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(Original Signature of Member)

117TH CONGRESS
1ST SESSION

H. R.

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

IN THE HOUSE OF REPRESENTATIVES

Mr. TRONE introduced the following bill; which was referred to the Committee on _____

A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “CARA 3.0 Act of 2021”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.

TITLE I—EDUCATION, PREVENTION, AND RESEARCH

- Sec. 101. National Education Campaign.
- Sec. 102. Research into non-opioid pain management.
- Sec. 103. Long-term treatment and recovery support services research.
- Sec. 104. National Commission for Excellence on Post-Overdose Response.
- Sec. 105. Workforce for prevention, treatment, and recovery support services.
- Sec. 106. Reauthorization of community-based coalition enhancement grants to address local drug crises.
- Sec. 107. Access to non-opioid treatments for pain.

TITLE II—TREATMENT

- Sec. 201. Evidence-based substance use disorder treatment and intervention demonstrations.
- Sec. 202. Improving treatment for pregnant, postpartum, and parenting women.
- Sec. 203. Require the use of prescription drug monitoring programs.
- Sec. 204. Prescriber education.
- Sec. 205. Prohibition of utilization control policies or procedures for medication-assisted treatment under Medicaid.
- Sec. 206. Medication-assisted treatment for recovery from substance use disorder.
- Sec. 207. Telehealth response for e-prescribing addiction therapy services.
- Sec. 208. Pilot program on expanding access to treatment.
- Sec. 209. Reauthorization of PRAC Ed grant program.
- Sec. 210. GAO study on parity.
- Sec. 211. Improving substance use disorder prevention workforce act.

TITLE III—RECOVERY

Subtitle A—General Provisions

- Sec. 301. Building communities of recovery.
- Sec. 302. Recovery in the workplace.
- Sec. 303. National youth and young adult recovery initiative.

Subtitle B—Recovery Housing

- Sec. 311. Clarifying the role of SAMHSA in promoting the availability of high-quality recovery housing.
- Sec. 312. Developing guidelines for States to promote the availability of high-quality recovery housing.
- Sec. 313. Coordination of Federal activities to promote the availability of high-quality recovery housing.
- Sec. 314. NAS study and report.
- Sec. 315. Filling research and data gaps.
- Sec. 316. Grants for States to promote the availability of high quality recovery housing.
- Sec. 317. Reputable providers and analysts of recovery housing services definition.
- Sec. 318. Technical correction.

TITLE IV—CRIMINAL JUSTICE

- Sec. 401. Medication-Assisted Treatment Corrections and Community Reentry Program.
- Sec. 402. Deflection and pre-arrest diversion.
- Sec. 403. Housing.

Sec. 404. Veterans treatment courts.

Sec. 405. Infrastructure for reentry.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) In the 1980s and 1990s, pharmaceutical
4 companies began developing new drugs for pain
5 treatment, including extended release oxycodone.
6 These companies aggressively marketed these drugs
7 to the medical community as a way to address
8 “under-treatment” of physical pain. Drug companies
9 distributed 76,000,000,000 oxycodone and
10 hydrocodone pain pills nationwide from 2006 to
11 2012.

12 (2) The combination of a rising number of pre-
13 scriptions, misinformation about the addictive prop-
14 erties of prescription opioids, and the perception
15 that prescription drugs are less harmful than illicit
16 drugs has caused an increase in drug misuse.

17 (3) As legitimate production and illegal diver-
18 sion of opioids skyrocketed, so did the number of
19 opioid overdose deaths. From 1999 to 2017, almost
20 218,000 people died in the United States from
21 overdoses related to prescription opioids. More re-
22 cently, fentanyl, a powerful synthetic opioid, sur-
23 passed prescription opioids as the most lethal over-

1 dose substance and now is linked to nearly 3 times
2 as many deaths.

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

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

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

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

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

15 (5) The opioid crisis has also led to a cascade
16 of other negative health impacts. For example, sy-
17 ringe sharing among people who inject drugs has led
18 to increases in hepatitis C virus infections and infec-
19 tive endocarditis, as well as localized HIV outbreaks.

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

22 (A) The majority of people in the United
23 States with an opioid use disorder do not re-
24 ceive substance use treatment, and many who
25 do receive such treatment do not receive evi-

1 dence-based treatment. Although medication-as-
2 sisted treatment has been endorsed by the Na-
3 tional Institutes of Health and the World
4 Health Organization, only one-third of treat-
5 ment programs offer any of the 3 drugs ap-
6 proved by the Food and Drug Administration
7 for the treatment of opioid use disorder, and
8 just 6 percent of medication-offering facilities
9 provide all 3.

10 (B) Facilities that provide medications for
11 the treatment of opioid disorder are con-
12 centrated in the Northeast and Southwest, leav-
13 ing many of the areas hit hardest by the opioid
14 crisis without access to evidence-based treat-
15 ment. The need is particularly acute in rural
16 areas, which often do not have enough providers
17 to meet the demand.

18 (C) Unlike other health care needs, sub-
19 stance use treatment is largely funded by State
20 and local revenues and Federal block grants,
21 rather than the Medicare program, the Med-
22 icaid program, and private insurance.

23 (D) While new substances, particularly
24 synthetic drugs, continue to make inroads into
25 communities in the United States, funding

1 streams are often dedicated to particular sub-
2 stances, limiting providers' ability to adapt to
3 changing needs.

4 (E) The stigma associated with substance
5 use disorder prevents people from seeking treat-
6 ment. Too often, people enter substance use
7 treatment only after committing a criminal of-
8 fense, whether through a court mandate, as a
9 condition of parole or probation supervision, or
10 as a condition of regaining employment after
11 conviction. In 2003, 36 percent of all substance
12 use treatment admissions, 40 percent of all al-
13cohol abuse treatment admissions, and 57 per-
14cent of all marijuana use treatment admissions
15were referrals from the criminal justice system.

16 (F) The stigma of substance use disorder
17also limits people's ability to find jobs and
18housing. These obstacles are exacerbated by the
19criminalization of substance use disorder—even
20convictions for drug possession for personal use
21can create lifelong collateral consequences. The
22absence of stable housing and employment
23make it even more difficult for people to live
24drug free.

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

7 (8) Inadequate access to substance use treat-
8 ment can exacerbate other health disparities. Indi-
9 viduals with substance use disorders have higher
10 rates of suicide attempts than individuals in the gen-
11 eral population, high health care expenses, and sig-
12 nificant disability.

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

16 **TITLE I—EDUCATION,**
17 **PREVENTION, AND RESEARCH**

18 **SEC. 101. NATIONAL EDUCATION CAMPAIGN.**

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

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

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

3 (3) in subsection (c)—

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

6 (B) in paragraph (3), by striking the pe-
7 riod and inserting a semicolon; and

8 (C) by adding at the end the following:

9 “(4) use destigmatizing language promoting hu-
10 mane and culturally competent (as defined in section
11 102 of the Developmental Disabilities Assistance
12 and Bill of Rights Act of 2000 (42 U.S.C. 15002))
13 treatment of all individuals who experience sub-
14 stance use disorder, including such individuals who
15 use medication-assisted treatment for recovery pur-
16 poses;

17 “(5) educate stakeholders on the evidence base
18 and validation of harm reduction and where to ob-
19 tain harm reduction services;

20 “(6) include information about polysubstance
21 use; and

22 “(7) include information about prevention and
23 treatment using medication-assisted treatment and
24 recovery support.”; and

25 (4) by adding at the end the following:

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2022 through 2026.”.

5 **SEC. 102. RESEARCH INTO NON-OPIOID PAIN MANAGE-**
6 **MENT.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services, acting through the Director of the Na-
9 tional Institutes of Health and the Director of the Centers
10 for Disease Control and Prevention, shall carry out re-
11 search with respect to non-opioid methods of pain manage-
12 ment, including non-pharmaceutical remedies for pain and
13 integrative medicine solutions.

14 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
15 out this section, there are authorized to be appropriated
16 such sums as may be necessary for each of fiscal years
17 2022 through 2026.

18 **SEC. 103. LONG-TERM TREATMENT AND RECOVERY SUP-**
19 **PORT SERVICES RESEARCH.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services shall award grants to eligible entities to
22 carry out evidence-based research, over 5-year periods, for
23 different modalities of treatment and recovery support for
24 substance use disorder, including culturally competent (as
25 defined in section 102 of the Developmental Disabilities

1 Assistance and Bill of Rights Act of 2001 (42 U.S.C.
2 15002)) treatment.

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

6 (1) measure—

7 (A) mortality and morbidity;

8 (B) physical and emotional health;

9 (C) employment;

10 (D) stable housing;

11 (E) criminal justice involvement;

12 (F) family relationships; and

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

14 (2) distinguish long-term outcomes based on—

15 (A) race;

16 (B) gender;

17 (C) socioeconomic status; and

18 (D) other relevant characteristics.

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

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

24 (a) ESTABLISHMENT.—The Assistant Secretary of
25 Health and Human Services for Mental Health and Sub-

1 stance Use (referred to in this section as the “Assistant
2 Secretary”), in consultation with the Director of the Office
3 of National Drug Control Policy, and the President of the
4 National Academy of Medicine, shall establish an advisory
5 commission to be known as the National Commission for
6 Excellence on Post-Overdose Response (in this section re-
7 ferred to as the “Commission”).

8 (b) DUTIES.—The Commission shall—

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

14 (A) researchers and evaluators;

15 (B) clinicians and clinical teams;

16 (C) quality improvement experts; and

17 (D) healthcare decision makers;

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

20 (A) achieving equitable outcomes with re-
21 spect to race and socioeconomic status; and

22 (B) effectively and appropriately reducing
23 the rate of—

24 (i) inpatient hospital admissions
25 where equivalent services are available to

1 treat patients in a similar condition
2 through outpatient hospital visits or non-
3 hospital treatment facilities;

4 (ii) emergency department admissions;

5 and

6 (iii) other adverse events related to
7 care for individuals described in such para-
8 graph; and

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

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

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

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

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

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

1 (5) a substance use disorder specialist ap-
2 pointed by the Assistant Secretary;

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

5 (7) an individual with experience in harm re-
6 duction; and

7 (8) any other individual that the Assistant Sec-
8 retary determines appropriate.

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

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

14 (a) EMPLOYMENT AND TRAINING SERVICES.—Sub-
15 part 2 of part B of title V of the Public Health Service
16 Act (42 U.S.C. 290bb–21 et seq.) is amended by adding
17 at the end the following:

18 **“SEC. 519E. EMPLOYMENT AND TRAINING SERVICES.**

19 “(a) IN GENERAL.—The Director of the Prevention
20 Center shall—

21 “(1) beginning not later than 30 days after the
22 date of enactment of this Act, award grants or enter
23 into contracts with eligible entities to support em-
24 ployment and training services for substance use

1 treatment professionals, including peer recovery spe-
2 cialists; and

3 “(2) subject to the availability of funds appro-
4 priated pursuant to subsection (d), not later than 45
5 days after the date on which an entity submits an
6 application that meets the requirements of the Sec-
7 retary under this section, award funds under this
8 section to such entity.

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

14 “(c) MINIMUM.—A recipient shall use not less than
15 15 percent of funds awarded under subsection (a) for ac-
16 tivities related to retention of substance use treatment
17 professionals.

18 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2022 through 2026.”.

22 (b) FUNDING FOR MENTAL AND BEHAVIORAL
23 HEALTH EDUCATION AND TRAINING GRANTS.—Section
24 756(f) of the Public Health Service Act (42 U.S.C. 294e–
25 1(f)) is amended—

1 (1) in the matter preceding paragraph (1), by
2 striking “\$50,000,000” and inserting
3 “\$55,000,000”; and

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

5 “(5) For continuing education and other activi-
6 ties to increase retention and to strengthen the sub-
7 stance use disorder workforce, \$5,000,000.”.

8 **SEC. 106. REAUTHORIZATION OF COMMUNITY-BASED COA-**
9 **LITION ENHANCEMENT GRANTS TO ADDRESS**
10 **LOCAL DRUG CRISES.**

11 Section 103(i) of the Comprehensive Addiction and
12 Recovery Act of 2016 (21 U.S.C. 1536(i)) is amended by
13 striking the period at the end and inserting “, and
14 \$10,000,000 for each of fiscal years 2022 through 2026.”

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

16 (a) IN GENERAL.—Section 1833(t) of the Social Se-
17 curity Act (42 U.S.C. 1395l(t)) is amended—

18 (1) in paragraph (2)(E), by inserting “, sepa-
19 rate payments for non-opioid treatments under para-
20 graph (16)(G), and” after “payments under para-
21 graph (6) and”; and

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

24 “(G) ACCESS TO NON-OPIOID TREATMENTS
25 FOR PAIN.—

1 “(i) IN GENERAL.—Notwithstanding
2 any other provision of this subsection, with
3 respect to a covered OPD service (or group
4 of services) furnished on or after January
5 1, 2022, and before January 1, 2027, the
6 Secretary shall not package, and shall
7 make a separate payment as specified in
8 clause (ii) for, a non-opioid treatment (as
9 defined in clause (iii)) furnished as part of
10 such service (or group of services).

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

15 “(I) a drug or biological product,
16 the amount of payment for such drug
17 or biological determined under section
18 1847A; or

19 “(II) a medical device, the
20 amount of the hospital’s charges for
21 the device, adjusted to cost.

22 “(iii) DEFINITION OF NON-OPIOID
23 TREATMENT.—A ‘non-opioid treatment’
24 means—

1 “(I) a drug or biological product
2 that is indicated to produce analgesia
3 without acting upon the body’s opioid
4 receptors; or

5 “(II) an implantable, reusable, or
6 disposable medical device cleared or
7 approved by the Administrator for
8 Food and Drugs for the intended use
9 of managing or treating pain;
10 that has demonstrated the ability to re-
11 place, reduce, or avoid opioid use or the
12 quantity of opioids prescribed in a clinical
13 trial or through data published in a peer-
14 reviewed journal.”.

15 (b) AMBULATORY SURGICAL CENTER PAYMENT SYS-
16 TEM.—Section 1833(i)(2)(D) of the Social Security Act
17 (42 U.S.C. 1395l(i)(2)(D)) is amended—

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

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

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

24 “(vi) In the case of surgical services
25 furnished on or after January 1, 2022, and

1 before January 1, 2027, the payment sys-
2 tem described in clause (i) shall provide, in
3 a budget-neutral manner, for a separate
4 payment for a non-opioid treatment (as de-
5 fined in clause (iii) of subsection
6 (t)(16)(G)) furnished as part of such serv-
7 ices in the amount specified in clause (ii)
8 of such subsection.”.

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

11 (1) REPORT TO CONGRESS.—Not later than 1
12 year after the date of the enactment of this Act, the
13 Secretary of Health and Human Services, acting
14 through the Administrator of the Centers for Medi-
15 care & Medicaid Services, shall submit to Congress
16 a report on—

17 (A) limitations, gaps, barriers to access, or
18 deficits in coverage under the Medicare pro-
19 gram under title XVIII of the Social Security
20 Act (42 U.S.C. 1395 et seq.) or reimbursement
21 for restorative therapies, behavioral approaches,
22 and complementary and integrative health serv-
23 ices that—

24 (i) are identified by the Pain Manage-
25 ment Best Practices Inter-Agency Task

1 Force under section 101 of the Com-
2 prehensive Addiction and Recovery Act of
3 2016 (42 U.S.C. 201 note); and

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

6 (B) recommendations to address the limi-
7 tations, gaps, barriers to access, or deficits
8 identified under subparagraph (A) to improve
9 such coverage and reimbursement for such
10 therapies, approaches, and services.

11 (2) PUBLIC CONSULTATION.—In developing the
12 report described in paragraph (1), the Secretary of
13 Health and Human Services shall consult with ap-
14 propriate entities as determined by the Secretary.

15 (3) EXCLUSIVE TREATMENT.—Any drug, bio-
16 logical product, or medical device that is a non-
17 opioid treatment (as defined in section
18 1833(t)(16)(G)(iii) of the Social Security Act, as
19 added by subsection (a)) shall not be considered a
20 therapeutic service for the purpose of the report de-
21 scribed in paragraph (1).

1 **TITLE II—TREATMENT**
2 **SEC. 201. EVIDENCE-BASED SUBSTANCE USE DISORDER**
3 **TREATMENT AND INTERVENTION DEM-**
4 **ONSTRATIONS.**

5 Section 514B of the Public Health Service Act (42
6 U.S.C. 290bb–10) is amended—

7 (1) in subsection (a), by adding at the end the
8 following:

9 “(3) USE OF FUNDS FOR TRAINING.—Funds
10 awarded under paragraph (1) may be used by a re-
11 cipient for training emergency room technicians,
12 physicians, nurses, or other health care professionals
13 on identifying the presence of substance use dis-
14 orders; how effectively to engage with, intervene with
15 respect to, and refer patients for assessment and
16 specialized substance use disorder care, including
17 medication-assisted treatment and care for co-occur-
18 ring disorders; and offering peer-based interventions
19 in the emergency room and other health care envi-
20 ronments to connect people to clinical and commu-
21 nity-based supports for substance use disorder.”;

22 (2) in subsection (d), by inserting “, and Indian
23 tribes and tribal organizations (as defined in section
24 4 of the Indian Self-Determination and Education

1 Assistance Act)” before the period of the first sen-
2 tence; and

3 (3) in subsection (f), by striking “\$25,000,000
4 for each of fiscal years 2017 through 2021” and in-
5 serting “\$300,000,000 for each of fiscal years 2022
6 through 2026”.

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

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

11 (1) in subsection (m)—

12 (A) by striking “that agrees to use” and
13 inserting “that agrees—
14 “(1) to use”;

15 (B) by striking the period at the end and
16 inserting “; or”; and

17 (C) by adding at the end the following:

18 “(2) to—

19 “(A) allow participation in the program
20 supported by the award by individuals taking a
21 drug or combination of drugs approved by the
22 Food and Drug Administration as a medication
23 for addiction treatment, including such individ-
24 uals taking an opioid agonist;

1 “(B) provide culturally competent services
2 (as defined in section 102 of the Developmental
3 Disabilities Assistance and Bill of Rights Act of
4 2000);

5 “(C) ensure flexible lengths of stay in the
6 treatment program; and

7 “(D) use peer recovery advocates in the
8 program supported by the award.”;

9 (2) in subsection (p), by inserting “, and demo-
10 graphic data on the individuals served by programs
11 funded under this section and case outcomes, as re-
12 ported to the Director by award recipients” before
13 the period at the end of the third sentence; and

14 (3) in subsection (s), by striking “\$29,931,000
15 for each of fiscal years 2019 through 2023” and in-
16 serting “100,000,000 for each of fiscal years 2022
17 through 2026”.

18 **SEC. 203. REQUIRE THE USE OF PRESCRIPTION DRUG MON-**
19 **ITORING PROGRAMS.**

20 (a) DEFINITIONS.—In this section:

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

1 (2) COVERED STATE.—The term “covered
2 State” means a State that receives funding under
3 the Harold Rogers Prescription Drug Monitoring
4 Program established under the Departments of
5 Commerce, Justice, and State, the Judiciary, and
6 Related Agencies Appropriations Act, 2002 (Public
7 Law 107–77; 115 Stat. 748), under this Act (or an
8 amendment made by this Act), or under the con-
9 trolled substance monitoring program under section
10 3990 of the Public Health Service Act (42 U.S.C.
11 280g–3).

12 (3) DISPENSER.—The term “dispenser”—

13 (A) means a person licensed or otherwise
14 authorized by a State to deliver a prescription
15 drug product to a patient or an agent of the pa-
16 tient; and

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

19 (4) PDMP.—The term “PDMP” means a pre-
20 scription drug monitoring program.

21 (5) PRACTITIONER.—The term “practitioner”
22 means a practitioner registered under section 303(f)
23 of the Controlled Substances Act (21 U.S.C. 823(f))
24 to prescribe, administer, or dispense controlled sub-
25 stances.

1 (6) STATE.—The term “State” means each of
2 the several States and the District of Columbia.

3 (b) IN GENERAL.—Beginning 1 year after the date
4 of enactment of this Act, each covered State shall re-
5 quire—

6 (1) each prescribing practitioner within the cov-
7 ered State or their designee, who shall be licensed or
8 registered healthcare professionals or other employ-
9 ees who report directly to the practitioner, to consult
10 the PDMP of the covered State before initiating
11 treatment with a prescription for a controlled sub-
12 stance listed in schedule II, III, or IV of section
13 202(c) of the Controlled Substances Act (21 U.S.C.
14 812(c)), and every 3 months thereafter as long as
15 the treatment continues;

16 (2) the PDMP of the covered State to provide
17 proactive notification to a practitioner when patterns
18 indicative of controlled substance misuse, including
19 opioid misuse, are detected;

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

1 (4) that the PDMP make available a quarterly
2 de-identified data set and an annual report for pub-
3 lic and private use, including use by healthcare pro-
4 viders, health plans and health benefits administra-
5 tors, State agencies, and researchers, which shall, at
6 a minimum, meet requirements established by the
7 Attorney General, in coordination with the Secretary
8 of Health and Human Services;

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

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

13 (B) provide reports to prescriber licensing
14 boards describing any prescribing practitioner
15 that repeatedly fall outside of expected norms
16 or standard practices for the prescribing practi-
17 tioner's field; and

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

20 (c) NONCOMPLIANCE.—If a covered State fails to
21 comply with subsection (a), the Attorney General or the
22 Secretary of Health and Human Services may withhold
23 grant funds from being awarded to the covered State
24 under the Harold Rogers Prescription Drug Monitoring
25 Program established under the Departments of Com-

1 merce, Justice, and State, the Judiciary, and Related
2 Agencies Appropriations Act, 2002 (Public Law 107–77;
3 115 Stat. 748), under this Act (or an amendment made
4 by this Act), or under the controlled substance monitoring
5 program under section 3990 of the Public Health Service
6 Act (42 U.S.C. 280g–3).

7 **SEC. 204. PRESCRIBER EDUCATION.**

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

10 (1) in subsection (f), in the matter preceding
11 paragraph (1), by striking “The Attorney General
12 shall register” and inserting “Subject to subsection
13 (m), the Attorney General shall register”; and

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

15 “(l) PRESCRIBER EDUCATION.—

16 “(1) DEFINITIONS.—In this subsection—

17 “(A) the term ‘covered agent or employee’
18 means an agent or employee of a covered facil-
19 ity who—

20 “(i) prescribes controlled substances
21 for humans under the registration of the
22 facility under this part; and

23 “(ii) is a medical resident;

24 “(B) the term ‘covered facility’ means a
25 practitioner—

1 “(i) that is a hospital or other institu-
2 tion;

3 “(ii) that is licensed under State law
4 to prescribe controlled substances; and

5 “(iii) under whose registration under
6 this part agents or employees of the practi-
7 tioner prescribe controlled substances;

8 “(C) the term ‘covered individual practi-
9 tioner’ means a practitioner who—

10 “(i) is an individual;

11 “(ii) is not a veterinarian; and

12 “(iii) is licensed under State law to
13 prescribe controlled substances; and

14 “(D) the term ‘specified continuing edu-
15 cation topics’ means—

16 “(i) alternatives to opioids for pain
17 management;

18 “(ii) palliative care;

19 “(iii) substance use disorder;

20 “(iv) adverse events;

21 “(v) potential for dependence;

22 “(vi) tolerance;

23 “(vii) prescribing contraindicated sub-
24 stances;

25 “(viii) medication-assisted treatment;

1 “(ix) overdose prevention and re-
2 response, including the administration of
3 naloxone;

4 “(x) culturally competent (as defined
5 in section 102 of the Developmental Dis-
6 abilities Assistance and Bill of Rights Act
7 of 2000 (42 U.S.C. 15002)) services;

8 “(xi) bias and stigma in prescribing
9 trends; and

10 “(xii) any other topic that the Attor-
11 ney General determines appropriate.

12 “(2) CERTIFICATION OF CONTINUING EDU-
13 CATION.—

14 “(A) INDIVIDUAL PRACTITIONERS.—As a
15 condition of granting or renewing the registra-
16 tion of a covered individual practitioner under
17 this part to dispense controlled substances in
18 schedule II, III, IV, or V, the Attorney General
19 shall require the practitioner to certify that,
20 during the 3-year period preceding the date of
21 the grant or renewal of registration, the practi-
22 tioner completed course work or training from
23 an organization accredited by the Accreditation
24 Council for Continuing Medical Education
25 (commonly known as the ‘ACCME’), or by a

1 State medical society accreditor recognized by
2 the ACCME, that included not fewer than 3
3 hours of content on the specified continuing
4 education topics.

5 “(B) FACILITIES.—As a condition of
6 granting or renewing the registration of a cov-
7 ered facility under this part to dispense con-
8 trolled substances in schedule II, III, IV, or V,
9 the Attorney General shall require the covered
10 facility to certify that the facility does not allow
11 a covered agent or employee to prescribe con-
12 trolled substances for humans under the reg-
13 istration of the facility unless, during the pre-
14 ceding 3-year period, the covered agent or em-
15 ployee completed course work or training from
16 an organization accredited by the Accreditation
17 Council for Continuing Medical Education
18 (commonly known as the ‘ACCME’), or a State
19 medical society accreditor recognized by the
20 ACCME, that included not fewer than 3 hours
21 of content on the specified continuing education
22 topics.”.

23 (b) EFFECTIVE DATE.—Subsection (l) of section 303
24 of the Controlled Substances Act (21 U.S.C. 823), as
25 added by subsection (a), shall apply to any grant or re-

1 newal of registration described in such subsection (l) that
2 occurs on or after the date that is 2 years after the date
3 of enactment of this Act.

4 **SEC. 205. PROHIBITION OF UTILIZATION CONTROL POLI-**
5 **CIES OR PROCEDURES FOR MEDICATION-AS-**
6 **SISTED TREATMENT UNDER MEDICAID.**

7 Section 1905 of the Social Security Act (42 U.S.C.
8 1396d) is amended—

9 (1) in subsection (a)—

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

13 (B) in paragraph (29), by inserting “and
14 to the extent allowed in paragraph (4) of such
15 subsection” after “paragraph (1) of such sub-
16 section”; and

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

19 “(4) PROHIBITION OF UTILIZATION CONTROL
20 POLICIES OR PROCEDURES FOR MEDICATION-AS-
21 SISTED TREATMENT.—As a condition for a State re-
22 ceiving payments under section 1903(a) for medical
23 assistance for medication-assisted treatment, a State
24 may not impose any utilization control policies or
25 procedures (as defined by the Secretary), including

1 prior authorization requirements, with respect to
2 such treatment.”.

3 **SEC. 206. MEDICATION-ASSISTED TREATMENT FOR RECOV-**
4 **ERY FROM SUBSTANCE USE DISORDER.**

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

7 (1) by striking paragraph (2);

8 (2) by striking “(g)(1) Except as provided in
9 paragraph (2), practitioners who dispense narcotic
10 drugs to individuals for maintenance treatment or
11 detoxification treatment” and inserting “(g) Practi-
12 tioners who dispense narcotic drugs (other than nar-
13 cotic drugs in schedule III, IV, or V) to individuals
14 for maintenance treatment or detoxification treat-
15 ment”;

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

19 (4) in paragraph (2), as redesignated, by redesi-
20 gnating clauses (i) and (ii) as subparagraphs (A)
21 and (B), respectively.

22 (b) TECHNICAL AND CONFORMING EDITS.—

23 (1) IN GENERAL.—

24 (A) Section 304 of the Controlled Sub-
25 stances Act (21 U.S.C. 824) is amended—

1 (i) in subsection (a), by striking
2 “303(g)(1)” each place it appears and in-
3 serting “303(g)”; and

4 (ii) in subsection (d)(1), by striking
5 “303(g)(1)” and inserting “303(g)”.

6 (B) Section 309A(a) of the Controlled
7 Substances Act (21 U.S.C. 829a(a)) is amended
8 by striking paragraph (2) and inserting the fol-
9 lowing:

10 “(2) the controlled substance—

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

14 “(B) is to be administered by injection or
15 implantation;”.

16 (C) Section 520E–4(c) of the Public
17 Health Service Act (42 U.S.C. 290bb–36d(c)) is
18 amended, in the matter preceding paragraph
19 (1), by striking “information on any qualified
20 practitioner that is certified to prescribe medi-
21 cation for opioid dependency under section
22 303(g)(2)(B) of the Controlled Substances Act”
23 and inserting “information on any practitioner
24 who prescribes narcotic drugs in schedule III,
25 IV, or V of section 202 of the Controlled Sub-

1 stances Act for the purpose of maintenance or
2 detoxification treatment”.

3 (D) Section 544(a)(3) of the Public Health
4 Service Act (42 U.S.C. 290dd–3) is amended by
5 striking “any practitioner dispensing narcotic
6 drugs pursuant to section 303(g) of the Con-
7 trolled Substances Act” and inserting “any
8 practitioner dispensing narcotic drugs for the
9 purpose of maintenance or detoxification treat-
10 ment”.

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

14 (F) Section 1834(o) of the Social Security
15 Act (42 U.S.C. 1395m(o)) is amended by strik-
16 ing paragraph (3).

17 (G) Section 1866F(c)(3) of the Social Se-
18 curity Act (42 U.S.C. 1395ee–6(c)(3)) is
19 amended—

20 (i) in subparagraph (A), by inserting
21 “and” at the end;

22 (ii) in subparagraph (B), by striking
23 “; and” and inserting a period; and

24 (iii) by striking subparagraph (C).

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

4 (i) in clause (i), by inserting “and” at
5 the end;

6 (ii) by striking clause (ii); and

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

9 (2) EFFECTIVE DATE OF MEDICARE AMEND-
10 MENTS.—The amendments made by subparagraphs
11 (E) and (F) of paragraph (1) shall take effect one
12 year after the date of enactment of this Act.

13 **SEC. 207. TELEHEALTH RESPONSE FOR E-PRESCRIBING AD-**
14 **DICTION THERAPY SERVICES.**

15 (a) FUNDING FOR THE TESTING OF INCENTIVE PAY-
16 MENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR
17 ADOPTION AND USE OF CERTIFIED ELECTRONIC
18 HEALTH RECORD TECHNOLOGY.—In addition to amounts
19 appropriated under subsection (f) of section 1115A of the
20 Social Security Act (42 U.S.C. 1315a), there are author-
21 ized to be appropriated to the Center for Medicare and
22 Medicaid Innovation such sums as may be necessary for
23 fiscal year 2022 to design, implement, and evaluate the
24 model under subsection (b)(2)(B)(xxv) of such section.

1 Amounts appropriated under the preceding sentence shall
2 remain available until expended.

3 (b) TELEHEALTH FOR SUBSTANCE USE DISORDER
4 TREATMENT.—

5 (1) SUBSTANCE USE DISORDER SERVICES FUR-
6 NISHED THROUGH TELEHEALTH UNDER MEDI-
7 CARE.—Section 1834(m)(7) of the Social Security
8 Act (42 U.S.C. 1395m(m)(7)) is amended by adding
9 at the end the following: “With respect to telehealth
10 services described in the preceding sentence that are
11 furnished on or after January 1, 2020, nothing shall
12 preclude the furnishing of such services through
13 audio or telephone only technologies in the case
14 where a physician or practitioner has already con-
15 ducted an in-person medical evaluation or a tele-
16 health evaluation that utilizes both audio and visual
17 capabilities with the eligible telehealth individual.”.

18 (2) CONTROLLED SUBSTANCES DISPENSED BY
19 MEANS OF THE INTERNET.—Section 309(e)(2) of
20 the Controlled Substances Act (21 U.S.C. 829(e)(2))
21 is amended—

22 (A) in subparagraph (A)(i)—

23 (i) by striking “at least 1 in-person
24 medical evaluation” and inserting the fol-
25 lowing: “at least—

1 “(I) 1 in-person medical evalua-
2 tion”); and

3 (ii) by adding at the end the fol-
4 lowing:

5 “(II) for purposes of prescribing
6 a controlled substance in schedule III
7 or IV, 1 telehealth evaluation; or”;
8 and

9 (B) by adding at the end the following:

10 “(D)(i) In this subsection, the term ‘tele-
11 health evaluation’ means a medical evaluation
12 that is conducted in accordance with applicable
13 Federal and State laws by a practitioner (other
14 than a pharmacist) who is at a location remote
15 from the patient and is communicating with the
16 patient using a telecommunications system re-
17 ferred to in section 1834(m) of the Social Secu-
18 rity Act (42 U.S.C. 1395m(m)) that includes,
19 at a minimum, audio and video equipment per-
20 mitting two-way, real-time interactive commu-
21 nication between the patient and distant site
22 practitioner.

23 “(ii) Nothing in clause (i) shall be con-
24 strued to imply that 1 telehealth evaluation
25 demonstrates that a prescription has been

1 issued for a legitimate medical purpose within
2 the usual course of professional practice.

3 “(iii) A practitioner who prescribes the
4 drugs or combination of drugs that are covered
5 under section 303(g)(2)(C) using the authority
6 under subparagraph (A)(i)(II) of this para-
7 graph shall adhere to nationally recognized evi-
8 dence-based guidelines for the treatment of pa-
9 tients with opioid use disorders and a diversion
10 control plan, as those terms are defined in sec-
11 tion 8.2 of title 42, Code of Federal Regula-
12 tions, as in effect on the date of enactment of
13 this subparagraph.”.

14 **SEC. 208. PILOT PROGRAM ON EXPANDING ACCESS TO**
15 **TREATMENT.**

16 The Secretary of Health and Human Services (re-
17 ferred to in this section as the “Secretary”) shall establish
18 a 5-year pilot program in not less than 5 diverse regions
19 to study the use of mobile methadone clinics in rural and
20 underserved environments. At the end of the pilot pro-
21 gram, the Secretary shall report to Congress on the pro-
22 gram outcomes, including the number of people served and
23 the demographics of people served, including race and in-
24 come.

1 **SEC. 209. REAUTHORIZATION OF PRACTICED GRANT PRO-**
2 **GRAM.**

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

8 **SEC. 210. GAO STUDY ON PARITY.**

9 The Comptroller General of the United States shall
10 conduct a study examining the reimbursement parity be-
11 tween substance use disorder services and other health
12 care services, and the effect of any inequity in reimburse-
13 ment with respect to substance use disorder services on
14 the substance use disorder workforce, and not later than
15 December 31, 2023, submit a report to Congress on the
16 findings of such study.

17 **SEC. 211. IMPROVING SUBSTANCE USE DISORDER PREVEN-**
18 **TION WORKFORCE ACT.**

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

1 **“SEC. 519F. PILOT PROGRAM TO HELP ENHANCE SUB-**
2 **STANCE USE DISORDER PREVENTION WORK-**
3 **FORCE.**

4 “(a) IN GENERAL.—The Director of the Prevention
5 Center (referred to in this section as the ‘Director’) shall
6 develop a pilot program to assist State alcohol and drug
7 agencies in addressing the substance use disorder preven-
8 tion workforce needs in the States.

9 “(b) DEFINITIONS.—In this section, the term ‘State
10 alcohol and drug agency’ means the State agency respon-
11 sible for administering the substance abuse prevention and
12 treatment block grant under subpart II of part B of title
13 XIX.

14 “(c) APPLICATION.—A State alcohol and drug agency
15 may apply to the Director for approval of a grant author-
16 ized in this section. Such application shall include a de-
17 scription of the proposed workforce activities that will be
18 carried out using grant funds, which may include, with
19 respect to substance use disorder prevention—

20 “(1) enhancing or developing training curricula;

21 “(2) supporting or coordinating with institutes
22 of higher education regarding curricula development;

23 “(3) partnering with elementary schools, middle
24 schools, high schools or institutions of higher edu-
25 cation to generate early student interest in avoiding
26 misuse of substances;

1 “(4) enhancing or establishing initiatives re-
2 lated to credentialing or other certification processes
3 recognized by the State alcohol and drug agency, in-
4 cluding scholarships or support for certification costs
5 and testing;

6 “(5) establishing or enhancing initiatives that
7 promote recruitment, professional development, and
8 access to education and training that increase the
9 State’s ability to address diversity, equity, and inclu-
10 sion in the workforce, including communication ini-
11 tiatives or campaigns designed to draw interest in a
12 career in substance use disorder prevention;

13 “(6) supporting loan repayment programs for
14 individuals in the substance use disorder prevention
15 workforce;

16 “(7) establishing or enhancing internships, fel-
17 lowships and other career opportunities; and

18 “(8) retention initiatives that may include
19 training, leadership development or other edu-
20 cational opportunities.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there are authorized to be appro-
23 priated such sums as may be necessary.

1 **“SEC. 519G. NATIONAL STUDY ON SUBSTANCE USE DIS-**
2 **ORDER WORKFORCE.**

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

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

10 “(2) challenges in maintaining support for an
11 adequate substance use disorder prevention work-
12 force and a plan to address such challenges; and

13 “(3) potential programming to help implement
14 the plan.

15 “(b) CONSULTATION.—The Director shall ensure the
16 study under this section is developed in consultation with
17 key substance use disorder prevention workforce stake-
18 holders, including organizations representing State alcohol
19 and drug agencies, community anti-drug coalitions, work-
20 force credentialing bodies, researchers, and others.

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

1 **TITLE III—RECOVERY**
2 **Subtitle A—General Provisions**

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

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

6 (1) by striking subsection (c);

7 (2) by redesignating subsection (d) as sub-
8 section (c);

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

10 (A) in paragraph (1), by striking “and” at
11 the end;

12 (B) in paragraph (2)(C)(iv), by striking
13 the period and inserting “; and”; and

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

15 “(3) may be used as provided for in subsection
16 (d).”;

17 (4) by inserting after subsection (c) (as so re-
18 designated), the following:

19 “(d) **ESTABLISHMENT OF REGIONAL TECHNICAL AS-**
20 **SISTANCE CENTERS.**—

21 “(1) **IN GENERAL.**—Grants awarded under sub-
22 section (b) may be used to provide for the establish-
23 ment of regional technical assistance centers to pro-
24 vide regional technical assistance for the following:

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

5 “(B) Establishment of recovery community
6 organizations.

7 “(C) Establishment of recovery community
8 centers.

9 “(D) Naloxone training and dissemination.

10 “(E) Development of connections between
11 recovery support services, community organiza-
12 tions, and community centers and the broader
13 medical community.

14 “(F) Establishment of online recovery sup-
15 port services, with parity to physical health
16 services.

17 “(G) Development of recovery wellness
18 plans to address perceived barriers to recovery,
19 including social determinants of health.

20 “(H) Collect and maintain accurate and
21 reliable data to inform service delivery and
22 monitor and evaluate the impact of culturally
23 competent (as defined in section 102 of the De-
24 velopmental Disabilities Assistance and Bill of

1 Rights Act of 2000) services on health equity
2 outcomes.

3 “(I) Building capacity for recovery commu-
4 nity organizations to meet national accredita-
5 tion standards for the delivery of peer recovery
6 support services.

7 “(J) Expanding or enhancing recovery
8 support service programs.

9 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
10 ceive a grant under paragraph (1), an entity shall
11 be—

12 “(A) a national nonprofit entity with a net-
13 work of local affiliates and partners that are
14 geographically and organizationally diverse; or

15 “(B) a national nonprofit organization led
16 by individuals in personal and family recovery
17 with established networks of recovery commu-
18 nity organizations providing peer recovery sup-
19 port services.

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

23 “(A) provide culturally competent (as de-
24 fined in section 102 of the Developmental Dis-
25 abilities Assistance and Bill of Rights Act of

1 2000) services, promote racial equity, and are
2 responsive to diverse cultural health beliefs and
3 practices, preferred languages, health literacy,
4 and other communication needs;

5 “(B) allow participation by individuals re-
6 ceiving medication-assisted treatment that in-
7 volves prescription drugs approved by the Food
8 and Drug Administration (at least one of which
9 is an opioid agonist);

10 “(C) use peer recovery advocates; and

11 “(D) meet national best practice and ac-
12 creditation standards.”; and

13 (5) in subsection (f), by striking “2023” and
14 inserting “2021, and \$200,000,000 for each of fiscal
15 years 2022 through 2027”.

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

18 (1) IN GENERAL.—The Secretary shall award
19 grants to peer recovery support service organiza-
20 tions, for the purposes of providing continuing care
21 and ongoing community support for individuals to
22 maintain recovery from substance use disorders.

23 (2) DEFINITION.—For purposes of this sub-
24 section, the term “peer recovery support service or-
25 ganization” means an independent nonprofit organi-

1 zation that provides peer recovery support services
2 (as defined by the Secretary), through credentialed
3 peer support professionals.

4 (3) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this subsection, there is authorized to be
6 appropriated, for each of fiscal years 2022 through
7 2027, \$50,000,000.

8 **SEC. 302. RECOVERY IN THE WORKPLACE.**

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

14 **SEC. 303. NATIONAL YOUTH AND YOUNG ADULT RECOVERY**
15 **INITIATIVE.**

16 (a) DEFINITIONS.—In this section:

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

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

23 (B) an institution of higher education;

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

1 (D) a nonprofit organization; or

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

10 (2) HIGH SCHOOL.—The term “high school”
11 has the meaning given the term in section 8101 of
12 the Elementary and Secondary Education Act of
13 1965 (20 U.S.C. 7801).

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

18 (4) RECOVERY PROGRAM.—The term “recovery
19 program” means a program—

20 (A) to help youth or young adults who are
21 recovering from substance use disorders to ini-
22 tiate, stabilize, and maintain healthy and pro-
23 ductive lives in the community; and

24 (B) that includes peer-to-peer support de-
25 livered by individuals with lived experience in

1 recovery, and communal activities to build re-
2 covery skills and supportive social networks.

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

8 (1) provide culturally competent (as defined in
9 section 102 of the Developmental Disabilities Assist-
10 ance and Bill of Rights Act of 2000 (42 U.S.C.
11 15002)) substance use recovery support services to
12 youth and young adults enrolled in high school or an
13 institution of higher education;

14 (2) help build communities of support for youth
15 and young adults in substance use recovery through
16 a spectrum of activities such as counseling, job
17 training, recovery coaching, alternative peer groups,
18 life-skills workshops, family support groups, and
19 health and wellness-oriented social activities; and

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

23 (c) APPLICATION.—An eligible entity desiring a grant
24 under this section shall submit to the Assistant Secretary
25 for Mental Health and Substance Use an application at

1 such time, in such manner, and containing such informa-
2 tion as the Assistant Secretary may require.

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

10 (e) USE OF FUNDS.—Grants awarded under sub-
11 section (b) may be used for activities to develop, support,
12 or maintain substance use recovery support services for
13 youth or young adults, including—

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

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

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

20 (4) the establishment of a substance use recov-
21 ery high school;

22 (5) the coordination of a peer delivered sub-
23 stance use recovery program with—

24 (A) substance use disorder treatment pro-
25 grams and systems that utilize culturally com-

1 petent (as defined in section 102 of the Devel-
2 opmental Disabilities Assistance and Bill of
3 Rights Act of 2000 (42 U.S.C. 15002)) services
4 that reflect the communities they serve;

5 (B) providers of mental health services;

6 (C) primary care providers;

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

9 (E) employers;

10 (F) recovery housing services;

11 (G) child welfare services;

12 (H) high schools; and

13 (I) institutions of higher education;

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

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

21 (f) RESOURCE CENTER.—The Assistant Secretary
22 for Mental Health and Substance Use shall establish a re-
23 source center to provide technical support to recipients of
24 grants under this section.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$10,000,000 for each of fiscal years 2022 through 2027.

4 **Subtitle B—Recovery Housing**

5 **SEC. 311. CLARIFYING THE ROLE OF SAMHSA IN PRO-** 6 **MOTING THE AVAILABILITY OF HIGH-QUAL-** 7 **ITY RECOVERY HOUSING.**

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

10 (1) in paragraph (24)(E), by striking “and” at
11 the end;

12 (2) in paragraph (25), by striking the period at
13 the end and inserting “; and”; and

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

15 “(26) collaborate with national accrediting enti-
16 ties and reputable providers and analysts of recovery
17 housing services and all relevant Federal agencies,
18 including the Centers for Medicare & Medicaid Serv-
19 ices, the Health Resources and Services Administra-
20 tion, other offices and agencies within the Depart-
21 ment of Health and Human Services, the Office of
22 National Drug Control Policy, the Department of
23 Justice, the Department of Housing and Urban De-
24 velopment, and the Department of Agriculture, to
25 promote the availability of high-quality recovery

1 housing for individuals with a substance use dis-
2 order.”.

3 **SEC. 312. DEVELOPING GUIDELINES FOR STATES TO PRO-**
4 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
5 **RECOVERY HOUSING.**

6 Title V of the Public Health Service Act is amended
7 by inserting after section 550 of such Act (42 U.S.C.
8 290ee–5) (relating to national recovery housing best prac-
9 tices) the following:

10 **“SEC. 550A. DEVELOPING GUIDELINES FOR STATES TO**
11 **PROMOTE THE AVAILABILITY OF HIGH-QUAL-**
12 **ITY RECOVERY HOUSING.**

13 “(a) IN GENERAL.—Not later than one year after the
14 date of the enactment of this section, the Secretary, acting
15 through the Assistant Secretary, shall develop, and pub-
16 lish on the internet website of the Substance Abuse and
17 Mental Health Services Administration, consensus-based
18 guidelines and nationally recognized standards for States
19 to promote the availability of high-quality recovery hous-
20 ing for individuals with a substance use disorder. Such
21 guidelines shall—

22 “(1) be developed in consultation with national
23 accrediting entities, reputable providers and analysts
24 of recovery housing services, and States and be con-

1 sistent with the best practices developed under sec-
2 tion 550; and

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

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

11 “(c) EXCLUSION OF GUIDELINE ON TREATMENT
12 SERVICES.—In developing the guidelines under subsection
13 (a), the Secretary may not include any guideline or stand-
14 ard with respect to substance use disorder treatment serv-
15 ices.

16 “(d) SUBSTANCE USE DISORDER TREATMENT SERV-
17 ICES.—In this section, the term ‘substance use disorder
18 treatment services’ means items or services furnished for
19 the treatment of a substance use disorder, including—

20 “(1) medications approved by the Food and
21 Drug Administration for use in such treatment, ex-
22 cluding each such medication used to prevent or
23 treat a drug overdose;

24 “(2) the administering of such medications;

25 “(3) recommendations for such treatment;

1 “(4) clinical assessments and referrals;

2 “(5) counseling with a physician, psychologist,
3 or mental health professional (including individual
4 and group therapy); and

5 “(6) toxicology testing.”.

6 **SEC. 313. COORDINATION OF FEDERAL ACTIVITIES TO PRO-**
7 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
8 **RECOVERY HOUSING.**

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

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

14 (2) by inserting after subsection (d) the fol-
15 lowing:

16 “(e) COORDINATION OF FEDERAL ACTIVITIES TO
17 PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOV-
18 ERY HOUSING FOR INDIVIDUALS WITH A SUBSTANCE
19 USE DISORDER.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Assistant Secretary, and the Secretary
22 of the Department of Housing and Urban Develop-
23 ment shall convene and serve as the co-chairs of an
24 interagency working group composed of representa-
25 tives of each of the Federal agencies described in

1 paragraph (2) (referred to in this section as the
2 ‘working group’) for the following purposes:

3 “(A) To increase collaboration, coopera-
4 tion, and consultation among such Federal
5 agencies, with respect to promoting the avail-
6 ability of high-quality recovery housing.

7 “(B) To align the efforts of such agencies
8 and avoid duplication of such efforts by such
9 agencies.

10 “(C) To develop objectives, priorities, and
11 a long-term plan for supporting State, Tribal,
12 and local efforts with respect to the operation
13 of high-quality recovery housing that is con-
14 sistent with the best practices developed under
15 this section.

16 “(D) To coordinate inspection and enforce-
17 ment among Federal and State agencies.

18 “(E) To coordinate data collection on the
19 quality of recovery housing.

20 “(2) FEDERAL AGENCIES DESCRIBED.—The
21 Federal agencies described in this paragraph are the
22 following:

23 “(A) The Department of Health and
24 Human Services.

1 “(B) The Centers for Medicare & Medicaid
2 Services.

3 “(C) The Substance Abuse and Mental
4 Health Services Administration.

5 “(D) The Health Resources and Services
6 Administration.

7 “(E) The Indian Health Service.

8 “(F) The Department of Housing and
9 Urban Development.

10 “(G) The Department of Agriculture.

11 “(H) The Department of Justice.

12 “(I) The Office of National Drug Control
13 Policy.

14 “(J) The Bureau of Indian Affairs.

15 “(K) The Department of Labor.

16 “(L) Any other Federal agency as the co-
17 chairs determine appropriate.

18 “(3) MEETINGS.—The working group shall
19 meet on a quarterly basis.

20 “(4) REPORTS TO CONGRESS.—Beginning not
21 later than one year after the date of the enactment
22 of this section and annually thereafter, the working
23 group shall submit to the Committee on Energy and
24 Commerce, the Committee on Ways and Means, the
25 Committee on Agriculture, and the Committee on

1 Financial Services of the House of Representatives
2 and the Committee on Health, Education, Labor,
3 and Pensions, the Committee on Agriculture, Nutri-
4 tion, and Forestry, and the Committee on Finance
5 of the Senate a report describing the work of the
6 working group and any recommendations of the
7 working group to improve Federal, State, and local
8 policy with respect to recovery housing operations.

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

13 **SEC. 314. NAS STUDY AND REPORT.**

14 (a) IN GENERAL.—Not later than 60 days after the
15 date of enactment of this Act, the Secretary of Health and
16 Human Services, acting through the Assistant Secretary
17 for Mental Health and Substance Use, shall enter into an
18 arrangement with the National Academies of Sciences,
19 Engineering, and Medicine to conduct a study, which may
20 include a literature review and case studies as appropriate,
21 on—

22 (1) the quality and effectiveness of recovery
23 housing in the United States, including the avail-
24 ability in the United States of high-quality recovery

1 housing and whether that availability meets the de-
2 mand for such housing in the United States; and

3 (2) State, Tribal, and local regulation and over-
4 sight of recovery housing.

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

7 (1) examine the quality of, and effectiveness
8 outcomes for, the types and characteristics of cov-
9 ered recovery housing programs listed in subsection
10 (c); and

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

15 (c) TYPE AND CHARACTERISTICS.—The types and
16 characteristics of covered recovery housing programs re-
17 ferred to in subsection (b) consist of the following:

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

20 (2) Private and public covered recovery housing.

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

23 (A) residents on a voluntary basis; and

24 (B) residents pursuant to a judicial order.

1 (4) Number of clients served, disaggregated to
2 the extent possible by covered recovery housing serv-
3 ing—

4 (A) 6 or fewer recovering residents;

5 (B) 10 to 13 recovering residents; and

6 (C) 18 or more recovering residents.

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

9 (A) single room occupancy;

10 (B) 2 residents occupying 1 room; and

11 (C) more than 2 residents occupying 1
12 room.

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

16 (A) 30 days or fewer;

17 (B) 31 to 90 days;

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

20 (D) 6 months or more.

21 (7) Certification levels of staff.

22 (8) Fraudulent and abusive practices by opera-
23 tors of covered recovery housing and inpatient and
24 outpatient treatment facilities, both individually and
25 in concert, including—

1 (A) deceptive or misleading marketing
2 practices, including—

3 (i) inaccurate outcomes-based mar-
4 keting; and

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

7 (B) illegal patient brokering;

8 (C) third-party recruiters;

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

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

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

17 (1) completing the study under such subsection;

18 and

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

21 (A) the results of the study;

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

1 (C) research and data gaps;

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

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

7 (F) recommendations to eliminate restric-
8 tions by recovery housing that exclude individ-
9 uals who take prescribed medications for opioid
10 use disorder; and

11 (G) a summary of allegations, assertions,
12 or formal legal actions on the State and local
13 levels by governments and nongovernmental or-
14 ganizations with respect to the opening and op-
15 eration of recovery housing.

16 (e) DEFINITIONS.—In this subsection:

17 (1) The term “covered recovery housing” means
18 recovery housing that utilizes compensated or volun-
19 teer onsite staff who are not health care profes-
20 sionals to support residents.

21 (2) The term “effectiveness outcomes” may in-
22 clude decreased substance use, reduced probability of
23 relapse or reoccurrence, lower rates of incarceration,
24 higher income, increased employment, and improved
25 family functioning.

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

4 (4) The term “recovery housing” means a
5 shared living environment that is or purports to
6 be—

7 (A) free from alcohol and use of nonpre-
8 scribed drugs; and

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

12 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there is authorized to be appropriated
14 \$1,500,000 for fiscal year 2022.

15 **SEC. 315. FILLING RESEARCH AND DATA GAPS.**

16 Not later than 60 days after the completion of the
17 study under section 314, the Secretary of Health and
18 Human Services shall enter into an agreement with an ap-
19 propriate entity to conduct such research as may be nec-
20 essary to fill the research and data gaps identified in re-
21 porting pursuant to such section.

1 **SEC. 316. GRANTS FOR STATES TO PROMOTE THE AVAIL-**
2 **ABILITY OF HIGH QUALITY RECOVERY HOUS-**
3 **ING.**

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

9 “(f) GRANTS FOR IMPLEMENTING NATIONAL RECOV-
10 ERY HOUSING BEST PRACTICES.—

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

14 “(A) for the provision of technical assist-
15 ance by national accrediting entities and rep-
16 utable providers and analysts of recovery hous-
17 ing services to implement the guidelines, nation-
18 ally recognized standards, and recommendations
19 developed under section 313 of the CARA 3.0
20 Act of 2021 and this section; and

21 “(B) to promote the availability of high-
22 quality recovery housing for individuals with a
23 substance use disorder and practices to main-
24 tain housing quality long term.

25 “(2) STATE ENFORCEMENT PLANS.—Beginning
26 not later than 90 days after the date of the enact-

1 ment of this paragraph and every 2 years thereafter,
2 as a condition on the receipt of a grant under para-
3 graph (1), each State (or political subdivisions there-
4 of), Tribe, or territory receiving such a grant shall
5 submit to the Secretary, and make publicly available
6 on a publicly accessible Internet website of the State
7 (or political subdivisions thereof), Tribe, or terri-
8 tory—

9 “(A) the plan of the State (or political sub-
10 divisions thereof), Tribe, or territory, with re-
11 spect to the promotion of high-quality recovery
12 housing for individuals with a substance use
13 disorder located within the jurisdiction of such
14 State (or political subdivisions thereof), Tribe,
15 or territory; and

16 “(B) a description of how such plan is con-
17 sistent with the best practices developed under
18 this section and guidelines developed under sec-
19 tion 550A.

20 “(3) REVIEW OF ACCREDITING ENTITIES.—The
21 Secretary shall periodically review, by developing a
22 rubric to evaluate accreditation, the accrediting enti-
23 ties providing technical assistance pursuant to para-
24 graph (1)(A).

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

5 **SEC. 317. REPUTABLE PROVIDERS AND ANALYSTS OF RE-**
6 **COVERY HOUSING SERVICES DEFINITION.**

7 Subsection (h) of section 550 of the Public Health
8 Service Act (42 U.S.C. 290ee–5) (relating to national re-
9 covery housing best practices), as redesignated by section
10 313, is amended by adding at the end the following:

11 “(4) The term ‘reputable providers and analysts
12 of recovery housing services’ means recovery housing
13 service providers and analysts that—

14 “(A) use evidence-based approaches;

15 “(B) act in accordance with guidelines
16 issued by the Assistant Secretary;

17 “(C) have not been found guilty of health
18 care fraud, patient brokering, or false adver-
19 tising by the Department of Justice, the De-
20 partment of Health and Human Services, or a
21 Medicaid Fraud Control Unit;

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

1 “(E) do not employ individuals with a past
2 conviction of criminal, domestic, or sexual vio-
3 lence, or significant drug distribution, in the
4 care or supervision of individuals.”.

5 **SEC. 318. TECHNICAL CORRECTION.**

6 Title V of the Public Health Service Act (42 U.S.C.
7 290aa et seq.) is amended—

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

12 (2) moving such section so it appears after sec-
13 tion 550A, as added by section 312.

14 **TITLE IV—CRIMINAL JUSTICE**

15 **SEC. 401. MEDICATION-ASSISTED TREATMENT CORREC-**
16 **TIONS AND COMMUNITY REENTRY PROGRAM.**

17 (a) DEFINITIONS.—In this section—

18 (1) the term “Attorney General” means the At-
19 torney General, acting through the Director of the
20 National Institute of Corrections;

21 (2) the term “certified recovery coach” means
22 an individual—

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

25 (B) who—

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

4 (I) a single State agency; or

5 (II) a recovery community orga-
6 nization that is capable of conducting
7 that training and making that deter-
8 mination; and

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

14 (3) the term “correctional facility” has the
15 meaning given the term in section 901 of title I of
16 the Omnibus Crime Control and Safe Streets Act of
17 1968 (34 U.S.C. 10251);

18 (4) the term “covered grant or cooperative
19 agreement” means a grant received, or cooperative
20 agreement entered into, under the Program;

21 (5) the term “covered program” means a pro-
22 gram—

23 (A) to provide medication-assisted treat-
24 ment to individuals who have opioid use dis-
25 order and are incarcerated within the jurisdic-

1 tion of the State or unit of local government
2 carrying out the program; and

3 (B) that is developed, implemented, or ex-
4 panded through a covered grant or cooperative
5 agreement;

6 (6) the term “medication-assisted treatment”
7 means the use of any drug or combination of drugs
8 that have been approved under the Federal Food,
9 Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or
10 section 351 of the Public Health Service Act (42
11 U.S.C. 262) for the treatment of an opioid use dis-
12 order, in combination with evidence-based counseling
13 and behavioral therapies, such as psychosocial coun-
14 seling, overseen by 1 or more social work profes-
15 sionals and 1 or more qualified clinicians, to provide
16 a comprehensive approach to the treatment of sub-
17 stance use disorders;

18 (7) the term “nonprofit organization” means an
19 organization that is described in section 501(c)(3) of
20 the Internal Revenue Code of 1986 and is exempt
21 from taxation under section 501(a) of such Code;

22 (8) the term “Panel” means the medication-as-
23 sisted treatment Corrections and Community Re-
24 entry Application Review Panel established under
25 subsection (f)(2);

1 (9) the term “participant” means an individual
2 who participates in a covered program;

3 (10) the term “political appointee” has the
4 meaning given the term in section 714(h) of title 38,
5 United States Code;

6 (11) the term “Program” means the medica-
7 tion-assisted treatment Corrections and Community
8 Reentry Program established under subsection (b);

9 (12) the term “psychosocial” means the inter-
10 relation of social factors and individual thought and
11 behavior;

12 (13) the term “recovery community organiza-
13 tion” has the meaning given the term in section 547
14 of the Public Health Service Act (42 U.S.C. 290ee-
15 2);

16 (14) the term “single State agency” means,
17 with respect to a State or unit of local government,
18 the single State agency identified by the State, or
19 the State in which the unit of local government is
20 located, in the plan submitted by that State under
21 section 1932(b)(1)(A)(i) of the Public Health Serv-
22 ice Act (42 U.S.C. 300x-32(b)(1)(A)(i));

23 (15) the term “State” means—

24 (A) each State of the United States;

25 (B) the District of Columbia; and

1 (C) each commonwealth, territory, or pos-
2 session of the United States; and

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

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

14 (1) that shall be known as the “medication-as-
15 sisted treatment Corrections and Community Re-
16 entry Program”; and

17 (2) under which the Attorney General—

18 (A) may make grants to, and enter into co-
19 operative agreements with, States or units of
20 local government to develop, implement, or ex-
21 pand 1 or more programs to provide medica-
22 tion-assisted treatment that meets the standard
23 of care generally accepted for the treatment of
24 opioid use disorder to individuals who have
25 opioid use disorder and are incarcerated within

1 the jurisdictions of the States or units of local
2 government; and

3 (B) shall establish a working relationship
4 with 1 or more knowledgeable corrections orga-
5 nizations with expertise in security, medical
6 health, mental health, and substance use dis-
7 order care to oversee and support implementa-
8 tion of the program, including through the use
9 of evidence-based clinical practices.

10 (c) USE OF FUNDS FOR INFRASTRUCTURE.—In de-
11 veloping, implementing, or expanding a medication-as-
12 sisted treatment program under subsection (b)(2)(A), a
13 State or unit of local government may use funds from a
14 grant or cooperative agreement under that subsection to
15 develop the infrastructure necessary to provide the medi-
16 cation-assisted treatment, such as—

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

19 (2) obtaining appropriate licenses for the indi-
20 viduals who will administer the treatment.

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

23 (1) develop culturally competent (as defined in
24 section 102 of the Developmental Disabilities Assist-
25 ance and Bill of Rights Act of 2000 (42 U.S.C.

1 15002)) medication-assisted treatment programs in
2 consultation with nonprofit organizations and com-
3 munity organizations that are qualified to provide
4 technical support for the programs;

5 (2) reduce the risk of overdose to participants
6 after the participants are released from incarcer-
7 ation; and

8 (3) reduce the rate of reincarceration.

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

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

17 (2) in providing medication-assisted treatment
18 under the covered program, shall offer to partici-
19 pants each type of drug that has been approved
20 under the Federal Food, Drug, and Cosmetic Act
21 (21 U.S.C. 301 et seq.) or section 351 of the Public
22 Health Service Act (42 U.S.C. 262) for the treat-
23 ment of an opioid use disorder; and

24 (3) shall use—

1 (A) screening tools with psychometric reli-
2 ability and validity that provide useful clinical
3 data to guide the long-term treatment of par-
4 ticipants who have—

5 (i) opioid use disorder; or

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

8 (B) at each correctional facility at which
9 the covered program is carried out, a sufficient
10 number of personnel, as determined by the At-
11 torney General in light of the number of indi-
12 viduals incarcerated at the correctional facility
13 and the number of those individuals whom the
14 correctional facility has screened and identified
15 as having opioid use disorder, to—

16 (i) monitor participants with active
17 opioid use disorder who begin participation
18 in the covered program while dem-
19 onstrating, or develop, signs and symptoms
20 of opioid withdrawal;

21 (ii) provide evidence-based medically
22 managed withdrawal care or assistance to
23 the participants described in clause (i);

24 (iii) prescribe or otherwise dispense—

1 (I) the drugs that are offered
2 under the covered program, as re-
3 quired under paragraph (1); and

4 (II) naloxone or any other emer-
5 gency opioid antagonist approved by
6 the Commissioner of Food and Drugs
7 to treat opioid overdose;

8 (iv) discuss with participants the risks
9 and benefits of, and differences among, the
10 opioid antagonist, opioid agonist, and par-
11 tial agonist drugs used to treat opioid use
12 disorder; and

13 (v) prepare a plan for release, includ-
14 ing connecting participants with mental
15 health and substance use treatment pro-
16 grams, medical care, public benefits, and
17 housing; and

18 (C) a certified recovery coach, social work
19 professional, or other qualified clinician who, in
20 order to support the sustained recovery of par-
21 ticipants, shall work with participants who are
22 recovering from opioid use disorder.

23 (f) APPLICATION.—

24 (1) IN GENERAL.—A State or unit of local gov-
25 ernment desiring a covered grant or cooperative

1 agreement shall submit to the Attorney General an
2 application that—

3 (A) shall include—

4 (i) a description of—

5 (I) the objectives of the medica-
6 tion-assisted treatment program that
7 the applicant will develop, implement,
8 or expand under the covered grant or
9 cooperative agreement;

10 (II) the activities that the appli-
11 cant will carry out under the covered
12 program;

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

16 (IV) the outreach and education
17 component of the covered program
18 that the applicant will carry out in
19 order to encourage maximum partici-
20 pation in the covered program; and

21 (V) how the applicant will de-
22 velop connections to culturally com-
23 petent (as defined in section 102 of
24 the Developmental Disabilities Assist-
25 ance and Bill of Rights Act of 2000

1 (42 U.S.C. 15002)) substance use and
2 mental health treatment providers,
3 medical professionals, nonprofit orga-
4 nizations, and other State agencies in
5 order to plan for participants to re-
6 ceive a continuum of care and appro-
7 priate wrap-around services after re-
8 lease from incarceration;

9 (ii) if, under the covered program that
10 the applicant will carry out, the applicant
11 will not, in providing medication-assisted
12 treatment, offer to participants not less
13 than 1 drug that uses an opioid antago-
14 nist, not less than 1 drug that uses an
15 opioid agonist, and not less than 1 drug
16 that uses an opioid partial agonist, an ex-
17 planation of why the applicant is unable to
18 or chooses not to offer a drug that uses an
19 opioid antagonist, a drug that uses an
20 opioid agonist, or a drug that uses an
21 opioid partial agonist, as applicable;

22 (iii) a plan for—

23 (I) measuring progress in achiev-
24 ing the objectives described in clause
25 (i)(I), including a strategy to collect

1 data that can be used to measure that
2 progress;

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

8 (aa) if participants so desire,
9 participants have continuity of
10 care after release from incarcer-
11 ation with respect to the form of
12 medication-assisted treatment the
13 participants received during in-
14 carceration, including—

15 (AA) by working with
16 community service providers
17 to assist eligible partici-
18 pants, before release from
19 incarceration in registering
20 for the Medicaid program
21 under title XIX of the Social
22 Security Act (42 U.S.C.
23 1396 et seq.) or other min-
24 imum essential coverage, as
25 defined in section 5000A(f)

1 of the Internal Revenue
2 Code of 1986; and
3 (BB) if a participant
4 cannot afford, or does not
5 qualify for, health insurance
6 that provides coverage with
7 respect to enrollment in a
8 medication-assisted treat-
9 ment program, and if the
10 participant cannot pay the
11 cost of enrolling in a medi-
12 cation-assisted treatment
13 program, by working with
14 units of local government,
15 nonprofit organizations,
16 opioid use disorder treat-
17 ment providers, and entities
18 carrying out programs under
19 substance use disorder
20 grants to, before the partici-
21 pant is released from incar-
22 ceration, identify a resource,
23 other than the applicant or
24 the covered program to be
25 carried out by the applicant,

1 that may be used to pay the
2 cost of enrolling the partici-
3 pant in a medication-as-
4 sisted treatment program;
5 (bb) medications are se-
6 curely stored; and
7 (cc) protocols relating to di-
8 version are maintained; and
9 (III) with respect to each com-
10 munity in which a correctional facility
11 at which a covered program will be
12 carried out is located, collaborating
13 with State agencies responsible for
14 overseeing programs relating to sub-
15 stance use disorder and local public
16 health officials and nonprofit organi-
17 zations in the community to help en-
18 sure that medication-assisted treat-
19 ment provided at each correctional fa-
20 cility at which the covered program
21 will be carried out is also available at
22 locations that are not correctional fa-
23 cilities in those communities, to the
24 greatest extent practicable; and
25 (iv) a certification that—

1 (I) each correctional facility at
2 which the covered program will be
3 carried out has access to a sufficient
4 number of clinicians who are licensed
5 to prescribe or otherwise dispense to
6 participants the drugs for the treat-
7 ment of opioid use disorder required
8 to be offered under subsection (e)(1),
9 which may include clinicians who use
10 telemedicine, in accordance with regu-
11 lations issued by the Administrator of
12 the Drug Enforcement Administra-
13 tion, to provide services under the cov-
14 ered program; and

15 (II) the covered program will
16 provide culturally competent (as de-
17 fined in section 102 of the Develop-
18 mental Disabilities Assistance and Bill
19 of Rights Act of 2000 (42 U.S.C.
20 15002)) evidence-based counseling
21 and behavioral therapies, which may
22 include counseling and therapy admin-
23 istered through the use of telemedi-
24 cine, as appropriate, to participants as
25 part of the medication-assisted treat-

1 ment provided under the covered pro-
2 gram; and

3 (B) may include a statement indicating the
4 number of participants that the applicant ex-
5 pects to serve through the covered program.

6 (2) MEDICATION-ASSISTED TREATMENT COR-
7 RECTIONS AND COMMUNITY REENTRY APPLICATION
8 REVIEW PANEL.—

9 (A) IN GENERAL.—Not later than 60 days
10 after the date of enactment of this Act, the At-
11 torney General shall establish a Medication-As-
12 sisted Treatment Corrections and Community
13 Reentry Application Review Panel that shall—

14 (i) be composed of not fewer than 10
15 individuals and not more than 15 individ-
16 uals; and

17 (ii) include—

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

20 (aa) the Department of Jus-
21 tice;

22 (bb) the Substance Abuse
23 and Mental Health Service Ad-
24 ministration;

1 (cc) the National Center for
2 Injury Prevention and Control at
3 the Centers for Disease Control
4 and Prevention; and

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

7 (II) other stakeholders who—

8 (aa) have expert knowledge
9 relating to the opioid epidemic,
10 drug treatment, health equity,
11 culturally competent (as defined
12 in section 102 of the Develop-
13 mental Disabilities Assistance
14 and Bill of Rights Act of 2000
15 (42 U.S.C. 15002)) care, or com-
16 munity substance use disorder
17 services; and

18 (bb) represent law enforce-
19 ment organizations and public
20 health entities.

21 (B) DUTIES.—

22 (i) IN GENERAL.—The Panel shall—

23 (I) review and evaluate applica-
24 tions for covered grants and coopera-
25 tive agreements; and

1 (II) make recommendations to
2 the Attorney General relating to the
3 awarding of covered grants and coop-
4 erative agreements.

5 (ii) RURAL COMMUNITIES.—In review-
6 ing and evaluating applications under
7 clause (i), the Panel shall take into consid-
8 eration the unique circumstances, including
9 the lack of resources relating to the treat-
10 ment of opioid use disorder, faced by rural
11 States and units of local government.

12 (C) TERMINATION.—The Panel shall ter-
13minate on the last day of fiscal year 2023.

14 (3) PUBLICATION OF CRITERIA IN FEDERAL
15 REGISTER.—Not later than 90 days after the date of
16 enactment of this Act, the Attorney General, in con-
17 sultation with the Panel, shall publish in the Federal
18 Register—

19 (A) the process through which applications
20 submitted under paragraph (1) shall be sub-
21 mitted and evaluated; and

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

24 (g) DURATION.—A covered grant or cooperative
25 agreement shall be for a period of not more than 4 years,

1 except that the Attorney General may extend the term of
2 a covered grant or cooperative agreement based on out-
3 come data or extenuating circumstances relating to the
4 covered program carried out under the covered grant or
5 cooperative agreement.

6 (h) REPORT.—

7 (1) IN GENERAL.—Not later than 2 years after
8 the date on which a State or unit of local govern-
9 ment is awarded a covered grant or cooperative
10 agreement, and each year thereafter until the date
11 that is 1 year after the date on which the period of
12 the covered grant or cooperative agreement ends, the
13 State or unit of local government shall submit a re-
14 port to the Attorney General that includes informa-
15 tion relating to the covered program carried out by
16 the State or unit of local government, including in-
17 formation relating to—

18 (A) the goals of the covered program;

19 (B) any evidence-based interventions car-
20 ried out under the covered program;

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

23 (i) be reported in a manner that dis-
24 tinguishes the outcomes based on the cat-

1 egories of, with respect to the participants
2 in the covered program—

3 (I) the race of the participants;

4 and

5 (II) the gender of the partici-
6 pants; and

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

10 (D) expenditures under the covered pro-
11 gram.

12 (2) PUBLICATION.—

13 (A) AWARDEE.—A State or unit of local
14 government that submits a report under para-
15 graph (1) shall make the report publicly avail-
16 able on—

17 (i) the website of each correctional fa-
18 cility at which the State or unit of local
19 government carried out the covered grant
20 program; and

21 (ii) if a correctional facility at which
22 the State or unit of local government car-
23 ried out the covered grant program does
24 not operate a website, the website of the
25 State or unit of local government.

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

5 (3) SUBMISSION TO CONGRESS.—Not later than
6 2 years after the date on which the Attorney Gen-
7 eral awards the first covered grant or cooperative
8 agreement, and each year thereafter, the Attorney
9 General shall submit to the Committee on the Judi-
10 ciary of the Senate and the Committee on the Judi-
11 ciary of the House of Representatives a summary
12 and compilation of the reports that the Attorney
13 General has received under paragraph (1) during the
14 year preceding the date on which the Attorney Gen-
15 eral submits the summary and compilation.

16 (i) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated \$50,000,000 to carry
18 out this section for each of fiscal years 2022 through
19 2026.

20 **SEC. 402. DEFLECTION AND PRE-ARREST DIVERSION.**

21 (a) FINDINGS.—Congress finds the following:

22 (1) Law enforcement officers and other first re-
23 sponders are at the front line of the opioid epidemic.
24 However, a traditional law enforcement response to

1 substance use often fails to disrupt the cycle of ad-
2 diction and arrest, or reduce the risk of overdose.

3 (2) Law enforcement-assisted deflection and di-
4 version programs have the potential to improve pub-
5 lic health, decrease the number of people entering
6 the criminal justice system for low-level offenses,
7 and address racial disparities.

8 (3) According to the Bureau of Justice Assist-
9 ance of the Department of Justice, “Five pathways
10 have been most commonly associated with opioid
11 overdose prevention and diversion to treatment.”
12 The 5 pathways are—

13 (A) “self-referral”, in which—

14 (i) an individual voluntarily initiates
15 contact with a first responder, such as a
16 law enforcement officer, firefighter, or
17 emergency medical services professional,
18 for a treatment referral (without fear of
19 arrest); and

20 (ii) the first responder personally in-
21 troduces the individual to a treatment pro-
22 vider (commonly known as a “warm hand-
23 off”);

24 (B) “active outreach”, in which a law en-
25 forcement officer or other first responder—

1 (i) identifies or seeks out individuals
2 in need of substance use disorder treat-
3 ment; and

4 (ii) makes a warm handoff of such an
5 individual to a treatment provider, who en-
6 gages the individual in treatment;

7 (C) “naloxone plus”, in which a law en-
8 forcement officer or other first responder en-
9 gages an individual in treatment as a follow-up
10 to an overdose response;

11 (D) “officer prevention referral”, in which
12 a law enforcement officer or other first re-
13 sponder initiates treatment engagement with an
14 individual, but no criminal charges are filed
15 against the individual; and

16 (E) “officer intervention referral”, in
17 which—

18 (i) a law enforcement officer or other
19 first responder initiates treatment engage-
20 ment with an individual; and

21 (ii)(I) criminal charges are filed
22 against the individual and held in abey-
23 ance; or

24 (II) a citation is issued to the indi-
25 vidual.

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

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

9 (1) in subsection (a)(1)(E), by inserting before
10 the period at the end the following: “, including law
11 enforcement-assisted deflection programs and law
12 enforcement-assisted pre-arrest and pre-booking di-
13 version programs (as those terms are defined in sub-
14 section (h))”; and

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

16 “(h) LAW ENFORCEMENT-ASSISTED DEFLECTION
17 PROGRAMS AND LAW ENFORCEMENT-ASSISTED PRE-AR-
18 REST AND PRE-BOOKING DIVERSION PROGRAMS.—

19 “(1) DEFINITIONS.—In this subsection:

20 “(A) COVERED GRANT.—The term ‘cov-
21 ered grant’ means a grant for a deflection or di-
22 version program awarded under subsection
23 (a)(1)(E).

24 “(B) DEFLECTION OR DIVERSION PRO-
25 GRAM.—The term ‘deflection or diversion pro-

1 gram’ means a law enforcement-assisted deflec-
2 tion program or a law enforcement-assisted pre-
3 arrest or pre-booking diversion, including a pro-
4 gram under which—

5 “(i) an individual voluntarily initiates
6 contact with a first responder for a sub-
7 stance use disorder or mental health treat-
8 ment referral without fear of arrest and re-
9 ceives a warm handoff to such treatment;

10 “(ii) a law enforcement officer or
11 other first responder identifies or seeks out
12 individuals in need of substance use dis-
13 order or mental health treatment and a
14 warm handoff is made to a treatment pro-
15 vider, who engages the individuals in treat-
16 ment;

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

21 “(iv) a law enforcement officer or
22 other first responder initiates substance
23 use disorder or mental health treatment
24 engagement, but no criminal charges are
25 filed;

1 “(v) a law enforcement officer or
2 other first responder initiates substance
3 use disorder or mental health treatment
4 engagement with an individual; or

5 “(vi) charges are filed against an indi-
6 vidual who has committed an offense that
7 is not a crime against a person, and the
8 primary cause of which appears to be
9 based on a substance use disorder or men-
10 tal health disorder and held in abeyance or
11 a citation is issued to such an individual.

12 “(C) LAW ENFORCEMENT-ASSISTED DE-
13 FLECTION PROGRAM.—The term ‘law enforce-
14 ment-assisted deflection program’ means a pro-
15 gram under which a law enforcement officer,
16 when encountering an individual who is not en-
17 gaged in criminal activity but appears to have
18 a substance use disorder or mental health dis-
19 order, instead of taking no action at the time
20 of contact or taking action at a later time, at-
21 tempts to connect the individual to substance
22 use disorder treatment providers or mental
23 health treatment providers—

24 “(i) without the use of coercion or
25 fear of arrest; and

1 “(ii) using established pathways for
2 connections to local, community-based
3 treatment.

4 “(D) LAW ENFORCEMENT-ASSISTED PRE-
5 ARREST OR PRE-BOOKING DIVERSION PRO-
6 GRAM.—The term ‘law enforcement-assisted
7 pre-arrest or pre-booking diversion program’
8 means a program—

9 “(i) under which a law enforcement
10 officer, when encountering an individual
11 who has committed an offense that is not
12 a crime against a person, and the primary
13 cause of which appears to be based on a
14 substance use disorder or the mental
15 health disorder of the individual, instead of
16 arresting the individual, or instead of
17 booking the individual after having ar-
18 rested the individual, attempts to connect
19 the individual to substance use disorder
20 treatment providers or mental health treat-
21 ment providers—

22 “(I) without the use of coercion;
23 and

1 “(II) using established pathways
2 for connections to local, community-
3 based treatment;

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

7 “(I) issue a civil citation; or

8 “(II) take no action with respect
9 to the offense for which the officer
10 would otherwise have arrested the in-
11 dividual described in clause (i); and

12 “(iii) that may authorize a law en-
13 forcement officer to refer an individual to
14 substance use disorder treatment providers
15 or mental health treatment providers if the
16 individual appears to have a substance use
17 disorder or mental health disorder and the
18 officer suspects the individual of chronic
19 violations of law but lacks probable cause
20 to arrest the individual (commonly known
21 as a ‘social contact referral’).

22 “(2) SENSE OF CONGRESS REGARDING DEFLEC-
23 TION OR DIVERSION PROGRAMS.—It is the sense of
24 Congress that a deflection or diversion program
25 funded under this subpart should not exclude indi-

1 viduals who are chronically exposed to the criminal
2 justice system.

3 “(3) REPORTS TO ATTORNEY GENERAL.—Not
4 later than 2 years after the date on which a State
5 or unit of local government is awarded a covered
6 grant, and each year thereafter until the date that
7 is 1 year after the date on which the period of the
8 covered grant ends, the State or unit of local govern-
9 ment shall submit a report to the Attorney General
10 that includes information relating to the deflection
11 or diversion program carried out by the State or
12 unit of local government, including information re-
13 lating to—

14 “(A) the goals of the deflection or diver-
15 sion program;

16 “(B) any evidence-based interventions car-
17 ried out under the deflection or diversion pro-
18 gram;

19 “(C) outcomes of the deflection or diver-
20 sion program, which shall—

21 “(i) be reported in a manner that dis-
22 tinguishes the outcomes based on the cat-
23 egories of, with respect to the participants
24 in the deflection or diversion program—

1 “(I) the race of the participants;

2 and

3 “(II) the gender of the partici-

4 pants; and

5 “(ii) include information relating to

6 the rate of reincarceration among partici-

7 pants in the deflection or diversion pro-

8 gram, if available; and

9 “(D) expenditures under the deflection or
10 diversion program.”.

11 (c) TECHNICAL ASSISTANCE GRANT PROGRAM.—

12 (1) DEFINITIONS.—In this subsection—

13 (A) the term “deflection or diversion pro-

14 gram” has the meaning given the term in sub-

15 section (h) of section 501 of title I of the Omni-

16 bus Crime Control and Safe Streets Act of

17 1968 (34 U.S.C. 10152), as added by sub-

18 section (b); and

19 (B) the terms “State” and “unit of local

20 government” have the meanings given those

21 terms in section 901 of title I of the Omnibus

22 Crime Control and Safe Streets Act of 1968

23 (34 U.S.C. 10251).

24 (2) GRANT AUTHORIZED.—The Attorney Gen-

25 eral shall award a single grant to an entity with sig-

1 nificant experience in working with law enforcement
2 agencies, community-based treatment providers, and
3 other community-based human service providers to
4 develop or administer both deflection and diversion
5 programs that use each of the 5 pathways described
6 in subsection (a)(3), to promote and maximize the
7 effectiveness and racial equity of deflection or diver-
8 sion programs, in order to—

9 (A) help State and units of local govern-
10 ment launch and expand deflection or diversion
11 programs;

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

14 (i) recommendations on community
15 input and engagement in order to imple-
16 ment deflection or diversion programs as
17 rapidly as possible and with regard to the
18 particular needs of a community, including
19 regular community meetings and other
20 mechanisms for engagement with—

21 (I) law enforcement agencies;

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

1 (III) the recovery community;

2 and

3 (IV) the community at-large; and

4 (ii) the implementation of metrics to
5 measure community satisfaction con-
6 cerning the meaningful participation and
7 interaction of the community with the de-
8 flection or diversion program and program
9 stakeholders;

10 (C) develop and publish a training and
11 technical assistance tool kit for deflection or di-
12 version for public education purposes;

13 (D) disseminate uniform criteria and
14 standards for the delivery of deflection or diver-
15 sion program services; and

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

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

21 (4) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated to the At-
23 torney General \$30,000,000 for the grant under
24 paragraph (2).

1 **SEC. 403. HOUSING.**

2 (a) IN GENERAL.—Section 576 of the Quality Hous-
3 ing and Work Responsibility Act of 1998 (42 U.S.C.
4 13661) is amended by striking subsections (a), (b), and
5 (c) and inserting the following:

6 “(a) INELIGIBILITY OF ILLEGAL DRUG USERS AND
7 ALCOHOL ABUSERS.—Notwithstanding any other provi-
8 sion of law, a public housing agency or an owner of feder-
9 ally assisted housing, as determined by the Secretary, may
10 only prohibit admission to the program or admission to
11 federally assisted housing for an individual whom the pub-
12 lic housing agency or owner determines is illegally using
13 a controlled substance or abusing alcohol if—

14 “(1) the agency or owner determines that the
15 individual is using the controlled substance or abus-
16 ing alcohol in a manner that interferes with the
17 health or safety of other residents; and

18 “(2) the individual is not participating in a sub-
19 stance use disorder assessment and treatment.

20 “(b) AUTHORITY TO DENY ADMISSION TO CRIMINAL
21 OFFENDERS.—

22 “(1) IN GENERAL.—Except as provided in sub-
23 section (a), in addition to any other authority to
24 screen applicants, and subject to paragraphs (2) and
25 (3) of this subsection, a public housing agency or an
26 owner of federally assisted housing may only pro-

1 hibit admission to the program or to federally as-
2 sisted housing for an individual based on criminal
3 activity of the individual if the public housing agency
4 or owner determines that the individual, during a
5 reasonable time preceding the date on which the in-
6 dividual would otherwise be selected for admission,
7 was convicted of a crime involving conduct that
8 threatens the health or safety of other residents.

9 “(2) EXCEPTIONS AND LIMITATIONS.—A con-
10 viction that has been vacated, a conviction the
11 record of which has been sealed or expunged, or a
12 conviction for a crime committed by an individual
13 when the individual was less than 18 years of age,
14 shall not be grounds for denial of admission under
15 paragraph (1).

16 “(3) ADMISSION POLICY.—

17 “(A) FACTORS TO CONSIDER.—In evalu-
18 ating the criminal history of an individual
19 under paragraph (1), a public housing agency
20 or an owner of federally assisted housing shall
21 consider—

22 “(i) whether an offense of which the
23 individual was convicted bears a relation-
24 ship to the safety and security of other
25 residents;

1 “(ii) the level of violence, if any, of an
2 offense of which the individual was con-
3 victed;

4 “(iii) the length of time since a con-
5 viction;

6 “(iv) the number of convictions;

7 “(v) if the individual is in recovery for
8 a substance use disorder, whether the indi-
9 vidual was under the influence of alcohol
10 or illegal drugs at the time of an offense;
11 and

12 “(vi) any rehabilitation efforts that
13 the individual has undertaken since the
14 time of a conviction, including completion
15 of a substance use treatment program.

16 “(B) WRITTEN POLICY.—A public housing
17 agency or an owner of federally assisted hous-
18 ing shall establish and make available to appli-
19 cants a written admission policy that enumer-
20 ates the specific factors, including the factors
21 described in subparagraph (A), that will be con-
22 sidered when the public housing agency or
23 owner evaluates the criminal history of an indi-
24 vidual under paragraph (1).”.

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

6 **SEC. 404. VETERANS TREATMENT COURTS.**

7 Section 2991 of title I of the Omnibus Crime Control
8 and Safe Streets Act of 1968 (34 U.S.C. 10651) is amend-
9 ed—

10 (1) in subsection (a)—

11 (A) in paragraph (2)—

12 (i) in the matter preceding subpara-
13 graph (A)—

14 (I) by inserting “, substance use
15 disorder,” after “mental health”; and

16 (II) by inserting “or adults or ju-
17 veniles with substance use disorders”
18 after “mentally ill adults or juve-
19 niles”;

20 (ii) in subparagraph (A), by inserting
21 “or substance use” after “mental health”;
22 and

23 (iii) in subparagraph (B), by inserting
24 “or substance use” after “mental health”;

25 (B) in paragraph (4)—

1 (i) in subparagraph (A), by inserting
2 “or substance use disorder” after “mental
3 health”; and

4 (ii) in subparagraph (C), by inserting
5 “or offenders with substance use dis-
6 orders” after “mentally ill offenders”;
7 (C) in paragraph (5)—

8 (i) in the heading, by inserting “OR
9 SUBSTANCE USE DISORDER” after “MEN-
10 TAL HEALTH”;

11 (ii) by striking “mental health agen-
12 cy” and inserting “mental health or sub-
13 stance use agency”; and

14 (iii) by inserting “, substance use
15 services,” after “mental health services”;
16 (D) in paragraph (9)—

17 (i) in subparagraph (A)—

18 (I) in clause (i)—

19 (aa) in subclause (I), by in-
20 serting “, a substance use dis-
21 order,” after “a mental illness”;
22 and

23 (bb) in subclause (II), by in-
24 serting “, substance use dis-

1 order,” after “mental illness”;

2 and

3 (II) in clause (ii)(II), by inserting

4 “or substance use” after “mental

5 health”;

6 (E) by redesignating paragraph (11) as

7 paragraph (12); and

8 (F) by inserting after paragraph (10) the

9 following:

10 “(11) SUBSTANCE USE COURT.—The term ‘sub-

11 stance use court’ means a judicial program that

12 meets the requirements of part EE of this title.”;

13 (2) in subsection (b)—

14 (A) in paragraph (2)—

15 (i) in subparagraph (A), by inserting

16 “, substance use courts,” after “mental

17 health courts”;

18 (ii) in subparagraph (B)—

19 (I) by inserting “mental health

20 disorders, substance use disorders, or”

21 before “co-occurring mental illness

22 and substance use problems”; and

23 (II) by striking “illnesses” and

24 inserting “disorders, illnesses, or

25 problems”;

- 1 (iii) in subparagraph (C)—
- 2 (I) in the matter preceding clause
- 3 (i)—
- 4 (aa) by striking “mental
- 5 health agencies” and inserting
- 6 “mental health or substance use
- 7 agencies”; and
- 8 (bb) by striking “and, where
- 9 appropriate,” and inserting “or”;
- 10 and
- 11 (II) in clause (i), by inserting “,
- 12 substance use disorders,” after “men-
- 13 tal illness”; and
- 14 (iv) in subparagraph (D), by inserting
- 15 “or offender with a substance use dis-
- 16 order” after “mentally ill offender”; and
- 17 (B) in paragraph (5)—
- 18 (i) in subparagraph (B)—
- 19 (I) in clause (i)—
- 20 (aa) by inserting “or sub-
- 21 stance use court” after “mental
- 22 health court”; and
- 23 (bb) by striking “mental
- 24 health agency” and inserting

1 “mental health or substance use
2 agency”; and

3 (II) in clause (ii), by striking
4 “and substance use services for indi-
5 viduals with co-occurring mental
6 health and substance use disorders”
7 and inserting “or substance use serv-
8 ices”;

9 (ii) in subparagraph (C)—
10 (I) in clause (i)(I), by inserting
11 “, substance use disorders,” after
12 “mental illness”;

13 (II) in clause (ii)—
14 (aa) in subclause (II), by in-
15 serting “, substance use,” after
16 “mental health,”;

17 (bb) in subclause (V), by
18 striking “mental health services”
19 and inserting “mental health or
20 substance use services”; and

21 (cc) in subclause (VI), by in-
22 serting “or individuals with sub-
23 stance use disorders” after “men-
24 tally ill individuals”;

1 (iii) in subparagraph (D), by inserting
2 “or offenders with substance use dis-
3 orders” after “mentally ill offenders”;

4 (iv) in subparagraph (E), by inserting
5 “or substance use disorders” after “mental
6 illness”;

7 (v) in subparagraph (H), by striking
8 “and mental health” and inserting “, men-
9 tal health, and substance use”; and

10 (vi) in subparagraph (I)—

11 (I) in clause (i)—

12 (aa) in the heading, by in-
13 serting “, SUBSTANCE USE
14 COURTS,” after “MENTAL
15 HEALTH COURTS”;

16 (bb) by inserting “or sub-
17 stance use courts” after “mental
18 health courts”; and

19 (cc) by inserting “or part
20 EE, as applicable,” after “part
21 V”; and

22 (II) in clause (iv), by inserting
23 “or substance use” after “mental
24 health”;

25 (3) in subsection (c)—

1 (A) in paragraph (1), by inserting “, of-
2 fenders with substance use disorders,” after
3 “mentally ill offenders”;

4 (B) in paragraph (2), by inserting “ and
5 offenders with substance use disorders” after
6 “mentally ill offenders”; and

7 (C) in paragraph (3), by inserting “or sub-
8 stance use courts” after “mental health
9 courts”;
10 (4) in subsection (e)—

11 (A) in paragraph (1), by inserting “or sub-
12 stance use disorders” after “mental illness”;
13 and

14 (B) in paragraph (4), by inserting “or sub-
15 stance use disorders” after “mental illness”;
16 (5) in subsection (h)—

17 (A) in the heading, by inserting “AND OF-
18 FENDERS WITH SUBSTANCE USE DISORDERS”
19 after “MENTALLY ILL OFFENDERS”;

20 (B) in paragraph (1)—

21 (i) in subparagraph (A), by inserting
22 “or substance use disorders” after “mental
23 illnesses”;

1 (ii) in subparagraph (C), by inserting
2 “or offenders with substance use dis-
3 orders” after “mentally ill offenders”;

4 (iii) in subparagraph (D)—

5 (I) by inserting “or substance
6 use” after “mental health”; and

7 (II) by inserting “or offenders
8 with substance use disorders” after
9 “mentally ill offenders”;

10 (iv) in subparagraph (E), by inserting
11 “or substance use disorders” after “mental
12 illnesses”; and

13 (v) in subparagraph (F), by inserting
14 “, substance use disorders,” after “mental
15 health disorders”; and

16 (C) in paragraph (2), by inserting “or sub-
17 stance use disorders” after “mental illnesses”;

18 (6) in subsection (i)(2)—

19 (A) in subparagraph (B)—

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

23 (ii) in the matter preceding subclause
24 (I), as so redesignated, by striking “shall
25 give priority to applications that—” and

1 inserting the following: “shall give priority
2 to—

3 “(i) applications that—”; and

4 (iii) by striking the period at the end
5 and inserting the following: “; and

6 “(ii) applications to establish or ex-
7 pand veterans treatment court programs
8 that—

9 “(I) allow participation by a vet-
10 eran receiving any type of medication-
11 assisted treatment that involves the
12 use of any drug or combination of
13 drugs that have been approved under
14 the Federal Food, Drug, and Cos-
15 metic Act (21 U.S.C. 301 et seq.) or
16 section 351 of the Public Health Serv-
17 ice Act (42 U.S.C. 262) for the treat-
18 ment of an opioid use disorder;

19 “(II) follow the Adult Drug
20 Court Best Practice Standards pub-
21 lished by the National Association of
22 Drug Court Professionals; and

23 “(III) provide culturally com-
24 petent (as defined in section 102 of
25 the Developmental Disabilities Assist-

1 ance and Bill of Rights Act of 2000
2 (42 U.S.C. 15002)) services.”; and

3 (B) by adding at the end the following:

4 “(C) DISCLOSURE AND REPORTING RE-
5 QUIREMENTS.—

6 “(i) REQUIREMENTS FOR VETERANS
7 TREATMENT COURT PROGRAM GRANT-
8 EES.—An applicant that receives a grant
9 under this subsection to establish or ex-
10 pand a veterans treatment court program
11 shall—

12 “(I) disclose to the Attorney
13 General any contract or relationship
14 between the applicant and a local
15 treatment provider;

16 “(II) track and report to the At-
17 torney General the number of refer-
18 rals to local treatment providers pro-
19 vided by the program; and

20 “(III) track and report to the At-
21 torney General, with respect to each
22 participant in the program—

23 “(aa) each charge brought
24 against the participant;

1 “(bb) the demographics of
2 the participant; and

3 “(cc) the outcome of the
4 participant’s case.

5 “(ii) ATTORNEY GENERAL REPORT.—
6 The Attorney General shall periodically
7 submit to Congress a report containing the
8 information reported to the Attorney Gen-
9 eral under clause (i).

10 “(D) SENSE OF CONGRESS REGARDING
11 VETERANS TREATMENT COURT PROGRAMS.—It
12 is the sense of Congress that a veterans treat-
13 ment court program that receives funding from
14 a grant under this subsection should not ex-
15 clude individuals who are chronically exposed to
16 the criminal justice system.”;

17 (7) in subsection (j)—

18 (A) in paragraph (1), by inserting “or sub-
19 stance use disorders” after “mental illness”;
20 and

21 (B) in paragraph (2)(A), by inserting “or
22 substance use disorders” after “mental ill-
23 nesses”;

1 (8) in subsection (k)(3)(A)(i)(I)(aa), by insert-
2 ing “ or substance use disorders” after “mental ill-
3 nesses”;

4 (9) in subsection (l)—

5 (A) in paragraph (1)(B)(ii), by inserting
6 “or substance use disorder” after “mental ill-
7 ness” each place that term appears; and

8 (B) in paragraph (2)—

9 (i) in subparagraph (C)(iii), by insert-
10 ing “or substance use” after “mental
11 health”; and

12 (ii) in subparagraph (D), by striking
13 “mental health or” and inserting “mental
14 health disorders, substance use disorders,
15 or”;

16 (10) in subsection (o)(3)—

17 (A) by striking “LIMITATION” and insert-
18 ing “VETERANS”;

19 (B) by striking “Not more than” and in-
20 serting the following:

21 “(A) LIMITATION.—Not more than”;

22 (C) in subparagraph (A), as so designated,
23 by striking “this section” and inserting “para-
24 graph (1)”;

25 (D) by adding at the end the following:

1 “(B) **ADDITIONAL FUNDING.**—In addition
2 to the amounts authorized under paragraph (1),
3 there are authorized to be appropriated to the
4 Department of Justice to carry out subsection
5 (i) \$20,000,000 for each of fiscal years 2022
6 through 2026.”.

7 **SEC. 405. INFRASTRUCTURE FOR REENTRY.**

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

11 (1) in subparagraph (A)—

12 (A) by striking “to private, nonprofit orga-
13 nizations that are community development cor-
14 porations” and inserting the following: “to—

15 “(i) private, nonprofit community de-
16 velopment corporations”;

17 (B) by striking the period at the end and
18 inserting “; or”; and

19 (C) by adding at the end the following:

20 “(ii) community development corpora-
21 tions described in clause (i), or partner-
22 ships between such a corporation and an-
23 other private, nonprofit entity, to fund and
24 oversee the construction of facilities for
25 treatment of mental and substance use dis-

1 orders, supportive housing, or of re-entry
2 centers, that are not jails, prisons, or other
3 correctional facilities.”;

4 (2) in subparagraph (C)—

5 (A) by inserting “or partnership” after
6 “corporation” each place it appears;

7 (B) by striking “principal purpose plan-
8 ning” and inserting “principal purpose—

9 “(i) planning”;

10 (C) by striking the period at the end and
11 inserting “; or”; and

12 “(ii) planning or constructing facilities
13 for crisis intervention, treatment of mental
14 and substance use disorders, supportive
15 housing, or of re-entry centers.”; and

16 (3) by adding at the end the following:

17 “(F) DEFINITION.—In this paragraph, the
18 term ‘crisis intervention’ means the provision of
19 immediate, short-term assistance to individuals
20 who are experiencing acute emotional, mental,
21 physical, and behavioral distress or problems
22 using a ‘one-stop’ model.”.

23 (b) CDBG ASSISTANCE FOR CONSTRUCTION OF SUB-
24 STANCE ABUSE AND MENTAL HEALTH TREATMENT FA-
25 CILITIES, SUPPORTIVE HOUSING, AND REENTRY CEN-

1 TERS.—Section 105(a) of the Housing and Community
2 Development Act of 1974 (42 U.S.C. 5305(a)) is amend-
3 ed—

4 (1) in paragraph (25), by striking “and” at the
5 end;

6 (2) in paragraph (26), by striking the period at
7 the end and inserting “; and”; and

8 (3) by adding at the end the following:

9 “(27) the construction of crisis intervention
10 centers, substance abuse and mental health treat-
11 ment facilities, supportive housing, and reentry cen-
12 ters.”.

13 (c) COMMUNITIES FACILITIES LOAN AND GRANT
14 PROGRAMS.—Section 306(a) of the Consolidated Farm
15 and Rural Development Act (7 U.S.C. 1926(a)) is amend-
16 ed—

17 (1) by inserting after paragraph (6) the fol-
18 lowing:

19 “(7) PROHIBITION ON USE OF LOANS FOR CER-
20 TAIN PURPOSES.—No loan made or insured under
21 this subsection shall be used to support the con-
22 struction, renovation, equipment purchasing, oper-
23 ation, staffing, or any other function of a jail, pris-
24 on, detention center, or other correctional facility.”;
25 and

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

3 “(C) PROHIBITION ON USE OF GRANTS
4 FOR CERTAIN PURPOSES.—No grant made
5 under this paragraph shall be used to support
6 the construction, renovation, equipment pur-
7 chasing, operation, staffing, or any other func-
8 tion of a jail, prison, detention center, or other
9 correctional facility.

10 “(D) INCLUSION OF CERTAIN INFRA-
11 STRUCTURE FOR REENTRY.—In this paragraph,
12 the terms ‘essential community facility’ and ‘fa-
13 cility’ include a crisis intervention center, sub-
14 stance abuse or mental health treatment facil-
15 ity, a supportive housing facility, and a reentry
16 center.”.