NASADAD
National Association of State Alcohol and Drug Abuse Directors

115th Congress, March 2018

Comprehensive Addiction and Recovery Act (CARA) 2.0 of 2018:

A Section-by-Section Analysis

Senate Sponsors: *Senators Rob Portman (R-OH), Sheldon Whitehouse (D-RI), Shelley Moore Capito (R-WV), Amy Klobuchar (D-MN), Dan Sullivan (R-AK), Maggie Hassan (D-NH), Bill Cassidy (R-LA), and Maria Cantwell (D-WA)*

Section 1: Short Title

This section identifies the bill as the "CARA 2.0 Act of 2018".

Section 2: National Education Campaign

Section 102 of CARA 2016 called for the Secretary of Health and Human Services (HHS) to advance public awareness of opioid use disorders, including the association between prescription opioid misuse and heroin use, as well as the risks of fentanyl. CARA 2016 did not include a specific authorization level.

This section of CARA 2.0 **authorizes $10 million for each of fiscal years 2019 through 2023 for this opioid use disorder awareness campaign.**

Section 3: Three-Day Limit on Opioid Prescriptions

This section **prohibits the Attorney General from registering or renewing the registration of a practitioner who prescribes more than a 3-day supply of an opioid medication for acute pain.** Acute pain is defined as, "pain with abrupt onset and caused by an injury or other process that is not ongoing." Opioid prescriptions for chronic pain, cancer, hospice or end of life care, and palliative care are exempt from this 3-day limit.

Section 4: First Responder Training

This provision amends a program authorized in section 202 of CARA 2016. Section 202 of CARA 2016 amended part D of title V of the Public Health Service Act to authorize the Secretary of Health and Human Services (HHS) to make grants to States, local governments, Indian tribes, and tribal organizations to allow first responders to administer a drug or device to treat an opioid overdose (e.g. naloxone). This provision of CARA 2.0 amends the allowable uses of the grant by adding that **funds may be used to train and provide resources to first responders in order to increase their safety around fentanyl**, and train them on actions to take after exposure to dangerous illicit substances.

This provision **authorizes $300 million for each of fiscal years 2019 through 2023 for the first responder training grants.** The original authorization for the first responder training provision in CARA 2016 was $12 million for each of fiscal years 2017 through 2021.

Section 5: Evidence-Based Prescription Opioid and Heroin Treatment and Intervention Demonstrations

This provision amends a program authorized in section 301 of CARA 2016. Section 301 of CARA 2016 amended subpart 1 of part B of title V of the Public Health Service Act by authorizing the Secretary of Health and Human Services (HHS) to award grants, contracts, or cooperative agreements to State alcohol and drug agencies, local governments, nonprofit organizations, Indian tribes, and tribal organizations that have a high rate, or have had a rapid increase, in the use of heroin or other opioids, in order to expand treatment, including medication-assisted treatment (MAT).

This provision of **CARA 2.0 authorizes $300 million for each of fiscal years 2019 through 2023 for this program.** The original authorization for the Evidence-Based Prescription Opioid and Heroin Treatment and Intervention Demonstrations in CARA 2016 was $25 million for each of fiscal years 2017 through 2021.

Section 6: Building Communities of Recovery

This provision amends a program authorized in section 302 of CARA 2016. Section 302 of CARA 2016 amended part D of title V of the Public Health Service Act to authorize the Secretary of Health and Human Services (HHS) to award grants to recovery community organizations (RCOs) to enable them to develop, expand, and enhance recovery services. Grant funds may be used to build connections between recovery support services and networks, including treatment programs, mental health providers, treatment systems, and other recovery supports. Funds may also be used on efforts to reduce the stigma associated with substance use disorders and to conduct public education on issues related to substance use disorders and recovery.

This provision of CARA 2.0 amends the allowable uses of the grant by adding that funds may be used to establish regional technical assistance centers that will help with: implementation of regionally driven peer delivered addiction recovery support services before, during, after, or in lieu of addiction treatment; establishment of RCOs; establishment of recovery community centers; and naloxone training and dissemination.

This provision **authorizes $200 million for each of fiscal years 2019 through 2023.** The original authorization for building communities of recovery in CARA 2016 was $1 million for each of fiscal years 2017 through 2021.

Section 7: Medication-Assisted Treatment (MAT) for Recovery from Addiction

This provision amends section 303 of CARA 2016, which amended section 303 of the Controlled Substances Act. Specifically, this provision of CARA 2.0 **makes permanent section 303 of CARA of 2016, which allows physician assistants (PAs) and nurse practitioners (NPs) to prescribe buprenorphine under the direction of a qualified physician**, instead of sunsetting in 2021. This provision also **allows States to waive the current 100-patient limit** that a physician can treat with buprenorphine. Additionally, this provision requires any entity—including a prison or jail—that receives federal funds for a program or activity that offers MAT, to offer at least 2 types of medications for the treatment of opioid use disorders (at least 1 opioid antagonist approved by the Food and Drug Administration [FDA] and at least 1 opioid agonist or partial agonist approved by the FDA).

Section 8: National Youth Recovery Initiative

This provision authorizes the Assistant Secretary for Mental Health and Substance Use, in consultation with the Secretary of Education, to award **grants for the purpose of: 1) providing substance use recovery support services to youth and young adults enrolled in high school or an institution of higher education; 2) helping build communities of support for youth and young adults in substance use recovery through a spectrum of activities such as counseling, job training, recovery coaching, alternative peer groups, life-skills workshops, family support groups, and health and wellness-oriented social activities; and 3) encouraging initiatives designed to help youth and young adults achieve and sustain recovery from substance use disorders.** Eligible entities for this grant program are: a high school that has been accredited as a substance use recovery high school or that is seeking to establish or expand substance use recovery support services; an institution of higher education; a recovery program at an institution of higher education; a nonprofit organization; or a technical assistance center that can help grantees install recovery support service programs aimed at youth and young adults.

This provision authorizes $10 million for each of fiscal years 2019 through 2023 for the youth recovery initiative.

Section 9: National Recovery Residence Standards

This provision authorizes the Secretary of Health and Human Services (HHS), acting through the Director of the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration (SAMHSA), to publish **best practices for operating recovery housing, based on: 1) the applicable domains, core principles, and standards of the National Alliance for Recovery Residences (NARR); and 2) input from other nationally accredited recovery housing entities and from stakeholders**. The Secretary of HHS: shall disseminate the best practices to each State; may provide technical assistance to States that are seeking to adopt the best practices; shall identify barriers with respect to recovery housing—State licensure, zoning restrictions, and discrimination against individuals receiving medication-assisted treatment (MAT) for the treatment of opioid use disorders—and shall develop strategies to address those barriers. The term "recovery housing" is defined as a family-like, shared living environment free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders.

CARA 2.0 does not include a specific authorization level for this provision.

Section 10: Improving Treatment for Pregnant and Postpartum Women

Section 501 of CARA 2016 amended section 508 of the Public Health Service Act by reauthorizing the Residential Treatment Program for Pregnant and Postpartum Women within SAMHSA's Center for Substance Abuse Treatment (CSAT). Section 501 of CARA 2016 also authorized the Director of CSAT to carry out a pilot program making competitive

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grants available to State alcohol and drug agencies to enhance flexibility in the use of funds for family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder. Pilot program funds help SSAs address gaps in services to women across the continuum of care, including in non-residential settings, and promote new approaches and evidence-based models of service delivery.

This provision of CARA 2.0 authorizes $100 million for each of fiscal years 2019 through 2023 to carry out the residential services grant program for pregnant and postpartum women. As authorized in CARA 2016, **a maximum of 25 percent of the funds appropriated to the residential services grant program may be used to implement the pilot program.** The original authorization for the residential services grant program for pregnant and postpartum women in CARA 2016 was $16.9 million for each of fiscal years 2017 through 2021.

Section 11: Veterans Treatment Courts

This section amends a program authorized in section 502 of CARA 2016. Section 502 of CARA 2016 amended section 2991 of the Omnibus Crime Control and Safe Streets Act by adding that the Attorney General, in consultation with the Secretary of Veterans Affairs, could award grants to establish or expand veterans treatment court programs; peer-to-peer services or programs for qualified veterans; practices that identify and provide treatment, rehabilitation, legal, transitional, and other appropriate services to qualified veterans who have been incarcerated; or training programs to teach criminal justice, law enforcement, corrections, mental health, and substance use disorder personnel how to identify and appropriately respond to incidents involving qualified veterans. In awarding grants under this subsection, the Attorney General may prioritize applications that: demonstrate collaboration between and joint investments by criminal justice, mental health, substance use, and veterans service agencies; promote effective strategies to identify and reduce the risk of harm to qualified veterans and public safety; and propose interventions with empirical support to improve outcomes for qualified veterans. Those veterans dishonorably discharged due to a substance use disorder are eligible to participate in this program. The Attorney General may prioritize applications that demonstrate collaboration with State alcohol and drug agencies.

CARA 2.0 authorizes $20 million for each of fiscal years 2019 through 2023 for veterans treatment courts. CARA 2016 did not include a specific authorization level for veterans treatment courts.

Section 12: Infant Plan of Safe Care

This section amends section 503 of CARA 2016. Section 503 of CARA 2016 amended the Child Abuse Prevention and Treatment Act (CAPTA) by adding that the Secretary of HHS will maintain and disseminate information about the best practices relating to the development of plans of safe care for infants born and identified as being affected by substance use or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder. Section 503 of CARA 2016 also amended CAPTA by adding that a State plan will ensure the safety and well-being of an infant following release from the care of health care providers, including through, 1) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and 2) the development and implementation by the State of monitoring systems regarding the implementation of plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver. Additionally, section 503 of CARA 2016 amended CAPTA by adding to the contents of data reports the number of infants for whom a plan of safe care was developed, and for whom a referral was made for appropriate services, including services for the affected family or caregiver. Section 503 of CARA 2016 also added to CAPTA a section on monitoring and oversight.

This provision of CARA 2.0 authorizes $60 million for each of fiscal years 2019 through 2023 to provide funds for States to collaboratively develop policies and procedures for plans of safe care, implement the plans, and develop systems to monitor the plans. CARA 2016 did not include a specific authorization level for infant plans of safe care.

Section 13: Require the Use of Prescription Drug Monitoring Programs

This provision mandates any State that receives funding under the Harold Rogers Prescription Drug Monitoring Program (PDMP), the controlled substance monitoring program under section 399O of the Public Health Service Act (National All Schedules Prescription Electronic Reporting), or under CARA 2.0, to **require all licensed or registered prescribing practitioners to consult the State's PDMP prior to prescribing a schedule II, III, or IV controlled substance.** Prescribing practitioners must check the PDMP every three months following the initial prescription of such a controlled substance, for as long as treatment continues.

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This provision also requires: 1) PDMPs to notify a practitioner when patterns indicative of substance misuse are detected; 2) pharmacists to report to the PDMP each prescription for a controlled substance that is dispensed within 24 hours; 3) PDMPs to make available a quarterly de-identified data set and an annual report for public and private use, including use by health care providers, health plans and health benefits administrators, State agencies, and researchers; 4) each State agency that administers the PDMP to proactively analyze data available through the PDMP and provide reports to law enforcement agencies and prescriber licensing boards describing any practitioner that repeatedly falls outside of standard prescribing practices; and 5) that PDMP data be made available to other States.

If a State that receives grant funding under the Harold Rogers PDMP, the controlled substance monitoring program under section 399O of the Public Health Service Act, or under CARA 2.0 does not comply with these requirements, the Attorney General or the Secretary of Health and Human Services (HHS) may withhold those grant funds from being awarded to the State.

Section 14: Increasing Civil and Criminal Penalties for Opioid Manufacturers

This section increases the civil and criminal penalties for opioid manufacturers that fail to report suspicious orders for opioids or fail to maintain effective controls against diversion of opioids. This section raises the maximum amount for each individual civil fine from $10,000 to $100,000. Additionally, this provision increases criminal penalties for willful disregard and/or knowingly failing to keep proper systems or report suspicious activity from a maximum of $250,000 to $500,000.

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