Providers*, HEALTH AFFAIRS, (Apr. 26, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180423.449595/full/.

[160] *See id.*

[161] *See, e.g.*, U.S. Gov't Accountability Office, GAO-18-315, Substance Use Disorder, Information on Recovery Housing Prevalence, Selected States' Oversight, and Funding (2018) at 8-11.

In light of these reports, some Members of Congress raised questions about the adequacy of federal enforcement mechanisms to address these payment practices.[162] In September 2017, HHS noted that abusive patient brokering practices involving opioid treatment facilities primarily affected private health insurance plans, but that the anti-kickback statute does not apply to privately insured patients.[163]

Provision

Section 8122 establishes a new criminal prohibition on remuneration for referrals to recovery homes, clinical treatment facilities, and certain laboratories.[164] More specifically, it inserts a new Section 220 in Title 18 of the U.S. Code, titled "Illegal remunerations for referrals to recovery homes, clinical treatment facilities, and laboratories." This new section generally prohibits the knowing and willful solicitation, receipt, payment or offer of remuneration with respect to patient referrals to these entities.[165] Violators of this section may be subject to a $200,000 fine, imprisonment of up to 10 years, or both, for each violation of the section.[166]

Unlike the anti-kickback statute, which applies to federal health care programs, Section 8122 applies with respect to services covered by "health care benefit programs."[167] A health care benefit program is a broader term that means "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."[168] Accordingly, the criminal prohibitions in Section 8122 apply to private health insurance arrangements. Section 8122 also specifies that the new criminal penalties do not apply to conduct prohibited by the anti-kickback statute, and that this provision should not be construed to preempt certain state laws that address the same types of misconduct.[169]

In addition, similar to the anti-kickback statute, Section 8122 includes exceptions for certain business arrangements. For example, under Section 8122, "remuneration" does not include a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity.[170]

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[162] *See, e.g.,* Letter from Members of House of Representatives, Committee on Energy and Commerce to Dr. Thomas Price, Secretary of Health and Human Services (July13, 2017), https://energycommerce.house.gov/news/letter/letter-hhs-regarding-reports-patient-brokering/.

[163] Letter from Barbara Pisaro Clark, Acting Assistant Secretary for Legislation, Department of Health and Human Services, to the Honorable Greg Walden, Chairman, Committee on Energy and Commerce, U.S. House of Representatives (Sept. 12, 2017), https://energycommerce.house.gov/news/letter/letter-hhs-regarding-reports-patient-brokering/.

[164] SUPPORT for Patients and Communities Act, P.L. 115-271, 132 Stat. 3894, § 8122 (2018).

[165] *See id.* § 8122(a).

[166] *See id.*

[167] *See id.*

[168] *See id.* § 8122(e).

[169] *See id.* § 8122(d).

[170] *See id.* § 8122(b).

Subtitle K: Substance Abuse Prevention

Section 8201: Short Title

Background

See Section 8022 below.

Provision

This section states that the subtitle (Section 8201-8222) may be cited as the "Substance Abuse Prevention Act of 2018."

Section 8202: Reauthorization of the Office of National Drug Control Policy

Background

ONDCP is responsible for creating, implementing, and evaluating U.S. drug control policies to reduce the use, manufacturing, and trafficking of illicit drugs, as well as drug-related health consequences, crime, and violence. ONDCP is located in the Executive Office of the President.[171] It was created by the Anti-Drug Abuse Act of 1988 (P.L. 100-690) and was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006 (P.L. 109-469). Authorization of appropriations for ONDCP expired at the end of FY2010, but it has continued to receive funding.

The ONDCP director must develop a National Drug Control Strategy (Strategy) to direct the nation's antidrug efforts—and a companion National Drug Control Budget (Budget)—and evaluate the implementation of the Strategy by agencies contributing to the Federal Drug Control Program as well as its outcomes (reducing illicit drug use and its consequences). In addition, ONDCP manages the High Intensity Drug Trafficking Areas (HIDTA) program and other programs, including Drug Free Communities (DFC).

Provision

Section 8202 revives and restores the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. §§1701 et seq.) as was in effect on September 29, 2003. It authorizes $18.4 million in appropriations for ONDCP for each of FY2018-FY2023 and repeals the statutory termination of the office.[172]

Section 8203: Reauthorization of the Drug-Free Communities Program

Background

Congress and President Clinton created the Drug-Free Communities Support (DFC) Program through the Drug-Free Communities Act of 1997 (P.L. 105-20).[173] This grant program is co-administered by ONDCP and SAMHSA and funds community-based coalitions that aim to

[171] For more information on ONDCP, see CRS Insight IN10912, *The Role of the Office of National Drug Control Policy (ONDCP)*.

[172] 21 U.S.C. §1712.

[173] 21 U.S.C. §1521 et seq.

prevent youth substance use. Authorization of appropriations for the DFC Program expired at the end of FY2012, but it has continued to receive funding.

Provision

Section 8203 amends and reauthorizes the DFC Program. In statute, it replaces "substance abuse" with "substance use and misuse." It also defines the terms "substance use and misuse." Section 8203 also sets new conditions on the renewal of grants, and authorizes $99 million in appropriations for ONDCP for the DFC Program for each of FY2018 through FY2023.

Section 8203 also amends the termination provision for ONDCP by adding Sections 1021 through 1035 to the National Narcotics Leadership Act of 1988.[174]

Section 8204: Reauthorization of the National Community Anti-Drug Coalition Institute

Background

In 2001, Congress and President George W. Bush first-authorized the grant to an eligible nonprofit organization to establish the National Community Antidrug Coalition Institute (NCI; P.L. 107-82).[175] It authorized the NCI to (1) provide education, training, and technical assistance for coalition leaders and community teams; (2) develop and disseminate evaluation tools, mechanisms, and measures to better assess and document coalition performance measures and outcomes; and (3) bridge the gap between research and practice by translating knowledge from research into practical information. This program is administered by ONDCP and SAMHSA. Authorization of appropriations expired in FY2011, but it has continued to receive funding.

Provision

Section 8204 amends 21 U.S.C. §1521 note and authorizes the Director of ONDCP to make a grant of $2 million for each of FY2018 through FY2023 to maintain NCI. However, a code citation referenced in Section 8204 (15 U.S.C. §1532) appears to be inconsistent with this goal as it does not refer to the NCI, but rather to functions of the Secretary of Commerce.

Section 8205: Reauthorization of the High-Intensity Drug Trafficking Area Program

Background

Congress and President Reagan initially created the High Intensity Drug Trafficking Areas (HIDTA) program[176] through the Anti-Drug Abuse Act of 1988 (P.L. 100-690) and permanently authorized it through the Office of National Drug Control Policy Reauthorization Act of 2006 (P.L. 109-469). The HIDTA program, authorized at 21 U.S.C. §1706, provides assistance to law enforcement agencies—at the federal, state, local, and tribal levels—operating in areas of the United States that have been deemed as critical drug trafficking regions. Funds support multiagency enforcement initiatives involving investigations, interdictions, and prosecutions, as well as drug use treatment and prevention initiatives. However, in 2006, Congress implemented a prohibition on the use of HIDTA funds to establish or expand drug treatment programs and

[174] P.L. 100-690, Title I, Subtitle A. Of note, Section 8203 incorrectly refers to 21 U.S.C. §1056.

[175] 21 U.S.C. §1521 note.

[176] For more information on the HIDTA program, see CRS Report R45188, *High Intensity Drug Trafficking Areas (HIDTA) Program*.

specified that, while HIDTAs could support drug prevention activities, only a maximum of 5% of funds could be used to establish drug prevention programs.

The HIDTA program's authorization of appropriations expired at the end of FY2011, at which time the authorized level was $280 million. The program has, however, continued to receive appropriations in each subsequent fiscal year. The authorizing statute required that funds be used "to ensure the safety of neighborhoods and the protection of communities" as well as "to combat illegal drug trafficking through such methods as the [HIDTA program] Director considers appropriate."

Provision

Section 8205 removes the prohibition on the use of HIDTA funds to establish or expand drug treatment programs and specifies that a maximum of 5% of HIDTA appropriated funds can be used for "substance use disorder treatment programs and drug prevention programs."

This section also authorizes $280 million to be appropriated for the HIDTA program for each of FY2018 through FY2023 and provides additional examples of how HIDTA funds may be used to ensure the safety of neighborhoods and protection of communities. It also requires that the HIDTA Director develop and disseminate to HIDTAs best practices for helping state, local, and tribal governments with "witness protection or assistance in cases of illegal drug distribution and related activities."

Section 8206: Reauthorization of Drug Court Program

Background

DOJ administers the primary federal grant program that supports drug courts,[177] the Drug Court Discretionary Grant Program (Drug Courts Program).[178] DOJ's Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA), jointly administers this competitive grant program along with SAMHSA within HHS. Grants are distributed to state, local, and tribal governments, as well as to state and local courts themselves, to establish and enhance drug courts for nonviolent offenders with substance abuse issues.[179] Funding is currently authorized for this program under CARA as part of a broader authorization for the Comprehensive Opioid Abuse Grant Program for each of FY2017-FY2021.[180]

Provision

Section 8206 authorizes $75 million for the Drug Courts Program for each of FY2018-FY2023.

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[177] For more information on drug courts, see CRS Report R44467, *Federal Support for Drug Courts: In Brief*.

[178] 34 U.S.C. §§10611-10619. The Drug Court Discretionary Grant program was first authorized under Title V of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322). It has been reauthorized twice: first, under the 21st Century Department of Justice Appropriations Authorization Act (P.L. 107-273), and second, under the Violence Against Women and Department of Justice Reauthorization Act of 2005 (P.L. 109-162). It was amended by CARA (P.L. 114-198).

[179] SAMHSA jointly administers only part of the Drug Court Discretionary Grant Program with BJA. For more information on this program and how grant funds are used, see the program description and grant solicitations available at https://www.bja.gov/ProgramDetails.aspx?Program_ID=58.

[180] See 34 U.S.C. §10701(a)(1)(D) and 34 U.S.C. §10261(a)(27).

Section 8207: Drug Court Training and Technical Assistance

Background

ONDCP supports training and technical assistance (TTA) for states, state courts, local courts, and units of local government with drug courts or considering drug courts in developing, maintaining, and enhancing alternatives to incarceration for individuals with addiction through a competitive grant program.[181] While this TTA does not have a specific statutory authority, it receives an appropriation each year under ONDCP, Other Federal Drug Control Programs account.[182]

Provision

Section 8207 provides an authorization for the Drug Court Training and Technical Assistance Program under ONDCP. It authorizes $2 million for each of FY2018-FY2023.

Section 8208: Drug Overdose Response Strategy

Background

ONDCP is currently charged with annually developing the National Drug Control Strategy to reduce illicit drug use and the consequences of such illicit drug use in the United States by limiting the availability of, and reducing the demand for, illegal drugs.[183] It does not specifically create a drug overdose response strategy.

Provision

Section 8208 authorizes the ONDCP Director to use funds to implement a drug overdose response strategy in HIDTA by (1) coordinating multidisciplinary efforts to prevent, reduce, and respond to drug overdoses, including the uniform reporting of fatal and nonfatal overdoses to public health and safety officials; (2) increasing data sharing among public safety and public health officials concerning drug-related abuse trends and related crime; and (3) enabling collaborative deployment of prevention, intervention, and enforcement resources to address substance use addiction and narcotics trafficking.

Section 8209: Protecting Law Enforcement Officers from Accidental Exposure

Background

ONDCP administers several grant programs related to drug control. It does not currently have a grant program that addresses protecting law enforcement officers from accidental exposure to fentanyl and new psychoactive substances.

Provision

Section 8209 authorizes the ONDCP Director to use $10 million of the funds otherwise appropriated to ONDCP to provide supplemental competitive grants to HIDTAs that have

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[181] For more information on this technical assistance grant, see Office of National Drug Control Policy, *Drug Court Training and Technical Assistance Grant*, ONDCP-DRUGCOURTTTA-2018, May 11, 2018. For more information on drug courts, see CRS Report R44467, *Federal Support for Drug Courts: In Brief*.

[182] See U.S. Congress, House Committee on Appropriations, *Joint Explanatory Statement to Accompany the Consolidated Appropriations Act, 2018*, P.L. 115-141, committee print, 115th Cong., 2nd sess., p. 796.

[183] 21 U.S.C. §1705.

experienced high seizures of fentanyl and new psychoactive substances for the purposes of (1) purchasing portable equipment to test for fentanyl and other substances; (2) training law enforcement officers and other first responders on best practices for handling fentanyl and other substances; and (3) purchasing protective equipment, including overdose reversal drugs.[184]

Section 8210: COPS Anti-Meth Program

Background

The Community Oriented Policing Services (COPS) program awards grants to state, local, and tribal law enforcement agencies throughout the United States so they can hire and train law enforcement officers to participate in community policing, purchase and deploy new crime-fighting technologies, and develop and test new and innovative policing strategies.[185]

Authorized appropriations for the COPS program expired at the end of FY2009. Prior to that, the program was authorized at $1.047 billion annually for FY2006-FY2009. Congress has continued to provide an appropriation for the COPS program even though authorized appropriations expired in FY2009. Since FY2014, as a part of the annual appropriation for the COPS program, Congress has provided funding for an Anti-Methamphetamine Task Force program, and since FY2015, Congress has provided funding for an Anti-Heroin Task Force program.

Provision

Section 8210 amends the authorization for the COPS program (34 U.S.C. §10381) to require DOJ, beginning with FY2019, to use a portion of the funding appropriated for the COPS program to make competitive awards of not less than $1 million to state law enforcement agencies with high seizures of precursor chemicals, finished methamphetamine, laboratories, and laboratory dump seizures for the purpose of locating or investigating illicit activities, such as precursor diversion, laboratories, or methamphetamine traffickers. In effect, this provision authorizes the COPS Anti-Methamphetamine Task Force program for which Congress has appropriated funding since FY2014.

Section 8211: COPS Anti-Heroin Task Force Program

Background

See “Background” for Section 8210 above.

Provision

Section 8211 amends the authorization for the COPS program (34 U.S.C. §10381) to require DOJ, beginning with FY2019, to use a portion of the funding appropriated for the COPS program to make competitive awards to state law enforcement agencies in states with high per capita rates of primary treatment admissions, for the purpose of locating or investigating illicit activities, through state-wide collaboration, related to the distribution of heroin, fentanyl, or carfentanil or related to the unlawful distribution of prescription opioids. In effect, this provisions authorizes the COPS Anti-Heroin Task Force program for which Congress has appropriated funding since FY2015.

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[184] For more information on the HIDTA program, see CRS Report R45188, *High Intensity Drug Trafficking Areas (HIDTA) Program*.

[185] For more information on the COPS program, see CRS In Focus IF10922, *Community Oriented Policing Services (COPS) Program*.

Section 8212: Comprehensive Addiction and Recovery Act Education and Awareness

Background

CARA (P.L. 114-198) aimed to address the opioid epidemic through provisions that authorized new opioid-related activities, reauthorized and amended existing activities, and codified activities already taking place. Many of these provisions authorized new opioid abuse grants that supported a variety of preventive, treatment, and educational activities. SAMHSA, as the lead agency for federal substance use disorder service activities, was responsible for administering many of these new grant programs. Through its grant programs, SAMHSA supports a variety of substance use disorder treatment, prevention, and recovery activities for individuals and families. Title VII of CARA included "miscellaneous" provisions related to substance abuse prevention, treatment, and payment activities.

Provision

Section 8212 amends Title VII of CARA by adding a new Section 709, which permits the Secretary to make grants to entities that focus on substance use disorders and specialize in family and patient services, family and patient advocacy, and education. Grants may be used for nonprofit organizations that engage in a variety of specified activities, including (1) expansion of clinical services; (2) development of health information technology (HIT) systems; (3) enhancement of treatment and recovery resources, SUD education materials, and informational tools for families, individuals, and community stakeholders; (4) provision of technical assistance to specified stakeholders; (5) implementation of educational information using evidence-based information on SUDs; (6) expansion of training community stakeholders regarding topics related to SUDs; and (7) program evaluation. No additional funding is authorized.

Section 8213: Reimbursement of Substance Use Disorder Treatment Professionals

Background

When a consumer obtains a health care service, the health care provider charges a certain dollar amount for services rendered. Payments from programs and insurance entities (e.g., Medicare, Medicaid, private health insurers) for substance use disorder treatment services may vary widely depending on a number of factors. The type of service provided, the location (i.e., inpatient versus outpatient), the type of provider, and the entity being billed all affect how treatment services are paid.

HRSA's National Center for Health Workforce Analysis examines various aspects of the health workforce, but generally focuses on access to services.[186] CMS sets forth policies for payments made to its programs (Medicare, Medicaid, and the State Children's Health Insurance Program or CHIP) for services and such policies include the substance abuse workforce.

[186] Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Care Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025*, Rockville, MD, November 2016, https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf.

Provision

Section 8213 requires GAO to submit a report to Congress examining how substance use disorder services are reimbursed. The report is to be submitted no later than January 1, 2020.

Section 8214: Sobriety Treatment and Recovery Teams (START)

Background

Sobriety Treatment and Recovery Teams (START) is a crisis intervention program model that works with families affected by both SUD and child abuse or neglect. The program is led by child protection agencies in close collaboration with SUD and mental health treatment providers and the courts. It provides families with quick access to services, SUD assessment and treatment and works to help children to remain with their parents whenever possible. Each family is paired with a mentor who is an individual in long-term recovery and who works closely with the multidisciplinary START team to engage the family and to identify and ensure necessary supports are provided through treatment and recovery.[187]

A handful of states have or are using the START program model using various funding streams, including RPGs. The RPG program, authorized in SSA Section 437(f), provides grants for collaborative and multidisciplinary efforts to improve outcomes for children and families affected by SUDs. RPGs are administered by ACF. The National Center on Substance Abuse and Child Welfare (NCSACW) provides technical assistance for RPG grantees. NCSACW was established in 2002 and is jointly funded by SAMHSA and ACF.[188]

Provision

Section 8214 adds a new PHSA Section 550, "Sobriety Treatment and Recovery Teams," which permits the Secretary to make grants to states, units of local government, or tribal governments to establish START or similar programs and to determine the effectiveness of providing families facing co-occurring SUDs and child abuse or neglect with a social worker or mentor who can offer the family peer support, intensive treatment, and child welfare services. The section specifies the permissible uses of funding under this program and that the program must be used to serve families with current child welfare agency involvement and where that involvement is the result of SUD. The section also specifies that the Secretary may reserve not more than 5% of funds provided under this section for NCSACW to provide technical assistance on establishing or expanding START or similar programs funded under this section.

Section 8215: Provider Education

Background

S.Rept. 114-239, which accompanied the Veterans Care Financial Protection Act of 2017 (P.L. 115-131, enacted on March 9, 2018), included a direction to the Attorney General to coordinate with the HHS Secretary to take additional steps to limit opioid overprescribing and to identify how the DEA could help regulate registrations in ways that limit opioid overprescribing. It required that DOJ and HHS submit a plan to Congress not later than 90 days after enactment (i.e., June 9, 2018) on their progress that includes ways for medical professionals to demonstrate, via

[187] A description of START is available on the website of the California Evidence-Based Clearinghouse (CEBC) http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/.

[188] For information about the RPG program and technical assistance provided, see the NCSACW website https://ncsacw.samhsa.gov/technical/rpg.aspx.

certification to the DEA, that they have obtained training in proper prescribing of opioids, including pain management, and the prevention and treatment of addiction. Generally, as part of the DEA registration process to prescribe controlled substances, providers must prove that they are licensed in states where they conduct business, but they are not required to have completed specific training in opioids or pain management.

Provision

The section requires the Attorney General, in consultation with the Secretary, to complete the plan required by S.Rept. 114-239 not later than 60 days after enactment.

Section 8217: Amendments to Administration of the Office

Background

ONDCP was initially created by the Anti-Drug Abuse Act of 1988[189] and was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006.[190] Its responsibilities and programs have been amended several times since its creation. For background on the office and information on some of the past changes, see CRS Insight IN10912, *The Role of the Office of National Drug Control Policy (ONDCP)*.

Provision

Section 8217 makes several amendments to the administration of ONDCP, including those related to the office's responsibilities and ethics guidelines surrounding gifts and donations. It establishes that the position of Director will have the same rank and status as the head of an executive department and lists various positions to be appointed by the Director. It requires ONDCP to consult with various agencies, congressional committees, and the public when formulating policies. It also permits ONDCP to form advisory councils and request data from other entities and authorizes new positions including a U.S. Performance Budget Coordinator, and a State, Local, and Tribal Affairs Coordinator. The section also (1) specifies a number of requirements related to ONDCP funds including that no funds authorized under Title 21[191] may be obligated for advocating for or against ballot initiatives, (2) specifies that transfers of funds from ONDCP may only be used for certain drug control activities, and (3) authorizes $1.25 million for the Model State Drug Laws grant program for each of FY2018-FY2023.

Section 8218: Emerging Threats Committee, Plan, and Media Campaign

Background

In 1998, ONDCP launched the National Youth Anti-Drug Media Campaign aiming to change youth attitudes about drug use and reverse youth drug trends through targeted media ads.[192] In multiple evaluations, it was reported that the program did not have favorable effects on youth behavior or beliefs.[193] These initial ads were phased out, and ONDCP recreated the youth media

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[189] P.L. 110-690, Title I, Subtitle A, National Narcotics Leadership Act of 1988, November 18, 1988, 102 Stat. 4181.

[190] P.L. 109-469.

[191] 21 U.S.C. sets forth Food and Drug laws.

[192] Office of National Drug Control Policy, *The National Drug Control Strategy, 1998: Budget Summary*.

[193] Westat, *Evaluation of the National Youth Anti-Drug Media Campaign: 2004 Report of Findings*, Executive Summary, Rockville, MD, http://archives.drugabuse.gov/initiatives/westat/NSPY2004Report/ExecSumVolume.pdf; Westat and Annenberg School for Communication, *Evaluation of the National Youth Anti-Drug Media Campaign:*

campaign in "Above the Influence" (ATI), with a new approach of using a "highly visible and effective national messaging presence while encouraging youth participation with ATI at the community level."[194] One study indicated that ATI was "trending toward positive impacts on attitudes and behavior" and "continues to have noteworthy potential."[195] Another study noted positive impacts in discouraging female 8th grade students from initiating marijuana use, but did not identify any significant influence over male 8th grade students or over students in grades 10 and 12.[196] The National Youth Anti-Drug Media Campaign last received appropriations in FY2011.

Provision

Section 8218 establishes various requirements and responsibilities for a new Emerging Threats Coordinator and Committee. Among other requirements, the new committee must monitor evolving and emerging drug threats in the United States.

Section 8218 also authorizes $25.0 million for the National Anti-Drug Media Campaign for each of FY2018-FY2023 and specifies various functions of the program. It outlines various restrictions on the use of funds under this program and sets measures of financial and performance accountability. The Director of ONDCP must submit an annual report to Congress on the performance of this program.

Section 8219: Drug Interdiction

Background

The U.S. Interdiction Coordinator (coordinator) is responsible for coordinating U.S. interdiction efforts to support the National Drug Control Strategy. As part of this charge, the coordinator is required to develop an annual National Interdiction Command and Control Plan. The coordinator must also evaluate and advise the ONDCP director on U.S. interdiction efforts. This coordinator is also responsible for reporting to Congress on the current National Interdiction Command and Control Plan, as well as on certain information regarding drug seizures and air and maritime patrol hours by federal drug control agencies. The coordinator has been required to present any relevant classified or law enforcement sensitive information to Congress separately from this report to Congress.

The Interdiction Committee is responsible for meeting on issues regarding coordination, oversight, and integration of U.S. interdiction efforts (domestic, international, and border efforts) to support the National Drug Control Strategy. The head of the committee is designated by the ONDCP director, and all committee members have been required to meet at least once annually. The committee also reviews the National Interdiction Command and Control Plan and advises the coordinator and ONDCP director on drug interdiction strategy and policy. The committee head is also responsible for submitting a report with results of committee meetings and findings to the

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2003 Report of Findings, Executive Summary, Rockville, MD; and Westat and Annenberg School for Communication, *Evaluation of the National Youth Anti-Drug Media Campaign: Fifth Semi-Annual Report of Findings*, Executive Summary, Rockville, MD.

[194] ONDCP, *National Youth Anti-Drug Media Campaign*, https://obamawhitehouse.archives.gov/ondcp.

[195] Michael D. Slater, Kathleen J. Kelly, and Frank R. Lawrence, et al., "Assessing Media Campaigns Linking Marijuana Non-Use with Autonomy and Aspirations: 'Be Under Your Own Influence' and ONDCP's 'Above the Influence,'" *Prevention Science*, vol. 12, no. 1 (March 2011), pp. 12-22.

[196] Christopher S. Carpenter and Cornelia Pechmann, "Exposure to the Above the Influence Antidrug Advertisements and Adolescent Marijuana Use in the United States, 2006-2008," *American Journal of Public Health*, vol. 101, no. 5 (May 2011), pp. 948-854.

ONDCP director and to relevant congressional committees. The report is due by the end of each fiscal year. The committee head has been required to present any relevant classified or law enforcement sensitive information to Congress separately from this report to Congress.

Provision

Section 8219 specifies that the ONDCP director is responsible for appointing the U.S. Interdiction Coordinator and that this individual must be in the Senior Executive Service or equivalent to a level 15 position in the General Schedule. It clarifies that the ONDCP director may request that relevant agencies detail or assign staff to assist the coordinator in carrying out his/her responsibilities.

It also specifies that the National Interdiction Command and Control Plan is required by September 1 each year—six months later than had been previously specified—and that it must be issued before the ONDCP director releases the National Drug Control Strategy. Section 8219 removes a previous clause stating that the National Interdiction Command and Control Plan could itself recommend changes to agency authorities and laws governing interagency relationships, but that it could not make those changes itself. Instead, it specifies that the required report to Congress (which includes the National Interdiction Command and Control Plan) could include these recommended changes. The section also requires that the coordinator shall provide this required congressional report no later than September 1 each year—six months later than had been previously specified. The provision specifies that this report should now include information on how federal drug control agencies are engaging with international partners.

Section 8219 changes the language used to describe the head of the Interdiction Committee from "chairman" to "chairperson." It also specifies that the committee meetings should be held prior to June 1 of each year—three months later than had been previously specified.

Section 8219 clarifies that any classified or law enforcement sensitive information in the congressional reports submitted by the coordinator or committee that were previously required to be presented in separate reports to Congress may now be included in an annex to these reports.

Section 8220: GAO Audit

Background

In 2017, GAO released its audit findings on (1) the federal government's progress achieving the National Drug Control strategy goals, (2) results of a Comptroller General Forum on preventing illicit drug use, and (3) GAO's review of the DFC Program. GAO found that the government made mixed progress toward achieving its goals laid out in the 2010 National Drug Control Strategy.[197] GAO also reported that ONDCP and SAMHSA had strengthened their management of the DFC program by employing leading collaboration practices, however, they could enhance DFC grantee compliance and performance monitoring.

Provision

Section 8220 requires that GAO, within four years of enactment, conduct an audit relating to ONDCP's programs and operations and submit an evaluation and recommendations to the Director of ONDCP and appropriate congressional committees.

[197] See Office of National Drug Control Policy, *2010 National Drug Control Strategy*, https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/ndcs2010_0.pdf.

Section 8221: National Drug Control Strategy

Background

Congress previously specified that the purpose of the National Drug Control Strategy (the Strategy) is to outline a plan to reduce (1) illicit drug consumption in the United States and (2) the consequences of such use.[198] In creating the Strategy, ONDCP consults with the contributing federal Drug Control Program agencies; Congress; state, local, and tribal officials; foreign government representatives; and private sector representatives with expertise in both supply and demand reduction. In each Strategy since 2010, ONDCP has outlined specific objectives aimed at reducing both illicit drug use and its consequences.

Over the past several years, ONDCP has not released its Strategy during the relevant fiscal year, and it did notrelease a 2017 or 2018 Strategy to accompany the FY2018 Budget highlights released in May 2017.

Provision

Section 8221 amends Section 706 of the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. §1705) to reestablish the requirements for a Strategy. Previously, ONDCP was required to submit the Strategy to Congress by February 1 each year. Section 8221 requires the ONDCP Director to release a statement of drug control policy priorities in the calendar year of a presidential inauguration following the inauguration, but not later than April 1. It then requires the President to submit a Strategy the first Monday in February following the year in which the term of the President commences and every two years thereafter. If the Director fails to meet the deadline for submitting a Strategy, the Director must send a notification to the appropriate congressional committees explaining why the Strategy was not submitted and specifying the date by which the Strategy will be submitted.

Section 8221 directs the process for development and submission of the Strategy and outlines the required contents which includes, among other things, a mission statement; quantifiable goals that are both long-ranged and annual; a performance evaluation for each goal, including the data needed to evaluate these goals and challenges associated with achieving these goals; and a plan to address these challenges. It is also required to include a five-year projection for the program and budget priorities, and a review of international, state, local, and private sector drug control activities to ensure coordination. The mission statement is also required to include a number of data elements, such as a description of the current prevalence of illicit drug use in the United States, including both the availability of illicit drugs and the prevalence of SUDs and other statistical data and information as the ONDCP Director considers appropriate, and a plan to collect such data

The ONDCP Director must also set counternarcotics strategies for the Southwest and Northern borders. In addition to general requirements for the Southwest Border Strategy, Section 8221 states that the Director must specify a strategy to end the construction and use of tunnels and subterranean passages that cross the international border between the United States and Mexico for the purpose of illegal drug trafficking and make recommendations for criminal penalties for persons who construct or use such a tunnel or subterranean passage for such a purpose. In addition to general requirements for the Northern Border Strategy, the Director must specify a strategy to end the illegal trafficking of drugs to or through Indian reservations on or near the international border between the United States and Canada and make recommendations for additional assistance, if any, needed by tribal law enforcement agencies relating to the strategy,

[198] 21 U.S.C. §1705.

including an evaluation of federal technical and financial assistance, infrastructure capacity building, and interoperability deficiencies.

The Section also requires the ONDCP Director to establish a publicly available, online data portal to be known as the Drug Control Data Dashboard. To the extent practicable, the data made available on the dashboard must be in a machine-readable format and searchable by year, agency, drug, and location. The data must be updated annually, at a minimum, and must include for each substance identified by the Director as having a significant impact on the prevalence of illicit drug use. These include data sufficient to show the quantities of such substance available and used in the United States, including a number of specified elements related to drug seizure, flow, production, pricing, and data on substance use by specified populations and criminal activity and prosecutions related to substance use. The Dashboard must also include data related to overdose fatalities; the prevalence of SUD; the number of individuals receiving treatment and the unmet need for treatment; data on prescription drug diversion, trafficking, and misuse; and other quantifiable measures the Director determines appropriate to detail progress toward the achievement of the Strategy.

Finally, the Section requires the Director to develop and submit an Annual National Drug Control Assessment. No later than the first Monday in February each year, the Director must submit a report to the President and Congress assessing the progress of each National Drug Control Program agency toward achieving each goal, objective, and target contained in the Strategy applicable to the prior fiscal year. Section 8221 outlines the process for development of this assessment and the required contents.

Section 8222: Technical and Conforming Amendments to the Office of National Drug Control Policy Reauthorization Act of 1998

Background

In 1993, the Counter-narcotics Technology Center (CTAC) was established by law[199] and partially funded by ONDCP. It was led by a Chief Scientist who was appointed by the ONDCP Director, and it handled various counternarcotics research initiatives. The CTAC program was discontinued in FY2011.[200]

Provision

Section 8222 makes various technical and conforming amendments the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. §§ 1701 et seq.). Among other changes, it alters the maximum amount of funds allowed to be transferred from a National Drug Control Program agency without approval from the Director of ONDCP. It changed the maximum amount from $1 million to $5 million, or 10% of a specific program or account. The language under 21 U.S.C. §1703(c)(4)(A) will now read as follows:

> No National Drug Control Program agency shall submit to Congress a reprogramming or transfer request with respect to any amount of appropriated funds in an amount exceeding $5,000,000 or 10 percent of a specific program or account that is included in the National Drug Control Program budget unless the request has been approved by the Director. If the Director has not responded to a request for reprogramming subject to this subparagraph

[199] P.L. 101-359.

[200] For more information on CTAC and its creation and cancellation, see Office of National Drug Control Policy, *National Drug Control Strategy: Budget Summary*, February 1994, p. 123; and ONDCP, *National Drug Control Strategy: FY2011 Budget Summary*, 2010, p. 149.

> within 30 days after receiving notice of the request having been made, the request shall be deemed approved by the Director under this subparagraph and forwarded to Congress.

Section 8222 also deletes the authorization for the CTAC program.

Subtitle L: Budgetary Effects

Section 8231: Budgetary Effect

Background

The CBO estimated that the act would increase the on-budget deficit by $1,001 million over five years (FY2019-2023) but reduce the on-budget deficit by $52 million over 10 years (FY2019-FY2028).[201] Generally, pay-as-you-go (PAYGO) scorecards record the effects resulting from legislative changes affecting direct spending and revenues; however, Section 8231 of the SUPPORT ACT excludes such budgetary effects from PAYGO scorecards, thus precluding any possible sequestration as a result of the enactment of the legislation.[202]

Provision

This section provides that the estimated budgetary effects of the SUPPORT for Patients and Communities Act are not entered on PAYGO scorecards, thus precluding any possible sequestration as a result of the enactment of this act.

Title IV – Offsets

Section 4003: Additional Religious Exemption from Health Coverage Responsibility Requirement

Background

Section 5000A of the Internal Revenue Code (IRC) establishes the requirement that most individuals must maintain minimum essential coverage for themselves and their dependents or pay a penalty for noncompliance (i.e., individual mandate).[203] Individuals may be exempted from this requirement and its associated penalty if they qualify for a religious conscience exemption. To qualify, an individual must be a member of a recognized religious sect or division (as described in Section 1402(g)(1) of the IRC) by reason of which he or she is conscientiously opposed to acceptance of the benefits of any private or public insurance that makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or

[201] CBO, Estimated Direct Spending and Revenue Effects of H.R. 6, Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, September 27, 2018, https://www.cbo.gov/system/files?file=2018-09/H.R. 6 ConferenceSept27.pdf.

[202] For more information on the PAYGO scorecards, see CRS Report R41157, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, and CRS Report RL31943, *Budget Enforcement Procedures: The Senate Pay-As-You-Go (PAYGO) Rule*.

[203] The types of coverage that are considered minimum essential coverage are listed in Section 5000A of the IRC and its implementing regulations. Most types of comprehensive coverage are considered minimum essential coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance and nongroup, or individual, insurance). 26 U.S.C. §5000A(f) and 26 C.F.R. §1.5000A-2.

provides services for, medical care (e.g., Medicare). Such sect or division must have been in existence at all times since December 31, 1950.

The individual mandate was modified under the 2017 tax revision, P.L. 115-97, which was enacted on December 22, 2017. The law effectively eliminated the penalty associated with the individual mandate beginning in 2019 (i.e., the penalty is in effect through 2018), but the requirement to maintain minimum essential coverage will remain in effect.

Provision

Section 4003 expands the definition of those who qualify for a religious conscience exemption from the individual mandate to also include any individual who is a member of a religious sect or division not described in Section 1402(g)(1) of the IRC, relies solely on a religious method of healing, and has religious beliefs that are inconsistent with the acceptance of medical health services. To receive this type of religious conscience exemption, an individual must apply for the exemption through an exchange and attest that the he or she had not received medical health services during the preceding taxable year.

As used in this provision, medical health services exclude routine dental, vision, and hearing services; midwifery services; vaccinations; necessary medical services provided to children; services required by law or by a third party; and any other service as determined by the Secretary.

This section applies to taxable years beginning after December 31, 2018. CBO estimates that this provision would decrease direct spending outlays by $26 million from FY2019 through FY2028.

Appendix. Public Health and Miscellaneous Provisions in the SUPPORT for Patients and Communities Act: Implementation, Reporting Requirements, and Deadlines

The table below includes relevant provisions (listed in order number) that include an effective date, a required report, or an explicit sunset date. The table does not include every provision described in this report, nor does it include required internal reports (i.e., reports required by grantees); it includes only reports that must be made public or be delivered to Congress.

Table A-1. Public Health and Miscellaneous SUPPORT ACT Provisions, with Implementation Dates, Reporting Requirements, or Other Deadlines

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
Section 4003	Additional Religious Exemption from Health Coverage Responsibility Requirement	Expands the definition of those who would qualify for a religious conscience exemption from the requirement to maintain minimum essential coverage.	Taxable years beginning after December 31, 2018
Section 7001	Report on Effects on Public Health of Synthetic Drug Use	Requires the Secretary, in coordination with the Surgeon General to submit a report, to specified congressional committees, on the health effects of new psychoactive substances.	Three years after enactment, (i.e., October 24, 2021)
Section 7021	Establishment of Substance Use Disorder Information Dashboard	Requires the Secretary, in coordination with the Office of National Drug Control Policy (ONDCP) Director, to establish a substance use disorder (SUD) Information Dashboard on the HHS website.	Not later than six months after enactment, (i.e., April 24, 2019)
Section 7022	Interdepartmental Substance Use Disorders Coordinating Committee	Requires the Secretary, in coordination with the ONDCP Director, to establish a committee.	Not later than three months after enactment, (i.e., January 24, 2019)
		The committee is required to publish an annual report on the HHS website.	Not later than one year after enactment and annually thereafter
		The committee sunsets six years after it is established.	Six years after the committee is established
Section 7023	National Milestones to Measure Success in Curtailing the Opioid Crisis	Requires the Secretary to develop or identify national indicators ("milestones") to measure success in curtailing the opioid epidemic.	Not later than 180 days after enactment, (i.e., April 22, 2019)
		Requires the Secretary identify a reasonable goal to achieve within five years following enactment.	Not later than 180 days after enactment, (i.e., April 22, 2019)
		Requires the Secretary to publish annual reports on progress in achieving the goals established in the national milestones. Report must be published on the HHS website and submitted to specified congressional committees.	Not later than one year after enactment, (i.e., October 24, 2019), annually thereafter
Section 7024	Study on Prescribing Limits	Requires the Secretary to submit a report, to specified congressional committees, on the impact of state and federal regulations affecting opioid prescriptions.	Not later than one year after enactment, (i.e., October 24, 2019)

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
Section 7051	Inclusion of Opioid Addiction History in Patient Records	Requires the Secretary to identify or facilitate the development of best practices regarding the display of information about a patient's history of opioid use disorder in the medical record at the patient's request.	One year after enactment, (i.e., October 24, 2019)
Section 7053	Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records	Requires the Secretary to identify model programs and materials for health care providers and patients on the privacy of SUD patient records.	Not later than one year after enactment, (i.e., October 24, 2019)
Section 7061	Report on Addressing Maternal and Infant Health in the Opioid Crisis	Requires the Secretary in coordination with specified HHS agencies, to submit report on information regarding specified issues related to pain management and SUD during and after pregnancy.	Not later than 18 months after enactment, (i.e., April 24, 2020)
Section 7062	Protecting Moms and Infants	Requires the Secretary to submit a report to specified congressional committees and publish on the HHS website that includes the progress made on implementing on recommendations included in a report required by Protecting Our Infants Act (P.L. 114-191).	Not later than 60 days after enactment, (i.e., December 23, 2018)
Section 7064	Prenatal and Postnatal Health	Requires the CDC Director to issue specified public reports on the analysis of data related to long-term outcomes of children affected by NAS, health outcomes associated with prenatal substance use, and other relevant information as the Secretary determines appropriate.	No date specified
Section 7065	Plans of Safe Care	Requires the Secretary to submit a report to specified congressional committees that includes state-reported data on substance-exposed infants for whom plans of safe care are developed and information on lessons learned from implementation of plan of safe care grants.	Annual report; no date specified
		Sunset of authority to award grants to states to child welfare agencies to coordinate activities related to infants affected by substance use.	September 30, 2023
		Repeal of The Abandoned Infants Assistance Act of 1988 (P.L. 100-505, as amended).	At enactment (i.e., October 24, 2018)

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
Section 7071	Loan Repayment Program for Substance Use Disorder Treatment Workforce	Requires the Secretary to submit report to specified congressional committees about the Substance Use Disorder Treatment Loan Repayment Program.	Not later than five years after enactment, (i.e., October 24, 2023)
Section 7081	Program to Support Coordination and Continuation of Care for Drug Overdose Patients	Requires the Secretary to submit report to specified congressional committees that evaluates the effectiveness of the grant program for developing best practice related to the emergency treatment of known or suspected overdose.	Not later than five years after enactment, (i.e., October 24, 2023)
Section 7091	Emergency Department Alternatives to Opioids Demonstration Program	Requires the Secretary to submit report to specified congressional committees on the results of the demonstration to develop, implement, or study alternatives to opioids for pain management in hospital or emergency department settings.	Not later than one year after completion of the demonstration program
Section 7102	Youth Prevention and Recovery	Requires the Secretary to submit report to specified congressional committees that summarizes the effectiveness of the grant program to support evidence-based substance use disorder prevention, treatment, and recovery programs for children, adolescents, and young adults.	Not later than October 1, 2022
Section 7121	Comprehensive Opioid Recovery Centers	Requires the Secretary to submit a preliminary report to specified congressional committees with a summary of information provided by each grantee regarding activities funded by the grant, health outcomes of individuals served, retention rates of program participants, and any other information the Secretary requests.	Not later than three years after enactment, (i.e., October 24, 2021)
		Requires the Secretary to submit a final report to specified congressional committees with an evaluation of the effectiveness of the centers funded under the Comprehensive Opioid Recovery Center grant program and recommendations for ways to improve federal programs related to SUDs.	Not later than two years after submitting the preliminary report
Section 7132	Task Force to Develop Best Practices for Trauma-Informed Identification, Referral, and Support	Members must be appointed to task force by the heads of specified federal departments and agencies.	Not later than 60 days after enactment, (i.e., December 23, 2018)
		Task force is required to hold its first meeting.	Not later than 120 days after enactment, (i.e., Thursday, February 21, 2019)

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
		Task force is required to submit a report to Congress identifying recommendations that require additional legislative authority to implement.	No specified timetable
		Task force is required to submit a report to the Governors describing opportunities for local and state-level partnerships.	No specified timetable
		Task force is required to submit an operating plan to Congress and specified cabinet secretaries.	Not later than two years after enactment, (i.e., October 24, 2020)
		Task force is required to submit a final report including its findings and recommendations.	Not later than three years after its first meeting
		Task force sunset date.	60 days after the submission of the final report but not later than September 30, 2023
Section 7162	Prescription Drug Monitoring Program	Requires the Secretary to submit a report to Congress that reports the results of a study that determines the progress of grantees in establishing and implementing prescription drug monitoring programs (PDMPs).	Not later than three years after enactment, (i.e., October 24, 2021)
Section 7171	Review of Substance Use Disorder Treatment Providers Receiving Federal Funding	Requires the Secretary to develop and submit to Congress a plan to direct appropriate resources to entities that provide SUD treatment services.	Not later than two years after enactment, (i.e., October 24, 2020)
Section 7181	State Response to the Opioid Abuse Crisis	Requires the Secretary to submit a report to specified congressional committees that summarizes information recipients of the State Targeted Response (STR) grants provide about the use of grant funds including the purposes for which grant funds are awarded and the activities of grantees.	Not later than one year after the date on which amounts are first awarded after the date of enactment and annually thereafter
Section 7182	Report on Investigations Regarding Parity in Mental Health and Substance Use Disorder Benefits	Amends a Cures Act requirement for the Assistant Secretary of Labor of the Employee Benefits Security Administration, in collaboration with Centers for Medicare and Medicaid Services and the Secretary of the Treasury, to submit a report to specified congressional committees on federal investigations pertaining to compliance with mental health and substance use disorder coverage requirements.	Annually for the five years after the enactment of the Cures Act (i.e., through 2021)

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
Section 7183	CAREER Act	Requires the Secretary to submit a preliminary report to specified congressional committees that analyzes the data submitted by grantees.	Not later than two years after the end of the first year of the grant period
		Requires the Secretary to submit a final report to specified congressional committees that includes a description of how the grant funding was used including evaluating what programs were most effective at supporting individuals in SUD treatment and recovery to live independently and participate in the workforce.	Not later than two years after the preliminary report is delivered
Title VIII—Miscellaneous			
Section 8002	Customs Fees	Imposes a $1 charge per Inbound Express Mail item sent through the international postal network (plus additional charges on certain items). Beginning FY2021, the Secretary of the Treasury, in consultation with the Postmaster General, may annually adjust these charges no more than once per fiscal year	January 1, 2020
Section 8003	Mandatory Advance Electronic Information for Postal Shipments	Requires the U.S. Postal Service to shall arrange for the transmission of advance electronic data for not less than 70% of all inbound international mail shipments, and 100% of inbound international mail shipments from the People's Republic of China. Section 8002 provides for phased implementation of advance electronic information requirements. A country may be excluded from advance data requirement by determination from Commissioner, in consultation with the Postmaster General.	Not later than December 31, 2018, at least 70% compliance from all countries and 100% compliance from People's Republic of China Not later than December 31, 2020, 100% compliance from all countries
		If USPS fails to meet advance information transmission targets, GAO must submit a report assessing the reasons for the failure.	June 30, 2019
		Requires the Secretary of Homeland Security and the Postmaster General to develop and submit to the appropriate congressional committees a joint strategic plan detailing specific performance measures for achieving transmission of advance electronic information and inspection of inbound international mail by Customs and Border Protection.	Not later than 60 days after enactment, (i.e., December 23, 2018)

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
		Requires the Secretary of Homeland Security and the Postmaster General to, in consultation with the Secretary of State, develop and submit to the appropriate congressional committees a joint strategic plan detailing ways in which U. S. Postal Service and Customs and Border Protection are engage in efforts to help countries enhance their ability to collect and transmit advance electronic information.	Not later than one year after enactment, (i.e., October 24, 2019)
		Requires the Postmaster General and Secretary of Homeland Security to provide regular consultations and briefings to appropriate congressional committees.	Not later than180 days after enactment and annually thereafter (i.e., April 22, 2018)
		Requires a GAO report, submitted to appropriate congressional committees, on the progress of U. S. Postal Service in achieving requirements for transmission of advance electronic data for inbound international mail shipments to Customs and Border Protection.	June 30, 2019
Section 8009	Effective Date; Regulations	Requires regulations necessary to carry out Subtitle A be prescribed.	Not later than one year after enactment (i.e., October 24, 2019)
Section 8051	Peer Support Counseling Program for Women Veterans	Requires the Secretary of Veterans Affairs to submit a report to specified congressional committees that includes the number of peer support counselors in the program, an assessment of the effectiveness of the program, and a description of the oversight of the program.	Not later than two years after enactment, (i.e., October 24, 2020)
Section 8071	Pilot Program to Help Individuals in Recovery from a Substance Use Disorder Become Stably Housed	Requires the Secretary of Housing and Urban Development to establish criteria to be used within a funding formula that will be used to award grants to states for housing for individuals in recovery from a SUD.	Not later than 60 days after enactment, (i.e., December 23, 2018)
Section 8081	Supporting Family-Focused Residential Treatment	Requires the Secretary to develop and issue guidance to states that identify opportunities to support family-focused SUD treatment.	Not later than 180 days after enactment, (i.e., April 22, 2018)
Section 8082	Improving Recovery and Reunifying Families	Requires the Secretary to publish on the HHS website four specified reports that evaluate the Family Recovery and Reunification Program.	No date specified

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
		Clarifies that a state child welfare agency must not be considered a legally liable third party for purposes of paying the costs of prevention services or programs if that cost would have been paid by another private or public source except for the enactment of the Title IV-E prevention support in P.L. 115-123. However, Title IV-E may be used to pay such costs if this is necessary to prevent delay of service provision, pending reimbursement from the private or public source with ultimate responsibility.	February 9, 2018
Section 8102	Alcohol and Controlled Substance Testing of Mechanical Employees	Requires the Secretary of Transportation to publish a rule that revises the regulations promulgated under 49 U.S.C. §20140 to cover all employees of railroad carriers who perform mechanical activities.	Not later than two years after enactment, (i.e., October 24, 2020)
Section 8103	Department of Transportation Public Drug and Alcohol Testing Database	Requires the Secretary of Transportation to establish a database of the drug and alcohol testing data reported by employers for each mode of transportation.	Not later than March 31, 2019
Section 8104	GAO report on Department of Transportation's Collection and Use of Drug and Alcohol Testing Data	Requires a GAO Report on the Department of Transportation's collection and use of drug and alcohol testing data.	Not later than two years after the DOT database required in Section 8103 is established
Section 8105	Transportation Workplace Drug and Alcohol Testing Program; Addition of Fentanyl and Other Substances	Requires the Secretary to determine whether it is justified to expand the Mandatory Guidelines for Federal Workplace Drug Testing Programs to include fentanyl or other substances.	Not later than 180 days after enactment, (i.e., April 22, 2018)
		Requires the Secretary to publish a final notice of Mandatory Guidelines for Federal Workplace Drug Testing Programs in the *Federal Register*.	Not later than 18 months after the Secretary determines whether it is justified to expand the Mandatory Guidelines
Section 8106	Status Reports on Hair Testing Guidelines	Requires the Secretary to submit a report to specified congressional committees on the status of hair testing guidelines, why they have not been issued, and the estimated date that the guidelines will be completed.	Not later than 60 days after enactment, (i.e., December 23, 2018), annually thereafter until the guidelines are published
Section 8107	Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid	Requires the Secretary to publish a final notice of the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid in the *Federal Register*.	Not later than December 31, 2018

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
Section 8108	Electronic Recordkeeping	Requires the Secretary to ensure that each certified laboratory that requests approval for the use of completely paperless electronic Federal Drug Testing Custody and Control Forms receives approval, and establish a deadline for such approval.	Not later than one year after enactment, (i.e., October 24, 2019)
		Requires the Secretary of Transportation to issue a final rule revising part 40 of title 49 of the CFR (Procedures for Transportation Workplace Drug and Alcohol Testing Programs).	Not later than 18 months after the established deadline for certified laboratories to request electronic forms
Section 8109	Status Reports on Commercial Driver's License Drug and Alcohol Clearinghouse	Requires the Administrator of the Federal Motor Carrier Safety Administration to submit a status report to specified congressional committees on the progress of the Commercial Driver's License Drug and Alcohol Clearinghouse.	Not later than 60 days after enactment, (i.e., December 23, 2018), annually thereafter
Section 8213	Reimbursement of Substance Use Disorder Treatment Professionals	Requires GAO submit a report to Congress examining how substance use disorder services are reimbursed.	Not later than January 1, 2020
Section 8215	Provider Education	Requires the Attorney General to complete the plan related to how to use the DEA registration process to limit opioid overprescribing.	Not later than 60 days after enactment, (i.e., December 23, 2018)
Section 8217	Amendments to Administration of the Office	Requires each National Drug Control Program agency to submit to the Director of ONDCP a detailed accounting of all funds expended for National Drug Control Program activities during the previous fiscal year.	Not later than April 1 of each year
		Requires a GAO report that examines ONDCP's implementation of the Tracking System for Federally Funded Grant Programs.	Not later than three years after enactment, (i.e., October 24, 2021)
Section 8218	Emerging Threats Committee, Plan, and Media Campaign	Requires the Emerging Threats Committee to develop and recommend criteria to be used to identify an emerging drug threat or the termination of an emerging drug threat designation.	Not later than 180 days after the date on which the committee first meets
		Requires the Director of ONDCP to publish and make publicly available an Emerging Threat Response Plan.	Not later than 90 days after designating an emerging threat
		Requires the Director of ONDCP to issue guidance on the implementation of the Emerging Threat Response Plan to the National Drug Control Program agencies and any other relevant agency.	Not later than 120 days after a designation is made

Provision Number	Title	Brief Description	Implementation/Reporting Deadline
		Requires the Director of ONDCP to designate an independent entity to evaluate the effectiveness of the national media campaign.	Not later than April 20 each year
Section 8219	Drug Interdiction	Amends requirements that the U.S. Interdiction Coordinator develop the National Interdiction Command and Control Plan and submit this plan and corresponding report to Congress.	Not later than September 1 each year
		Amends requirements regarding the Interdiction Committee's required report to Congress.	Not later than the end of each fiscal year
Section 8220	GAO Audit	Requires a GAO audit relating to the programs and operations of ONDCP.	Not later than four years after enactment, (i.e., October 24, 2022), every four years thereafter
Section 8221	National Drug Control Strategy	Requires the Director of ONDCP to release a statement of drug control policy priorities.	Not later than April 1 in the calendar year of a presidential inauguration that follows the inauguration
		Requires the President to submit a National Drug Control Strategy.	Not later than the first Monday in February following the year in which the term of the President commences, every two years thereafter
		Requires the Director of ONDCP to submit an explanation of why a National Drug Control Strategy was not submitted (if the deadline to submit is missed) and specify the date by which a strategy will be submitted.	Not later than five days after the first Monday in February following the year in which the term of the President commences
		Requires the ONDCP Director to develop an Annual National Drug Control Assessment.	Not later than the first Monday in February of each year
		Requires the ONDCP Director to establish a Drug Control Data Dashboard with specified information regarding illicit drug use.	No date specified; the dashboard must be updated annually, at a minimum.

Source: Table prepared by the Congressional Research Service (CRS) based on statutory language contained in Titles VII and VIII of the SUPPORT for Patients and Communities Act (P.L. 115-271).

Notes: Secretary=Secretary of the Department of Health and Human Services (HHS); DEA= Drug Enforcement Agency; GAO=Government Accountability Office; HHS=Department of Health and Human Services; ONDCP=Office of National Drug Control Policy; SUD=Substance Use Disorder; U.S.C. =U.S. Code.

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