The GAO must also provide recommendations for improvements that will ensure access to treatment for infants with neonatal abstinence syndrome under state Medicaid programs.

Additionally, the measure modifies Medicaid to provide incentives for the development of abuse-deterrent formulations of prescription drugs and to prevent disclosure of Medicaid anti-fraud algorithms.

The bill requires that GAO's report identify the prevalence of neonatal abstinence syndrome in the United States, including the proportion of affected children who are eligible for Medicaid at birth and the costs associated with neonatal abstinence syndrome.

GAO will also be required to examine Medicaid-eligible services that are available for treatment of infants with neonatal abstinence syndrome, settings for such treatment, related reimbursement methodologies and costs, and the utilization of various care settings under state Medicaid programs for such treatment.

This GAO's report must be submitted to Congress within one year of the bill's enactment.

Seeking to right the same wrongs as H.R. 4978, the ''Nurturing And Supporting Healthy Babies Act,'' I introduced the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016,'' or the ''SIMARRA Act,'' which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders, by establishing a pilot program of critical-stage, developmental nurseries in Federal prisons for children born to inmates.

It is time that our nation recognizes a long-persistent need to break the cycle of generational, institutional incarceration amongst mothers serving time for non-violent crimes and the children they birth behind prison bars.

H.R. 5130, the, ''SIMARRA Act of 2016,'' gives those infants born to incarcerated mothers a chance to succeed in life.

''SIMARRA'' is not merely yet another second chance program, demanding leniency from the criminal justice system.

Instead, H.R. 5130 asks our national criminal justice system what it can do for those young Americans born and relegated to a life of nearly impossible odds of survival.

''SIMARRA'' provides that first chance—a first chance for American infants—that many of their mothers, born themselves to mothers behind bars, never received.

The bill excludes abuse-deterrent formulations of prescription drugs from Medicaid's additional rebate requirement for new prescription drug formulations, which is intended to encourage the development of these drugs by allowing drug companies to reduce the rebates they otherwise must pay to Medicaid.

The measure also limits disclosure of predictive modeling and other analytics technologies that are used to identify and prevent waste, fraud and abuse in Medicaid, including by exempting covered program integrity algorithms from the Freedom of Information Act (FOIA) and requiring state Medicaid and Children's Health Insurance Program (CHIP) agencies to have adequate data security policies to ensure the security of covered algorithms.

Finally, the measure makes $5 million available to the Medicaid Improvement Fund for expenditures for FY 2021 and beyond.

CBO estimates that enacting H.R. 4978 would not, on net, change direct spending over the 2017–2026 period.

While opponents argue that some provisions of the bill will increase direct spending by $80 million over that period, I point out that other provisions would decrease direct spending by the same amount balancing the total cost.

Enacting the legislation would affect direct spending, rather than revenues.

Under current law, pharmaceutical manufacturers are required to pay rebates to states for prescription drugs provided through Medicaid.

The formula which determines rebate amounts in the Medicaid program has several components, with some components generating rebates that are paid to states and shared with the federal government, and others generating rebates that are paid to states and subsequently transferred in their entirety to the federal government.

Abuse deterrent formulation, or ADF, is a new technology that is being implemented by the pharmaceutical industry to prevent the abuse of prescription pain medications.

For example, some ADFs make it more difficult for an individual to crush, break, or dissolve a drug to inappropriately extract and use its active ingredient.

Under the bill, the component of the rebate formula that would no longer apply to ADFs of brand-name drugs is one that is paid to states and transferred in full to the federal government.

Therefore, states would not be directly affected by this section of the bill.

CBO estimates that this section would increase federal Medicaid costs by about $75 million over the 2017–2026 period by reducing rebates.

CBO anticipates that an increasing number of ADFs of brand name drugs will launch over time; therefore, the component of the rebate affected by H.R. 4978 would also grow over time.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2026.

H.R. 4978 contains no intergovernmental or private-sector mandate as defined in UMRA and would impose no costs on state, local, or tribal governments.

In sum, H.R. 4978, the ''Nurturing & Supporting Healthy Babies Act,'' is a valuable piece of legislation that I encourage my colleagues to support.

Additionally, I urge my colleagues to join me in sponsoring and supporting all legislation targeting the improvement of care for the prevention of infant abuse and neglect, such as H.R. 5130, the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016'' or the ''SIMARRA Act.''

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 4978, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to require the Government Accountability Office to submit to Congress a report on neonatal abstinence syndrome (NAS) in the United States and its treatment under Medicaid, and for other purposes.''.

A motion to reconsider was laid on the table.

IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass 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, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3691

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act of 2015, introduced by my colleagues on the Energy and Commerce Committee, Mr. BEN RAY LUJÁN of New Mexico, Mr. TONKO of New York, Ms. CLARKE of New York, Ms. MATSUI of California, and Mr. CÁRDENAS of California.

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.

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 H.R. 3691 helps support residential treatment facilities where women and their children receive support, education, treatment, and counseling that they need to address opioid addiction and NAS. The newly created pilot program will allow States more flexibility in providing these services for women and children in need.

Mr. Speaker, I urge my colleagues to support this legislation.

I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise and voice my support for H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act. The Pregnant and Postpartum Women—PPW—program is administered by the Substance Abuse and Mental Health Services Administration—SAMHSA—Center for Substance Abuse Treatment.

The program was designed to expand the availability of comprehensive residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women and their children. The program provides grants to public and nonprofit private entities to provide substance use disorder treatment to women in residential facilities.

For too long our laws have taken a punitive approach with pregnant women and new mothers suffering from addiction. Criminal approaches have failed to work. Solutions should emphasize a nonpunitive, public health approach like the PPW program.

Substance abuse treatment that supports the family as a unit has proven effective for maintaining sobriety and enhancing child well-being. Given the magnitude of this epidemic, there is a need for increased availability of treatment options that are responsive to women's complex responsibilities.

H.R. 3691 reauthorizes residential treatment programs for pregnant and postpartum women. This vital program provides for substance use treatment for women in need as well as their minor children. Family-based treatment services include individual and family counseling, prenatal and postpartum care, and training on parenting.

The bill will also create a pilot program to allow up to 25 percent of the grants to be made for outpatient treatment services. This will give State substance abuse agencies greater flexibility to provide access to treatment and address gaps in delivery of care for pregnant and postpartum women, including services in nonresidential settings, and encourage new approaches of services available to pregnant women along the continuum of care.

I want to thank the bill's sponsor, Representative BEN RAY LUJÁN, who is a member of the Energy and Commerce Committee and the Health Subcommittee, for his leadership in introducing this bill.

I urge my colleagues to support the Improving Treatment for Pregnant and Postpartum Women Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 3691 so that pregnant and postpartum women can receive comprehensive, residential substance abuse treatment when fighting opioid drug addiction.

According to the National Perinatal Association, 4 percent of all live births in the U.S. occur in women who abuse illicit or prescription drugs, such as

opioid pain relievers. This would equate to 159,436 births in 2014 from women who abuse illicit or prescription drugs.

This is simply unacceptable. We must take action to ensure that pregnant and postpartum women receive the care they need to protect American families.

H.R. 3691 simply states that support should be extended for residential substance abuse treatment programs for pregnant and postpartum women through 2020 and the Center for Substance Abuse Treatment should carry out a pilot program to make grants to State substance abuse agencies to support services for pregnant and postpartum women who have a substance abuse disorder.

By extending these services and working through this pilot program, we can ensure that pregnant and postpartum women can receive the care that they need so that they can care for their families. That is why I am supporting H.R. 3691.

I encourage my colleagues to support this bill so we can extend care to all mothers and soon-to-be mothers who fight drug addiction.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentleman from New Mexico (Mr. BEN RAY LUJÁN), the cosponsor of the bill.

Mr. BEN RAY LUJÁN of New Mexico. Mr. Speaker, I would like to start by thanking the chairman and ranking member of the Energy and Commerce Committee and the Subcommittee on Health for their bipartisan efforts to address the Nation's drug crisis and for advancing my legislation, the Improving Treatment for Pregnant and Postpartum Women Act.

Our Nation continues to face a substance abuse crisis that is tearing apart communities and families. In New Mexico, we have seen a crisis that is multi-generational, with people growing up in communities where abuse is commonplace.

The grant program for residential treatment that my bill enhances is an important part of our effort to break the cycle of drug abuse that grips our communities. My bill would also increase funding for the Pregnant and Postpartum Women grant.

As originally written, my bill contained an authorization of $40 million, significantly above the current level, to avoid any cuts to existing residential programs. Through bipartisan cooperation, we arrived at a small increase over the next 5 years.

By focusing on women with young children and soon-to-be mothers, we help ensure that these families get on the right path from the very beginning. People want to be better. But, unfortunately, too often there are too few resources and avenues for help.

Certainly this is true in New Mexico, which is among the States most impacted by the epidemic plaguing our country. Too many people are suffering, and too many people are being shut out from access to help.

This bill helps address this by creating a demonstration project in the existing Pregnant and Postpartum Women grant program to allow grants to be used for nonresidential care.

Residential programs are critically important where they are available. In my home State of New Mexico, there are far too few residential programs to serve the needs of my constituents. In addition, many of the existing facilities have wait lists. With New Mexico's vastness, residential facilities are out of reach for too many.

That is why this demonstration project is critical. It will allow us, while continuing to support residential treatment programs, to explore how to ensure the services and care we are providing work for those in need.

While I am pleased that we have been able to work together across the aisle in an effort to authorize increased funding and ensure the inclusion of the demonstration project, I think it is important to say more must be done.

Supporting residential facilities and innovation to make treatment more available is essential, and both will require significant investments.

Mr. Speaker, in 2014, 47,055 people died from drug overdoses. That is 129 people per day. We must do more.

I hope that, as we continue this conversation beyond today, we can all come to recognize the need for funding above and beyond what we are doing today.

I respectfully ask for support of this bill.

Mr. GUTHRIE. Mr. Speaker, I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentlewoman from Texas (Ms. JACKSON LEE), my colleague and neighbor from Houston.

Ms. JACKSON LEE. Mr. Speaker, let me congratulate the gentleman from Texas for his leadership and the gentleman from New Mexico for his outstanding leadership on this important legislation and his concern and passion.

Let me thank my friends who are managing the legislation and let the American people know and our colleagues know that we are continuing our commitment on dealing with the issues of addiction, in this instance, opioid. And, of course, we know that there are other forms of addiction, from alcohol, to crack, to cocaine, but we are moving forward.

I rise to support H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act of 2015. It is clear that this is an issue that has plagued both the woman and as well the newborn baby.

Let me offer to say that President Obama has updated that guideline to encourage doctors to be more cautious when prescribing opioid painkillers and to emphasize nonopioid therapies for certain conditions. Many times women who are pregnant are under treatment.

Additionally, the Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services. In the President's FY 2017 budget, the administration proposed $1.1 billion to combat drug addition considering modifying certain rules to improve treatment.

As misuse of opioids have increased over the past decade, so has the incidence of neonatal abstinence syndrome, referring to the medical effects on newborn infants suffering from drug withdrawal because their mothers were drug addicts.

The GAO report found that a lack of available treatment programs for pregnant women and newborns with neonatal abstinence syndrome, including the availability of comprehensive care and enabling services, such as transportation and child care, has hampered Federal efforts to address the issue.

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I am glad that this bill, which is why I rise to support it, reauthorizes residential treatment grant programs for pregnant and postpartum women who have substance abuse problems—programs that are administered by the Health and Human Service Department's Center for Substance Abuse Treatment, increasing the authorized funding level by 6 percent. This gives me an opportunity to say that, with regard to all of these bills, I know that we will all join together to make sure the right funding is available for these bills to really work.

I join in support of this legislation and add to it legislation that I have introduced, Improving Safe Care for the Prevention of Infant Abuse and Neglect Act, and, which I introduced recently, the Stop Infant Mortality and Recidivism Reduction Act of 2016, which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders by establishing a pilot program of critical stage development nurseries in Federal prisons for children born to inmates. Likewise, at that time, one may discover the concerns that are being expressed here today.

However, the Improving Treatment for Pregnant and Postpartum Women Act of 2016, also establishes a pilot program to provide grants to State substance abuse agencies to promote innovative service delivery models for pregnant women who have a substance use disorder, such as opioid addiction, including for family-based services in nonresidential settings.

This is a good bill because it is more than the adult who is being treated here. It is a good bill because we are concerned about the newborn, the innocent baby who needs to have a start in life. In this instance, this legislation will both treat the mother and provide assistance—residential and nonresidential care—so that these individuals can have the starts in life that they need.

Let us be reminded of the fact that this addiction of these drugs becomes

an illness. We have seen overdoses that cause the loss of life. Let us be part of stemming the tide, but, more importantly, let us help those who are trying to hang onto life and to start a new life. This legislation does that, and I ask my colleagues to support it.

Again, I thank the gentleman from Texas for his leadership, and I thank him for yielding to me.

Mr. Speaker, I rise in support of H.R. 3691, the ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' that was approved by the Energy and Commerce Committee.

In the past decade and a half, the growth in the number of physicians prescribing opioids to help patients deal with pain from surgeries, dental work and chronic conditions has resulted in an increasing number of patients becoming dependent on the powerful and highly addictive painkillers—with patients not only abusing the use of those painkillers but often turning to heroin once their opioid prescription ended.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States.

It is estimated that in 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

The Health and Human Services Department estimates that the number of unintentional overdose deaths from prescription painkillers almost quadrupled between 1999 and 2013.

Abuse of prescription opioids now kills nearly 30,000 Americans each year.

Both states and the federal government have begun responding to this growing public health crisis, with many states moving to make anti-overdose drugs more available and shield first-responders from liability in administering those drugs.

President Obama, meanwhile, has updated prescribing guidelines to encourage doctors to be more cautious when prescribing opioid painkillers and to emphasize non-opioid therapies for certain conditions.

Additionally, the Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services.

In the president's FY 2017 budget the administration proposed $1.1 billion to combat drug addiction, considering modifying certain rules to improve treatment.

As misuse of opioids has increased over the past decade, so has the incidence of neonatal abstinence syndrome, referring to the medical effects on newborn infants suffering from drug withdrawal because their mothers were drug addicts.

A 2015 Government Accountability Office (GAO) report found that a lack of available treatment programs for pregnant women and newborns with neonatal abstinence syndrome, including the availability of comprehensive care and enabling services such as transportation and child care, has hampered federal efforts to address the issue.

This bill reauthorizes residential treatment grant programs for pregnant and postpartum women who have substance abuse problems that are administered by the Health and Human Services (HHS) Department's Center for Substance Abuse Treatment, increasing the authorized funding level by 6%.

Seeking to right the same wrongs as H.R. 4843, the ''Improving Safe Care for the Prevention of Infant Abuse and Neglect Act,'' I introduced the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016,'' or the ''SIMARRA Act,'' which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders, by establishing a pilot program of critical-stage, developmental nurseries in Federal prisons for children born to inmates.

It is time that our nation recognizes a long-persistent need to break the cycle of generational, institutional incarceration amongst mothers serving time for non-violent crimes and the children they birth behind prison bars.

H.R. 5130, the, ''SIMARRA Act of 2016,'' gives those infants born to incarcerated mothers a chance to succeed in life.

''SIMARRA'' is not merely yet another second chance program, demanding leniency from the criminal justice system.

Instead, H.R. 5130 asks our national criminal justice system what it can do for those young Americans born and relegated to a life of nearly impossible odds of survival.

''SIMARRA'' provides that first chance—a first chance for American infants—that many of their mothers, born themselves to mothers behind bars, never received.

The ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' also establishes a pilot program to provide grants to state substance abuse agencies to promote innovative service delivery models for pregnant women who have a substance use disorder, such as opioid addiction, including for family-based services in nonresidential settings.

Of the amounts appropriated for the HHS residential treatment program, up to 25% would be available to carry out the pilot program.

No funds would be made available to carry out the pilot program for a fiscal year, however, unless the amount made available to carry out the residential treatment program for the fiscal year is more than the comparable amount made available for FY 2016.

The Senate on March 10, 2016, passed by a 94–1 vote, S 524, an antiopioid abuse bill that would authorize grants for opioid treatment services and first-responder training in using anti-overdose drugs, as well as create a task force to review and update best practices for prescribing pain medication.

The measure offsets the increased authorization through a $5 million reduction in the existing FY 2017 authorization for Centers for Disease Control (CDC) public health capability enhancement activities.

Under current law, $138.3 million is authorized for those activities each year through FY 2018.

The Congressional Budget Office (CBO) has not yet released a cost estimate for the bill.

H.R. 3691 would also mandate investigations into heroin distribution and unlawful distribution of prescription opioids, and require the creation of a national drug awareness campaign that takes into account the association between prescription opioid abuse and heroin use.

This week we are scheduled to consider a series of more than a dozen bills that address the opioid abuse problem facing America.

This measure reauthorizes grants from HHS's Center for Substance Abuse Treatment to public and nonprofit private entities that provide residential substance abuse treatment for pregnant and postpartum women, authorizing $16.9 million each year through FY 2021—$1 million (6%) more than the current $15.9 million authorization.

Under the pilot grant program, proposed services for eligible pregnant and postpartum women would not have to be provided solely to women who reside in facilities.

However, the center must specify a minimum set of services, including substance abuse counseling, and it must solicit stakeholder input.

The bill directs HHS's Center for Behavioral Health Statistics and Quality to fund an evaluation of the pilot program at the conclusion of the first grant cycle.

Under the program, grant recipients are required to provide an individualized plan of services for each participating woman that includes substance abuse counseling and certain supplemental services, such as pediatric health care for the woman's children.

The measure directs the Center for Substance Abuse Treatment to carry out a five-year pilot grant program to help state substance abuse agencies address identified gaps in the services that are furnished to pregnant and postpartum women with substance abuse issues, and encourage new approaches and models of service delivery.

H.R. 3691, the ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' is a valuable piece of legislation that I encourage my colleagues to support.

Additionally, I urge my colleagues to join me in sponsoring and supporting all legislation targeting the improvement of care for the prevention of infant abuse and neglect, such as H.R. 5130, the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016'' or the ''SIMARRA Act.''

Mr. GENE GREEN of Texas. Mr. Speaker, I have no further requests for time.

I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I encourage all of my colleagues to vote for H.R. 3691.

I yield back the balance of my time.

The SPEAKER pro tempore (Mr. JODY B. HICE of Georgia). The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 3691, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

VETERAN EMERGENCY MEDICAL TECHNICIAN SUPPORT ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1818) to amend the Public Health Service Act to provide grants to States to streamline State requirements and procedures for veterans with military emergency medical training to become civilian emergency medical technicians, as amended.