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REPORT
114–554

IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN ACT OF 2016

MAY 10, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 3691]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3691) to amend the Public Health Service Act to reauthorize the residential treatment programs for pregnant and postpartum women and to establish a pilot program to provide grants to State substance abuse agencies to promote innovative service delivery models for such women, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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59–006

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Treatment for Pregnant and Postpartum Women Act of 2016".

SEC. 2. REAUTHORIZATION OF RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.

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

(1) in subsection (p), in the first sentence, by inserting "(other than subsection (r))" after "section"; and

(2) in subsection (r), by striking "such sums" and all that follows through "2003" and inserting "$16,900,000 for each of fiscal years 2017 through 2021".

SEC. 3. PILOT PROGRAM GRANTS FOR STATE SUBSTANCE ABUSE AGENCIES.

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

(1) by redesignating subsection (r), as amended by section 2, as subsection (s); and

(2) by inserting after subsection (q) the following new subsection:

"(r) PILOT PROGRAM FOR STATE SUBSTANCE ABUSE AGENCIES.—

"(1) IN GENERAL.—From amounts made available under subsection (s), the Director of the Center for Substance Abuse Treatment shall carry out a pilot program under which competitive grants are made by the Director to State substance abuse agencies to—

"(A) enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

"(B) help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential based settings; and

"(C) promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery.

"(2) REQUIREMENTS.—In carrying out the pilot program under this subsection, the Director shall—

"(A) require State substance abuse agencies to submit to the Director applications, in such form and manner and containing such information as specified by the Director, to be eligible to receive a grant under the program;

"(B) identify, based on such submitted applications, State substance abuse agencies that are eligible for such grants;

"(C) require services proposed to be furnished through such a grant to support family-based treatment and other services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

"(D) not require that services furnished through such a grant be provided solely to women that reside in facilities;

"(E) not require that grant recipients under the program make available through use of the grant all services described in subsection (d); and

"(F) consider not applying requirements described in paragraphs (1) and (2) of subsection (f) to applicants, depending on the circumstances of the applicant.

"(3) REQUIRED SERVICES.—

"(A) IN GENERAL.—The Director shall specify a minimum set of services required to be made available to eligible women through a grant awarded under the pilot program under this subsection. Such minimum set—

"(i) shall include requirements described in subsection (c) and be based on the recommendations submitted under subparagraph (B); and

"(ii) may be selected from among the services described in subsection (d) and include other services as appropriate.

"(B) STAKEHOLDER INPUT.—The Director shall convene and solicit recommendations from stakeholders, including State substance abuse agencies, health care providers, persons in recovery from substance abuse, and other appropriate individuals, for the minimum set of services described in subparagraph (A).

"(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

"(5) EVALUATION AND REPORT TO CONGRESS.—The Director of the Center for Behavioral Health Statistics and Quality shall fund an evaluation of the pilot program at the conclusion of the first grant cycle funded by the pilot program. The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on such evaluation. The report shall include at a minimum outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs; engagement in treatment services; retention in the appropriate level and duration of services; increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and other appropriate measures.

"(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term 'State substance abuse agency' means, with respect to a State, the agency in such State that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.".

(b) FUNDING.—Subsection (s) of section 508 of the Public Health Service Act (42 U.S.C. 290bb–1), as amended by section 2 and redesignated by subsection (a), is further amended by adding at the end the following new sentence: "Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.".

SEC. 4. CUT-GO COMPLIANCE.

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by striking "through 2018" and inserting "through 2016, $133,300,000 for fiscal year 2017, and $138,300,000 for fiscal year 2018".

PURPOSE AND SUMMARY

H.R. 3691, the "Improving Treatment for Pregnant and Postpartum Women Act of 2016," was introduced by Rep. Ben Ray Luján (D–NM), Rep. Tonko (D–NY), Rep. Clarke (D–NY), Rep. Matsui (D–CA), and Rep. Cárdenas (D–CA). This legislation reauthorizes a grant program for residential treatment for pregnant and postpartum women who have an opioid use disorder and for their children, 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.

BACKGROUND AND NEED FOR LEGISLATION

In most instances, withdrawal or detoxification is not clinically appropriate for pregnant women with opioid use disorders. The withdrawal symptoms associated with discontinuing opioid use in pregnant women can lead to miscarriage or other negative birth outcomes. Buprenorphine and methadone can be used to treat a woman's opioid use disorder while pregnant. Such treatment can result in improved outcomes for both mothers and babies.

Unfortunately, babies exposed to opioids in utero may be born with neonatal abstinence syndrome (NAS), which refers to medical issues associated with opioid withdrawal in newborns. Mothers suffering from opioid use disorder may be sent home with babies who have NAS with very little guidance or support which can have negative consequences for their babies. In the United States, the incidence of NAS has risen from 1.20 per 1,000 hospital births in 2000

to 3.9 per 1,000 hospital births in 2009. NAS can result from the use of prescription opioids as prescribed for medical reasons, abuse of prescription opioid medication, or the use of illegal opioids like heroin.

The grant program reauthorized in Section 508 of the Public Health Service Act helps support residential treatment facilities where women and their children receive support, education, treatment, and counseling that they need. The pilot program will allow states more flexibility in providing these services for women and children in need.

HEARINGS

The Subcommittee on Health held a hearing on H.R. 3391 on October 20, 2015. The Subcommittee received testimony from:

- Mr. Michael Botticelli, Director, National Drug Control Policy, Executive Office of the President;
- Dr. Richard Frank, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services;
- Mr. Jack Riley, Deputy Administrator, Drug Enforcement Administration;
- Dr. Allen Anderson, President, American Orthopaedic Society for Sports Medicine;
- Dr. Paul Halverson, Dean, Indiana University, Richard M. Fairbanks School of Public Health;
- Dr. Kenneth Katz, Lehigh Valley Health Network, Department of Emergency Medicine, Section of Medical Toxicology;
- Dr. Chapman Sledge, Chief Medical Officer, Cumberland Heights; and,
- Dr. Robert Corey Waller, Chair, Legislative Advocacy Committee, American Society of Addiction Medicine.

COMMITTEE CONSIDERATION

On April 20, 2016, the Subcommittee on health met in open markup session and forwarded H.R. 3691, without amendment, to the full Committee by a voice vote. On April 26, 27, and 28, 2016, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 3691 reported to the House, as amended, by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 3691 reported.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of this legislation is to reauthorize the residential treatment programs for pregnant and postpartum women and to estab-

lish a pilot program to provide grants to state substance abuse agencies to promote innovative service delivery models for such women.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 3691 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

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 Committee finds that H.R. 3691 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

MAY 9, 2016.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act of 2015.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ellen Werble.

Sincerely,

KEITH HALL.

Enclosure.

H.R. 3691—Improving Treatment for Pregnant and Postpartum Women Act of 2015

Summary: H.R. 3691 would reauthorize programs for residential treatment of pregnant and postpartum women. The bill also would require the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish a pilot program to award grants to support programs that treat substance abuse in pregnant and postpartum women. Additionally, H.R. 3691 would reduce amounts authorized to be appropriated for existing activities related to bioterrorism and public health emergencies at the Centers for Disease Control and Prevention (CDC). Assuming appropriation actions consistent with the bill, CBO estimates that implementing H.R.

3691 would have a net discretionary cost of $65 million over the 2017–2021 period.

Pay-as-you-go procedures do not apply because enacting H.R. 3691 would not affect direct spending or revenues. CBO estimates that enacting H.R. 3691 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027

H.R. 3691 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 3691 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Substance Abuse and Mental Health Services Administration:						
Authorization Level	17	17	17	17	17	85
Estimated Outlays	5	14	16	17	17	69
Centers for Disease Control and Prevention:						
Authorization Level	−5	0	0	0	0	−5
Estimated Outlays	−2	−2	−1	*	*	−5
Total Changes:						
Authorization Level	12	17	17	17	17	80
Estimated Outlays	4	12	16	17	17	65

Notes: * = between $0 and −$500,000; details may not add to totals because of rounding.

Basis of estimate: For this estimate, CB0 assumes that H.R. 3691 will be enacted near the end of fiscal year 2016 and that spending will follow historical patterns for similar programs.

Substance abuse and mental health services administration

H.R. 3691 would reauthorize grants for residential treatment programs for pregnant and postpartum women. The authority for those grant programs at SAMHSA expired in 2003; however, the Congress has continued to appropriate funds each year. For fiscal year 2016, SAMHSA received an appropriation of $15.9 million for those programs. The bill also would require SAMHSA to establish a pilot program to award grants to support programs to treat substance abuse in pregnant and postpartum women and to fund an evaluation of the pilot program. The bill would authorize the appropriation of $16.9 million for these activities for each of fiscal years 2017 through 2021. Assuming appropriation of the specified amounts, CB0 estimates that implementing these provisions would cost about $69 million over the 2017–2021 period.

Centers for Disease Control and Prevention

Under current law, an authorization of appropriation of $138 million exists for 2017 for CDC activities related to bioterrorism and public health emergencies. H.R. 3691 would reduce the amount authorized by $5 million in 2017. Assuming appropriations are reduced accordingly, CBO estimates that implementing this provision would result in $5 million less in discretionary outlays for those activities over 2017–2021 period.

Pay-as-you-go considerations: None.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 3691 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

Intergovernmental and private-sector impact: H.R. 3691 contains no intergovernmental or private-sector mandates as defined in UMRA. Any costs incurred by states or local governments that apply for grants authorized by the bill would be incurred voluntarily as a condition of federal assistance.

Estimate prepared by: Federal Costs: Ellen Werble; Impact on State, Local, and Tribal Governments: Leo Lexi; Impact on the Private Sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 3691 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 3691 specifically directs to be completed 0 rule makings within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 states that the legislation may be cited as the "Improving Treatment for Pregnant and Postpartum Women Act of 2016."

Section 2. Reauthorization of residential treatment programs for pregnant and postpartum women

Section 2 reauthorizes Section 508 of the Public Health Service Act, residential treatment programs for pregnant and postpartum

women. Section 508 is reauthorized for fiscal years 2017 to 2021 for $16.9 million a year over those five years.

Section 3. Pilot program grants for state substance abuse agencies

Section 3 creates a pilot program under Section 508 of the Public Health Service Act to enhance flexibility in the use of funds to support family-based services for pregnant and postpartum women with a primary diagnosis of substance use disorder, including opioid use disorder, and help states identify gaps in service. This grant will also help promote coordinated, effective and efficient state systems.

Section 4. Cut-Go compliance

Section 4 reduces the authorization of Section 319D of the Public Health Service Act by $5,000,000 for fiscal year 2018 to bring the legislation into compliance with Cut-Go. This reduction is equal to the increase in authorization of appropriations above the last appropriated level for the program being reauthorized in Section 2 of H.R. 3691.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART B—FEDERAL-STATE COOPERATION

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SEC. 319D. REVITALIZING THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) FACILITIES; CAPACITIES.—

(1) FINDINGS.—Congress finds that the Centers for Disease Control and Prevention has an essential role in defending against and combatting public health threats domestically and abroad and requires secure and modern facilities, and expanded and improved capabilities related to bioterrorism and other public health emergencies, sufficient to enable such Centers to conduct this important mission.

(2) FACILITIES.—

(A) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may design, construct, and equip new facilities, renovate existing facilities (including laboratories, laboratory support buildings, scientific communication facilities, transshipment complexes, secured

and isolated parking structures, office buildings, and other facilities and infrastructure), and upgrade security of such facilities, in order to better conduct the capacities described in section 319A, and for supporting public health activities.

(B) MULTIYEAR CONTRACTING AUTHORITY.—For any project of designing, constructing, equipping, or renovating any facility under subparagraph (A), the Director of the Centers for Disease Control and Prevention may enter into a single contract or related contracts that collectively include the full scope of the project, and the solicitation and contract shall contain the clause "availability of funds" found at section 52.232–18 of title 48, Code of Federal Regulations.

(3) IMPROVING THE CAPACITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.—The Secretary shall expand, enhance, and improve the capabilities of the Centers for Disease Control and Prevention relating to preparedness for and responding effectively to bioterrorism and other public health emergencies. Activities that may be carried out under the preceding sentence include—

(A) expanding or enhancing the training of personnel;

(B) improving communications facilities and networks, including delivery of necessary information to rural areas;

(C) improving capabilities for public health surveillance and reporting activities, taking into account the integrated system or systems of public health alert communications and surveillance networks under subsection (b); and

(D) improving laboratory facilities related to bioterrorism and other public health emergencies, including increasing the security of such facilities.

(b) NATIONAL COMMUNICATIONS AND SURVEILLANCE NETWORKS.—

(1) IN GENERAL.—The Secretary, directly or through awards of grants, contracts, or cooperative agreements, shall provide for the establishment of an integrated system or systems of public health alert communications and surveillance networks between and among—

(A) Federal, State, and local public health officials;

(B) public and private health-related laboratories, hospitals, poison control centers, and other health care facilities; and

(C) any other entities determined appropriate by the Secretary.

(2) REQUIREMENTS.—The Secretary shall ensure that networks under paragraph (1) allow for the timely sharing and discussion, in a secure manner, of essential information concerning bioterrorism or another public health emergency, or recommended methods for responding to such an attack or emergency, allowing for coordination to maximize all-hazards medical and public health preparedness and response and to minimize duplication of effort.

(3) STANDARDS.—Not later than one year after the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the Secretary, in cooperation with health care providers and State and local public

health officials, shall establish any additional technical and reporting standards (including standards for interoperability) for networks under paragraph (1) and update such standards as necessary.

(c) MODERNIZING PUBLIC HEALTH SITUATIONAL AWARENESS AND BIOSURVEILLANCE.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Secretary, in collaboration with State, local, and tribal public health officials, shall establish a near real-time electronic nationwide public health situational awareness capability through an interoperable network of systems to share data and information to enhance early detection of rapid response to, and management of, potentially catastrophic infectious disease outbreaks, novel emerging threats, and other public health emergencies that originate domestically or abroad. Such network shall be built on existing State situational awareness systems or enhanced systems that enable such connectivity.

(2) STRATEGY AND IMPLEMENTATION PLAN.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Secretary shall submit to the appropriate committees of Congress a coordinated strategy and an accompanying implementation plan that identifies and demonstrates the measurable steps the Secretary will carry out to—

(A) develop, implement, and evaluate the network described in paragraph (1), utilizing the elements described in paragraph (3);

(B) modernize and enhance biosurveillance activities; and

(C) improve information sharing, coordination, and communication among disparate biosurveillance systems supported by the Department of Health and Human Services.

(3) ELEMENTS.—The network described in paragraph (1) shall include data and information transmitted in a standardized format from—

(A) State, local, and tribal public health entities, including public health laboratories;

(B) Federal health agencies;

(C) zoonotic disease monitoring systems;

(D) public and private sector health care entities, hospitals, pharmacies, poison control centers or professional organizations in the field of poison control, community health centers, health centers and clinical laboratories, to the extent practicable and provided that such data are voluntarily provided simultaneously to the Secretary and appropriate State, local, and tribal public health agencies; and

(E) such other sources as the Secretary may deem appropriate.

(4) RULE OF CONSTRUCTION.—Paragraph (3) shall not be construed as requiring separate reporting of data and information from each source listed.

(5) REQUIRED ACTIVITIES.—In establishing and operating the network described in paragraph (1), the Secretary shall—

(A) utilize applicable interoperability standards as determined by the Secretary, and in consultation with the Office of the National Coordinator for Health Information Technology, through a joint public and private sector process;

(B) define minimal data elements for such network;

(C) in collaboration with State, local, and tribal public health officials, integrate and build upon existing State, local, and tribal capabilities, ensuring simultaneous sharing of data, information, and analyses from the network described in paragraph (1) with State, local, and tribal public health agencies; and

(D) in collaboration with State, local, and tribal public health officials, develop procedures and standards for the collection, analysis, and interpretation of data that States, regions, or other entities collect and report to the network described in paragraph (1).

(6) CONSULTATION WITH THE NATIONAL BIODEFENSE SCIENCE BOARD.—In carrying out this section and consistent with section 319M, the National Biodefense Science Board shall provide expert advice and guidance, including recommendations, regarding the measurable steps the Secretary should take to modernize and enhance biosurveillance activities pursuant to the efforts of the Department of Health and Human Services to ensure comprehensive, real-time, all-hazards biosurveillance capabilities. In complying with the preceding sentence, the National Biodefense Science Board shall—

(A) identify the steps necessary to achieve a national biosurveillance system for human health, with international connectivity, where appropriate, that is predicated on State, regional, and community level capabilities and creates a networked system to allow for two-way information flow between and among Federal, State, and local government public health authorities and clinical health care providers;

(B) identify any duplicative surveillance programs under the authority of the Secretary, or changes that are necessary to existing programs, in order to enhance and modernize such activities, minimize duplication, strengthen and streamline such activities under the authority of the Secretary, and achieve real-time and appropriate data that relate to disease activity, both human and zoonotic; and

(C) coordinate with applicable existing advisory committees of the Director of the Centers for Disease Control and Prevention, including such advisory committees consisting of representatives from State, local, and tribal public health authorities and appropriate public and private sector health care entities and academic institutions, in order to provide guidance on public health surveillance activities.

(d) STATE AND REGIONAL SYSTEMS TO ENHANCE SITUATIONAL AWARENESS IN PUBLIC HEALTH EMERGENCIES.—

(1) IN GENERAL.—To implement the network described in subsection (c), the Secretary may award grants to States or consortia of States to enhance the ability of such States or consortia of States to establish or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies, in collaboration with appropriate public health agencies, sentinel hospitals, clinical laboratories, pharmacies, poison control centers, other health care organizations, and animal health organizations within such States.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), the State or consortium of States shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an assurance that the State or consortium of States will submit to the Secretary—

(A) reports of such data, information, and metrics as the Secretary may require;

(B) a report on the effectiveness of the systems funded under the grant; and

(C) a description of the manner in which grant funds will be used to enhance the timelines and comprehensiveness of efforts to detect, respond to, and manage potentially catastrophic infectious disease outbreaks and public health emergencies.

(3) USE OF FUNDS.—A State or consortium of States that receives an award under this subsection—

(A) shall establish, enhance, or operate a coordinated public health situational awareness system for regional or Statewide early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and public health emergencies;

(B) may award grants or contracts to entities described in paragraph (1) within or serving such State to assist such entities in improving the operation of information technology systems, facilitating the secure exchange of data and information, and training personnel to enhance the operation of the system described in subparagraph (A); and

(C) may conduct a pilot program for the development of multi-State telehealth network test beds that build on, enhance, and securely link existing State and local telehealth programs to prepare for, monitor, respond to, and manage the events of public health emergencies, facilitate coordination and communication among medical, public health, and emergency response agencies, and provide medical services through telehealth initiatives within the States that are involved in such a multi-State telehealth network test bed.

(4) LIMITATION.—Information technology systems acquired or implemented using grants awarded under this section must be compliant with—

(A) interoperability and other technological standards, as determined by the Secretary; and

(B) data collection and reporting requirements for the network described in subsection (c).

(5) INDEPENDENT EVALUATION.—Not later than 3 years after the date of enactment of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the Government Accountability Office shall conduct an independent evaluation, and submit to the Secretary and the appropriate committees of Congress a report concerning the activities conducted under this subsection and subsection (c).

(e) TELEHEALTH ENHANCEMENTS FOR EMERGENCY RESPONSE.—

(1) EVALUATION.—The Secretary, in consultation with the Federal Communications Commission and other relevant Federal agencies, shall—

(A) conduct an inventory of telehealth initiatives in existence on the date of enactment of the Pandemic and All-Hazards Preparedness Act, including—

(i) the specific location of network components;

(ii) the medical, technological, and communications capabilities of such components;

(iii) the functionality of such components; and

(iv) the capacity and ability of such components to handle increased volume during the response to a public health emergency;

(B) identify methods to expand and interconnect the regional health information networks funded by the Secretary, the State and regional broadband networks funded through the rural health care support mechanism pilot program funded by the Federal Communications Commission, and other telehealth networks;

(C) evaluate ways to prepare for, monitor, respond rapidly to, or manage the events of, a public health emergency through the enhanced use of telehealth technologies, including mechanisms for payment or reimbursement for use of such technologies and personnel during public health emergencies;

(D) identify methods for reducing legal barriers that deter health care professionals from providing telemedicine services, such as by utilizing State emergency health care professional credentialing verification systems, encouraging States to establish and implement mechanisms to improve interstate medical licensure cooperation, facilitating the exchange of information among States regarding investigations and adverse actions, and encouraging States to waive the application of licensing requirements during a public health emergency;

(E) evaluate ways to integrate the practice of telemedicine within the National Disaster Medical System; and

(F) promote greater coordination among existing Federal interagency telemedicine and health information technology initiatives.

(2) REPORT.—Not later than 12 months after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall prepare and submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House

of Representatives regarding the findings and recommendations pursuant to subparagraphs (A) through (F) of paragraph (1).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $138,300,000 for each of fiscal years 2014 [through 2018] *through 2016, $133,300,000 for fiscal year 2017, and $138,300,000 for fiscal year 2018*.

(g) DEFINITION.—For purposes of this section the term "biosurveillance" means the process of gathering near real-time biological data that relates to human and zoonotic disease activity and threats to human or animal health, in order to achieve early warning and identification of such health threats, early detection and prompt ongoing tracking of health events, and overall situational awareness of disease activity.

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TITLE V—SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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PART B—CENTERS AND PROGRAMS

Subpart 1—Center for Substance Abuse Treatment

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RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN

SEC. 508. (a) IN GENERAL.—The Director of the Center for Substance Abuse Treatment shall provide awards of grants, cooperative agreement, or contracts to public and nonprofit private entities for the purpose of providing to pregnant and postpartum women treatment for substance abuse through programs in which, during the course of receiving treatment—

(1) the women reside in facilities provided by the programs;

(2) the minor children of the women reside with the women in such facilities, if the women so request; and

(3) the services described in subsection (d) are available to or on behalf of the women.

(b) AVAILABILITY OF SERVICES FOR EACH PARTICIPANT.—A funding agreement for an award under subsection (a) for an applicant is that, in the program operated pursuant to such subsection—

(1) treatment services and each supplemental service will be available through the applicant, either directly or through agreements with other public or nonprofit private entities; and

(2) the services will be made available to each woman admitted to the program.

(c) INDIVIDUALIZED PLAN OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—

(1) in providing authorized services for an eligible woman pursuant to such subsection, the applicant will, in consultation with the women, prepare an individualized plan for the provision to the woman of the services; and

(2) treatment services under the plan will include—

(A) individual, group, and family counseling, as appropriate, regarding substance abuse; and

(B) follow-up services to assist the woman in preventing a relapse into such abuse.

(d) REQUIRED SUPPLEMENTAL SERVICES.—In the case of an eligible woman, the services referred to in subsection (a)(3) are as follows:

(1) Prenatal and postpartum health care.

(2) Referrals for necessary hospital services.

(3) For the infants and children of the woman—

(A) pediatric health care, including treatment for any perinatal effects of maternal substance abuse and including screenings regarding the physical and mental development of the infants and children;

(B) counseling and other mental health services, in the case of children; and

(C) comprehensive social services.

(4) Providing supervision of children during periods in which the woman is engaged in therapy or in other necessary health or rehabilitative activities.

(5) Training in parenting.

(6) Counseling on the human immunodeficiency virus and on acquired immune deficiency syndrome.

(7) Counseling on domestic violence and sexual abuse.

(8) Counseling on obtaining employment, including the importance of graduating from a secondary school.

(9) Reasonable efforts to preserve and support the family units of the women, including promoting the appropriate involvement of parents and others, and counseling the children of the women.

(10) Planning for and counseling to assist reentry into society, both before and after discharge, including referrals to any public or nonprofit private entities in the community involved that provide services appropriate for the women and the children of the women.

(11) Case management services, including—

(A) assessing the extent to which authorized services are appropriate for the women and their children;

(B) in the case of the services that are appropriate, ensuring that the services are provided in a coordinated manner; and

(C) assistance in establishing eligibility for assistance under Federal, State, and local programs providing health services, mental health services, housing services, employment services, educational services, or social services.

(e) MINIMUM QUALIFICATIONS FOR RECEIPT OF AWARD.—

(1) CERTIFICATION BY RELEVANT STATE AGENCY.—With respect to the principal agency of the State involved that administers programs relating to substance abuse, the Director may make an award under subsection (a) to an applicant only if the agency has certified to the Director that—

(A) the applicant has the capacity to carry out a program described in subsection (a);

(B) the plans of the applicant for such a program are consistent with the policies of such agency regarding the treatment of substance abuse; and

(C) the applicant, or any entity through which the applicant will provide authorized services, meets all applicable State licensure or certification requirements regarding the provision of the services involved.

(2) STATUS AS MEDICAID PROVIDER.—

(A) Subject to subparagraphs (B) and (C), the Director may make an award under subsection (a) only if, in the case of any authorized service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State involved—

(i) the applicant for the award will provide the service directly, and the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

(ii) the applicant will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement plan and is qualified to receive such payments.

(B)(i) In the case of an entity making an agreement pursuant to subparagraph (A)(ii) regarding the provision of services, the requirement established in such subparagraph regarding a participation agreement shall be waived by the Director if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits plan.

(ii) A determination by the Director of whether an entity referred to in clause (i) meets the criteria for a waiver under such clause shall be made without regard to whether the entity accepts voluntary donations regarding the provision of services to the public.

(C) With respect to any authorized service that is available pursuant to the State plan described in subparagraph (A), the requirements established in such subparagraph shall not apply to the provision of any such service by an institution for mental diseases to an individual who has attained 21 years of age and who has not attained 65 years of age. For purposes of the preceding sentence, the term "institution for mental diseases" has the meaning given such term in section 1905(i) of the Social Security Act.

(f) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—With respect to the costs of the program to be carried out by an applicant pursuant to subsection (a), a funding agreement for an award under such subsection is that the applicant will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that—

(A) for the first fiscal year for which the applicant receives payments under an award under such subsection, is

not less than $1 for each $9 of Federal funds provided in the award;

(B) for any second such fiscal year, is not less than $1 for each $9 of Federal funds provided in the award; and

(C) for any subsequent such fiscal year, is not less than $1 for each $3 of Federal funds provided in the award.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(g) OUTREACH.—A funding agreement for an award under subsection (a) for an applicant is that the applicant will provide outreach services in the community involved to identify women who are engaging in substance abuse and to encourage the women to undergo treatment for such abuse.

(h) ACCESSIBILITY OF PROGRAM; CULTURAL CONTEXT OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that—

(1) the program operated pursuant to such subsection will be operated at a location that is accessible to low-income pregnant and postpartum women; and

(2) authorized services will be provided in the language and the cultural context that is most appropriate.

(i) CONTINUING EDUCATION.—A funding agreement for an award under subsection (a) is that the applicant involved will provide for continuing education in treatment services for the individuals who will provide treatment in the program to be operated by the applicant pursuant to such subsection.

(j) IMPOSITION OF CHARGES.—A funding agreement for an award under subsection (a) for an applicant is that, if a charge is imposed for the provision of authorized services to on behalf of an eligible woman, such charge—

(1) will be made according to a schedule of charges that is made available to the public;

(2) will be adjusted to reflect the income of the woman involved; and

(3) will not be imposed on any such woman with an income of less than 185 percent of the official poverty line, as established by the Director of the Office for Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(k) REPORTS TO DIRECTOR.—A funding agreement for an award under subsection (a) is that the applicant involved will submit to the Director a report—

(1) describing the utilization and costs of services provided under the award;

(2) specifying the number of women served, the number of infants served, and the type and costs of services provided; and

(3) providing such other information as the Director determines to be appropriate.

(l) REQUIREMENT OF APPLICATION.—The Director may make an award under subsection (a) only if an application for the award is

submitted to the Director containing such agreements, and the application is in such form, is made in such manner, and contains such other agreements and such assurances and information as the Director determines to be necessary to carry out this section.

(m) EQUITABLE ALLOCATION OF AWARDS.—In making awards under subsection (a), the Director shall ensure that the awards are equitably allocated among the principal geographic regions of the United States, subject to the availability of qualified applicants for the awards.

(n) DURATION OF AWARD.—The period during which payments are made to an entity from an award under subsection (a) may not exceed 5 years. The provision of such payments shall be subject to annual approval by the Director of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. This subsection may not be construed to establish a limitation on the number of awards under such subsection that may be made to an entity.

(o) EVALUATIONS; DISSEMINATION OF FINDINGS.—The Director shall, directly or through contract, provide for the conduct of evaluations of programs carried out pursuant to subsection (a). The Director shall disseminate to the States the findings made as a result of the evaluations.

(p) REPORTS TO CONGRESS.—Not later than October 1, 1994, the Director shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing programs carried out pursuant to this section *(other than subsection (r))*. Every 2 years thereafter, the Director shall prepare a report describing such programs carried out during the preceding 2 years, and shall submit the report to the Administrator for inclusion in the biennial report under section 501(k). Each report under this subsection shall include a summary of any evaluations conducted under subsection (m) during the period with respect to which the report is prepared.

(q) DEFINITIONS.—For purposes of this section:

(1) The term "authorized services" means treatment services and supplemental services.

(2) The term "eligible woman" means a woman who has been admitted to a program operated pursuant to subsection (a).

(3) The term "funding agreement under subsection (a)", with respect to an award under subsection (a), means that the Director may make the award only if the applicant makes the agreement involved.

(4) The term "treatment services" means treatment for substance abuse, including the counseling and services described in subsection (c)(2).

(5) The term "supplemental services" means the services described in subsection (d).

(r) PILOT PROGRAM FOR STATE SUBSTANCE ABUSE AGENCIES.—

(1) IN GENERAL.—From amounts made available under subsection (s), the Director of the Center for Substance Abuse Treatment shall carry out a pilot program under which competitive grants are made by the Director to State substance abuse agencies to—

(A) enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

(B) help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential based settings; and

(C) promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery.

(2) REQUIREMENTS.—In carrying out the pilot program under this subsection, the Director shall—

(A) require State substance abuse agencies to submit to the Director applications, in such form and manner and containing such information as specified by the Director, to be eligible to receive a grant under the program;

(B) identify, based on such submitted applications, State substance abuse agencies that are eligible for such grants;

(C) require services proposed to be furnished through such a grant to support family-based treatment and other services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

(D) not require that services furnished through such a grant be provided solely to women that reside in facilities;

(E) not require that grant recipients under the program make available through use of the grant all services described in subsection (d); and

(F) consider not applying requirements described in paragraphs (1) and (2) of subsection (f) to applicants, depending on the circumstances of the applicant.

(3) REQUIRED SERVICES.—

(A) IN GENERAL.—The Director shall specify a minimum set of services required to be made available to eligible women through a grant awarded under the pilot program under this subsection. Such minimum set—

(i) shall include requirements described in subsection (c) and be based on the recommendations submitted under subparagraph (B); and

(ii) may be selected from among the services described in subsection (d) and include other services as appropriate.

(B) STAKEHOLDER INPUT.—The Director shall convene and solicit recommendations from stakeholders, including State substance abuse agencies, health care providers, persons in recovery from substance abuse, and other appropriate individuals, for the minimum set of services described in subparagraph (A).

(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

(5) EVALUATION AND REPORT TO CONGRESS.—The Director of the Center for Behavioral Health Statistics and Quality shall fund an evaluation of the pilot program at the conclusion of the first grant cycle funded by the pilot program. The Director of

the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on such evaluation. The report shall include at a minimum outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs; engagement in treatment services; retention in the appropriate level and duration of services; increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and other appropriate measures.

(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term "State substance abuse agency" means, with respect to a State, the agency in such State that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.

[(r)**]** *(s)* AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated **[**such sums as may be necessary to fiscal years 2001 through 2003**]** *$16,900,000 for each of fiscal years 2017 through 2021. Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.*

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