COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA) 3.0

The COVID-19 crisis has exacerbated America's deadly drug epidemic. Due to despair, unemployment, and substance abuse, addiction is rising in America. Suspected overdoses rose 18 percent nationally during the first three months of the pandemic compared to prior months, according to the Overdose Detection Mapping Application Program.

The *Comprehensive Addiction & Recovery Act* (CARA) became law on July 22, 2016. CARA's evidence-based programs have received strong federal investment. Several key provisions of *CARA 2.0* were enacted as part of the *SUPPORT Act* on October 24, 2018. In FY 2021, Congress funded CARA programs at $782 million. As we come out of the COVID-19 pandemic, there is bipartisan agreement that more resources are necessary to turn the tide on the addiction epidemic.

CARA 3.0 builds on the original CARA and CARA 2.0 by increasing funding for prevention, education, treatment, and recovery. Coupled with policy changes to strengthen the federal government's response to this crisis, CARA 3.0 authorizes $785 million in dedicated resources to evidence-based prevention, enforcement, treatment, criminal justice, and recovery programs. CARA 3.0 answers the urgent call for adequate and sustained resources that appropriately reflect the magnitude of the crisis.

CARA 3.0 policy changes:

- Authorizes new research into non-opioid pain management alternatives.
- Authorizes new research on long-term treatment outcomes to sustain recovery from addiction.
- Establishes a National Commission for Excellence in Post-Overdose Response to improve the quality and safety of care for drug overdoses and substance use disorders.
- Requires physicians and pharmacists use their state prescription drug monitoring programs upon prescribing or dispensing opioids.
- Mandates physician education on addiction, treatment, and pain management.
- Prohibits States from requiring prior authorization for medication-assisted treatment under Medicaid.
- Establishes a pilot program to study the use of mobile methadone clinics in rural and underserved areas.
- Removes the limit on the number patients a physician can treat with buprenorphine and methadone.
- States that an employee using medication-assisted treatment is not in violation of the drug-free workplace requirement.
- Permanently allows providers to prescribe medication-assisted treatment (MAT) and other necessary drugs via audio-only telehealth following an initial in-person or audio-visual appointment, and to bill Medicare for audio-only telehealth services.
- Expands access to federal housing for individuals who have misused substances or have a criminal conviction.

Authorization levels:

- $10 million or more for a research-based national drug awareness campaign designed to reduce and prevent substance use disorder
- $55 million for training and employment for substance abuse professionals, including peer recovery specialists, and $5 million set aside for workforce retention efforts.
- $10 million for community-based coalition enhancement grants to address local drug crises.
- $300 million to expand evidence-based MAT.
- $200 million to build a national infrastructure for recovery support services to help individuals move successfully from treatment into long-term recovery.
- $10 million in grants to promote high-quality recovery housing
- $100 million to expand treatment for pregnant and postpartum women, including facilities that allow children to reside with their mothers.
- $20 million to expand Veterans Treatment Courts.
- $10 million for a National Youth Recovery Initiative to develop, support, and maintain youth recovery support services.
- $50 million to provide quality treatment for addiction in correctional facilities and in community reentry programs.
- $30 million for deflection and pre-arrest diversion programs in the criminal justice system.