

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 524), to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment to the text of the bill struck all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment that is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

Joint Explanatory Statement of the Committee of the Conference

S. 524, the Comprehensive Addiction and Recovery Act (CARA), authorizes the Attorney General and the Secretary of Health and Human Services to award grants to address the national epidemics of addiction to heroin and prescription opioids, and makes various other changes to Federal law to combat opioid addiction and abuse.

TITLE I – PREVENTION AND EDUCATION

Section 101 – Task force on Pain Management

S. 524 included a task force to review best practices for chronic and acute pain management and prescribing pain medication. It was unclear which best practices the task force would review, modify, and update. The task force would have been required to convene not later than December 14, 2018, and within 180 days, modify and update such best practices, as appropriate, and amend them further, if appropriate, after soliciting and taking into consideration public comment. Not later than 90 days after that, the task force would have been required to submit a report to Congress, including a strategy for disseminating best practices as reviewed, modified, or updated.

The House amendment included the same timeframes and underlying activities but added a number of participants to the task force. The House amendment also added considerations that the task force would have been required to take into account while reviewing, modifying, and updating best practices, several of which extended beyond the scope of chronic and acute pain management.

Section 101 of the conference report requires the Secretary of Health and Human Services (HHS), within two years of enactment, to convene a task force comprised of federal agencies and non-governmental stakeholders to identify, review, and as appropriate, determine whether there are gaps or inconsistencies between best practices for chronic and acute pain management that have been developed or adopted by Federal agencies. The task force is required to consider a number of factors, existing research, and related efforts, and, within one year of convening, propose any updates to such best practices and recommendations on addressing gaps or inconsistencies after providing the public with at least 90 days to submit comments. The task force would also develop a strategy for disseminating information about best practices prior to disbanding three years after enactment.

Section 102 – Awareness Campaigns

Section 102 requires that the Secretary of HHS, as appropriate, to advance education and awareness of issues related to opioid abuse. The Secretary is directed to carry out these activities through existing programs and activities. The awareness campaigns should address information on prevention and detection of opioid abuse. Section 102 of S. 524 included a similar provision.

Section 103 – Community-Based Coalition Enhancement Grants to Address Local Drug Crises

Section 103 authorizes the Office of National Drug Control Policy (ONDCP) to award grants to implement community-wide prevention strategies for addressing the local drug crisis or emerging drug abuse issue in areas with high rates of opioid or methamphetamine abuse. The section authorizes the appropriation of \$5 million for each of fiscal years 2017 through 2021, and allows ONDCP to delegate authority for carrying out the grant program. Section 103 of S. 524 included a similar provision.

Section 104 – Information Materials and Resources to Prevent Addiction Related to Youth Sports Injuries

Section 104 directs the Secretary of HHS to make publically available a report determining the extent to which informational materials and resources are available with respect to youth sports injuries for which opioids are potentially prescribed. The Secretary may then facilitate the development of materials if gaps are found in resources that are currently available. Teenage athletes who are prescribed an opioid are uniquely susceptible to opioid addiction. The House amendment included similar language.

Section 105 – Assisting Veterans with Military Emergency Medical Training to Meet Requirements for Becoming Civilian Health Care Professionals

Section 105 would award demonstration grants to states to streamline the licensure requirements for veterans who held military occupational specialties related to medical care or who completed certain military medical training to more easily meet civilian health care licensure requirements. The House amendment included similar language that applied only to military emergency medical technicians.

Section 106 – FDA Opioid Action Plan

Section 106 requires that the Food and Drug Administration (FDA) consult with advisory committees prior to approval or labeling of certain new opioids in pediatric populations. FDA must also issue final guidance for generic drugs that claim abuse deterrence within 18 months of the date of enactment, and develop recommendations regarding educational programs for prescribers of opioids. The House amendment included similar language.

Section 107 – Improving Access to Overdose Treatment

Currently, there are questions as to when co-prescribing or prescribing of opioid reversal drugs approved by the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose is appropriate. Section 107 would allow the Secretary of HHS, the Secretary of Veterans Affairs (VA), and the Secretary of Defense, 180 days after enactment, to provide information to prescribers on co-prescribing or prescribing a drug or device for emergency treatment of known or suspected opioid overdose. It explicitly states that the best

practices in this section are not to be construed as or to establish a medical standard of care. This section also establishes a grant program to increase access to opioid overdose treatment. The House amendment included similar language.

Section 108 – NIH Opioid Research

Section 108 allows the National Institutes of Health (NIH) to intensify and coordinate fundamental, translational, and clinical research with respect to the understanding of pain, the discovery and development of therapies for chronic pain, and the development of alternatives to opioids for effective pain treatments in order to advance the discovery and development of novel, safe, non-addictive, effective, and affordable pharmaceuticals and other therapies for chronic pain.

Section 109 – National All Schedules Prescription Electronic Reporting Reauthorization

Section 109 reauthorizes the National All Schedules Prescription Electronic Reporting (NASPER) Act within HHS to provide grants to states to establish, implement, and improve state-based prescription drug monitoring programs (PDMPs). NASPER first became law in 2005 but expired in 2010. CARA will extend funding for NASPER for five years at \$10 million a year for FY 2017 through FY 2021. The House amendment included similar language.

Section 110 – Opioid Overdose Reversal Medication Access and Education Grant Programs

Section 110 would allow the Secretary of HHS to make grants available for states to implement standing orders for opioid reversal drugs approved by the Federal Food, Drug and Cosmetic Act for emergency treatment of known or suspected opioid overdose. These grants may target states that have a significantly higher per-capita rate of opioid overdoses than the national average. Each state that is awarded a grant under this program must submit a report to the Secretary of HHS evaluating the grant and the services that were provided. The House amendment included similar language.

TITLE II – LAW ENFORCEMENT AND TREATMENT

Section 201 – Comprehensive Opioid Abuse Grant Program

Section 201 includes the provisions of Title II of the House amendment to S. 524. It creates a comprehensive grant program at the Department of Justice (DOJ) to address the problems of opioid addiction and abuse. Though there is no corresponding provision in S. 524 as passed by the Senate, the program created by this section includes several “allowable uses” that are similar to provisions in that bill. Minor changes have been made to the conference provisions for clarity. The allowable uses of grant funds include:

(1) Alternatives to incarceration programs, which replaces Section 201 of the Senate bill. The list of allowable alternatives to incarceration programs is very similar to the programs in the

Senate bill, including pre- and post-booking treatment programs such as drug courts and veterans treatment courts, and criminal justice training programs.

- (2) Collaboration between criminal justice agencies and substance abuse systems, which is nearly identical to Section 201 of the Senate bill;
- (3) Training for first responders in carrying and administering opioid overdose reversal drugs and purchasing such drugs for first responders who have received training;
- (4) Investigative purposes related to the unlawful distribution of opioids;
- (5) Medication-assisted treatment by criminal justice agencies, which is highlighted in Section 302 of the Senate bill;
- (6) Prescription drug monitoring programs administered by states;
- (7) Programs that address juvenile opioid abuse, which does not have a Senate companion;
- (8) Initiatives to prevent pilfering of prescription opioids, which does not have a Senate companion;
- (9) Prescription drug take-back programs; and
- (10) Development of a jurisdiction's own comprehensive opioid abuse reduction program.

\$103,000,000 is authorized to be appropriated for each of fiscal years 2017 through 2021 to carry out this grant program. This discretionary authorization is fully offset in accordance with the House's CUTGO protocol.

This section also allows grantees to make subawards to local or regional nonprofit organizations, including faith-based organizations, units of local government, and tribal organizations. This section would permit organizations that are private and nonprofit to receive subawards, including organizations that provide alternative complementary mental health services.

This section requires that the Attorney General ensure equitable distribution of funds, taking into consideration the needs of underserved populations such as rural and tribal communities, and the prevalence of opioid abuse in a community. It also ensures that entities that provide services to pregnant women are eligible for grants under the Family-Based Substance Abuse Grant Program.

Finally, this section directs the Government Accountability Office (GAO) to study and report on how federal agencies, including ONDCP, through grant programs, are addressing prevention, treatment, and recovery from substance abuse disorders on the part of adolescents and young adults.

Section 202 – First Responder Training

Section 201 of the conference report codifies an existing grant program at the Substance Abuse and Mental Health Services Administration (SAMSHA) to expand access to life-saving opioid overdose reversal drugs by supporting the purchase and distribution of opioid overdose reversal drugs and training for first responders and other key community sectors. S. 524 included similar language.

Section 203 – Prescription Drug Take-Back Expansion

This section, identical to Section 203 of the Senate bill, authorizes the Attorney General, in coordination with the Administrator of the Drug Enforcement Administration (DEA), the Secretary of HHS, and the Director of ONDCP, to coordinate with certain entities in expanding or making available disposal sites for unwanted prescription medications. These entities include state and local law enforcement agencies, manufacturers and distributors of prescription medications, retail pharmacies, narcotic treatment programs, hospitals with on-site pharmacies, and long-term care facilities.

TITLE III – TREATMENT AND RECOVERY

Section 301 – Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration

Section 301 of the conference report codifies an existing grant program at SAMHSA to support states in expanding access to addiction treatment services for individuals with an opioid use disorder, including evidence-based medication assisted treatment. This program is targeted toward areas where there is a high rate or a rapid increase in the use of heroin or other opioids, including rural areas. S. 524 included this language.

Section 302 – Building Communities of Recovery

Section 302 of the conference report allows HHS to provide grants to community organizations to develop, expand, and enhance recovery services and build connections between recovery networks, including physicians, the criminal justice system, employers, and other recovery support systems. Recovery services help individuals with a substance use disorder get and stay well and increase long-term recovery from substance use disorders. S. 524 included this language.

Section 303 – Medication-Assisted Treatment for Recovery From Addiction

The House amendment included provisions amending the Controlled Substances Act to permit nurse practitioners and physician assistants (NPs and PAs) who meet certain criteria to receive a waiver from SAMHSA to dispense certain drugs for maintenance or detoxification treatment in an office-based setting to up to 30 patients in the first year and up to 100 patients after the first year and going forward. In states where NPs and PAs are required to practice in collaboration with, or under the supervision of a physician, such physician would also need to be a qualifying practitioner (i.e., have their own waiver from SAMHSA). This new authority for NPs and PAs would sunset three years after the date of enactment.

Section 303 of the conference report includes similar operative language to the House amendment, though it requires the implementing regulations to be updated no later than 18 months after the date of enactment and the new authority for NPs and PAs expires October 1, 2021. Further, this section would not preempt any state law that establishes a lower limit on the number of patients a qualifying practitioner can treat at any given time or requires a qualifying practitioner to comply with additional requirements relating to the dispensing of such drugs.

TITLE IV – ADDRESSING COLLATORAL CONSEQUENCES

Section 401 – GAO Report on Recovery and Collateral Consequences

This section directs GAO to submit a report to the Senate and House Judiciary Committees on recovery and the collateral consequences of drug-related criminal convictions within one year of the date of the Act’s enactment. The report will study the collateral consequences for individuals with convictions for non-violent drug-related offenses and the effects of these collateral consequences on individuals in recovery on their ability to resume their personal and professional activities. The report will also discuss the policy bases and justifications for imposing these collateral consequences and provide perspectives on the potential for mitigating the effect of these collateral consequences on individuals in recovery.

TITLE V- ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

Section 501 – Improving Treatment for Pregnant and Postpartum Women

Section 501 reauthorizes a grant program for residential treatment for pregnant and postpartum women who have an opioid use disorder. This program also provides services for the children of such women, including those who may be born with neonatal abstinence syndrome. It creates a new pilot program to enhance the flexibility of the funds so states can more broadly support family-based services for pregnant and postpartum women and their children. S. 524 included language to reauthorize this program and create a pilot program but at a lower authorized level than the language included in the House amendment.

Section 502 – Veterans Treatment Courts

The language in this section is drawn from the House amendment to S. 524, and replaces the language from Section 503 of the Senate bill. However, consistent with the Senate bill, this section defines “qualified veterans” for purposes of the DOJ grant program as those who have served on active duty in any branch of the Armed Services and have been discharged under conditions other than dishonorable, unless the reason for the dishonorable discharge was attributable to a substance abuse disorder.

Additionally, this section provides a definitional framework for “peer-to peer” programs, “veterans treatment court” programs, and “veterans assistance” programs that are eligible under this section. This section is cross-referenced in the “alternatives to incarceration” piece of section 201 of the conference report, and should provide guidance on how grantees are to use grant funds received for veterans courts.

Section 503 – Infant Plan of Safe Care

Section 503 incorporates text originally passed as part of the House amendment to S. 524 and responds to concerns about the increased number of infants born suffering from opioid withdrawal symptoms and ensures states are in compliance with the *Child Abuse Prevention and*

Treatment Act (CAPTA). No corresponding provision was included in S. 524. This section requires the Department of HHS to review and confirm states have CAPTA policies in place as required under the law, strengthens protections for infants born with substance exposure by clarifying the intent of safe care plans, and requires the HHS Secretary to share best practices for developing plans to keep infants and their caregivers safe and healthy. It also improves accountability related to the care of infants and their families by requiring additional information be shared on incidents of infants exposed and their subsequent care. Additionally, it encourages the use of information made available through other child welfare laws in verifying CAPTA compliance. Finally, section 503 prevents HHS from adding new requirements to state assurances and plans.

Section 504 – GAO Report on Neonatal Abstinence Syndrome (NAS)

Section 504 requires the Comptroller General of the United States to, one year after enactment, issue a report on neonatal abstinence syndrome (NAS), including information on the treatment for infants with NAS under Medicaid. Specifically, the report will examine what is known about the prevalence of NAS in the country; the Medicaid-reimbursable services available to treat NAS; the types of, and reimbursement for care settings in which infants with NAS receive care; and any federal policy barriers for treating infants with NAS and what is known about best practices for caring for infants with NAS. Similar language was included in the House amendment.

TITLE VI – INCENTIVIZING STATE COMPREHENSIVE INITIATIVES TO ADDRESS PRESCRIPTION OPIOID ABUSE

Section 601 – State Demonstration Grants for Comprehensive Opioid Abuse Response

Section 601 of the conference report supports State efforts to combat opioid abuse by authorizing HHS to award grants to States and combinations of States to carry out a comprehensive opioid abuse response, including education, treatment, and recovery efforts, maintaining prescription drug monitoring programs, and efforts to prevent overdose deaths. S. 524 included this language; there was no corresponding legislation in the House amendment.

TITLE VII – MISCELLANEOUS

Section 701 – Grant Accountability and Evaluations

This section combines language that originated in both the House and Senate on grant oversight. It requires the DOJ Inspector General, at his or her discretion, to conduct audits of covered grantees to prevent waste, fraud, and abuse of funds. This section prohibits grantees with unresolved audit findings from receiving grants in the following fiscal year, and prioritizes grantees that do not have unresolved audit findings. If a grantee nevertheless receives funds inappropriately, this section also compels DOJ to reimburse the Department of the Treasury for the amount awarded, and to seek to recoup the funds from the grantee.

With respect to nonprofit organizations, this section prohibits nonprofits that hold money in offshore accounts for the purpose of avoiding certain federal taxes from receiving subawards from grant recipients. It also requires nonprofit organizations to disclose, in a grant application, the compensation of its board of directors. Finally, this section limits the use of grant funds for conference expenditures, and prevents the awarding of duplicative grants.

This section also contains the provisions applicable to DOJ from Title VI of the House amendment to S. 524, the Opioid Program Evaluation (OPEN) Act, which did not have a Senate companion. It requires the Attorney General to complete an evaluation of the effectiveness of the Comprehensive Opioid Abuse Grant Program based upon the information reported by grantees not later than 5 years after the enactment of the Act. It requires the Attorney General to identify outcomes to be achieved under the Comprehensive Opioid Grant Abuse Program, and the metrics by which the achievement of such outcomes shall be determined, not later than 180 days after the enactment of the Act.

This section provides that the Attorney General must require grantees and those receiving subawards to collect and annually report data on the activities conducted using their grant funding. It requires that the Attorney General publish the outcomes and metrics to be used to evaluate the program not later than 30 days after identifying such outcomes and metrics, and that the entity conducting the evaluation publish the results and issue a report to the House and Senate Judiciary Committees not later than 90 days after completion of the evaluation. It further requires the data collected from grantees to be published along with the report.

Finally, this section requires that the Attorney General enter into an arrangement with the National Academy of Sciences—or another non-government entity with expertise in conducting and evaluating research pertaining to opioid use and abuse and drawing conclusions about overall opioid use and abuse on the basis of that research—to identify the outcomes to be achieved, the metrics by which performance will be evaluated, and the evaluation of the Comprehensive Opioid Abuse Grant Program.

Section 701 also authorizes HHS to evaluate grants authorized within the Comprehensive Addiction Recovery Act and identify outcomes to be achieved by the programs, and metrics by which to measure those outcomes.

This section also places restrictions on conference expenditures using funding under a grant program in this Act.

Section 702 – Partial Fill of Schedule II Controlled Substances

Section 702 clarifies that if a doctor or patient requests a prescription for a Schedule II substance (such as an opioid) not be filled in its entirety, in accordance with state law; pharmacists are permitted to dispense only part of the prescription. This change could lead to fewer opioids being dispensed. The House amendment to CARA permitted more flexibility in filling Schedule II prescriptions such as opioids.

Section 703 – Good Samaritan Assessment

This section includes the provisions of Title V of the House amendment to S. 524, the Good Samaritan Assessment Act, which did not have a Senate companion. It directs the GAO to issue a report to the House and Senate Judiciary Committees, the House Oversight and Government Reform Committee, and the Senate Homeland Security and Governmental Affairs Committee, on the extent to which ONDCP has reviewed Good Samaritan laws and the findings from such a review; efforts by the ONDCP Director to encourage the enactment of Good Samaritan laws; and a compilation of Good Samaritan laws in effect in the States, the territories, and the District of Columbia.

Currently, more than half the states and the District of Columbia have some form of Good Samaritan law on the books, to protect citizens who render help to someone in need – or, in the context of opioids, to exempt from criminal or civil liability someone who administers an opioid overdose reversal drug or device, such as naloxone, or who calls 911 to report an overdose.

Given the widespread activity in state legislatures on this issue, and the differences between individual state statutes, this section directs GAO to study and report to Congress on the effects of the various Good Samaritan laws at the state level, and efforts by ONDCP to address the issue.

Section 704 – Programs to Prevent Prescription Drug Abuse under Medicare Parts C and D

Section 704 would allow prescription drug plans in Medicare, including Medicare Part D plans as well as standalone Medicare Advantage Prescription Drug Plans, to develop a safe prescribing and dispensing program for beneficiaries that are at risk of abuse or diversion of drugs that are frequently abused or diverted. The provision allows the Secretary of HHS to work with private drug plan sponsors to facilitate the creation and management of “lock-in” programs to curb identified fraud, abuse, and misuse of prescribed medications while at the same time ensuring that legitimate beneficiary access to needed medications is not impeded.

Such controls would prevent doctor/pharmacy shopping as well as duplicative and inappropriate drug therapies that can lead to prescription drug abuse. The conference report gives the Secretary responsibility to define an at-risk beneficiary using clinical guidelines developed in consultation with stakeholders. Plans would be able to identify enrolled Medicare beneficiaries deemed at high risk of abusing prescription drugs, and to limit such beneficiaries’ choice of prescribers or pharmacies in order to better monitor their use of these medications. For example, restrictions might be placed on beneficiaries suspected of abusing or reselling certain controlled substances, but not placed on beneficiaries with cancer or other conditions for which those drugs are considered appropriate. Plan sponsors, under the conference report, would have to take into consideration where an at-risk beneficiary lives and works, as well as other relevant factors when assigning providers and pharmacies and would also consider the beneficiary’s preferences unless it is deemed the cause of potential abuse. Plan sponsors also will have to comply with a number of beneficiary protections including ensuring access, notifications and disclosure requirements, as well as appeal rights. S. 524 included similar language.

Sections 705-707 – Exempting Abuse-Deterrent Formulations of Prescription Drugs from the Medicaid Additional Rebate Requirement for New Formulations of Prescription Drugs; Limiting Disclosure of Predictive Modeling and Other Analytics Technologies to Identify and Prevent Fraud, Waste, and Abuse; and Medicaid Improvement Fund

Sections 705-707 would exempt abuse deterrent formulations of opioid drugs (ADFs) from the definition of “line extension” for the purpose of calculating Medicaid rebates. In its Opioids Action Plan, FDA said its goal is to “expand access to abuse deterrent formulations to discourage abuse.” And in its ADF guidance to manufacturers, the agency has said it “considers the development of these products a high public health priority.” This policy was also included in the President’s FY 2017 Budget, which noted that this statutory change would “incentivize continued development of abuse deterrent formulations.”

The budgetary impact of the ADF policy is being offset by a policy from the President’s budget that prevents the public disclosure of program integrity algorithms used to identify and predict waste, fraud, and abuse in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) and places the remaining savings in a Medicaid Improvement Fund. The mathematical algorithms and predictive technologies the Centers for Medicare and Medicaid Services (CMS) uses in Medicare, Medicaid, and CHIP are vital to uncovering fraud, waste, and abuse. However, if various aspects of these algorithms were to become publicly known, fraudsters could utilize the information to re-direct their schemes to other areas of the Medicare, Medicaid, and CHIP programs or adjust their schemes to avoid detection. This policy would simply prevent the disclosure of these anti-fraud tools through FOIA-related laws while still allowing CMS and state Medicaid and CHIP programs to freely share algorithms and other predictive analytical tools.

The conference provision is the same as the provision included in the House amendment.

Section 708 – Sense of Congress Regarding Treatment of Substance Abuse Epidemics

This section includes a Sense of Congress that decades of experience and research have demonstrated that a fiscally responsible approach to addressing the opioid abuse epidemic and other substance abuse epidemics requires treating such epidemics as a public health emergency emphasizing prevention, treatment, and recovery.

TITLE VIII – KINGPIN DESIGNATION IMPROVEMENT

Section 801 – Protection of Classified Information

This section incorporates the provisions of Title IV of the House amendment to S. 524, which passed the House on May 10, 2016, and its Senate companion, S. 2914, the “Kingpin Designation Improvement Act.” The section amends Section 804 of the Foreign Narcotics Kingpin Designation Act to include language to protect classified information from disclosure during a federal court challenge by a designee.

Under current law, the Treasury Department’s Office of Foreign Assets Control (OFAC) uses the International Emergency Economic Powers Act (IEEPA) and the Foreign Narcotics Kingpin Designation Act (the “Kingpin Act”) to target and apply sanctions to international narcotics traffickers and their organizations. The Kingpin Act is the principal mechanism by which OFAC sanctions foreign persons tied to global narcotics trafficking.

OFAC’s designations are often based upon classified information. Unlike in a related federal statute, the Kingpin Act does not contain such a mechanism to protect classified information from release during a “de-listing” process. That means OFAC may lose the opportunity to designate a high-level drug kingpin because it cannot risk the disclosure of classified information.

This section clarifies that OFAC can submit classified information to defend its designations *ex parte* and *in camera* in the relevant U.S. district court, thereby ensuring classified information can be protected from disclosure.

TITLE IX – DEPARTMENT OF VETERANS AFFAIRS

Section 901 – Short Title

Includes the title “Jason Simcakoski Memorial and Promise Act.”

Section 902 – Definitions

This section includes various definitions of terms used throughout Title IX.

Section 911 – Improvement of Opioid Safety Measures by the Department of Veterans Affairs

This provision requires the Secretary to expand the Opioid Safety Initiative to include all VA medical facilities within 180 days of enactment of this act, and would require that all VA employees who prescribe opioids receive education and training on pain management and safe opioid prescribing practices. The Secretary would also be required to establish enhanced standards with respect to the use of routine and random drug tests for all patients before and during opioid therapy. Directors of each medical facility will be required to designate a pain management team of health care professionals responsible for coordinating and overseeing pain management therapy and will provide an annual report identifying the members of the facility’s pain management team, certification as to education and training, and compliance with the stepped-care model or other pain management policies. This provision also requires participation in state prescription drug monitoring programs; a report on the feasibility and advisability of advanced real-time tracking of opioid use data in the Opioid Therapy Risk Report tool; an increase in the availability of opioid receptor antagonists such as naloxone and a report on compliance; inclusion in the Opioid Therapy Risk Report tool of information identifying when health care providers access the tool and the most recent urine drug test for each veteran; and notification of opioid abuse risk in the computerized patient record system.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 912 – Strengthening of Joint Working Group on Pain Management of the Department of Veterans Affairs and the Department of Defense

H.R. 4063 and S. 2921, as reported, require that VA and the Department of Defense (DOD) ensure that the Health Executive Committee’s Pain Management Working Group (PMWG) includes a focus on the opioid prescribing practices of health care providers of each Department; the ability of each Department to manage acute and chronic pain, including training health care providers with respect to pain management; the use by each Department of complementary and integrative health; the concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines; the use of care transition plans by health care providers of each Department to address case management issues for patients receiving opioid therapy who transition between inpatient and outpatient settings; coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from DOD to VA; and the ability of each Department to screen, identify, and treat patients with substance use disorders who are seeking treatment for acute and chronic pain.

This provision also ensures the PMWG coordinates its activities with other relevant working groups; consults with other relevant federal agencies, including the Centers for Disease Control and Prevention; consults with the VA and DOD with respect to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; and reviews and comments on the guideline before any update to such guideline is released.

This provision requires VA and DOD to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain within 180 days of enactment. This provision requires that the PMWG, in coordination with the Clinical Practice Guideline VA/DOD Management of Opioid Therapy for Chronic Pain Working Group, examine whether the guidelines should include numerous elements. The elements to be considered include, but are not limited to, enhanced guidance with respect to: opioid and other drug prescription practices; treatment of patients with behaviors or comorbidities that require co-management of opioid therapy; patient status assessments conducted by providers; governance of the methodologies used by VA and DOD providers to taper opioid therapy; appropriate case management for opioid patients transitioning from an inpatient setting to an outpatient setting; appropriate case management for opioid patients transitioning from active duty to post-military health care networks; how providers should discuss with patients options for pain management therapies before initiating opioid therapy; provision of evidence-based non-opioid treatments within VA and DOD; and consideration of guidelines developed by CDC for safely prescribing opioids.

Section 913 – Review, Investigation, and Report on Use of Opioids in Treatment by Department Of Veterans Affairs

This provision requires GAO, not later than 2 years after enactment, to submit a report on the Opioid Safety Initiative and the opioid prescribing practices of VA health care providers. This provision also requires semi-annual progress reports on the implementation of any GAO

recommendations generated by this report. The Secretary must also review and report annually on the patient population receiving opioid therapy and the prescription rates of each medical facility and conduct investigations, through the Office of the Medical Inspector, on prescription rates that conflict with or are otherwise inconsistent with the standards of appropriate and safe care.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 914 – Mandatory Disclosure of Certain Veteran Information to State Controlled Substance Monitoring Programs

This provision includes the H.R. 4063, as reported, language requiring that VA providers shall disclose certain veteran information to state controlled substance monitoring programs.

Section 915 – Elimination of Copayment Requirement for Veterans Receiving Opioid Antagonists or Education on Use of Opioid Antagonists

This provision includes the S. 2921, as reported, language that would eliminate the copayment requirement for veterans receiving opioid antagonists or education on the use of opioid antagonists.

Section 921 – Community Meetings on Improving Care Furnished by Department of Veterans Affairs

This provision requires that, within 90 days of the enactment of this act, and quarterly thereafter, each VA medical facility hosts a public community meeting on improving VA health care; and within one year of the enactment of this act, and at least annually thereafter, that each community-based outpatient clinic (CBOC) hosts such a community meeting. These meetings will require regular senior leadership attendance and notice will be given to the Committees on Veterans' Affairs of the House and of the Senate and the Members of Congress who represent the area in which the facility is located at least ten days in advance.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 922 – Improvement of Awareness of Patient Advocacy Program and Patient Bill of Rights of Department of Veterans Affairs

This provision would require, within 90 days of the enactment of this act, the display of, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients at each VA medical facility: (1) the purposes of the VA Patient Advocacy Program and the contact information for the patient advocate at each medical facility; and (2) the rights and responsibilities of patients and family members and, with respect to community living centers and other VA residential facilities.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 923 – Comptroller General Report on Patient Advocacy Programs of Department of Veterans Affairs

Both H.R. 4063 and S.2921 require that, within two years of the enactment of this act, GAO submit a report on the VA Patient Advocacy Program to the Committees on Veterans' Affairs of the House and of the Senate. The report will include: (1) a description of the Program, including the Program's purpose, activities, and sufficiency in achieving its purpose; (2) an assessment of the sufficiency of the Program's staffing; (3) an assessment of the Program's employee training; (4) an assessment of veterans' and family members' awareness of and utilization of the Program; (5) recommendations for improving the Program; and (6) any other information the GAO considers appropriate.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 924 – Establishment of Office of Patient Advocacy of the Department of Veterans Affairs

This section establishes an office of patient advocacy within the Office of the Undersecretary for Health of the Department of Veterans Affairs. This office will ensure patient advocates appropriately advocate for veteran patients and are trained in their responsibilities.

Section 931 – Expansion of Research and Education on and Delivery of Complementary and Integrative Health to Veterans

H.R. 4063, as reported, establishes a Commission to examine the evidence-based therapy treatment model used by VA for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health as standard practice throughout the Department. The Commission would: (1) examine the efficacy of the evidence-based therapy model used by VA to treat mental health illnesses and identify areas of improvement; (2) conduct a patient-centered survey within each VISN to examine: the experiences of veterans with VA facilities regarding mental health care, the experiences of veterans with non-VA facilities regarding mental health care, the preferences of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective, the experience, if any, of veterans with respect to the complementary and integrative health treatment therapies, the prevalence of prescribing medication to veterans seeking treatment for mental health disorders through VA, and the outreach efforts of VA regarding the availability of benefits and treatments for veterans for addressing mental health issues; (3) examine available research on complementary and integrative health for mental health disorders in areas of therapy including: music therapy, equine therapy, training and caring for service dogs, yoga therapy, acupuncture therapy, meditation therapy, outdoor sports therapy, hyperbaric oxygen therapy, accelerated resolution therapy, art therapy, magnetic resonance therapy, and others; (4) study the sufficiency of VA resources to deliver quality mental health care; and (5) study the current treatments and resources available within VA and assess: the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans, the number of veterans who have been diagnosed with mental health issues, the percentage of veterans who have

completed VA counseling sessions, and the efforts of VA to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by VA.

Section 932 – Pilot Program on Integration of Complementary and Integrative Health and Related Issues for Veterans and Family Members of Veterans

The provision requires that the Secretary, informed by the Commission’s findings, commence a pilot program to assess the feasibility and advisability of using wellness-based programs to complement pain management and related health care services. The pilot program would last for three years and be carried out at no fewer than 15 VA facilities providing pain management, two of which must be polytrauma centers. The Secretary should prioritize medical centers at which there is a prescription rate that is inconsistent with the standards of appropriate care when selecting medical centers for the pilot. The Secretary will report on findings and conclusions regarding the use and efficacy of complementary and integrative health services established under the pilot program, the outreach conducted by VA about the pilot, and an assessment of the benefit of the pilot program to covered veterans, as well as identify any unresolved barriers to VA’s use of complementary and integrative medicine, and make recommendations for the continuation or expansion of the pilot program.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 941 – Additional Requirements for Hiring of Health Care Providers by Department of Veterans Affairs

This provision would require that, as part of the hiring process for all health care providers considered for a position after the date of the enactment of this act, that the Secretary require from the medical board of the State in which the applicant is licensed: (1) information on any violations of the requirements of medical license over the previous 20 years; and (2) information on whether the provider has entered into any settlement agreements for disciplinary charges related to the practice of medicine.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 942 – Provision of Information on Health Care Providers of Department of Veterans Affairs to State Medical Boards

This provision would require that VA provide to the medical board of each State in which the provider is licensed information regarding violations, regardless of whether the board has requested such information.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 943 – Report on Compliance by Department of Veterans Affairs with Reviews of Health Care Providers Leaving the Department or Transferring to Other Facilities

This provision would require that, within 180 days of the enactment of this act, that the Secretary submit to the Committees on Veterans' Affairs of the House and of the Senate a report on VA's compliance with VA policy to conduct a review of each provider who transfers from another VA medical facility, retires, or is terminated, and to take appropriate actions with respect to any concerns, complaints, or allegations against the provider.

Both H.R. 4063 and S. 2921, as reported, included similar language.

Section 951 – Modification to Limitation on Bonus and Awards

This provision limits the amounts of funds available for payment as bonuses and awards and directs those amounts now available within the budget toward the payment for the programs and services directed in this title.

This section also includes a Sense of Congress that states the limitation under this subsection should not disproportionately impact lower-wage employees within the VA.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of Rule XXI of the Rules of the House of Representatives, the conference report and joint explanatory statement contain no earmarks, limited tax benefits, or limited tariff benefits.

CONSTITUTIONAL STATEMENT OF AUTHORITY

Congress has the power to enact this legislation pursuant to the following: Article I, Section 8, Clause 3 of the United States Constitution.


S. 524

*Managers on the part of the
HOUSE**Managers on the part of the
SENATE*


For consideration of the Senate bill and the House
amendments, and modifications committed to
conference:



Mr. Upton




Mr. Pitts




Mr. Lance



Mr. Guthrie



Mr. Kinzinger of Illinois


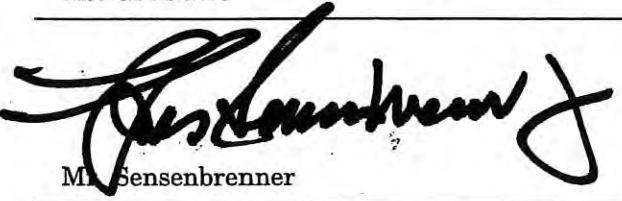
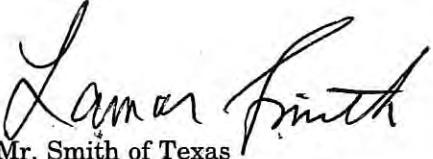

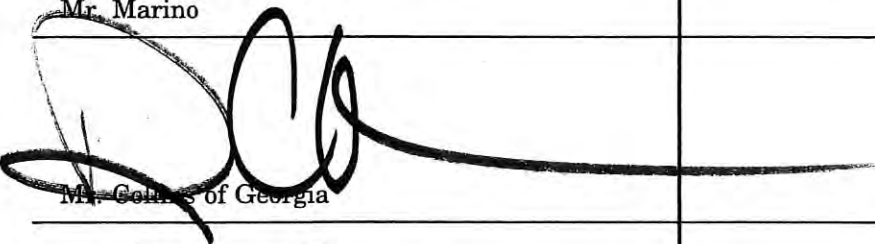

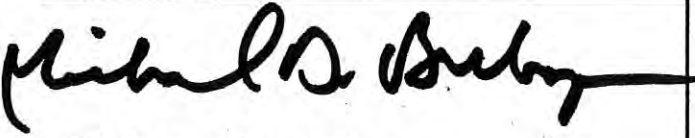
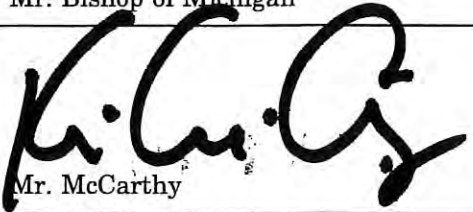


Mr. Bucshon



Mrs. Brooks of Indiana

S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
 Mr. Goodlatte	
 Mr. Sensenbrenner	
 Mr. Smith of Texas	
 Mr. Marino	
 Mr. Collins of Georgia	
 Mr. Trott	
 Mr. Bishop of Michigan	
 Mr. McCarthy	


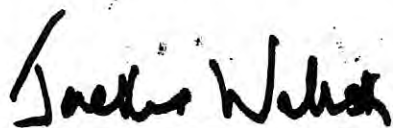
S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
Mr. Puller	
Mr. Don Ray, Engr. of New Mexico	
Mr. Sarbanes	
Mr. Cono, Green of Texas	
Mr. Conyers	
Ms. Jackson Lee	
Ms. Judy Chu of California	
Mr. Cohen	

[illegible]

S. 524—Continued[illegible]

S. 524—Continued


<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Veterans' Affairs, for consideration of title III of the House amendment, and modifications committed to conference:	
Mr. Bilirakis 	
Mrs. Walorski 	
Mr. Ruiz	

S. 524—Continued***Managers on the part of the
HOUSE******Managers on the part of the
SENATE***

From the Committee on Ways and Means, for consideration of sec. 705 of the Senate bill, and sec. 804 of the House amendment, and modifications committed to conference:




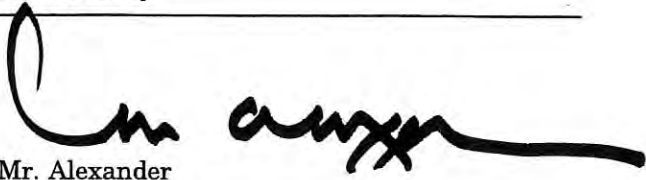


Mr. Meehan



Mr. Dold

~~Mr. McDermott~~

S. 524—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	 Mr. Grassley
	 Mr. Alexander
	 Mr. Hatch
	 Mr. Sessions
	