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Senate

The Senate was not in session today. Its next meeting will be held on Monday, June 25, 2018, at 3 p.m.

House of Representatives

FRIDAY, JUNE 22, 2018

The House met at 9 a.m. and was called to order by the Speaker pro tempore (Mr. BACON).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
June 22, 2018.

I hereby appoint the Honorable DON BACON to act as Speaker pro tempore on this day.

PAUL D. RYAN,
Speaker of the House of Representatives.

PRAYER

The Chaplain, the Reverend Patrick J. Conroy, offered the following prayer:

God of grace and goodness, thank You for giving us another day.

These are days fraught with important and contentious issues that go to our core as a nation. It is difficult to resolve the different priorities and positions regarding immigration and our borders.

Help all Members to be their best selves so that we, as a nation, can be our best self. Endow them with the wisdom of Solomon, the patience of Job, and compassion to be a shining example of a people intent on making the world a better place, especially for those whose burdens in life seem insurmountable.

May all that is done this day be for Your greater honor and glory.

Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER pro tempore. The question is on the Speaker's approval of the Journal.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 8, rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Florida (Mr. MAST) come forward and lead the House in the Pledge of Allegiance.

Mr. MAST led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain up to five requests for 1-minute speeches on each side of the aisle.

CELEBRATING RELIGIOUS FREEDOM WEEK

(Mr. THOMPSON of Pennsylvania asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. THOMPSON of Pennsylvania. Mr. Speaker, today marks the beginning of Religious Freedom Week.

Freedom of religion is a fundamental human right and protected by our Constitution. The First Amendment's protection of freedom of religion, along with the freedom of speech and the press, afford us the opportunity to have open and thoughtful debates on the floor of the House every day, and it protects the space in which members of all religions can peacefully join together and solve the world's most pressing issues.

For thousands of years, people have sought the freedom to practice their religion without the fear of persecution. Since our founding, we have continued to recognize freedom for all.

Our great Nation and its foundation of freedom and liberty for all were conceived by individuals in search of religious freedom.

Mr. Speaker, the United States of America will always be a beacon of light in the world, and we will always

protect our fundamental unified commitment of religious freedom. It is a central part of what makes us exceptional and affords our citizens the right to live in a free society.

ISSUES OF IMMIGRATION

(Ms. TSONGAS asked and was given permission to address the House for 1 minute.)

Ms. TSONGAS. Mr. Speaker, I want to enter into the RECORD two haunting stories from migrant mothers reported this month.

The first, ''Don't take my child away,'' said a mother, and her child started screaming and vomiting and crying hysterically. And she asked the officers, ''Can I at least have 5 minutes to console her?'' They declined.

And next, another mother set her 2-year-old daughter down and an agent began to run gloved hands across her body. Immediately, the girl began to scream. It all happened so quickly, and the girl's despair was so complete in those few seconds. She would be taken from her mother when the van reached its destination.

There are more than 2,300 similarly heartbreaking and unimaginable stories.

The Trump administration cannot undo the trauma and terror they have caused, but they must immediately outline their plan to reunite these loved ones.

KNOB NOSTER HIGH SCHOOL LADY PANTHERS ARE STATE CHAMPIONS

(Mrs. HARTZLER asked and was given permission to address the House for 1 minute.)

Mrs. HARTZLER. Mr. Speaker, I rise today to congratulate the Knob Noster High School Lady Panthers track team on winning the 2018 Class 2 Missouri State Track Championship.

The Lady Panthers' win marks the first women's team State championship in their school's history. The Lady Panthers took home the title with 50 team points after rain delayed the final track events for nearly 2 hours.

In addition to winning the State championship, the Lady Panthers' Jessica Sader recorded the second furthest javelin throw in Missouri history to claim the Class 2 title. Sader won her third straight title, throwing 143 feet, breaking her own Class 2 State record of 134.6 feet.

The team's outstanding accomplishments mark a great milestone for the girls track team and its coaches and creates a legacy that will be cherished and heralded for years to come.

Mr. Speaker, please join me in congratulating the Knob Noster High School Lady Panthers on this momentous achievement.

PRESIDENT TRUMP'S IMMIGRATION POLICY

(Ms. ADAMS asked and was given permission to address the House for 1 minute.)

Ms. ADAMS. Mr. Speaker, I rise today in support of the thousands of families being ripped apart by President Trump. Like the majority of Americans, I vehemently oppose Trump's cruel and immoral zero-tolerance policy.

In less than 2 months, nearly 2,000 children have been snatched from their parents. Why? Because this administration is willing to use toddlers as bargaining chips for a wall.

This Trump-created nightmare is absolutely unacceptable. This executive order does nothing to stop immigrant families from being detained. What a shame.

Congress has the responsibility to act and create a bipartisan solution. The Ryan immigration bill is not that. It codifies hatred, putting families at greater risk.

I urge my colleagues to abandon this hyperpartisanship and find a way to keep all families together and to reunite these children with their parents.

TAX CUTS PROMOTE JOBS

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, last week the National Federation of Independent Business released their May Small Business Optimism Index, which is the highest Small Business Optimism rating in history.

The NFIB reports that expansion plans for small businesses have hit an all-time high. The positive sales trends for independent businesses are at their highest level since 1995.

These statistics show that the Republican tax cuts and President Donald Trump's economic deregulation have promoted jobs.

Thanks to the Tax Cuts and Jobs Act, the National Association of Manufacturers, led by President Jay Timmons, reports 77 percent of manufacturers plan to increase hiring, and 72 percent plan to increase wages or benefits.

Current unemployment is 3.8 percent, the lowest level in almost 50 years. In addition, African American unemployment is the lowest ever recorded.

In conclusion, God bless our troops, and we will never forget September the 11th in the global war on terrorism.

Our sympathy to the family and talented associates of Charles Krauthammer, a megastar for truth on FOX News.

RECOGNIZING THE CAREER OF DOM BETRO

(Mr. TAKANO asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. TAKANO. Mr. Speaker, I rise today to commend the career of Dom Betro, a resident of my district, who is retiring this month as the president and CEO of the Family Service Association of Western Riverside County.

Over the last 33 years, Dom has overseen phenomenal growth in the impact of this agency, which today helps more than 75,000 people a year. Under Dom's leadership, the FSA developed more than 90 units of senior housing and provided counseling and childcare service to countless individuals.

Dom's record of public service includes volunteer work for organizations such as the Nonprofit Policy Counsel of California. He is a lecturer at California State University San Marcos and served for 4 years on the City of Riverside City Council.

The legacy of Dom's dedication to the Inland Empire will continue long after his retirement. He has made our community a better place to live. On behalf of my constituents, I want to thank him for his service.

HOW MUCH POLLUTION IS TOO MUCH?

(Mr. MAST asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MAST. Mr. Speaker, today is day 22 of water exactly like this being discharged into my community in Lake Okeechobee. You can see exactly how disgusting it is.

What you cannot see is the disgusting smell that emanates from it. You cannot see the toxins that are inside of it. You cannot see the airborne pathogens that come off of it.

What you see behind me is a satellite image of the hundreds of square miles of algae bloom that are in this lake that are being discharged miles and miles away into my community.

My community did not put the algae bloom on the lake; they did not put the nutrients into the lake that caused this algae bloom; but my community pays the price, all under the umbrella of flood control for other communities.

I believe my community is owed, at a minimum, one answer: How much pollution is too much? How much danger to our community is too much? How much before this will stop?

CELEBRATING GROWN FLOWER MONTH

(Mr. CARBAJAL asked and was given permission to address the House for 1 minute.)

Mr. CARBAJAL. Mr. Speaker, this July, our Nation will come together to celebrate American Grown Flower Month and the contributions of the cut flower industry to our country.

The cut-flower industry generates thousands of jobs across our State and produces $1.13 billion in economic activity each year through flower farmers, distributors, and florists.

Whether it is celebrating Mother's Day, an anniversary, or a graduation, flowers have been used to mark special occasions for thousands of years.

California, alone, produces a staggering three-quarters of all cut flowers grown in the United States. During my visits to flower growers and artistic florists on the central coast of California, I have seen firsthand the value of the flower industry as an economic engine in our region.

By designating July as American Grown Flower Month, we celebrate the incomparable beauty of flowers and what they bring to our homes and our celebrations year-round.

HONORING THE LIFE OF ALIVEA COX

(Mr. CARTER of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CARTER of Georgia. Mr. Speaker, I rise today to remember Alivea Cox of Richmond Hill, Georgia, a kind-hearted 14-year-old who passed away on June 4, hours after being diagnosed with a rare form of cancer.

We can all be inspired by her passion for life, exemplified in her hobbies and her ability to make everyone around her a little happier every day.

Alivea was musically talented, playing the French horn, the trumpet, and the piano. Her middle school band teacher recognized her for both outstanding musical talent and outstanding character.

Alivea cofounded a weekly prayer club for students modeled after 1 Timothy 4:12.

In a letter to a teacher, she mentioned important life lessons she learned: to be patient with yourself and others, and that bad days do not define you.

I offer my deepest sympathy to her parents, her family, schoolteachers, and her friends.

RECOGNIZING NEPHCURE KIDNEY INTERNATIONAL

(Mr. DEUTCH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DEUTCH. Mr. Speaker, I rise today to recognize the work of NephCure Kidney International.

Roughly 31 million Americans live with kidney disease, and 3 in every 100,000 people suffer from nephrotic syndrome.

Nephrotic syndrome is not a disease itself; rather, it is an umbrella term for the signs and symptoms that result from damage in the kidneys' filtering units.

NephCure Kidney International is the only organization committed exclusively to supporting research into finding the cause of the kidney disease focal segmental glomerulosclerosis, or FSGS, and nephrotic syndrome.

I am proud of the work of this organization and their leaader, Dr. Irving Smokler, NephCure's president and founder and a constituent of mine.

In 1999, Dr. Smokler launched the NephCure Foundation, inspired by his son, Matthew, who was diagnosed with FSGS when he was just 11 years old.

Dr. Smokler has since dedicated himself to the fulfillment of the foundation's mission: to find the cause of and cure for FSGS and nephrotic syndrome.

Mr. Speaker, today I call on all of our colleagues to recognize and support the goals of this important organization and to support robust funding for research at NIH to help find a cure for FSGS and nephrotic syndrome.

SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT

GENERAL LEAVE

Mr. WALDEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous materials on H.R. 6.

The SPEAKER pro tempore (Mr. CARTER of Georgia). Is there objection to the request of the gentleman from Oregon?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 949 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 6.

The Chair appoints the gentleman from Nebraska (Mr. BACON) to preside over the Committee of the Whole.

□ 0916

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 6) to provide for opioid use disorder prevention, recovery, and treatment, and for other purposes, with Mr. BACON in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

Pursuant to the order of the House of June 21, 2018, general debate shall not exceed 1 hour, with 40 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce and 20 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Ways and Means.

The gentleman from Oregon (Mr. WALDEN) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes. The gentleman from Texas (Mr. BRADY) and the gentleman from Massachusetts (Mr. NEAL) each will control 10 minutes.

The Chair recognizes the gentleman Oregon.

Mr. WALDEN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today in support of H.R. 6. This is the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, or the SUPPORT for Patients and Communities Act.

I was proud to introduce this bill with my bipartisan colleagues: Energy and Commerce Committee ranking member, my friend from New Jersey, Mr. PALLONE; Ways and Means Committee Chairman KEVIN BRADY; and Ways and Means Ranking Member RICHARD NEAL.

These past 2 weeks, this House, the people's House, has dedicated tremendous amounts of time and energy to send a simple message to millions of Americans impacted by the opioid crisis. And that message is: Help is on the way.

Not only are we passing legislation, dozens and dozens of bills that will save lives, but also we want to leave no doubt in the minds of those suffering from addiction that the United States House of Representatives, Republicans and Democrats alike, stand with them together.

For too long, embarrassment and stigma surrounded the disease of addiction. It is time for that to change. If you are struggling with addiction, if you are fighting that invisible battle, please know that it is okay to seek help.

Opioid overdoses take the lives of more than 100 Americans each and every day. In fact, Mr. Chairman, a thousand people in our country will go to an emergency room in the next 24 hours, suffering an overdose from opioids. We don't want those people to become part of that deadly statistic.

You matter. You are worthwhile. And I pray that the various legislation we vote on here today, and that we voted on throughout the last 2 weeks, can help you begin your journey of recovery.

H.R. 6 includes several bills that went through regular order at the Energy and Commerce and Ways and Means Committees, but the bill we will vote on today also includes dozens of other pieces of legislation that have recently passed the House, most unanimously or with very strong bipartisan majorities.

You see, at a time when it seems we couldn't be more divided, it is clear that striking back against addiction is something that transcends politics and brings us together as a community, as a country, and as a Congress.

Remember, this legislation is not the first action that this Congress has taken to combat the opioid crisis, and I am sure it will not be the last. I guarantee you that.

The Comprehensive Addiction Recovery Act and the 21st Century Cures Act, both of which were signed into law nearly 2 years ago, and an additional $4 billion in resources for States and communities that was provided in the omnibus appropriations bill just a few

months ago, indicate we have been at this for awhile, and we will be at this for a while longer.

Taken together, this is one of the most significant congressional efforts against a drug crisis in our Nation's history. But we must continue to legislate, evaluate, conduct oversight, and work together to provide new solutions, so that we can rise to this ever-challenging situation.

Today, we have an opportunity to continue our work to combat this crisis, an opportunity to save lives, and we cannot let it pass. The legislation before us will help advance treatment and recovery initiatives, improve prevention and educational efforts, protect our communities, and bolster our efforts to fight deadly synthetic drugs like fentanyl.

We owe it to the families we have heard from. We owe it to our friends. Our communities need this and our country needs this to lift our people out of addiction and, together, win this fight.

Mr. Chair, I urge my colleagues to support H.R. 6, the SUPPORT for Patients and Communities Act, and I reserve the balance of my time.

Mr. PALLONE. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in support of H.R. 6, the SUPPORT for Patients and Communities Act. This bill makes incremental changes to support those affected by the opioid crisis, but it is far from perfect.

H.R. 6 does not adequately deal with the magnitude of the crisis that this country is facing, and there are provisions that I did not support at the subcommittee or full committee markup, including provisions that most Democrats voted against. Nonetheless, I am pleased that Democrats were able to secure positive provisions in the final package that we are considering today.

Most notably, H.R. 6 includes provisions from a bill introduced by Representative TONKO and Representative LUJÁN that would extend access to evidence-based, medication-assisted treatment. Specifically, this section of the bill will allow advanced practice registered nurses, including midwives, to treat patients with buprenorphine for opiate use disorder for 5 years. The bill will also allow nurse practitioners and physician assistants to treat patients with buprenorphine permanently, and allow qualified providers to treat up to 100 patients instead of 30 patients in their first year.

This is a critical step forward in the expansion of treatment, one of the major challenges that we continue to face in the fight against this epidemic.

Mr. Chair, I commend Representative TONKO and Representative LUJÁN for their ongoing leadership in this area.

This bill also expands coverage through Medicare by adding methadone clinics to the Medicare program. Right now, methadone clinics are not Medicare providers. Seniors who want to get treatment from methadone clinics have to pay out of pocket. Adding methadone clinics will address an important coverage gap in the Medicare program and meaningfully expand access to treatment for opiate use disorders.

The bill also improves coverage for vulnerable populations in Medicaid, ensures coverage for former foster youth up to the age of 26 nationwide, and supports State efforts to ensure continuity of coverage for people with substance use disorders as they leave incarceration.

The bill will also provide funding to Medicaid substance use disorder health homes, give States money to expand the treatment capacity of Medicaid providers, and raise reimbursement rates. It also mandates coverage of Medicaid for all forms of medication-assisted treatment for 5 years.

The legislation also mandates comprehensive substance use disorder benefits in the Children's Health Insurance Program, better known as CHIP. I am also pleased that H.R. 3528, the Every Prescription Conveyed Securely Act, authored by Representative CLARK of Massachusetts, is included in the bill. E-prescribing is an important tool that will reduce opiate diversion and prescription fraud.

Further, the bill gives the Secretary of HHS the authority to expand the use of telehealth services in Medicare for substance use disorder treatment to help reach more people across the country.

These were all important Democratic provisions and priorities that we worked hard to have included in the final package. I think these will all make a real difference in our fight against the opioid epidemic.

Having said that, Mr. Chairman, I still have concerns with some of the provisions included in this final negotiated bill and the process by which we arrived here. For instance, there are two Medicare bills that I opposed through the committee process that I am concerned may not have a meaningful impact on the opioid crisis.

H.R. 5804 would increase reimbursement for certain interventional pain injections in the ambulatory surgery setting under Medicare. I have seen no evidence that increasing reimbursement for these injections would have a meaningful impact on opioid prescribing. While it is important that Congress finds ways to promote nonopioid therapies that will reduce opioid prescribing, this legislation endorses and incentivizes interventions that may not be effective for a majority of the patients receiving them.

I also have some concerns about H.R. 5809, which would extend a temporary pass-through payment for nonopioid analgesics for postsurgical pain management from 3 to 5 years in Medicare. I do question if this bill will have a meaningful impact on the opioid crisis.

I am also disappointed that partisan legislation that would direct the FDA to issue guidance on how the agency will apply the criteria for accelerated approval and breakthrough therapy designation to nonaddictive pain and addiction treatment was included in this package. This legislation would set the precedent of having the FDA opine on how expedited programs may apply differently for therapeutic areas.

It requires the agency to host a public meeting to discuss this and other topics, but provides no resources for the agency to complete these tasks. This is not legislation that FDA asked for or highlighted as a priority in fighting the opioid crisis.

While they may now be comfortable with the changes that have been made to the bill, I am not comfortable with the policy.

Finally, Mr. Chairman, I think it is essential that we keep this opioid package in the context of a larger healthcare debate in Congress. As I have stated before, my Republican colleagues are interested in taking credit today for some policies that helped those affected by the crisis while at the same time actively threatening and sabotaging the very healthcare coverage that many of the same people rely on in the first place. The ongoing efforts by House Republicans and the Trump administration to repeal or sabotage the Affordable Care Act have only harmed those affected by this crisis.

Earlier this month, Republicans directly threatened the healthcare of people with opioid use disorder when the Trump administration asked a Federal court to strike down key patient protections in the Affordable Care Act. If successful, the Trump administration's action would eliminate protections that ensure more than 130 million Americans with preexisting conditions cannot be denied coverage. And guess what is considered to be a preexisting condition? Opioid use disorders and people with it.

Republicans also continue with their attempts to gut the Medicaid program, which is our most important weapon in the fight against this epidemic. Both the consumer protections of the ACA and Medicaid have saved countless lives that would have otherwise been destroyed by the opioid crisis. So it is nice that we are passing this bipartisan package today, but we should not forget the tremendous harm Republican policies would inflict elsewhere on the same people we seek to help with this opioid package.

Mr. Chair, I reserve the balance of my time.

Mr. WALDEN. Mr. Chairman, I yield 1 minute to the gentleman from Kentucky (Mr. GUTHRIE), the vice chairman of the Subcommittee on Health, a great leader on these issues and more.

Mr. GUTHRIE. Mr. Chair, I thank the gentleman for yielding, and I rise in support of the SUPPORT for Patients and Communities Act.

Kentucky has been one of the hardest hit by our Nation's opioid crisis, and I have heard from many Kentuckians

across the Second District about the devastating effects the opioid crisis is having in the Commonwealth.

Parents have lost children to opioid use disorder. Employers are having a hard time finding employees. And the opioid crisis has taken a terrible toll on our communities.

Last Congress, I was proud to work with my colleagues as we crafted the Comprehensive Addiction and Recovery Act. We also passed the 21st Century Cures Act. We have come together to build on those two laws with more legislation to address the ongoing opioid epidemic. Over the past 2 weeks, we have passed more than 50 bills out of the House, including my bill, the Comprehensive Opioid Recovery Centers Act.

Today, we vote on the SUPPORT for Patients and Communities Act, the culmination of our work over the past year to combat the opioid crisis.

I urge my colleagues to support this important bill that will help all Americans affected by this awful epidemic.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Chairman, I rise in support of H.R. 6, and I thank our ranking member for yielding time to me.

There isn't any question that our country is in the midst of a destructive opioid epidemic that claims 142 lives every day. This is a national crisis, and it is our duty as Members of Congress to do everything in our power to stem the tide of addiction and the devastation that this epidemic is causing. It is claiming more lives than were lost in the Vietnam war. They are staggering figures.

□ 0930

H.R. 6 includes policies to expand the number and types of providers who can administer medication such as buprenorphine and naloxone to opioid-addicted patients, and it allows Medicare to pay for opioid treatment programs. That is a very important addition in the legislation. This will help people suffering from opioid use disorder to get access to the critical treatment they need on the day this legislation is signed into law.

H.R. 6 also creates a payment structure that incents rather than discourages the use of nonopioid alternatives. I think this is a very important provision in the legislation because it will help to decrease the number of opioids prescribed and keep patients from becoming addicted in the first place.

I want to point something out that I believe is deeply troubling, and the ranking member did as well. The majority has repeatedly voted to gut funding for the benefits offered by Medicaid, which is the single largest payer of mental health services, providing health coverage to 27 percent of adults with a serious mental illness.

The majority has also consistently and repeatedly undermined the Affordable Care Act, including refusing to defend the protections for patients with preexisting conditions.

The CHAIR. The time of the gentlewoman has expired.

Mr. PALLONE. Mr. Chairman, I yield the gentlewoman from California an additional 30 seconds.

Ms. ESHOO. Mr. Chairman, this is very serious because this would provide critical access to treatment for substance abuse disorders. So the majority gives with one hand and takes away with the other.

These policies will harm millions of vulnerable Americans and limit our responsibility to respond and recover from this epidemic.

This is an important first step. We need to do more to address the causes of the epidemic, stem the tide of addiction, expand meaningful access, and pay for it so that we can help the very people who need the most help.

Mr. WALDEN. Mr. Chairman, I yield 1 minute to the gentleman from West Virginia (Mr. MCKINLEY), who has been a fierce fighter to resolve this issue in his State and our country.

Mr. MCKINLEY. Mr. Chairman, I rise in support of H.R. 6. Over the past 2 weeks, America has witnessed something impressive. Both parties have come together, once again, to take action on one of the more challenging issues of our time: the opioid epidemic.

But this health threat is not unique. In the past, Congress faced the AIDS epidemic that claimed the lives of hundreds of thousands of Americans, and stared down the Ebola nightmare. Congress responded methodically and thoughtfully by investing massive resources into medical research at the NIH and into treatment and prevention programs.

That is exactly what Congress is trying to do today. In this bill, we are funding NIH to develop alternatives to opioids for pain management, increasing treatment and prevention programs, and equipping our law enforcement to stop dangerous drugs like fentanyl from coming into America.

This bill is going to make a difference in the lives of millions of Americans. Congress is building on the work that it started with CARA and with the 21st Century Cures, but this isn't the end. It is vital to continue working together.

Mr. Chair, I urge my colleagues to support H.R. 6.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. PETERS).

Mr. PETERS. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I want to take a moment to say a special thank you to Mr. PALLONE and his committee staff for their tireless work to address this crisis.

The opioid crisis has ravaged our Nation. It twice has been declared a national public health emergency under Federal law. More than 100 people will die from an overdose just today.

That is why this bipartisan effort to address it is so important. There is certainly work to be done, but I am happy that legislation that I worked on with my colleague, Dr. BUCSHON, is included in this bill, and it aims to stop addiction where it frequently begins: after surgery. Millions of Americans are prescribed opioids following routine surgeries because they are cheap and accessible, and nearly 70 percent of those pills go unused.

Our bill reverses the perverse incentive that put so many cheap pills in people's hands in the first place. It allows innovators to receive extra compensation for nonaddictive opioid alternatives if they can show that their alternative therapies have substantial clinical benefit.

In the short term, the policy reduces the incentive to simply use the cheapest postsurgical pain treatment, which is typically an opioid. In the long term, it will spur innovation by providing additional compensation for the future development of nonaddictive alternatives. That means as long as this crisis takes to solve, there will be an incentive to continue to develop nonopioid alternatives.

Of course, access isn't enough. These treatments must also be affordable. We will continue to work with CMS and FDA to ensure that safer and more effective nonopioids are affordable for the people who need them most. We must find better ways to treat this problem where it starts.

Mr. Chairman, I urge my colleagues to support the bill.

Mr. WALDEN. Mr. Chairman, we were glad to work with Mr. PETERS on his legislation to make it bipartisan and get it across the line.

Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act, a bipartisan bill that will aid our overall efforts to combat the opioid crisis.

I am proud that two provisions of mine are included in the final package of the bill. These provisions would establish a mandatory drug management program for at-risk beneficiaries in Medicaid and Medicare.

This bipartisan effort shows that we can do things when we put partisan politics aside and work together.

I want to thank Chairman WALDEN for all of his hard work over the past year as we crafted this bill. He led the charge, and I appreciate it, Mr. Chairman, so much.

I also want to thank Congressman BEN RAY LUJÁN, my Democratic colleague and friend. Five years ago we developed the first drug management program in Medicare, and now we developed a drug management program in Medicaid.

Mr. Chairman, I encourage my colleagues to support this bill.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentlewoman from Massachusetts (Ms. CLARK).

Ms. CLARK of Massachusetts. Mr. Chairman, I thank the ranking member for yielding and for all his work on this issue and continuing to underscore the need to actually fund access to healthcare so that we can curb this horrible epidemic in a meaningful way.

One of the many factors that contributes to the opioid crisis is the sheer volume of opioids in circulation. According to the CDC, over 214 million prescriptions were written for opioids in 2016, and we can see that in our own Federal programs.

A 2016 study showed that one in three Medicare part D recipients received opioids. That is almost 80 million prescriptions for a cost of $4.1 billion. The sheer volume makes it hard to prevent abuse, addiction, waste, and fraud. Almost 90,000 beneficiaries of Medicare are at serious risk for abuse and overdose, receiving over 2½ times the recommended dosing. This study eliminated anyone who is on hospice care. Additionally, 70,000 recipients receive an extreme amount of opioids. That is the equivalent of 24 Vicodin every single day.

That is why I, along with my colleague, MARKWAYNE MULLIN, have introduced the Every Prescription Conveyed Securely Act. This bill will require that every prescription written for a Medicare part D beneficiary be prescribed electronically by 2021. We know this technology will save lives by making it harder to forge prescriptions, easier for doctors to know if a patient is doctor shopping, and be able to prevent fraud and save the government money.

Mr. Chairman, this is a commonsense bill that can help fight the opioid crisis. I am very grateful to Chairman WALDEN and the ranking member for including it in this package.

Mr. WALDEN. Mr. Chairman, I want to thank Ms. CLARK and Mr. MULLIN for bringing that issue to our attention. We were proud to work with them to get it in the bill.

Mr. Chairman, I yield 1 minute to the gentleman from Indiana (Mr. BUCSHON), who is one of our doctors on the committee.

Mr. BUCSHON. Mr. Chairman, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act. This bill will help our struggling communities combat the opioid epidemic ravaging our Nation by focusing on providing care to those in need while addressing prevention of opioid misuse and abuse.

I am proud that two pieces of legislation that I introduced are included in H.R. 6 as sections 202 and 203. Section 202, which I worked closely with Representative PETERS on to introduce, would incentivize development of nonopioid pain alternatives for postsurgical pain.

Section 203 would increase screening for chronic pain, address possible nonopioid pain alternatives, and increase early detection of opioid use disorder in seniors as they enter Medicare.

Mr. Chairman, I am proud to have worked with my colleagues on solutions to this serious crisis, and I urge my colleagues to support H.R. 6.

Mr. PALLONE. Mr. Chairman, I yield 3 minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Chairman, I thank the gentleman from New Jersey for yielding.

Mr. Chairman, I rise in support of H.R. 6, the SUPPORT for Patients and Communities Act. The SUPPORT for Patients and Communities Act incorporates legislation that I introduced along with my good friend and colleague, Representative BEN RAY LUJÁN of New Mexico, which will provide a meaningful expansion to addiction treatment across our country, especially in rural areas, and for vulnerable populations like pregnant and postpartum women and the 13,000 babies born on average each year with neonatal abstinence syndrome.

Our legislation includes three main policy changes to expand access to treatment. First, it eliminates the current sunset provision that would prohibit nurse practitioners and physician assistants from treating patients with addiction medicine after 2021.

By ending this sunset, we can provide certainty to our healthcare community and encourage more NPs and PAs to become part of the addiction treatment workforce.

Second, this legislation would expand the classes of practitioners eligible to prescribe buprenorphine to other advanced practice nursing professionals to include nurse midwives, clinical nurse specialists, and certified nurse anesthetists.

This provision was included based on feedback that my office has received from medical groups such as the American Society of Addiction Medicine and the American College of Obstetricians and Gynecologists who are on the front lines of this crisis who have made the case that adding additional classes of highly skilled nurses can help more people access treatment and find that important road to recovery.

In many rural areas, advanced practice nurses play an outsized role in providing care, and this legislation will help expand addiction treatment capacity in these rural areas where it is most needed.

In addition, these advanced practice nursing professionals are already providing primary care for some of our most vulnerable populations: pregnant and postpartum women. By allowing these skilled providers to provide addiction treatment as well, we can bolster continuity of care for our moms and for our babies.

Finally, our legislation would make a technical change that would allow DATA 2000 waivered providers to treat up to 100 patients in their first year if they possess additional credentialing or are practicing in a qualified practice setting.

Taken together, these three changes will make a meaningful difference in moving toward a system of treatment on demand for individuals struggling with the disease of addiction.

To those who would say we need more data or we need to be cautious about expanding access to treatment, I would respond that more and more people are dying in our streets every day. We don't have time to drag our feet any longer.

Finally, I want to thank Ranking Member PALLONE, Chairman WALDEN, and their staffs for the continued efforts on these provisions through many months of back and forth. In a personal way and a very upfront way, let me thank Representative PALLONE, our ranking member, and his outstanding staff for the intellect and the energy they poured into this because it truly made this a better bill, and it is going to save lives.

Mr. Chairman, I urge my colleagues to support H.R. 6.

Mr. WALDEN. It is now my great honor, Mr. Chairman, to yield 1 minute to the gentleman from California (Mr. MCCARTHY), who is the majority leader of the United States House of Representatives. He has been extraordinarily helpful in our efforts to move this entire bipartisan package forward to save lives and help people in addiction.

Mr. MCCARTHY. Mr. Chairman, I thank the gentleman for yielding, and I want to congratulate the gentleman for his work, his tireless effort, and his passion for those who have been afflicted with the addiction and have lost the battle.

Mr. Chairman, I rise today to urge the passage of H.R. 6 which contains more than 50 opioid-related bills which we have considered in the past 2 weeks.

We have in this body the opportunity nearly every day to approve legislation of great consequence to millions of people. But rarely do the consequences feel so immediate and so vital as they do for the opioids package we are considering. That is because this legislation has to do with the deadliest drug crisis in our Nation's history.

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The grim truth is this: More Americans have died from drug overdoses since the turn of the century than died in the Civil War. Yes, you heard that right. In less than two decades, more than 630,000 people have died because of drugs. Half of those deaths had to do with opioids. This death toll is the ''American carnage'' that President Trump referred to in his inaugural address.

My hometown of Bakersfield has been devastated by illegal drugs, mostly heroin and meth. In 2016 alone, 54 people in my county died of an opioid overdose. This is a statistic made up of 54 stories of unimaginable sadness. They are stories of happy families torn apart by deceit, abuse, and death; stories of parents robbed of children, children robbed of parents, and friends robbed of friends. My local news talked

to one man in Bakersfield who has lost four friends to overdoses in the past few years alone.

Of course, these tragic events are not confined to just my district; they are happening everywhere across the country, coast to coast.

So I would like to tell you another story, this time from the other side of the country. It is the story of Eamon Eric Callanan, age 28. He did not live to see age 29.

Eamon came from a family with deep roots in Rochester, New York. One of his great-grandfathers was a chief of police in Rochester. His grandfather was a judge, and his parents are attorneys. They were the very definition, in other words, of a law-abiding family. But in early 2012, a series of events took place that sent Eamon down a different path and stole him from his family forever.

At age 25, Eamon hurt his back—a story that many in America have seen—while he was on his job. He began taking opioid painkillers in response to his pain. When the pills became too expensive, Eamon, like many Americans, switched to heroin. Before long, the loyal, goofy kid his family once knew was gone. Drugs had dampened the beautiful music of his life and turned it into a sorrowful echo.

Eamon Eric Callanan died of a drug overdose on June 8, 2016. Last Wednesday marked the 2-year anniversary of his funeral.

In many respects, Eamon's story is not unique. He was one of 169 people in his county—42,000 people in our country—to die of an opioid overdose that year. Eamon was just one body in a grim tide of overdose deaths.

So why am I telling you this story? I am telling it to remind you that each one of those victims had a name and a life and friends and family whom they loved and left behind.

One of those people Eamon loved and who loves him deeply in return is actually sitting in this Chamber right now. Her name is Erin. She is Eamon's sister and my press secretary. Erin was 24 days from her wedding when she learned that she would never see her brother again and that he would not be there to celebrate with her on one of the happiest days of her life.

Let that be a lesson to all of us. There is no event so joyful, no place so safe that it is untouched by the drug crisis—even a wedding chapel, even here in the Halls of power, even in my office.

Mr. Chair, if we hope to defeat the deadliest drug crisis in history, we will need the biggest response in history. Rest assured that the response is already underway, led by this administration and this Congress. We are wrapping up voting on more than 50 bills to help millions of Americans affected by the opioid crisis. We are about to vote on a package that contains almost all of those bills, H.R. 6.

Among others, it contains a bill by Congressman MIKE BISHOP that will reduce the flow of Chinese fentanyl into our country by giving law enforcement new tools to detect suspicious packages in the mail. It includes a reform to the so-called IMD exclusion, an outdated regulation that restricts Medicaid funding for large inpatient treatment programs, programs with the potential to heal substance abuse patients like Eamon.

Those are just two of the important bills that are part of this package. It is no exaggeration to say that they can save lives and save families from the immeasurable grief of losing a loved one to an overdose.

Yes, I am confident these bills will help stem the tide of drug abuse, but I will end on a note of caution.

If defeating the opioid crisis is left to government alone, then we will surely fail. Healing the wounds of drug abuse will take more than just this body can provide; it will take the commitment by every citizen to fulfill our duties to one another.

We have all been touched by this tragedy, so we all have a part to play in its resolution. That means supporting people near us who are struggling with drug addiction. It means rebuilding families and towns torn apart by isolation, addiction, distrust, and death. It means supporting the many charities, ministries, and nonprofits that are already healing the sick in our communities.

In Bakersfield, that means groups like The Mission, the Christian charity where I volunteer. The Mission operates a faith-based addiction recovery program that is changing lives, even knitting together families that have come apart at the seams.

Because of The Mission, a husband and wife with five children overcame their past of drug addiction and drug dealing, and they did it together. Then they convinced their niece to get clean, too.

We need more stories like that. In the days ahead, this House has a chance to do its part to ensure that more stories of abuse and despair have their own happy ending. We will do this work for the healers and protectors, for the suffering, and for all those like Eamon who are now at rest.

Mr. PALLONE. Mr. Chairman, may I ask how much time I have remaining.

The CHAIR. The gentleman from New Jersey has 5 minutes remaining.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Ms. BASS).

Ms. BASS. Mr. Chair, I rise today in support of H.R. 6 and the foster youth who will benefit from its passage.

One of the most popular provisions of the Affordable Care Act allows young adults to stay on their parents' health insurance until they turn 26. It is only fair that young adults who age out of foster care should keep their coverage until they turn 26, too.

But when the ACA was implemented, the Department of Health and Human Services gave States the option of covering young adults who aged out of foster care in a different State. For example, if a young adult aged out of the system at 18 and had coverage in California but then moved to New York, New York would have the option to cover them under Medicaid until they turned 26 or not.

This extended coverage was never supposed to be optional. After all, former foster youth should have every opportunity to move freely without the fear of losing lifesaving health insurance. This is why I introduced the Health Insurance for Former Foster Youth Act.

Last month, over 100 former foster youth were on the Hill and shadowed their Members of Congress. We celebrated that many of the young adults had been accepted to college, some out of State. This bill will ensure that when former foster youth age out of the system, they can keep their healthcare coverage until 26, no matter where they live.

This is about fairness. Former foster youth should be treated the same way we treat all young people.

I am grateful to my colleagues on both sides of the aisle for including my bill in this bipartisan opioid package.

Just this week, The Hill reported the States hardest hit by the opioid epidemic have seen the number of children in foster care or State care increase dramatically.

Again, I thank my colleagues for working with me to clarify this law, and I thank Chairman WALDEN and Ranking Member PALLONE for their leadership on this issue.

Mr. WALDEN. Mr. Chair, I thank my colleague from California for bringing this issue to our attention and helping us help these kids who need this assistance.

Mr. Chair, I yield 1 minute to the gentleman from Wisconsin (Mr. RYAN), the Speaker of the United States House of Representatives.

Mr. RYAN of Wisconsin. Mr. Chair, I thank the gentleman for yielding.

Mr. Chair, I first want to start by thanking the chair and the ranking member.

But for a moment, I would like to address another issue. I want to pause to honor the life of Dr. Charles Krauthammer.

Dr. Krauthammer was a widely respected conservative thinker. He wrote columns for which he won a Pulitzer Prize. Paralyzed since college, he wrote the most vigorous commentary of our age. He was a Harvard-educated psychiatrist and had the perfect training to analyze our politics.

He passed away yesterday, leaving behind a family that loved him, colleagues that admired him, and grateful friends and readers like myself.

If I had to think about this, Charles was a good friend of mine. He had a beautiful mind, and he had a wonderful, wonderful way about him. Simply put, I loved this man. I loved his work. I would marvel over not just what he said, but how he would say it.

He had a unique ability to take the issue of the moment and place it perfectly in the context of bigger things. ''America is the only country founded on an idea,'' he would say, and his vocation was the defense of that idea.

As great as his intellect was, there was absolutely no arrogance about him. Charles was good company, so gracious, so curious. Take any topic and he had already thought through his argument, your argument, and all the counterarguments before you even got started thinking. He was always willing to enjoy the fight, but with good cheer—he enjoyed it; he reveled in it; he excelled at it.

Charles used his immeasurable gifts to contribute to our civic discourse—and he did it civilly—and we are all the better for it. We will be wiser for what he has done for us. I only hope and pray that we can try to emulate his spirit and his sense of wonder and civility.

The House and this Nation are in his debt. Our prayers are with his family.

Mr. Chair, I rise to express my wholehearted support for H.R. 6.

Today, our Nation is fighting a grave opioid epidemic. It is a threat to a generation of young people and the very fabric that holds our communities together. But to me, this legislation is about hope.

I have had the honor of speaking with and knowing three brave Wisconsin families who have dealt with this, families that I have gotten to know over the course of time.

Kyle Pucek is a guy I know from Janesville. He had an ankle injury treated with opioid medication, just like a lot of people have. He developed a dependency and eventually turned to heroin. He is now clean, and he works with nonprofits in Janesville to encourage others to seek treatment. He is helping make sure people don't make the mistakes he made. He is making a huge difference.

Michelle Jaskulski has two sons, former high school athletes, who became addicted to heroin. They are in recovery. She understands the loneliness that comes with being a mother in this situation. She understands how isolating it can all feel. Now she advocates for more resources to fight this epidemic and supports other families so that they don't feel like they are facing this fight alone, like she did.

Jason Simcakoski was a marine who served our country. He went to a VA hospital looking for help for his anxiety. He was overprescribed opioids, and he lost his life. His family has made it their mission to ensure that others do not experience the same fate.

This is the heart of America. After suffering such unspeakable pain, these families overcame. Now they are making it their mission in life to make sure others have a place to turn to and that others don't have to go down the path they went.

Asking for help is not a sign of weakness; it is actually an act of strength. We all have a role to play in this, and it begins with reaching out, with listening, and with being there for one another. All of our institutions at every level should emulate and encourage this kind of fellowship. We should make sure to make clear that no one is alone, that every life matters.

This bill has the perfect title: SUPPORT for Patients and Communities Act. It is bipartisan. It is high time we do it. It is a very, very strong and good step in the right direction. It will advance treatment and recovery; it will improve prevention; it will give resources to communities; and it will fight deadly drugs like fentanyl.

So I thank Chairman WALDEN and Chairman BRADY. I also thank Mr. PALLONE and Mr. NEAL. I thank all the members of the Energy and Commerce Committee and the Ways and Means Committee.

Let's not stop here. Let's not stop until we have instilled hope in all of those who may be struggling. Let's not stop until we have ended this epidemic.

I urge the entire House to vote ''yes.''

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Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. CÁRDENAS).

Mr. CÁRDENAS. Mr. Chair, I thank the authors for all the hard work coming to this moment to get this very important bill on the floor.

Mr. Chair, I rise today to say how glad I am that my bill, the At-Risk Youth Medicaid Protection Act, has been included in today's opioid package.

According to a June 2017 MACPAC report, the opioid epidemic disproportionately affects Medicaid beneficiaries. Therefore, State Medicaid programs are taking the lead in identifying and tailoring strategies to prevent and treat opioid use disorder. Among those affected are our most vulnerable American population, our youth.

Currently, most children who are covered by Medicaid and come into contact with the criminal justice system end up having their enrollment terminated by States. While some States are beginning to suspend instead of terminate their enrollment, only a few States and the District of Columbia suspend their enrollment for the exact duration of the incarceration. This results in unnecessary, costly delays.

I say again: When somebody is terminated rather than suspended, this results in an unnecessary, costly delay, delaying their coverage and preventing them from receiving timely and much-needed health and mental care upon the child's release.

The At-Risk Youth Medicaid Protection Act would require States to automatically restore the child's Medicaid enrollment upon their release. Further, States would be required to process applications for medical assistance by or on behalf of the child and make access to medical assistance for children under foster care consistent with the Affordable Care Act by extending the age of eligibility to age 26.

Mr. Chairman, we owe it to the American people to do everything in our power to decrease the already 64,000 families broken by this epidemic and restore faith in our government system. While this package covers many fronts, the inclusion of this commonsense bill, the At-Risk Youth Medicaid Protection Act, extends the effort to attack this epidemic from all angles, modifying the package's foundation.

Mr. WALDEN. Mr. Chairman, I want to thank my colleague from California for working with us. We were happy to include his bill in this compilation of legislation.

Mr. Chair, I yield 1 minute to the gentleman from Georgia (Mr. CARTER), our resident pharmacist in the United States Congress and on the Energy and Commerce Committee.

Mr. CARTER of Georgia. Mr. Chair, I thank my colleagues for introducing this critical legislation.

Since this committee began tackling the opioid epidemic, I have said there are three major parts to the crisis: prevention, treatment, and law enforcement. This legislation touches all three prongs of the opioid crisis with a number of creative solutions, in addition to providing offsets to ensure that solving a public health crisis does not lead to a fiscal one.

I voted for many of these bills when they came before the committee for mark up, and I want to offer my full support for this legislation.

Mr. PALLONE. Mr. Chairman, I want to enter into the RECORD my extended remarks regarding a provision included in H.R. 6 that does not enjoy bipartisan support.

Section 301 was passed out of the Energy and Commerce Committee on a party-line vote. Had a committee report been filed, I would have filed the dissenting views that I am now seeking to have added to the RECORD.

Mr. Chair, H.R. 5806, the 21st Century Tools for Pain and Addiction Treatment Act, would require the Food and Drug Administration (FDA) to hold a public meeting regarding the challenges and barriers of developing non-addictive pain and addiction treatments and to issue guidance regarding the eligibility of such treatments for either the Accelerated Approval Program or Breakthrough Therapy Designation. This legislation could undermine FDA's implementation of the Accelerated Approval and Breakthrough Therapy Designation programs and divert critical financial and personnel resources away from activities related to addressing the opioid crisis for purposes of incentivizing an industry that is already taking advantage of these programs. This legislation is a solution in search of a problem.

Opioid overdose death rates are now the leading cause of unintentional, non-traumatic deaths in the United States. According to the Centers for Disease Control and Prevention (CDC), overdose deaths from opioids have quadrupled in the last 20 years. Approximately 116 deaths per day occur from an opioid overdose resulting in over 42,000 deaths per year.

Of those deaths, 40 percent are due to a prescription opioid. Every day, over 1,000 individuals are treated in emergency departments for complications due to the misuse of opioids, and hospitalizations have increased by over 60 percent since 2005. It is within this context that there has been increasing interest in developing non-addictive treatments for pain and substance use disorders.

FDA, led by Commissioner Scott Gottlieb, has acknowledged that the agency has a role to play in addressing the opioid crisis, including ensuring that fewer individuals become addicted through medical use of these products. According to Commissioner Gottlieb, this includes ''helping support the development of new, safe and effective treatments for pain that don't carry all the same risks of addiction as opioid medicines.'' One of his first actions was the creation of the Opioid Policy Steering Committee (OPSC) that has been tasked with fostering the development of novel pain treatment therapies, and the advancement of non-addictive drugs and devices to treat pain was also included as one of the agency's priorities in FDA's 2018 Strategic Policy Roadmap.

Despite this, concerns have been raised from some pharmaceutical manufacturers that more could be done to help incentivize manufacturers to develop non-addictive treatments for pain and addiction. This included legislation that would direct FDA to issue guidance clarifying how and when the agency would provide accelerated approval and breakthrough therapy designation for medicines to treat pain or addiction. In addition, the proposal includes requiring a detailed annual report in which the agency would account for the number of requests received, granted, or denied for consideration under the expedited programs, the common reasons for granting or denying an application for expedited programs, timelines for drug development, timelines for product review, comparison of metrics among review divisions, common reasons for longer timelines for drug development and product review, as well as recommendations as to how the expedited programs could be better utilized. This legislation was subsequently released by Representative BURGESS (R-TX) and was one of the bills noticed for a hearing on March 21, 2018. At this hearing, a representative from BIO testified that the legislation is needed to ''serve as a powerful signal to stakeholders and investors that treatment and therapies that improve and protect the lives of patients suffering from pain and addiction is a top public health priority.''

H.R. 5806, the 21st Century Tools for Pain and Addiction Treatment Act, was formally introduced on May 15, 2018, with Reps. BUCSHON and GRIFFITH joining as co-authors. As introduced, the legislation would direct FDA to hold at least one public meeting within one year of enactment to discuss the challenges and barriers of developing non-addictive medical products intended to treat pain or addiction, including the application of novel clinical trial designs and the use of real world evidence and patient experience, as well as the application of eligibility criteria for the Accelerated Approval program and the Breakthrough Therapy designation. In addition, the bill would also direct FDA to issue final guidance or update existing guidance regarding how the agency would apply eligibility criteria for the Accelerated Approval program and the Breakthrough Therapy designation to non-addictive medical products for pain or addiction, including considering the risk of addiction to controlled substances for pain when establishing unmet medical need, and considering whether pain, pain control, or pain management in assessing whether a disease or condition is a serious or life-threatening disease or condition. The guidance must also cover the methods by which sponsors may evaluate acute and chronic pain, endpoints for non-addictive medical products intended to treat pain and how the endpoints would be evaluated for efficacy.

FDA has repeatedly noted that it is actively working with industry and other government partners to encourage the development of non-opioid treatments for pain and addiction. Both former FDA Commissioner Robert Califf and current FDA Commissioner Scott Gottlieb have stated that FDA will use all of the tools at the agency's disposal to move alternatives to opioids as expeditiously as possible. This is a commitment that Commissioner Gottlieb has continued to echo in testimony before the Energy and Commerce Committee (the Committee), specifically noting that ''This includes programs such as Fast Track and Breakthrough Therapy Designations that are intended to facilitate development and to expedite review of products that, for example, are intended to treat a serious condition for which there is an unmet medical need. As a part of these efforts, FDA is meeting with innovators who are pursuing non-opioid alternatives for the treatment of pain to provide guidance on their individual products.''

However, FDA's commitment to this development has not been limited to testimony before Congress or through meetings with industry. In the last five years, FDA has taken a number of actions to help with development of alternative pain and addiction treatments, including convening the Science Board to discuss issues related to challenges facing FDA in supporting the development of pain medications; issuing final guidance and hosting two public meetings regarding the development of opioids with abuse deterrent properties; and as mentioned previously, the advancement of non-addictive drugs and devices to treat pain was also included in FDA's 2018 Strategic Policy Roadmap. Further, the agency also participated in a public-private-partnership under the Critical Path initiative, the Analgesic Clinical Trial Translation, Innovations, Opportunities, and Networks (ACTTION). ACTTION is a collaboration among a broad range of national and international groups working to advance the science in non-opioid and non-addictive pain medications, and includes participation from academia, government agencies, pharmaceutical and device companies, professional organizations, and patient advocacy groups. The agency has also approved non-opioid medications for treatment of chronic pain, including gabapentin, pregabalin, milnacipran, and duloxetine, among others.

These actions are all in addition to the consultation and meetings offered by FDA to sponsors in this space in a one-on-one setting. FDA has committed, to discussion with individual sponsors related to questions about the development of non-opioid and non-addictive medical products for pain or addiction. No evidence has been provided by supporters of this legislation, or by the Majority, that has shown otherwise.

FDA has in place four pathways by which review and consideration of a drug can be expedited—Priority Review, Breakthrough Therapy, Accelerated Approval, and Fast Track. These pathways provide the sponsor of certain drugs with access to assistance and streamlined review from the agency. At issue in H.R. 5806 is the application of Accelerated Approval and Breakthrough Therapy Designation.

Accelerated Approval, first established in 1992 and codified in 2012, allows drugs for serious conditions that meet an unmet medical need to be approved based on a surrogate endpoint. The use of a surrogate endpoint may predict the clinical benefit of a drug earlier, and FDA is able to require the manufacturers to conduct post-market confirmatory studies to verify the clinical benefit. The Breakthrough Therapy Designation, established in 2012, provides sponsors of drugs to treat a serious condition with preliminary evidence that they demonstrate substantial improvement over other available treatments with access to intensive guidance regarding their drug development program, more frequent meetings and communication with FDA, and rolling review. Both pathways are desirable from a manufacturer's perspective as it can allow products to come to market sooner. A recent study conducted by Friends of Cancer Research found that cancer drugs that received Breakthrough Therapy Designation received FDA approval nearly three months sooner than drugs that did not, and their development time was reduced by nearly two years.

The additional guidance, communication, and expedited review provided by these two programs does have an impact on both the financial and personnel resources of FDA. In fact, the Breakthrough Therapy Designation program received far more interest than originally projected, and given the access to FDA staff throughout the development and review process and has been described by the agency as posing a ''strain'' because the creation of the designation did not come with any additional resources. According to testimony from Dr. Janet Woodcock, Director of the Center for Drug Evaluation and Research, over the first four years of the program the agency had received 492 requests for designation, and of those, granted 165 requests. As a result, industry and FDA negotiated to increase the number of staff dedicated to the Breakthrough Therapy Designation program by 36 full-time employees as part of the Prescription Drug User Fee Act reauthorization signed into law as a part of the Food and Drug Administration Reauthorization Act. While user fee resources may help to address the issues associated with the implementation of the Breakthrough Therapy Designation program, the Office of New Drugs within the Center for Drug Evaluation and Review (CDER) continues to be short-staffed with one estimate noting that the Office is 10 percent under the authorized staffing ceiling.

As previously mentioned, proponents of the legislation have argued it is necessary in order to help ''enable the utilization of Accelerated Approval and Breakthrough Therapy pathways'' for non-addictive pain and addiction treatments. ''Enactment and implementation of this legislation would provide FDA and the biopharmaceutical industry with a greater understanding of what is required to meet criteria for these expedited approval pathways and ensure processes intended to expedite development and approval meet the unique needs of

pain and addiction medicines,'' noted Ms. Cartier Esham, Executive Vice President, Emerging Companies Section and Senior Vice President, Science & Regulatory Affairs at BIO, in testimony before the Committee. Despite the claims of lack of clarity, there is evidence that industry has been taking advantage of both of these pathways currently.

Accordingly, in technical assistance provided by FDA the agency stated, ''We believe, however, that sponsors and potential sponsors of [non-opioid and non-addictive medical] products are already aware of these programs, and have been taking advantage of them. We also believe that to the extent there is a need for additional outreach on application of the expedited programs to these products, FDA has, and is committed to using, other means to accomplish this, such as public meetings . . . and discussion with individual sponsors.'' More than 60 percent of new molecular entities and biologics license applications approved in 2017 were eligible for one of the expedited programs—Fast Track, Breakthrough Therapy, Priority Review, or Accelerated Approval. This includes products in the pain and addiction space. On Breakthrough Therapy Designation, there have been 19 requests for designation from drugs with pain indications since the program was created, three of those were granted, 14 were denied, and two were withdrawn. According to FDA, ''In general, if a drug meets the statutory criteria it will get the designation.'' In regard to Accelerated Approval, there has been one drug with an indication for pain; another product has received Fast Track designation. All evidence indicates that sponsors of non-opioid and non-addictive medical products for pain and addiction are receiving access to FDA and have been able to take advantage of the expedited programs if they meet the statutory criteria.

The opioid crisis has made everyone rethink how we treat pain and addiction in this country and there is broad agreement that this conversation should include examining alternatives to opioids that are non-addictive. Patients and providers deserve to have options other than opioids for pain and addiction. It is clear that FDA has prioritized this effort and has been assisting sponsors in their development. No evidence has been provided that demonstrates otherwise. H.R. 5806 is legislation in search of a problem.

A key provision of H.R. 5806 is directing FDA to issue, or update, guidance regarding how the agency will apply the Accelerated Approval and Breakthrough Therapy Designation program to non-addictive medical products for pain or addiction. This would include the circumstances under which FDA may apply eligibility criteria to these products, how FDA will consider the risk of addiction of controlled substances approved to treat pain when establishing unmet medical need, and how FDA will consider pain, pain control, or pain management in assessing whether a disease or condition is a serious or life-threatening condition. Such an effort would be precedent-setting for the agency as it would be the first time the agency would do such a regulatory guidance for a product specific area.

In order to help drug sponsors make determinations about whether or not their products would be eligible for expedited programs pathways, as well as Fast Track and Priority Review, the agency issued comprehensive guidance outlining the requirements and features of each of the pathways in May 2014. As noted in the guidance, ''The purpose of this guidance for industry is to provide a single resource for information on FDA's policies and procedures for these four programs as well as threshold criteria generally applicable to concluding that a drug is a candidate for these expedited development and review programs.'' H.R. 5806 would move to change this by requiring the agency to issue new guidance for non-addictive pain or addiction treatments. According to technical assistance received from FDA:

> Typically, FDA refrains from issuing product area-specific guidance documents unless there is a need to address scientific or clinical issues specific to those products. It is not clear what scientific or clinical issues specific to application of our expedited programs to non-opioid or non-addictive medical products to treat pain or substance use disorder would benefit from FDA guidance. To the extent sponsors have questions about how FDA's expedited programs apply to their specific products, such questions are better addressed in our existing guidance on the use of expedited programs in general and in meetings or other communications between FDA and individual sponsors. These latter interactions with FDA permit targeted, product-specific discussion of a type that is typically not possible in guidance—even product area-specific guidance.

By requiring the agency to issue such guidance, despite FDA's concerns, H.R. 5806 is now raising questions regarding whether or not the criteria for the expedited programs applies differently for each product area, and could expose the agency to a multitude of additional requests from other therapeutic areas for product area-specific guidance about the eligibility for these pathways.

In addition, H.R. 5806 would also require the agency to host at least one public meeting to examine challenges and barriers facing non-addictive medical products for pain and addiction, including application of novel clinical trial designs, use of real world evidence and patient experience data, as well as the eligibility criteria for Accelerated Approval and Breakthrough Therapy Designation. Public meetings and guidance require considerable staff time and financial resources, diverting time away from other activities such as meeting one-on-one with sponsors or responding to questions regarding submissions. This legislation does not provide any new resources for these activities, and would have been more appropriately discussed during consideration of the user fee reauthorization that could have accounted for the need for additional resources to implement these activities.

As FDA has noted, the agency grants access to the expedited programs if products meet the statutory requirements of such programs. Proponents have argued that legislation is necessary to incentivize industry to develop non-addictive pain and addiction treatments as well as to make sure that the expedited programs and processes ''meet the unique needs of pain and addiction medicines.'' This makes clear the legislation is not about greater clarity as supporters have argued, but is instead about re-interpreting the requirements of the expedited programs to ensure that non-addictive pain or addiction treatments will be eligible. H.R. 5806 as such could be used in the future for stakeholder to request the eligibility for the expedited programs be changed to guarantee that their products can receive Accelerated Approval and Breakthrough Therapy Designation should the guidance provided under this legislation not be suffice. This could have the effect of unintentionally weakening the benefits of Accelerated Approval and Breakthrough Therapy Designation pathway by expanding it to even more products, and put strain on FDA's resources by expanding such programs to products that were not planned for under the user fee reauthorizations. While we all want to bring alternatives to opioids to market sooner, we must seriously consider the implications of expanding FDA's expedited programs.

Finally, this is not legislation that FDA has asked for or highlighted as a priority in fighting the opioid crisis. While the agency has indicated that they are not opposing the legislation and believe the changes that have been made are helpful, this legislation can have real and serious implications for the drug approval process.

It is for all these reasons that Democrats unanimously opposed H.R. 5806.

Mr. Chair, I reserve the balance of my time.

Mr. WALDEN. Mr. Chair, I yield 1 minute to the gentleman from New Jersey (Mr. LANCE), who has been very, very involved in this effort.

Mr. LANCE. Mr. Chair, I rise today in support of this bipartisan package, H.R. 6.

The Energy and Commerce Committee, under the leadership of Chairman WALDEN, has again delivered for the American people on the pressing public health challenges facing the Nation. From combating childhood cancer, to improving mental health care, to fighting the scourge of drug addiction, the Energy and Commerce Committee produces results.

The menace of drug abuse and addiction has manifested itself in opiates. Every corner of this country has known the heartache of losing a life from this terrible problem. Congress has acted before with passage of the Comprehensive Addiction and Recovery Act, but CARA needs reinforcement. H.R. 6 delivers more resources, treatment, and mitigation tools to fight opiate addiction.

Included in this package is the Eliminating Opioid-Related Infectious Diseases Act, legislation I have authored with my colleague on the Energy and Commerce Committee, Congressman JOSEPH P. KENNEDY III.

Infectious diseases compound and complicate the lifelong path toward recovery from substance abuse, and threaten the lives and safety of the loved ones of those addicted, especially children.

This is how Congress is supposed to work, both sides coming together to confront a national crisis, going through the committee process with bipartisan bills, and getting to the root of the country's challenges.

Mr. Chair, I urge a ''yes'' vote.

Mr. PALLONE. Mr. Chair, I have no additional speakers, and I reserve the balance of my time.

Mr. WALDEN. Mr. Chairman, I yield 1 minute to the gentleman from Michigan (Mr. WALBERG), who has been very involved in this effort as well.

Mr. WALBERG. Mr. Chairman, I am grateful for your leadership and for the work my colleagues on the Energy and Commerce Committee are doing to tackle the opioid crisis.

Mr. Chair, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act. Everywhere I go around Michigan, I hear about the opioid crisis plaguing our State and country. It is a deeply personal and painful issue for many of our friends and loved ones, including the family of Jessie Grubb, whose life was cut short. Her family grieves that a mistake was made that, because of our legislation, hopefully, will never happen again.

Over the past 2 weeks, the House has considered more than 70 bills to enhance treatment and recovery programs, increase prevention efforts, protect communities, and fight the synthetic drug fentanyl. These measures include two bipartisan bills I introduced with Congresswoman DEBBIE DINGELL. They have been incorporated into legislation we are voting on today, including Jessie's Law.

This is an urgent crisis, and I urge the Senate to take swift action and advance these solutions. There is not a moment to waste.

Mr. PALLONE. Mr. Chair, I continue to reserve the balance of my time.

Mr. WALDEN. Mr. Chairman, I yield 1 minute to the gentleman from Georgia (Mr. ALLEN).

Mr. ALLEN. Mr. Chair, I rise today in support of H.R. 6, the SUPPORT for Patients and Communities Act.

Mr. Chair, I want to thank Chairman WALDEN and the entire Energy and Commerce Committee for their work on this important legislation. The SUPPORT for Patients and Communities Act is yet another bipartisan effort aimed at preventing further opioid abuse and assisting those currently dealing with this addiction.

This legislation will strengthen our efforts to advance treatment and recovery initiatives, improve prevention, protect our communities, and bolster the fight against deadly illicit drugs.

We have made meaningful progress in our fight against the opioid epidemic throughout the country by passing more than 50 bills in the House, but our work is far from over.

No community is immune from this crisis. In 2016 alone, more than 1,300 Georgians lost their lives to opioid abuse. Many of them in my community, my closest friends, have had to deal with this.

Our Senate colleagues should take note of this important work that we have done here in the House over the past 2 weeks to combat the opioid crisis, and I urge all of my colleagues to support H.R. 6.

Mr. PALLONE. Mr. Chairman, I want to thank the staff who worked so hard on H.R. 6 and the opioid bills, in general. Democrats worked to make H.R. 6 a better bill, even though we have concerns about the overall impact of the opioid package.

Mr. Chair, I ask my colleagues to support the legislation, and I yield back the balance of my time.

Mr. WALDEN. Mr. Chair, I yield myself the balance of my time.

Mr. Chair, I want to thank my colleagues on both sides of the aisle. We have had individual Members come to the floor today from both parties. Together, we have broken through what others might see as dysfunction in Washington to achieve a comprehensive legislative package that will provide treatment; save lives; stop illegal fentanyl from coming into this country; and, in no small measure, move America forward in a much better direction.

I want to share with you, Mr. Chair, a letter to the Speaker and to Ms. PELOSI, urging us to support H.R. 6. It comes from not 1 or 2 but, literally, 161 different groups that are very involved in the recovery effort.

I want to share a couple of comments, Mr. Chairman: ''Substance use disorder not only impacts the individual, but the family and community as well. According to the Substance Abuse and Mental Health Services Administration, approximately 9 million children across our Nation live in a home with at least one parent who uses an illicit drug.

''Tragically,'' they write, ''children in these homes are at an increased risk for depression, suicide, poverty, delinquency, anxiety, homelessness, and substance use disorder. In addition, while our Nation has made significant strides in both our understanding and response to the drug crisis, it is clear that too many communities across our Nation still have fragmented prevention, treatment, and recovery infrastructures.''

Introduced by myself, Mr. PALLONE, Mr. NEAL, and Mr. BRADY, they write: ''The SUPPORT for Patients and Communities Act,'' this bill, ''would strengthen key Federal low-income assistance and senior health insurance programs to better respond to our Nation's drug crisis. In addition to serving as the vehicle that will advance many other significant proposals already considered in the House, this legislation will give critical Federal safety net programs more tools to prevent and help treat substance use disorder.''

They write: ''We applaud the champions of H.R. 6 for treating addiction like the disease that it is and for their bold leadership, in their respective committees and on the House floor, to advance so many innovative, bipartisan proposals that will have an immediate and positive impact to address addiction. We respectfully urge the full House to immediately consider and pass H.R. 6, which represents a significant step toward building the comprehensive response needed in our Nation so that fewer lives are lost to substance use disorder.''

Mr. Chair, this comes from the people who live this every day, who help our neighbors, our friends, our families, and our American citizens get the help they need to beat the disease of addiction and to reclaim their lives, their families, and their future.

Mr. Chairman, I urge my colleagues to support passage of H.R. 6, and I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Chair, I yield myself such time as I may consume.

Mr. Chair, the opioid crisis has impacted every community in America and robbed countless individuals of their potential.

A recent poll found that more than 4 out of 10 Americans who are young, in their 20s and 30s, personally know someone who has dealt with opioid addiction. It is a staggering number, and it shows that this crisis touches a huge part of our society.

All too often, we hear stories of loved ones exposed to opioids, and then quickly addicted, from routine surgeries that may not have required opioid treatment in the first place. This can be prevented. That is why I rise today in support of H.R. 6, known as the SUPPORT for Patients and Communities Act.

This bill, which incorporates legislation recently approved by the Ways and Means Committee, addresses this crisis by putting in place many commonsense measures to reduce the unnecessary prescription of opioids and also to help those who have become addicted.

One important policy within H.R. 6, which has been championed by Congressman PETER ROSKAM, who leads our Subcommittee on Health, will prevent abuse by making sure folks are not able to game the system by visiting multiple doctors' offices in order to receive an opioid. H.R. 6 ensures that patients have selected prescribers and selected pharmacies that will be best able to address their needs.

Another important measure expands access to more forms of really broad, holistic treatments for addiction through the use of medication-assisted treatment. Americans who are struggling with addiction must be able to find treatment that works for them.

□ 1015

While we still have a long way to go to solve this crisis, this bill, which is made up of many commonsense, Republican and Democrat proposals, takes meaningful strides to help millions of Americans recapture their lost hopes and dreams.

I thank Representatives MIKE BISHOP, DAVE REICHERT, CARLOS CURBELO, PETER ROSKAM, ERIK PAULSEN, and JACKIE WALORSKI for their leadership on this important issue. And I thank all of our committee members, Republicans and Democrats, for their hard work on this important legislation. I look forward to working with the Senate to ensure that we send this important bill to the President's desk.

Mr. Chairman, I reserve the balance of my time.

Mr. NEAL. Mr. Chairman, I yield myself 4 minutes.

Mr. Chairman, I rise in support of H.R. 6.

It has become all too clear that the ongoing opioid epidemic has gripped our Nation's families and communities. It crosses social spectrums and is a public health, safety, and economic crisis as well.

In Massachusetts in 2016 there were 2,083 confirmed cases of opioid-related overdose deaths. This is a 26 percent increase from 2015 and a 54 percent increase from 2014. In 2017 there was a small decrease, but clearly there was still a strong need to address this devastating trend.

This week, the House has considered opioid bills in committee and on the floor, and some of these, in fact, will expand treatment options for the care that is necessary.

However, a number of the Democratic priorities here, I think, really provide real investment and opportunity. For example, it incorporates a bill I introduced that would expand Medicare coverage for opioid treatment programs. Currently, Medicare does not cover this sort of treatment. This would give Medicare beneficiaries access to a broad range of treatment options, leading to opportunities for lasting recovery.

Although many think of opioid use disorders as a problem faced by young people, many may be surprised to learn that it is rapidly growing among our Medicare beneficiaries. Medicare part D spending on opioids for treatment outpaces enrollment, growing 165 percent from 2006 to 2015. In 13 States, the over-65 population has the highest rate of opioid-related inpatient stays.

H.R. 6 also expands coverage of medication-assisted treatments and allows nurse practitioners and physician assistants to prescribe or dispense certain opioid treatment drugs. The measure also provides consistent Medicaid coverage for at-risk youth and expands Medicaid coverage for foster youth until the age of 26.

These bills are pieces of a large, complex puzzle. We need to find realistic solutions with long-term outcomes. Part of this approach is to protect and strengthen Medicaid and the Affordable Care Act.

The ACA guarantees parity and nondiscrimination for people who need substance use disorder treatment and mental health treatment. Thanks to the ACA, millions of previously uninsured adults now have access to health insurance and, I might add, the expansion of Medicaid.

There are many efforts here, I think, time and time again, to dismantle the Medicare proposal, as well as cutting back on many of the initiatives that we have proposed in the past. Instead of strengthening and ensuring a sustainable future for the ACA and for Medicaid, some of our colleagues want to cut them to pay for a $2.3 trillion tax plan. Efforts to sabotage the ACA, coupled with premium hikes, slashing preexisting condition protections, and increasing drug prices will lead to more uncertainty.

Dismantling current health benefits would damage any progress that we are making today with the opioid crisis. It would also increase healthcare costs and lower coverage and quality of life for Americans and their families.

I urge my colleagues to recognize that many families, who are devastated by addiction, are going to need the opportunities that we are embracing today.

The impact of the opioid crisis on the labor participation rates in America should concern all of us. According to a recent report, the economic burden from opioids was estimated at $95 billion.

The American people are facing two-pronged obstacle health challenges. Uncertainty remains one of them. We want to make sure that we don't sabotage the ACA. And part of the path forward today is highlighted by the achievement we are all about to recognize.

Mr. Chairman, I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Chairman, I am proud to yield 2 minutes to the gentleman from Illinois (Mr. ROSKAM), the leader of the Health Subcommittee.

Mr. ROSKAM. Mr. Chairman, I want to thank Chairman BRADY for his leadership on this.

I have done a lot of work over the past several months, as I know we all have, of listening to my constituents in suburban Chicago, and here is what I have heard: They want us to take a multifaceted approach.

One of the things that I am doing this morning is highlighting a portion of this bill that Mr. BRADY mentioned in his opening statement, and that is a lock-in phenomenon.

Here is the story: The power of this molecule, when it gets into our bodies, is breathtaking and is sobering. Here is one statistic that should make us shudder: One-third of part D Medicare beneficiaries were prescribed an opioid in 2016—one-third of Medicare part D beneficiaries were prescribed an opioid in 2016. There is nothing good that is going on with that.

So here is what we are trying to do: We are saying that we need to resist pharmacy shopping. We need to resist doctor shopping. And we need to make sure that people can be identified who have a predisposition towards this addiction.

So what this bill does—what part of this bill does—is it says: Medicare part D programs don't just have the option of requiring a lock-in program, we are now locking in on lock-in. We are saying: You have got to do this.

Unambiguously, it is a mandate, it is a good mandate, and it is something that has been a long time coming. TRICARE uses this, and a number of other distribution systems use it, but the time is ripe and we have absolutely got to get this done. It is part of a holistic approach that I think is really welcome.

Mr. Chairman, I congratulate and thank Mr. LEVIN, the ranking member; Mr. BILIRAKIS; and Mr. LUJÁN, also who similarly worked on this legislation. I am confident that in 10 years' time, our country, based on the work that this House is doing now, is going to reflect back, and it is going to say: America responded. We did it on a bipartisan basis. And we are going to be having a better and different conversation.

Mr. NEAL. Mr. Chairman, I yield 4 minutes to the gentleman from Illinois (Mr. DANNY K. DAVIS).

Mr. DANNY K. DAVIS of Illinois. Mr. Chairman, I thank Mr. NEAL for yielding.

Mr. Chairman, I support H.R. 6 as a step to the puzzle to address substance abuse. However, I think we need to expand this bill in an important way as it moves forward.

To prevent opioid addiction, we must address the social and emotional harm caused by trauma that often underlies opiate use.

Research demonstrates that exposure to four or more adverse childhood experiences, such as neglect, experiencing a parent battling addiction, witnessing violence, or observing domestic violence, makes an individual 10 times more likely to misuse illicit narcotics. These drugs serve as a coping response to traumatic life experiences.

The Senate's bipartisan Opioid Crisis Response Act included provisions from my Trauma-Informed Care Act with Senator DURBIN to help improve the Federal response to trauma to help prevent opioid abuse. These provisions would expand the workforce capacity to help children exposed to trauma, they would improve our understanding of trauma by improving Federal data and best practices, and they would increase services for children exposed to trauma to help these young people heal.

Our efforts to prevent the opioid crisis will be insufficient unless we address the role of trauma in it, which is why 28 organizations supported my effort to amend H.R. 6 to focus on trauma—organizations like the Child Welfare League of America, the Jewish Child and Family Services, the National Association of Social Workers, Partners for Our Children with the University of Washington, and the YMCA USA—but my amendment was not made in order.

The science is clear that trauma has devastating effects on a child's healthy development well into adulthood. When children experience traumatic events, stress alters the developing brain, which harms them physically and mentally.

Mr. Chairman, I include in the RECORD this outline of the research by

the Society for Research in Child Development documenting the harm caused by trauma and parental separation.

[From the Society for Research in Child Development, June 20, 2018]

STATEMENT OF THE EVIDENCE—THE SCIENCE IS CLEAR: SEPARATING FAMILIES HAS LONG-TERM DAMAGING PSYCHOLOGICAL AND HEALTH CONSEQUENCES FOR CHILDREN, FAMILIES, AND COMMUNITIES

After the United States Department of Justice announced the ''Zero olerance Policy for Criminal Illegal Entry,'' Immigration and Custom Enforcement (ICE—an arm of the Department of Homeland Security) separated approximately 2,000 children from their parents in April and May 2018 as they approached the U.S. border. Children and parents were placed in separate facilities as they were being processed and were not told when or how they would be reunited. This policy and its consequences have raised significant concerns among researchers, child welfare advocates, policy makers, and the public, given the overwhelming scientific evidence that separation between children and parents, except in cases where there is evidence of maltreatment, is harmful to the development of children, families, and communities. Family separations occurring in the presence of other stressors, such as detention or natural disaster, only adds to their negative effects.

EVIDENCE ON HARMFUL EFFECTS OF PARENT-CHILD SEPARATION

The evidence that family separation is harmful dates back to studies on the effects of parent-child separations on children's well-being during World War II. This research documented far reaching effects of these separations into adulthood, including increased risk for mental health problems, poor social functioning, insecure attachment, disrupted stress reactivity, and mortality (Pesonen & Raikkonen, 2012; Rusby & Tasker, 2009; Mitrani, Santiste-ban, & Muir, 2004). Other research similarly documents the harmful effects of parental separation on child wellbeing in a variety of other child populations including children in Romanian orphanages (Zeanah, Nelson, Fox, et al., 2003), children in foster care (Flannery, Beauchamp, & Fisher, 2017) and children of incarcerated parents (Geller, Garfinkel, Cooper & Mincy, 2009; Miller, 2006). More recent work has documented the increased mental health risk faced by both parents and children when they are separated in the immigration process (Suarez-Orozco, Bang, & Kim., 2011; Rusch & Reyes, 2013). Parent-child separation has long-term effects on child well-being, even if there is subsequent reunification. After being separated, reunited children can experience difficulty with emotional attachment to their parents, self-esteem, and physical and psychological health (Smith, Lalonde, & Johnson, 2004; Gubernskaya & Debry, 2017). For some children, time does not appear to fully heal these psychological wounds (Shonkoff et al., 2012).

PARENTS BUFFER CHILDREN FROM ADVERSE EFFECTS OF TOXIC STRESS

Parental separation is considered a toxic stressor, an experience that engages strong and prolonged activation of the body's stress-management system (Bridgman, 2014) The physiological and psychological toll of early life stress, including parental separation, changes how the body responds to stress in the long term, disrupting higher-order cognitive and affective processes as well as negatively altering brain structures and functioning (Lupien, McEwen, Gunnar, & Heim, 2009; Pechtel & Pizzagalli, 2011; Kumar et al., 2014). Such stressors put children at greater risk for a multitude of health and psychological impairments, including anxiety, depression, post-traumatic stress disorder, lower IQ, obesity, immune system functioning, physical growth, cancer, heart and lung disease, stroke, and morbidity (Granqvist, Sroufe, Dozier, Hesse, & Steele, 2017, Heim & Nemeroff, 2001; Mamam, Antornadis, & Morris, 2014; Pechtel & Pizzagalli, 2011; Shirtdiff, Coe, & Pollak, 2009; Taylor, 2010).

Children depend on their primary caretakers to successfully navigate stressful and traumatic events. Children's physiological responses to stress can be significantly reduced by access to their primary caretaker (Hostinar, Sullivan, & Gunnar, 2013). The separation of the family unit under extreme conditions of stress worsens the psychological and physiological ramifications of that stressor on children, especially younger children (Masten & Narayan, 2012). Conversely, ongoing contact with primary caregivers under conditions of stress can protect against risk (Rodriguez & Margolin, 2015).

CHILD-SEPARATION FROM PARENTS IMPACTS CHILDREN AT ALL AGES

Much of the research on family separation has focused on the impacts on children early in development. However, puberty is also an especially vulnerable time of rapid change (Doom & Gunnar, 2013). Stressors during adolescence can have lasting impacts—the effects of which may not become evident until adulthood—(Humphreys, Gleason, Drury, et al., 2015; Lupien, McEwen, Gunnar, & Heim, 2009). Further, the effects of traumatic experiences are cumulative; children and adolescents who have already faced previous adversity are particularly susceptible to long term further negative consequences (Brown, Anda, & Tiemeier, et al, 2009, MacKenzie, Bosk, & Zeanah, 2017) Thus, the research shows that across infancy, childhood, and adolescence, child-family separations can be related to negative outcomes across the lifespan.

IMPACT OF BORDER FAMILY SEPARATIONS ON U.S. CITIZENS

There is also evidence that family separations harm U S. citizens whose family members experience border detention or deportation. Parental separation increases the risk for these U.S. children's mental health problems such as anxiety, depression, behavior problems, and symptoms of post-traumatic stress disorder (Allen, Cisneros, & Tellez, 2015; Rojas-Flores, Clements, Hwang Koo, & London, 2017; Zayas, Aguilar-Gaxiola, Yoon, & Rey, 2015). U.S. citizens of Latino descent also report heightened worries and concerns for their families and their communities as a result of changes in implementation of immigration policies such as the Deferred Action for Childhood Arrivals (DACA) policy (Roche, Vaquera, White, & Rivera, 2018). Moreover, countries with supportive integration policies are more likely to have child populations with better overall health and mental health indicators than those with less supportive approaches (Marks, McKenna, & Garcia Coll, 2018). Thus, there is evidence that policies about parental separations can negatively affect American citizens.

THE POLICY IMPLICATIONS ARE CLEAR

The scientific evidence is conclusive. Parent-child separations lead to a host of long-term psychological, social, and health problems that are not necessarily resolved upon reunification. In particular, the disruption of biological stress regulation mechanisms in the body induced by the need to seek refugee or asylum status are further taxed by the absence of parental support. The science is clear: policies that separate immigrant families upon entry to the U.S. have devastating and long-term developmental consequences for children and their families.

Mr. DANNY K. DAVIS of Illinois. That is why the administration's intentional infliction of trauma on children by separating children from their parents is so cruel and inhumane. Causing intentional harm to children is a human rights violation and is un-American. We must stop this appalling policy immediately, reunite parents and children without delay, and provide intensive services to help these families heal.

Mr. BRADY of Texas. Mr. Chairman, I am proud to yield 2 minutes to the gentleman from Michigan (Mr. BISHOP), the leader of the STOP Act, which prevents illegal smuggling of fentanyl into the United States.

Mr. BISHOP of Michigan. Mr. Chairman, I thank Chairman BRADY for his steadfast leadership in finding a solution to this crisis.

Mr. Chairman, I rise in strong support of H.R. 6, the SUPPORT for Patients and Communities Act. I am pleased that we are voting on this legislation today, which includes important reforms to Medicare and Medicaid policies, to help combat the opioid crisis in our country.

Mr. Chairman, the opioid crisis has affected every segment of our Nation's population. Every Member of this Chamber has a community in crisis. Each and every day, 115 Americans die from opioid overdoses. We are talking about valued members of our communities: mothers, fathers, and, especially, so many young children who have left us way too early because of the tragedy of opioids.

As I travel across my district in Michigan, I hear frequently from constituents about this crisis at townhall meetings and roundtables I have hosted. I have heard personal stories from constituents about the devastating impact this crisis is having in southeast Michigan.

I have also been meeting with elected officials across the district on this crisis, including firefighters, police officers, emergency responders, and medical professionals. They all want me to do something, do it urgently, and for Congress to be involved.

While there is no silver bullet to address this issue, I am pleased that over the past several weeks the House has passed over 70 bills to address the opioid crisis. It includes the legislation that I authored, the STOP Act, to stop the flow of synthetic opioids into the country.

H.R. 6 will do more than that. It will expand the Medicare coverage for opioid treatment services, like substance abuse counseling, individual and group therapy, and medication-assisted treatment. These reforms will empower our Americans to overcome addiction and once again become productive members of our society.

Mr. Chairman, again, I thank Chairman BRADY and Chairman WALDEN for

their leadership in crafting this legislation, and for their steadfast leadership to address the opioid crisis.

Mr. NEAL. Mr. Chairman, I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Chairman, I am proud to yield 2 minutes to the gentleman from North Carolina (Mr. HOLDING).

Mr. HOLDING. Mr. Chairman, I would like to highlight the importance of medication-assisted treatment in combating the opioid epidemic.

This epidemic has pervaded all populations, including our seniors. Medicare beneficiaries have among the highest and fastest rate of opioid use disorder, yet they do not currently have coverage for the most effective treatment.

The SUPPORT Act, which will be before the House today, would change that. This bill provides for a fully coordinated, bundled-care model that will help patients through medication-assisted treatment, which combines the use of medication with counseling, group therapy, and drug testing.

Just this week, the NIH released a study that found delivering medication-assisted treatment to patients following an opioid overdose dropped the death rate by 59 percent.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also cited the value of medication-assisted treatment in reducing overdoses and relapses while retaining patients in a treatment program.

For example, a constituent named Jeff from North Carolina became dependent on opioids after a difficult back surgery. He initially tried to stop cold, but went into withdrawal and relapsed. Fortunately, Jeff was able to receive treatment from the Goldsboro Comprehensive Treatment Center where he went through counseling. His progress was monitored, and monthly drug screens kept him accountable. He—Jeff—now says that his life has changed 100 percent for the better.

□ 1030

Every Member of this House has constituents just like Jeff who have struggled with addiction but can regain their life with the right treatment. While there is no silver bullet to this crisis, we need to ensure patients and doctors have all options at their disposal to combat the opioid epidemic.

Mr. NEAL. Mr. Chair, I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Chair, I yield 1 minute to the gentlewoman from Indiana (Mrs. WALORSKI), a leader on the opioid crisis.

Mrs. WALORSKI. Mr. Chair, I thank Chairman BRADY for all of his work.

Mr. Chair, I rise today in support for the SUPPORT for Patients and Communities Act. It includes my bill, the Dr. Todd Graham Pain Management, Treatment, and Recovery Act, that passed the House earlier this week.

H.R. 6 is also vital for equipping those on the front lines with important treatment and recovery initiatives. This includes people in my district like Erin LaCourt at Victory Clinical Services in South Bend. Victory provides comprehensive treatment for individuals with substance abuse disorders, but H.R. 6 will help them expand those services to include seniors.

This bill will also help Justin Phillips, who founded Overdose Lifeline, which is dedicated to helping those affected by addiction, assist even more Hoosiers on their road to recovery.

Solving the opioid epidemic requires every one of us to work together. I want to thank Erin, Justin, and all the other hardworking Hoosiers in my district who deserve recognition and to let them know we have noticed all their hard work.

Mr. Chair, I urge my colleagues to support this bill.

Mr. NEAL. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I want to close by thanking Chairman KEVIN BRADY and acknowledging Chairman WALDEN and Ranking Member PALLONE for their hard work on what is really a good step forward.

As I said earlier in my remarks, this bill is not going to solve the opioid crisis tomorrow, but it does include a number of important provisions that will expand access to treatment and recovery options for all Americans. This was a bipartisan piece of work in our committee. I think we can be proud of it. We know many who need treatment now cannot access it, and this bill will take significant steps to change that.

I want to thank Jessica Shapiro and Karl Hagnauer from the House Legislative Counsel for their hours of work in helping us to put together H.R. 6; the staff of the Centers for Medicare and Medicaid Office of Legislation, in particular Ira Burney and Jennifer Druckman; and the staff of the Congressional Budget Office, including Rebecca Yip and Lara Robillard.

Finally, I want to thank the Ways and Means Republican staffers led by Emily Murry, the Energy and Commerce Democratic staff led by Tiffany Guarascio, the Energy and Commerce Republican staff led by Josh Trent, and my own Democratic staff at Ways and Means, which is always superb, led by Amy Hall, Melanie Egorin, and Rachel Dolin.

A lot of hard work goes into this sort of legislation and a lot of complexities have to be addressed during the process, and oftentimes that is not the sort of information that finds its way to the public light. But acknowledging here those people who helped to put this together as well as the men and women of the committee, I think, frequently is missed, and we want to do that so that they receive the, I think, due praise that they are entitled to.

I hope that this, when matched with Senate provisions, will quickly become law.

One of the things that unites every one of us in this Chamber is that we all know somebody—a family member, somebody who lives down the street, or a coworker—who has an opiate addiction. I think that Congress taking this step today in this direction will provide some sense of hope for those families and friends who find themselves, for a variety of reasons, suffering from the pain economically and physically that comes from opiate addictions.

I think, as we close here, this is a good day for the Ways and Means Committee, Energy and Commerce Committee, and, I think, for the members and the staffers whose work is reflected in this product.

Mr. Chair, I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Chair, I yield myself the balance of my time.

Mr. Chair, I agree with Mr. NEAL. Republicans and Democrats have come together from the Ways and Means Committee and Energy and Commerce to help millions of Americans through prevention of overprescribing, education for patients and prescribers, and access to treatment. This is a major step forward.

Mr. Chair, I urge Congress to pass this bill. I look forward to getting it to the President's desk.

Mr. Chair, I yield back the balance of my time.

The Acting CHAIR (Mr. POE of Texas). All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule.

The amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–76, modified by Rules Committee Print 115–78 and the amendment printed in part A of House Report 115–766, shall be considered as adopted. The bill, as amended, shall be considered as an original bill for the purpose of further amendment under the 5-minute rule and shall be considered as read.

The text of the bill, as amended, is as follows:

H.R. 6

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act'' or the ''SUPPORT for Patients and Communities Act''.

(b) TABLE OF CONTENTS.—The table of contents for the Act is as follows:

TITLE I—MEDICAID PROVISIONS TO ADDRESS THE OPIOID CRISIS

SEC. 101. AT-RISK YOUTH MEDICAID PROTECTION.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (82);

(B) by striking the period at the end of paragraph (83) and inserting ''; and''; and

(C) by inserting after paragraph (83) the following new paragraph:

''(84) provide that—

''(A) the State shall not terminate eligibility for medical assistance under the State plan for an individual who is an eligible juvenile (as defined in subsection (nn)(2)) because the juvenile is an inmate of a public institution (as defined in subsection (nn)(3)), but may suspend coverage during the period the juvenile is such an inmate;

''(B) in the case of an individual who is an eligible juvenile described in paragraph (2)(A) of subsection (nn), the State shall, prior to the individual's release from such a public institution, conduct a redetermination of eligibility for such individual with respect to such medical assistance (without requiring a new application from the individual) and, if the State determines pursuant to such redetermination that the individual continues to meet the eligibility requirements for such medical assistance, the State shall restore coverage for such medical assistance to such an individual upon the individual's release from such public institution; and

''(C) in the case of an individual who is an eligible juvenile described in paragraph (2)(B) of subsection (nn), the State shall process any application for medical assistance submitted by, or on behalf of, such individual such that the State makes a determination of eligibility for such individual with respect to such medical assistance upon release of such individual from such public institution.''; and

(2) by adding at the end the following new subsection:

''(nn) JUVENILE; ELIGIBLE JUVENILE; PUBLIC INSTITUTION.—For purposes of subsection (a)(84) and this subsection:

''(1) JUVENILE.—The term 'juvenile' means an individual who is—

''(A) under 21 years of age; or

''(B) described in subsection (a)(10)(A)(i)(IX).

''(2) ELIGIBLE JUVENILE.—The term 'eligible juvenile' means a juvenile who is an inmate of a public institution and who—

''(A) was determined eligible for medical assistance under the State plan immediately before becoming an inmate of such a public institution; or

''(B) is determined eligible for such medical assistance while an inmate of a public institution.

''(3) INMATE OF A PUBLIC INSTITUTION.—The term 'inmate of a public institution' has the meaning given such term for purposes of applying the subdivision (A) following paragraph (29) of section 1905(a), taking into account the exception in such subdivision for a patient of a medical institution.''.

(b) NO CHANGE IN EXCLUSION FROM MEDICAL ASSISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—Nothing in this section shall be construed as changing the exclusion from medical assistance under the subdivision (A) following paragraph (29) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act for such assistance.

(c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BEFORE ADJUDICATION OR SENTENCING.—Nothing in this section shall be construed to mandate, encourage, or suggest that a State suspend or terminate coverage for individuals before they have been adjudicated or sentenced.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to eligibility of juveniles who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act.

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 102. HEALTH INSURANCE FOR FORMER FOSTER YOUTH.

(a) COVERAGE CONTINUITY FOR FORMER FOSTER CARE CHILDREN UP TO AGE 26.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)) is amended—

(A) in item (bb), by striking ''are not described in or enrolled under'' and inserting ''are not described in and are not enrolled under'';

(B) in item (cc), by striking ''responsibility of the State'' and inserting ''responsibility of a State''; and

(C) in item (dd), by striking ''the State plan under this title or under a waiver of the'' and inserting ''a State plan under this title or under a waiver of such a''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect with respect to foster youth who attain 18 years of age on or after January 1, 2023.

(b) GUIDANCE.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to States, with respect to the State Medicaid programs of such States—

(1) on best practices for—

(A) removing barriers and ensuring streamlined, timely access to Medicaid coverage for former foster youth up to age 26; and

(B) conducting outreach and raising awareness among such youth regarding Medicaid coverage options for such youth; and

(2) which shall include examples of States that have successfully extended Medicaid coverage to former foster youth up to age 26.

SEC. 103. DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY UNDER THE MEDICAID PROGRAM.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY.—

''(1) IN GENERAL.—Not later than the date that is 180 days after the date of the enactment of this section, the Secretary shall, in consultation, as appropriate, with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, conduct a 54-month demonstration project for the purpose described in paragraph (2) under which the Secretary shall—

''(A) for the first 18-month period of such project, award planning grants described in paragraph (3); and

''(B) for the remaining 36-month period of such project, provide to each State selected under paragraph (4) payments in accordance with paragraph (5).

''(2) PURPOSE.—The purpose described in this paragraph is for each State selected under paragraph (4) to increase the treatment capacity of providers participating under the State plan (or a waiver of such plan) to provide substance use disorder treatment or recovery services under such plan (or waiver) through the following activities:

''(A) For the purpose described in paragraph (3)(C)(i), activities that support an ongoing assessment of the behavioral health treatment needs of the State, taking into account the matters described in subclauses (I) through (IV) of such paragraph.

''(B) Activities that, taking into account the results of the assessment described in subparagraph (A), support the recruitment, training, and provision of technical assistance for providers participating under the State plan (or a waiver of such plan) that offer substance use disorder treatment or recovery services.

''(C) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that—

''(i) are authorized to dispense drugs approved by the Food and Drug Administration for individuals with a substance use disorder who need

withdrawal management or maintenance treatment for such disorder;

''(ii) have in effect a registration or waiver under section 303(g) of the Controlled Substances Act for purposes of dispensing narcotic drugs to individuals for maintenance treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use for purposes of carrying out the requirements of such section 303(g); and

''(iii) are qualified under applicable State law to provide substance use disorder treatment or recovery services.

''(D) Improved reimbursement for and expansion of, through the provision of education, training, and technical assistance, the number or treatment capacity of providers participating under the State plan (or waiver) that have the qualifications to address the treatment or recovery needs of—

''(i) individuals enrolled under the State plan (or a waiver of such plan) who have neonatal abstinence syndrome, in accordance with guidelines issued by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists relating to maternal care and infant care with respect to neonatal abstinence syndrome;

''(ii) pregnant women, postpartum women, and infants, particularly the concurrent treatment, as appropriate, and comprehensive case management of pregnant women, postpartum women and infants, enrolled under the State plan (or a waiver of such plan);

''(iii) adolescents and young adults between the ages of 12 and 21 enrolled under the State plan (or a waiver of such plan); or

''(iv) American Indian and Alaska Native individuals enrolled under the State plan (or a waiver of such plan).

''(3) PLANNING GRANTS.—

''(A) IN GENERAL.—The Secretary shall, with respect to the first 18-month period of the demonstration project conducted under paragraph (1), award planning grants to at least 10 States selected in accordance with subparagraph (B) for purposes of preparing an application described in paragraph (4)(C) and carrying out the activities described in subparagraph (C).

''(B) SELECTION.—In selecting States for purposes of this paragraph, the Secretary shall—

''(i) select States that have a State plan (or waiver of the State plan) approved under this title;

''(ii) select States in a manner that ensures geographic diversity; and

''(iii) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

''(C) ACTIVITIES DESCRIBED.—Activities described in this subparagraph are, with respect to a State, each of the following:

''(i) Activities that support the development of an initial assessment of the behavioral health treatment needs of the State to determine the extent to which providers are needed (including the types of such providers and geographic area of need) to improve the network of providers that treat substance use disorders under the State plan (or waiver), including the following:

''(I) An estimate of the number of individuals enrolled under the State plan (or a waiver of such plan) who have a substance use disorder.

''(II) Information on the capacity of providers to provide substance use disorder treatment or recovery services to individuals enrolled under the State plan (or waiver), including information on providers who provide such services and their participation under the State plan (or waiver).

''(III) Information on the gap in substance use disorder treatment or recovery services under the State plan (or waiver) based on the information described in subclauses (I) and (II).

''(IV) Projections regarding the extent to which the State participating under the demonstration project would increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

''(ii) Activities that, taking into account the results of the assessment described in clause (i), support the development of State infrastructure to, with respect to the provision of substance use disorder treatment or recovery services under the State plan (or a waiver of such plan), recruit prospective providers and provide training and technical assistance to such providers.

''(D) FUNDING.—For purposes of subparagraph (A), there is appropriated, out of any funds in the Treasury not otherwise appropriated, $50,000,000, to remain available until expended.

''(4) POST-PLANNING STATES.—

''(A) IN GENERAL.—The Secretary shall, with respect to the remaining 36-month period of the demonstration project conducted under paragraph (1), select not more than 5 States in accordance with subparagraph (B) for purposes of carrying out the activities described in paragraph (2) and receiving payments in accordance with paragraph (5).

''(B) SELECTION.—In selecting States for purposes of this paragraph, the Secretary shall—

''(i) select States that received a planning grant under paragraph (3);

''(ii) select States that submit to the Secretary an application in accordance with the requirements in subparagraph (C), taking into consideration the quality of each such application;

''(iii) select States in a manner that ensures geographic diversity; and

''(iv) give preference to States with a prevalence of substance use disorders (in particular opioid use disorders) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses, or any other measure that the Secretary deems appropriate.

''(C) APPLICATIONS.—

''(i) IN GENERAL.—A State seeking to be selected for purposes of this paragraph shall submit to the Secretary, at such time and in such form and manner as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require, in addition to the following:

''(I) A proposed process for carrying out the ongoing assessment described in paragraph (2)(A), taking into account the results of the initial assessment described in paragraph (3)(C)(i).

''(II) A review of reimbursement methodologies and other policies related to substance use disorder treatment or recovery services under the State plan (or waiver) that may create barriers to increasing the number of providers delivering such services.

''(III) The development of a plan, taking into account activities carried out under paragraph (3)(C)(ii), that will result in long-term and sustainable provider networks under the State plan (or waiver) that will offer a continuum of care for substance use disorders. Such plan shall include the following:

''(aa) Specific activities to increase the number of providers (including providers that specialize in providing substance use disorder treatment or recovery services, hospitals, health care systems, Federally qualified health centers, and, as applicable, certified community behavioral health clinics) that offer substance use disorder treatment, recovery, or support services, including short-term detoxification services, outpatient substance use disorder services, and evidence-based peer recovery services.

''(bb) Strategies that will incentivize providers described in subparagraphs (C) and (D) of paragraph (2) to obtain the necessary training, education, and support to deliver substance use disorder treatment or recovery services in the State.

''(cc) Milestones and timeliness for implementing activities set forth in the plan.

''(dd) Specific measurable targets for increasing the substance use disorder treatment and recovery provider network under the State plan (or a waiver of such plan).

''(IV) A proposed process for reporting the information required under paragraph (6)(A), including information to assess the effectiveness of the efforts of the State to expand the capacity of providers to deliver substance use disorder treatment or recovery services during the period of the demonstration project under this subsection.

''(V) The expected financial impact of the demonstration project under this subsection on the State.

''(VI) A description of all funding sources available to the State to provide substance use disorder treatment or recovery services in the State.

''(VII) A preliminary plan for how the State will sustain any increase in the capacity of providers to deliver substance use disorder treatment or recovery services resulting from the demonstration project under this subsection after the termination of such demonstration project.

''(VIII) A description of how the State will coordinate the goals of the demonstration project with any waiver granted (or submitted by the State and pending) pursuant to section 1115 for the delivery of substance use services under the State plan, as applicable.

''(ii) CONSULTATION.—In completing an application under clause (i), a State shall consult with relevant stakeholders, including Medicaid managed care plans, health care providers, and Medicaid beneficiary advocates, and include in such application a description of such consultation.

''(5) PAYMENT.—

''(A) IN GENERAL.—For each quarter occurring during the period for which the demonstration project is conducted (after the first 18 months of such period), the Secretary shall pay under this subsection, subject to subparagraph (C), to each State selected under paragraph (4) an amount equal to 80 percent of so much of the qualified sums expended during such quarter.

''(B) QUALIFIED SUMS DEFINED.—For purposes of subparagraph (A), the term 'qualified sums' means, with respect to a State and a quarter, the amount equal to the amount (if any) by which the sums expended by the State during such quarter attributable to substance use treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds 1/4 of such sums expended by the State during fiscal year 2018 attributable to substance use treatment or recovery services.

''(C) NON-DUPLICATION OF PAYMENT.—In the case that payment is made under subparagraph (A) with respect to expenditures for substance use treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan), payment may not also be made under subsection (a) with respect to expenditures for the same services so furnished.

''(6) REPORTS.—

''(A) STATE REPORTS.—A State receiving payments under paragraph (5) shall, for the period of the demonstration project under this subsection, submit to the Secretary a quarterly report, with respect to expenditures for substance use treatment or recovery services for which payment is made to the State under this subsection, on the following:

''(i) The specific activities with respect to which payment under this subsection was provided.

''(ii) The number of providers that delivered substance use disorder treatment or recovery services in the State under the demonstration project compared to the estimated number of providers that would have otherwise delivered such services in the absence of such demonstration project.

''(iii) The number of individuals enrolled under the State plan (or a waiver of such plan) who received substance use disorder treatment

or recovery services under the demonstration project compared to the estimated number of such individuals who would have otherwise received such services in the absence of such demonstration project.

''(iv) Other matters as determined by the Secretary.

''(B) CMS REPORTS.—

''(i) INITIAL REPORT.—Not later than October 1, 2020, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an initial report on—

''(I) the States awarded planning grants under paragraph (3);

''(II) the criteria used in such selection; and

''(III) the activities carried out by such States under such planning grants.

''(ii) INTERIM REPORT.—Not later than October 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress an interim report—

''(I) on activities carried out under the demonstration project under this subsection;

''(II) on the extent to which States selected under paragraph (4) have achieved the stated goals submitted in their applications under subparagraph (C) of such paragraph;

''(III) with a description of the strengths and limitations of such demonstration project; and

''(IV) with a plan for the sustainability of such project.

''(iii) FINAL REPORT.—Not later than October 1, 2024, the Administrator of the Centers for Medicare & Medicaid Services shall, in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use, submit to Congress a final report—

''(I) providing updates on the matters reported in the interim report under clause (ii);

''(II) including a description of any changes made with respect to the demonstration project under this subsection after the submission of such interim report; and

''(III) evaluating such demonstration project.

''(C) AHRQ REPORT.—Not later than three years after the date of the enactment of this subsection, the Director of the Agency for Healthcare Research and Quality, on consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall submit to Congress a summary on the experiences of States awarded planning grants under paragraph (3) and States selected under paragraph (4).

''(7) DATA SHARING AND BEST PRACTICES.—During the period of the demonstration project under this subsection, the Secretary shall, in collaboration with States selected under paragraph (4), facilitate data sharing and the development of best practices between such States and States that were not so selected.

''(8) CMS FUNDING.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $5,000,000 to the Centers for Medicare & Medicaid Services for purposes of implementing this subsection. Such amount shall remain available until expended.''.

SEC. 104. DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1927 (42 U.S.C. 1396r–8) the following new section:

''SEC. 1927A. DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.

''(a) IN GENERAL.—Beginning January 1, 2020, a State shall operate a qualified drug management program under which a State may enroll certain at-risk beneficiaries identified by the State under the program.

''(b) QUALIFIED DRUG MANAGEMENT PROGRAM.—For purposes of this section, the term 'qualified drug management program' means, with respect to a State, a program carried out by the State (including through a contract with a pharmacy benefit manager) that provides at least for the following:

''(1) IDENTIFICATION OF AT-RISK INDIVIDUALS.—Under the program, the State identifies, in accordance with subsection (c), individuals enrolled under the State plan (or waiver of the State plan) who are at-risk beneficiaries.

''(2) ELEMENTS OF PROGRAM.—

''(A) IN GENERAL.—Under the program, the State, with respect to each individual identified under paragraph (1) and enrolled under the program under paragraph (5)—

''(i) subject to subparagraphs (B) and (C), selects at least one, but not more than three, health care providers and at least one, but not more than three, pharmacies for each such individual for purposes of clause (ii), in accordance with a selection process that takes into account reasonable factors such as the individual's previous utilization of items and services from health care providers and pharmacies, geographic proximity of the individual to such health care providers and pharmacies, access of the individual to health care, reasonable travel time, information regarding housing status, and any known preference of the individual for a certain health care provider or pharmacy; and

''(ii) requires that any controlled substance furnished to such individual during the period for which such individual is enrolled under the program be prescribed by a health care provider selected under clause (i) for such individual and dispensed by a pharmacy selected under clause (i) for such individual in order for such controlled substance to be covered under the State plan (or waiver).

''(B) BENEFICIARY PREFERENCE.—In the case of an individual receiving a notice under paragraph (3)(A) of being identified as potentially being an at-risk beneficiary described in such paragraph, such individual may submit, during the 30-day period following receipt of such notice, preferences for which health care providers and pharmacies the individual would prefer the State to select under subparagraph (A). The State shall select or change the selection of health care providers and pharmacies under subparagraph (A) for the individuals based on such preferences, except that in the case that State determines that such selection (or change of selection) of a health care provider or pharmacy under subparagraph (A) is contributing or would contribute to prescription drug abuse or drug diversion by the individual, the State may select or change the selection of health care provider or pharmacy for the individual without regard to the preferences of the individual described in this subparagraph. If the State selects or changes the selection pursuant to the preceding sentence without regard to the preferences of the individual, the State shall provide the individual with at least 30 days written notice of the selection or change of selection and a rationale for the selection or change.

''(C) TREATMENT OF PHARMACY WITH MULTIPLE LOCATIONS.—For purposes of subparagraph (A)(i), in the case of a pharmacy that has multiple locations that share real-time electronic prescription data, all such locations of the pharmacy shall collectively be treated as one pharmacy.

''(D) TREATMENT OF EXISTING FFS DRUG MANAGEMENT PROGRAMS.—In the case of a patient review and restriction program (as identified in the annual report submitted to the Secretary under section 1927(g)(3)(D)) operated by a State pursuant to section 1915(a)(2) before the date of the enactment of this section, such program shall be treated as a qualified drug management program.

''(E) REASONABLE ACCESS.—The program shall ensure, including through waiver of elements of the program (including under subparagraph (A)(ii)), reasonable access to health care (including access to health care providers and pharmacies with respect to prescription drugs described in subparagraph (A)) in the case of individuals with multiple residences, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(ii)(II)).

''(3) NOTIFICATION TO IDENTIFIED INDIVIDUALS.—Under the program, the State provides each individual who is identified under paragraph (1), prior to enrolling such individual under the program, at least one notification of each of the following:

''(A) Notice that the State has identified the individual as potentially being an at-risk beneficiary for abuse or misuse of a controlled substance.

''(B) The name, address, and contact information of each health care provider and pharmacy that may be selected for the individual under paragraph (2)(A).

''(C) Information describing all State and Federal public health resources that are designed to address such abuse or misuse to which the individual has access, including mental health services, substance use disorder and recovery services, and other counseling services.

''(D) Notice of, and information about, the right of the individual to—

''(i) submit preferences of the individual for health care providers and pharmacies to be selected under paragraph (2)(A), including as described in paragraph (2)(B);

''(ii) appeal under paragraph (4)—

''(I) such identification described in subparagraph (A); and

''(II) the selection of health care providers and pharmacies under paragraph (2)(A).

''(E) An explanation of the meaning and consequences of the identification of the individual as potentially being an at-risk beneficiary for abuse or misuse of a controlled substance, including an explanation of the program.

''(F) Information, including a contact list and clear instructions, that explain how the individual can contact the appropriate entities administering the program in order to submit preferences described in paragraph (2)(B) and any other communications relating to the program.

''(4) APPEALS PROCESS.—Under the program, the State provides for an appeals process under which, with respect to an individual identified under paragraph (1)—

''(A) such individual may appeal—

''(i) such identification; and

''(ii) the selection of a health care provider or pharmacy under paragraph (2)(A);

''(B) in the case of an appeal described in subparagraph (A)(ii), the State shall accommodate the health care provider or pharmacy preferred by the individual for selection for purposes of paragraph (2)(A), unless the State determines that a change to the selection of health care provider or pharmacy under such paragraph is contributing or would contribute to prescription drug abuse or drug diversion by the individual;

''(C) such individual is provided a period of not less than 30 days following the date of receipt of the notice described in paragraph (3) to submit such appeal; and

''(D) the State must make a determination with respect to an appeal described in subparagraph (A), and notify the individual of such determination, prior to enrollment of such individual in the program.

''(5) ENROLLMENT.—Under the program, the State initially enrolls individuals who are identified under paragraph (1) in the program for a 12-month period—

''(A) in the case of such an individual who does not submit an appeal under paragraph (4) within the period applied by the State pursuant to subparagraph (C) of such paragraph, beginning on the day after the last day of such period; and

''(B) in the case of such an individual who does submit an appeal under paragraph (4) within the period applied by the State pursuant to subparagraph (C) of such paragraph but such appeal is denied, beginning not later than 30 days after the date of such denial.

''(6) NOTIFICATION OF HEALTH CARE PROVIDERS AND PHARMACIES.—Under the program, the State provides to each health care provider and pharmacy selected for an individual under paragraph (2)—

''(A) notification that the individual is an at-risk beneficiary enrolled under the program and that the provider or pharmacy has been selected for the individual under paragraph (2);

''(B) information on such program and the role of being so selected; and

''(C) a process through which the provider or pharmacy can submit a concern or complaint with respect to being so selected.

''(7) CONTINUATION OF ENROLLMENT.—Under the program, the State, with respect to an individual enrolled under the program, provides for a process to—

''(A) not later than 30 days before the end of the 12-month period for which the individual is so enrolled pursuant to paragraph (5)—

''(i) assess, in accordance with publicly available evidence-based guidelines, whether or not such individual should continue to be enrolled under the program; and

''(ii) notify such individual of the results of the assessment under clause (i);

''(B) continue, subject to subparagraph (C), enrollment of such individual if such assessment recommends such continuation; and

''(C) appeal the continuation of enrollment in accordance with the appeals process described in paragraph (4).

''(c) AT-RISK BENEFICIARY.—

''(1) IDENTIFICATION.—For purposes of this section, a State shall identify an individual enrolled under the State plan (or waiver of the State plan) as an at-risk beneficiary if the individual is not an exempted individual described in paragraph (2) and—

''(A) is identified as such an at-risk beneficiary through the use of publicly available evidence-based guidelines that indicate misuse or abuse of a controlled substance; or

''(B) the State received notification from a PDP sponsor or Medicare Advantage organization that such individual was identified as being an at-risk beneficiary for prescription drug abuse for enrollment in a drug management program established by the sponsor or organization pursuant to section 1860D–4(c)(5) and such identification has not been terminated under subparagraph (F) of such section.

''(2) EXEMPTED INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an exempted individual described in this paragraph is an individual who—

''(A) is receiving—

''(i) hospice or palliative care; or

''(ii) treatment for cancer;

''(B) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

''(C) the State elects to treat as an exempted individual for purposes of paragraph (1).

''(d) APPLICATION OF PRIVACY RULES CLARIFICATION.—The Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subsection (b)(6) in the same manner as the Secretary is required under subparagraph (J) of section 1860D–4(c)(5) to clarify privacy requirements related to the sharing of data described in such subparagraph.

''(e) REPORTS.—

''(1) ANNUAL REPORTS.—A State operating a qualified drug management program shall include in the annual report submitted to the Secretary under section 1927(g)(3)(D), beginning with such reports submitted for 2021, the following information:

''(A) The number of individuals enrolled under the State plan (or waiver of the State plan) who are enrolled under the program and the percentage of individuals enrolled under the State plan (or waiver) who are enrolled under such program.

''(B) The number of prescriptions for controlled substances that were dispensed per month during each such year per individual enrolled under the program, including the daily morphine milligram equivalents and the quantity prescribed for each such prescription.

''(C) The number of pharmacies filling prescriptions for controlled substances for individuals enrolled under such program.

''(D) The number of health care providers writing prescriptions for controlled substances (other than prescriptions for a refill) for individuals enrolled under such program.

''(E) Any other data that the Secretary may require.

''(F) Any report submitted by a managed care entity under subsection (f)(1)(B) with respect to the year involved.

For each such report for a year after 2021, the information described in this paragraph shall be provided in a manner that compares such information with respect to the prior calendar year to such information with respect to the second prior calendar year.

''(2) MACPAC REPORTS AND REVIEW.—Not later than two years after the date of the enactment of this section, the Medicaid and CHIP Payment and Access Commission (in this section referred to as 'MACPAC'), in consultation with the National Association of Medicaid Directors, pharmacy benefit managers, managed care organizations, health care providers (including pharmacists), beneficiary advocates, and other stakeholders, shall publish a report that includes—

''(A) best practices for operating drug management programs, based on a review of a representative sample of States administering such a program;

''(B) a summary of the experience of the appeals process under drug management programs operated by several States, such as the frequency at which individuals appealed the identification of being an at-risk individual, the frequency at which individuals appealed the selection of a health care provider or pharmacy under such a program, the timeframes for such appeals, a summary of the reasons for such appeals, and the design of such appeals processes;

''(C) a summary of trends and the effectiveness of qualified drug management programs operated under this section; and

''(D) recommendations to States on how improvements can be made with respect to the operation of such programs.

In reporting on State practices, the MACPAC shall consider how such programs have been implemented in rural areas, under fee-for-service as well as managed care arrangements, and the extent to which such programs have resulted in increased efficiencies to such States or to the Federal Government under this title.

''(3) REPORT ON PLAN FOR COORDINATED CARE.—Not later than January 1, 2021, each State operating a qualified drug management program shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on how such State plans to provide coordinated care for individuals enrolled under the State plan (or waiver of the State plan) and—

''(A) who are enrolled under the program; or

''(B) who are enrolled with a managed care entity and enrolled under such a qualified drug management program operated by such entity.

''(f) APPLICABILITY TO MANAGED CARE ENTITIES.—

''(1) IN GENERAL.—With respect to any contract that a State enters into on or after January 1, 2020, with a managed care entity (as defined in section 1932(a)(1)(B)) pursuant to section 1903(m), the State shall, as a condition of the contract, require the managed care entity—

''(A) to operate a qualified drug management program (as defined in subsection (b)) for at-risk beneficiaries who are enrolled with such entity and identified by the managed care entity by means of application of paragraph (2);

''(B) to submit to the State an annual report on the matters described in subparagraphs (A) through (E) of subsection (e)(1); and

''(C) to submit to the State a list (and as necessary update such list) of individuals enrolled with such entity under the qualified drug management program operated by such entity under subparagraph (A) for purposes of allowing State plans for which medical assistance is paid on a fee-for-service basis to have access to such information.

''(2) APPLICATION.—For purposes of applying, with respect to a managed care entity—

''(A) under paragraph (1)(A)—

''(i) the definition of the term 'qualified drug management program' under subsection (b), other than paragraph (2)(D) of such subsection; and

''(ii) the provisions of paragraphs (1) and (2) of subsection (c); and

''(B) under paragraph (1)(B), the report requirements described in subparagraphs (A) through (E) of subsection (e)(1);

each reference in such subsection (b) and paragraphs of subsection (c) to 'a State' or 'the State' (other than to 'a State plan' or 'the State plan') shall be deemed a reference to the managed care entity, each reference under such subsection, paragraphs, or subparagraphs to individuals enrolled under the State plan (or waiver of the State plan) shall be deemed a reference to individuals enrolled with such entity, and each reference under such subsection, paragraphs, or subparagraphs to individuals enrolled under the qualified drug management program operated by the State shall be deemed a reference to individuals enrolled under the qualified drug management program operated by the managed care entity.

''(g) CONTROLLED SUBSTANCE DEFINED.—For purposes of this section, the term 'controlled substance' means a drug that is included in schedule II, III, or IV of section 202(c) of the Controlled Substances Act, or any combination thereof, as specified by the State.''.

(b) GUIDANCE ON AT-RISK POPULATION TRANSITIONING BETWEEN MEDICAID FFS AND MANAGED CARE.—Not later than October 1, 2019, the Secretary of Health and Human Services shall issue guidance for State Medicaid programs, with respect to individuals who are enrolled under a State plan (or waiver of such plan) under title XIX of the Social Security Act and under a drug management program, for purposes of providing best practices—

(1) for transitioning, as applicable, such individuals from fee-for-service Medicaid (and such a program operated by the State) to receiving medical assistance under such title through a managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act) with a contract that with the State pursuant to section 1903(m) of such Act (and such a program operated by such entity); and

(2) for transitioning, as applicable, such individuals from receiving medical assistance under such title through a managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act) with a contract that with the State pursuant to section 1903(m) of such Act (and such a program operated by such entity) to fee-for-service Medicaid (and such a program operated by the State).

(c) GUIDANCE ON AT-RISK POPULATION TRANSITIONING TO MEDICARE.—

(1) IN GENERAL.—Not later than January 1, 2020, the Secretary of Health and Human Services, after consultation with the Federal Coordinated Health Care Office established under section 2602 of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b), shall issue guidance for State Medicaid programs, with respect to transitioning individuals, providing for—

(A) notification to be submitted by the State to the Centers for Medicare & Medicaid Services and such individuals of the status of such individuals as transitioning individuals;

(B) notification to such individuals about enrollment under a prescription drug plan under part D of such title or under a MA–PD plan under part C of such title;

(C) best practices for transitioning such individuals to such a plan; and

(D) best practices for coordination between the qualified drug management program (as described in section 1927A(b) of the Social Security Act, as added by subsection (a)) carried out by the State and a drug management program carried out under such a plan pursuant to section 1860D–4(c)(5) of the Social Security Act (42 U.S.C. 1395w–10(c)(5)).

(2) TRANSITIONING INDIVIDUALS.—For purposes of paragraph (1), a transitioning individual is an individual who, with respect to a month—

(A) is enrolled under the State plan (or waiver of the State plan) and under the qualified drug management program (as described in section 1927A(b) of the Social Security Act, as added by subsection (a)) carried out by the State; and

(B) is expected to become eligible for the Medicare program under title XVIII of such Act during the subsequent 12-month period.

SEC. 105. MEDICAID DRUG REVIEW AND UTILIZATION.

(a) MEDICAID DRUG UTILIZATION REVIEW.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 101, is further amended—

(A) in paragraph (83), at the end, by striking ''and'';

(B) in paragraph (84), at the end, by striking the period and inserting ''; and''; and

(C) by inserting after paragraph (84) the following new paragraph:

''(85) provide that the State is in compliance with the drug review and utilization requirements under subsection (oo)(1).''.

(2) DRUG REVIEW AND UTILIZATION REQUIREMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 101, is further amended by adding at the end the following new subsection:

''(oo) DRUG REVIEW AND UTILIZATION REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of subsection (a)(85), the drug review and utilization requirements under this subsection are, subject to paragraph (3) and beginning October 1, 2019, the following:

''(A) CLAIMS REVIEW LIMITATIONS.—

''(i) IN GENERAL.—The State has in place—

''(I) safety edits (as specified by the State) for subsequent fills for opioids and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the State plan (or under a waiver of the State plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the State;

''(II) safety edits (as specified by the State) on the maximum daily morphine equivalent that can be prescribed to an individual enrolled under the State plan (or under a waiver of the State plan) for treatment of chronic pain and a claims review automated process (as designed and implemented by the State) that indicates when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any limitation that may be identified by the State; and

''(III) a claims review automated process (as designed and implemented by the State) that monitors when an individual enrolled under the State plan (or under a waiver of the State plan) is concurrently prescribed opioids and—

''(aa) benzodiazepines; or

''(bb) antipsychotics.

''(ii) MANAGED CARE ENTITIES.—The State requires each managed care entity (as defined in section 1932(a)(1)(B)) with respect to which the State has a contract under section 1903(m) or under section 1905(t)(3) to have in place, subject to paragraph (3), with respect to individuals who are eligible for medical assistance under the State plan (or under a waiver of the State plan) and who are enrolled with the entity, the limitations described in subclauses (I) and (II) of clause (i) and a claims review automated process described in subclause (III) of such clause.

''(iii) RULES OF CONSTRUCTION.—Nothing in this subparagraph may be construed as prohibiting a State or managed care entity from designing and implementing a claims review automated process under this subparagraph that provides for prospective or retrospective reviews of claims. Nothing in this subparagraph shall be understood as prohibiting the exercise of clinical judgment from a provider enrolled as a participating provider in a State plan (or waiver of the State plan) or contracting with a managed care entity regarding the best items and services for an individual enrolled under such State plan (or waiver).

''(B) PROGRAM TO MONITOR ANTIPSYCHOTIC MEDICATIONS BY CHILDREN.—The State has in place a program (as designed and implemented by the State) to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the State plan (or under a waiver of the State plan) and submits annually to the Secretary such information as the Secretary may require on activities carried out under such program for individuals not more than the age of 18 years generally and children in foster care specifically.

''(C) FRAUD AND ABUSE IDENTIFICATION.—The State has in place a process (as designed and implemented by the State) that identifies potential fraud or abuse of controlled substances by individuals enrolled under the State plan (or under a waiver of the State plan), health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

''(D) REPORTS.—The State shall include in the annual report submitted to the Secretary under section 1927(g)(3)(D) information on the limitations, requirement, program, and processes applied by the State under subparagraphs (A) through (C) in accordance with such manner and time as specified by the Secretary.

''(E) CLARIFICATION.—Nothing shall prevent a State from satisfying the requirement—

''(i) described in subparagraph (A) by having safety edits or a claims review automated process described in such subparagraph that was in place before October 1, 2019;

''(ii) described in subparagraph (B) by having a program described in such subparagraph that was in place before such date; or

''(iii) described in subparagraph (C) by having a process described in such subparagraph that was in place before such date.

''(2) ANNUAL REPORT BY SECRETARY.—For each fiscal year beginning with fiscal year 2020, the Secretary shall submit to Congress a report on the most recent information submitted by States under paragraph (1)(D).

''(3) EXCEPTIONS.—

''(A) CERTAIN INDIVIDUALS EXEMPTED.—The drug review and utilization requirements under this subsection shall not apply with respect to an individual who—

''(i) is receiving—

''(I) hospice or palliative care; or

''(II) treatment for cancer;

''(ii) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

''(iii) the State elects to treat as exempted from such requirements.

''(B) EXCEPTION RELATING TO ENSURING ACCESS.—In order to ensure reasonable access to health care, the Secretary shall waive the drug review and utilization requirements under this subsection, with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(ii)(II)).''.

(3) MANAGED CARE ENTITIES.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

''(i) DRUG UTILIZATION REVIEW ACTIVITIES AND REQUIREMENTS.—Beginning not later than October 1, 2019, each contract under a State plan with a managed care entity (other than a primary care case manager) under section 1903(m) shall provide that the entity is in compliance with the applicable provisions of section 438.3(s)(2) of title 42 of the Code of Federal Regulations, section 483.3(s)(4)) of such title, and section 483.3(s)(5) of such title, as such provisions were in effect on March 31, 2018.''.

(b) IDENTIFYING AND ADDRESSING INAPPROPRIATE PRESCRIBING AND BILLING PRACTICES UNDER MEDICAID.—

(1) IN GENERAL.—Section 1927(g) of the Social Security Act (42 U.S.C. 1396r–8(g)) is amended—

(A) in paragraph (1)(A)—

(i) by striking ''of section 1903(i)(10)(B)'' and inserting ''of section 1902(a)(54)'';

(ii) by striking '', by not later than January 1, 1993,'';

(iii) by inserting after ''gross overuse,'' the following: ''excessive utilization,''; and

(iv) by striking ''or inappropriate or medically unnecessary care'' and inserting ''inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization''; and

(B) in paragraph (2)(B)—

(i) by inserting after ''gross overuse,'' the following: ''excessive utilization,''; and

(ii) by striking ''or inappropriate or medically unnecessary care'' and inserting ''inappropriate or medically unnecessary care, or prescribing or billing practices that indicate abuse or excessive utilization''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect with respect to retrospective drug use reviews conducted on or after October 1, 2020.

SEC. 106. GUIDANCE TO IMPROVE CARE FOR INFANTS WITH NEONATAL ABSTINENCE SYNDROME AND THEIR MOTHERS; GAO STUDY ON GAPS IN MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER.

(a) GUIDANCE.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidance to improve care for infants with neonatal abstinence syndrome and their families. Such guidance shall include—

(1) the types of services, including post-discharge services and parenting supports, for families of babies with neonatal abstinence syndrome that States may cover under the Medicaid program under title XIX of the Social Security Act;

(2) best practices from States with respect to innovative or evidenced-based payment models that focus on prevention, screening, treatment, plans of safe care, and post-discharge services for mothers and fathers with substance use disorders and babies with neonatal abstinence syndrome that improve care and clinical outcomes;

(3) recommendations for States on available financing options under the Medicaid program under title XIX of such Act and under the Children's Health Insurance Program under title XXI of such Act for Children's Health Insurance Program Health Services Initiative funds for parents with substance use disorders, infants with neonatal abstinence syndrome, and home visiting services; and

(4) guidance and technical assistance to State Medicaid agencies regarding additional flexibilities and incentives related to screening, prevention, and post-discharge services, including parenting supports.

(b) GAO STUDY.—Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to Congress a report, addressing gaps in coverage for pregnant women with substance use disorder under the Medicaid program under title XIX of the Social Security Act, and gaps in coverage for postpartum women with substance use disorder who had coverage during their pregnancy under the Medicaid program under such title.

SEC. 107. MEDICAID HEALTH HOMES FOR OPIOID-USE-DISORDER MEDICAID ENROLLEES.

(a) EXTENSION OF ENHANCED FMAP FOR CERTAIN HEALTH HOMES FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS.—Section 1945 of the Social Security Act (42 U.S.C. 1396w–4) is amended—

(1) in subsection (c)—

(A) in paragraph (1), by inserting ''subject to paragraph (4),'' after ''except that,''; and

(B) by adding at the end the following new paragraph:

''(4) SPECIAL RULE RELATING TO SUBSTANCE USE DISORDER HEALTH HOMES.—

''(A) IN GENERAL.—In the case of a State with an SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the application of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-eligible individuals under such State plan amendment, in addition to the first 8 fiscal year quarters the State plan amendment is in effect, for the subsequent 2 fiscal year quarters that the State plan amendment is in effect. Nothing in this section shall be construed as prohibiting a State with a State plan amendment that is approved under this section and that is not an SUD-focused State plan amendment from additionally having approved on or after such date an SUD-focused State plan amendment under this section, including for purposes of application of this paragraph.

''(B) REPORT REQUIREMENTS.—In the case of a State with an SUD-focused State plan amendment for which the application of the Federal medical assistance percentage has been extended under subparagraph (A), such State shall, at the end of the period of such State plan amendment, submit to the Secretary a report on the following, with respect to SUD-eligible individuals provided health home services under such State plan amendment:

''(i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

''(ii) The access of such individuals to health care.

''(iii) The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall specify all applicable measures for determining quality, access, and expenditures.

''(C) BEST PRACTICES.—Not later than October 1, 2020, the Secretary shall make publicly available on the Internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on the experiences of States that have State plan amendments approved under this section that include SUD-eligible individuals.

''(D) DEFINITIONS.—For purposes of this paragraph:

''(i) SUD-ELIGIBLE INDIVIDUALS.—The term 'SUD-eligible individual' means, with respect to a State, an individual who satisfies all of the following:

''(I) The individual is an eligible individual with chronic conditions.

''(II) The individual is an individual with a substance use disorder.

''(III) The individual has not previously received health home services under any other State plan amendment approved for the State under this section by the Secretary.

''(ii) SUD-FOCUSED STATE PLAN AMENDMENT.—The term 'SUD-focused State plan amendment' means a State plan amendment under this section that is designed to provide health home services primarily to SUD-eligible individuals.''.

(b) REQUIREMENT FOR STATE MEDICAID PLANS TO PROVIDE COVERAGE FOR MEDICATION-ASSISTED TREATMENT.—

(1) REQUIREMENT FOR STATE MEDICAID PLANS TO PROVIDE COVERAGE FOR MEDICATION-ASSISTED TREATMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in the matter preceding clause (i), by striking ''and (28)'' and inserting ''(28), and (29)''.

(2) INCLUSION OF MEDICATION-ASSISTED TREATMENT AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(A) in paragraph (28), by striking ''and'' at the end;

(B) by redesignating paragraph (29) as paragraph (30); and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) subject to paragraph (2) of subsection (ee), for the period beginning October 1, 2020, and ending September 30, 2025, medication-assisted treatment (as defined in paragraph (1) of such subsection); and''.

(3) MEDICATION-ASSISTED TREATMENT DEFINED; WAIVERS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(ee) MEDICATION-ASSISTED TREATMENT.—

''(1) DEFINITION.—For purposes of subsection (a)(29), the term 'medication-assisted treatment'—

''(A) means all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and

''(B) includes, with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

''(2) EXCEPTION.—The provisions of paragraph (29) of subsection (a) shall not apply with respect to a State for the period specified in such paragraph, if before the beginning of such period the State certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3).''.

(4) EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall apply with respect to medical assistance provided on or after October 1, 2020, and before October 1, 2025.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by the amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

TITLE II—MEDICARE PROVISIONS TO ADDRESS THE OPIOID CRISIS

SEC. 201. AUTHORITY NOT TO APPLY CERTAIN MEDICARE TELEHEALTH REQUIREMENTS IN THE CASE OF CERTAIN TREATMENT OF A SUBSTANCE USE DISORDER OR CO-OCCURRING MENTAL HEALTH DISORDER.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (2)(B)(i), by inserting ''and paragraph (7)(E)'' after ''Subject to clause (ii)''; and

(2) by adding at the end the following new paragraphs:

''(7) AUTHORITY NOT TO APPLY CERTAIN REQUIREMENTS IN THE CASE OF CERTAIN TREATMENT OF SUBSTANCE USE DISORDER OR CO-OCCURRING MENTAL HEALTH DISORDER.—

''(A) IN GENERAL.—For purposes of payment under this subsection, in the case of telehealth services described in subparagraph (C) furnished on or after January 1, 2020, to an eligible beneficiary (as defined in subparagraph (F)) for the treatment of a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder, the Secretary is authorized to, through rulemaking, not apply any of the requirements described in subparagraph (B).

''(B) REQUIREMENTS DESCRIBED.—For purposes of this paragraph, the requirements described in this subparagraph are any of the following:

''(i) Qualifications for an originating site under paragraph (4)(C)(ii).

''(ii) Geographic limitations under paragraph (4)(C)(i).

''(C) TELEHEALTH SERVICES DESCRIBED.—For purposes of this paragraph, the telehealth services described in this subparagraph are services that are both telehealth services and identified by the Secretary, through rulemaking, as services that are the most commonly furnished (as defined by the Secretary) under this part to individuals diagnosed with a substance use disorder or a mental health disorder that is co-occurring with a substance use disorder.

''(D) CLARIFICATION.—Nothing in this paragraph shall be construed as limiting or otherwise affecting the authority of the Secretary to limit or eliminate the non-application pursuant to this paragraph of any of the requirements under subparagraph (B).

''(E) TREATMENT OF ORIGINATING SITE FACILITY FEE.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (B) for which payment is made under this subsection by reason of the non-application of a requirement described in subparagraph (B) pursuant to this paragraph if payment for such service would not otherwise be permitted under this subsection if such requirement were applied.

''(F) ELIGIBLE BENEFICIARY DEFINED.—For purposes of this paragraph, the term 'eligible beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under this part;

''(ii) has a diagnosis for a substance use disorder; and

''(iii) meets such other criteria as the Secretary determines appropriate.

''(G) REPORT.—Not later than 5 years after the date of the enactment of this paragraph, the Secretary shall submit to Congress a report on the impact of any non-application under this paragraph of any of the requirements described in subparagraph (B) on

''(i) the utilization of health care services related to substance use disorder, such as behavioral health services and emergency department visits; and

''(ii) health outcomes related to substance use disorder, such as substance use overdose deaths.

''(H) FUNDING.—For purposes of carrying out this paragraph, in addition to funds otherwise

available, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $3,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to remain available until expended.

''(8) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed as waiving requirements under this title to comply with applicable State law, including State licensure requirements.''.

SEC. 202. ENCOURAGING THE USE OF NON-OPIOID ANALGESICS FOR THE MANAGEMENT OF POST-SURGICAL PAIN.

Section 1833(t)(6) of the Social Security Act (42 U.S.C. 1395l(t)(6)) is amended—

(1) in subparagraph (C)(i), by inserting ''or, in the case of an eligible non-opioid analgesic (as defined in subparagraph (J)), during a period of 5 years,'' after ''3 years,''; and

(2) by adding at the end the following new subparagraph:

''(J) ELIGIBLE NON-OPIOID ANALGESIC DEFINED.—In this paragraph, the term 'eligible non-opioid analgesic' means a drug or biological—

''(i) that is an analgesic that is not an opioid;

''(ii) that demonstrated substantial clinical improvement; and

''(iii) for which payment—

''(I) as an outpatient hospital service under this part was not being made as of the date of the enactment of this subparagraph; or

''(II) was being made under this paragraph as of such date.''.

SEC. 203. REQUIRING A REVIEW OF CURRENT OPIOID PRESCRIPTIONS FOR CHRONIC PAIN AND SCREENING FOR OPIOID USE DISORDER TO BE INCLUDED IN THE WELCOME TO MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) IN GENERAL.—Section 1861(ww) of the Social Security Act (42 U.S.C. 1395x(ww)) is amended—

(1) in paragraph (1), by inserting ''and a review of current opioid prescriptions and screening for opioid use disorder (as defined in paragraph (4)),'' before ''but does not include''; and

(2) by adding at the end the following new paragraph:

''(4)(A) For purposes of paragraph (1), the term 'a review of current opioid prescriptions and screening for opioid use disorder' means, with respect to an individual—

''(i) a review by a physician or qualified nonphysician practitioner of all current prescriptions of the individual; and

''(ii) in the case of an individual determined by the review of a physician or qualified nonphysician practitioner under subparagraph (A) to have a current prescription for opioids for chronic pain that has been prescribed for a minimum period of time (as specified by the Secretary)—

''(I) a review by the physician or practitioner of the potential risk factors to the individual for opioid use disorder;

''(II) an evaluation by the physician or practitioner of pain of the individual;

''(III) the provision of information regarding non-opioid treatment options for the treatment and management of any chronic pain of the individual; and

''(IV) if determined necessary by the physician or practitioner based on the results of the review and evaluation conducted as described in this paragraph, an appropriate referral by the physician or practitioner for additional treatment.

''(B) For purposes of this paragraph, the term 'qualified non-physician practitioner' means a physician assistant, nurse practitioner, or certified clinical nurse specialist.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to initial preventive physical examinations furnished on or after January 1, 2020.

SEC. 204. MODIFICATION OF PAYMENT FOR CERTAIN OUTPATIENT SURGICAL SERVICES.

(a) FREEZE OF PAYMENT FOR CERTAIN SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1833(i)(2) of the Social Security Act (42 U.S.C. 1395l(i)(2)) is amended by adding at the end the following new subparagraph:

''(F)(i) With respect to a targeted procedure (as defined in clause (ii)) furnished during 2020 or a subsequent year (before 2024) to an individual in an ambulatory surgical center, the payment amount for such procedure that would otherwise be determined under the revised payment system under subparagraph (D), without application of this subparagraph, shall be equal to the payment amount for such procedure furnished in 2016.

''(ii) For purposes of clause (i), the term 'targeted procedure' means a procedure to which Healthcare Common Procedure Coding System 62310 (or, for years beginning after 2016, 62321), 62311 (or, for years beginning after 2016, 62323), 62264, 64490, 64493, or G0260 (or any successor code) applies.

''(iii) This subparagraph shall not be applied in a budget-neutral manner.''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—The Comptroller General shall collect data relating to the cost differential between targeted procedures (as defined in section 1833(i)(2)(F)(ii) of the Social Security Act, as added by subsection (a)) that are performed in a hospital operating room and such procedures that are performed in an office setting within a hospital in order to determine whether such procedures are being properly coded for claims, based on setting, for payment under section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) and to determine if further changes are needed in the classification system for covered outpatient department services (as described in section 1833(t)(2)(A) of the Social Security Act (42 U.S.C. 1395l(t)(2)(A)).

(2) REPORT.—Not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate containing—

(A) a determination of whether procedures described in paragraph (1) are being properly coded for claims, based on setting, for payment under section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)); and

(B) recommendations on any changes the Comptroller General determines are needed in the classification system for covered outpatient department services (as described in section 1833(t)(2)(A) of the Social Security Act (42 U.S.C. 1395l(t)(2)(A)).

(c) STUDY.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study and submit to Congress a report on the extent to which procedures described in section 1833(i)(2)(F)(ii) of the Social Security Act, as added by subsection (a), are effective at preventing the need for opioids for individuals furnished such procedures.

SEC. 205. REQUIRING E-PRESCRIBING FOR COVERAGE OF COVERED PART D CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 1860D–4(e) of the Social Security Act (42 U.S.C. 1395w–104(e)) is amended by adding at the end the following:

''(7) REQUIREMENT OF E-PRESCRIBING FOR CONTROLLED SUBSTANCES.—

''(A) IN GENERAL.—Subject to subparagraph (B), a prescription for a covered part D drug under a prescription drug plan (or under an MA–PD plan) for a schedule II, III, IV, or V controlled substance shall be transmitted by a health care practitioner electronically in accordance with an electronic prescription drug program that meets the requirements of paragraph (2).

''(B) EXCEPTION FOR CERTAIN CIRCUMSTANCES.—The Secretary shall, pursuant to rulemaking, specify circumstances with respect to which the Secretary may waive the requirement under subparagraph (A), with respect to a covered part D drug, including in the case of—

''(i) a prescription issued when the practitioner and dispenser are the same entity;

''(ii) a prescription issued that cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;

''(iii) a prescription issued by a practitioner who has received a waiver or a renewal thereof for a specified period determined by the Secretary, not to exceed one year, from the requirement to use electronic prescribing, pursuant to a process established by regulation by the Secretary, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner;

''(iv) a prescription issued by a practitioner under circumstances in which, notwithstanding the practitioner's ability to submit a prescription electronically as required by this subsection, such practitioner reasonably determines that it would be impractical for the individual involved to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition involved;

''(v) a prescription issued by a practitioner allowing for the dispensing of a non-patient specific prescription pursuant to a standing order, approved protocol for drug therapy, collaborative drug management, or comprehensive medication management, in response to a public health emergency, or other circumstances where the practitioner may issue a non-patient specific prescription;

''(vi) a prescription issued by a practitioner prescribing a drug under a research protocol;

''(vii) a prescription issued by a practitioner for a drug for which the Food and Drug Administration requires a prescription to contain elements that are not able to be included in electronic prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use; and

''(viii) a prescription issued by a practitioner for an individual who—

''(I) receives hospice care under this title; or

''(II) is a resident of a skilled nursing facility (as defined in section 1819(a)), or a medical institution or nursing facility for which payment is made for an institutionalized individual under section 1902(g)(1)(B), for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy, as determined by the Secretary in accordance with this paragraph.

''(C) DISPENSING.—Nothing in this paragraph shall be construed as requiring a sponsor of a prescription drug plan under this part, MA organization offering an MA–PD plan under part C, or a pharmacist to verify that a practitioner, with respect to a prescription for a covered part D drug, has a waiver (or is otherwise exempt) under subparagraph (B) from the requirement under subparagraph (A). Nothing in this paragraph shall be construed as affecting the ability of the plan to cover or the pharmacists' ability to continue to dispense covered part D drugs from otherwise valid written, oral or fax prescriptions that are consistent with laws and regulations. Nothing in this paragraph shall be construed as affecting the ability of the beneficiary involved to designate a particular pharmacy to dispense a prescribed drug to the extent consistent with the requirements under subsection (b)(1) and under this paragraph.

''(D) ENFORCEMENT.—The Secretary shall, pursuant to rulemaking, have authority to enforce and specify appropriate penalties for noncompliance with the requirement under subparagraph (A).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage of drugs prescribed on or after January 1, 2021.

SEC. 206. REQUIRING PRESCRIPTION DRUG PLAN SPONSORS UNDER MEDICARE TO ESTABLISH DRUG MANAGEMENT PROGRAMS FOR AT-RISK BENEFICIARIES.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended—

(1) in paragraph (1), by inserting after subparagraph (E) the following new subparagraph:

''(F) With respect to plan years beginning on or after January 1, 2021, a drug management program for at-risk beneficiaries described in paragraph (5).''; and

(2) in paragraph (5)(A), by inserting ''(and for plan years beginning on or after January 1, 2021, a PDP sponsor shall)'' after ''A PDP sponsor may''.

SEC. 207. MEDICARE COVERAGE OF CERTAIN SERVICES FURNISHED BY OPIOID TREATMENT PROGRAMS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (FF), by striking at the end ''and'';

(2) in subparagraph (GG), by inserting at the end ''; and''; and

(3) by adding at the end the following new subparagraph:

''(HH) opioid use disorder treatment services (as defined in subsection (jjj)).''.

(b) OPIOID USE DISORDER TREATMENT SERVICES AND OPIOID TREATMENT PROGRAM DEFINED.—Section 1861 of the Social Security Act is amended by adding at the end the following new subsection:

''(jjj) OPIOID USE DISORDER TREATMENT SERVICES; OPIOID TREATMENT PROGRAM.—

''(1) OPIOID USE DISORDER TREATMENT SERVICES.—The term 'opioid use disorder treatment services' means items and services that are furnished by an opioid treatment program for the treatment of opioid use disorder, including—

''(A) opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug and Cosmetic Act for use in the treatment of opioid use disorder;

''(B) dispensing and administration of such medications, if applicable;

''(C) substance use counseling by a professional to the extent authorized under State law to furnish such services;

''(D) individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law);

''(E) toxicology testing, and

''(F) other items and services that the Secretary determines are appropriate (but in no event to include meals or transportation).

''(2) OPIOID TREATMENT PROGRAM.—The term 'opioid treatment program' means an entity that is opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any successor regulation) that—

''(A) is enrolled under section 1866(j);

''(B) has in effect a certification by the Substance Abuse and Mental Health Services Administration for such a program;

''(C) is accredited by an accrediting body approved by the Substance Abuse and Mental Health Services Administration; and

''(D) meets such additional conditions as the Secretary may find necessary to ensure—

''(i) the health and safety of individuals being furnished services under such program; and

''(ii) the effective and efficient furnishing of such services.''.

(c) PAYMENT.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (BB)'' and inserting ''(BB)''; and

(B) by inserting before the semicolon at the end the following '', and (CC) with respect to opioid use disorder treatment services furnished during an episode of care, the amount paid shall be equal to the amount payable under section 1834(w) less any copayment required as specified by the Secretary''.

(2) PAYMENT DETERMINATION.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(w) OPIOID USE DISORDER TREATMENT SERVICES.—

''(1) IN GENERAL.—The Secretary shall pay to an opioid treatment program (as defined in paragraph (2) of section 1861(jjj)) an amount that is equal to 100 percent of a bundled payment under this part for opioid use disorder treatment services (as defined in paragraph (1) of such section) that are furnished by such program to an individual during an episode of care (as defined by the Secretary) beginning on or after January 1, 2020. The Secretary shall ensure, as determined appropriate by the Secretary, that no duplicative payments are made under this part or part D for items and services furnished by an opioid treatment program.

''(2) CONSIDERATIONS.—The Secretary may implement this subsection through one or more bundles based on the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug), the frequency of services, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine appropriate. In developing such bundles, the Secretary may consider payment rates paid to opioid treatment programs for comparable services under State plans under title XIX or under the TRICARE program under chapter 55 of title 10 of the United States Code.

''(3) ANNUAL UPDATES.—The Secretary shall provide an update each year to the bundled payment amounts under this subsection.''.

(d) INCLUDING OPIOID TREATMENT PROGRAMS AS MEDICARE PROVIDERS.—Section 1866(e) of the Social Security Act (42 U.S.C. 1395cc(e)) is amended—

(1) in paragraph (1), by striking at the end ''and'';

(2) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(3) opioid treatment programs (as defined in paragraph (2) of section 1861(jjj)), but only with respect to the furnishing of opioid use disorder treatment services (as defined in paragraph (1) of such section).''.

TITLE III—OTHER HEALTH PROVISIONS TO ADDRESS THE OPIOID CRISIS

SEC. 301. CLARIFYING FDA REGULATION OF NON-ADDICTIVE PAIN AND ADDICTION THERAPIES.

(a) PUBLIC MEETINGS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall hold not less than one public meeting to address the challenges and barriers of developing non-addictive medical products intended to treat pain or addiction, which may include—

(1) the application of novel clinical trial designs (consistent with section 3021 of the 21st Century Cures Act (Public Law 114–255)), use of real world evidence (consistent with section 505F of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355g)), and use of patient experience data (consistent with section 569C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c)) for the development of non-addictive medical products intended to treat pain or addiction; and

(2) the application of eligibility criteria under sections 506 and 515B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356, 360e–3) for non-addictive medical products intended to treat pain or addiction.

(b) GUIDANCE.—Not later than one year after the public meetings are conducted under subsection (a) the Secretary shall issue one or more final guidance documents, or update existing guidance documents, to help address challenges to developing non-addictive medical products to treat pain or addiction. Such guidance documents shall include information regarding—

(1) how the Food and Drug Administration may apply sections 506 and 515B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356, 360e–3) to non-addictive medical products intended to treat pain or addiction, including the circumstances under which the Secretary—

(A) may apply the eligibility criteria under such sections 506 and 515B to non-opioid or non-addictive medical products intended to treat pain or addiction;

(B) considers the risk of addiction of controlled substances approved to treat pain when establishing unmet medical need; and

(C) considers pain, pain control, or pain management in assessing whether a disease or condition is a serious or life-threatening disease or condition; and

(2) the methods by which sponsors may evaluate acute and chronic pain, endpoints for non-addictive medical products intended to treat pain, the manner in which endpoints and evaluations of efficacy will be applied across and within review divisions, taking into consideration the etiology of the underlying disease, and the manner in which sponsors may use surrogate endpoints, intermediate endpoints, and real world evidence.

(c) MEDICAL PRODUCT DEFINED.—In this section, the term ''medical product'' means a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1))), biological product (as defined in section 351(i) of the Public Health Service Act (42 U.S.C. 262(i))), or device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))).

SEC. 302. SURVEILLANCE AND TESTING OF OPIOIDS TO PREVENT FENTANYL DEATHS.

(a) PUBLIC HEALTH LABORATORIES TO DETECT FENTANYL.—Part F of title III of the Public Health Service Act (42 U.S.C. 262 et seq.) is amended—

(1) in the heading of part F, by striking ''AND CLINICAL LABORATORIES'' and inserting '', CLINICAL LABORATORIES, AND PUBLIC HEALTH LABORATORIES''; and

(2) by adding at the end the following new subpart:

''Subpart 4—Public Health Laboratories

''SEC. 355. PUBLIC HEALTH LABORATORIES TO DETECT FENTANYL.

''(a) IN GENERAL.—The Secretary shall establish a program to award grants to Federal, State, and local agencies to support the establishment or operation of public health laboratories to detect fentanyl, its analogues, and other synthetic opioids, as described in subsection (b).

''(b) STANDARDS.—The Secretary, in consultation with the Director of the National Institute of Standards and Technology, shall—

''(1) develop standards for safely and effectively handling and testing fentanyl, its analogues, and other synthetic opioids;

''(2) develop fentanyl and fentanyl analog reference materials and quality control standards and protocols to calibrate instrumentation for clinical diagnostics and postmortem surveillance; and

''(3) include in the standards developed pursuant to paragraph (1) procedures for encountering new and emerging synthetic opioid formulations and reporting those findings to other Federal, State, and local public health laboratories.

''(c) LABORATORIES.—The Secretary shall require grantees under subsection (a) to—

''(1) follow the standards established under subsection (b) and be capable of providing systematic and routine laboratory testing of drugs

for the purposes of obtaining and disseminating public health information to Federal, State, and local public health officials, laboratories, and other entities the Secretary deems appropriate;

''(2) work with law enforcement agencies and public health authorities, as feasible, to develop real-time information on the purity and movement of fentanyl, its analogues, and other synthetic opioids;

''(3) assist State and local law enforcement agencies in testing seized drugs when State and local forensic laboratories request additional assistance;

''(4) provide early warning information and advice to Federal, State, and local law enforcement agencies and public health authorities regarding potential significant changes in the supply of fentanyl, its analogues, and other synthetic opioids;

''(5) provide biosurveillance for non-fatal exposures; and

''(6) provide diagnostic testing for non-fatal exposures of emergency personnel.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2019 through 2023.''.

(b) ENHANCED FENTANYL SURVEILLANCE.—Title III of the Public Health Service Act is amended by inserting after section 317T of such Act (42 U.S.C. 247b–22) the following new section:

''SEC. 317U. ENHANCED FENTANYL SURVEILLANCE.

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall enhance its drug surveillance program by—

''(1) expanding its surveillance program to include all 50 States and the territories of the United States;

''(2) increasing and accelerating the collection of data on fentanyl, its analogues, and other synthetic opioids and new emerging drugs of abuse, including related overdose data from medical examiners and drug treatment admissions; and

''(3) utilizing available and emerging information on fentanyl, its analogues, and other synthetic opioids and new emerging drugs of abuse, including information from—

''(A) the National Drug Early Warning System;

''(B) State and local public health authorities; and

''(C) Federal, State, and local public health laboratories.

''(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2019 through 2023.''.

(c) PILOT PROGRAM FOR POINT-OF-USE TESTING OF ILLICIT DRUGS FOR DANGEROUS CONTAMINANTS.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

''SEC. 399V-7. PILOT PROGRAM FOR POINT-OF-USE TESTING OF ILLICIT DRUGS FOR DANGEROUS CONTAMINANTS.

''(a) IN GENERAL.—The Secretary shall—

''(1) establish a pilot program through which 5 State or local agencies conduct, in 5 States, point-of-use testing of illicit drugs for dangerous contaminants;

''(2) establish metrics to evaluate the success of the pilot program in reducing drug overdose rates; and

''(3) based on such metrics, conduct an annual evaluation of the pilot program and submit an annual report to the Congress containing the results of such evaluation.

''(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2019 through 2023.''.

SEC. 303. ALLOWING FOR MORE FLEXIBILITY WITH RESPECT TO MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDERS.

(a) CONFORMING APPLICABLE NUMBER.—Subclause (II) of section 303(g)(2)(B)(iii) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(B)(iii)) is amended to read as follows:

''(II) The applicable number is—

''(aa) 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients;

''(bb) 100 if the practitioner holds additional credentialing, as defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations); or

''(cc) 100 if the practitioner provides medication-assisted treatment (MAT) using covered medications (as such terms are defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations)) in a qualified practice setting (as described in section 8.615 of title 42, Code of Federal Regulations (or successor regulations)).''.

(b) ELIMINATING ANY TIME LIMITATION FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO BECOME QUALIFYING PRACTITIONERS.—Clause (iii) of section 303(g)(2)(G) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)) is amended—

(1) in subclause (I), by striking ''or'' at the end; and

(2) by amending subclause (II) to read as follows:

''(II) a qualifying other practitioner, as defined in clause (iv), who is a nurse practitioner or physician assistant; or''.

(c) IMPOSING A TIME LIMITATION FOR CLINICAL NURSE SPECIALISTS, CERTIFIED REGISTERED NURSE ANESTHETISTS, AND CERTIFIED NURSE MIDWIFES TO BECOME QUALIFYING PRACTITIONERS.—Clause (iii) of section 303(g)(2)(G) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)), as amended by subsection (b), is further amended by adding at the end the following:

''(III) for the period beginning on October 1, 2018, and ending on October 1, 2023, a qualifying other practitioner, as defined in clause (iv), who is a clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife.''.

(d) DEFINITION OF QUALIFYING OTHER PRACTITIONER.—Section 303(g)(2)(G)(iv) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(iv)) is amended by striking ''nurse practitioner or physician assistant'' each place it appears and inserting ''nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant''.

(e) REPORT BY SECRETARY.—Not later than two years after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration, shall submit to Congress a report that assesses the care provided by qualifying practitioners (as defined in section 303(g)(2)(G)(iii) of the Controlled Substances Act (21 U.S.C. 823(g)(2)(G)(iii))) who are treating, in the case of physicians, 100 or more patients, and in the case of qualifying practitioners who are not physicians, 30 or more patients. Such report shall include recommendations on future applicable patient number levels and limits. In preparing such report, the Secretary shall study, with respect to opioid use disorder treatment—

(1) the average frequency with which qualifying practitioners see their patients;

(2) the average frequency with which patients receive counseling, including the rates by which such counseling is provided by such a qualifying practitioner directly, or by referral;

(3) the average frequency with which random toxicology testing is administered;

(4) the average monthly patient caseload for each type of qualifying practitioner;

(5) the treatment retention rates for patients;

(6) overdose and mortality rates; and

(7) any available information regarding the diversion of drugs by patients receiving such treatment from such a qualifying practitioner.

TITLE IV—OFFSETS

SEC. 401. PROMOTING VALUE IN MEDICAID MANAGED CARE.

Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended by adding at the end the following new paragraph:

''(7)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020 (and before fiscal year 2025), in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1905(b) (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1905(y).

''(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

''(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

''(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is equal to or greater than 85 percent; or

''(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

''(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

''(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this title (or a waiver of the plan) that is equal to or greater than 85 percent.

''(D) For purposes of this paragraph:

''(i) The term 'managed care entity' means a medicaid managed care organization described in section 1932(a)(1)(B)(i).

''(ii) The term 'minimum medical loss ratio' means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this title (or a waiver of the plan).

''(iii) The term 'other specified entity' means—

''(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

''(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).''.

SEC. 402. EXTENDING PERIOD OF APPLICATION OF MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.

Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ''and before January 1, 2020'' after ''date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following new sentence: ''Effective for items and services furnished on or after January 1, 2020 (with respect to periods beginning on or after July 1, 2018), clauses (i) and (ii) shall be applied by substituting '33-month' for '12-month' each place it appears.''.

SEC. 403. REQUIRING REPORTING BY GROUP HEALTH PLANS OF PRESCRIPTION DRUG COVERAGE INFORMATION FOR PURPOSES OF IDENTIFYING PRIMARY PAYER SITUATIONS UNDER THE MEDICARE PROGRAM.

Clause (i) of section 1862(b)(7)(A) of the Social Security Act (42 U.S.C. 1395y(b)(7)(A)) is amended to read as follows:

''(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

''(I) a primary plan to the program under this title; or

''(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and''.

TITLE V—OTHER MEDICAID PROVISIONS

Subtitle A—Mandatory Reporting With Respect to Adult Behavioral Health Measures

SEC. 5001. MANDATORY REPORTING WITH RESPECT TO ADULT BEHAVIORAL HEALTH MEASURES.

Section 1139B of the Social Security Act (42 U.S.C. 1320b–9b) is amended—

(1) in subsection (b)—

(A) in paragraph (3)—

(i) by striking ''Not later than January 1, 2013'' and inserting the following:

''(A) VOLUNTARY REPORTING.—Not later than January 1, 2013''; and

(ii) by adding at the end the following:

''(B) MANDATORY REPORTING WITH RESPECT TO BEHAVIORAL HEALTH MEASURES.—Beginning with the State report required under subsection (d)(1) for 2024, the Secretary shall require States to use all behavioral health measures included in the core set of adult health quality measures and any updates or changes to such measures to report information, using the standardized format for reporting information and procedures developed under subparagraph (A), regarding the quality of behavioral health care for Medicaid eligible adults.''; and

(B) in paragraph (5), by adding at the end the following new subparagraph:

''(C) BEHAVIORAL HEALTH MEASURES.—Beginning with respect to State reports required under subsection (d)(1) for 2024, the core set of adult health quality measures maintained under this paragraph (and any updates or changes to such measures) shall include behavioral health measures.''; and

(2) in subsection (d)(1)(A)—

(A) by striking ''the such plan'' and inserting ''such plan''; and

(B) by striking ''subsection (a)(5)'' and inserting ''subsection (b)(5) and, beginning with the report for 2024, all behavioral health measures included in the core set of adult health quality measures maintained under such subsection (b)(5) and any updates or changes to such measures (as required under subsection (b)(3))''.

Subtitle B—Medicaid IMD Additional Info

SEC. 5011. SHORT TITLE.

This subtitle may be cited as the ''Medicaid Institutes for Mental Disease Are Decisive in Delivering Inpatient Treatment for Individuals but Opportunities for Needed Access are Limited without Information Needed about Facility Obligations Act'' or the ''Medicaid IMD ADDITIONAL INFO Act''.

SEC. 5012. MACPAC EXPLORATORY STUDY AND REPORT ON INSTITUTIONS FOR MENTAL DISEASES REQUIREMENTS AND PRACTICES UNDER MEDICAID.

(a) IN GENERAL.—Not later than January 1, 2020, the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act (42 U.S.C. 1396) shall conduct an exploratory study, using data from a representative sample of States, and submit to Congress a report on at least the following information, with respect to services furnished to individuals enrolled under State plans under the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) (or waivers of such plans) who are patients in institutions for mental diseases and for which payment is made through fee-for-service or managed care arrangements under such State plans (or waivers):

(1) A description of such institutions for mental diseases in each such State, including at a minimum—

(A) the number of such institutions in the State;

(B) the facility type of such institutions in the State; and

(C) any coverage limitations under each such State plan (or waiver) on scope, duration, or frequency of such services.

(2) With respect to each such institution for mental diseases in each such State, a description of—

(A) such services provided at such institution;

(B) the process, including any timeframe, used by such institution to clinically assess and reassess such individuals; and

(C) the discharge process used by such institution, including any care continuum of relevant services or facilities provided or used in such process.

(3) A description of—

(A) any Federal waiver that each such State has for such institutions and the Federal statutory authority for such waiver; and

(B) any other Medicaid funding sources used by each such State for funding such institutions, such as supplemental payments.

(4) A summary of State requirements (such as certification, licensure, and accreditation) applied by each such State to such institutions in order for such institutions to receive payment under the State plan (or waiver) and how each such State determines if such requirements have been met.

(5) A summary of State standards (such as quality standards, clinical standards, and facility standards) that such institutions must meet to receive payment under such State plans (or waivers) and how each such State determines if such standards have been met.

(6) Recommendations for actions by Congress and the Centers for Medicare & Medicaid Services. such as how State Medicaid programs may improve care and improve standards and including a recommendation for how the Centers for Medicare & Medicaid Services can improve data collection from such programs to address any gaps in information.

(b) STAKEHOLDER INPUT.—In carrying out subsection (a), the Medicaid and CHIP Payment and Access Commission shall seek input from State Medicaid directors and stakeholders, including at a minimum the Substance Abuse and Mental Health Services Administration, Centers for Medicare & Medicaid Services, State Medicaid officials, State mental health authorities, Medicaid beneficiary advocates, health care providers, and Medicaid managed care organizations.

(c) DEFINITIONS.—In this section:

(1) REPRESENTATIVE SAMPLE OF STATES.—The term ''representative sample of States'' means a non-probability sample in which at least two States are selected based on the knowledge and professional judgment of the selector.

(2) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, and any commonwealth or territory of the United States.

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given such term in section 435.1009 of title 42, Code of Federal Regulations, or any successor regulation.

Subtitle C—CHIP Mental Health Parity

SEC. 5021. SHORT TITLE.

This subtitle may be cited as the ''CHIP Mental Health Parity Act''.

SEC. 5022. ENSURING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES FOR CHILDREN AND PREGNANT WOMEN UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2103(c)(1) of the Social Security Act (42 U.S.C. 1397cc(c)(1)) is amended by adding at the end the following new subparagraph:

''(E) Mental health and substance use disorder services (as defined in paragraph (5)).''.

(b) MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.—

(1) IN GENERAL.—Section 2103(c) of the Social Security Act (42 U.S.C. 1397cc(c)) is amended—

(A) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (6), (7), (8), and (9), respectively; and

(B) by inserting after paragraph (4) the following new paragraph:

''(5) MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.—Regardless of the type of coverage elected by a State under subsection (a), child health assistance provided under such coverage for targeted low-income children and, in the case that the State elects to provide pregnancy-related assistance under such coverage pursuant to section 2112, such pregnancy-related assistance for targeted low-income women (as defined in section 2112(d)) shall—

''(A) include coverage of mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders; and

''(B) be delivered in a culturally and linguistically appropriate manner.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 2103(a) of the Social Security Act (42 U.S.C. 1397cc(a)) is amended, in the matter before paragraph (1), by striking ''paragraphs (5), (6), and (7)'' and inserting ''paragraphs (5), (6), (7), and (8)''.

(B) Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj(a)) is amended—

(i) in paragraph (18), by striking ''substance abuse'' each place it appears and inserting ''substance use''; and

(ii) in paragraph (19), by striking ''substance abuse'' and inserting ''substance use''.

(C) Section 2110(b)(5)(A)(i) of the Social Security Act (42 U.S.C. 1397jj(b)(5)(A)(i)) is amended by striking ''subsection (c)(5)'' and inserting ''subsection (c)(6)''.

(c) ASSURING ACCESS TO CARE.—Section 2102(a)(7)(B) of the Social Security Act (42 U.S.C. 1397bb(c)(2)) is amended by striking ''section 2103(c)(5)'' and inserting ''paragraphs (5) and (6) of section 2103(c)''.

(d) MENTAL HEALTH SERVICES PARITY.—Subparagraph (A) of paragraph (7) of section 2103(c) of the Social Security Act (42 U.S.C. 1397cc(c)) (as redesignated by subsection (b)(1)) is amended to read as follows:

''(A) IN GENERAL.—A State child health plan shall ensure that the financial requirements and treatment limitations applicable to mental health and substance use disorder services (as described in paragraph (5)) provided under such plan comply with the requirements of section 2726(a) of the Public Health Service Act in the same manner as such requirements or limitations apply to a group health plan under such section.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall take effect with respect to child health assistance provided on or after the date that is one year after the date of the enactment of this Act.

(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State child health plan under title XXI of the Social Security Act (or a waiver of such plan), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan (or waiver) to meet any requirement imposed by the

amendments made by this section, the respective plan (or waiver) shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this section. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

Subtitle D—Medicaid Reentry

SEC. 5031. SHORT TITLE.

This subtitle may be cited as the ''Medicaid Reentry Act''.

SEC. 5032. PROMOTING STATE INNOVATIONS TO EASE TRANSITIONS INTEGRATION TO THE COMMUNITY FOR CERTAIN INDIVIDUALS.

(a) STAKEHOLDER GROUP DEVELOPMENT OF BEST PRACTICES; STATE MEDICAID PROGRAM INNOVATION.—

(1) STAKEHOLDER GROUP BEST PRACTICES.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall convene a stakeholder group of representatives of managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other relevant representatives from local, State, and Federal jail and prison systems to develop best practices (and submit to the Secretary and Congress a report on such best practices) for States—

(A) to ease the health care-related transition of an individual who is an inmate of a public institution from the public institution to the community, including best practices for ensuring continuity of health insurance coverage or coverage under the State Medicaid plan under title XIX of the Social Security Act, as applicable, and relevant social services; and

(B) to carry out, with respect to such an individual, such health care-related transition not later than 30 days after such individual is released from the public institution.

(2) STATE MEDICAID PROGRAM INNOVATION.—The Secretary of Health and Human Services shall work with States on innovative strategies to help individuals who are inmates of public institutions and otherwise eligible for medical assistance under the Medicaid program under title XIX of the Social Security Act transition, with respect to enrollment for medical assistance under such program, seamlessly to the community.

(b) GUIDANCE ON INNOVATIVE SERVICE DELIVERY SYSTEMS DEMONSTRATION PROJECT OPPORTUNITIES.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a State Medicaid Director letter, based on best practices developed under subsection (a)(1), regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act, including systems for, with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released from such institution—

(1) providing assistance and education for enrollment under a State plan under the Medicaid program under title XIX of such Act for such individuals during such period; and

(2) providing health care services for such individuals during such period.

(c) RULE OF CONSTRUCTION.—Nothing under title XIX of the Social Security Act or any other provision of law precludes a State from reclassifying or suspending (rather than terminating) eligibility of an individual for medical assistance under title XIX of the Social Security Act while such individual is an inmate of a public institution.

Subtitle E—Medicaid Partnership

SEC. 5041. SHORT TITLE.

This subtitle may be cited as the ''Medicaid Providers Are Required To Note Experiences in Record Systems to Help In-need Patients Act'' or the ''Medicaid PARTNERSHIP Act''.

SEC. 5042. MEDICAID PROVIDERS ARE REQUIRED TO NOTE EXPERIENCES IN RECORD SYSTEMS TO HELP IN-NEED PATIENTS.

(a) REQUIREMENTS UNDER THE MEDICAID PROGRAM RELATING TO QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAMS AND PRESCRIBING CERTAIN CONTROLLED SUBSTANCES.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1943 the following new section:

''SEC. 1944. REQUIREMENTS RELATING TO QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAMS AND PRESCRIBING CERTAIN CONTROLLED SUBSTANCES.

''(a) IN GENERAL.—Beginning October 1, 2021, a State shall, subject to subsection (d), require each covered provider to check, in accordance with such timing, manner, and form as specified by the State, the prescription drug history of a covered individual being treated by the covered provider through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

''(b) QUALIFIED PRESCRIPTION DRUG MONITORING PROGRAM DESCRIBED.—A qualified prescription drug monitoring program described in this subsection is, with respect to a State, a prescription drug monitoring program administered by the State that, at a minimum, satisfies each of the following criteria:

''(1) The program facilitates access by a covered provider to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:

''(A) Information regarding the prescription drug history of a covered individual with respect to controlled substances.

''(B) The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period.

''(C) The name, location, and contact information (or other identifying number selected by the State, such as a national provider identifier issued by the National Plan and Provider Enumeration System of the Centers for Medicare & Medicaid Services) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.

''(2) The program facilitates the integration of information described in paragraph (1) into the workflow of a covered provider, which may include the electronic system the covered provider uses to prescribe controlled substances.

A qualified prescription drug monitoring program described in this subsection, with respect to a State, may have in place, in accordance with applicable State and Federal law, a data sharing agreement with the State Medicaid program that allows the medical director and pharmacy director of such program (and any designee of such a director who reports directly to such director) to access the information described in paragraph (1) in an electronic format. The State Medicaid program under this title may facilitate reasonable and limited access, as determined by the State and ensuring documented beneficiary protections regarding the use of such data, to such qualified prescription drug monitoring program for the medical director or pharmacy director of any managed care entity (as defined under section 1932(a)(1)(B)) that has a contract with the State under section 1903(m) or under section 1905(t)(3), or the medical director or pharmacy director of any entity has a contract to manage the pharmaceutical benefit with respect to individuals enrolled in the State plan (or waiver of the State plan). All applicable State and Federal security and privacy laws shall apply to the directors or designees of such directors of any State Medicaid program or entity accessing a qualified prescription drug monitoring program under this section.

''(c) APPLICATION OF PRIVACY RULES CLARIFICATION.—The Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), related to the sharing of data under subsection (b) in the same manner as the Secretary is required under subparagraph (J) of section 1860D–4(c)(5) to clarify privacy requirements related to the sharing of data described in such subparagraph.

''(d) ENSURING ACCESS.—In order to ensure reasonable access to health care, the Secretary shall waive the application of the requirement under subsection (a), with respect to a State, in the case of natural disasters and similar situations, and in the case of the provision of emergency services (as defined for purposes of section 1860D–4(c)(5)(D)(ii)(II)).

''(e) REPORTS.—

''(1) STATE REPORTS.—Each State shall include in the annual report submitted to the Secretary under section 1927(g)(3)(D), beginning with such reports submitted for 2023, information including, at a minimum, the following information for the most recent 12-month period:

''(A) The percentage of covered providers (as determined pursuant to a process established by the State) who checked the prescription drug history of a covered individual through a qualified prescription drug monitoring program described in subsection (b) before prescribing to such individual a controlled substance.

''(B) Aggregate trends with respect to prescribing controlled substances such as—

''(i) the quantity of daily morphine milligram equivalents prescribed for controlled substances;

''(ii) the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and

''(iii) the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled under both this title and title XVIII).

''(C) Whether or not the State requires (and a detailed explanation as to why the State does or does not require) pharmacists to check the prescription drug history of a covered individual through a qualified drug management program before dispensing a controlled substance to such individual.

''(2) REPORT BY CMS.—Not later than October 1, 2023, the Administrator of the Centers for Medicare & Medicaid Services shall publish on the publicly available website of the Centers for Medicare & Medicaid Services a report including the following information:

''(A) Guidance for States on how States can increase the percentage of covered providers who use qualified prescription drug monitoring programs described in subsection (b).

''(B) Best practices for how States and covered providers should use such qualified prescription drug monitoring programs to reduce the occurrence of abuse of controlled substances.

''(f) INCREASE TO FEDERAL MATCHING RATE FOR CERTAIN EXPENDITURES RELATING TO QUALIFIED PRESCRIPTION DRUG MANAGEMENT PROGRAMS.—The Secretary shall increase the Federal medical assistance percentage or Federal matching rate that would otherwise apply

to a State under section 1903(a) for a calendar quarter occurring during the period beginning October 1, 2018, and ending September 30, 2021, for expenditures by the State for activities under the State plan (or waiver of the State plan) to implement a prescription drug management program that satisfies the criteria described in paragraphs (1) and (2) of subsection (b) if the State (in this subsection referred to as the 'administering State') has in place agreements with all States that are contiguous to such administering State that, when combined, enable covered providers in all such contiguous States to access, through the prescription drug management program, the information that is described in subsection (b)(1) of covered individuals of such administering State and that covered providers in such administering State are able to access through such program. In no case shall an increase under this subsection result in a Federal medical assistance percentage or Federal matching rate that exceeds 100 percent.

''(g) RULE OF CONSTRUCTION.—Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified drug management program before dispensing controlled substances to such individuals.

''(h) DEFINITIONS.—In this section:

''(1) CONTROLLED SUBSTANCE.—The term 'controlled substance' means a drug that is included in schedule II of section 202(c) of the Controlled Substances Act and, at the option of the State involved, a drug included in schedule III or IV of such section.

''(2) COVERED INDIVIDUAL.—The term 'covered individual' means, with respect to a State, an individual who is enrolled in the State plan (or under a waiver of such plan). Such term does not include an individual who—

''(A) is receiving—

''(i) hospice or palliative care; or

''(ii) treatment for cancer;

''(B) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

''(C) the State elects to treat as exempted from such term.

''(3) COVERED PROVIDER.—

''(A) IN GENERAL.—The term 'covered provider' means, subject to subparagraph (B), with respect to a State, a health care provider who is participating under the State plan (or waiver of the State plan) and licensed, registered, or otherwise permitted by the State to prescribe a controlled substance (or the designee of such provider).

''(B) EXCEPTIONS.—

''(i) IN GENERAL.—Beginning October 1, 2021, for purposes of this section, such term does not include a health care provider included in any type of health care provider determined by the Secretary to be exempt from application of this section under clause (ii).

''(ii) EXCEPTIONS PROCESS.—Not later than October 1, 2020, the Secretary, after consultation with the National Association of Medicaid Directors, national health care provider associations, Medicaid beneficiary advocates, and advocates for individuals with rare diseases, shall determine, based on such consultations, the types of health care providers (if any) that should be exempted from the definition of the term 'covered provider' for purposes of this section.''.

(b) GUIDANCE.—Not later than October 1, 2019, the Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall issue guidance on best practices on the uses of prescription drug monitoring programs required of prescribers and on protecting the privacy of Medicaid beneficiary information maintained in and accessed through prescription drug monitoring programs.

(c) DEVELOPMENT OF MODEL STATE PRACTICES.—

(1) IN GENERAL.—Not later than October 1, 2020, the Secretary of Health and Human Services shall develop and publish model practices to assist State Medicaid program operations in identifying and implementing strategies to utilize data sharing agreements described in the matter following paragraph (2) of section 1944(b) of the Social Security Act, as added by subsection (a), for the following purposes:

(A) Monitoring and preventing fraud, waste, and abuse.

(B) Improving health care for individuals enrolled in a State plan under title XIX of such Act (or waiver of such plan) who—

(i) transition in and out of coverage under such title;

(ii) may have sources of health care coverage in addition to coverage under such title; or

(iii) pay for prescription drugs with cash.

(C) Any other purposes specified by the Secretary.

(2) ELEMENTS OF MODEL PRACTICES.—The model practices described in paragraph (1)—

(A) shall include strategies for assisting States in allowing the medical director or pharmacy director (or designees of such a director) of managed care organizations or pharmaceutical benefit managers to access information with respect to all covered individuals served by such managed care organizations or pharmaceutical benefit managers to access as a single data set, in an electronic format; and

(B) shall include any appropriate beneficiary protections and privacy guidelines.

(3) CONSULTATION.—In developing model practices under this subsection, the Secretary shall consult with the National Association of Medicaid Directors, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act) with contracts with States pursuant to section 1903(m) of such Act, pharmaceutical benefit managers, physicians and other health care providers, beneficiary advocates, and individuals with expertise in health care technology related to prescription drug monitoring programs and electronic health records.

(d) REPORT BY COMPTROLLER GENERAL.—Not later than October 1, 2020, the Comptroller General of the United States shall issue a report examining the operation of prescription drug monitoring programs administered by States, including data security and access standards used by such programs.

TITLE VI—OTHER MEDICARE PROVISIONS

Subtitle A—Testing of Incentive Payments for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology

SEC. 6001. TESTING OF INCENTIVE PAYMENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR ADOPTION AND USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

''(xv) Providing, for the adoption and use of certified EHR technology (as defined in section 1848(o)(4)) to improve the quality and coordination of care through the electronic documentation and exchange of health information, incentive payments to behavioral health providers (such as psychiatric hospitals (as defined in section 1861(f)), community mental health centers (as defined in section 1861(ff)(3)(B)), hospitals that participate in a State plan under title XIX or a waiver of such plan, treatment facilities that participate in such a State plan or such a waiver, mental health or substance use disorder providers that participate in such a State plan or such a waiver, clinical psychologists (as defined in section 1861(ii)), nurse practitioners (as defined in section 1861(aa)(5)) with respect to the provision of psychiatric services, and clinical social workers (as defined in section 1861(hh)(1))).''.

Subtitle B—Abuse Deterrent Access

SEC. 6011. SHORT TITLE.

This subtitle may be cited at the ''Abuse Deterrent Access Act of 2018''.

SEC. 6012. STUDY ON ABUSE-DETERRENT OPIOID FORMULATIONS ACCESS BARRIERS UNDER MEDICARE.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study and submit to Congress a report on the adequacy of access to abuse-deterrent opioid formulations for individuals with chronic pain enrolled in an MA–PD plan under part C of title XVIII of the Social Security Act or a prescription drug plan under part D of such title of such Act, taking into account any barriers preventing such individuals from accessing such formulations under such MA–PD or part D plans, such as cost-sharing tiers, fail-first requirements, the price of such formulations, and prior authorization requirements.

(b) DEFINITION OF ABUSE-DETERRENT OPIOID FORMULATION.—In this section, the term ''abuse-deterrent opioid formulation'' means an opioid that is a prodrug or that has certain abuse-deterrent properties, such as physical or chemical barriers, agonist or antagonist combinations, aversion properties, delivery system mechanisms, or other features designed to prevent abuse of such opioid.

Subtitle C—Medicare Opioid Safety Education

SEC. 6021. SHORT TITLE.

This subtitle may be cited as the ''Medicare Opioid Safety Education Act of 2018''.

SEC. 6022. PROVISION OF INFORMATION REGARDING OPIOID USE AND PAIN MANAGEMENT AS PART OF MEDICARE & YOU HANDBOOK.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(d) The notice provided under subsection (a) shall include—

''(1) educational resources, compiled by the Secretary, regarding opioid use and pain management; and

''(2) a description of alternative, non-opioid pain management treatments covered under this title.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to notices distributed prior to each Medicare open enrollment period beginning after January 1, 2019.

Subtitle D—Opioid Addiction Action Plan

SEC. 6031. SHORT TITLE.

This subtitle may be cited as the ''Opioid Addiction Action Plan Act''.

SEC. 6032. ACTION PLAN ON RECOMMENDATIONS FOR CHANGES UNDER MEDICARE AND MEDICAID TO PREVENT OPIOIDS ADDICTIONS AND ENHANCE ACCESS TO MEDICATION-ASSISTED TREATMENT.

(a) IN GENERAL.—Not later than January 1, 2019, the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in collaboration with the Pain Management Best Practices Inter-Agency Task Force convened under section 101(b) of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), shall develop an action plan that provides recommendations described in subsection (b).

(b) ACTION PLAN COMPONENTS.—Recommendations described in this subsection are, based on an examination by the Secretary of potential obstacles to an effective response to the opioid crisis, recommendations, as determined appropriate by the Secretary, on the following:

(1) Recommendations on changes to the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act that would enhance coverage and payment under such programs of all medication-assisted treatment approved by the Food and Drug Administration for the treatment of

opioid addiction and other therapies that manage chronic and acute pain and treat and minimize risk of opioid addiction, including recommendations on changes to the Medicare prospective payment system for hospital inpatient department services under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) and the Medicare prospective payment system for hospital outpatient department services under section 1833(t) of such Act (42 U.S.C. 1395l(t)) that would allow for separate payment for such therapies, if medically appropriate and if necessary to encourage development and adoption of such therapies.

(2) Recommendations for payment and service delivery models to be tested by the Center for Medicare and Medicaid Innovation and other federally authorized demonstration projects, including value-based models, that may encourage the use of appropriate medication-assisted treatment approved by the Food and Drug Administration for the treatment of opioid addiction and other therapies that manage chronic and acute pain and treat and minimize risk of opioid addiction.

(3) Recommendations for data collection that could facilitate research and policy making regarding prevention of opioid addiction and coverage and payment under the Medicare and Medicaid programs of appropriate opioid addiction treatments.

(4) Recommendations for policies under the Medicare program and under the Medicaid program that can expand access for rural, or medically underserved communities to the full range of medication-assisted treatment approved by the Food and Drug Administration for the treatment of opioid addiction and other therapies that manage chronic and acute pain and treatment and minimize risk of opioid addiction.

(5) Recommendations on changes to the Medicare program and the Medicaid program to address coverage or payment barriers to patient access to medical devices that are non-opioid based treatments approved by the Food and Drug Administration for the management of acute pain and chronic pain, for monitoring substance use withdrawal and preventing overdoses of controlled substances, and for treating substance use disorder.

(c) STAKEHOLDER MEETINGS.—

(1) IN GENERAL.—Beginning not later than 3 months after the date of the enactment of this Act, the Secretary shall convene a public stakeholder meeting to solicit public comment on the components of the action plan recommendations described in subsection (b).

(2) PARTICIPANTS.—Participants of meetings described in paragraph (1) shall include representatives from the Food and Drug Administration and National Institutes of Health, biopharmaceutical industry members, medical researchers, health care providers, the medical device industry, the Medicare program, the Medicaid program, and patient advocates.

(d) REQUEST FOR INFORMATION.—Not later than 3 months after the date of the enactment of this section, the Secretary shall issue a request for information seeking public feedback regarding ways in which the Centers for Medicare & Medicaid Services can help address the opioid crisis through the development of and application of the action plan.

(e) REPORT TO CONGRESS.—Not later than June 1, 2019, the Secretary shall submit to Congress, and make public, a report that includes—

(1) a summary of recommendations that have emerged under the action plan;

(2) the Secretary's planned next steps with respect to the action plan; and

(3) an evaluation of price trends for drugs used to reverse opioid overdoses (such as naloxone), including recommendations on ways to lower such prices for consumers.

(f) DEFINITION OF MEDICATION-ASSISTED TREATMENT.—In this section, the term ''medication-assisted treatment'' includes opioid treatment programs, behavioral therapy, and medications to treat substance abuse disorder.

Subtitle E—Advancing High Quality Treatment for Opioid Use Disorders in Medicare

SEC. 6041. SHORT TITLE.

This subtitle may be cited as the ''Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act''.

SEC. 6042. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866E (42 U.S.C. 1395cc–5) the following new section:

''SEC. 1866F. OPIOID USE DISORDER TREATMENT DEMONSTRATION PROGRAM.

''(a) IMPLEMENTATION OF 4-YEAR DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 2021, the Secretary shall implement a 4-year demonstration program under this title (in this section referred to as the 'Program') to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce expenditures under this title. Under the Program, the Secretary shall make payments under subsection (e) to participants (as defined in subsection (c)(1)(A)) for furnishing opioid use disorder treatment services delivered through opioid use disorder care teams, or arranging for such services to be furnished, to applicable beneficiaries participating in the Program.

''(2) OPIOID USE DISORDER TREATMENT SERVICES.—For purposes of this section, the term 'opioid use disorder treatment services'—

''(A) means, with respect to an applicable beneficiary, services that are furnished for the treatment of opioid use disorders and that utilize drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act for the treatment of opioid use disorders in an outpatient setting; and

''(B) includes—

''(i) medication assisted treatment;

''(ii) treatment planning;

''(iii) psychiatric, psychological, or counseling services (or any combination of such services), as appropriate;

''(iv) social support services, as appropriate; and

''(v) care management and care coordination services, including coordination with other providers of services and suppliers not on an opioid use disorder care team.

''(b) PROGRAM DESIGN.—

''(1) IN GENERAL.—The Secretary shall design the Program in such a manner to allow for the evaluation of the extent to which the Program accomplishes the following purposes:

''(A) Reduces hospitalizations and emergency department visits.

''(B) Increases use of medication-assisted treatment for opioid use disorders.

''(C) Improves health outcomes of individuals with opioid use disorders, including by reducing the incidence of infectious diseases (such as hepatitis C and HIV).

''(D) Does not increase the total spending on items and services under this title.

''(E) Reduces deaths from opioid overdose.

''(F) Reduces the utilization of inpatient residential treatment.

''(2) CONSULTATION.—In designing the Program, including the criteria under subsection (e)(2)(A), the Secretary shall, not later than 3 months after the date of the enactment of this section, consult with specialists in the field of addiction, clinicians in the primary care community, and beneficiary groups.

''(c) PARTICIPANTS; OPIOID USE DISORDER CARE TEAMS.—

''(1) PARTICIPANTS.—

''(A) DEFINITION.—In this section, the term 'participant' means an entity or individual—

''(i) that is otherwise enrolled under this title and that is—

''(I) a physician (as defined in section 1861(r)(1));

''(II) a group practice comprised of at least one physician described in subclause (I);

''(III) a hospital outpatient department;

''(IV) a federally qualified health center (as defined in section 1861(aa)(4));

''(V) a rural health clinic (as defined in section 1861(aa)(2));

''(VI) a community mental health center (as defined in section 1861(ff)(3)(B));

''(VII) a clinic certified as a certified community behavioral health clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014; or

''(VIII) any other individual or entity specified by the Secretary;

''(ii) that applied for and was selected to participate in the Program pursuant to an application and selection process established by the Secretary; and

''(iii) that establishes an opioid use disorder care team (as defined in paragraph (2)) through employing or contracting with health care practitioners described in paragraph (2)(A), and uses such team to furnish or arrange for opioid use disorder treatment services in the outpatient setting under the Program.

''(B) PREFERENCE.—In selecting participants for the Program, the Secretary shall give preference to individuals and entities that are located in areas with a prevalence of opioid use disorders that is higher than the national average prevalence.

''(2) OPIOID USE DISORDER CARE TEAMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'opioid use disorder care team' means a team of health care practitioners established by a participant described in paragraph (1)(A) that—

''(i) shall include—

''(I) at least one physician (as defined in section 1861(r)(1)) furnishing primary care services or addiction treatment services to an applicable beneficiary; and

''(II) at least one eligible practitioner (as defined in paragraph (3)(A)), who may be a physician who meets the criterion in subclause (I); and

''(ii) may include other practitioners licensed under State law to furnish psychiatric, psychological, counseling, and social services to applicable beneficiaries.

''(B) REQUIREMENTS FOR RECEIPT OF PAYMENT UNDER PROGRAM.—In order to receive payments under subsection (e), each participant in the Program shall—

''(i) furnish opioid use disorder treatment services through opioid use disorder care teams to applicable beneficiaries who agree to receive the services;

''(ii) meet minimum criteria, as established by the Secretary; and

''(iii) submit to the Secretary, in such form, manner, and frequency as specified by the Secretary, with respect to each applicable beneficiary for whom opioid use disorder treatment services are furnished by the opioid use disorder care team, data and such other information as the Secretary determines appropriate to—

''(I) monitor and evaluate the Program;

''(II) determine if minimum criteria are met under clause (ii); and

''(III) determine the incentive payment under subsection (e).

''(3) ELIGIBLE PRACTITIONERS; OTHER PROVIDER-RELATED DEFINITIONS AND APPLICATION PROVISIONS.—

''(A) ELIGIBLE PRACTITIONERS.—For purposes of this section, the term 'eligible practitioner' means a physician or other health care practitioner, such as a nurse practitioner, that—

''(i) is enrolled under section 1866(j)(1);

''(ii) is authorized to prescribe or dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment; and

''(iii) has in effect a waiver in accordance with section 303(g) of the Controlled Substances Act for such purpose and is otherwise in compliance with regulations promulgated by the Substance Abuse and Mental Health Services Administration to carry out such section.

''(B) ADDICTION SPECIALISTS.—For purposes of subsection (e)(1)(B)(iv), the term 'addiction specialist' means a physician that possesses expert knowledge and skills in addiction medicine, as evidenced by appropriate certification from a specialty body, a certificate of advanced qualification in addiction medicine, or completion of an accredited residency or fellowship in addiction medicine or addiction psychiatry, as determined by the Secretary.

''(d) PARTICIPATION OF APPLICABLE BENEFICIARIES.—

''(1) APPLICABLE BENEFICIARY DEFINED.—In this section, the term 'applicable beneficiary' means an individual who—

''(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C;

''(C) has a current diagnosis for an opioid use disorder; and

''(D) meets such other criteria as the Secretary determines appropriate.

Such term shall include an individual who is dually eligible for benefits under this title and title XIX if such individual satisfies the criteria described in subparagraphs (A) through (D).

''(2) VOLUNTARY BENEFICIARY PARTICIPATION; LIMITATION ON NUMBER OF BENEFICIARIES.—An applicable beneficiary may participate in the Program on a voluntary basis and may terminate participation in the Program at any time. Not more than 20,000 applicable beneficiaries may participate in the Program at any time.

''(3) SERVICES.—In order to participate in the Program, an applicable beneficiary shall agree to receive opioid use disorder treatment services from a participant. Participation under the Program shall not affect coverage of or payment for any other item or service under this title for the applicable beneficiary.

''(4) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging providers to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from a participant in the Program.

''(e) PAYMENTS.—

''(1) PER APPLICABLE BENEFICIARY PER MONTH CARE MANAGEMENT FEE.—

''(A) IN GENERAL.—The Secretary shall establish a schedule of per applicable beneficiary per month care management fees. Such a per applicable beneficiary per month care management fee shall be paid to a participant in addition to any other amount otherwise payable under this title to the health care practitioners in the participant's opioid use disorder care team or, if applicable, to the participant. A participant may use such per applicable beneficiary per month care management fee to deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under this title.

''(B) PAYMENT AMOUNTS.—In carrying out subparagraph (A), the Secretary shall—

''(i) consider payments otherwise payable under this title for opioid use disorder treatment services and the needs of applicable beneficiaries;

''(ii) pay a higher per applicable beneficiary per month care management fee for an applicable beneficiary who receives more intensive treatment services from a participant and for whom those services are appropriate based on clinical guidelines for opioid use disorder care;

''(iii) pay a higher per applicable beneficiary per month care management fee for the month in which the applicable beneficiary begins treatment with a participant than in subsequent months, to reflect the greater time and costs required for the planning and initiation of treatment, as compared to maintenance of treatment;

''(iv) pay higher per applicable beneficiary per month care management fees for participants that have established opioid use disorder care teams that include an addiction specialist (as defined in subsection (c)(3)(B)); and

''(v) take into account whether a participant's opioid use disorder care team refers applicable beneficiaries to other suppliers or providers for any opioid use disorder treatment services.

''(C) NO DUPLICATE PAYMENT.—The Secretary shall make payments under this paragraph to only one participant for services furnished to an applicable beneficiary during a calendar month.

''(2) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—Under the Program, the Secretary shall establish a performance-based incentive payment, which shall be paid (using a methodology established and at a time determined appropriate by the Secretary) to participants based on the performance of participants with respect to criteria, as determined appropriate by the Secretary, in accordance with subparagraph (B).

''(B) CRITERIA.—

''(i) IN GENERAL.—Criteria described in subparagraph (A) may include consideration of the following:

''(I) Patient engagement and retention in treatment.

''(II) Evidence-based medication-assisted treatment.

''(III) Other criteria established by the Secretary.

''(ii) REQUIRED CONSULTATION AND CONSIDERATION.—In determining criteria described in subparagraph (A), the Secretary shall—

''(I) consult with stakeholders, including clinicians in the primary care community and in the field of addiction medicine; and

''(II) consider existing clinical guidelines for the treatment of opioid use disorders.

''(C) NO DUPLICATE PAYMENT.—The Secretary shall ensure that no duplicate payments under this paragraph are made with respect to an applicable beneficiary.

''(f) MULTIPAYER STRATEGY.—In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applied under the Program under subsection (e)(2)(C). The Secretary may enter into a memorandum of understanding with other payers to align the methodology for payment provided by such a payer related to opioid use disorder treatment services with such methodology for payment under the Program.

''(g) EVALUATION.—

''(1) IN GENERAL.—The Secretary shall conduct an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program.

''(2) REPORTS.—The Secretary shall submit to the Secretary and Congress—

''(A) a report with respect to the intermediate evaluation under paragraph (1) not later than 3 years after the date of the implementation of the Program; and

''(B) a report with respect to the final evaluation under paragraph (1) not later than 6 years after such date.

''(h) FUNDING.—

''(1) ADMINISTRATIVE FUNDING.—For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), $5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(2) CARE MANAGEMENT FEES AND INCENTIVES.—For the purposes of making payments under subsection (e), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 for each of fiscal years 2021 through 2024.''.

''(3) AVAILABILITY.—Amounts transferred under this subsection for a fiscal year shall be available until expended.

''(i) WAIVERS.—The Secretary may waive any provision of this title as may be necessary to carry out the Program under this section.''.

Subtitle F—Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment

SEC. 6051. SHORT TITLE.

This subtitle may be cited as the ''Responsible Education Achieves Care and Healthy Outcomes for Users' Treatment Act of 2018'' or the ''REACH OUT Act of 2018''.

SEC. 6052. GRANTS TO PROVIDE TECHNICAL ASSISTANCE TO OUTLIER PRESCRIBERS OF OPIOIDS.

(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, through the Centers for Medicare & Medicaid Services, award grants, contracts, or cooperative agreements to eligible entities for the purposes described in subsection (b).

(b) USE OF FUNDS.—Grants, contracts, and cooperative agreements awarded under subsection (a) shall be used to support eligible entities through technical assistance—

(1) to educate and provide outreach to outlier prescribers of opioids about best practices for prescribing opioids;

(2) to educate and provide outreach to outlier prescribers of opioids about non-opioid pain management therapies; and

(3) to reduce the amount of opioid prescriptions prescribed by outlier prescribers of opioids.

(c) APPLICATION.—Each eligible entity seeking to receive a grant, contract, or cooperative agreement under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(d) GEOGRAPHIC DISTRIBUTION.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall prioritize establishing technical assistance resources in each State.

(e) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(A) an organization—

(i) that has demonstrated experience providing technical assistance to health care professionals on a State or regional basis; and

(ii) that has at least—

(I) one individual who is a representative of consumers on its governing body; and

(II) one individual who is a representative of health care providers on its governing body; or

(B) an entity that is a quality improvement entity with a contract under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.).

(2) OUTLIER PRESCRIBER OF OPIOIDS.—The term ''outlier prescriber of opioids'' means a prescriber, identified by the Secretary of Health and Human Services (through use of prescriber information provided by prescriber National Provider Identifiers included pursuant to section 1860D–4(c)(4)(A) of the Social Security Act (42 U.S.C. 1395w–104(c)(4)(A)) on claims for covered part D drugs for part D eligible individuals enrolled in prescription drug plans under part D of title XVIII of such Act (42 U.S.C. 1395w–101 et seq.) and MA–PD plans under part C of such title (42 U.S.C. 1395w–21 et seq.)) as prescribing, as compared to other prescribers in the specialty of the prescriber and geographic area, amounts of opioids in excess of a threshold (and other criteria) specified by the Secretary, after consultation with stakeholders.

(3) PRESCRIBERS.—The term ''prescriber'' means any health care professional, including a nurse practitioner or physician assistant, who is licensed to prescribe opioids by the State or territory in which such professional practices.

(f) FUNDING.—For purposes of implementing this section, $75,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to remain available until expended.

Subtitle G—Preventing Addiction for Susceptible Seniors

SEC. 6061. SHORT TITLE.

This subtitle may be cited as the ''Preventing Addiction for Susceptible Seniors Act of 2018'' or the ''PASS Act of 2018''.

SEC. 6062. ELECTRONIC PRIOR AUTHORIZATION FOR COVERED PART D DRUGS.

(a) INCLUSION IN ELECTRONIC PRESCRIPTION PROGRAM.—Section 1860D–4(e)(2) of the Social Security Act (42 U.S.C. 1395w–104(e)(2)) is amended by adding at the end the following new subparagraph:

''(E) ELECTRONIC PRIOR AUTHORIZATION.—

''(i) IN GENERAL.—Not later than January 1, 2021, the program shall provide for the secure electronic transmission of—

''(I) a prior authorization request from the prescribing health care professional for coverage of a covered part D drug for a part D eligible individual enrolled in a part D plan (as defined in section 1860D–23(a)(5)) to the PDP sponsor or Medicare Advantage organization offering such plan; and

''(II) a response, in accordance with this subparagraph, from such PDP sponsor or Medicare Advantage organization, respectively, to such professional.

''(ii) ELECTRONIC TRANSMISSION.—

''(I) EXCLUSIONS.—For purposes of this subparagraph, a facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission described in clause (i).

''(II) STANDARDS.—In order to be treated, for purposes of this subparagraph, as an electronic transmission described in clause (i), such transmission shall comply with technical standards adopted by the Secretary in consultation with the National Council for Prescription Drug Programs, other standard setting organizations determined appropriate by the Secretary, and stakeholders including PDP sponsors, Medicare Advantage organizations, health care professionals, and health information technology software vendors.

''(III) APPLICATION.—Notwithstanding any other provision of law, for purposes of this subparagraph, the Secretary may require the use of such standards adopted under subclause (II) in lieu of any other applicable standards for an electronic transmission described in clause (i) for a covered part D drug for a part D eligible individual.''.

(b) SENSE OF CONGRESS REGARDING ELECTRONIC PRIOR AUTHORIZATION.—It is the sense of the Congress that—

(1) there should be increased use of electronic prior authorizations for coverage of covered part D drugs for part D eligible individuals enrolled in prescription drug plans under part D of title XVIII of the Social Security Act and MA–PD plans under part C of such title to reduce access delays by resolving coverage issues before prescriptions for such drugs are transmitted; and

(2) greater priority should be placed on increasing the adoption of use of such electronic prior authorizations among prescribers of such drugs, pharmacies, PDP sponsors, and Medicare Advantage organizations.

SEC. 6063. PROGRAM INTEGRITY TRANSPARENCY MEASURES UNDER MEDICARE PARTS C AND D.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(i) PROGRAM INTEGRITY TRANSPARENCY MEASURES.—

''(1) PROGRAM INTEGRITY PORTAL.—

''(A) IN GENERAL.—Not later than two years after the date of the enactment of this subsection, the Secretary shall, after consultation with stakeholders, establish a secure Internet website portal (or other successor technology) that would allow a secure path for communication between the Secretary, MA plans under this part, prescription drug plans under part D, and an eligible entity with a contract under section 1893 (such as a Medicare drug integrity contractor or an entity responsible for carrying out program integrity activities under this part and part D) for the purpose of enabling through such portal (or other successor technology)—

''(i) the referral by such plans of substantiated fraud, waste, and abuse for initiating or assisting investigations conducted by the eligible entity; and

''(ii) data sharing among such MA plans, prescription drug plans, and the Secretary.

''(B) REQUIRED USES OF PORTAL.—The Secretary shall disseminate the following information to MA plans under this part and prescription drug plans under part D through the secure Internet website portal (or other successor technology) established under subparagraph (A):

''(i) Providers of services and suppliers that have been referred pursuant to subparagraph (A)(i) during the previous 12-month period.

''(ii) Providers of services and suppliers who are the subject of an active exclusion under section 1128 or who are subject to a suspension of payment under this title pursuant to section 1862(o) or otherwise.

''(iii) Providers of services and suppliers who are the subject of an active revocation of participation under this title, including for not satisfying conditions of participation.

''(iv) In the case of such a plan that makes a referral under subparagraph (A)(i) through the portal (or other successor technology) with respect to activities of substantiated fraud, waste, or abuse of a provider of services or supplier, if such provider or supplier has been the subject of an administrative action under this title or title XI with respect to similar activities, a notification to such plan of such action so taken.

''(C) RULEMAKING.—For purposes of this paragraph, the Secretary shall, through rulemaking, specify what constitutes substantiated fraud, waste, and abuse, using guidance such as what is provided in the Medicare Program Integrity Manual 4.7.1. In carrying out this subsection, a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for substantiated fraud, waste, or abuse

''(D) HIPAA COMPLIANT INFORMATION ONLY.—For purposes of this subsection, communications may only occur if the communications are permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(2) QUARTERLY REPORTS.—Beginning two years after the date of enactment of this subsection, the Secretary shall make available to MA plans under this part and prescription drug plans under part D in a timely manner (but no less frequently than quarterly) and using information submitted to an entity described in paragraph (1) through the portal (or other successor technology) described in such paragraph or pursuant to section 1893, information on fraud, waste, and abuse schemes and trends in identifying suspicious activity. Information included in each such report shall—

''(A) include administrative actions, pertinent information related to opioid overprescribing, and other data determined appropriate by the Secretary in consultation with stakeholders; and

''(B) be anonymized information submitted by plans without identifying the source of such information.

''(3) CLARIFICATION.—Nothing in this subsection shall be construed as precluding or otherwise affecting referrals described in subparagraph (A) that may otherwise be made to law enforcement entities or to the Secretary.''.

(b) CONTRACT REQUIREMENT TO COMMUNICATE PLAN CORRECTIVE ACTIONS AGAINST OPIOID OVER-PRESCRIBERS.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(5) COMMUNICATING PLAN CORRECTIVE ACTIONS AGAINST OPIOIDS OVER-PRESCRIBERS.—

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2021, a contract under this section with an MA organization shall require the organization to submit to the Secretary, through the process established under subparagraph (B), information on the investigations and other actions taken by such plans related to providers of services who prescribe a high volume of opioids.

''(B) PROCESS.—Not later than January 1, 2021, the Secretary shall, in consultation with stakeholders, establish a process under which MA plans and prescription drug plans shall submit to the Secretary information described in subparagraph (A).

''(C) REGULATIONS.—For purposes of this paragraph, including as applied under section 1860D–12(b)(3)(D), the Secretary shall, pursuant to rulemaking—

''(i) specify a definition for the term 'high volume of opioids' and a method for determining if a provider of services prescribes such a high volume; and

''(ii) establish the process described in subparagraph (B) and the types of information that shall be submitted through such process.''.

(c) REFERENCE UNDER PART D TO PROGRAM INTEGRITY TRANSPARENCY MEASURES.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(m) PROGRAM INTEGRITY TRANSPARENCY MEASURES.—For program integrity transparency measures applied with respect to prescription drug plan and MA plans, see section 1859(i).''.

SEC. 6064. EXPANDING ELIGIBILITY FOR MEDICATION THERAPY MANAGEMENT PROGRAMS UNDER PART D.

Section 1860D–4(c)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–104(c)(2)(A)(ii)) is amended—

(1) by redesignating subclauses (I) through (III) as items (aa) through (cc), respectively, and adjusting the margins accordingly;

(2) by striking ''are part D eligible individuals who—'' and inserting ''are the following:

''(I) Part D eligible individuals who—''; and

(3) by adding at the end the following new subclause:

''(II) Beginning January 1, 2021, at-risk beneficiaries for prescription drug abuse (as defined in paragraph (5)(C)).''.

SEC. 6065. MEDICARE NOTIFICATIONS TO OUTLIER PRESCRIBERS OF OPIOIDS.

Section 1860D–4(c)(4) of the Social Security Act (42 U.S.C. 1395w–104(c)(4)) is amended by adding at the end the following new subparagraph:

''(D) OUTLIER PRESCRIBER NOTIFICATION.—

''(i) NOTIFICATION.—Beginning not later than two years after the date of the enactment of this subparagraph, the Secretary shall, in the case of a prescriber identified by the Secretary under clause (ii) to be an outlier prescriber of opioids, provide, subject to clause (iv), an annual notification to such prescriber that such prescriber has been so identified and that includes resources on proper prescribing methods and other information specified in accordance with clause (iii).

''(ii) IDENTIFICATION OF OUTLIER PRESCRIBERS OF OPIOIDS.—

''(I) IN GENERAL.—The Secretary shall, subject to subclause (III), using the valid prescriber National Provider Identifiers included pursuant to subparagraph (A) on claims for covered part D drugs for part D eligible individuals enrolled in prescription drug plans under this part or MA–PD plans under part C and based on the threshold established under subclause (II), conduct an analysis to identify prescribers that are outlier opioid prescribers for a period specified by the Secretary.

''(II) ESTABLISHMENT OF THRESHOLD.—For purposes of subclause (I) and subject to subclause (III), the Secretary shall, after consultation with stakeholders, establish a threshold, based on prescriber specialty and geographic area, for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers of opioids within such specialty and area.

''(III) EXCLUSIONS.—The Secretary may exclude the following individuals and prescribers from the analysis under this clause:

''(aa) Individuals receiving hospice services.

''(bb) Individuals with a cancer diagnosis.

''(cc) Prescribers who are the subject of an investigation by the Centers for Medicare & Medicaid Services or the Office of Inspector General of the Department of Health and Human Services.

''(iii) CONTENTS OF NOTIFICATION.—The Secretary shall, based on input from stakeholders, specify the resources and other information to be included in notifications provided under clause (i).

''(iv) MODIFICATIONS AND EXPANSIONS.—

''(I) FREQUENCY.—Beginning 5 years after the date of the enactment of this subparagraph, the Secretary may change the frequency of the notifications described in clause (i) based on stakeholder input.

''(II) EXPANSION TO OTHER PRESCRIPTIONS.—The Secretary may expand notifications under this subparagraph to include identifications and notifications with respect to concurrent prescriptions of covered Part D drugs used in combination with opioids that are considered to have adverse side effects when so used in such combination, as determined by the Secretary.

''(v) OPIOIDS DEFINED.—For purposes of this subparagraph, the term 'opioids' has such meaning as specified by the Secretary through program instruction or otherwise.''.

SEC. 6066. NO ADDITIONAL FUNDS AUTHORIZED.

No additional funds are authorized to be appropriated to carry out the requirements of this subtitle and the amendments made by this subtitle. Such requirements shall be carried out using amounts otherwise authorized to be appropriated.

Subtitle H—Expanding Oversight of Opioid Prescribing and Payment

SEC. 6071. SHORT TITLE.

This subtitle may be cited as the ''Expanding Oversight of Opioid Prescribing and Payment Act of 2018''.

SEC. 6072. MEDICARE PAYMENT ADVISORY COMMISSION REPORT ON OPIOID PAYMENT, ADVERSE INCENTIVES, AND DATA UNDER THE MEDICARE PROGRAM.

Not later than March 15, 2019, the Medicare Payment Advisory Commission shall submit to Congress a report on, with respect to the Medicare program under title XVIII of the Social Security Act, the following:

(1) A description of how the Medicare program pays for pain management treatments (both opioid and non-opioid pain management alternatives) in both inpatient and outpatient hospital settings.

(2) The identification of incentives under the hospital inpatient prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and incentives under the hospital outpatient prospective payment system under section 1833(t) of such Act (42 U.S.C. 1395l(t)) for prescribing opioids and incentives under each such system for prescribing non-opioid treatments, and recommendations as the Commission deems appropriate for addressing any of such incentives that are adverse incentives.

(3) A description of how opioid use is tracked and monitored through Medicare claims data and other mechanisms and the identification of any areas in which further data and methods are needed for improving data and understanding of opioid use.

SEC. 6073. NO ADDITIONAL FUNDS AUTHORIZED.

No additional funds are authorized to be appropriated to carry out the requirements of this subtitle. Such requirements shall be carried out using amounts otherwise authorized to be appropriated.

Subtitle I—Dr. Todd Graham Pain Management, Treatment, and Recovery

SEC. 6081. SHORT TITLE.

This subtitle may be cited as the ''Dr. Todd Graham Pain Management, Treatment, and Recovery Act of 2018''.

SEC. 6082. REVIEW AND ADJUSTMENT OF PAYMENTS UNDER THE MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM TO AVOID FINANCIAL INCENTIVES TO USE OPIOIDS INSTEAD OF NON-OPIOID ALTERNATIVE TREATMENTS.

(a) OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

''(22) REVIEW AND REVISIONS OF PAYMENTS FOR NON-OPIOID ALTERNATIVE TREATMENTS.—

''(A) IN GENERAL.—With respect to payments made under this subsection for covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification, the Secretary—

''(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;

''(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and

''(iii) shall consider the extent to which revisions under this subsection to such payments (such as the creation of additional groups of covered OPD services to classify separately those procedures that utilize opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

''(B) PRIORITY.—In conducting the review under clause (i) of subparagraph (A) and considering revisions under clause (iii) of such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification, ambulatory payment classifications that primarily include surgical services, and other services determined by the Secretary which generally involve treatment for pain management.

''(C) REVISIONS.—If the Secretary identifies revisions to payments pursuant to subparagraph (A)(iii), the Secretary shall, as determined appropriate, begin making such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (9)(B).

''(D) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed to preclude the Secretary—

''(i) from conducting a demonstration before making the revisions described in subparagraph (C); or

''(ii) prior to implementation of this paragraph, from changing payments under this subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.''.

(b) AMBULATORY SURGICAL CENTERS.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

''(8) The Secretary shall conduct a similar type of review as required under paragraph (22) of section 1833(t)), including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection, and make such revisions under this paragraph, in an appropriate manner (as determined by the Secretary).''.

SEC. 6083. EXPANDING ACCESS UNDER THE MEDICARE PROGRAM TO ADDICTION TREATMENT IN FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834(o) of the Social Security Act (42 U.S.C. 1395m(o)) is amended by adding at the end the following new paragraph:

''(3) ADDITIONAL PAYMENTS FOR CERTAIN FQHCS WITH PHYSICIANS OR OTHER PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

''(A) IN GENERAL.—In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally-qualified health center services (as defined in section 1861(aa)(3)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in subparagraph (C) the Secretary shall, subject to availability of funds under subparagraph (D), make a payment (at such time and in such manner as specified by the Secretary) to such Federally qualified health center after receiving and approving an application submitted by such Federally qualified health center under subparagraph (B). Such a payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in subparagraph (C)(ii). Such a payment may be made only one time with respect to each such physician or practitioner.

''(B) APPLICATION.—In order to receive a payment described in subparagraph (A), a Federally-qualified health center shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A Federally-qualified health center may apply for such a payment for each physician or practitioner described in subparagraph (A) furnishing services described in such subparagraph at such center.

''(C) REQUIREMENTS.—For purposes of subparagraph (A), the requirements described in this subparagraph, with respect to a physician or practitioner, are the following:

''(i) The physician or practitioner is employed by or working under contract with a Federally qualified health center described in subparagraph (A) that submits an application under subparagraph (B).

''(ii) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Acton or after January 1, 2019.

''(D) FUNDING.—For purposes of making payments under this paragraph, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $6,000,000, which shall remain available until expended.''.

(b) RURAL HEALTH CLINIC.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(1) by redesignating the subsection (z) relating to medical review of spinal subluxation services as subsection (aa); and

(2) by adding at the end the following new subsection:

''(bb) ADDITIONAL PAYMENTS FOR CERTAIN RURAL HEALTH CLINICS WITH PHYSICIANS OR PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

''(1) IN GENERAL.—In the case of a rural health clinic with respect to which, beginning on or after January 1, 2019, rural health clinic services (as defined in section 1861(aa)(1)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in paragraph (3), the Secretary shall, subject to availability of funds

under paragraph (4), make a payment (at such time and in such manner as specified by the Secretary) to such rural health clinic after receiving and approving an application described in paragraph (2). Such payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in paragraph (3)(B). Such payment may be made only one time with respect to each such physician or practitioner.

''(2) APPLICATION.—In order to receive a payment described in paragraph (1), a rural health clinic shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A rural health clinic may apply for such a payment for each physician or practitioner described in paragraph (1) furnishing services described in such paragraph at such clinic.

''(3) REQUIREMENTS.—For purposes of paragraph (1), the requirements described in this paragraph, with respect to a physician or practitioner, are the following:

''(A) The physician or practitioner is employed by or working under contract with a rural health clinic described in paragraph (1) that submits an application under paragraph (2).

''(B) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Acton or after January 1, 2019.

''(4) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.''.

SEC. 6084. STUDYING THE AVAILABILITY OF SUPPLEMENTAL BENEFITS DESIGNED TO TREAT OR PREVENT SUBSTANCE USE DISORDERS UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report on the availability of supplemental health care benefits (as described in section 1852(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(3)(A))) designed to treat or prevent substance use disorders under Medicare Advantage plans offered under part C of title XVIII of such Act. Such report shall include the analysis described in subsection (c) and any differences in the availability of such benefits under specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act (42 U.S.C. 1395w–28(b)(6))) offered to individuals entitled to medical assistance under title XIX of such Act and other such Medicare Advantage plans.

(b) CONSULTATION.—The Secretary shall develop the report described in subsection (a) in consultation with relevant stakeholders, including—

(1) individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act;

(2) entities who advocate on behalf of such individuals;

(3) Medicare Advantage organizations;

(4) pharmacy benefit managers; and

(5) providers of services and suppliers (as such terms are defined in section 1861 of such Act (42 U.S.C. 1395x)).

(c) CONTENTS.—The report described in subsection (a) shall include an analysis on the following:

(1) The extent to which plans described in such subsection offer supplemental health care benefits relating to coverage of—

(A) medication-assisted treatments for opioid use, substance use disorder counseling, peer recovery support services, or other forms of substance use disorder treatments (whether furnished in an inpatient or outpatient setting); and

(B) non-opioid alternatives for the treatment of pain.

(2) Challenges associated with such plans offering supplemental health care benefits relating to coverage of items and services described in subparagraph (A) or (B) of paragraph (1).

(3) The impact, if any, of increasing the applicable rebate percentage determined under section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) for plans offering such benefits relating to such coverage would have on the availability of such benefits relating to such coverage offered under Medicare Advantage plans.

(4) Potential ways to improve upon such coverage or to incentivize such plans to offer additional supplemental health care benefits relating to such coverage.

SEC. 6085. CLINICAL PSYCHOLOGIST SERVICES MODELS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION; GAO STUDY AND REPORT.

(a) CMI MODELS.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B) is amended by adding at the end the following new clauses:

''(xxv) Supporting ways to familiarize individuals with the availability of coverage under part B of title XVIII for qualified psychologist services (as defined in section 1861(ii)).

''(xxvi) Exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services (such as for treating depression) through use of a 24-hour, 7-day a week help line that may inform individuals about the availability of treatment options, including the availability of qualified psychologist services (as defined in section 1861(ii)).''.

(b) GAO STUDY AND REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study, and submit to Congress a report, on mental and behavioral health services under the Medicare program under title XVIII of the Social Security Act, including an examination of the following:

(1) Information about services furnished by psychiatrists, clinical psychologists, and other professionals.

(2) Information about ways that Medicare beneficiaries familiarize themselves about the availability of Medicare payment for qualified psychologist services (as defined in section 1861(ii) of the Social Security Act (42 U.S.C. 1395x(ii)) and ways that the provision of such information could be improved.

SEC. 6086. PAIN MANAGEMENT STUDY.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a study analyzing best practices as well as payment and coverage for pain management services under title XVIII of the Social Security Act and submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report containing options for revising payment to providers and suppliers of services and coverage related to the use of multi-disciplinary, evidence-based, non-opioid treatments for acute and chronic pain management for individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act. The Secretary shall make such report available on the public website of the Centers for Medicare & Medicaid Services.

(b) CONSULTATION.—In developing the report described in subsection (a), the Secretary shall consult with—

(1) relevant agencies within the Department of Health and Human Services;

(2) licensed and practicing osteopathic and allopathic physicians, behavioral health practitioners, physician assistants, nurse practitioners, dentists, pharmacists, and other providers of health services;

(3) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

(4) substance abuse and mental health professional organizations;

(5) pain management professional organizations and advocacy entities, including individuals who personally suffer chronic pain;

(6) medical professional organizations and medical specialty organizations;

(7) licensed health care providers who furnish alternative pain management services;

(8) organizations with expertise in the development of innovative medical technologies for pain management;

(9) beneficiary advocacy organizations; and

(10) other organizations with expertise in the assessment, diagnosis, treatment, and management of pain, as determined appropriate by the Secretary.

(c) CONTENTS.—The report described in subsection (a) shall include the following:

(1) An analysis of payment and coverage under title XVIII of the Social Security Act with respect to the following:

(A) Evidence-based treatments and technologies for chronic or acute pain, including such treatments that are covered, not covered, or have limited coverage under such title.

(B) Evidence-based treatments and technologies that monitor substance use withdrawal and prevent overdoses of opioids.

(C) Evidence-based treatments and technologies that treat substance use disorders.

(D) Items and services furnished by practitioners through a multi-disciplinary treatment model for pain management, including the patient-centered medical home.

(E) Medical devices, non-opioid based drugs, and other therapies (including interventional and integrative pain therapies) approved or cleared by the Food and Drug Administration for the treatment of pain.

(F) Items and services furnished to beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, or have comorbidities and require consultation or management of pain with one or more specialists in pain management, mental health, or addiction treatment.

(2) An evaluation of the following:

(A) Barriers inhibiting individuals entitled to benefits under part A or enrolled under part B of such title from accessing treatments and technologies described in subparagraphs (A) through (F) of paragraph (1).

(B) Costs and benefits associated with potential expansion of coverage under such title to include items and services not covered under such title that may be used for the treatment of pain, such as acupuncture, therapeutic massage, and items and services furnished by integrated pain management programs.

(C) Pain management guidance published by the Federal Government that may be relevant to coverage determinations or other coverage requirements under title XVIII of the Social Security Act.

(3) An assessment of all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids. Such assessment shall consider incorporating into such guidance relevant elements of the ''Va/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain'' published in February 2017 by the Department of Veterans Affairs and Department of Defense, including adoption of elements of the Department of Defense and Department of Veterans Affairs pain rating scale.

(4) The options described in subsection (d).

(5) The impact analysis described in subsection (e).

(d) OPTIONS.—The options described in this subsection are, with respect to individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act, legislative and administrative options for accomplishing the following:

(1) Improving coverage of and payment for pain management therapies without the use of opioids, including interventional pain therapies, and options to augment opioid therapy with other clinical and complementary, integrative health services to minimize the risk of substance use disorder, including in a hospital setting.

(2) Improving coverage of and payment for medical devices and non-opioid based pharmacological and non-pharmacological therapies approved or cleared by the Food and Drug Administration for the treatment of pain as an alternative or augment to opioid therapy.

(3) Improving and disseminating treatment strategies for beneficiaries with psychiatric disorders, substance use disorders, or who are at risk of suicide, and treatment strategies to address health disparities related to opioid use and opioid abuse treatment.

(4) Improving and disseminating treatment strategies for beneficiaries with comorbidities who require a consultation or comanagement of pain with one or more specialists in pain management, mental health, or addiction treatment, including in a hospital setting.

(5) Educating providers on risks of coadministration of opioids and other drugs, particularly benzodiazepines.

(6) Ensuring appropriate case management for beneficiaries who transition between inpatient and outpatient hospital settings, or between opioid therapy to non-opioid therapy, which may include the use of care transition plans.

(7) Expanding outreach activities designed to educate providers of services and suppliers under the Medicare program and individuals entitled to benefits under part A or under part B of such title on alternative, non-opioid therapies to manage and treat acute and chronic pain.

(8) Creating a beneficiary education tool on alternatives to opioids for chronic pain management.

(e) IMPACT ANALYSIS.—The impact analysis described in this subsection consists of an analysis of any potential effects implementing the options described in subsection (d) would have—

(1) on expenditures under the Medicare program; and

(2) on preventing or reducing opioid addiction for individuals receiving benefits under the Medicare program.

Subtitle J—Combating Opioid Abuse for Care in Hospitals

SEC. 6091. SHORT TITLE.

This subtitle may be cited as the ''Combating Opioid Abuse for Care in Hospitals Act of 2018'' or the ''COACH Act of 2018''.

SEC. 6092. DEVELOPING GUIDANCE ON PAIN MANAGEMENT AND OPIOID USE DISORDER PREVENTION FOR HOSPITALS RECEIVING PAYMENT UNDER PART A OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Not later than January 1, 2019, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop and publish on the public website of the Centers for Medicare & Medicaid Services guidance for hospitals receiving payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) on pain management strategies and opioid use disorder prevention strategies with respect to individuals entitled to benefits under such part.

(b) CONSULTATION.—In developing the guidance described in subsection (a), the Secretary shall consult with relevant stakeholders, including—

(1) medical professional organizations;

(2) providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x));

(3) health care consumers or groups representing such consumers; and

(4) other entities determined appropriate by the Secretary.

(c) CONTENTS.—The guidance described in subsection (a) shall include, with respect to hospitals and individuals described in such subsection, the following:

(1) Best practices regarding evidence-based screening and practitioner education initiatives relating to screening and treatment protocols for opioid use disorder, including—

(A) methods to identify such individuals at-risk of opioid use disorder, including risk stratification;

(B) ways to prevent, recognize, and treat opioid overdoses; and

(C) resources available to such individuals, such as opioid treatment programs, peer support groups, and other recovery programs.

(2) Best practices for such hospitals to educate practitioners furnishing items and services at such hospital with respect to pain management and substance use disorders, including education on—

(A) the adverse effects of prolonged opioid use;

(B) non-opioid, evidence-based, non-pharmacological pain management treatments;

(C) monitoring programs for individuals who have been prescribed opioids; and

(D) the prescribing of naloxone along with an initial opioid prescription.

(3) Best practices for such hospitals to make such individuals aware of the risks associated with opioid use (which may include use of the notification template described in paragraph (4)).

(4) A notification template developed by the Secretary, for use as appropriate, for such individuals who are prescribed an opioid that—

(A) explains the risks and side effects associated with opioid use (including the risks of addiction and overdose) and the importance of adhering to the prescribed treatment regimen, avoiding medications that may have an adverse interaction with such opioid, and storing such opioid safely and securely;

(B) highlights multimodal and evidence-based non-opioid alternatives for pain management;

(C) encourages such individuals to talk to their health care providers about such alternatives;

(D) provides for a method (through signature or otherwise) for such an individual, or person acting on such individual's behalf, to acknowledge receipt of such notification template;

(E) is worded in an easily understandable manner and made available in multiple languages determined appropriate by the Secretary; and

(F) includes any other information determined appropriate by the Secretary.

(5) Best practices for such hospital to track opioid prescribing trends by practitioners furnishing items and services at such hospital, including—

(A) ways for such hospital to establish target levels, taking into account the specialties of such practitioners and the geographic area in which such hospital is located, with respect to opioids prescribed by such practitioners;

(B) guidance on checking the medical records of such individuals against information included in prescription drug monitoring programs;

(C) strategies to reduce long-term opioid prescriptions; and

(D) methods to identify such practitioners who may be over-prescribing opioids.

(6) Other information the Secretary determines appropriate, including any such information from the Opioid Safety Initiative established by the Department of Veterans Affairs or the Opioid Overdose Prevention Toolkit published by the Substance Abuse and Mental Health Services Administration.

SEC. 6093. REQUIRING THE REVIEW OF QUALITY MEASURES RELATING TO OPIOIDS AND OPIOID USE DISORDER TREATMENTS FURNISHED UNDER THE MEDICARE PROGRAM AND OTHER FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1890A of the Social Security Act (42 U.S.C. 1395aaa–1) is amended by adding at the end the following new subsection:

''(g) TECHNICAL EXPERT PANEL REVIEW OF OPIOID AND OPIOID USE DISORDER QUALITY MEASURES.—

''(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall establish a technical expert panel for purposes of reviewing quality measures relating to opioids and opioid use disorders, including care, prevention, diagnosis, health outcomes, and treatment furnished to individuals with opioid use disorders. The Secretary may use the entity with a contract under section 1890(a) and amend such contract as necessary to provide for the establishment of such technical expert panel.

''(2) REVIEW AND ASSESSMENT.—Not later than 1 year after the date the technical expert panel described in paragraph (1) is established (and periodically thereafter as the Secretary determines appropriate), the technical expert panel shall—

''(A) review quality measures that relate to opioids and opioid use disorders, including existing measures and those under development;

''(B) identify gaps in areas of quality measurement that relate to opioids and opioid use disorders, and identify measure development priorities for such measure gaps; and

''(C) make recommendations to the Secretary on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such measures in the Merit-Based Incentive Payment System under section 1848(q), the alternative payment models under section 1833(z)(3)(C), the shared savings program under section 1899, the quality reporting requirements for inpatient hospitals under section 1886(b)(3)(B)(viii), and the hospital value-based purchasing program under section 1886(o).

''(3) CONSIDERATION OF MEASURES BY SECRETARY.—The Secretary shall consider—

''(A) using opioid and opioid use disorder measures (including measures used under the Merit-Based Incentive Payment System under section 1848(q), measures recommended under paragraph (2)(C), and other such measures identified by the Secretary) in alternative payment models under section 1833(z)(3)(C) and in the shared savings program under section 1899; and

''(B) using opioid measures described in subparagraph (A), as applicable, in the quality reporting requirements for inpatient hospitals under section 1886(b)(3)(B)(viii),and in the hospital value-based purchasing program under section 1886(o).

''(4) PRIORITIZATION OF MEASURE DEVELOPMENT.—The Secretary shall prioritize for measure development the gaps in quality measures identified under paragraph (2)(B).''.

(b) EXPEDITED ENDORSEMENT PROCESS FOR OPIOID MEASURES.—Section 1890(b)(2) of the Social Security Act (42 U.S.C. 1395aaa(b)(2)) is amended by adding at the end the following new flush sentence:

''Such endorsement process shall, as determined practicable by the entity, provide for an expedited process with respect to the endorsement of such measures relating to opioids and opioid use disorders.''.

SEC. 6094. TECHNICAL EXPERT PANEL ON REDUCING SURGICAL SETTING OPIOID USE; DATA COLLECTION ON PERIOPERATIVE OPIOID USE.

(a) TECHNICAL EXPERT PANEL ON REDUCING SURGICAL SETTING OPIOID USE.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall convene a technical expert panel, including medical and surgical specialty societies and hospital organizations, to provide recommendations on reducing opioid use in the inpatient and outpatient surgical settings and on best practices for pain management, including with respect to the following:

(A) Approaches that limit patient exposure to opioids during the perioperative period, including pre-surgical and post-surgical injections, and that identify such patients at risk of opioid use disorder pre-operation.

(B) Shared decision making with patients and families on pain management, including recommendations for the development of an evaluation and management code for purposes of payment under the Medicare program under title XVIII of the Social Security Act that would account for time spent on shared decision making.

(C) Education on the safe use, storage, and disposal of opioids.

(D) Prevention of opioid misuse and abuse after discharge.

(E) Development of a clinical algorithm to identify and treat at-risk, opiate-tolerant patients and reduce reliance on opioids for acute pain during the perioperative period.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress and make public a report containing the recommendations developed under paragraph (1) and an action plan for broader implementation of pain management protocols that limit the use of opioids in the perioperative setting and upon discharge from such setting.

(b) DATA COLLECTION ON PERIOPERATIVE OPIOID USE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that contains the following:

(1) The diagnosis-related group codes identified by the Secretary as having the highest volume of surgeries.

(2) With respect to each of such diagnosis-related group codes so identified, a determination by the Secretary of the data that is both available and reported on opioid use following such surgeries, such as with respect to—

(A) surgical volumes, practices, and opioid prescribing patterns;

(B) opioid consumption, including—

(i) perioperative days of therapy;

(ii) average daily dose at the hospital, including dosage greater than 90 milligram morphine equivalent;

(iii) post-discharge prescriptions and other combination drugs that are used before intervention and after intervention;

(iv) quantity and duration of opioid prescription at discharge; and

(v) quantity consumed and number of refills;

(C) regional anesthesia and analgesia practices, including pre-surgical and post-surgical injections;

(D) naloxone reversal;

(E) post-operative respiratory failure;

(F) information about storage and disposal; and

(G) such other information as the Secretary may specify.

(3) Recommendations for improving data collection on perioperative opioid use, including an analysis to identify and reduce barriers to collecting, reporting, and analyzing the data described in paragraph (2), including barriers related to technological availability.

SEC. 6095. REQUIRING THE POSTING AND PERIODIC UPDATE OF OPIOID PRESCRIBING GUIDANCE FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall post on the public website of the Centers for Medicare & Medicaid Services all guidance published by the Department of Health and Human Services on or after January 1, 2016, relating to the prescribing of opioids and applicable to opioid prescriptions for individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) or enrolled under part B of such title of such Act (42 U.S.C. 1395j et seq.).

(b) UPDATE OF GUIDANCE.—

(1) PERIODIC UPDATE.—The Secretary shall, in consultation with the entities specified in paragraph (2), periodically (as determined appropriate by the Secretary) update guidance described in subsection (a) and revise the posting of such guidance on the website described in such subsection.

(2) CONSULTATION.—The entities specified in this paragraph are the following:

(A) Medical professional organizations.

(B) Providers and suppliers of services (as such terms are defined in section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(C) Health care consumers or groups representing such consumers.

(D) Other entities determined appropriate by the Secretary.

Subtitle K—Stop Excessive Narcotics in Our Retirement Communities Protection

SEC. 6101. SHORT TITLE.

This subtitle may be cited as the ''Stop Excessive Narcotics in our Retirement Communities Protection Act of 2018'' or the ''SENIOR Communities Protection Act of 2018''.

SEC. 6102. SUSPENSION OF PAYMENTS BY MEDICARE PRESCRIPTION DRUG PLANS AND MA–PD PLANS PENDING INVESTIGATIONS OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.

(a) IN GENERAL.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.—

''(A) IN GENERAL.—The provisions of section 1862(o) shall apply with respect to a PDP sponsor with a contract under this part, a pharmacy, and payments to such pharmacy under this part in the same manner as such provisions apply with respect to the Secretary, a provider of services or supplier, and payments to such provider of services or supplier under this title.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of a PDP sponsor to conduct postpayment review.''.

(b) APPLICATION TO MA–PD PLANS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following new subparagraph:

''(D) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD BY PHARMACIES.—Section 1860D–12(b)(7).''.

(c) CONFORMING AMENDMENT.—Section 1862(o)(3) of the Social Security Act (42 U.S.C. 1395y(o)(3)) is amended by inserting '', section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)),'' after ''this subsection''.

(d) CLARIFICATION RELATING TO CREDIBLE ALLEGATION OF FRAUD.—Section 1862(o) of the Social Security Act (42 U.S.C. 1395y(o)) is amended by adding at the end the following new paragraph:

''(4) CREDIBLE ALLEGATION OF FRAUD.—In carrying out this subsection, section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)), and section 1903(i)(2)(C), a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2020.

Subtitle L—Providing Reliable Options for Patients and Educational Resources

SEC. 6111. SHORT TITLE.

This subtitle may be cited as the ''Providing Reliable Options for Patients and Educational Resources Act of 2018'' or the ''PROPER Act of 2018''.

SEC. 6112. REQUIRING MEDICARE ADVANTAGE PLANS AND PART D PRESCRIPTION DRUG PLANS TO INCLUDE INFORMATION ON RISKS ASSOCIATED WITH OPIOIDS AND COVERAGE OF NONPHARMACOLOGICAL THERAPIES AND NONOPIOID MEDICATIONS OR DEVICES USED TO TREAT PAIN.

Section 1860D–4(a)(1) of the Social Security Act (42 U.S.C. 1395w–104(a)(1)) is amended—

(1) in subparagraph (A), by inserting '', subject to subparagraph (C),'' before ''including'';

(2) in subparagraph (B), by adding at the end the following new clause:

''(vi) For plan year 2021 and each subsequent plan year, subject to subparagraph (C), with respect to the treatment of pain—

''(I) the risks associated with prolonged opioid use; and

''(II) coverage of nonpharmacological therapies, devices, and nonopioid medications—

''(aa) in the case of an MA-PD plan under part C, under such plan; and

''(bb) in the case of a prescription drug plan, under such plan and under parts A and B.''; and

(3) by adding at the end the following new subparagraph:

''(C) TARGETED PROVISION OF INFORMATION.—A PDP sponsor of a prescription drug plan may, in lieu of disclosing the information described in subparagraph (B)(vi) to each enrollee under the plan, disclose such information through mail or electronic communications to a subset of enrollees under the plan, such as enrollees who have been prescribed an opioid in the previous two-year period.''.

SEC. 6113. REQUIRING MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS TO PROVIDE INFORMATION ON THE SAFE DISPOSAL OF PRESCRIPTION DRUGS.

(a) MEDICARE ADVANTAGE.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(n) PROVISION OF INFORMATION RELATING TO THE SAFE DISPOSAL OF CERTAIN PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—In the case of an individual enrolled under an MA or MA-PD plan who is furnished an in-home health risk assessment on or after January 1, 2021, such plan shall ensure that such assessment includes information on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under paragraph (2). Such information shall include information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal.

''(2) CRITERIA.—The Secretary shall, through rulemaking, establish criteria the Secretary determines appropriate with respect to information provided to an individual to ensure that such information sufficiently educates such individual on the safe disposal of prescription drugs that are controlled substances.''.

(b) PRESCRIPTION DRUG PLANS.—Section 1860D–4(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–104(c)(2)(B)) is amended—

(1) by striking ''may include elements that promote'';

(2) by redesignating clauses (i) through (iii) as subclauses (I) through (III) and adjusting the margins accordingly;

(3) by inserting before subclause (I), as so redesignated, the following new clause:

''(i) may include elements that promote—'';

(4) in subclause (III), as so redesignated, by striking the period at the end and inserting ''; and''; and

(5) by adding at the end the following new clause:

''(ii) with respect to plan years beginning on or after January 1, 2021, shall provide for—

''(I) the provision of information to the enrollee on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under section 1852(n)(2), including information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal; and

''(II) cost-effective means by which an enrollee may so safely dispose of such drugs.''.

SEC. 6114. REVISING MEASURES USED UNDER THE HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS SURVEY RELATING TO PAIN MANAGEMENT.

(a) RESTRICTION ON THE USE OF PAIN QUESTIONS IN HCAHPS.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended by adding at the end the following new subclause:

''(XII)(aa) With respect to a Hospital Consumer Assessment of Healthcare Providers and Systems survey (or a successor survey) conducted on or after January 1, 2019, such survey may not include questions about communication by hospital staff with an individual about such individual's pain unless such questions take into account, as applicable, whether an individual experiencing pain was informed about risks associated with the use of opioids and about non-opioid alternatives for the treatment of pain.

''(bb) The Secretary shall not include on the Hospital Compare Internet website any measures based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 about communication by hospital staff with an individual about such individual's pain.''.

(b) RESTRICTION ON USE OF 2018 PAIN QUESTIONS IN THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.—Section 1886(o)(2)(B) of the Social Security Act (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding at the end the following new clause:

''(iii) HCAHPS PAIN QUESTIONS.—The Secretary may not include under subparagraph (A) a measure that is based on the questions appearing on the Hospital Consumer Assessment of Healthcare Providers and Systems survey in 2018 about communication by hospital staff with an individual about the individual's pain.''.

TITLE VII—OTHER HEALTH PROVISIONS

Subtitle A—Synthetic Drug Awareness

SEC. 7001. SHORT TITLE.

This subtitle may be cited as the ''Synthetic Drug Awareness Act of 2018''.

SEC. 7002. REPORT ON EFFECTS ON PUBLIC HEALTH OF SYNTHETIC DRUG USE.

(a) IN GENERAL.—Not later than three years after the date of the enactment of this Act, the Surgeon General of the Public Health Service shall submit to Congress a report on the health effects of new psychoactive substances (including synthetic drugs) used since January 2010 by persons who are at least 12 years of age but no more than 18 years of age.

(b) NEW PSYCHOACTIVE SUBSTANCE DEFINED.—For purposes of subsection (a), the term ''new psychoactive substance'' means a controlled substance analogue (as defined in section 102(32) of the Controlled Substances Act (21 U.S.C. 802(32)).

Subtitle B—Empowering Pharmacists in the Fight Against Opioid Abuse

SEC. 7011. SHORT TITLE.

This subtitle may be cited as the ''Empowering Pharmacists in the Fight Against Opioid Abuse Act''.

SEC. 7012. PROGRAMS AND MATERIALS FOR TRAINING ON CERTAIN CIRCUMSTANCES UNDER WHICH A PHARMACIST MAY DECLINE TO FILL A PRESCRIPTION.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, the Commissioner of Food and Drugs, the Director of the Centers for Disease Control and Prevention, and the Assistant Secretary for Mental Health and Substance Use, shall develop and disseminate programs and materials for training pharmacists, health care providers, and patients on—

(1) circumstances under which a pharmacist may, consistent with section 201 of the Controlled Substances Act (21 U.S.C. 811) and regulations thereunder, including section 1306.04 of title 21, Code of Federal Regulations, decline to fill a prescription for a controlled substance because the pharmacist suspects the prescription is fraudulent, forged, or otherwise indicative of abuse or diversion; and

(2) any Federal requirements pertaining to declining to fill a prescription under such circumstances.

(b) MATERIALS INCLUDED.—In developing materials under subsection (a), the Secretary of Health and Human Services shall include information educating—

(1) pharmacists on how to decline to fill a prescription and actions to take after declining to fill a prescription; and

(2) other health care practitioners and the public on a pharmacist's responsibility to decline to fill prescriptions in certain circumstances.

(c) STAKEHOLDER INPUT.—In developing the programs and materials required under subsection (a), the Secretary of Health and Human Services shall seek input from relevant national, State, and local associations, boards of pharmacy, medical societies, licensing boards, health care practitioners, and patients.

Subtitle C—Indexing Narcotics, Fentanyl, and Opioids

SEC. 7021. SHORT TITLE.

This subtitle may be cited as the ''Indexing Narcotics, Fentanyl, and Opioids Act of 2018'' or the ''INFO Act''.

SEC. 7022. ESTABLISHMENT OF SUBSTANCE USE DISORDER INFORMATION DASHBOARD.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following new section:

''SEC. 1711. ESTABLISHMENT OF SUBSTANCE USE DISORDER INFORMATION DASHBOARD.

''(a) IN GENERAL.—Not later than six months after the date of the enactment of this section, the Secretary of Health and Human Services shall, in consultation with the Director of National Drug Control Policy, establish and periodically update a public information dashboard that—

''(1) coordinates information on programs within the Department of Health and Human Services related to the reduction of opioid abuse and other substance use disorders;

''(2) provides access to publicly available data from other Federal agencies; State, local, and Tribal governments; nonprofit organizations; law enforcement; medical experts; public health educators; and research institutions regarding prevention, treatment, recovery, and other services for opioid use disorder and other substance use disorders;

''(3) provides comparable data on substance use disorder prevention and treatment strategies in different regions and population of the United States;

''(4) provides recommendations for health care providers on alternatives to controlled substances for pain management, including approaches studied by the National Institutes of Health Pain Consortium and the National Center for Complimentary and Integrative Health; and

''(5) provides guidelines and best practices for health care providers regarding treatment of substance use disorders.

''(b) CONTROLLED SUBSTANCE DEFINED.—In this section, the term 'controlled substance' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).''.

SEC. 7023. INTERAGENCY SUBSTANCE USE DISORDER COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—Not later than three months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, in consultation with the Director of National Drug Control Policy, establish a committee, to be known as the Interagency Substance Use Disorder Coordinating Committee (in this section referred to as the ''Committee''), to coordinate all efforts within the Department of Health and Human Services concerning substance use disorder.

(b) MEMBERSHIP.—

(1) FEDERAL MEMBERS.—The following individuals shall be the Federal members of the Committee:

(A) The Secretary, who shall service as the Chair of the Committee.

(B) The Attorney General of the United States.

(C) The Secretary of Labor.

(D) The Secretary of Housing and Urban Development.

(E) The Secretary of Education.

(F) The Secretary of Veterans Affairs.

(G) The Commissioner of Social Security.

(H) The Assistant Secretary for Mental Health and Substance Use.

(I) The Director of the Centers for Disease Control and Prevention.

(J) The Director of the National Institutes of Health and the Directors of such national research institutes of the National Institutes of Health as the Secretary determines appropriate.

(K) The Administrator of the Centers for Medicare & Medicaid Services.

(L) The Director of National Drug Control Policy.

(M) Representatives of other Federal agencies that serve individuals with substance use disorder.

(2) NON-FEDERAL MEMBERS.—The Committee shall include a minimum of 17 non-Federal members appointed by the Secretary, of which—

(A) at least two such members shall be an individual who has received treatment for a diagnosis of an opioid use disorder;

(B) at least two such members shall be an individual who has received treatment for a diagnosis of a substance use disorder other than an opioid use disorder;

(C) at least two such members shall be a State Alcohol and Substance Abuse Director;

(D) at least two such members shall be a representative of a leading research, advocacy, or service organization for adults with substance use disorder;

(E) at least two such members shall—

(i) be a physician, licensed mental health professional, advance practice registered nurse, or physician assistant; and

(ii) have experience in treating individuals with opioid use disorder or other substance use disorders;

(F) at least one such member shall be a substance use disorder treatment professional who is employed with an opioid treatment program;

(G) at least one such member shall be a substance use disorder treatment professional who has research or clinical experience in working with racial and ethnic minority populations;

(H) at least one such member shall be a substance use disorder treatment professional who has research or clinical mental health experience in working with medically underserved populations;

(I) at least one such member shall be a State-certified substance use disorder peer support specialist;

(J) at least one such member shall be a drug court judge or a judge with experience in adjudicating cases related to substance use disorder;

(K) at least one such member shall be a law enforcement officer or correctional officer with extensive experience in interacting with adults with a substance use disorder; and

(L) at least one such member shall be an individual with experience providing services for homeless individuals and working with adults with a substance use disorder.

(c) TERMS.—

(1) IN GENERAL.—A member of the Committee appointed under subsection (b)(2) shall be appointed for a term of three years and may be reappointed for one or more three-year terms.

(2) VACANCIES.—A vacancy on the Committee shall be filled in the same manner in which the original appointment was made. Any individual appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term and may serve after the expiration of such term until a successor has been appointed.

(d) MEETINGS.—The Committee shall meet not fewer than two times each year.

(e) DUTIES.—The Committee shall—

(1) monitor opioid use disorder and other substance use disorder research, services, and support and prevention activities across all relevant Federal agencies, including coordination of Federal activities with respect to opioid use disorder and other substance use disorders;

(2) identify and provide to the Secretary recommendations for improving Federal grants and programs for the prevention and treatment of, and recovery from, opioid use disorder and other substance use disorders;

(3) review substance use disorder prevention and treatment strategies in different regions and populations in the United States and evaluate the extent to which Federal substance use disorder prevention and treatment strategies are aligned with State and local substance use disorder prevention and treatment strategies;

(4) make recommendations to the Secretary regarding any appropriate changes with respect to the activities and strategies described in paragraphs (1) through (3);

(5) make recommendations to the Secretary regarding public participation in decisions relating to opioid use disorder and other substance use disorders and the process by which public feedback can be better integrated into such decisions; and

(6) make recommendations to ensure that opioid use disorder and other substance use disorder research, services, and support and prevention activities of the Department of Health and Human Services and other Federal agencies are not unnecessarily duplicative.

(f) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, and annually thereafter for the life of the Committee, the Committee shall publish on the public information dashboard established under section 7022(a) a report summarizing the activities carried out by the Committee pursuant to subsection (e), including any findings resulting from such activities.

(2) RECOMMENDATION FOR COMMITTEE EXTENSION.—After the publication of the second report of the Committee under paragraph (1), the Secretary shall submit to Congress a recommendation on whether or not the operations of the Committee should continue after the termination date described in subsection (i).

(g) WORKING GROUPS.—The Committee may establish working groups for purposes of carrying out the duties described in subsection (e). Any such working group shall be composed of members of the Committee (or the designees of such members) and may hold such meetings as are necessary to enable the working group to carry out the duties delegated to the working group.

(h) FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee only to the extent that the provisions of such Act do not conflict with the requirements of this section.

(i) SUNSET.—The Committee shall terminate on the date that is six years after the date on which the Committee is established under subsection (a).

Subtitle D—Ensuring Access to Quality Sober Living

SEC. 7031. SHORT TITLE.

This subtitle may be cited as the ''Ensuring Access to Quality Sober Living Act of 2018''.

SEC. 7032. NATIONAL RECOVERY HOUSING BEST PRACTICES.

Part P of title III of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 399V–7. NATIONAL RECOVERY HOUSING BEST PRACTICES.

''(a) BEST PRACTICES.—The Secretary of Health and Human Services, in consultation with the Secretary for Housing and Urban Development, patients with a history of opioid use disorder, and other stakeholders, which may include State accrediting entities and reputable providers, analysts, and stakeholders of recovery housing services, such as the National Alliance for Recovery Residences, shall identify or facilitate the development of best practices, which may include model laws for implementing suggested minimum standards, for operating recovery housing.

''(b) DISSEMINATION.—The Secretary shall disseminate the best practices identified or developed under subsection (a) to—

''(1) State agencies, which may include the provision of technical assistance to State agencies seeking to adopt or implement such best practices;

''(2) recovery housing entities; and

''(3) the public, as appropriate.

''(c) DEFINITIONS.—In this section:

''(1) The term 'recovery housing' means a shared living environment free from alcohol and illicit drug use and centered on peer support and connection to services, including medication-assisted treatment services, that promote sustained recovery from substance use disorders.

''(2) The term 'State' includes any of the several States, the District of Columbia, each Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), and any territory or possession of the United States.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $3,000,000 for the period of fiscal years 2019 through 2021.''.

Subtitle E—Advancing Cutting Edge Research

SEC. 7041. SHORT TITLE.

This subtitle may be cited as the ''Advancing Cutting Edge Research Act'' or the ''ACE Research Act''.

SEC. 7042. UNIQUE RESEARCH INITIATIVES.

Section 402(n)(1) of the Public Health Service Act (42 U.S.C. 282(n)(1)) is amended—

(1) in subparagraph (A), by striking ''or'';

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) high impact cutting-edge research that fosters scientific creativity and increases fundamental biological understanding leading to the prevention, diagnosis, or treatment of diseases and disorders, or research urgently required to respond to a public health threat.''.

Subtitle F—Jessie's Law

SEC. 7051. SHORT TITLE.

This subtitle may be cited as ''Jessie's Law''.

SEC. 7052. INCLUSION OF OPIOID ADDICTION HISTORY IN PATIENT RECORDS.

(a) BEST PRACTICES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with appropriate stakeholders, including a patient with a history of opioid use disorder, an expert in electronic health records, an expert in the confidentiality of patient health information and records, and a health care provider, shall identify or facilitate the development of best practices regarding—

(A) the circumstances under which information that a patient has provided to a health care provider regarding such patient's history of opioid use disorder should, only at the patient's request, be prominently displayed in the medical records (including electronic health records) of such patient;

(B) what constitutes the patient's request for the purpose described in subparagraph (A); and

(C) the process and methods by which the information should be so displayed.

(2) DISSEMINATION.—The Secretary shall disseminate the best practices developed under paragraph (1) to health care providers and State agencies.

(b) REQUIREMENTS.—In identifying or facilitating the development of best practices under subsection (a), as applicable, the Secretary, in consultation with appropriate stakeholders, shall consider the following:

(1) The potential for addiction relapse or overdose, including overdose death, when opioid medications are prescribed to a patient recovering from opioid use disorder.

(2) The benefits of displaying information about a patient's opioid use disorder history in a manner similar to other potentially lethal medical concerns, including drug allergies and contraindications.

(3) The importance of prominently displaying information about a patient's opioid use disorder when a physician or medical professional is prescribing medication, including methods for avoiding alert fatigue in providers.

(4) The importance of a variety of appropriate medical professionals, including physicians, nurses, and pharmacists, to have access to information described in this section when prescribing or dispensing opioid medication, consistent with Federal and State laws and regulations.

(5) The importance of protecting patient privacy, including the requirements related to consent for disclosure of substance use disorder information under all applicable laws and regulations.

(6) All applicable Federal and State laws and regulations.

SEC. 7053. COMMUNICATION WITH FAMILIES DURING EMERGENCIES.

(a) PROMOTING AWARENESS OF AUTHORIZED DISCLOSURES DURING EMERGENCIES.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Health Resources and Services Administration, shall annually develop and disseminate written materials (electronically or by other means) to health care providers regarding permitted disclosures under Federal health care privacy law during emergencies, including overdoses, of certain health information to families, caregivers, and health care providers.

(b) USE OF MATERIAL.—For the purposes of carrying out subsection (a), the Secretary of Health and Human Services may use material produced under section 11004 of the 21st Century Cures Act (42 U.S.C. 1320d–2 note).

Subtitle G—Safe Disposal of Unused Medication

SEC. 7061. SHORT TITLE.

This subtitle may be cited as the ''Safe Disposal of Unused Medication Act''.

SEC. 7062. DISPOSAL OF CONTROLLED SUBSTANCES OF A DECEASED HOSPICE PATIENT BY EMPLOYEES OF A QUALIFIED HOSPICE PROGRAM.

Subsection (g) of section 302 of the Controlled Substances Act (21 U.S.C. 822) is amended by adding at the end the following:

''(5)(A) In the case of a person receiving hospice care, an employee of a qualified hospice program, acting within the scope of employment, may handle, without being registered under this section, any controlled substance that was lawfully dispensed to the person receiving hospice care, for the purpose of disposal of the controlled substance after the death of such person, so long as such disposal occurs onsite in accordance with all applicable Federal, State, Tribal, and local law.

''(B) For the purposes of this paragraph:

''(i) The terms 'hospice care' and 'hospice program' have the meanings given to those terms in section 1861(dd) of the Social Security Act.

''(ii) The term 'employee of a qualified hospice program' means a physician, nurse, or other person who—

''(I) is employed by, or pursuant to arrangements made by, a qualified hospice program;

''(II)(aa) is licensed to perform medical or nursing services by the jurisdiction in which the person receiving hospice care was located; and

''(bb) is acting within the scope of such employment in accordance with applicable State law; and

''(III) has completed training through the qualified hospice program regarding the disposal of controlled substances in a secure and responsible manner so as to discourage abuse, misuse, or diversion.

''(iii) The term 'qualified hospice program' means a hospice program that—

''(I) has written policies and procedures for assisting in the disposal of the controlled substances of a person receiving hospice care after the person's death;

''(II) at the time when the controlled substances are first ordered—

''(aa) provides a copy of the written policies and procedures to the patient or patient representative and family;

''(bb) discusses the policies and procedures with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe disposal of controlled substances; and

''(cc) documents in the patient's clinical record that the written policies and procedures were provided and discussed; and

''(III) at the time following the disposal of the controlled substances—

''(aa) documents in the patient's clinical record the type of controlled substance, dosage, route of administration, and quantity so disposed; and

''(bb) the time, date, and manner in which that disposal occurred.''.

Subtitle H—Substance Use Disorder Workforce Loan Repayment

SEC. 7071. SHORT TITLE.

This subtitle may be cited as the ''Substance Use Disorder Workforce Loan Repayment Act of 2018''.

SEC. 7072. LOAN REPAYMENT PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT EMPLOYEES.

Title VII of the Public Health Service Act is amended—

(1) by redesignating part F as part G; and

(2) by inserting after part E (42 U.S.C. 294n et seq.) the following:

''PART F—SUBSTANCE USE DISORDER TREATMENT EMPLOYEES

''SEC. 781. LOAN REPAYMENT PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT EMPLOYEES.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall carry out a program under which—

''(1) the Secretary enters into agreements with individuals to make payments in accordance with subsection (b) on the principal of and interest on any eligible loan; and

''(2) the individuals each agree to complete a period of service in a substance use disorder treatment job, as described in subsection (d).

''(b) PAYMENTS.—For each year of obligated service by an individual pursuant to an agreement under subsection (a), the Secretary shall make a payment to such individual as follows:

''(1) SERVICE IN A SHORTAGE AREA.—The Secretary shall pay—

''(A) for each year of obligated service by an individual pursuant to an agreement under subsection (a), 1/6 of the principal of and interest on each eligible loan of the individual which is outstanding on the date the individual began service pursuant to the agreement; and

''(B) for completion of the sixth and final year of such service, the remainder of such principal and interest.

''(2) MAXIMUM AMOUNT.—The total amount of payments under this section to any individual shall not exceed $250,000.

''(c) ELIGIBLE LOANS.—The loans eligible for repayment under this section are each of the following:

''(1) Any loan for education or training for a substance use disorder treatment job.

''(2) Any loan under part E of title VIII (relating to nursing student loans).

''(3) Any Federal Direct Stafford Loan, Federal Direct PLUS Loan, or Federal Direct Unsubsidized Stafford Loan, or Federal Direct Consolidation Loan (as such terms are used in section 455 of the Higher Education Act of 1965).

''(4) Any Federal Perkins Loan under part E of title I of the Higher Education Act of 1965.

''(5) Any other Federal loan as determined appropriate by the Secretary.

''(d) PERIOD OF SERVICE.—The period of service required by an agreement under subsection (a) shall consist of up to 6 years of full-time employment, with no more than one year passing between any two years of covered employment, in a substance use disorder treatment job in the United States in—

''(1) a Mental Health Professional Shortage Area, as designated under section 332; or

''(2) a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past 3 years for which official data is available from the State, is higher than the most recent available national average overdose death rate per 100,000 people, as reported by the Centers for Disease Control and Prevention.

''(e) INELIGIBILITY FOR DOUBLE BENEFITS.—No borrower may, for the same service, receive a reduction of loan obligations or a loan repayment under both—

''(1) this subsection; and

''(2) any Federally supported loan forgiveness program, including under section 338B, 338I, or 846 of this Act, or section 428J, 428 L, 455(m), or 460 of the Higher Education Act of 1965.

''(f) BREACH.—

''(1) LIQUIDATED DAMAGES FORMULA.—The Secretary may establish a liquidated damages formula to be used in the event of a breach of an agreement entered into under subsection (a).

''(2) LIMITATION.—The failure by an individual to complete the full period of service obligated pursuant to such an agreement, taken alone, shall not constitute a breach of the agreement, so long as the individual completed in good faith the years of service for which payments were made to the individual under this section.

''(g) ADDITIONAL CRITERIA.—The Secretary—

''(1) may establish such criteria and rules to carry out this section as the Secretary determines are needed and in addition to the criteria and rules specified in this section; and

''(2) shall give notice to the committees specified in subsection (h) of any criteria and rules so established.

''(h) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of the Substance Use Disorder Workforce Loan Repayment Act of 2018, and every other year thereafter, the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on—

''(1) the number and location of borrowers who have qualified for loan repayments under this section; and

''(2) the impact of this section on the availability of substance use disorder treatment employees nationally and in shortage areas and counties described in subsection (d).

''(i) DEFINITION.—In this section:

''(1) The term 'municipality' means a city, town, or other public body created by or pursuant to State law, or an Indian Tribe.

''(2) The term 'substance use disorder treatment job' means a full-time job (including a fellowship)—

''(A) where the primary intent and function of the job is the direct treatment or recovery support of patients with or in recovery from a substance use disorder, such as a physician, physician assistant, registered nurse, nurse practitioner, advanced practice registered nurse, social worker, recovery coach, mental health counselor, addictions counselor, psychologist or other behavioral health professional, or any other relevant professional as determine by the Secretary; and

''(B) which is located at a substance use disorder treatment program, private physician practice, hospital or health system-affiliated inpatient treatment center or outpatient clinic (including an academic medical center-affiliated treatment program), correctional facility or program, youth detention center or program, inpatient psychiatric facility, crisis stabilization unit, community health center, community mental health or other specialty community behavioral health center, recovery center, school, community-based organization, telehealth platform, migrant health center, health program or facility operated by a tribe or tribal organization, Federal medical facility, or any other facility as determined appropriate for purposes of this section by the Secretary.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $25,000,000 for each of fiscal years 2019 through 2028.''.

Subtitle I—Preventing Overdoses While in Emergency Rooms

SEC. 7081. SHORT TITLE.

This subtitle may be cited as the ''Preventing Overdoses While in Emergency Rooms Act of 2018''.

SEC. 7082. PROGRAM TO SUPPORT EMERGENCY ROOM DISCHARGE AND CARE COORDINATION FOR DRUG OVERDOSE PATIENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a program (in this subtitle referred to as the ''Program'') to develop protocols for discharging patients who have presented with a drug overdose and enhance the integration and coordination of care and treatment options for individuals with substance use disorder after discharge.

(b) GRANT ESTABLISHMENT AND PARTICIPATION.—

(1) IN GENERAL.—In carrying out the Program, the Secretary shall award grants on a competitive basis to not more than 20 eligible entities described in paragraph (2).

(2) ELIGIBILITY.—

(A) IN GENERAL.—To be eligible for a grant under this subsection, an entity shall be—

(i) a health care site described in subparagraph (B); or

(ii) a health care site coordinator described in subparagraph (C).

(B) HEALTH CARE SITES.—To be eligible for a grant under this section, a health care site shall—

(i) submit an application to the Secretary at such time, in such manner, and containing such information as specified by the Secretary;

(ii) have an emergency department;

(iii)(I) have a licensed health care professional onsite who has a waiver under section

303(g) of the Controlled Substances Act (21 U.S.C. 823(g)) to dispense or prescribe covered drugs; or

(II) have a demonstrable plan to hire a sufficient number of full-time licensed health care professionals who have waivers described in subclause (I) to administer such treatment onsite;

(iv) have in place an agreement with a sufficient number and range of entities certified under applicable State and Federal law, such as pursuant to registration or a waiver under section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)) or certification as described in section 8.2 of title 42 of the Code of Federal Regulations, to provide treatment for substance use disorder such that the entity or the resulting network of entities with an agreement with the hospital cumulatively are capable of providing all evidence-based services for the treatment of substance use disorder, as medically appropriate for the individual involved, including—

(I) medication-assisted treatment;

(II) withdrawal and detoxification services that include patient evaluation, stabilization, and readiness for and entry into treatment; and

(III) counseling;

(v) deploy onsite peer recovery specialists to help connect patients with treatment and recovery support services; and

(vi) include the provision of overdose reversal medication in discharge protocols for opioid overdose patients.

(C) HEALTH CARE SITE COORDINATORS.—To be eligible for a grant under this section, a health care site coordinator shall—

(i) be an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 (and exempt from tax under section 501(a) of such Code) or a State, local, or Tribal government;

(ii) submit an application to the Secretary at such time, in such manner, and containing such information as specified by the Secretary; and

(iii) have an agreement with multiple eligible health care sites described in subparagraph (B).

(3) PREFERENCE.—In awarding grants under this section, the Secretary may give preference to eligible entities described in paragraph (2) that meet either or both of the following criteria:

(A) The eligible health care site is, or the eligible health care site coordinator has an agreement described in paragraph (2)(C)(iii) with a site that is, a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act (42 U.S.C. 1395x(mm)(1))), a low-volume hospital (as defined in section 1886(d)(12)(C)(i) of such Act (42 U.S.C. 1395ww(d)(12)(C)(i))), or a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

(B) The eligible health care site or the eligible health care site coordinator is located in a geographic area with a drug overdose rate that is higher than the national rate, or in a geographic area with a rate of emergency department visits for overdoses that is higher than the national rate, as determined by the Secretary based on the most recent data from the Centers for Disease Control and Prevention.

(4) MEDICATION-ASSISTED TREATMENT DEFINED.—For purposes of this section, the term ''medication-assisted treatment'' means the use of a drug approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or a biological product licensed under section 351 of the Public Health Service Act (42 U.S.C. 262), in combination with behavioral health services, to provide an individualized approach to the treatment of substance use disorders, including opioid use disorders.

(c) PERIOD OF GRANT.—A grant awarded to an eligible entity under this section shall be for a period of at least 2 years.

(d) GRANT USES.—

(1) REQUIRED USES.—A grant awarded under this section to an eligible entity shall be used for both of the following purposes:

(A) To establish policies and procedures that address the provision of overdose reversal medication, prescription and dispensing of medication-assisted treatment to an emergency department patient who has had a non-fatal overdose or who is at risk of a drug overdose, and the subsequent referral to evidence-based treatment upon discharge for patients who have experienced a non-fatal drug overdose or who are at risk of a drug overdose.

(B) To develop best practices for treating non-fatal drug overdoses, including with respect to care coordination and integrated care models for long term treatment and recovery options for individuals who have experienced a non-fatal drug overdose.

(2) ADDITIONAL PERMISSIBLE USES.—A grant awarded under this section to an eligible entity may be used for any of the following purposes:

(A) To hire emergency department peer recovery specialists; counselors; therapists; social workers; or other licensed medical professionals specializing in the treatment of substance use disorder.

(B) To establish integrated models of care for individuals who have experienced a non-fatal drug overdose which may include patient assessment, follow up, and transportation to treatment facilities.

(C) To provide for options for increasing the availability and access of medication-assisted treatment and other evidence-based treatment for individuals with substance use disorders.

(D) To offer consultation with and referral to other supportive services that help in treatment and recovery.

(e) REPORTING REQUIREMENTS.—

(1) REPORTS BY GRANTEES.—Each eligible entity awarded a grant under this section shall submit to the Secretary an annual report for each year for which the entity has received such grant that includes information on—

(A) the number of individuals treated at the site (or, in the case of an eligible health care site coordinator, at sites covered by the agreement referred to in subsection (b)(2)(C)(iii)) for non-fatal overdoses in the emergency department;

(B) the number of individuals administered each medication-assisted treatment at such site or sites in the emergency department;

(C) the number of individuals referred by such site or sites to other treatment facilities after a non-fatal overdose, the types of such other facilities, and the number of such individuals admitted to such other facilities pursuant to such referrals;

(D) the frequency and number of patient readmissions for non-fatal overdoses and substance use disorder;

(E) for what the grant funding was used; and

(F) the effectiveness of, and any other relevant additional data regarding, having an onsite health care professional to administer and begin medication-assisted treatment for substance use disorders.

(2) REPORT BY SECRETARY.—Not less than one year after the conclusion of the Program, the Secretary shall submit to Congress a report that includes—

(A) findings of the Program;

(B) overall patient outcomes under the Program, such as with respect to hospital readmission;

(C) what percentage of patients treated by a site funded through a grant under this section were readmitted to a hospital for non-fatal or fatal overdose;

(D) an evaluation determining the effectiveness of having a practitioner onsite to administer and begin medication-assisted treatment for substance use disorder; and

(E) a compilation of voluntary guidelines and best practices from the reports submitted under paragraph (1).

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subtitle $50,000,000 for the period of fiscal years 2019 through 2023.

Subtitle J—Alternatives to Opioids in the Emergency Department

SEC. 7091. SHORT TITLE.

This subtitle may be cited as the ''Alternatives to Opioids in the Emergency Department Act'' or the ''ALTO Act''.

SEC. 7092. EMERGENCY DEPARTMENT ALTERNATIVES TO OPIOIDS DEMONSTRATION PROGRAM.

(a) DEMONSTRATION PROGRAM GRANTS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall carry out a demonstration program under which the Secretary shall award grants to hospitals and emergency departments, including freestanding emergency departments, to develop, implement, enhance, or study alternative pain management protocols and treatments that limit the use and prescription of opioids in emergency departments.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a hospital or emergency department shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(c) GEOGRAPHIC DIVERSITY.—In awarding grants under this section, the Secretary shall seek to ensure geographical diversity among grant recipients.

(d) USE OF FUNDS.—Grants under subsection (a) shall be used to—

(1) target common painful conditions, such as renal colic, sciatica, headaches, musculoskeletal pain, and extremity fractures;

(2) train providers and other hospital personnel on protocols and the use of treatments that limit the use and prescription of opioids in the emergency department; and

(3) provide alternatives to opioids to patients with painful conditions, not including patients who present with pain related to cancer, end-of-life symptom palliation, or complex multisystem trauma.

(e) CONSULTATION.—The Secretary shall implement a process for recipients of grants under subsection (a) to consult (in a manner that allows for sharing of evidence-based best practices) with each other and with persons having robust knowledge, including emergency departments and physicians that have successfully deployed alternative pain management protocols, such as non-drug approaches studied through the National Center for Complimentary and Integrative Health including acupuncture that limit the use of opioids. The Secretary shall offer to each recipient of a grant under subsection (a) technical support as necessary.

(f) REPORT TO THE SECRETARY.—Each recipient of a grant under this section shall submit to the Secretary (during the period of such grant) annual reports on the progress of the program funded through the grant. These reports shall include, in accordance with State and Federal statutes and regulations regarding disclosure of patient information—

(1) a description of and specific information about the alternative pain management protocols employed;

(2) data on the alternative pain management protocols and treatments employed, including—

(A) during a baseline period before the program began, as defined by the Secretary;

(B) at various stages of the program, as determined by the Secretary; and

(C) the conditions for which the alternative pain management protocols and treatments were employed;

(3) the success of each specific alternative pain management protocol;

(4) data on the opioid prescriptions written, including—

(A) during a baseline period before the program began, as defined by the Secretary;

(B) at various stages of the program, as determined by the Secretary; and

(C) the conditions for which the opioids were prescribed;

(5) the demographic characteristics of patients who were treated with an alternative pain management protocol, including age, sex, race, ethnicity, and insurance status and type;

(6) data on patients who were eventually prescribed opioids after alternative pain management protocols and treatments were employed; and

(7) any other information the Secretary deems necessary.

(g) REPORT TO CONGRESS.—Not later than one year after completion of the demonstration program under this section, the Secretary shall submit a report to the Congress on the results of the demonstration program and include in the report—

(1) the number of applications received and the number funded;

(2) a summary of the reports described in subsection (f), including standardized data; and

(3) recommendations for broader implementation of pain management protocols that limit the use and prescription of opioids in emergency departments or other areas of the health care delivery system.

(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2019 through 2021.

Subtitle K—Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now

SEC. 7101. SHORT TITLE.

This subtitle may be cited as the ''Stop Counterfeit Drugs by Regulating and Enhancing Enforcement Now Act'' or the ''SCREEN Act''.

SEC. 7102. DETENTION, REFUSAL, AND DESTRUCTION OF DRUGS OFFERED FOR IMPORTATION.

(a) INCREASING THE MAXIMUM DOLLAR AMOUNT OF DRUGS SUBJECT TO DESTRUCTION.—The sixth sentence in section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)) is amended by striking ''except that the Secretary'' and all that follows through the two periods at the end and inserting ''except that the Secretary of Health and Human Services may destroy, without the opportunity for export, any drug refused admission under this section, if such drug is declared to be valued at an amount that is $2,500 or less (or such higher amount as the Secretary of the Treasury may set by regulation pursuant to section 498(a)(1) of the Tariff Act of 1930 or such higher amount as the Commissioner of Food and Drugs may set based on a finding by the Commissioner that the higher amount is in the interest of public health), or if such drug is entering the United States by mail, and was not brought into compliance as described under subsection (b).''.

(b) DESTRUCTION OF ARTICLES OF CONCERN.—The sixth sentence of section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)), as amended by subsection (a), is further amended by inserting before the period at the end the following: ''; and the Secretary of Health and Human Services may destroy, without the opportunity for export, any article refused admission under clause (6) of the third sentence of this subsection''.

(c) TECHNICAL AMENDMENTS.—The seventh, eighth, and ninth sentences of section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)) are amended—

(1) by striking ''a drug'' each place it appears and inserting ''an article''; and

(2) by striking ''the drug'' each place it appears and inserting ''the article''.

(d) RULE OF CONSTRUCTION.—The last sentence in section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)) is amended to read as follows: ''Clauses (2), (5), and (6) of the third sentence of this subsection shall not be construed to prohibit the admission of narcotic or nonnarcotic drugs or other substances, the importation of which is permitted under the Controlled Substances Import and Export Act.''.

SEC. 7103. NOTIFICATION, NONDISTRIBUTION, AND RECALL OF ADULTERATED OR MISBRANDED DRUG PRODUCTS.

(a) PROHIBITED ACTS.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by adding at the end the following:

''(eee) The failure to comply with any order issued under section 569D.''.

(b) NOTIFICATION, NONDISTRIBUTION, AND RECALL OF ADULTERATED OR MISBRANDED DRUGS.—Subchapter E of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb et seq.) is amended by adding at the end the following:

''SEC. 569D. NOTIFICATION, NONDISTRIBUTION, AND RECALL OF ADULTERATED OR MISBRANDED DRUGS.

''(a) ORDER TO CEASE DISTRIBUTION AND RECALL.—

''(1) IN GENERAL.—Upon a determination that the use or consumption of, or exposure to, a drug may present an imminent or substantial hazard to the public health, the Secretary shall issue an order requiring any person who distributes the drug to immediately cease distribution of the drug.

''(2) HEARING.—An order under paragraph (1) shall provide the person subject to the order with an opportunity for an informal hearing, to be held not later than 10 days after the date of issuance of the order, on—

''(A) the actions required by the order; and

''(B) whether the order should be amended to require a recall of the drug.

''(3) INADEQUATE GROUNDS.—If, after providing an opportunity for a hearing under paragraph (2), the Secretary determines that inadequate grounds exist to support the actions required by the order, the Secretary shall vacate the order.

''(4) AMENDMENT TO ORDER TO REQUIRE RECALL.—If, after providing an opportunity for an informal hearing under paragraph (2), the Secretary determines that the order should be amended to include a recall of the drug with respect to which the order was issued, the Secretary shall—

''(A) amend the order to require a recall; and

''(B) after consultation with the drug sponsor, specify a timetable in which the recall will occur.

''(5) NOTICE TO PERSONS AFFECTED.—An order under this subsection shall require any person who distributes the drug to provide for notice, including to individuals as appropriate, to persons who may be affected by the order to cease distribution of or recall the drug, as applicable.

''(6) ACTION FOLLOWING ORDER.—Any person who is subject to an order under paragraph (1) or (4) shall immediately cease distribution of or recall, as applicable, the drug and provide notification as required by such order.

''(b) NOTICE TO CONSUMERS AND HEALTH OFFICIALS.—The Secretary shall, as the Secretary determines to be necessary, provide notice of a recall order under this section to—

''(1) consumers to whom the drug was, or may have been, distributed; and

''(2) appropriate State and local health officials.

''(c) ORDER TO RECALL.—

''(1) CONTENTS.—An order to recall a drug under subsection (a) shall—

''(A) require periodic reports to the Secretary describing the progress of the recall; and

''(B) provide for notice, including to individuals as appropriate, to persons who may be affected by the recall.

''(2) ASSISTANCE ALLOWED.—In providing for notice under paragraph (1)(B), the Secretary may allow for the assistance of health professionals, State or local officials, or other individuals designated by the Secretary.

''(3) NONDELEGATION.—An order under this section shall be ordered by the Secretary or an official designated by the Secretary. An official may not be so designated under this section unless the official is the Director of the Center for Drug Evaluation and Research, is an official senior to such Director, or is so designated by such Director.

''(d) SAVINGS CLAUSE.—Nothing contained in this section shall be construed as limiting—

''(1) the authority of the Secretary to issue an order to cease distribution of, or to recall, an drug under any other provision of this Act or the Public Health Service Act; or

''(2) the ability of the Secretary to request any person to perform a voluntary activity related to any drug subject to this Act or the Public Health Service Act.''.

(c) DRUGS SUBJECT TO REFUSAL.—The third sentence of subsection (a) of section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by inserting ''or (5) in the case of a drug, such drug is subject to an order under section 568 to cease distribution of or recall the drug,'' before ''then such article shall be refused admission''.

(d) APPLICATION.—Sections 301(eee) and 569D of the Federal Food, Drug, and Cosmetic Act, as added by subsections (a) and (b), shall apply with respect to a drug as of such date, not later than 1 year after the date of the enactment of this Act, as the Secretary of Health and Human Services shall specify.

SEC. 7104. SINGLE SOURCE PATTERN OF SHIPMENTS OF ADULTERATED OR MISBRANDED DRUGS.

Section 801 of the Federal Food, Drug, and Cosmetic Act is amended by adding at the end the following:

''(t) SINGLE SOURCE PATTERN OF SHIPMENTS OF ADULTERATED OR MISBRANDED DRUGS.—If the Secretary identifies a pattern of adulterated or misbranded drugs being offered for import from the same manufacturer, distributor, or importer, the Secretary may by order choose to treat all drugs being offered for import from such manufacturer, distributor, or importer as adulterated or misbranded unless otherwise demonstrated.''.

SEC. 7105. FUND TO STRENGTHEN EFFORTS OF FDA TO COMBAT THE OPIOID AND SUBSTANCE USE EPIDEMIC.

Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 1015. FUND TO STRENGTHEN EFFORTS OF FDA TO COMBAT THE OPIOID AND SUBSTANCE USE EPIDEMIC.

''(a) IN GENERAL.—The Commissioner of Food and Drugs shall use any funds appropriated pursuant to the authorization of appropriations under subsection (c) to carry out the programs and activities described in subsection (d) to strengthen and facilitate the Food and Drug Administration's efforts to address the opioid and substance use epidemic. Such funds shall be in addition to any funds which are otherwise available to carry out such programs and activities.

''(b) FDA OPIOID AND SUBSTANCE USE EPIDEMIC RESPONSE FUND.—

''(1) ESTABLISHMENT OF FUND.—There is established in the Treasury a fund, to be known as the FDA Opioid and Substance Use Epidemic Response Fund (referred to in this subsection as the 'Fund'), for purposes of funding the programs and activities described in subsection (d).

''(2) TRANSFER.—For the period of fiscal years 2019 through 2023, $110,000,000 shall be transferred to the Fund from the general fund of the Treasury.

''(3) AMOUNTS DEPOSITED.—Any amounts transferred under paragraph (2) shall remain unavailable in the Fund until such amounts are appropriated pursuant to subsection (c).

''(c) APPROPRIATIONS.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the period of fiscal years 2019 through 2023, there is authorized to be appropriated from the Fund to the Food and Drug Administration, for the purpose of carrying out the programs and activities described in subsection (d), an amount

not to exceed the total amount transferred to the Fund under subsection (b)(2). Notwithstanding subsection (g), such funds shall remain available until expended.

''(2) OFFSETTING FUTURE APPROPRIATIONS.—For any of fiscal years 2019 through 2023, for any discretionary appropriation out of the Fund to the Food and Drug Administration pursuant to the authorization of appropriations under paragraph (1) for the purpose of carrying out the programs and activities described in subsection (d), the total amount of such appropriations for the applicable fiscal year (not to exceed the total amount remaining in the Fund) shall be subtracted from the estimate of discretionary budget authority and the resulting outlays for any estimate under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985, and the amount transferred to the Fund shall be reduced by the same amount.

''(d) FOOD AND DRUG ADMINISTRATION.—The entirety of the funds made available pursuant to subsection (c)(1) shall be for the Commissioner of Food and Drugs, pursuant to applicable authorities in the Public Health Service Act (42 U.S.C. 201 et seq.) or this Act and other applicable Federal law, to support widespread innovation in non-opioid and non-addictive medical products for pain treatment, access to opioid addiction treatments, appropriate use of approved opioids, and efforts to reduce illicit importation of opioids. Such support may include the following programs and activities:

''(1) Obligating contract funds beginning in fiscal year 2019 for an educational campaign that will—

''(A) educate patients and their families to differentiate opioid medications;

''(B) raise awareness about preferred storage and disposal methods; and

''(C) inform patients, families, and communities about medication-assisted treatment options.

''(2) Building the Food and Drug Administration's presence in international mail facilities, including through—

''(A) improvements in equipment and information technology enhancements to identify unapproved, counterfeit, or other unlawful pharmaceuticals for destruction;

''(B) increased and improved surveillance;

''(C) renovations at international mail facility locations; and

''(D) the purchase of laboratory equipment.

''(3) Enhancing the identification and targeting of entities offering products and products being offered by such entities for import into the United States through review and analysis of Internet websites, import data, and other sources of intelligence for purposes of making the best use of the Food and Drug Administration's inspection and analytical resources.

''(4) Increasing the number of staff of the Food and Drug Administration to increase the number of packages being examined, ensuring the safety of the staff undertaking such examinations, and ensuring that packages identified as illegal, counterfeit, misbranded, or adulterated are removed from commerce through available authorities, including administrative destruction.

''(5) Enhancing the Food and Drug Administration's criminal investigations resources (including full-time equivalent employees and equipment), imports surveillance, and international work.

''(6) Obtaining for the Food and Drug Administration equipment and full-time equivalent employees needed to efficiently screen and analyze products offered for import, including by building data libraries of new substances and analogues to facilitate identification and evaluation of pharmaceutical-based agents and by purchasing screening technologies for use at international mail facilities.

''(7) Operating the Food and Drug Administration's forensic laboratory facility to ensure adequate laboratory space and functionality for additional work and full-time equivalent employees.

''(e) ACCOUNTABILITY AND OVERSIGHT.—

''(1) WORK PLAN.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Commissioner of Food and Drugs shall submit to the Committee on Health, Education, Labor and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a work plan including the proposed allocation of funds appropriated pursuant to the authorization of appropriations under subsection (c) for each of fiscal years 2019 through 2023 and the contents described in subparagraph (B).

''(B) CONTENTS.—The work plan submitted under subparagraph (A) shall include—

''(i) the amount of money to be obligated or expended out of the Fund in each fiscal year for each program and activity described in subsection (d); and

''(ii) a description and justification of each such program and activity.

''(2) REPORTS.—

''(A) ANNUAL REPORTS.—Not later than October 1 of each of fiscal years 2020 through 2024, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that includes—

''(i) the amount of money obligated or expended out of the Fund in the prior fiscal year for each program and activity described in subsection (d);

''(ii) a description of all programs and activities using funds provided pursuant to the authorization of appropriations under subsection (c); and

''(iii) how the programs and activities are advancing public health.

''(B) ADDITIONAL REPORTS.—At the request of the Committee on Health, Education, Labor and Pensions of the Senate or the Committee on Energy and Commerce of the House of Representatives, the Commissioner shall provide an update in the form of testimony and any additional reports to the respective congressional committee regarding the allocation of funding under this section or the description of the programs and activities undertaken with such funding.

''(f) LIMITATIONS.—Notwithstanding any transfer authority authorized by this section or any appropriations Act, any funds made available pursuant to the authorization of appropriations under subsection (c) may not be used for any purpose other than the programs and activities described in subsection (d) to strengthen and facilitate the Food and Drug Administration's efforts to address the opioid and substance use epidemic.

''(g) SUNSET.—This section shall expire on September 30, 2022, except that—

''(1) this subsection does not apply to reporting under subsection (e)(2); and

''(2) this section shall remain in effect until such time, and to such extent, as may be necessary for the funds transferred by subsection (b)(2) to be fully expended.''.

SEC. 7106. CONSIDERATION OF POTENTIAL FOR MISUSE AND ABUSE REQUIRED FOR DRUG APPROVAL.

(a) IN GENERAL.—Section 505(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(d)) is amended—

(1) in the first sentence—

(A) by striking ''or (7)'' and inserting ''(7)''; and

(B) by inserting ''or (8) if the drug is or contains a controlled substance for which a listing in any schedule is in effect under the Controlled Substances Act or that is permanently scheduled pursuant to section 201 of such Act, on the basis of information submitted to him as part of the application, or upon the basis of any other information before him with respect to such drug, the drug is unsafe for use due to the risks of abuse or misuse or there is insufficient information to show that the drug is safe for use considering such risks;'' before ''he shall issue an order refusing to approve the application''; and

(2) in the second sentence, by striking ''(6)'' and inserting ''(8)''.

(b) WITHDRAWAL AUTHORITY.—Section 505(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(e)) is amended in the first sentence—

(1) by striking ''or (5)'' and inserting ''(5)''; and

(2) by inserting the following: ''; or (6) that, in the case of a drug that is or contains a controlled substance for which a listing in any schedule is in effect under the Controlled Substances Act or that is permanently scheduled pursuant to section 201 of such Act, on the basis of new information before him with respect to such drug, evaluated together with the information available to him when the application was approved, that the drug is unsafe for use due to the risks of abuse or misuse'' after ''of a material fact''.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to limit or narrow, in any manner, the meaning or application of the provisions of paragraphs (1), (2), (3), (4), (5), and (7) of section 505(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(d)) or paragraphs (1) and (2) of section 505(e) of such Act (21 U.S.C. 355(e)).

Subtitle L—Treatment, Education, and Community Help to Combat Addiction

SEC. 7111. SHORT TITLE.

This subtitle may be cited as the ''Treatment, Education, and Community Help to Combat Addiction Act of 2018'' or the ''TEACH to Combat Addiction Act of 2018''.

SEC. 7112. ESTABLISHMENT OF REGIONAL CENTERS OF EXCELLENCE IN SUBSTANCE USE DISORDER EDUCATION.

Part D of title V of the Public Health Service Act is amended by inserting after section 549 (42 U.S.C. 290ee–4) the following new section:

''SEC. 550. REGIONAL CENTERS OF EXCELLENCE IN SUBSTANCE USE DISORDER EDUCATION.

''(a) IN GENERAL.—The Secretary, in consultation with such other agencies as are appropriate, shall, subject to the availability of appropriations, establish a solicitation process and award cooperative agreements to eligible entities for the designation of such entities as Regional Centers of Excellence in Substance Use Disorder Education and support of such regional centers of excellence to enhance and improve how health professionals are educated in substance use disorder prevention, treatment, and recovery through development, evaluation, and distribution of evidence-based curricula for health profession schools. An eligible entity designated by the Secretary as a Regional Center of Excellence in Substance Use Disorder Education shall carry out the activities described in subsection (b).

''(b) SELECTION OF CENTERS OF EXCELLENCE.—

''(1) ELIGIBLE ENTITIES.—To be eligible to receive a cooperative agreement under subsection (a), an entity shall—

''(A) be an entity specified by the Secretary that offers education to students in various health professions, which may include—

''(i) a health system;

''(ii) a teaching hospital;

''(iii) a medical school;

''(iv) a certified behavioral health clinic; or

''(v) any other health profession school, school of public health, or Cooperative Extension Program at institutions of higher education engaged in an aspect of the prevention, treatment, or recovery of substance use disorders;

''(B) be accredited by the appropriate educational accreditation body;

''(C) demonstrate an existing strategy, and have in place a plan for continuing such strategy, or a proposed strategy to implement a curriculum based on best practices for substance use disorder prevention, treatment, and recovery;

''(D) demonstrate community engagement and participation through community partners, including other health profession schools, mental health counselors, social workers, peer recovery specialists, substance use treatment programs, community health centers, physicians' offices, certified behavioral health clinics, law enforcement, and the business community; and

''(E) provide to the Secretary such information, at such time, and in such manner, as the Secretary may require.

''(2) DIVERSITY.—In awarding cooperative agreements under subsection (a), the Secretary shall take into account regional differences among eligible entities and shall make an effort to ensure geographic diversity.

''(c) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC POSTING.—The Secretary shall make information provided to the Secretary under subsection (b)(1)(E) publically available on the Internet website of the Department of Health and Human Services.

''(2) EVALUATION.—The Secretary shall evaluate each project carried out by a Regional Center of Excellence in Substance Use Disorder Education under this section and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(d) FUNDING.—There is authorized to be appropriated to carry out this section, $4,000,000 for each of fiscal years 2019 through 2023.''.

Subtitle M—Guidance From National Mental Health and Substance Use Policy Laboratory

SEC. 7121. GUIDANCE FROM NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

Section 501A(b) of the Public Health Service Act (42 U.S.C. 290aa–0(b)) is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(7) issue and periodically update guidance for entities applying for grants from the Substance Abuse and Mental Health Services Administration in order to—

''(A) encourage the funding of evidence-based practices;

''(B) encourage the replication of promising or effective practices; and

''(C) inform applicants on how to best articulate the rationale for the funding of a program or activity.''.

Subtitle N—Comprehensive Opioid Recovery Centers

SEC. 7131. SHORT TITLE.

This subtitle may be cited as the ''Comprehensive Opioid Recovery Centers Act of 2018''.

SEC. 7132. COMPREHENSIVE OPIOID RECOVERY CENTERS.

(a) IN GENERAL.—Part D of title V of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 550. COMPREHENSIVE OPIOID RECOVERY CENTERS.

''(a) IN GENERAL.—The Secretary shall award grants on a competitive basis to eligible entities to establish or operate a comprehensive opioid recovery center (referred to in this section as a 'Center').

''(b) GRANT PERIOD.—

''(1) IN GENERAL.—A grant awarded under subsection (a) shall be for a period not less than three years and not more than five years.

''(2) RENEWAL.—A grant awarded under subsection (a) may be renewed, on a competitive basis, for additional periods of time, as determined by the Secretary. In determining whether to renew a grant under this paragraph, the Secretary shall consider the data submitted under subsection (h).

''(c) MINIMUM NUMBER OF CENTERS.—The Secretary shall allocate the amounts made available under subsection (i) in such amounts that not fewer than 10 Centers will be established across the United States.

''(d) APPLICATION.—In order to be eligible for a grant under subsection (a), an entity shall submit an application to the Secretary at such time and in such manner as the Secretary may require. Such application shall include—

''(1) evidence that such entity carries out, or is capable of coordinating with other entities to carry out, the activities described in subsection (g); and

''(2) such other information as the Secretary may require.

''(e) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities located in a State or Indian country (as defined in section 1151 of title 18, United States Code)—

''(1) with a high per capita drug overdose mortality rate, as determined by the Director of the Centers for Disease Control and Prevention; or

''(2) based on any other criteria or need, as determined by the Secretary.

''(f) USE OF GRANT FUNDS.—An eligible entity awarded a grant under subsection (a) shall use the grant funds to establish or operate a Center to carry out the activities described in subsection (g).

''(g) CENTER ACTIVITIES AND SERVICES.—Each Center shall, at a minimum, carry out the activities described in this subsection. In the case of a Center that determines that a service described in paragraph (2) cannot reasonably be carried out by the Center, such Center shall contract with such other entities as may be necessary to ensure that patients have access to the full range of services described in such paragraph.

''(1) COMMUNITY OUTREACH.—Each Center shall carry out the following outreach activities:

''(A) Train and supervise outreach staff to work with schools, workplaces, faith-based organizations, State and local health departments, law enforcement, and first responders to ensure that such institutions are aware of the services of the Center.

''(B) Disseminate and make available online evidence-based resources that educate professionals and the public on opioid use disorder and other substance use disorders.

''(2) TREATMENT AND RECOVERY SERVICES.—Each Center shall provide the following treatment and recovery services:

''(A) Ensure that intake evaluations meet the clinical needs of patients.

''(B) Periodically conduct patient assessments to ensure continued and meaningful recovery, as defined by the Assistant Secretary for Mental Health and Substance Use.

''(C) Provide the full continuum of treatment services, including—

''(i) all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act and all biological products licensed under section 351 of this Act, including methadone, to treat substance use disorders, including opioid use disorder and alcohol use disorder;

''(ii) withdrawal management, which shall include medically supervised detoxification that includes patient evaluation, stabilization, and readiness for and entry into treatment;

''(iii) counseling and case management, including counseling and recovery services for any possible co-occurring mental illness;

''(iv) residential rehabilitation;

''(v) recovery housing;

''(vi) community-based and peer recovery support services;

''(vii) job training and placement assistance to support reintegration into the workforce; and

''(viii) other best practices, as determined by the Secretary.

''(D) Administer an onsite pharmacy and provide toxicology services.

''(E) Establish and operate a secure and confidential electronic health information system.

''(F) Offer family support services such as child care, family counseling, and parenting interventions to help stabilize families impacted by substance use disorder.

''(h) DATA REPORTING AND PROGRAM OVERSIGHT.—With respect to a grant awarded under subsection (a) to an eligible entity for a Center, not later than 90 days after the end of the first year of the grant period, and annually thereafter for the duration of the grant period (including the duration of any renewal period for such grant), the entity shall submit data, as appropriate, to the Secretary regarding—

''(1) the programs and activities funded by the grant;

''(2) health outcomes of individuals with a substance use disorder who received services from the Center;

''(3) the effectiveness of interventions designed, tested, and evaluated by the Center; and

''(4) any other information that the Secretary may require for the purpose of—

''(A) evaluating the effectiveness of the Center; and

''(B) ensuring that the Center is complying with all the requirements of the grant, including providing the full continuum of services described in subsection (g)(2)(C) and providing drugs and devices for overdose reversal under such subsection.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $10,000,000 for each of fiscal years 2019 through 2023 for purposes of carrying out this section.''.

(b) REPORTS TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than three years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a preliminary report that analyzes data submitted under section 550(h) of the Public Health Service Act, as added by subsection (a).

(2) FINAL REPORT.—Not later than one year after submitting the preliminary report required under paragraph (1), the Secretary of Health and Human Services shall submit to Congress a final report that includes—

(A) an evaluation of the effectiveness of comprehensive opioid recovery centers established or operated pursuant to section 550 of the Public Health Service Act, as added by subsection (a);

(B) recommendations on whether the grant program established under such section 550 should be reauthorized and expanded; and

(C) standards and best practices for the treatment of substance use disorders, as identified through such grant program.

Subtitle O—Poison Center Network Enhancement

SEC. 7141. SHORT TITLE.

This subtitle may be cited as the ''Poison Center Network Enhancement Act of 2018''.

SEC. 7142. REAUTHORIZATION OF POISON CONTROL CENTERS NATIONAL TOLL-FREE NUMBER.

Section 1271 of the Public Health Service Act (42 U.S.C. 300d–71) is amended to read as follows:

''SEC. 1271. ESTABLISHMENT AND MAINTENANCE OF THE NATIONAL TOLL-FREE NUMBER AND ENHANCED COMMUNICATIONS CAPABILITIES.

''(a) IN GENERAL.—The Secretary shall provide coordination and assistance to poison control centers for—

''(1) the development, establishment, implementation, and maintenance of a nationwide toll-free phone number; and

''(2) the enhancement of communications capabilities, which may include text capabilities.

''(b) CONSULTATION.—The Secretary may consult with nationally recognized professional organizations in the field of poison control to determine the best and most effective means of

achieving the goals described in paragraphs (1) and (2) of subsection (a).

''(c) RULE OF CONSTRUCTION.—In assisting with public health emergencies, responses, or preparedness, nothing in this section shall be construed to restrict the work of poison control centers or the use of their resources by the Secretary or other governmental agencies.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $700,000 for each of fiscal years 2019 through 2023.''.

SEC. 7143. REAUTHORIZATION OF NATIONWIDE PUBLIC AWARENESS CAMPAIGN TO PROMOTE POISON CONTROL CENTER UTILIZATION.

Section 1272 of the Public Health Service Act (42 U.S.C. 300d–72) is amended to read as follows:

''SEC. 1272. NATIONWIDE PUBLIC AWARENESS CAMPAIGN TO PROMOTE POISON CONTROL CENTER UTILIZATION AND THEIR PUBLIC HEALTH EMERGENCY RESPONSE CAPABILITIES.

''(a) IN GENERAL.—The Secretary shall—

''(1) carry out, and expand upon, a national public awareness campaign to educate the public and health care providers about—

''(A) poisoning, toxic exposure, and drug misuse prevention; and

''(B) the availability of poison control center resources in local communities; and

''(2) as part of such campaign, highlight the nationwide toll-free number and enhanced communications capabilities supported under section 1271.

''(b) CONSULTATION.—In carrying out and expanding upon the national campaign under subsection (a), the Secretary may consult with nationally recognized professional organizations in the field of poison control response for the purpose of determining the best and most effective methods for achieving public awareness.

''(c) CONTRACT WITH ENTITY.—The Secretary may carry out subsection (a) by entering into contracts with one or more public or private entities, including nationally recognized professional organizations in the field of poison control and national media firms, for the development and implementation of the awareness campaign under subsection (a), which may include—

''(1) the development and distribution of poisoning and toxic exposure prevention, poison control center, and public health emergency awareness and response materials;

''(2) television, radio, internet, and newspaper public service announcements; and

''(3) other means and activities to provide for public and professional awareness and education.

''(d) EVALUATION.—The Secretary shall—

''(1) establish baseline measures and benchmarks to quantitatively evaluate the impact of the nationwide public awareness campaign carried out under this section; and

''(2) on a biennial basis, prepare and submit to the appropriate committees of Congress an evaluation of the nationwide public awareness campaign.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $800,000 for each of fiscal years 2019 through 2023.''.

SEC. 7144. REAUTHORIZATION OF THE POISON CONTROL CENTER GRANT PROGRAM.

Section 1273 of the Public Health Service Act (42 U.S.C. 300d–73) is amended to read as follows:

''SEC. 1273. MAINTENANCE OF THE POISON CONTROL CENTER GRANT PROGRAM.

''(a) AUTHORIZATION OF PROGRAM.—The Secretary shall award grants to poison control centers accredited under subsection (c) (or granted a waiver under subsection (d)) and nationally recognized professional organizations in the field of poison control for the purposes of—

''(1) preventing, and providing treatment recommendations for, poisonings and toxic exposures including opioid and drug misuse;

''(2) assisting with public health emergencies, responses, and preparedness; and

''(3) complying with the operational requirements needed to sustain the accreditation of the center under subsection (c).

''(b) ADDITIONAL USES OF FUNDS.—In addition to the purposes described in subsection (a), a poison center or professional organization awarded a grant under such subsection may also use amounts received under such grant—

''(1) to research, establish, implement, and evaluate best practices in the United States for poisoning prevention, poison control center outreach, opioid and drug misuse information and response, and public health emergency, response, and preparedness programs;

''(2) to research, develop, implement, revise, and communicate standard patient management guidelines for commonly encountered toxic exposures;

''(3) to improve national toxic exposure and opioid misuse surveillance by enhancing cooperative activities between poison control centers in the United States and the Centers for Disease Control and Prevention and other governmental agencies;

''(4) to research, improve, and enhance the communications and response capability and capacity of the Nation's network of poison control centers to facilitate increased access to the centers through the integration and modernization of the current poison control centers communications and data system, including enhancing the network's telephony, internet, data, and social networking technologies;

''(5) to develop, support, and enhance technology and capabilities of nationally recognized professional organizations in the field of poison control to collect national poisoning, toxic occurrence, and related public health data;

''(6) to develop initiatives to foster the enhanced public health utilization of national poison data collected by such organizations;

''(7) to support and expand the toxicologic expertise within poison control centers; and

''(8) to improve the capacity of poison control centers to answer high volumes of contacts and internet communications, and to sustain and enhance the poison control center's network capability to respond during times of national crisis or other public health emergencies.

''(c) ACCREDITATION.—Except as provided in subsection (d), the Secretary may award a grant to a poison control center under subsection (a) only if—

''(1) the center has been accredited by a nationally recognized professional organization in the field of poison control, and the Secretary has approved the organization as having in effect standards for accreditation that reasonably provide for the protection of the public health with respect to poisoning; or

''(2) the center has been accredited by a State government, and the Secretary has approved the State government as having in effect standards for accreditation that reasonably provide for the protection of the public health with respect to poisoning.

''(d) WAIVER OF ACCREDITATION REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary may grant a waiver of the accreditation requirements of subsection (c) with respect to a nonaccredited poison control center that applies for a grant under this section if such center can reasonably demonstrate that the center will obtain such an accreditation within a reasonable period of time as determined appropriate by the Secretary.

''(2) RENEWAL.—The Secretary may renew a waiver under paragraph (1).

''(3) LIMITATION.—The Secretary may not, after the date of enactment of the Poison Control Network Enhancement Act of 2018, grant to a poison control center waivers or renewals that total more than 5 years.

''(e) SUPPLEMENT NOT SUPPLANT.—Amounts made available to a poison control center under this section shall be used to supplement and not supplant other Federal, State, or local funds provided for such center.

''(f) MAINTENANCE OF EFFORT.—A poison control center, in utilizing the proceeds of a grant under this section, shall maintain the annual recurring expenditures of the center for its activities at a level that is not less than 80 percent of the average level of such recurring expenditures maintained by the center for the preceding 3 fiscal years for which a grant is received.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $28,600,000 for each of fiscal years 2019 through 2023. The Secretary may utilize an amount not to exceed 6 percent of the amount appropriated pursuant to the preceding sentence for each fiscal year for coordination, dissemination, technical assistance, program evaluation, data activities, and other program administration functions, which are determined by the Secretary to be appropriate for carrying out the program under this section.''.

Subtitle P—Eliminating Opioid Related Infectious Diseases

SEC. 7151. SHORT TITLE.

This subtitle may be cited as the ''Eliminating Opioid Related Infectious Diseases Act of 2018''.

SEC. 7152. REAUTHORIZATION AND EXPANSION OF PROGRAM OF SURVEILLANCE AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.

Section 317N of the Public Health Service Act (42 U.S.C. 247b–15) is amended to read as follows:

''SEC. 317N. SURVEILLANCE AND EDUCATION REGARDING INFECTIONS ASSOCIATED WITH ILLICIT DRUG USE AND OTHER RISK FACTORS.

''(a) IN GENERAL.—The Secretary may (directly and through grants to public and nonprofit private entities) provide for programs for the following:

''(1) To cooperate with the States and Indian tribes in implementing or maintaining a surveillance system to determine the incidence of infections commonly associated with illicit drug use, including infections commonly associated with injection drug use such as viral hepatitis, human immunodeficiency virus, and infective endocarditis, and to assist the States in determining the prevalence of such infections, which may include the reporting of cases of such infections.

''(2) To identify, counsel, and offer testing to individuals who are at risk of infections as a result of injection drug use, receiving blood transfusions prior to July 1992, or other risk factors.

''(3) To provide appropriate referrals for counseling, testing, and medical treatment of individuals identified under paragraph (2) and to ensure, to the extent practicable, the provision of appropriate follow-up services.

''(4) To develop and disseminate public information and education programs for the detection and control of infections described in paragraph (1), with priority given to high-risk populations as determined by the Secretary.

''(5) To improve the education, training, and skills of health professionals in the detection and control of infections and the coordination of treatment of addiction and infectious diseases described in paragraph (1), with priority given to substance use disorder treatment providers, pediatricians and other primary care providers, obstetrician-gynecologists, infectious diseases clinicians, and HIV clinicians.

''(b) LABORATORY PROCEDURES.—The Secretary may (directly or through grants to public and nonprofit private entities) carry out programs to provide for improvements in the quality of clinical-laboratory procedures regarding infections described in subsection (a)(1).

''(c) DEFINITIONS.—In this section:

''(1) The term 'Indian tribe' has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act.

''(2) The term 'injection drug use' means—

''(A) intravenous administration of a substance in schedule I under section 202 of the Controlled Substances Act;

''(B) intravenous administration of a substance in schedule II, III, IV, or V under section 202 of the Controlled Substances Act that has not been approved for intravenous use under—

''(i) section 505 of the Federal Food, Drug and Cosmetic Act; or

''(ii) section 351 of the Public Health Service Act; or

''(C) intravenous administration of a substance in schedule II, III, IV, or V under section 202 of the Controlled Substances Act that has not been prescribed to the person using the substance.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $40,000,000 for each of the fiscal years 2019 through 2023.''.

Subtitle Q—Better Pain Management Through Better Data

SEC. 7161. SHORT TITLE.

This subtitle may be cited as the ''Better Pain Management Through Better Data Act of 2018''.

SEC. 7162. GUIDANCE ADDRESSING ALTERNATIVE APPROACHES TO DATA COLLECTION AND LABELING CLAIMS FOR OPIOID SPARING.

(a) IN GENERAL.—For purposes of assisting sponsors in collecting and incorporating opioid-sparing data in product labeling, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a public meeting and update or issue one or more guidances in accordance with subsection (b).

(b) GUIDANCE.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall update or issue one or more guidances addressing—

(A) alternative methods for data collection on opioid sparing;

(B) alternative methods for inclusion of such data in product labeling; and

(C) investigations other than clinical trials, including partially controlled studies and objective trials without matched controls such as historically controlled analyses, open-label studies, and meta-analyses, on opioid sparing for inclusion in product labeling.

(2) CONTENTS.—The guidances under paragraph (1) shall address—

(A) innovative clinical trial designs for ethically and efficiently collecting data on opioid sparing for inclusion in product labeling;

(B) primary and secondary endpoints for the reduction of opioid use while maintaining adequate pain control;

(C) use of real world evidence, including patient registries, and patient reported outcomes to support inclusion of opioid-sparing data in product labeling; and

(D) how sponsors may obtain feedback from the Secretary relating to such issues prior to—

(i) commencement of such data collection; or

(ii) the submission of resulting data to the Secretary.

(3) PUBLIC MEETING.—Prior to updating or issuing the guidances required by paragraph (1), the Secretary shall consult with stakeholders, including representatives of regulated industry, academia, patients, and provider organizations, through a public meeting to be held not later than 12 months after the date of enactment of this Act.

(4) TIMING.—The Secretary shall—

(A) not later than 12 months after the date of the public meeting required by paragraph (3), update or issue the one or more draft guidances required by paragraph (1); and

(B) not later than 12 months after the date on which the public comment period for such draft guidances closes, finalize such guidances.

(c) DEFINITION.—In this section:

(1) The terms ''opioid sparing'' and ''opioid-sparing'' refer to the use of drugs or devices (as defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) that reduce pain while enabling the reduction, replacement, or avoidance of oral opioids.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle R—Special Registration for Telemedicine Clarification

SEC. 7171. SHORT TITLE.

This subtitle may be cited as the ''Special Registration for Telemedicine Clarification Act of 2018''.

SEC. 7172. DEADLINE FOR INTERIM FINAL REGULATIONS FOR A SPECIAL REGISTRATION TO ENGAGE IN THE PRACTICE OF TELEMEDICINE.

Section 311(h)(2) of the Controlled Substances Act (21 U.S.C. 831(h)(2)) is amended by striking ''The Attorney General shall, with the concurrence of the Secretary, promulgate regulations'' and inserting ''Not later than 1 year after the date of enactment of the Special Registration for Telemedicine Clarification Act of 2018, the Attorney General shall, with the concurrence of the Secretary, promulgate interim final regulations''.

Subtitle S—Peer Support Communities of Recovery

SEC. 7181. SHORT TITLE.

This subtitle may be cited as the ''Peer Support Communities of Recovery Act''.

SEC. 7182. BUILDING COMMUNITIES OF RECOVERY.

Section 547 of the Public Health Service Act (42 U.S.C. 290ee–2) is amended—

(1) in subsection (a)—

(A) in the heading, by striking ''DEFINITION'' and inserting ''DEFINITIONS'';

(B) in the matter preceding paragraph (1), by striking ''In this section, the term 'recovery community organization' means an independent nonprofit organization that—'' and inserting ''In this section:'';

(C) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs (as so redesignated) 2 ems to the right;

(D) by inserting before subparagraph (A) (as so redesignated) the following:

''(1) RECOVERY COMMUNITY ORGANIZATION.—The term 'recovery community organization' means an independent nonprofit organization that—''; and

(E) by adding at the end the following:

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a national nonprofit entity focused on substance use disorder with a network of local affiliates and partners that are geographically and organizationally diverse; or

''(B) a nonprofit organization—

''(i) focused on substance use disorder;

''(ii) established by individuals in personal or family recovery; and

''(iii) serving prevention, treatment, recovery, payor, faith-based, and criminal justice stakeholders in the implementation of local addiction and recovery initiatives.'';

(2) in subsection (b)—

(A) by striking ''The Secretary shall award grants to recovery community organizations'' and inserting ''The Secretary—

''(1) shall award grants to recovery community organizations'';

(B) by striking ''services.'' and inserting ''services and allow such organizations to use such grant funds to carry out the activities described in subparagraphs (A) through (C) of subsection (c)(2); and''; and

(C) by adding at the end the following:

''(2) may award grants to eligible entities for purposes of establishing regional technical assistance centers, in accordance with subsection (c)(2)(D).'';

(3) by striking subsection (c);

(4) by redesignating subsections (d) and (e) as subsections (c) and (d), respectively;

(5) in subsection (c) (as so redesignated)—

(A) in paragraph (1), by striking ''shall be used'' and inserting ''to a recovery community organization shall be used'';

(B) in paragraph (2)—

(i) in subparagraph (A), in the matter preceding clause (i), by inserting before ''build'' the following: ''in the case of a grant awarded to a recovery community organization,'';

(ii) in subparagraph (B)—

(I) by inserting before ''reduce'' the following: ''in the case of a grant awarded to a recovery community organization,''; and

(II) by striking ''and'' at the end;

(iii) in subparagraph (C)—

(I) by inserting before ''conduct'' the following: ''in the case of a grant awarded to a recovery community organization,''; and

(II) by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following:

''(D) in the case of a grant awarded to an eligible entity, provide for the establishment of regional technical assistance centers to provide regional technical assistance for the following:

''(i) Implementation of regionally driven, peer-delivered addiction recovery support services before, during, after, or in conjunction with addiction treatment.

''(ii) Establishment of recovery community organizations.

''(iii) Establishment of recovery community centers.''; and

(6) in subsection (d) (as so redesignated), by inserting before the period the following: '', and $15,000,000 for each of fiscal years 2019 through 2023''.

Subtitle T—Stop Illicit Drug Importation

SEC. 7191. SHORT TITLE.

This short title may be cited as the ''Stop Illicit Drug Importation Act of 2018''.

SEC. 7192. DETENTION, REFUSAL, AND DESTRUCTION OF DRUGS OFFERED FOR IMPORTATION.

(a) ARTICLES TREATED AS DRUGS FOR PURPOSES OF IMPORTATION.—Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by adding at the end the following:

''(t) ARTICLES TREATED AS DRUGS FOR PURPOSES OF THIS SECTION.—

''(1) LABELED ARTICLES.—An article shall not be treated as a drug pursuant to this subsection if—

''(A) an electronic import entry for such article is submitted using an authorized electronic data interchange system; and

''(B) such article is designated in such system as a drug, device, dietary supplement, or other product that is regulated under this Act.

''(2) ARTICLES COVERED.—Subject to paragraph (1), for purposes of this section, an article described in this paragraph may be treated by the Secretary as a drug if it—

''(A) is or contains an ingredient that is an active ingredient that is contained within—

''(i) a drug that has been approved under section 505 of this Act; or

''(ii) a biological product that has been approved under section 351 of the Public Health Service Act;

''(B) is or contains an ingredient that is an active ingredient in a drug or biological product if—

''(i) an investigational use exemption has been authorized for such drug or biological product under section 505(i) of this Act or section 351(a) of the Public Health Service Act;

''(ii) substantial clinical investigation has been instituted for such drug or biological product; and

''(iii) the existence of such clinical investigation has been made public; or

''(C) is or contains a substance that has a chemical structure that is substantially similar

to the chemical structure of an active ingredient in a drug or biological product described in subparagraph (A) or (B).

''(3) EFFECT.—Except to the extent that an article may be treated as a drug pursuant to paragraph (2), this subsection shall not be construed as bearing on or being relevant to the question of whether any article is a drug as defined in section 201(g).''.

(b) ARTICLES OF CONCERN.—

(1) DELIVERY BY TREASURY TO HHS.—The first sentence of section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)) is amended by striking ''and cosmetics'' and inserting ''cosmetics, and potential articles of concern (as defined in subsection (u))''.

(2) REFUSED ADMISSION.—The third sentence of section 801(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381(a)) is amended by striking ''then such article shall be refused admission'' and inserting ''or (5) such article is an article of concern (as defined in subsection (u)), or (6) such article is a drug that is being imported or offered for import in violation of section 301(cc), then such article shall be refused admission''.

(3) DEFINITION OF ARTICLE OF CONCERN.—Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381), as amended, is further amended by adding at the end the following:

''(u) ARTICLE OF CONCERN DEFINED.—For purposes of subsection (a), the term 'article of concern' means an article that is or contains a drug or other substance—

''(1) for which, during the 24-month period prior to the article being imported or offered for import, the Secretary of Health and Human Services—

''(A) has requested that, based on a determination that the drug or other substance appears to meet the requirements for temporary or permanent scheduling pursuant to section 201 of the Controlled Substances Act, the Attorney General initiate the process to control the drug or other substance in accordance with such Act; or

''(B) has, following the publication by the Attorney General of a notice in the Federal Register of the intention to issue an order temporarily scheduling such drug or substance in schedule I of section 202 of the Controlled Substances Act pursuant to section 201(h) of such Act, made a determination that such article presents an imminent hazard to public safety; and

''(2) with respect to which the Attorney General has not—

''(A) scheduled the drug or other substance under such Act; or

''(B) notified the Secretary of Health and Human Services that the Attorney General has made a determination not to schedule the drug or other substance under such Act.''.

SEC. 7193. SEIZURE.

Section 304(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 334(b)) is amended by striking the first sentence and inserting the following: ''The article, equipment, or other thing proceeded against shall be liable to seizure by process pursuant to the libel, and the procedure in cases under this section shall conform, as nearly as may be, to the procedure in admiralty rather than the procedure used for civil asset forfeiture proceedings set forth in section 983 of title 18, United States Code. On demand of either party any issue of fact joined in any such a case brought under this section shall be tried by jury. A seizure brought under this section is not governed by Rule G of the Supplemental Rules of Admiralty or Maritime Claims and Asset Forfeiture Actions. Exigent circumstances shall be deemed to exist for all seizures brought under this section, and in such cases, the summons and arrest warrant shall be issued by the clerk of the court without court review.''.

SEC. 7194. DEBARRING VIOLATIVE INDIVIDUALS OR COMPANIES.

(a) PROHIBITED ACT.—Section 301(cc) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(cc)) is amended—

(1) by inserting after ''an article of food'' the following: ''or a drug''; and

(2) by inserting after ''a person debarred'' the following: ''from such activity''.

(b) DEBARMENT.—Section 306(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 335a(b)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraph (2) or (3)'';

(B) in subparagraph (B), by striking ''or'' at the end;

(C) in subparagraph (C), by striking the period at the end and inserting '', or''; and

(D) by adding at the end the following:

''(D) a person from importing or offering to import into the United States—

''(i) a controlled substance as defined in section 102(6) of the Controlled Substances Act; or

''(ii) any drug, if such drug is declared to be valued at an amount that is $2,500 or less (or such higher amount as the Secretary of the Treasury may set by regulation pursuant to section 498(a)(1) of the Tariff Act of 1930), or if such drug is entering the United States by mail.''; and

(2) in paragraph (3)—

(A) in the paragraph heading after ''FOOD'' by inserting ''OR DRUG'';

(B) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and moving the indentation of each such clause 2 ems to the right;

(C) after making the amendments required by subparagraph (B), by striking ''A person is subject'' and inserting the following:

''(A) FOOD.—A person is subject''; and

(D) by adding at the end the following:

''(B) IMPORTATION OF DRUGS.—A person is subject to debarment under paragraph (1)(D) if—

''(i) the person has been convicted of a felony for conduct relating to the importation into the United States of any drug or controlled substance (as defined in section 102 of the Controlled Substances Act); or

''(ii) the person has engaged in a pattern of importing or offering for import articles of drug that are—

''(I)(aa) adulterated, misbranded, or in violation of section 505; and

''(bb) present a threat of serious adverse health consequences or death to humans or animals; or

''(II) controlled substances whose importation is prohibited pursuant to section 401(m) of the Tariff Act of 1930.

''(C) DEFINITION.—For purposes of subparagraph (B), the term 'pattern of importing or offering for import articles of drug' means importing or offering for import articles of drug described in subclause (I) or (II) of subparagraph (B)(ii) in an amount, frequency, or dosage that is inconsistent with personal or household use by the importer.''.

Subtitle U—Creating Opportunities That Necessitate New and Enhanced Connections That Improve Opioid Navigation Strategies

SEC. 7201. SHORT TITLE.

This subtitle may be cited as the ''Creating Opportunities that Necessitate New and Enhanced Connections That Improve Opioid Navigation Strategies Act of 2018'' or the ''CONNECTIONS Act''.

SEC. 7202. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

''SEC. 399V–7. PREVENTING OVERDOSES OF CONTROLLED SUBSTANCES.

''(a) EVIDENCE-BASED PREVENTION GRANTS.—

''(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may—

''(A) to the extent practicable, carry out any evidence-based prevention activity described in paragraph (2);

''(B) provide training and technical assistance to States, localities, and Indian tribes for purposes of carrying out any such activity; and

''(C) award grants to States, localities, and Indian tribes for purposes of carrying out any such activity.

''(2) EVIDENCE-BASED PREVENTION ACTIVITIES.—An evidence-based prevention activity described in this paragraph is any of the following activities:

''(A) With respect to a State, improving the efficiency and use of the State prescription drug monitoring program by—

''(i) encouraging all authorized users (as specified by the State) to register with and use the program and making the program easier to use;

''(ii) enabling such users to access any updates to information collected by the program in as close to real-time as possible;

''(iii) providing for a mechanism for the program to automatically flag any potential misuse or abuse of controlled substances and any detection of inappropriate prescribing practices relating to such substances;

''(iv) enhancing interoperability between the program and any electronic health records system, including by integrating the use of electronic health records into the program for purposes of improving clinical decisionmaking;

''(v) continually updating program capabilities to respond to technological innovation for purposes of appropriately addressing a controlled substance overdose epidemic as such epidemic may occur and evolve;

''(vi) facilitating data sharing between the program and the prescription drug monitoring programs of neighboring States; and

''(vii) meeting the purpose of the program established under section 399O, as described in section 399O(a).

''(B) Achieving community or health system interventions through activities such as—

''(i) establishing or improving controlled substances prescribing interventions for insurers and health systems;

''(ii) enhancing the use of evidence-based controlled substances prescribing guidelines across sectors and health care settings; and

''(iii) implementing strategies to align the prescription of controlled substances with the guidelines described in clause (ii).

''(C) Evaluating interventions to better understand what works to prevent overdoses, including those involving prescription and illicit controlled substances.

''(D) Implementing projects to advance an innovative prevention approach with respect to new and emerging public health crises and opportunities to address such crises, such as enhancing public education and awareness on the risks associated with opioids.

''(b) ENHANCED SURVEILLANCE OF CONTROLLED SUBSTANCE OVERDOSE GRANTS.—

''(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may—

''(A) to the extent practicable, carry out any controlled substance overdose surveillance activity described in paragraph (2);

''(B) provide training and technical assistance to States for purposes of carrying out any such activity;

''(C) award grants to States for purposes of carrying out any such activity; and

''(D) coordinate with the Assistant Secretary for Mental Health and Substance Use to collect data pursuant to section 505(d)(1)(A) (relating to the number of individuals admitted to the emergency rooms of hospitals as a result of the abuse of alcohol or other drugs).

''(2) CONTROLLED SUBSTANCE OVERDOSE SURVEILLANCE ACTIVITIES.—A controlled substance overdose surveillance activity described in this paragraph is any of the following activities:

''(A) Enhancing the timeliness of reporting data to the public, including data on fatal and nonfatal overdoses of controlled substances.

''(B) Enhancing comprehensiveness of data on controlled substances overdoses by collecting information on such overdoses from appropriate

sources such as toxicology reports, autopsy reports, death scene investigations, and other risk factors.

''(C) Using data to help identify risk factors associated with controlled substances overdoses.

''(D) With respect to a State, supporting entities involved in providing information to inform efforts within the State, such as by coroners and medical examiners, to improve accurate testing and reporting of causes and contributing factors to controlled substances overdoses.

''(E) Working to enable information sharing regarding controlled substances overdoses among data sources.

''(c) DEFINITIONS.—In this section:

''(1) CONTROLLED SUBSTANCE.—The term 'controlled substance' has the meaning given that term in section 102 of the Controlled Substances Act.

''(2) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section and section 399O, there is authorized to be appropriated $486,000,000 for each of fiscal years 2019 through 2023.''.

SEC. 7203. PRESCRIPTION DRUG MONITORING PROGRAM.

Section 399O of the Public Health Service Act (42 U.S.C. 280g–3) is amended to read as follows:

''SEC. 399O. PRESCRIPTION DRUG MONITORING PROGRAM.

''(a) PROGRAM.—

''(1) IN GENERAL.—Each fiscal year, the Secretary, in consultation with the Director of National Drug Control Policy, acting through the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, and the National Coordinator for Health Information Technology, shall support States for the purpose of improving the efficiency and use of PDMPs, including—

''(A) establishment and implementation of a PDMP;

''(B) maintenance of a PDMP;

''(C) improvements to a PDMP by—

''(i) enhancing functional components to work toward—

''(I) universal use of PDMPs among providers and their delegates, to the extent that State laws allow, within a State;

''(II) more timely inclusion of data within a PDMP;

''(III) active management of the PDMP, in part by sending proactive or unsolicited reports to providers to inform prescribing; and

''(IV) ensuring the highest level of ease in use and access of PDMPs by providers and their delegates, to the extent that State laws allow;

''(ii) improving the intrastate interoperability of PDMPs by—

''(I) making PDMPs more actionable by integrating PDMPs within electronic health records and health information technology infrastructure; and

''(II) linking PDMP data to other data systems within the State, including—

''(aa) the data of pharmacy benefit managers, medical examiners and coroners, and the State's Medicaid program;

''(bb) worker's compensation data; and

''(cc) prescribing data of providers of the Department of Veterans Affairs and the Indian Health Service within the State;

''(iii) improving the interstate interoperability of PDMPs through—

''(I) sharing of dispensing data in near-real time across State lines; and

''(II) integration of automated queries for multistate PDMP data and analytics into clinical workflow to improve the use of such data and analytics by practitioners and dispensers; or

''(iv) improving the ability to include treatment availability resources and referral capabilities within the PDMP.

''(2) STATE LEGISLATION.—As a condition on the receipt of support under this section, the Secretary shall require a State to demonstrate that the State has enacted legislation or regulations—

''(A) to provide for the implementation of the PDMP; and

''(B) to permit the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained by the PDMP.

''(b) PDMP STRATEGIES.—The Secretary shall encourage a State, in establishing, improving, or maintaining a PDMP, to implement strategies that improve—

''(1) the reporting of dispensing in the State of a controlled substance to an ultimate user so the reporting occurs not later than 24 hours after the dispensing event;

''(2) the consultation of the PDMP by each prescribing practitioner, or their designee, in the State before initiating treatment with a controlled substance, or any substance as required by the State to be reported to the PDMP, and over the course of ongoing treatment for each prescribing event;

''(3) the consultation of the PDMP before dispensing a controlled substance, or any substance as required by the State to be reported to the PDMP;

''(4) the proactive notification to a practitioner when patterns indicative of controlled substance misuse by a patient, including opioid misuse, are detected;

''(5) the availability of data in the PDMP to other States, as allowable under State law; and

''(6) the availability of nonidentifiable information to the Centers for Disease Control and Prevention for surveillance, epidemiology, statistical research, or educational purposes.

''(c) DRUG MISUSE AND ABUSE.—In consultation with practitioners, dispensers, and other relevant and interested stakeholders, a State receiving support under this section—

''(1) shall establish a program to notify practitioners and dispensers of information that will help to identify and prevent the unlawful diversion or misuse of controlled substances; and

''(2) may, to the extent permitted under State law, notify the appropriate authorities responsible for carrying out drug diversion investigations if the State determines that information in the PDMP maintained by the State indicates an unlawful diversion or abuse of a controlled substance.

''(d) EVALUATION AND REPORTING.—As a condition on receipt of support under this section, the State shall report on interoperability with PDMPs of other States and Federal agencies, where appropriate, intrastate interoperability with health information technology systems such as electronic health records, health information exchanges, and e-prescribing, where appropriate, and whether or not the State provides automatic, up-to-date, or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.

''(e) EVALUATION AND REPORTING.—A State receiving support under this section shall provide the Secretary with aggregate nonidentifiable information, as permitted by State law, to enable the Secretary—

''(1) to evaluate the success of the State's program in achieving the purpose described in subsection (a); or

''(2) to prepare and submit to the Congress the report required by subsection (i)(2).

''(f) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving support under this section shall take steps to—

''(1) facilitate prescribers and dispensers, and their delegates, as permitted by State law, to use the PDMP, to the extent practicable; and

''(2) educate prescribers and dispensers, and their delegates on the benefits of the use of PDMPs.

''(g) ELECTRONIC FORMAT.—The Secretary may issue guidelines specifying a uniform electronic format for the reporting, sharing, and disclosure of information pursuant to PDMPs.

''(h) RULES OF CONSTRUCTION.—

''(1) FUNCTIONS OTHERWISE AUTHORIZED BY LAW.—Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

''(2) ADDITIONAL PRIVACY PROTECTIONS.—Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

''(3) FEDERAL PRIVACY REQUIREMENTS.—Nothing in this section shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) and section 543 of this Act.

''(4) NO FEDERAL PRIVATE CAUSE OF ACTION.—Nothing in this section shall be construed to create a Federal private cause of action.

''(i) PROGRESS REPORT.—Not later than 3 years after the date of enactment of the CONNECTIONS Act, the Secretary shall—

''(1) complete a study that—

''(A) determines the progress of States in establishing and implementing PDMPs consistent with this section;

''(B) provides an analysis of the extent to which the operation of PDMPs has—

''(i) reduced inappropriate use, abuse, diversion of, and overdose with, controlled substances;

''(ii) established or strengthened initiatives to ensure linkages to substance use disorder treatment services; or

''(iii) affected patient access to appropriate care in States operating PDMPs;

''(C) determine the progress of States in achieving interstate interoperability and intrastate interoperability of PDMPs, including an assessment of technical, legal, and financial barriers to such progress and recommendations for addressing these barriers;

''(D) determines the progress of States in implementing near real-time electronic PDMPs;

''(E) provides an analysis of the privacy protections in place for the information reported to the PDMP in each State receiving support under this section and any recommendations of the Secretary for additional Federal or State requirements for protection of this information;

''(F) determines the progress of States in implementing technological alternatives to centralized data storage, such as peer-to-peer file sharing or data pointer systems, in PDMPs and the potential for such alternatives to enhance the privacy and security of individually identifiable data; and

''(G) evaluates the penalties that States have enacted for the unauthorized use and disclosure of information maintained in PDMPs, and the criteria used by the Secretary to determine whether such penalties qualify as appropriate for purposes of subsection (a)(2); and

''(2) submit a report to the Congress on the results of the study.

''(j) ADVISORY COUNCIL.—

''(1) ESTABLISHMENT.—A State may establish an advisory council to assist in the establishment, improvement, or maintenance of a PDMP consistent with this section.

''(2) LIMITATION.—A State may not use Federal funds for the operations of an advisory council to assist in the establishment, improvement, or maintenance of a PDMP.

''(3) SENSE OF CONGRESS.—It is the sense of the Congress that, in establishing an advisory council to assist in the establishment, improvement, or maintenance of a PDMP, a State should consult with appropriate professional boards and other interested parties.

''(k) DEFINITIONS.—For purposes of this section:

''(1) The term 'controlled substance' means a controlled substance (as defined in section 102 of the Controlled Substances Act) in schedule II, III, or IV of section 202 of such Act.

''(2) The term 'dispense' means to deliver a controlled substance to an ultimate user by, or pursuant to the lawful order of, a practitioner, irrespective of whether the dispenser uses the internet or other means to effect such delivery.

''(3) The term 'dispenser' means a physician, pharmacist, or other person that dispenses a controlled substance to an ultimate user.

''(4) The term 'interstate interoperability' with respect to a PDMP means the ability of the PDMP to electronically share reported information with another State if the information concerns either the dispensing of a controlled substance to an ultimate user who resides in such other State, or the dispensing of a controlled substance prescribed by a practitioner whose principal place of business is located in such other State.

''(5) The term 'intrastate interoperability' with respect to a PDMP means the integration of PDMP data within electronic health records and health information technology infrastructure or linking of a PDMP to other data systems within the State, including the State's Medicaid program, workers' compensation programs, and medical examiners or coroners.

''(6) The term 'nonidentifiable information' means information that does not identify a practitioner, dispenser, or an ultimate user and with respect to which there is no reasonable basis to believe that the information can be used to identify a practitioner, dispenser, or an ultimate user.

''(7) The term 'PDMP' means a prescription drug monitoring program that is State-controlled.

''(8) The term 'practitioner' means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which the individual practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

''(9) The term 'State' means each of the 50 States, the District of Columbia, and any commonwealth or territory of the United States.

''(10) The term 'ultimate user' means a person who has obtained from a dispenser, and who possesses, a controlled substance for the person's own use, for the use of a member of the person's household, or for the use of an animal owned by the person or by a member of the person's household.

''(11) The term 'clinical workflow' means the integration of automated queries for prescription drug monitoring programs data and analytics into health information technologies such as electronic health record systems, health information exchanges, and/or pharmacy dispensing software systems, thus streamlining provider access through automated queries.''.

Subtitle V—Securing Opioids and Unused Narcotics With Deliberate Disposal and Packaging

SEC. 7211. SHORT TITLE.

This subtitle may be cited as the ''Securing Opioids and Unused Narcotics with Deliberate Disposal and Packaging Act of 2018'' or the ''SOUND Disposal and Packaging Act''.

SEC. 7212. IMPROVED TECHNOLOGIES, CONTROLS, OR MEASURES WITH RESPECT TO THE PACKAGING OR DISPOSAL OF CERTAIN DRUGS.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act is amended by inserting after section 505–1 (21 U.S.C. 355–1) the following new section:

''SEC. 505–2. SAFETY-ENHANCING PACKAGING AND DISPOSAL FEATURES.

''(a) ORDERS.—

''(1) IN GENERAL.—The Secretary may issue an order requiring the holder of a covered application to implement or modify one or more technologies, controls, or measures with respect to the packaging or disposal of one or more drugs identified in the covered application, if the Secretary determines such technologies, controls, or measures to be appropriate to help mitigate the risk of abuse or misuse of such drug or drugs, which may include by reducing the availability of unused drugs.

''(2) PRIOR CONSULTATION.—The Secretary may not issue an order under paragraph (1) unless the Secretary has consulted with relevant stakeholders, through a public meeting, workshop, or otherwise, about matters that are relevant to the subject of the order.

''(3) ASSURING ACCESS AND MINIMIZING BURDEN.—Technologies, controls, or measures required under paragraph (1) shall—

''(A) be commensurate with the specific risk of abuse or misuse of the drug listed in the covered application;

''(B) considering such risk, not be unduly burdensome on patient access to the drug, considering in particular any available evidence regarding the expected or demonstrated public health impact of such technologies, controls, or measures; and

''(C) reduce the risk of abuse or misuse of such drug.

''(4) ORDER CONTENTS.—An order issued under paragraph (1) may—

''(A) provide for a range of options for implementing or modifying the technologies, controls, or measures required to be implemented by such order; and

''(B) incorporate by reference standards regarding packaging or disposal set forth in an official compendium, established by a nationally or internationally recognized standard development organization, or described on the public website of the Food and Drug Administration, so long as the order includes the rationale for incorporation of such standard.

''(5) ORDERS APPLICABLE TO DRUG CLASS.—When a concern about the risk of abuse or misuse of a drug relates to a pharmacological class, the Secretary may, after consultation with relevant stakeholders, issue an order under paragraph (1) which applies to the pharmacological class.

''(b) COMPLIANCE.—The holder of a covered application shall—

''(1) submit a supplement containing proposed changes to the covered application to comply with an order issued under subsection (a) not later than—

''(A) 180 calendar days after the date on which the order is issued; or

''(B)(i) such longer time period as specified by the Secretary in such order; or

''(ii) if a request for an alternative date is submitted by the holder of such application not later than 60 calendar days after the date on which such order is issued—

''(I) such requested alternative date if agreed to by the Secretary; or

''(II) another date as specified by the Secretary; and

''(2) implement the changes approved pursuant to such supplement not later than the later of—

''(A) 90 calendar days after the date on which the supplement is approved; or

''(B) the end of such longer period as is—

''(i) determined to be appropriate by the Secretary; or

''(ii) approved by the Secretary pursuant to a request by the holder of the covered application that explains why such longer period is needed, including to satisfy any other applicable Federal statutory or regulatory requirements.

''(c) ALTERNATIVE MEASURES.—The holder of the covered application may propose, and the Secretary shall approve, technologies, controls, or measures regarding packaging, storage, or disposal other than those specified in the applicable order issued under subsection (a), if such technologies, controls, or measures are supported by data and information demonstrating that such alternative technologies, controls, or measures can be expected to mitigate the risk of abuse or misuse of the drug or drugs involved, including by reducing the availability of unused drugs, to at least the same extent as the technologies, controls, or measures specified in such order.

''(d) DISPUTE RESOLUTION.—If a dispute arises in connection with a supplement submitted under subsection (b), the holder of the covered application may appeal a determination made with respect to such supplement using applicable dispute resolution procedures specified by the Secretary in regulations or guidance.

''(e) DEFINITIONS.—In this section—

''(1) the term 'covered application' means an application submitted under subsection (b) or (j) of section 505 for approval under such section or an application submitted under section 351 of Public Health Service Act for approval under such section, with respect to a drug that is or contains an opioid for which a listing in schedule II or III (on a temporary or permanent basis) is in effect under section 202 of the Controlled Substances Act; and

''(2) the term 'relevant stakeholders' may include scientific experts within the drug manufacturing industry; brand and generic drug manufacturers; standard development organizations; wholesalers and distributors; payers; health care providers; pharmacists; pharmacies; manufacturers; poison centers; and representatives of the National Institute on Drug Abuse, the National Institutes of Health, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Drug Enforcement Agency, the Consumer Product Safety Commission, individuals who specialize in treating addiction, and patient and caregiver groups.''.

(b) PROHIBITED ACTS.—Section 501 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351) is amended by inserting after paragraph (j) the following:

''(k) If it is a drug approved under a covered application (as defined in section 505–2(e)), the holder of which does not meet the requirements of paragraphs (1) and (2) of subsection (b) of such section.''.

(c) REQUIRED CONTENT OF AN ABBREVIATED NEW DRUG APPLICATION.—Section 505(j)(2)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(A)) is amended—

(1) in clause (vii)(IV), by striking ''and'' at the end;

(2) in clause (viii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(ix) if the drug is or contains an opioid for which a listing in schedule II or III (on a temporary or permanent basis) is in effect under section 202 of the Controlled Substances Act, information to show that the applicant has proposed technologies, controls, or measures related to the packaging or disposal of the drug that provide protections comparable to those provided by the technologies, controls, or measures required for the applicable listed drug under section 505–2, if applicable.''.

(d) GROUNDS FOR REFUSING TO APPROVE AN ABBREVIATED NEW DRUG APPLICATION.—Section 505(j)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(4)), is amended—

(1) in subparagraph (J), by striking ''or'' at the end;

(2) in subparagraph (K), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(L) if the drug is a drug described in paragraph (2)(A)(ix) and the applicant has not proposed technologies, controls, or measures related to the packaging or disposal of such drug that the Secretary determines provide protections comparable to those provided by the technologies, controls, or measures required for the applicable listed drug under section 505–2.''.

(e) RULES OF CONSTRUCTION.—

(1) Any labeling describing technologies, controls, or measures related to packaging or disposal intended to mitigate the risk of abuse or misuse of a drug product that is subject to an abbreviated new drug application, including labeling describing differences from the reference listed drug resulting from the application of section 505–2 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall not be construed—

(A) as changes to labeling not permissible under clause (v) of section 505(j)(2)(A) of such Act (21 U.S.C. 355(j)(2)(A)), or a change in the conditions of use prescribed, recommended, or suggested in the labeling proposed for the new drug under clause (i) of such section; or

(B) to preclude approval of an abbreviated new drug application under subparagraph (B) or (G) of section 505(j)(4) of such Act (21 U.S.C. 355(j)(4)).

(2) For a covered application that is an application submitted under subsection (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), subsection (j)(2)(A) of such section 505 shall not be construed to limit the type of data or information the Secretary of Health and Human Services may request or consider in connection with making any determination under section 505–2.

(f) GAO REPORT.—Not later than 12 months after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing—

(1) a description of available evidence, if any, on the effectiveness of site-of-use, in-home controlled substance disposal products and packaging technologies;

(2) identification of ways in which such disposal products intended for use by patients, consumers, and other end users that are not registrants under the Controlled Substances Act, are made available to the public and barriers to the use of such disposal products;

(3) identification of ways in which packaging technologies are made available to the public and barriers to the use of such technologies;

(4) a description of Federal oversight, if any, of site-of-use, in-home controlled substance disposal products, including—

(A) identification of the Federal agencies that oversee such products;

(B) identification of the methods of disposal of controlled substances recommended by these agencies for site-of-use, in-home disposal; and

(C) a description of the effectiveness of such recommendations at preventing the diversion of legally prescribed controlled substances;

(5) a description of Federal oversight, if any, of controlled substance packaging technologies, including—

(A) identification of the Federal agencies that oversee such technologies;

(B) identification of the technologies recommended by these agencies, including unit dose packaging, packaging that provides a set duration, or other packaging systems that may mitigate abuse or misuse; and

(C) a description of the effectiveness of such recommendations at preventing the diversion of legally prescribed controlled substances; and

(6) recommendations on—

(A) whether site-of-use, in-home controlled substance disposal products and packaging technologies require Federal oversight and, if so, which agencies should be responsible for such oversight and, as applicable, approval of such products or technologies; and

(B) the potential role of the Federal Government in evaluating such products to ensure product efficacy.

Subtitle W—Postapproval Study Requirements

SEC. 7221. POSTAPPROVAL STUDY REQUIREMENTS.

(a) PURPOSES OF STUDY.—Section 505(o)(3)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(3)(B)) is amended by adding at the end the following:

''(iv) To assess a potential reduction in effectiveness of the drug for the conditions of use prescribed, recommended, or suggested in the labeling thereof if—

''(I) the drug involved—

''(aa) is or contains a substance for which a listing in any schedule is in effect (on a temporary or permanent basis) under section 201 of the Controlled Substances Act; or

''(bb) is a drug that has not been approved under this section or licensed under section 351 of the Public Health Service Act, for which an application for such approval or licensure is pending or anticipated, and for which the Secretary provides notice to the sponsor that the Secretary intends to issue a scientific and medical evaluation and recommend controls under the Controlled Substances Act; and

''(II) the potential reduction in effectiveness could result in the benefits of the drug no longer outweighing the risks.''.

(b) ESTABLISHMENT OF REQUIREMENT.—Section 505(o)(3)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(3)(C)) is amended by striking ''such requirement'' and all that follows through ''safety information.'' and inserting the following: ''such requirement—

''(i) in the case of a purpose described in clause (i), (ii), or (iii) of subparagraph (B), only if the Secretary becomes aware of new safety information; and

''(ii) in the case of a purpose described in clause (iv) of such subparagraph, if the Secretary determines that new effectiveness information exists.''.

(c) APPLICABILITY.—Section 505(o)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(3)) is amended by adding at the end the following new subparagraph:

''(G) APPLICABILITY.—The conduct of a study or clinical trial required pursuant to this paragraph for the purpose specified in subparagraph (B)(iv) shall not be considered a new clinical investigation for the purpose of a period of exclusivity under clause (iii) or (iv) of subsection (c)(3)(E) or clause (iii) or (iv) of subsection (j)(5)(F).''.

(d) NEW EFFECTIVENESS INFORMATION DEFINED.—Section 505(o)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(2)) is amended by adding at the end the following new subparagraph:

''(D) NEW EFFECTIVENESS INFORMATION.—The term 'new effectiveness information', with respect to a drug that is or contains a controlled substance for which a listing in any schedule is in effect (on a temporary or permanent basis) under section 201 of the Controlled Substances Act, means new information about the effectiveness of the drug, including a new analysis of existing information, derived from—

''(i) a clinical trial; an adverse event report; a postapproval study or clinical trial (including a study or clinical trial under paragraph (3));

''(ii) peer-reviewed biomedical literature;

''(iii) data derived from the postmarket risk identification and analysis system under subsection (k); or

''(iv) other scientific data determined to be appropriate by the Secretary.''.

(e) CONFORMING AMENDMENTS WITH RESPECT TO LABELING CHANGES.—Section 505(o)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)(4)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by inserting ''OR NEW EFFECTIVENESS'' after ''SAFETY'';

(B) by striking ''safety information'' and inserting ''new safety information or new effectiveness information such''; and

(C) by striking ''believes should be'' and inserting ''believes changes should be made to'';

(2) in subparagraph (B)(i)—

(A) by striking ''new safety information'' and by inserting ''new safety information or new effectiveness information''; and

(B) by inserting ''indications,'' after ''boxed warnings,'';

(3) in subparagraph (C), by inserting ''or new effectiveness information'' after ''safety information''; and

(4) in subparagraph (E), by inserting ''or new effectiveness information'' after ''safety information''.

(f) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to alter, in any manner, the meaning or application of the provisions of paragraph (3) of section 505(o) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(o)) with respect to the authority of the Secretary of Health and Human Services to require a postapproval study or clinical trial for a purpose specified in clauses (i) through (iii) of subparagraph (B) of such paragraph (3) or paragraph (4) of such section 505(o) with respect to the Secretary's authority to require safety labeling changes.

TITLE VIII—MISCELLANEOUS

Subtitle A—Synthetics Trafficking and Overdose Prevention

SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.

This subtitle may be cited as the ''Synthetics Trafficking and Overdose Prevention Act of 2018'' or ''STOP Act of 2018''.

SEC. 8002. CUSTOMS FEES.

(a) IN GENERAL.—Section 13031(b)(9) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)) is amended by adding at the end the following:

''(D)(i) With respect to the processing of items that are sent to the United States through the international postal network by 'Inbound Express Mail service' or 'Inbound EMS' (as that service is described in the mail classification schedule referred to in section 3631 of title 39, United States Code), the following payments are required:

''(I) $1 per Inbound EMS item.

''(II) If an Inbound EMS item is formally entered, the fee provided for under subsection (a)(9), if applicable.

''(ii) Notwithstanding section 451 of the Tariff Act of 1930 (19 U.S.C. 1451), the payments required by clause (i), as allocated pursuant to clause (iii)(I), shall be the only payments required for reimbursement of U.S. Customs and Border Protection for customs services provided in connection with the processing of an Inbound EMS item.

''(iii)(I) The payments required by clause (i)(I) shall be allocated as follows:

''(aa) 50 percent of the amount of the payments shall be paid on a quarterly basis by the United States Postal Service to the Commissioner of U.S. Customs and Border Protection in accordance with regulations prescribed by the Secretary of the Treasury to reimburse U.S. Customs and Border Protection for customs services provided in connection with the processing of Inbound EMS items.

''(bb) 50 percent of the amount of the payments shall be retained by the Postal Service to reimburse the Postal Service for services provided in connection with the customs processing of Inbound EMS items.

''(II) Payments received by U.S. Customs and Border Protection under subclause (I)(aa) shall, in accordance with section 524 of the Tariff Act of 1930 (19 U.S.C. 1524), be deposited in the Customs User Fee Account and used to directly reimburse each appropriation for the amount paid out of that appropriation for the costs incurred in providing services to international mail facilities. Amounts deposited in accordance with the preceding sentence shall be available until expended for the provision of such services.

''(III) Payments retained by the Postal Service under subclause (I)(bb) shall be used to directly reimburse the Postal Service for the costs incurred in providing services in connection with the customs processing of Inbound EMS items.

''(iv) Beginning in fiscal year 2021, the Secretary, in consultation with the Postmaster General, may adjust, not more frequently than once

each fiscal year, the amount described in clause (i)(I) to an amount commensurate with the costs of services provided in connection with the customs processing of Inbound EMS items, consistent with the obligations of the United States under international agreements.''.

(b) CONFORMING AMENDMENTS.—Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) is amended—

(1) in paragraph (6), by inserting ''(other than an item subject to a fee under subsection (b)(9)(D))'' after ''customs officer''; and

(2) in paragraph (10)—

(A) in subparagraph (C), in the matter preceding clause (i), by inserting ''(other than Inbound EMS items described in subsection (b)(9)(D))'' after ''release''; and

(B) in the flush at the end, by inserting ''or of Inbound EMS items described in subsection (b)(9)(D),'' after ''(C),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2020.

SEC. 8003. MANDATORY ADVANCE ELECTRONIC INFORMATION FOR POSTAL SHIPMENTS.

(a) MANDATORY ADVANCE ELECTRONIC INFORMATION.—

(1) IN GENERAL.—Section 343(a)(3)(K) of the Trade Act of 2002 (Public Law 107–210; 19 U.S.C. 2071 note) is amended to read as follows:

''(K)(i) The Secretary shall prescribe regulations requiring the United States Postal Service to transmit the information described in paragraphs (1) and (2) to the Commissioner of U.S. Customs and Border Protection for international mail shipments by the Postal Service (including shipments to the Postal Service from foreign postal operators that are transported by private carrier) consistent with the requirements of this subparagraph.

''(ii) In prescribing regulations under clause (i), the Secretary shall impose requirements for the transmission to the Commissioner of information described in paragraphs (1) and (2) for mail shipments described in clause (i) that are comparable to the requirements for the transmission of such information imposed on similar non-mail shipments of cargo, taking into account the parameters set forth in subparagraphs (A) through (J).

''(iii) The regulations prescribed under clause (i) shall require the transmission of the information described in paragraphs (1) and (2) with respect to a shipment as soon as practicable in relation to the transportation of the shipment, consistent with subparagraph (H).

''(iv) Regulations prescribed under clause (i) shall allow for the requirements for the transmission to the Commissioner of information described in paragraphs (1) and (2) for mail shipments described in clause (i) to be implemented in phases, as appropriate, by—

''(I) setting incremental targets for increasing the percentage of such shipments for which information is required to be transmitted to the Commissioner; and

''(II) taking into consideration—

''(aa) the risk posed by such shipments;

''(bb) the volume of mail shipped to the United States by or through a particular country; and

''(cc) the capacities of foreign postal operators to provide that information to the Postal Service.

''(v)(I) Notwithstanding clause (iv), the Postal Service shall, not later than December 31, 2018, arrange for the transmission to the Commissioner of the information described in paragraphs (1) and (2) for not less than 70 percent of the aggregate number of mail shipments, including 100 percent of mail shipments from the People's Republic of China, described in clause (i).

''(II) If the requirements of subclause (I) are not met, the Comptroller General of the United States shall submit to the appropriate congressional committees, not later than June 30, 2019, a report—

''(aa) assessing the reasons for the failure to meet those requirements; and

''(bb) identifying recommendations to improve the collection by the Postal Service of the information described in paragraphs (1) and (2).

''(vi)(I) Notwithstanding clause (iv), the Postal Service shall, not later than December 31, 2020, arrange for the transmission to the Commissioner of the information described in paragraphs (1) and (2) for 100 percent of the aggregate number of mail shipments described in clause (i).

''(II) The Commissioner, in consultation with the Postmaster General, may determine to exclude a country from the requirement described in subclause (I) to transmit information for mail shipments described in clause (i) from the country if the Commissioner determines that the country—

''(aa) does not have the capacity to collect and transmit such information;

''(bb) represents a low risk for mail shipments that violate relevant United States laws and regulations; and

''(cc) accounts for low volumes of mail shipments that can be effectively screened for compliance with relevant United States laws and regulations through an alternate means.

''(III) The Commissioner shall, at a minimum on an annual basis, re-evaluate any determination made under subclause (II) to exclude a country from the requirement described in subclause (I). If, at any time, the Commissioner determines that a country no longer meets the requirements under subclause (II), the Commissioner may not further exclude the country from the requirement described in subclause (I).

''(IV) The Commissioner shall, on an annual basis, submit to the appropriate congressional committees—

''(aa) a list of countries with respect to which the Commissioner has made a determination under subclause (II) to exclude the countries from the requirement described in subclause (I); and

''(bb) information used to support such determination with respect to such countries.

''(vii)(I) The Postmaster General shall, in consultation with the Commissioner, refuse any shipments received after December 31, 2020, for which the information described in paragraphs (1) and (2) is not transmitted as required under this subparagraph, except as provided in subclause (II).

''(II) If remedial action is warranted in lieu of refusal of shipments pursuant to subclause (I), the Postmaster General and the Commissioner shall take remedial action with respect to the shipments, including destruction, seizure, controlled delivery or other law enforcement initiatives, or correction of the failure to provide the information described in paragraphs (1) and (2) with respect to the shipments.

''(viii) Nothing in this subparagraph shall be construed to limit the authority of the Secretary to obtain information relating to international mail shipments from private carriers or other appropriate parties.

''(ix) In this subparagraph, the term 'appropriate congressional committees' means—

''(I) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

''(II) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.''.

(2) JOINT STRATEGIC PLAN ON MANDATORY ADVANCE INFORMATION.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Homeland Security and the Postmaster General shall develop and submit to the appropriate congressional committees a joint strategic plan detailing specific performance measures for achieving—

(A) the transmission of information as required by section 343(a)(3)(K) of the Trade Act of 2002, as amended by paragraph (1); and

(B) the presentation by the Postal Service to U.S. Customs and Border Protection of all mail targeted by U.S. Customs and Border Protection for inspection.

(b) CAPACITY BUILDING.—

(1) IN GENERAL.—Section 343(a) of the Trade Act of 2002 (Public Law 107–210; 19 U.S.C. 2071 note) is amended by adding at the end the following:

''(5) CAPACITY BUILDING.—

''(A) IN GENERAL.—The Secretary, with the concurrence of the Secretary of State, and in coordination with the Postmaster General and the heads of other Federal agencies, as appropriate, may provide technical assistance, equipment, technology, and training to enhance the capacity of foreign postal operators—

''(i) to gather and provide the information required by paragraph (3)(K); and

''(ii) to otherwise gather and provide postal shipment information related to—

''(I) terrorism;

''(II) items the importation or introduction of which into the United States is prohibited or restricted, including controlled substances; and

''(III) such other concerns as the Secretary determines appropriate.

''(B) PROVISION OF EQUIPMENT AND TECHNOLOGY.—With respect to the provision of equipment and technology under subparagraph (A), the Secretary may lease, loan, provide, or otherwise assist in the deployment of such equipment and technology under such terms and conditions as the Secretary may prescribe, including nonreimbursable loans or the transfer of ownership of equipment and technology.''.

(2) JOINT STRATEGIC PLAN ON CAPACITY BUILDING.—Not later than one year after the date of the enactment of this Act, the Secretary of Homeland Security and the Postmaster General shall, in consultation with the Secretary of State, jointly develop and submit to the appropriate congressional committees a joint strategic plan—

(A) detailing the extent to which U.S. Customs and Border Protection and the United States Postal Service are engaged in capacity building efforts under section 343(a)(5) of the Trade Act of 2002, as added by paragraph (1);

(B) describing plans for future capacity building efforts; and

(C) assessing how capacity building has increased the ability of U.S. Customs and Border Protection and the Postal Service to advance the goals of this subtitle and the amendments made by this subtitle.

(c) REPORT AND CONSULTATIONS BY SECRETARY OF HOMELAND SECURITY AND POSTMASTER GENERAL.—

(1) REPORT.—Not later than 180 days after the date of the enactment of this Act, and annually thereafter until 3 years after the Postmaster General has met the requirement under clause (vi) of subparagraph (K) of section 343(a)(3) of the Trade Act of 2002, as amended by subsection (a)(1), the Secretary of Homeland Security and the Postmaster General shall, in consultation with the Secretary of State, jointly submit to the appropriate congressional committees a report on compliance with that subparagraph that includes the following:

(A) An assessment of the status of the regulations required to be promulgated under that subparagraph.

(B) An update regarding new and existing agreements reached with foreign postal operators for the transmission of the information required by that subparagraph.

(C) A summary of deliberations between the United States Postal Service and foreign postal operators with respect to issues relating to the transmission of that information.

(D) A summary of the progress made in achieving the transmission of that information for the percentage of shipments required by that subparagraph.

(E) An assessment of the quality of that information being received by foreign postal operators, as determined by the Secretary of Homeland Security, and actions taken to improve the quality of that information.

(F) A summary of policies established by the Universal Postal Union that may affect the ability of the Postmaster General to obtain the transmission of that information.

(G) A summary of the use of technology to detect illicit synthetic opioids and other illegal substances in international mail parcels and planned acquisitions and advancements in such technology.

(H) Such other information as the Secretary of Homeland Security and the Postmaster General consider appropriate with respect to obtaining the transmission of information required by that subparagraph.

(2) CONSULTATIONS.—Not later than 180 days after the date of the enactment of this Act, and every 180 days thereafter until the Postmaster General has met the requirement under clause (vi) of section 343(a)(3)(K) of the Trade Act of 2002, as amended by subsection (a)(1), to arrange for the transmission of information with respect to 100 percent of the aggregate number of mail shipments described in clause (i) of that section, the Secretary of Homeland Security and the Postmaster General shall provide briefings to the appropriate congressional committees on the progress made in achieving the transmission of that information for that percentage of shipments.

(d) GOVERNMENT ACCOUNTABILITY OFFICE REPORT.—Not later than June 30, 2019, the Comptroller General of the United States shall submit to the appropriate congressional committees a report—

(1) assessing the progress of the United States Postal Service in achieving the transmission of the information required by subparagraph (K) of section 343(a)(3) of the Trade Act of 2002, as amended by subsection (a)(1), for the percentage of shipments required by that subparagraph;

(2) assessing the quality of the information received from foreign postal operators for targeting purposes;

(3) assessing the specific percentage of targeted mail presented by the Postal Service to U.S. Customs and Border Protection for inspection;

(4) describing the costs of collecting the information required by such subparagraph (K) from foreign postal operators and the costs of implementing the use of that information;

(5) assessing the benefits of receiving that information with respect to international mail shipments;

(6) assessing the feasibility of assessing a customs fee under section 13031(b)(9) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 8002, on international mail shipments other than Inbound Express Mail service in a manner consistent with the obligations of the United States under international agreements; and

(7) identifying recommendations, including recommendations for legislation, to improve the compliance of the Postal Service with such subparagraph (K), including an assessment of whether the detection of illicit synthetic opioids in the international mail would be improved by—

(A) requiring the Postal Service to serve as the consignee for international mail shipments containing goods; or

(B) designating a customs broker to act as an importer of record for international mail shipments containing goods.

(e) TECHNICAL CORRECTION.—Section 343 of the Trade Act of 2002 (Public Law 107–210; 19 U.S.C. 2071 note) is amended in the section heading by striking ''**ADVANCED**'' *and inserting* ''**ADVANCE**''.

(f) APPROPRIATE CONGRESSIONAL COMMITTEES DEFINED.—In this section, the term ''appropriate congressional committees'' means—

(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

SEC. 8004. INTERNATIONAL POSTAL AGREEMENTS.

(a) EXISTING AGREEMENTS.—

(1) IN GENERAL.—In the event that any provision of this subtitle, or any amendment made by this Act, is determined to be in violation of obligations of the United States under any postal treaty, convention, or other international agreement related to international postal services, or any amendment to such an agreement, the Secretary of State should negotiate to amend the relevant provisions of the agreement so that the United States is no longer in violation of the agreement.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit delay in the implementation of this subtitle or any amendment made by this subtitle.

(b) FUTURE AGREEMENTS.—

(1) CONSULTATIONS.—Before entering into, on or after the date of the enactment of this Act, any postal treaty, convention, or other international agreement related to international postal services, or any amendment to such an agreement, that is related to the ability of the United States to secure the provision of advance electronic information by foreign postal operators, the Secretary of State should consult with the appropriate congressional committees (as defined in section 8003(f)).

(2) EXPEDITED NEGOTIATION OF NEW AGREEMENT.—To the extent that any new postal treaty, convention, or other international agreement related to international postal services would improve the ability of the United States to secure the provision of advance electronic information by foreign postal operators as required by regulations prescribed under section 343(a)(3)(K) of the Trade Act of 2002, as amended by section 8003(a)(1), the Secretary of State should expeditiously conclude such an agreement.

SEC. 8005. COST RECOUPMENT.

(a) IN GENERAL.—The United States Postal Service shall, to the extent practicable and otherwise recoverable by law, ensure that all costs associated with complying with this subtitle and amendments made by this subtitle are charged directly to foreign shippers or foreign postal operators.

(b) COSTS NOT CONSIDERED REVENUE.—The recovery of costs under subsection (a) shall not be deemed revenue for purposes of subchapter I and II of chapter 36 of title 39, United States Code, or regulations prescribed under that chapter.

SEC. 8006. DEVELOPMENT OF TECHNOLOGY TO DETECT ILLICIT NARCOTICS.

(a) IN GENERAL.—The Postmaster General and the Commissioner of U.S. Customs and Border Protection, in coordination with the heads of other agencies as appropriate, shall collaborate to identify and develop technology for the detection of illicit fentanyl, other synthetic opioids, and other narcotics and psychoactive substances entering the United States by mail.

(b) OUTREACH TO PRIVATE SECTOR.—The Postmaster General and the Commissioner shall conduct outreach to private sector entities to gather information regarding the current state of technology to identify areas for innovation relating to the detection of illicit fentanyl, other synthetic opioids, and other narcotics and psychoactive substances entering the United States.

SEC. 8007. CIVIL PENALTIES FOR POSTAL SHIPMENTS.

Section 436 of the Tariff Act of 1930 (19 U.S.C. 1436) is amended by adding at the end the following new subsection:

''(e) CIVIL PENALTIES FOR POSTAL SHIPMENTS.—

''(1) CIVIL PENALTY.—A civil penalty shall be imposed against the United States Postal Service if the Postal Service accepts a shipment in violation of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002.

''(2) MODIFICATION OF CIVIL PENALTY.—

''(A) IN GENERAL.—U.S. Customs and Border Protection shall reduce or dismiss a civil penalty imposed pursuant to paragraph (1) if U.S. Customs and Border Protection determines that the United States Postal Service—

''(i) has a low error rate in compliance with section 343(a)(3)(K) of the Trade Act of 2002;

''(ii) is cooperating with U.S. Customs and Border Protection with respect to the violation of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002; or

''(iii) has taken remedial action to prevent future violations of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002.

''(B) WRITTEN NOTIFICATION.—U.S. Customs and Border Protection shall issue a written notification to the Postal Service with respect to each exercise of the authority of subparagraph (A) to reduce or dismiss a civil penalty imposed pursuant to paragraph (1).

''(3) ONGOING LACK OF COMPLIANCE.—If U.S. Customs and Border Protection determines that the United States Postal Service—

''(A) has repeatedly committed violations of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002,

''(B) has failed to cooperate with U.S. Customs and Border Protection with respect to violations of section 343(a)(3)(K)(vii)(I) of the Trade Act of 2002, and

''(C) has an increasing error rate in compliance with section 343(a)(3)(K) of the Trade Act of 2002,

civil penalties may be imposed against the United States Postal Service until corrective action, satisfactory to U.S. Customs and Border Protection, is taken.''.

SEC. 8008. REPORT ON VIOLATIONS OF ARRIVAL, REPORTING, ENTRY, AND CLEARANCE REQUIREMENTS AND FALSITY OR LACK OF MANIFEST.

(a) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection shall submit to the appropriate congressional committees an annual report that contains the information described in subsection (b) with respect to each violation of section 436 of the Tariff Act of 1930 (19 U.S.C. 1436), as amended by section 8007, and section 584 of such Act (19 U.S.C. 1584) that occurred during the previous year.

(b) INFORMATION DESCRIBED.—The information described in this subsection is the following:

(1) The name and address of the violator.

(2) The specific violation that was committed.

(3) The location or port of entry through which the items were transported.

(4) An inventory of the items seized, including a description of the items and the quantity seized.

(5) The location from which the items originated.

(6) The entity responsible for the apprehension or seizure, organized by location or port of entry.

(7) The amount of penalties assessed by U.S. Customs and Border Protection, organized by name of the violator and location or port of entry.

(8) The amount of penalties that U.S. Customs and Border Protection could have levied, organized by name of the violator and location or port of entry.

(9) The rationale for negotiating lower penalties, organized by name of the violator and location or port of entry.

(c) APPROPRIATE CONGRESSIONAL COMMITTEES DEFINED.—In this section, the term ''appropriate congressional committees'' means—

(1) the Committee on Finance and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(2) the Committee on Ways and Means, the Committee on Oversight and Government Reform, and the Committee on Homeland Security of the House of Representatives.

SEC. 8009. EFFECTIVE DATE; REGULATIONS.

(a) EFFECTIVE DATE.—This subtitle and the amendments made by this subtitle (other than the amendments made by section 8002) shall take effect on the date of the enactment of this Act.

(b) REGULATIONS.—Not later than one year after the date of the enactment of this Act, such regulations as are necessary to carry out this subtitle and the amendments made by this subtitle shall be prescribed.

Subtitle B—Recognizing Early Childhood Trauma Related to Substance Abuse

SEC. 8011. SHORT TITLE.

This subtitle may be cited as the ''Recognizing Early Childhood Trauma Related to Substance Abuse Act of 2018''.

SEC. 8012. RECOGNIZING EARLY CHILDHOOD TRAUMA RELATED TO SUBSTANCE ABUSE.

(a) DISSEMINATION OF INFORMATION.—The Secretary of Health and Human Services shall disseminate information, resources, and, if requested, technical assistance to early childhood care and education providers and professionals working with young children on—

(1) ways to properly recognize children who may be impacted by trauma related to substance abuse by a family member or other adult; and

(2) how to respond appropriately in order to provide for the safety and well-being of young children and their families.

(b) GOALS.—The information, resources, and technical assistance provided under subsection (a) shall—

(1) educate early childhood care and education providers and professionals working with young children on understanding and identifying the early signs and risk factors of children who might be impacted by trauma due to exposure to substance abuse;

(2) suggest age-appropriate communication tools, procedures, and practices for trauma-informed care, including ways to prevent or mitigate the effects of trauma;

(3) provide options for responding to children impacted by trauma due to exposure to substance abuse that consider the needs of the child and family, including recommending resources and referrals for evidence-based services to support such family; and

(4) promote whole-family and multi-generational approaches to prevent separation and support re-unification of families whenever possible and in the best interest of the child.

(c) RULE OF CONSTRUCTION.—Such information, resources, and if applicable, technical assistance, shall not be construed to amend the requirements under—

(1) the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.);

(2) the Head Start Act (42 U.S.C. 9831 et seq.); or

(3) the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.).

Subtitle C—Assisting States' Implementation of Plans of Safe Care

SEC. 8021. SHORT TITLE.

This subtitle may be cited as the ''Assisting States' Implementation of Plans of Safe Care Act''.

SEC. 8022. ASSISTING STATES WITH IMPLEMENTATION OF PLANS OF SAFE CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide written guidance and, if appropriate, technical assistance to support States in complying with, and implementing, subsections (b)(2)(B)(iii) and (d)(18) of section 106 of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a) in order to promote better protections for young children and family-centered responses.

(b) REQUIREMENTS.—The guidance and technical assistance shall—

(1) enhance States' understanding of requirements and flexibilities under the law, including clarifying key terms;

(2) address State-identified challenges with developing, implementing, and monitoring plans of safe care;

(3) disseminate best practices related to developing and implementing plans of safe care, including differential response, collaboration and coordination, and identification and delivery of services, while recognizing needs of different populations and varying community approaches across States;

(4) support collaboration between health care providers, social service agencies, public health agencies, and the child welfare system, to promote a family-centered treatment approach;

(5) prevent separation and support reunification of families if in the best interests of the child;

(6) recommend treatment approaches for serving infants, pregnant women, and postpartum women whose infants may be affected by substance use that are designed to keep infants with their mothers and families whenever appropriate, including recommendations to encourage pregnant women to receive health and other support services during pregnancy;

(7) support State efforts to develop technology systems to manage and monitor implementation of plans of safe care; and

(8) help States improve the long-term safety and well-being of young children and their families.

(c) CONSTRUCTION.—The guidance and technical assistance shall not be construed to amend the requirements of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq.).

(d) DEFINITION.—For purposes of this section, the term ''State'' has the meaning given such term in section 3 of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 note).

Subtitle D—Improving the Federal Response to Families Impacted by Substance Use Disorder

SEC. 8031. SHORT TITLE.

This subtitle may be cited as the ''Improving the Federal Response to Families Impacted by Substance Use Disorder Act''.

SEC. 8032. INTERAGENCY TASK FORCE TO IMPROVE THE FEDERAL RESPONSE TO FAMILIES IMPACTED BY SUBSTANCE USE DISORDERS.

(a) ESTABLISHMENT.—There is established a task force, to be known as the ''Interagency Task Force to Improve the Federal Response to Families Impacted by Substance Use Disorders'' (in this section referred to as ''Task Force'').

(b) RESPONSIBILITIES.—The Task Force—

(1) shall identify, evaluate, and recommend ways in which Federal agencies can better coordinate responses to substance use disorders and the opioid crisis; and

(2) shall carry out the additional duties described in subsection (d).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Task Force shall be composed of 12 Federal officials having responsibility for, or administering programs related to, the duties of the Task Force. The Secretary of Health and Human Services, the Secretary of Education, the Secretary of Agriculture, and the Secretary of Labor shall each appoint two members to the Task Force from among the Federal officials employed by the Department of which they are the head. Additional Federal agency officials appointed by the Secretary of Health and Human Services shall fill the remaining positions of the Task Force.

(2) CHAIRPERSON.—The Secretary of Health and Human Services shall designate a Federal official employed by the Department of Health and Human Services to serve as the chairperson of the Task Force.

(3) DEADLINE FOR APPOINTMENT.—Each member shall be appointed to the Task Force not later than 60 days after the date of the enactment of this Act.

(4) ADDITIONAL AGENCY INPUT.—The Task Force may seek input from other Federal agencies and offices with experience, expertise, or information relevant in responding to the opioid crisis.

(5) VACANCIES.—A vacancy in the Task Force shall be filled in the manner in which the original appointment was made.

(6) PROHIBITION OF COMPENSATION.—Members of the Task Force may not receive pay, allowances, or benefits by reason of their service on the Task Force.

(d) DUTIES.—The Task Force shall carry out the following duties:

(1) Solicit input from stakeholders, including frontline service providers, medical professionals, educators, mental health professionals, researchers, experts in infant, child, and youth trauma, child welfare professionals, and the public, in order to inform the activities of the Task Force.

(2) Develop a strategy on how the Task Force and participating Federal agencies will collaborate, prioritize, and implement a coordinated Federal approach with regard to responding to substance use disorders, including opioid misuse, that shall include—

(A) identifying options for the coordination of existing grants that support infants, children, and youth, and their families as appropriate, who have experienced, or are at risk of experiencing, exposure to substance abuse disorders, including opioid misuse; and

(B) other ways to improve coordination, planning, and communication within and across Federal agencies, offices, and programs, to better serve children and families impacted by substance use disorders, including opioid misuse.

(3) Based off the strategy developed under paragraph (2), evaluate and recommend opportunities for local- and State-level partnerships, professional development, or best practices that—

(A) are designed to quickly identify and refer children and families, as appropriate, who have experienced or are at risk of experiencing exposure to substance abuse;

(B) utilize and develop partnerships with early childhood education programs, local social services organizations, and health care services aimed at preventing or mitigating the effects of exposure to substance use disorders, including opioid misuse;

(C) offer community-based prevention activities, including educating families and children on the effects of exposure to substance use disorders, including opioid misuse, and how to build resilience and coping skills to mitigate those effects;

(D) in accordance with Federal privacy protections, utilize non-personally identifiable data from screenings, referrals, or the provision of services and supports to evaluate and improve processes addressing exposure to substance use disorders, including opioid misuse; and

(E) are designed to prevent separation and support reunification of families if in the best interest of the child.

(4) In fulfilling the requirements of paragraphs (2) and (3), consider evidence-based, evidence-informed, and promising best practices related to identifying, referring, and supporting children and families at risk of experiencing exposure to substance abuse or experiencing substance use disorder, including opioid misuse, including—

(A) prevention strategies for those at risk of experiencing or being exposed to substance abuse, including misuse of opioids;

(B) whole-family and multi-generational approaches;

(C) community-based initiatives;

(D) referral to, and implementation of, trauma-informed practices and supports; and

(E) multi-generational practices that assist parents, foster parents, and kinship and other caregivers

(e) FACA.—The Federal Advisory Committee Act (5 U.S.C. App. 2) shall not apply to the Task Force.

(f) ACTION PLAN; REPORTS.—The Task Force—

(1) shall prepare a detailed action plan to be implemented by participating Federal agencies to create a collaborative, coordinated response to the opioid crisis, which shall include—

(A) relevant information identified and collected under subsection (d);

(B) a proposed timeline for implementing recommendations and efforts identified under subsection (d); and

(C) a description of how other Federal agencies and offices with experience, expertise, or information relevant in responding to the opioid crisis that have provided input under subsection (c)(4) will be participating in the coordinated approach;

(2) shall submit to the Congress a report describing the action plan prepared under paragraph (1), including, where applicable, identification of any recommendations included in such plan that require additional legislative authority to implement; and

(3) shall submit a report to the Governors describing the opportunities for local- and State-level partnerships, professional development, or best practices recommended under subsection (d)(3).

(g) DISSEMINATION.—

(1) IN GENERAL.—The action plan and reports required under subsection (f) shall be—

(A) disseminated widely, including among the participating Federal agencies and the Governors; and

(B) be made publicly available online in an accessible format.

(2) DEADLINE.—The action plan and reports required under subsection (f) may be released on separate dates but shall be released not later than 9 months after the date of the enactment of this Act.

(h) TERMINATION.—The Task Force shall terminate 30 days after the dissemination of the action plan and reports under subsection (g).

(i) FUNDING.—The administrative expenses of the Task Force shall be paid out of existing Department of Health and Human Services funds or appropriations.

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

(1) The term ''Governor'' means the chief executive officer of a State.

(2) The term ''participating Federal agencies'' means all the Executive agencies (as defined in section 105 of title 5, United States Code) whose officials have been appointed to the Task Force.

(3) The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Subtitle E—Establishment of an Advisory Committee on Opioids and the Workplace

SEC. 8041. ESTABLISHMENT OF AN ADVISORY COMMITTEE ON OPIOIDS AND THE WORKPLACE.

(a) ESTABLISHMENT.—Not later than 90 days after enactment of this Act, the Secretary of Labor shall establish an Advisory Committee on Opioids and the Workplace (referred to in this subtitle as the ''Advisory Committee'') to advise the Secretary on actions the Department of Labor can take to provide informational resources and best practices on how to appropriately address the impact of opioid abuse on the workplace and support workers abusing opioids.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Secretary of Labor shall appoint as members of the Advisory Committee 19 individuals with expertise in employment, workplace health programs, human resources, substance use disorder, and other relevant fields. The Advisory Committee shall be composed as follows:

(A) 4 of the members shall be individuals representative of employers or other organizations representing employers.

(B) 4 of the members shall be individuals representative of workers or other organizations representing workers, of which at least 2 must be representatives designated by labor organizations.

(C) 3 of the members shall be individuals representative of health benefit plans, employee assistance plan providers, workers' compensation program administrators, and workplace safety and health professionals.

(D) 8 of the members shall be individuals representative of substance abuse treatment and recovery experts, including medical doctors, licensed addiction therapists, and scientific and academic researchers, of which 1 individual may be a representative of a local or State government agency that oversees or coordinates programs that address substance use disorder.

(2) CHAIR.—From the members appointed under paragraph (1), the Secretary of Labor shall appoint a chairperson.

(3) TERMS.—Each member of the Advisory Committee shall serve for a term of three years. A member appointed to fill a vacancy shall be appointed only for the remainder of such term.

(4) QUORUM.—A majority of members of the Advisory Committee shall constitute a quorum and action shall be taken only by a majority vote of the members.

(5) VOTING.—The Advisory Committee shall establish voting procedures.

(6) NO COMPENSATION.—Members of the Advisory Committee shall serve without compensation.

(7) DISCLOSURE.—Every member of the Advisory Committee must disclose the entity, if applicable, that he or she is representing.

(c) DUTIES.—

(1) ADVISEMENT.—

(A) IN GENERAL.—The Advisory Committee established under subsection (a) shall advise the Secretary of Labor on actions the Department of Labor can take to provide informational resources and best practices on how to appropriately address the impact of opioid abuse on the workplace and support workers abusing opioids.

(B) CONSIDERATIONS.—In providing such advice, the Advisory Committee shall take into account—

(i) evidence-based and other employer substance abuse policies and best practices regarding opioid use or abuse, including benefits provided by employee assistance programs or other employer-provided benefits, programs, or resources;

(ii) the effect of opioid use or abuse on the safety of the workplace as well as policies and procedures addressing workplace safety and health;

(iii) the impact of opioid abuse on productivity and absenteeism, and assessments of model human resources policies that support workers abusing opioids, such as policies that facilitate seeking and receiving treatment and returning to work;

(iv) the extent to which alternative pain management treatments other than opioids are or should be covered by employer-sponsored health plans;

(v) the legal requirements protecting employee privacy and health information in the workplace, as well as the legal requirements related to nondiscrimination;

(vi) potential interactions of opioid abuse with other substance use disorders;

(vii) any additional benefits or resources available to an employee abusing opioids that promote retaining employment or reentering the workforce;

(viii) evidence-based initiatives that engage employers, employees, and community leaders to promote early identification of opioid abuse, intervention, treatment, and recovery;

(ix) workplace policies regarding opioid abuse that reduce stigmatization among fellow employees and management; and

(x) the legal requirements of the Mental Health Parity and Addiction Equity Act and other laws related to health coverage of substance abuse and mental health services and medications.

(2) REPORT.—Prior to its termination as provided in subsection (j), the Advisory Committee shall issue a report to the Secretary of Labor and to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, detailing successful programs and policies involving workplace resources and benefits, including recommendations or examples of best practices for how employers can support and respond to employees impacted by opioid abuse.

(d) MEETINGS.—The Advisory Committee shall meet at least twice a year at the call of the chairperson.

(e) STAFF SUPPORT.—The Secretary of Labor shall make available staff necessary for the Advisory Committee to carry out its responsibilities.

(f) FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act shall apply to the Advisory Committee established under this subtitle.

(g) NO APPROPRIATED FUNDS.—No additional funds are authorized to be appropriated to carry out this subtitle. Expenses of the Advisory Committee shall be paid with funds otherwise appropriated to Departmental Management within the Department of Labor.

(h) EX OFFICIO.—Three nonvoting representatives from agencies within the Department of Health and Human Services whose responsibilities include opioid prescribing guidelines, workplace safety, and monitoring of substance abuse and prevention programs shall be appointed by the Secretary of Labor and designated as ex officio members.

(i) AGENDA.—The Secretary of Labor or a representative of the Secretary shall consult with the Chair in establishing the agenda for Committee meetings.

(j) TERMINATION.—The Advisory Committee established under this subtitle shall terminate three years after the date of enactment of this Act.

Subtitle F—Veterans Treatment Court Improvement

SEC. 8051. SHORT TITLE.

This subtitle may be cited as the ''Veterans Treatment Court Improvement Act of 2018''.

SEC. 8052. HIRING BY DEPARTMENT OF VETERANS AFFAIRS OF ADDITIONAL VETERANS JUSTICE OUTREACH SPECIALISTS.

(a) HIRING OF ADDITIONAL VETERANS JUSTICE OUTREACH SPECIALISTS.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall hire not fewer than 50 Veterans Justice Outreach Specialists and place each such Veterans Justice Outreach Specialist at an eligible Department of Veterans Affairs medical center in accordance with this section.

(2) REQUIREMENTS.—The Secretary shall ensure that each Veterans Justice Outreach Specialist employed under paragraph (1)—

(A) serves, either exclusively or in addition to other duties, as part of a justice team in a veterans treatment court or other veteran-focused court; and

(B) otherwise meets Department hiring guidelines for Veterans Justice Outreach Specialists.

(b) ELIGIBLE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS.—For purposes of this section, an eligible Department of Veterans Affairs medical center is any Department of Veterans Affairs medical center that—

(1) complies with all Department guidelines and regulations for placement of a Veterans Justice Outreach Specialist;

(2) works within a local criminal justice system with justice-involved veterans;

(3) maintains an affiliation with one or more veterans treatment courts or other veteran-focused courts; and

(4) either—

(A) routinely provides Veterans Justice Outreach Specialists to serve as part of a justice team in a veterans treatment court or other veteran-focused court; or

(B) establishes a plan that is approved by the Secretary to provide Veterans Justice Outreach Specialists employed under subsection (a)(1) to serve as part of a justice team in a veterans treatment court or other veteran-focused court.

(c) PLACEMENT PRIORITY.—The Secretary shall prioritize the placement of Veterans Justice Outreach Specialists employed under subsection (a)(1) at eligible Department of Veterans Affairs medical centers that have or intend to establish an affiliation, for the purpose of carrying out the Veterans Justice Outreach Program, with a veterans treatment court, or other veteran-focused court, that—

(1) was established on or after the date of the enactment of this Act; or

(2)(A) was established before the date of the enactment of this Act; and

(B) is not fully staffed with Veterans Justice Outreach Specialists.

(d) REPORTS.—

(1) REPORT BY SECRETARY OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report on the implementation of this section and its effect on the Veterans Justice Outreach Program.

(B) CONTENTS.—The report submitted under paragraph (1) shall include the following:

(i) The status of the efforts of the Secretary to hire Veterans Justice Outreach Specialists pursuant to subsection (a)(1), including the total number of Veterans Justice Outreach Specialists hired by the Secretary pursuant to such subsection and the number that the Secretary expects to hire pursuant to such subsection.

(ii) The total number of Veterans Justice Outreach Specialists assigned to each Department of Veterans Affairs medical center that participates in the Veterans Justice Outreach Program, including the number of Veterans Justice Outreach Specialists hired under subsection (a)(1) disaggregated by Department of Veterans Affairs medical center.

(iii) The total number of eligible Department of Veterans Affairs medical centers that sought placement of a Veterans Justice Outreach Specialist under subsection (a)(1), how many Veterans Justice Outreach Specialists each such center sought, and how many of such medical centers received no placement of a Veterans Justice Outreach Specialist under subsection (a)(1).

(iv) For each eligible Department of Veterans Affairs medical center—

(I) the number of justice-involved veterans who were served or are expected to be served by a Veterans Justice Outreach Specialist hired under subsection (a)(1); and

(II) the number of justice-involved veterans who do not have access to a Veterans Justice Outreach Specialist.

(2) REPORT BY COMPTROLLER GENERAL OF THE UNITED STATES.—

(A) IN GENERAL.—Not later than three years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implementation of this section and the effectiveness of the Veterans Justice Outreach Program.

(B) CONTENTS.—The report required by subparagraph (A) shall include the following:

(i) An assessment of whether the Secretary has fulfilled the Secretary's obligations under this section.

(ii) The number of veterans who are served by Veterans Justice Outreach Specialists hired under subsection (a)(1), disaggregated by demographics (including discharge status).

(iii) An identification of any subgroups of veterans who underutilize services provided under laws administered by the Secretary, including an assessment of whether these veterans have access to Veterans Justice Outreach Specialists under the Veterans Justice Outreach Program.

(iv) Such recommendations as the Comptroller General may have for the Secretary to improve the effectiveness of the Veterans Justice Outreach Program.

(e) DEFINITIONS.—In this section:

(1) JUSTICE TEAM.—The term ''justice team'' means the group of individuals, which may include a judge, court coordinator, prosecutor, public defender, treatment provider, probation or other law enforcement officer, program mentor, and Veterans Justice Outreach Specialist, who assist justice-involved veterans in a veterans treatment court or other veteran-focused court.

(2) JUSTICE-INVOLVED VETERAN.—The term ''justice-involved veteran'' means a veteran with active, ongoing, or recent contact with some component of a local criminal justice system.

(3) LOCAL CRIMINAL JUSTICE SYSTEM.—The term ''local criminal justice system'' means law enforcement, jails, prisons, and Federal, State, and local courts.

(4) VETERANS JUSTICE OUTREACH PROGRAM.—The term ''Veterans Justice Outreach Program'' means the program through which the Department of Veterans Affairs identifies justice-involved veterans and provides such veterans with access to Department services.

(5) VETERANS JUSTICE OUTREACH SPECIALIST.—The term ''Veterans Justice Outreach Specialist'' means an employee of the Department of Veterans Affairs who serves as a liaison between the Department and the local criminal justice system on behalf of a justice-involved veteran.

(6) VETERANS TREATMENT COURT.—The term ''veterans treatment court'' means a State or local court that is participating in the veterans treatment court program (as defined in section 2991(i)(1) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(i)(1))).

Subtitle G—Peer Support Counseling Program for Women Veterans

SEC. 8061. PEER SUPPORT COUNSELING PROGRAM FOR WOMEN VETERANS.

(a) IN GENERAL.—Section 1720F(j) of title 38, United States Code, is amended by adding at the end the following new paragraph:

''(4)(A) As part of the counseling program under this subsection, the Secretary shall emphasize appointing peer support counselors for women veterans. To the degree practicable, the Secretary shall seek to recruit women peer support counselors with expertise in—

''(i) female gender-specific issues and services;

''(ii) the provision of information about services and benefits provided under laws administered by the Secretary; or

''(iii) employment mentoring.

''(B) To the degree practicable, the Secretary shall emphasize facilitating peer support counseling for women veterans who are eligible for counseling and services under section 1720D of this title, have post-traumatic stress disorder or suffer from another mental health condition, are homeless or at risk of becoming homeless, or are otherwise at increased risk of suicide, as determined by the Secretary.

''(C) The Secretary shall conduct outreach to inform women veterans about the program and the assistance available under this paragraph.

''(D) In carrying out this paragraph, the Secretary shall coordinate with such community organizations, State and local governments, institutions of higher education, chambers of commerce, local business organizations, organizations that provide legal assistance, and other organizations as the Secretary considers appropriate.

''(E) In carrying out this paragraph, the Secretary shall provide adequate training for peer support counselors, including training carried out under the national program of training required by section 304(c) of the Caregivers and Veterans Omnibus Health Services Act of 2010 (38 U.S.C. 1712A note).''.

(b) FUNDING.—The Secretary of Veterans Affairs shall carry out paragraph (4) of section 1720F(j) of title 38, United States Code, as added by subsection (a), using funds otherwise made available to the Secretary. No additional funds are authorized to be appropriated by reason of such paragraph.

(c) REPORT TO CONGRESS.—Not later than two years after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the peer support counseling program under section 1720F(j) of title 38, United States Code, as amended by this section. Such report shall include—

(1) the number of peer support counselors in the program;

(2) an assessment of the effectiveness of the program; and

(3) a description of the oversight of the program.

Subtitle H—Treating Barriers to Prosperity

SEC. 8071. SHORT TITLE.

This subtitle may be cited as the ''Treating Barriers to Prosperity Act of 2018''.

SEC. 8072. DRUG ABUSE MITIGATION INITIATIVE.

(a) IN GENERAL.—Chapter 145 of title 40, United States Code, is amended by inserting after section 14509 the following:

''§ 14510. Drug abuse mitigation initiative

''(a) IN GENERAL.—The Appalachian Regional Commission may provide technical assistance to, make grants to, enter into contracts with, or otherwise provide amounts to individuals or entities in the Appalachian region for projects and activities to address drug abuse, including opioid abuse, in the region, including projects and activities—

''(1) to facilitate the sharing of best practices among States, counties, and other experts in the region with respect to reducing such abuse;

''(2) to initiate or expand programs designed to eliminate or reduce the harm to the workforce and economic growth of the region that results from such abuse;

''(3) to attract and retain relevant health care services, businesses, and workers; and

''(4) to develop relevant infrastructure, including broadband infrastructure that supports the use of telemedicine.

''(b) LIMITATION ON AVAILABLE AMOUNTS.—Of the cost of any activity eligible for a grant under this section—

''(1) not more than 50 percent may be provided from amounts appropriated to carry out this section; and

''(2) notwithstanding paragraph (1)—

''(A) in the case of a project to be carried out in a county for which a distressed county designation is in effect under section 14526, not more than 80 percent may be provided from amounts appropriated to carry out this section; and

''(B) in the case of a project to be carried out in a county for which an at-risk designation is in effect under section 14526, not more than 70 percent may be provided from amounts appropriated to carry out this section.

''(c) SOURCES OF ASSISTANCE.—Subject to subsection (b), a grant provided under this section may be provided from amounts made available to carry out this section in combination with amounts made available—

''(1) under any other Federal program (subject to the availability of subsequent appropriations); or

''(2) from any other source.

''(d) FEDERAL SHARE.—Notwithstanding any provision of law limiting the Federal share under any other Federal program, amounts made available to carry out this section may be used to increase that Federal share, as the Appalachian Regional Commission determines to be appropriate.''.

(b) CLERICAL AMENDMENT.—The analysis for chapter 145 of title 40, United States Code, is amended by inserting after the item relating to section 14509 the following:

''14510. Drug abuse mitigation initiative.''.

Subtitle I—Supporting Grandparents Raising Grandchildren

SEC. 8081. SHORT TITLE.

This subtitle may be cited as the ''Supporting Grandparents Raising Grandchildren Act''.

SEC. 8082. FINDINGS.

Congress finds the following:

(1) More than 2,500,000 grandparents in the United States are the primary caretaker of their grandchildren, and experts report that such numbers are increasing as the opioid epidemic expands.

(2) Between 2009 and 2016, the incidence of parental alcohol or other drug use as a contributing factor for children's out-of-home placement rose from 25.4 to 37.4 percent.

(3) When children cannot remain safely with their parents, placement with relatives is preferred over placement in foster care with nonrelatives because placement with relatives provides stability for children and helps them maintain family connections.

(4) The number of foster children placed with a grandparent or other relative increased from 24 percent in 2006 to 32 percent in 2016, according to data from the Department of Health and Human Services.

(5) Grandparents' lives are enhanced by caring for their grandchildren; the overwhelming majority of grandparents report experiencing significant benefits in serving as their grandchildren's primary caregivers.

(6) Providing full-time care to their grandchildren may decrease grandparents' ability to address their own physical and mental health needs and personal well-being.

(7) Grandparents would benefit from better coordination and dissemination of information and resources available to support them in their caregiving responsibilities.

SEC. 8083. ADVISORY COUNCIL TO SUPPORT GRANDPARENTS RAISING GRANDCHILDREN.

(a) ESTABLISHMENT.—There is established an Advisory Council to Support Grandparents Raising Grandchildren.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Advisory Council shall be composed of the following members, or their designee:

(A) The Secretary of Health and Human Services.

(B) The Secretary of Education.

(C) The Administrator of the Administration for Community Living.

(D) The Director of the Centers for Disease Control and Prevention.

(E) The Assistant Secretary for Mental Health and Substance Use.

(F) The Assistant Secretary for the Administration for Children and Families.

(G) A grandparent raising a grandchild.

(H) An older relative caregiver of children.

(I) As appropriate, the head of other Federal departments, or agencies, identified by the Secretary of Health and Human Services as having responsibilities, or administering programs, relating to current issues affecting grandparents or other older relatives raising children.

(2) LEAD AGENCY.—The Department of Health and Human Services shall be the lead agency for the Advisory Council.

(c) DUTIES.—

(1) IN GENERAL.—

(A) INFORMATION.—The Advisory Council shall identify, promote, coordinate, and disseminate to the public information, resources, and the best practices available to help grandparents and other older relatives—

(i) meet the health, educational, nutritional, and other needs of the children in their care; and

(ii) maintain their own physical and mental health and emotional well-being.

(B) OPIOIDS.—In carrying out the duties described in subparagraph (A), the Advisory Council shall consider the needs of those affected by the opioid crisis.

(C) NATIVE AMERICANS.—In carrying out the duties described in subparagraph (A), the Advisory Council shall consider the needs of members of Native American tribes.

(2) REPORT.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Advisory Council shall submit a report to—

(i) the appropriate committees;

(ii) the State agencies that are responsible for carrying out family caregiver programs; and

(iii) the public online in an accessible format.

(B) REPORT FORMAT.—The report shall include—

(i) best practices, resources, and other useful information for grandparents and other older relatives raising children identified under paragraph (1)(A) including, if applicable, any information related to the needs of children who have been impacted by the opioid epidemic;

(ii) an identification of any gaps in items under clause (i); and

(iii) where applicable, identification of any additional Federal legislative authority necessary to implement the activities described in clause (i) and (ii).

(3) FOLLOW-UP REPORT.—Not later than 2 years after the date on which the report required under paragraph (2)(A) is submitted, the Advisory Council shall submit a follow-up report that includes the information identified in paragraph (2)(B) to—

(A) the appropriate committees;

(B) the State agencies that are responsible for carrying out family caregiver programs; and

(C) the public online in an accessible format.

(4) PUBLIC INPUT.—

(A) IN GENERAL.—The Advisory Council shall establish a process for public input to inform the development of, and provide updates to, the best practices, resources, and other information described in paragraph (1) that shall include—

(i) outreach to States, local entities, and organizations that provide information to, or support for, grandparents or other older relatives raising children; and

(ii) outreach to grandparents and other older relatives with experience raising children.

(B) NATURE OF OUTREACH.—Such outreach shall ask individuals to provide input on—

(i) information, resources, and best practices available, including identification of any gaps and unmet needs; and

(ii) recommendations that would help grandparents and other older relatives better meet the health, educational, nutritional, and other needs of the children in their care, as well as maintain their own physical and mental health and emotional well-being.

(d) FACA.—The Advisory Council shall be exempt from the requirements of the Federal Advisory Committee Act (5 U.S.C. App.).

(e) FUNDING.—No additional funds are authorized to be appropriated to carry out this subtitle.

(f) SUNSET.—The Advisory Council shall terminate on the date that is 3 years after the date of enactment of this Act.

SEC. 8084. DEFINITIONS.

In this subtitle:

(1) ADVISORY COUNCIL.—In this subtitle, the term ''Advisory Council'' means the Advisory Council to Support Grandparents Raising Grandchildren that is established under section 8083.

(2) APPROPRIATE COMMITTEES.—In this subtitle, the term ''appropriate committees'' means the following:

(A) The Special Committee on Aging of the Senate.

(B) The Committee on Health, Education, Labor, and Pensions of the Senate.

(C) The Committee on Education and the Workforce of the House of Representatives.

(D) The Committee on Energy and Commerce of the House of Representatives.

Subtitle J—Reauthorizing and Extending Grants for Recovery From Opioid Use Programs

SEC. 8091. SHORT TITLE.

This subtitle may be cited as the ''Reauthorizing and Extending Grants for Recovery from Opioid Use Programs Act of 2018'' or the ''REGROUP Act of 2018''.

SEC. 8092. REAUTHORIZATION OF THE COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

Section 1001(a)(27) of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10261(a)(27)) is amended by striking ''through 2021'' and inserting ''and 2018, and $330,000,000 for each of fiscal years 2019 through 2023''.

The Acting CHAIR. No further amendment to the bill, as amended, shall be in order except those printed in part B of House Report 115–766. Each such further amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENT NO. 1 OFFERED BY MR. WALDEN

The Acting CHAIR. It is now in order to consider amendment No. 1 printed in part B of House Report 115–766.

Mr. WALDEN. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 65, line 18, insert ''(as described in paragraph (4)(F))'' after ''telehealth services''.

Page 68, line 21, insert '', as determined by the Secretary'' after ''clinical improvement''.

Page 70, line 24, strike ''certified''.

Page 70, after line 25, insert the following:

(b) CLARIFICATION.—Nothing in the amendments made by subsection (a) shall be construed to prohibit separate payment for structured assessment and intervention services for substance abuse furnished to an individual on the same day as an initial preventive physical examination.

Page 71, line 1, redesignate the subsection (b) as a subsection (c).

Page 71, strike line 21 and all that follows through page 72, line 2, and insert the following:

''(ii) For purposes of clause (i), the term 'targeted procedure' means a procedure to which Healthcare Common Procedure Coding System code 62310 (or, for years beginning after 2016, 62321), 62311 (or, for years beginning after 2016, 62323), 62264, 64490, 64493, or G0260, or any successor code, apply.''.

Page 95, line 1, strike ''100 or more'' and insert ''more than 100''.

Page 95, line 2, strike ''30 or more'' and insert ''more than 30''.

Page 95, line 13, insert ''the frequency of toxicology testing, including'' before ''the average''.

page 96, line 10, strike ''2025'' and insert ''2024''.

page 97, strike line 7, and insert ''that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined)

that such State applied as of May 31, 2018; or''.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Oregon (Mr. WALDEN) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Oregon.

Mr. WALDEN. Mr. Chairman, I appreciate all the work that has been done on this bill up to this point, the great bipartisan work, the biggest effort, I think, Congress has ever undertaken to address this terrible, terrible addiction problem of opioids and everything related to it.

This amendment before us is a bipartisan manager's amendment. It is filed by chairmen and ranking members of the Committees on Energy and Commerce and Ways and Means. This amendment makes simple technical corrections and conforming changes to the underlying H.R. 6 bill that the leaders of our two committees introduced last week.

As has been noted, the policies in H.R. 6 were moved through regular order in our two committees. I appreciate the bipartisan cooperation and teamwork of my colleagues and our terrific staffs who have joined me in introducing H.R. 6.

Mr. Chair, I encourage support of the amendment, and I urge adoption of the amendment.

Mr. Chairman, I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Oregon (Mr. WALDEN).

The amendment was agreed to.

The Acting CHAIR. The Committee will rise informally.

The SPEAKER pro tempore (Mr. MARSHALL) assumed the chair.

MESSAGES FROM THE PRESIDENT

Messages in writing from the President of the United States were communicated to the House by Ms. Gabrielle Cuccia, one of his secretaries.

The SPEAKER pro tempore. The Committee will resume its sitting.

SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT

The Committee resumed its sitting.

AMENDMENT NO. 2 OFFERED BY MR. DUNN

The Acting CHAIR (Mr. POE of Texas). It is now in order to consider amendment No. 2 printed in part B of House Report 115–766.

Mr. DUNN. Mr. Chair, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 93, strike lines 18 through 22 and insert the following:

(2) in subclause (II), by striking ''during the period beginning on the date of enactment of the Comprehensive Addiction and Recovery Act of 2016 and ending on October 1, 2021,''.

Page 93, strike line 23 and all that follows through page 94, line 17.

Page 94, line 18, strike ''(e)'' and insert ''(c)''.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Florida (Mr. DUNN) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Florida.

Mr. DUNN. Mr. Chair, I rise in support of my amendment to H.R. 6. I am grateful for the opportunity to speak about it.

My amendment strikes language that would expand the classes of healthcare workers who would be authorized to dispense narcotics for narcotic treatment.

Let me be clear at the outset. H.R. 6 is, in large part, a great bill; however, as currently written, it allows nurse specialists, nurse midwives, and nurse anesthetists to prescribe buprenorphine. I believe this is a significant and impulsive expansion of prescribing authority.

Allowing more providers with less clinical experience to provide buprenorphine, a highly addictive opioid, opens up dangerous new potential for increased opioid abuse. The point of H.R. 6 is to decrease opioid abuse, but this provision increases the potential for abuse and vastly increases the supply of a dangerous opioid that is one of the major causes of opioid overdose and death in Europe.

Mr. Chair, I appreciate the opportunity to bring these concerns to light in this amendment.

Mr. Chair, I include in the RECORD a letter in support of my amendment from The OTP Consortium.

THE OTP CONSORTIUM,
June 19, 2018.

Hon. GREG WALDEN,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.
Hon. KEVIN BRADY,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.
Hon. FRANK PALLONE, Jr.,
Ranking Member, Committee on Energy and Commerce, House of Representatives, Washington, DC.
Hon. RICHARD NEAL,
Ranking Member, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR CHAIRMEN WALDEN AND BRADY AND RANKING MEMBERS PALLONE AND NEAL: On behalf of the Opioid Treatment Program (OTP) Consortium we would like to offer our support for H.R. 6, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. In particular, we strongly support Section 207 which would provide Medicare beneficiaries with life-saving Medication-Assisted Treatment (MAT) for opioid use disorder (OUD) in the highly-effective OTP setting. This policy was introduced by Ranking Member Neal and Congressman George Holding as part of H.R. 5776, the Medicare and Opioid Safe Treatment (MOST) Act of 2018. The OTP Consortium is comprised of nearly 350 OTPs across the country that provide care to more than 140,000 patients daily in 37 states, including at our 22 facilities in Massachusetts, 16 facilities in Texas, nine facilities in Oregon, and two facilities in New Jersey.

OTPs are highly-regulated, highly-structured, comprehensive treatment programs that provide MAT—which the National Institutes of Health states is the most effective solution to treat OUD. OTPs are the only provider where patients are guaranteed to receive MAT—including individual and group counseling, random toxicology screens, medication, and other supportive services such as case management, primary care, mental health services, HIV and Hepatitis C testing and more.

Medicare beneficiaries have the highest and fastest growing rate of OUD, yet they do not currently have coverage for the most effective form of treatment—H.R. 6 provides such coverage. More than 300,000 Medicare beneficiaries have been diagnosed with OUD—your legislation could end up saving their lives and many more. Medicare hospitalizations due to complications caused by opioid abuse or misuse increased 10% every year from 1993 to 2012—your bill would help reverse this alarming trend.

We do, however, have concerns about the policies contained in Section 303. While we are pleased that the 275-patient threshold was not codified, we do not support expanding or making permanent buprenorphine prescribing authority to non-physician providers before policymakers can fully analyze the data resulting from the critical questions asked in subsection (e). Americans need effective treatment and decades of evidence and outcomes show that medication simply assists the other treatment interventions. Medication should never be the sole aspect of treating SUD—thus the term Medication-Assisted Treatment. Office-based practices that focus on medication alone run the risk of becoming the next-generation pill mill. We hope that Congress will revisit office-based buprenorphine prescribing thresholds once this quality assessment has been completed and it can be determined whether or not patients are indeed truly receiving MAT in these settings. Improving access to buprenorphine is important, but it must be paired with the evidence-based MAT services that are proven to lead to recovery.

We support H.R. 6 and stand ready to work with you see that this critical Medicare OTP benefit is signed into law, without delay.

Sincerely,

PETER MORRIS,
Division President, Acadia Healthcare.
ALEX DODD,
CEO, Aegis Treatment Centers, LLC.
DAVID WHITE, PH.D.,
CEO, BayMark Health Service.
JAY HIGHAM,
CEO, Behavioral Health Group.
JOHN STEINBRUN,
CEO, New Season.

Mr. DUNN. Mr. Chair, I reserve the balance of my time.

Mr. WALDEN. Mr. Chair, I claim time in opposition to the amendment.

The Acting CHAIR. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Chair, I certainly appreciate Dr. DUNN and the good work that he has done on many of these issues, and I also appreciate his willingness to withdraw his amendment.

As a result of our committee process and various member conversations we have had, we have reached bipartisan compromise on the underlying bill on the issue of concern to Mr. DUNN.

I understand that thoughtful Members can find themselves on different sides of an issue at different times, and I certainly respect the gentleman's position. That being said, we believe our underlying policy represents a fair middle ground, and it ensures rigorous analysis on the issue going forward.

Mr. Chair, I appreciate the gentleman from Florida withdrawing the amendment.

Mr. Chair, I yield 2½ minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Chair, I thank Chairman WALDEN for yielding.

Although I know my colleague plans to withdraw, I rise in opposition to this amendment, and I just want to articulate a bit of my reasoning.

I think my colleagues and I both share the same goal of safely expanding access to addiction treatment. Where we differ is that I believe that the provisions in H.R. 6 expanding buprenorphine prescribing privileges to advanced practice nurses meet that test.

We all know that there is a dire need for expanded treatment capacity to meet the demands of this current epidemic. As many as 40 percent of counties across the country lack even a single provider that is able to offer buprenorphine. Advanced practice nurses play an outsized role in providing care in rural America, and H.R. 6 will help expand addiction treatment capacity into these communities where it is most needed.

Expanding buprenorphine prescribing privileges to APRNs is supported by medical groups that serve on the front lines of this epidemic, such as the American Society for Addiction Medicine and the American Congress of Obstetricians and Gynecologists.

All advanced practice nurses who wish to prescribe medication-assisted treatment would have to receive a special waiver from the DEA and would have to undergo three times as much specialized addiction training as their physician colleagues.

In addition, in order to receive a waiver, practitioners are required to be able to provide appropriate counseling and ancillary services that are the hallmark of high-quality addiction treatment. All APRNs wishing to prescribe buprenorphine would still be subject to State laws regarding prescription authority, scope of practice, and collaboration or supervision requirements with a physician.

While I understand that providing addiction treatment is a complex and nuanced area of medicine with potential complications if done poorly, I would point out that we don't restrict advanced practice registered nurses in Federal law from providing such high-risk services as delivering babies, administering anesthesia, or prescribing as many opioids as they wish. Why would we want to maintain an outdated barrier in Federal law that prevents these practitioners from being part of the solution to the opioid epidemic?

So in closing, I appreciate that my colleagues are withdrawing this amendment today, and I would urge that, as we move forward toward a potential conference committee, we continue to recognize the role that advanced practice nurses can play in addressing this epidemic.

Mr. WALDEN. Mr. Chairman, I reserve the balance of my time.

Mr. DUNN. Mr. Chair, I yield 1 minute to the gentleman from Tennessee (Mr. ROE), the chairman of the Veterans' Affairs Committee.

Mr. ROE of Tennessee. Mr. Chair, I thank the gentleman for yielding.

As a practicing physician for over 30 years, I have incredible respect for nurses and the work they do. I married a nurse. Some of the best employees I have worked with were nurses. I could not appreciate the job they do more, Mr. Chair, but care for patients is better directed with physician oversight.

Even with my training, we need fewer doctors like me writing these prescriptions and more physicians trained in pain management. The American Society of Addiction Medicine is establishing approved fellowships in training in addiction medicine today.

Expanding the scope of practice for nonphysician providers to dispense drugs like buprenorphine goes in the wrong direction, in my opinion.

There are many factors that contribute to the explosive growth in opioid use, but clearly a big factor was the lack of knowledge about opioids' addictive qualities. I would argue that we have a similar lack of knowledge about buprenorphine today, and allowing providers who have less training and less knowledge about these substances exponentially increases the chances of abuse in these substances.

□ 1045

If we remove the most highly-trained specialist from administration of buprenorphine, I fear that all the good we are trying to do in this bill could be negated.

The Acting CHAIR. The time of the gentleman has expired.

Mr. DUNN. I yield the gentleman an additional 1 minute.

Mr. ROE of Tennessee. There are plenty of provisions to support in this underlying bill. It is a good bill, but section 303 is not one of them.

I encourage my colleagues to support the amendment.

Mr. WALDEN. Mr. Chairman, I continue to reserve the balance of my time.

Mr. DUNN. Mr. Chairman, I yield 1 minute to the gentleman from Kansas (Mr. MARSHALL).

Mr. MARSHALL. Mr. Chairman, I thank Dr. DUNN for leading this amendment.

I had an over three-decade experience and great working relationship with physician assistants, nurse practitioners, as well as nurse anesthetists. I believe one of the secrets to that great work that we did was the collaboration between us and how we worked together.

I firmly believe that whenever narcotics are involved, there needs to be a very close working relationship between the supervising physician and these other groups and societies. As narcotic and opioid abuse has become a national crisis, we need to be working even more closely together so as not to exacerbate the problem.

Mr. WALDEN. Mr. Chairman, I yield back the balance of my time.

Mr. DUNN. Mr. Chair, buprenorphine was introduced in Finland in 1997, and now it has become the most widely-abused opioid in that country. Buprenorphine can kill people. It does kill people. And office-based practices involving merely prescribing buprenorphine run a large risk of harming patients, not helping them to recover.

In closing, I want to thank you for working with me on this amendment, and I thank Chairman WALDEN for his gracious commitment to continue to examine.

I yield back the balance of my time.

Mr. Chairman, I ask unanimous consent to withdraw my amendment.

The Acting CHAIR. Is there objection to the request of the gentleman from Florida?

There was no objection.

The Acting CHAIR. The amendment is withdrawn.

AMENDMENT NO. 3 OFFERED BY MR. BARTON

The Acting CHAIR. It is now in order to consider amendment No. 3 printed in part B of House Report 115–766.

Mr. BARTON. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

At the end of title III, insert the following new section:

SEC. 304. HIGH-QUALITY, EVIDENCE-BASED OPIOID ANALGESIC PRESCRIBING GUIDELINES AND REPORT.

(a) GUIDELINES.—The Commissioner of Food and Drugs shall develop high-quality, evidence-based opioid analgesic prescribing guidelines for the indication-specific treatment of acute pain in the relevant therapeutic areas where such guidelines do not exist.

(b) PUBLIC INPUT.—In developing the guidelines under subsection (a), the Commissioner of Food and Drugs shall—

(1) conduct a public workshop, open to representatives of State medical societies and medical boards, various medical specialties including pain medicine specialty societies, patient groups, pharmacists, universities, and others; and

(2) provide a period for the submission of comments by the public.

(c) REPORT.—Not later than the date that is 2 years after the date of enactment of this Act, the Commissioner of Food and Drugs shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate,

and post on the public website of the Food and Drug Administration, a report on how the guidelines under subsection (a) will be utilized to protect the public health.

(d) UPDATES.—The Commissioner of Food and Drugs shall periodically—

(1) update the guidelines under subsection (a), informed by public input described in subsection (b); and

(2) submit to the committees specified in subsection (c) and post on the public website of the Food and Drug Administration an updated report under subsection (c).

(e) STATEMENT TO ACCOMPANY GUIDELINES AND RECOMMENDATIONS.—The Commissioner of Food and Drugs shall ensure that any opioid analgesic prescribing guidelines and other recommendations developed under this section are accompanied by a clear statement that such guidelines or recommendations, as applicable—

(1) are intended to help inform clinical decisionmaking by prescribers and patients; and

(2) should not be used by other parties, including pharmacy benefit management companies, retail or community pharmacies, or public and private payors, for the purposes of restricting, limiting, delaying, or denying coverage for or access to a prescription issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice.

(f) DEFINITION.—In this section, the term ''evidence-based'' means informed by a robust and systemic review of treatment efficacy and clinical evidence.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Texas (Mr. BARTON) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Texas.

Mr. BARTON. Mr. Chairman, we have a great piece of legislation before us today. Chairman WALDEN and Ranking Member PALLONE have been great leaders in shepherding dozens of opioid-related bills through the Energy and Commerce Committee.

This particular bill, H.R. 6, is the crown jewel of all that legislation. We all know what a scourge the opioid epidemic is. Since 2015, more Americans have died annually from opioid overdoses than from the AIDS epidemic at its peak.

The amendment that is before us today is very simple. It requires the FDA, after consultation with all the stakeholders in open meetings and workshops, to develop some opioid prescription guidelines based on hard evidence.

This amendment gives the FDA 2 years to develop these guidelines. It requires the FDA to post the guidelines on their web page and to send the guidelines to the Energy and Commerce Committee in the House and to the Education and Workforce committee over in the Senate.

It is a bipartisan amendment. Congresswoman ANNIE KUSTER of New Hampshire and Congressman MARK MEADOWS of North Carolina have both worked with myself and other members of the committee to develop this amendment.

Opioids are a little bit different than some of the other drugs that are abused and lead to addiction in that most people are exposed to opioids the first time because of a prescription. They have some sort of acute pain that opioids can help manage and in prescribing these opioids the doctors are trying to help alleviate the pain. But everyone reacts to opioids somewhat differently, and sometimes what is acceptable in terms of the dosage for one individual is not acceptable with another individual.

These guidelines will, again, be based on facts, be based on evidence. They are advisory only. We are not trying to intervene in the doctor/patient relationship. It will still be up to the doctor to determine what is best for the patient. But at least the doctor will have some fact-based guidelines with which to make the decision on what level to prescribe these opioids if, in fact, opioids are necessary.

To quote the head of the FDA, Dr. Scott Gottlieb: ''Without evidence-based dosing recommendations at the point of care to support and inform rational prescribing, we're at serious risk of both undertreating some patients who could benefit from opioid therapy, and overtreating a lot of patients who are then placed at a higher risk of addiction.''

I will say that the amendment has drawn some concern, or at least interest, from the stakeholders, the chairman, the ranking member, myself and others are committed to working on this as it goes through the process. If we can fine-tune the amendment in some way, we are willing to at least consider that.

But as it is constructed today, Mr. Chairman, this is a good amendment, and I hope that the body will adopt it.

Mr. Chairman, I reserve the balance of my time.

Mr. PALLONE. Mr. Chairman, I would like to request time to speak in favor of the amendment.

The Acting CHAIR. Does anyone claim time in opposition?

Mr. WALDEN. I claim time in opposition, Mr. Chairman, although I am not opposed to the amendment, and I will yield to my friend from New Jersey in a second, but I do ask unanimous consent to claim the time in opposition.

The Acting CHAIR. Is there objection to the request of the gentleman from Oregon?

There was no objection.

The Acting CHAIR. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Chair, I rise in support of this amendment, and I want to thank Representatives BARTON and MEADOWS and KUSTER. They have really worked hard on this and it is a good amendment.

There is wide variation in the way acute, short-duration pain is treated with opioids, and there are concerns that patients may be over- or underprescribed opioid analgesics to treat that pain.

This amendment would direct the FDA Commissioner to develop high-quality, evidence-based opioid prescribing guidelines for the treatment of acute pain. By arming physicians with this type of information, we can give them more of the tools they need to treat patients' pain without overprescribing addictive medications.

The intent behind this policy is that evidence-based guidelines would add to the universe of available data in a way that would empower providers, patients, caregivers and others to make determinations about treatment in a more informed manner.

I understand that some stakeholders have raised some concerns about limitations on how these evidence-based guidelines can be used; so as we continue to work on these policies with our counterparts in the Senate, we are committed to working to ensure that the language accomplishes what the sponsors intend without having any unintended consequences.

I encourage my colleagues to support adoption of the amendment.

Mr. Chair, I yield to the gentleman from New Jersey (Mr. PALLONE) such time as he may consume.

Mr. PALLONE. Mr. Chairman, I rise in order to speak on the amendment offered by Representatives BARTON, MEADOWS and KUSTER.

FDA Commissioner Gottlieb testified before the Energy and Commerce Committee about the work the agency is doing currently to analyze and assess opioid analgesic use in situations of acute pain, such as following surgical procedures. The goal of this analysis is to provide evidence-based recommendations for appropriate opioid doses by indicators ensuring that prescribing more closely aligns with clinical need.

I believe this is a goal that we all support, which is why I support giving FDA the authority to conduct such work so as to inform policies that will better protect public health, and help to reduce the unneeded opioids from reaching individuals that are at risk for addiction.

Since this amendment has been filed, we have heard some concerns from stakeholders about the amendment possibly impeding the use of the FDA's evidence-based guidelines in making decisions related to dispensing or coverage of opioid prescriptions. I believe that such decisions should be informed by evidence-based guidelines such as those developed by the FDA, and I hope that we can work with the amendment's sponsors and the chairman to address these concerns moving forward.

Mr. WALDEN. Mr. Chairman, I have no further speakers on this matter. Again, I thank my friend, the former chairman of the full committee, Mr. BARTON, for his good leadership on this effort, along with other Members on both sides of the aisle.

I encourage our colleagues to support this amendment, and I yield back the balance of my time.

Mr. BARTON. Mr. Chairman, can I inquire how much time I still have.

The Acting CHAIR. The gentleman from Texas has 1 minute remaining.

Mr. BARTON. Mr. Chairman, I yield 1 minute to the gentlewoman from New Hampshire (Ms. KUSTER), who is an original cosponsor of the amendment and has worked very hard on it.

Ms. KUSTER of New Hampshire. Mr. Chairman, I rise in support of the Barton amendment. This amendment would require the FDA to create high-quality, evidence-based opioid prescribing guidelines for acute pain. These would complement prescribing guidelines for chronic pain created in 2015 by the Centers for Disease Control and Prevention.

Taken together, these guidelines would finally provide providers evidence-based recommendations on best practices for all types of pain.

While the opioid epidemic has many origins, it is universally agreed upon that the treatment of pain over the latter half of the 20th century is a significant contributing factor. In recent years, efforts by this Congress and the public to reconcile addiction and chronic pain has had a real and positive impact.

One of the most impacted communities are veterans, and in just the last few years, the VA has reported a remarkable decline in opioid prescriptions.

Yet, the focus until very recently has been on chronic pain. Acute pain impacts more people and is responsible for a massive share of opioid prescriptions. The country needs evidence-based guidance on treatment of acute pain.

FDA is armed with a trove of data on acute pain prescription rates and patterns. They are uniquely positioned to provide this needed guidance.

FDA Commissioner Scott Gottlieb told my colleagues on the Energy & Commerce Committee that this is something he wants to do and he underscored the importance of evidence-based opioid prescribing guidelines at the 2018 National Rx Drug Abuse & Heroin Summit.

While these guidelines are focused on the prescriber practices and patients, given the nature of pain management as team-based, we intend these recommendations to inform better practices by providers that have collaborative working relationships with prescribers.

I am committed to working with all stakeholders to improve this amendment as Congress continues to consider opioid legislation to ensure that these guidelines are considered consistent with law while still providing effective pain care for all Americans.

Mr. BARTON. Mr. Chair, I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Texas (Mr. BARTON).

The amendment was agreed to.

AMENDMENT NO. 4 OFFERED BY MR. CURTIS

The Acting CHAIR. It is now in order to consider amendment No. 4 printed in part B of House Report 115–766.

Mr. CURTIS. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Add at the end of title III the following:

SEC. 304. REPORT ON OPIOIDS PRESCRIBING PRACTICES FOR PREGNANT WOMEN.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in coordination with the Centers for Disease Control and Prevention, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration shall develop and submit to the Congress a report—

(1) on opioids prescribing practices for pregnant women and recommendations for such practices;

(2) that provides recommendations for identifying and reducing opioids misuse during pregnancy;

(3) on prescription opioid misuse during pregnancy in urban and rural areas;

(4) on prescription opioid use during pregnancy for the purpose of medication-assisted treatment in urban and rural areas;

(5) evaluating current utilization of non-opiate pain management practices in place of prescription opioids during pregnancy;

(6) providing guidelines encouraging the use of non-opioid pain management practices during pregnancy when safe and effective; and

(7) that provides recommendations for increasing public awareness and education of opioid use disorder in pregnancy, including available treatment resources in urban and rural areas.

(b) NO ADDITIONAL FUNDS.—No additional funds are authorized to be appropriated for purposes of carrying out subsection (a).

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Utah (Mr. CURTIS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Utah.

Mr. CURTIS. Mr. Chairman, I rise today to offer an amendment to improve research and public awareness of opioid use during pregnancy. I introduced the POPPY Study Act earlier this year to address this issue, and I am pleased that it is being considered here today in this form.

We all know the opioid epidemic has widespread and devastating effects. Nearly all of us know someone who has been affected by the crisis, and many of us have grieved through the heartbreak of losing loved ones to addiction.

Sadly, the impact this has had on Utah has been overwhelming. In my State, six Utahns die every week as a result of the opioid overdose, and we rank among the highest in the Nation for drug overdose deaths. Areas of my district have some of the highest rates of opioid prescriptions dispensed nationwide.

Tragically, Utah also leads out in prescribing the most opioids to pregnant women. Across the Nation, 1 in 5 women receive an opioid prescription during pregnancy but, in Utah, that number is doubled.

Of course, opioid use during pregnancy can have dramatic consequences for a mother and her unborn child. Neonatal abstinence syndrome presents itself as babies go through withdrawal, constant screaming, shaking, vomiting, and difficulty sleeping and eating.

□ 1100

This condition often requires long and expensive hospitalization. For Medicaid-covered babies, this syndrome costs more than $460 million in 2014 alone.

Tragically, from 2004 to 2014, the rate of infants diagnosed with opioid withdrawal symptoms increased more than 400 percent nationwide.

Across the Nation, women have been disproportionately impacted by the opioid epidemic, and little is known about the effect this has had on pregnant women.

Healthcare experts, providers, and patients agree there is simply too much we don't know about why pregnant women are being prescribed opioids and what possible alternatives might provide better healthcare outcomes for mothers and their unborn children.

My amendment calls for increased research on current opioid prescribing practices during pregnancy, more data on prescription opioid misuse during pregnancy, and evaluates and encourages nonopioid pain management therapies that are safe and effective during pregnancy.

I am proud of the work we have done here to curb the opioid epidemic, and I applaud the chairman, ranking member, and members of the committee for the work they have done to fight this crisis.

Mr. Chair, I encourage my colleagues to support this vital amendment as well as the underlying bill that will help us better serve our suffering communities, and I reserve the balance of my time.

Mr. WALDEN. Mr. Chair, although I am not opposed to the amendment, I ask unanimous consent to claim the time in opposition.

The Acting CHAIR. Is there objection to the request of the gentleman from Oregon?

There was no objection.

The Acting CHAIR. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Chairman, I rise to speak in support of the amendment and to thank my friend from Utah, Mr. CURTIS, for his hard work on this very thoughtful piece of legislation.

It is important that women who take opioid pain medications are aware of the possible risks during pregnancy. You heard him delineate those tragic, tragic risks, such as premature birth and neonatal abstinence syndrome, or NAS.

While there is increasing awareness and use of nonopioid approaches in the management of pain over all, information about their use in pregnant patients and unique considerations of mother and child are simply lacking.

So this amendment requires the Department of Health and Human Services to report on the opioid prescribing practices and opioid misuse during pregnancy, and evaluate nonopioid alternatives to pain management during pregnancy.

This will complement the efforts of the Protecting Our Infants Act, which required a report on prenatal opioid exposure and NAS, presenting a strategy and clinical recommendations for preventing and treating infants withdrawal.

I encourage my colleagues to support this amendment.

Mr. Chair, I yield such time as he may consume to the gentleman from Louisiana (Mr. SCALISE), a very important Member not only of the U.S. House of Representatives as our whip, but a very influential and effective member on our Energy and Commerce Committee.

Mr. SCALISE. Mr. Chairman, I thank the chairman for yielding me the time and for leading on this important issue.

Mr. Chairman, I rise in strong support of my friend from Utah's amendment. As he mentioned, Mr. Chairman, you look at this crisis in our country, and I am so glad that Congress is taking a wide array of actions to address the opioid crisis in our country, because it doesn't affect just one community or another. Everybody might think ''mine is the only problem,'' and then you talk to other Members of Congress from around the country, and you find out they are experiencing the same kind of crisis. And it is widespread. It is killing people every single day.

But as we are talking about on this amendment, Mr. Chairman, we are talking about children, children that are born to a mother that is addicted to opioids.

I highlight Kemper, a young boy from my district in Slidell, Louisiana. He was born addicted to opioids because his mother, while she was pregnant, was addicted to opioids herself.

Now, I wish that this was the only time that it had happened. Fortunately for all of us, Kemper is now a healthy young boy, but he spent his first 11 days of life in the hospital fighting to beat a drug addiction that was not created, of course, on his own.

We would like to think that this might be an isolated example, but, Mr. Chairman, this example highlights something the Centers for Disease Control has noted, and that is, once every 25 minutes in America, a baby is born addicted to opioids—one every 25 minutes. That is how widespread it is just for babies that are born.

When we talk about this entire package of bills, today, H.R. 6 is going to pull together 50 different bills covering many different parts of this problem. It is an incredibly bipartisan effort. I know, Mr. Chairman, so often we hear about the partisan wrangling in Congress. Clearly, there are divided lines on some high-profile issues, but this is an issue where Republicans and Democrats have come together.

I want to thank my friends from both sides of the aisle for recognizing this problem and coming together in a bipartisan way to solve it.

This is going to give real tools to our communities so that they can combat this at every different level we are seeing, including treatment, including law enforcement to stop these deadly drugs from getting on the streets so that more babies like Kemper are not born addicted to opioids.

Mr. Chairman, I encourage all my colleagues to support this amendment and the underlying package of bills.

Mr. WALDEN. Mr. Chairman, I urge passage, and I yield back the balance of my time.

Mr. CURTIS. Mr. Chairman, I thank the gentleman from Louisiana and the chairman for their speaking out in support of this important bill.

Mr. Chairman, this amendment is essential in helping us improve our understanding of the impact of using opioid prescription during pregnancy and, ultimately, preventing opioid use disorder entirely. It is vital that we have sound and accurate research to guide us in the best ways to help pregnant women suffering from addiction.

Mr. Chairman, this is a critical amendment. I urge my colleagues to support it, and I yield back the balance of my time.

The Acting CHAIR (Mr. WEBER of Texas). The question is on the amendment offered by the gentleman from Utah (Mr. CURTIS).

The amendment was agreed to.

AMENDMENT NO. 5 OFFERED BY MR. KEATING

The Acting CHAIR. It is now in order to consider amendment No. 5 printed in part B of House Report 115–766.

Mr. KEATING. Mr. Chair, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Add at the end of title III the following:

SEC. 304. GUIDELINES FOR PRESCRIBING NALOXONE.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidelines for prescribing an opioid overdose reversal drug.

(b) CONTENTS.—In issuing guidelines under subsection (a), the Secretary shall address the following:

(1) Co-prescribing an opioid overdose reversal drug in conjunction with any prescribed opioid.

(2) Dosage safety.

(3) Prescribing an opioid overdose reversal drug to an individual other than a patient.

(4) Standing orders.

(5) Other distribution, education, and safety measures as determined necessary.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Massachusetts (Mr. KEATING) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Massachusetts.

Mr. KEATING. Mr. Chairman, I rise in support of my amendment that directs the Department of the Health and Human Services to issue and expand guidelines for medical providers for prescribing naloxone to reflect a major shift that has occurred in the opioid health crisis that we continue to work to counter today.

Mr. Chairman, earlier this year, I sat in a room with my colleagues on the Bipartisan Heroin Task Force and listened to Dr. Francis Collins and the NIH leadership present data revealing how we have seen a shift in the opioid crisis.

For the first time, we learned that opioid overdoses from prescriptions of opioid drugs have dropped. That is good news.

The shocking news was that overdose rates for illicit opioids, heroin and fentanyl, had risen at an alarming rate.

If we are going to save lives of people overdosing from increasingly prevalent and increasingly unpredictable illicit compounds, we need to make sure naloxone gets in the right hands.

My amendment would provide necessary guidance to patients, providers, public health professionals, first responders, and loved ones on the ability to obtain effective doses of naloxone to combat overdoses of all types of opioids, prescriptions or otherwise.

It is so crucial that people dealing with this brain disease know how to use naloxone in an emergency and, importantly, understand that it is okay to have naloxone in the home.

I was proud that I and the gentleman from Pennsylvania (Mr. ROTHFUS), who also joins me as a cosponsor of this bipartisan amendment, were able to insert legislative language on prescribing guidelines into the Comprehensive Addiction and Recovery Act that passed Congress and became law last year. But giving HHS the option to issue guidelines didn't go far enough.

This amendment before us is firm in its requirement, and I believe my amendment will more explicitly and more expansively direct and yield necessary change.

Mr. Chairman, I conclude by reaffirming our commitment to ending this devastating epidemic that takes the lives of 115 people every day on average in our country.

I share this commitment with the Members of the House, and I pledge to work with you all to see this amendment's passage and to effect necessary change that reflects the ever-shifting landscape in this battle.

Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ROTHFUS), the cosponsor of this amendment.

Mr. ROTHFUS. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I rise to urge my colleagues to support this amendment to H.R. 6, and I want to thank my colleague, the gentleman from Massachusetts (Mr. KEATING), for his work on this effort. We have worked before on this issue of naloxone, and it is great that he is bringing forth this amendment. I am happy to be cosponsoring it with him.

The House has been doing amazing, wide-ranging work over the last 2 weeks to combat the opioid crisis, and

I am proud to have assisted with these efforts.

The amendment that I have cojoined with Congressman KEATING today is simple. It instructs the Secretary of Health and Human Services to give additional guidance to prescribing naloxone.

Naloxone is the drug used to reverse opioid overdoses, a situation that far too many Americans have found themselves in across the country and across western Pennsylvania.

Opioid addiction is tearing families apart. Unfortunately, an overdose is frequently the grim end to a long struggle.

If we can help some of our fellow Americans come back from the brink with increased knowledge for our Nation's medical professionals, I see no reason not to do it.

Mr. Chairman, I urge my colleagues to support this amendment. I again thank Congressman KEATING for his leadership on this.

Mr. WALDEN. Mr. Chairman, although I am not opposed to the amendment, I ask unanimous consent to claim time in opposition.

The Acting CHAIR. Is there objection to the request of the gentleman from Oregon?

There was no objection.

The Acting CHAIR. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Chairman, I rise to speak in support of the amendment that requires the Department of Health and Human Services to issue guidelines for prescribing an opioid overdose reversal drug.

The guidelines would cover dosage safety, standing orders and other education, and distribution measures.

In April, the Surgeon General issued an advisory calling for more people to carry naloxone.

Expanding the use of this lifesaving drug is a key part of the public health response to the opioid crisis, along with effective prevention, treatment, and recovery programs for substance use disorder.

I can just tell you, Mr. Chairman, from my own district, I have had multiple roundtables in every corner of the district. I have, of course, met with families that have been affected. I have met with addiction treatment specialists. I have met with medical providers. But I have also met with law enforcement.

In Oregon, we lead in a lot of this recovery effort, but also in making sure naloxone is available. This is the antidote.

Mr. Chair, these fentanyls that are coming into our country illegally, if I had a little salt shaker here and put out, I don't know, a half a dozen, a dozen grains of salt, and you put your hand on it, you would likely absorb that through your skin and pass out. And if somebody in this Chamber didn't have naloxone, or the medical people who are nearby didn't get to you in time, you would be one of those 115 people who will die in the next 24 hours, or one of the thousand that will show up in our emergency rooms.

So moving forward with guidelines for prescribing an opioid overdose reversal drug really makes sense. Moving forward with naloxone really makes sense.

We will save lives with this amendment, and I commend my colleagues from Massachusetts and Pennsylvania for their good work on this. We are happy to accept it as part of H.R. 6, and I yield back the balance of my time.

Mr. KEATING. Mr. Chairman, in Cape Cod, the islands, and South Shore and south coast of Massachusetts, the real cause of death in overdoses now is fentanyl. It is being mixed with cocaine. It is being mixed with marijuana. And this is very important.

This bipartisan amendment will save lives. I want to thank Chairman WALDEN. I want to thank Chairman BRADY. I want to thank my cosponsor Mr. ROTHFUS. I want to thank Ranking Member PALLONE and Ranking Member NEAL for their work on an amendment that will truly save lives.

Mr. WALDEN. Will the gentleman yield?

Mr. KEATING. Mr. Chairman, I yield to the gentleman from Oregon.

Mr. WALDEN. Mr. Chairman, because the gentleman raised the issue of these synthetics on other—we have talked a lot about fentanyl being cut into heroin over the course of this debate over 2 weeks.

We haven't talked as much about these synthetics being sprayed on marijuana or other things that you go: Oh, that is natural, mom. I can smoke that.

And what these evil people are doing is taking these deadly synthetics and literally creating a liquid or a spray and then spraying it.

And I talked to a father the other day whose daughter died of a heroin overdose, but when they did the autopsy, they discovered it was 100 percent fentanyl. So I thank the gentleman for his good work on this amendment.

Mr. KEATING. Mr. Chairman, I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Massachusetts (Mr. KEATING).

The amendment was agreed to.

The Acting CHAIR. It is now in order to consider amendment No. 6 printed in part B of House Report 115–766.

AMENDMENT NO. 7 OFFERED BY MS. MAXINE WATERS OF CALIFORNIA

The Acting CHAIR. It is now in order to consider amendment No. 7 printed in part B of House Report 115–766.

Ms. MAXINE WATERS of California. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Add at the end of title III the following new section:

SEC. _____. REQUIRING A SURVEY OF SUBSTANCE USE DISORDER TREATMENT PROVIDERS RECEIVING FEDERAL FUNDING.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a survey of all entities that receive Federal funding for the purpose of providing substance use disorder treatment services. The survey shall direct such entities to provide the following information:

(1) The length of time the entity has provided substance use disorder treatment servvices.

(2) A detailed description of the patient population served by the entity, including but not limited to the number of patients, type of addictions, geographic area served, as well as gender, racial, ethnic and socioeconomic demographics of such patients.

(3) A detailed description of the types of addiction for which the entity has the experience, capability, and capacity to provide such services.

(4) An explanation of how the entity handles patients requiring treatment for a substance use disorder that the organization is not able to treat.

(5) A description of what is needed, in the opinion of the entity, in order to improve the entity's ability to meet the addiction treatment needs of the communities served by that entity.

(6) Based on the identified needs of the communities served, a description of unmet needs and inadequate services and how such needs and services could be better addressed through additional Federal, State, or local government resources or funding to treat addiction to methamphetamine, crack cocaine, other types of cocaine, heroin, opioids, and other commonly abused drugs.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a plan to direct appropriate resources to entities that provide substance use disorder treatment services in order to address inadequacies in services or funding identified through the survey described in subsection (a).

The Acting CHAIR. Pursuant to House Resolution 949, the gentlewoman from California (Ms. MAXINE WATERS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from California.

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Ms. MAXINE WATERS of California. Mr. Chairman, first I would like to say that I appreciate the bipartisan work of the bill's sponsor, Chairman GREG WALDEN, and, of course, Chairman KEVIN BRADY and our cosponsor FRANK PALLONE and cosponsor RICHARD NEAL on this bill, H.R. 6, the SUPPORT for Patients and Communities Act.

The bill, as drafted, includes many positive provisions and extends well-intended legislative efforts to address the opioid crisis in this country. That said, as we all know, in the United States, people suffer from a wide range of substance use disorders, including alcoholism and the abuse of illegal drugs like heroin, methamphetamine, crack, and other forms of cocaine. Likewise, there are a range of entities that provide different types of substance abuse treatment services.

The purpose of my amendment is to ensure that we have a clear understanding of the substance abuse treatment services available, the communities and the populations that are being served, the types of substance use disorders being addressed, and any other unmet needs or inadequacies in the way we are addressing substance abuse issues.

My amendment would direct that the Department of Health and Human Services conduct a nationwide survey of entities that provide substance use disorder treatment services. Based on the results of that survey, my amendment directs HHS to develop and submit to Congress a plan to direct appropriate resources in order to address inadequacies in services or funding identified through the survey.

The survey called for by my amendment is intended to complement existing efforts by the Substance Abuse and Mental Health Services Administration, SAMHSA, to examine substance use treatment services in order to develop a concrete plan to address unmet needs.

Mr. Chairman, let me just say that I appreciate the information that was shared by the majority whip, Mr. SCALISE, when he talked about the baby who was born addicted, and we are going to have a lot of that.

I have one regret, having worked on the issue of crack cocaine, that we did not do something to do the research that was necessary on these babies that are born addicted, to find out what happens to them later on in life and whether or not these children are handicapped and disabled in some ways, have learning disabilities, and on and on and on. So I would like to work with Mr. SCALISE to do the follow-up for the research that is so necessary.

Mr. Chair, I reserve the balance of my time.

Mr. WALDEN. Mr. Chairman, although I am not opposed to the amendment, I ask unanimous consent to claim the time in opposition.

The Acting CHAIR. Is there objection to the request of the gentleman from Oregon?

There was no objection.

The Acting CHAIR. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Chair, I rise to speak in support of this amendment and to thank my friend, Ms. WATERS, for her work on this initiative.

Before I go through that, I just want to say we are more than happy to team up with the gentlewoman on this issue of crack cocaine and its effects, and I am sure that Mr. SCALISE, although I can't officially speak for him, I am sure that he would work in partnership with the gentlewoman.

The gentlewoman has raised an issue that we have dealt with in other parts of this legislation but not in the part that the gentlewoman has brought to us. There will be more going forward, I assure you, and we would be happy to work with the gentlewoman on that.

Mr. RUSH brought an amendment on the IMD issue to make sure that those suffering from cocaine and crack cocaine addiction also could get treatment under expansion in the IMD, so we would be happy to work with the gentlewoman on that.

This amendment directs the Secretary of Health and Human Services to conduct a survey of organizations that provide substance abuse treatment services and then develop a plan to direct resources to address any identified gaps in services for specific types of substance use disorders. This information will help us better understand how our Federal dollars are invested in interdiction treatment at the local level and what more can be done with Federal resources to yield even better returns in reducing drug-related crimes, accidents, overdoses, and deaths.

So I certainly appreciate the gentlewoman's work on this effort. It is important work that will help save lives and bring about the kind of treatment we need in our communities.

I encourage adoption of the amendment, and I yield back the balance of my time.

Ms. MAXINE WATERS of California. Mr. Chairman, I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentlewoman from California (Ms. MAXINE WATERS).

The amendment was agreed to.

The Acting CHAIR (Mrs. WALORSKI). The Chair understands that amendment No. 8 will not be offered.

There being no further amendments, under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. WEBER of Texas) having assumed the chair, Mrs. WALORSKI, Acting Chair of the Committee of the Whole House on the state of the Union, reported that that Committee, having had under consideration the bill (H.R. 6) to provide for opioid use disorder prevention, recovery, and treatment, and for other purposes, and, pursuant to House Resolution 949, she reported the bill, as amended by that resolution, back to the House with sundry further amendments adopted in the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any further amendment reported from the Committee of the Whole? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. TONKO. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. TONKO. I am opposed in its current form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Tonko moves to recommit the bill H.R. 6 to the Committee on Energy and Commerce and the Committee on Ways and Means with instructions to report the same back to the House forthwith with the following amendment:

Page 84, after line 14, insert the following:

SEC. 208. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS TO HELP COMBAT OPIOID CRISIS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraphs (7) and (8)'' and inserting ''paragraphs (7), (8), and (9)'';

(2) in paragraph (4)(H)(i), by striking ''paragraphs (7) and (8)'' and inserting ''paragraphs (7), (8), and (9)'';

(3) in paragraph (7)(E), by inserting ''paragraph (9),'' after ''paragraph (8),''; and

(4) by adding at the end the following new paragraph:

''(9) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS TO HELP COMBAT OPIOID CRISIS.—

''(A) ADDITIONAL RESIDENCY POSITIONS.—For each of fiscal years 2021 through 2025 (and succeeding fiscal years if the Secretary determines that there are additional residency positions available to distribute under subparagraph (D)), the Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1 of the fiscal year of the increase. Except as provided in subparagraph (B)(iv) or (D), the aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to 500 over the period of fiscal years 2021 through 2025, distributed in accordance with the succeeding subparagraphs of this paragraph.

''(B) DISTRIBUTION FOR FISCAL YEAR 2021.—

''(i) IN GENERAL.—For fiscal year 2021, the positions available for distribution with respect to the fiscal year as described in subparagraph (A) shall be distributed to hospitals that have existing established approved programs in addiction medicine, addiction psychiatry, or pain medicine as determined by the Secretary. The Secretary shall establish standards and a process for ensuring additional residency positions under this subparagraph are used to increase the number of residents studying in the fields specified in the previous sentence.

''(ii) NUMBER OF POSITIONS HOSPITAL ELIGIBLE TO RECEIVE.—Subject to clauses (iii) and (iv), the aggregate number of positions a hospital may receive under this subparagraph with respect to fiscal year 2021 is equal to the sum of the following:

''(I) The number of full-time-equivalent residents that will be training in addiction medicine, addiction psychiatry, or pain medicine as determined by the Secretary with respect to the fiscal year.

''(II) The associated number, as defined by the Secretary, of residents training in a prerequisite program, such as internal medicine, necessary for the number of full-time residents for the programs described in subclause (I).

''(iii) ADDITIONAL POSITIONS FOR EXPANSION OF EXISTING PROGRAM.—If a hospital demonstrates to the Secretary that the hospital is planning to increase the number of full-

time-equivalent residents in existing programs described in clause (i), the Secretary may increase the number of positions a hospital is eligible to receive under clause (ii) in order to accommodate that expansion, as determined by the Secretary.

''(iv) CONSIDERATIONS IN DISTRIBUTION.—The Secretary shall distribute additional residency positions under this subparagraph based on—

''(I) in the case of positions made available under clause (ii), the demonstrated likelihood, as defined by the Secretary, of the hospital filling such positions by July 1, 2021; and

''(II) in the case of positions made available under clause (iii), the demonstrated likelihood, as so defined, of the hospital filling such positions within the first three cost reporting periods beginning on or after July 1, 2021.

''(v) LIMITATION.—Notwithstanding clauses (ii) and (iv), an individual hospital may not receive more than 25 full-time-equivalent residency positions under this paragraph.

''(vi) POSITIONS NOT DISTRIBUTED DURING THE FISCAL YEAR.—If the number of resident full-time-equivalent positions distributed under this subparagraph is less than the aggregate number of positions available for distribution in the fiscal year (as described in subparagraph (A)), the difference between such number distributed and such number available for distribution shall be added to the aggregate number of positions available for distribution under subparagraph (C).

''(C) DISTRIBUTION FOR FISCAL YEARS 2022 THROUGH 2025.—

''(i) IN GENERAL.—For the period of fiscal years 2022 through 2025, the positions available for distribution with respect to such period (as described in subparagraph (A), including after application of subparagraph (B)(vi)) shall be distributed to hospitals which demonstrate to the Secretary that the hospital—

''(I) will establish an approved program in addiction medicine, addiction psychiatry, or pain medicine; and

''(II) will use all of the additional positions made available under this subparagraph in such program or a prerequisite residency program for such program within the first four cost reporting periods after the increase would be effective.

''(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 10-year period beginning after the date of such increase, that the hospital uses the positions received under clauses (i)(I) and (i)(II) for the programs for which the positions were distributed, or similar programs (as determined by the Secretary). The Secretary may determine whether a hospital has met the requirements under this clause during such 10-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 10-year period.

''(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet the requirements of such clause, the Secretary shall—

''(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this subparagraph; and

''(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

''(D) DISTRIBUTION OF REMAINING POSITIONS.—If the aggregate number of positions distributed under subparagraphs (B) and (C) during the period of fiscal years 2021 through 2025 is less than 500, the Secretary shall distribute the remaining residency positions in succeeding fiscal years according to criteria consistent with this paragraph until such time as the aggregate amount of positions distributed under this paragraph is equal to 500.

''(E) NOTIFICATION.—The Secretary shall notify hospitals of the number of positions distributed to the hospital under this paragraph as a result on an increase in the otherwise applicable resident limit by January 1 of the fiscal year of the increase. Such increase shall be effective for portions of cost reporting periods beginning on or after July 1 of that fiscal year.

''(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(G) PERMITTING FACILITIES TO APPLY AGGREGATION RULES.—The Secretary shall permit hospitals receiving additional residency positions attributable to the increase provided under this paragraph to, beginning in the fifth year after the effective date of such increase, apply such positions to the limitation amount under paragraph (4)(F) that may be aggregated pursuant to paragraph (4)(H) among members of the same affiliated group.

''(H) DEFINITIONS.—In this paragraph:

''(i) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraphs (7)(A), (7)(B), (8)(A), and (8)(B).

''(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the third sentence, is amended by striking ''and (h)(8)'' and inserting ''(h)(8), and (h)(9)''.

(2) CONFORMING PROVISION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) by redesignating clause (x), as added by section 5505(b) of the Patient Protection and Affordable Care Act (Public Law 111–148), as clause (xi) and moving such clause 4 ems to the left; and

(B) by adding after clause (xi), as redesignated by subparagraph (A), the following new clause:

''(xii) For discharges occurring on or after July 1, 2021, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(9), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

Page 95, after line 21, insert the following:

SEC. 304. ACTIONS FOR DELAYS OF GENERIC DRUGS AND BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) DEFINITIONS.—In this section—

(1) the term ''commercially reasonable, market-based terms'' means—

(A) a non-discriminatory price for the sale of the covered product at or below, but not greater than, the most recent wholesale acquisition cost for the drug, as defined in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B));

(B) a schedule for delivery that results in the transfer of the covered product to the eligible product developer consistent with the timing under subsection (b)(2)(A)(iv); and

(C) no additional conditions are imposed on the sale of the covered product;

(2) the term ''covered product''—

(A) means—

(i) any drug approved under subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or biological product licensed under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262);

(ii) any combination of a drug or biological product described in clause (i); or

(iii) when reasonably necessary to support approval of an application under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), or section 351 of the Public Health Service Act (42 U.S.C. 262), as applicable, or otherwise meet the requirements for approval under either such section, any product, including any device, that is marketed or intended for use with such a drug or biological product; and

(B) does not include any drug or biological product that the Secretary has determined to be currently in shortage and that appears on the drug shortage list in effect under section 506E of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356e), unless the shortage will not be promptly resolved—

(i) as demonstrated by the fact that the drug or biological product has been in shortage for more than 6 months; or

(ii) as otherwise determined by the Secretary;

(3) the term ''device'' has the meaning given the term in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321);

(4) the term ''eligible product developer'' means a person that seeks to develop a product for approval pursuant to an application for approval under subsection (b)(2) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or for licensing pursuant to an application under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k));

(5) the term ''license holder'' means the holder of an application approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or the holder of a license under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262) for a covered product;

(6) the term ''REMS'' means a risk evaluation and mitigation strategy under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1);

(7) the term ''REMS with ETASU'' means a REMS that contains elements to assure safe use under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1);

(8) the term ''Secretary'' means the Secretary of Health and Human Services;

(9) the term ''single, shared system of elements to assure safe use'' means a single, shared system of elements to assure safe use under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1); and

(10) the term ''sufficient quantities'' means an amount of a covered product that allows the eligible product developer to—

(A) conduct testing to support an application—

(i) for approval under subsection (b)(2) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); or

(ii) for licensing under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)); and

(B) fulfill any regulatory requirements relating to such an application for approval or licensing.

(b) CIVIL ACTION FOR FAILURE TO PROVIDE SUFFICIENT QUANTITIES OF A COVERED PRODUCT.—

(1) IN GENERAL.—An eligible product developer may bring a civil action against the license holder for a covered product seeking relief under this subsection in an appropriate district court of the United States alleging that the license holder has declined to provide sufficient quantities of the covered product to the eligible product developer on commercially reasonable, market-based terms.

(2) ELEMENTS.—

(A) IN GENERAL.—To prevail in a civil action brought under paragraph (1), an eligible product developer shall prove, by a preponderance of the evidence—

(i) that—

(I) the covered product is not subject to a REMS with ETASU; or

(II) if the covered product is subject to a REMS with ETASU—

(aa) the eligible product developer has obtained a covered product authorization from the Secretary in accordance with subparagraph (B); and

(bb) the eligible product developer has provided a copy of the covered product authorization to the license holder;

(ii) that, as of the date on which the civil action is filed, the product developer has not obtained sufficient quantities of the covered product on commercially reasonable, market-based terms;

(iii) that the eligible product developer has requested to purchase sufficient quantities of the covered product from the license holder; and

(iv) that the license holder has not delivered to the eligible product developer sufficient quantities of the covered product on commercially reasonable, market-based terms—

(I) for a covered product that is not subject to a REMS with ETASU, by the date that is 31 days after the date on which the license holder received the request for the covered product; and

(II) for a covered product that is subject to a REMS with ETASU, by 31 days after the later of—

(aa) the date on which the license holder received the request for the covered product; or

(bb) the date on which the license holder received a copy of the covered product authorization issued by the Secretary in accordance with subparagraph (B).

(B) AUTHORIZATION FOR COVERED PRODUCT SUBJECT TO A REMS WITH ETASU.—

(i) REQUEST.—An eligible product developer may submit to the Secretary a written request for the eligible product developer to be authorized to obtain sufficient quantities of an individual covered product subject to a REMS with ETASU.

(ii) AUTHORIZATION.—Not later than 120 days after the date on which a request under clause (i) is received, the Secretary shall, by written notice, authorize the eligible product developer to obtain sufficient quantities of an individual covered product subject to a REMS with ETASU for purposes of—

(I) development and testing that does not involve human clinical trials, if the eligible product developer has agreed to comply with any conditions the Secretary determines necessary; or

(II) development and testing that involves human clinical trials, if the eligible product developer has—

(aa)(AA) submitted protocols, informed consent documents, and informational materials for testing that include protections that provide safety protections comparable to those provided by the REMS for the covered product; or

(BB) otherwise satisfied the Secretary that such protections will be provided; and

(bb) met any other requirements the Secretary may establish.

(iii) NOTICE.—A covered product authorization issued under this subparagraph shall state that the provision of the covered product by the license holder under the terms of the authorization will not be a violation of the REMS for the covered product.

(3) AFFIRMATIVE DEFENSE.—In a civil action brought under paragraph (1), it shall be an affirmative defense, on which the defendant has the burden of persuasion by a preponderance of the evidence—

(A) that, on the date on which the eligible product developer requested to purchase sufficient quantities of the covered product from the license holder—

(i) neither the license holder nor any of its agents, wholesalers, or distributors was engaged in the manufacturing or commercial marketing of the covered product; and

(ii) neither the license holder nor any of its agents, wholesalers, or distributors otherwise had access to inventory of the covered product to supply to the eligible product developer on commercially reasonable, market-based terms; or

(B) that—

(i) the license holder sells the covered product through agents, distributors, or wholesalers;

(ii) the license holder has placed no restrictions, explicit or implicit, on its agents, distributors, or wholesalers to sell covered products to eligible product developers; and

(iii) the covered product can be purchased by the eligible product developer in sufficient quantities on commercially reasonable, market-based terms from the agents, distributors, or wholesalers of the license holder.

(4) REMEDIES.—

(A) IN GENERAL.—If an eligible product developer prevails in a civil action brought under paragraph (1), the court shall—

(i) order the license holder to provide to the eligible product developer without delay sufficient quantities of the covered product on commercially reasonable, market-based terms;

(ii) award to the eligible product developer reasonable attorney fees and costs of the civil action; and

(iii) award to the eligible product developer a monetary amount sufficient to deter the license holder from failing to provide other eligible product developers with sufficient quantities of a covered product on commercially reasonable, market-based terms, if the court finds, by a preponderance of the evidence—

(I) that the license holder delayed providing sufficient quantities of the covered product to the eligible product developer without a legitimate business justification; or

(II) that the license holder failed to comply with an order issued under clause (i).

(B) MAXIMUM MONETARY AMOUNT.—A monetary amount awarded under subparagraph (A)(iii) shall not be greater than the revenue that the license holder earned on the covered product during the period—

(i) beginning on—

(I) for a covered product that is not subject to a REMS with ETASU, the date that is 31 days after the date on which the license holder received the request; or

(II) for a covered product that is subject to a REMS with ETASU, the date that is 31 days after the later of—

(aa) the date on which the license holder received the request; or

(bb) the date on which the license holder received a copy of the covered product authorization issued by the Secretary in accordance with paragraph (2)(B); and

(ii) ending on the date on which the eligible product developer received sufficient quantities of the covered product.

(C) AVOIDANCE OF DELAY.—The court may issue an order under subparagraph (A)(i) before conducting further proceedings that may be necessary to determine whether the eligible product developer is entitled to an award under clause (ii) or (iii) of subparagraph (A), or the amount of any such award.

(c) LIMITATION OF LIABILITY.—A license holder for a covered product shall not be liable for any claim under Federal, State, or local law arising out of the failure of an eligible product developer to follow adequate safeguards to assure safe use of the covered product during development or testing activities described in this section, including transportation, handling, use, or disposal of the covered product by the eligible product developer.

(d) NO VIOLATION OF REMS.—The provision of samples of a drug pursuant to an authorization under subsection (b)(2)(B) shall not be considered a violation of the requirements of any risk evaluation and mitigation strategy that may be in place under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1) for such drug.

(e) RULE OF CONSTRUCTION.—

(1) DEFINITION.—In this subsection, the term ''antitrust laws''—

(A) has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12); and

(B) includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section applies to unfair methods of competition.

(2) ANTITRUST LAWS.—Nothing in this section shall be construed to limit the operation of any provision of the antitrust laws.

SEC. 305. REMS APPROVAL PROCESS FOR SUBSEQUENT FILERS.

Section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1) is amended—

(1) in subsection (g)(4)(B)—

(A) in clause (i) by striking ''or'' after the semicolon;

(B) in clause (ii) by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) accommodate different, comparable approved risk evaluation and mitigation strategies for a drug that is the subject of an abbreviated new drug application, and its reference drug product.'';

(2) in subsection (i)(1), by striking subparagraph (B) and inserting the following:

''(B) Elements to assure safe use, if required under subsection (f) for the listed drug.

''(i) Subject to clause (ii), a drug that is the subject of an abbreviated new drug application may use—

''(I) a single, shared system with the listed drug under subsection (f); or

''(II) a different, comparable aspect of the elements to assure safe use under subsection (f).

''(ii) The Secretary may require a drug that is the subject of an abbreviated new drug application and the listed drug to use a single, shared system under subsection (f), if the Secretary determines that no different, comparable aspect of the elements to assure safe use could satisfy the requirements of subsection (f).''; and

(3) by adding at the end the following:

''(l) SEPARATE REMS.—When used in this section, the terms ''different, comparable aspect of the elements to assure safe use'' or ''different, comparable approved risk evaluation and mitigation strategies'' means a risk

evaluation and mitigation strategy for a drug that is the subject of an application under section 505(j) that uses different methods or operational means than the strategy required under subsection (a) for the applicable reference drug, or other application under section 505(j) with the same such reference listed drug, but achieves the same level of safety as such strategy.''.

SEC. 306. FUNDING FOR OPIOID GRANT PROGRAM FOR STATE RESPONSE TO OPIOID ABUSE CRISIS.

Section 1003(c) of the 21st Century Cures Act (42 U.S.C. 290ee–3 note) is amended by adding at the end the following new paragraph:

''(3) For purposes of carrying out this subsection, there is appropriated, out of any funds in the Treasury not otherwise appropriated, $995,000,000 for each of fiscal years 2019 through 2021.''.

Page 98, strike line 20 and all that follows through page 99, line 9.

Mr. TONKO (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

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

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York is recognized for 5 minutes in support of his motion.

Mr. TONKO. Mr. Speaker, this is the final amendment to the bill, which will not kill the bill or send it back to committee. If adopted, the bill will immediately proceed to final passage, as amended.

For more than a year and a half, Republicans in the House have been engaged in an all-out ideological assault to weaken healthcare for Americans by working to repeal the Affordable Care Act and gutting protections for preexisting conditions. Republicans have repeatedly voted to strip Medicaid coverage for millions struggling with addiction. Thanks to Republican policies, we are seeing this uninsured rate rise sharply for the first time in years.

This attack on our healthcare has had serious consequences for our ability to adequately address the needs of those struggling with the opioid epidemic. I remind my friends that we can't have it both ways: We either are for fighting this epidemic every way we can, or we are not.

I have seen the carnage this epidemic can produce in my own backyard, where my hometown of Amsterdam, New York, with a population of a little over 18,000 people, saw four overdose deaths and a dozen close calls within a single month.

We know that, as of today, less than 20 percent of Americans who need substance abuse treatment are able to receive it. We need to move toward a system of treatment on demand so that, when an individual has that moment of clarity, we are ready with a helping hand to pull them away from the deadly grip of addiction.

While I am pleased that the bill before us will make some incremental progress in our fight against the opioid epidemic and is the product of a significant amount of bipartisan work, every single Member of this Chamber knows that we can and we should be doing more. This motion to recommit is our chance to do just that and to make additional progress in this fight.

First, the motion would invest in our addiction workforce by incorporating a proposal advanced by Representatives CROWLEY and COSTELLO to add 500 new resident physician slots to hospitals that have developed or are developing training programs in addiction medicine, addiction psychiatry, or pain medicine. We all have seen firsthand the need for more addiction specialists out there, and we have a chance to take action on that right now.

Secondly, this motion would allot an additional $1 billion annually to States through 2021 so that we can continue to invest in locally designed prevention, treatment, and recovery solutions. It is clearly going to take more than 2 years to battle the epidemic, and we need to let providers in States know that we are making sustained, meaningful investments in this area.

Finally, our motion to recommit includes a commonsense prescription drug policy which will reduce prescription drug prices for all Americans by reducing gaming by drug manufacturers to prevent generics from coming to market.

The CREATES Act, introduced by Representatives MARINO and CICILLINE, is estimated to save the Federal Government some $3.8 billion and patients far more. This legislation has been passed by the Senate Judiciary Committee on a bipartisan basis, but we have been denied a vote on the House floor to consider this practical, positive policy to halt pharma gaming and mischief.

Each of the policies contained in this package is bipartisan, fully paid for, and would bolster our ability to respond to the crisis. We have the opportunity to provide a more robust response for the American people and to save the lives of countless of our friends and neighbors all across this country who could be the next to fall victim to this deadly disease of addiction.

Every day, every week, every month, every year that passes, the challenge rests in our collective laps: Will we do more?

We need to do more. Let's do it for those families living with the pain and loss. Let's do it for those individuals who struggle with the illness of addiction. Let's be the light, the candle that brightens their darkness. Let's go forward with the recovery that is inspired by this legislation.

Mr. Speaker, I urge all of my colleagues on both sides of the aisle to support this motion to recommit, and I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, I claim the time in opposition to the motion.

The SPEAKER pro tempore. The gentleman from Oregon is recognized for 5 minutes.

Mr. WALDEN. Mr. Speaker, like a lot of our work here that has been bipartisan, we would hope, going forward, this, too, could become bipartisan, because we believe that getting prescription drug prices down is essential. The Trump administration believes that as well and is doing some things administratively. We are going to be working on this in the committee.

We also agree that this unmet workforce need is important as well. Over the course of five hearings, a full markup in subcommittee, two full markups in the full committee, this issue was never fully brought and vetted. There is more work to be done here, and we are committed to doing work on both the CREATES Act and on the Opioid Workforce Act.

As the gentleman from New York, my friend, knows, we have worked out our differences on many, many issues on this and other topics, and we intend to move forward. It is just that the agreement we have today, Mr. Speaker, is about all of us coming together with bills that were ready for prime time that would not somehow cause problems with the underlying document.

This proposal, while well-intended and, frankly, on the big scope of things makes a lot of sense, it is just not ready and agreed to yet. The gentleman knows that. We know that. We appreciate his passion on this issue. We share it. But I have to reluctantly oppose the motion to recommit because we have agreement that only issues we all agree on are going into this bill—that is, Republicans and Democrats at the top of both committees.

So I take the signal that he remains committed to this effort to fill the gap. We will work with him and others going forward because we have a lot more work to do, Mr. Speaker. This one is just not ready for prime time.

Mr. Speaker, I urge opposition to the motion to recommit, and I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. TONKO. Mr. Speaker, on that, I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of the bill, if ordered, and agreeing to the Speaker's approval of the Journal, if ordered.

The vote was taken by electronic device, and there were—yeas 185, nays 226, not voting 16, as follows:

[Roll No. 287]

YEAS—185

Adams	Barragán	Beatty
Aguilar	Bass	Bera

Beyer
Bishop (GA)
Blum
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Cooper
Correa
Costa
Courtney
Crist
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Engel
Eshoo
Espaillat
Esty (CT)
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gomez
Gonzalez (TX)
Gottheimer
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Lamb
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lieu, Ted
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Moore
Moulton
Murphy (FL)
Nadler
Napolitano
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Tonko
Torres
Tsongas
Vargas
Vela
Velázquez
Visclosky
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NAYS—226

Abraham
Aderholt
Allen
Amash
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bergman
Biggs
Bilirakis
Bishop (MI)
Bishop (UT)
Blackburn
Bost
Brady (TX)
Brat
Brooks (AL)
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Cheney
Coffman
Cole
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Curtis
Davidson
Davis, Rodney
Denham
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Estes (KS)
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Frelinghuysen
Gaetz
Gallagher
Garrett
Gianforte
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Handel
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lesko
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marino
Marshall
Massie
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Newhouse
Norman
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rooney, Francis
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOT VOTING—16

Black
Collins (GA)
Crowley
Delaney
Ellison
Hanabusa
Marchant
Meng
Noem
Payne
Reed
Rokita
Rooney, Thomas J.
Titus
Veasey
Walz

□ 1152

Messrs. DAVIDSON, RUTHERFORD, ROYCE of California, YOUNG of Iowa, BISHOP of Michigan, McHENRY, BISHOP of Utah, HOLLINGSWORTH, and COLE changed their vote from ''yea'' to ''nay.''

Ms. SÁNCHEZ changed her vote from ''nay'' to ''yea.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. WALDEN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 396, nays 14, not voting 17, as follows:

[Roll No. 288]

YEAS—396

Abraham
Adams
Aderholt
Aguilar
Allen
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barragán
Barton
Bass
Beatty
Bera
Bergman
Beyer
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Blackburn
Blum
Blumenauer
Blunt Rochester
Bonamici
Bost
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brat
Brooks (IN)
Brown (MD)
Brownley (CA)
Buchanan
Buck
Bucshon
Budd
Burgess
Bustos
Butterfield
Byrne
Calvert
Capuano
Carbajal
Cárdenas
Carson (IN)
Carter (GA)
Carter (TX)
Cartwright
Castor (FL)
Castro (TX)
Chabot
Cheney
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (NY)
Comer
Comstock
Conaway
Connolly
Cook
Cooper
Correa
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crist
Cuellar
Culberson
Cummings
Curbelo (FL)
Curtis
Davidson
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
DeLauro
DelBene
Demings
Denham
DeSantis
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Donovan
Doyle, Michael F.
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Engel
Eshoo
Espaillat
Estes (KS)
Esty (CT)
Evans
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foster
Foxx
Frankel (FL)
Frelinghuysen
Fudge
Gabbard
Gallagher
Gallego
Garamendi
Gianforte
Gibbs
Gomez
Goodlatte
Gottheimer
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Green, Al
Green, Gene
Griffith
Grijalva
Grothman
Guthrie
Gutiérrez
Handel
Harper
Harris
Hartzler
Hastings
Heck
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Higgins (NY)
Hill
Himes
Holding
Hollingsworth
Hoyer
Hudson
Huffman
Huizenga
Hultgren
Hunter
Hurd
Issa
Jackson Lee
Jayapal
Jeffries
Jenkins (KS)
Jenkins (WV)
Johnson (GA)
Johnson (LA)
Johnson (OH)
Johnson, E. B.
Johnson, Sam
Jordan
Joyce (OH)
Kaptur
Katko
Keating
Kelly (IL)
Kelly (MS)
Kelly (PA)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
King (IA)
King (NY)
Kinzinger
Knight
Krishnamoorthi
Kuster (NH)
Kustoff (TN)
LaHood
LaMalfa
Lamb
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latta
Lawrence
Lawson (FL)
Lee
Lesko
Levin
Lewis (GA)
Lewis (MN)
Lieu, Ted
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham, M.
Luján, Ben Ray
Lynch
MacArthur
Maloney, Carolyn B.
Maloney, Sean
Marino
Marshall
Mast
Matsui
McCarthy
McCaul
McCollum
McEachin
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meadows
Meeks
Messer
Mitchell
Moolenaar
Mooney (WV)
Moore
Moulton
Mullin
Murphy (FL)
Nadler
Napolitano
Neal
Newhouse
Nolan
Norcross
Norman
Nunes
O'Halleran
Olson
Palazzo
Pallone
Palmer
Panetta
Pascrell
Paulsen
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pocan
Poe (TX)
Poliquin
Polis
Posey
Price (NC)
Quigley
Raskin
Ratcliffe
Reichert
Renacci
Rice (NY)
Rice (SC)
Richmond
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rooney, Francis
Ros-Lehtinen
Rosen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce (CA)
Ruiz
Ruppersberger
Rush
Russell
Rutherford
Ryan (OH)
Sánchez
Sarbanes
Scalise
Schakowsky
Schiff
Schneider
Schrader
Schweikert
Scott (VA)
Scott, Austin
Scott, David
Sensenbrenner

Serrano	Takano	Walorski
Sessions	Taylor	Walters, Mimi
Sewell (AL)	Tenney	Wasserman Schultz
Shea-Porter	Thompson (CA)	Waters, Maxine
Sherman	Thompson (MS)	Watson Coleman
Shimkus	Thompson (PA)	Weber (TX)
Shuster	Thornberry	Webster (FL)
Simpson	Tipton	Welch
Sinema	Tonko	Wenstrup
Sires	Torres	Westerman
Smith (MO)	Trott	Williams
Smith (NE)	Tsongas	Wilson (FL)
Smith (NJ)	Turner	Wilson (SC)
Smith (TX)	Upton	Wittman
Smith (WA)	Valadao	Womack
Smucker	Vargas	Woodall
Soto	Vela	Yarmuth
Speier	Velázquez	Yoder
Stefanik	Visclosky	Yoho
Stewart	Wagner	Young (AK)
Stivers	Walberg	Young (IA)
Suozzi	Walden	Zeldin
Swalwell (CA)	Walker	

NAYS—14

Amash	Gohmert	Loudermilk
Biggs	Gonzalez (TX)	Massie
Brooks (AL)	Gosar	McClintock
Gaetz	Jones	Sanford
Garrett	Labrador	

NOT VOTING—17

Black	Marchant	Rokita
Collins (GA)	Meng	Rooney, Thomas J.
Crowley	Noem	
Delaney	O'Rourke	Titus
Ellison	Payne	Veasey
Hanabusa	Reed	Walz

□ 1201

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

THE JOURNAL

The SPEAKER pro tempore (Mr. MITCHELL). The unfinished business is the question on agreeing to the Speaker's approval of the Journal, which the Chair will put de novo.

The question is on the Speaker's approval of the Journal.

Pursuant to clause 1, rule I, the Journal stands approved.

FIREFIGHTER CANCER REGISTRY ACT OF 2017

Mr. COLLINS of New York. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (H.R. 931) to require the Secretary of Health and Human Services to develop a voluntary registry to collect data on cancer incidence among firefighters, with the Senate amendment thereto, and concur in the Senate amendment.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will report the Senate amendment.

The Clerk read as follows:

Senate amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the Firefighter Cancer Registry Act of 2018.

SEC. 2. VOLUNTARY REGISTRY FOR FIREFIGHTER CANCER INCIDENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the Secretary), acting through the Director of the Centers for Disease Control and Prevention and in coordination with other agencies as the Secretary determines appropriate, shall develop and maintain, directly or through a grant or cooperative agreement, a voluntary registry of firefighters (referred to in this section as the Firefighter Registry) to collect relevant health and occupational information of such firefighters for purposes of determining cancer incidence.

(b) USE OF FIREFIGHTER REGISTRY.—The Firefighter Registry may be used for the following purposes:

(1) To improve data collection and data coordination activities related to the nationwide monitoring of the incidence of cancer among firefighters.

(2) To collect, consolidate, and maintain, consistent with subsection (g), epidemiological information and analyses related to cancer incidence and trends among firefighters

(c) RELEVANT DATA.—

(1) DATA COLLECTION.—In carrying out the voluntary data collection for purposes of inclusion under the Firefighter Registry, the Secretary may collect the following:

(A) Information, as determined by the Secretary under subsection (d)(1), of volunteer, paid-on-call, and career firefighters, independent of cancer status or diagnosis.

(B) Individual risk factors and occupational history of firefighters.

(C) Information, if available, related to—

(i) basic demographic information, including—

(I) the age of the firefighter involved during the relevant dates of occupation as a firefighter; and

(II) the age of cancer diagnosis;

(ii) the status of the firefighter as either volunteer, paid-on-call, or career firefighter;

(iii) the total number of years of occupation as a firefighter and a detailing of additional employment experience, whether concurrent, before, or anytime thereafter;

(iv)(I) the approximate number of fire incidents attended, including information related to the type of fire incidents and the role of the firefighter in responding to the incident; or

(II) in the case of a firefighter for whom information on such number and type is unavailable, an estimate of such number and type based on the method developed under subsection (d)(1)(D); and

(v) other medical information and health history, including additional risk factors, as appropriate, and other information relevant to a cancer incidence study of firefighters.

(2) INFORMATION ON DIAGNOSES AND TREATMENT.—In carrying out paragraph (1), with respect to diagnoses and treatment of firefighters with cancer, the Secretary shall, as appropriate, enable the Firefighter Registry to electronically connect to State-based cancer registries, for a purpose described by clause (vi) or (vii) of section 399B(c)(2)(D) of the Public Health Service Act (42 U.S.C. 280e(c)(2)(D)), to obtain—

(A) date of diagnoses and source of information; and

(B) pathological data characterizing the cancer, including cancer site, state of disease (pursuant to Staging Guide), incidence, and type of treatment.

(d) FIREFIGHTER REGISTRY COORDINATION STRATEGY.—

(1) REQUIRED STRATEGY.—The Secretary shall, in consultation with the relevant stakeholders identified in subsection (e), including epidemiologists and pathologists, develop a strategy to coordinate data collection activities, including within existing State registries, for inclusion in the Firefighter Registry established under this Act. The strategy may include the following:

(A) Increasing awareness of the Firefighter Registry and encouraging participation among volunteer, paid-on-call, and career firefighters.

(B) Consideration of unique data collection needs that may arise to generate a statistically reliable representation of minority, female, and volunteer firefighters, including methods, as needed, to encourage participation from such populations.

(C) Information on how the Secretary will store data described in subsection (c)(1) and provide electronic access to relevant health information described in subsection (c)(2).

(D) Working in consultation with the experts described in subsection (e), a reliable and standardized method for estimating the number of fire incidents attended by a firefighter as well as the type of fire incident so attended in the case such firefighter is unable to provide such information.

(2) REPORT TO CONGRESS.—The Secretary shall submit the strategy described in paragraph (1) to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate not later than 30 days after the date of the completion of the strategy.

(3) GUIDANCE FOR INCLUSION AND MAINTENANCE OF DATA ON FIREFIGHTERS.—The Secretary shall develop, in consultation with the stakeholders identified in subsection (e), State health agencies, State departments of homeland security, and volunteer, paid-on-call, combination, and career firefighting agencies, a strategy for inclusion of firefighters in the registry that are representative of the general population of firefighters, that outlines the following:

(A) How new information about firefighters will be submitted to the Firefighter Registry for inclusion.

(B) How information about firefighters will be maintained and updated in the Firefighter Registry over time.

(C) A method for estimating the number of fire incidents attended by a firefighter as well as the type of fire incident so attended in the case such firefighter is unable to provide such information.

(D) Further information, as deemed necessary by the Secretary.

(e) CONSULTATION AND REPORT.—The Secretary shall consult with non-Federal experts on the Firefighter Registry established under this section, and shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that includes, as appropriate, information on goals achieved and improvements needed to strengthen the Firefighter Registry. Such non-Federal experts shall include the following:

(1) Public health experts with experience in developing and maintaining cancer registries.

(2) Epidemiologists with experience in studying cancer incidence.

(3) Clinicians with experience in diagnosing and treating cancer incidence.

(4) Active and retired volunteer, paid-on-call, and career firefighters as well as relevant national fire and emergency response organizations.

(f) RESEARCH AVAILABILITY.—Subject to subsection (g), the Secretary shall ensure that information and analysis in the Firefighter Registry are available, as appropriate, to the public, including researchers, firefighters, and national fire service organizations.

(g) PRIVACY.—In carrying out this Act, the Secretary shall ensure that information in and analysis of the Firefighter Registry are made available in a manner that, at a minimum, protects personal privacy to the extent required by applicable Federal and State privacy law.

(h) AUTHORIZATION OF FUNDS.—To carry out this section, there are authorized to be appropriated $2,500,000 for each of the fiscal years 2018 through 2022.

Mr. COLLINS of New York (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

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

There was no objection.

The SPEAKER pro tempore. Is there objection to the original request of the gentleman from New York?

Mr. PASCRELL. Mr. Speaker, reserving the right to object, I want to thank Representatives CHRIS COLLINS and FRANK PALLONE and Senators MENENDEZ and LISA MURKOWSKI for the support and work to get this bipartisan bill to protect the health and wellbeing of our Nation's firefighters across the finish line.

I am pleased this bill, which has the strong support of the firefighter community, will finally be on its way to the President's desk. I look forward to working with all the stakeholders to create a firefighter cancer registry with this bill.

Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the original request of the gentleman from New York?

There was no objection.

A motion to reconsider was laid on the table.

ALL CIRCUIT REVIEW ACT

Mr. ROSS. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (H.R. 2229) to amend title 5, United States Code, to provide permanent authority for judicial review of certain Merit Systems Protection Board decisions relating to whistleblowers, and for other purposes, with the Senate amendment thereto, and concur in the Senate amendment.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will report the Senate amendment.

The Clerk read as follows:

Senate amendment:

On page 2, after line 16, insert the following:

(c) RETROACTIVE EFFECTIVE DATE.—The amendments made by this section shall take effect as if enacted on November 26, 2017.

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

There was no objection.

A motion to reconsider was laid on the table.

LEGISLATIVE PROGRAM

(Mr. HOYER asked and was given permission to address the House for 1 minute.)

Mr. HOYER. Mr. Speaker, I rise for the purpose of inquiring of the majority leader the schedule for the week to come.

Mr. Speaker, I am pleased to yield to the gentleman from California (Mr. MCCARTHY), my friend, the majority leader.

(Mr. MCCARTHY asked and was given permission to revise and extend his remarks.)

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, on Monday, the House will meet at noon for morning hour and at 2 p.m. for legislative business. Votes will be postponed until 6:30 p.m.

On Tuesday and Wednesday, the House will meet at 10 a.m. for morning hour and noon for legislative business.

On Thursday, the House will meet at 9 a.m. for legislative business. Last votes are expected no later than 3 p.m.

On Friday, no votes are expected in the House.

Mr. Speaker, the House will consider a number of suspensions next week, a complete list of which will be announced by close of business today.

In addition, the House will continue our work on appropriations by taking up the 2019 Defense Appropriations bill sponsored by Representative KAY GRANGER.

Mr. Speaker, Republicans are committed to national security and rebuilding our military. This bill fully funds a well-deserved 2.6 percent pay raise for our brave men and women in uniform, their largest pay raise in 9 years. It prepares for the future by investing more than $90 billion into the research and development of new defense systems and technology. Above all, it ensures American Armed Forces have the equipment and training necessary to successfully carry out their missions around the world.

This bill passed 48 to 4 out of subcommittee, so I hope my friends across the aisle will consider voting for this important bill when it reaches the floor.

Speaking of national security, the House will also make a motion to go to conference on the National Defense Authorization Act, which the House passed last month.

Finally, Mr. Speaker, additional legislative items are possible in the House, including two bills from the Committee on Natural Resources.

First, H.R. 200, the Strengthening Fishing Communities and Increasing Flexibility in Fisheries Management Act, sponsored by Representative DON YOUNG: This bill would reauthorize Magnuson-Stevens and replace one-size-fits-all regulations with a tailored approach that will ensure vibrant American fisheries.

Next, H.R. 2083, the Endangered Salmon and Fisheries Predation Prevention Act, sponsored by Representative JAIME HERRERA BEUTLER: This bill will allow State and Tribal authorities to respond more quickly to predators of the native salmon population.

Mr. Speaker, the House is also expected to consider legislation related to border security and immigration.

As soon as our schedule is finalized, I will be sure to inform all Members.

With that, I thank my friend.

Mr. HOYER. Mr. Speaker, I thank the gentleman for the information.

Mr. Speaker, I note that the bill that was supposed to be on the floor either yesterday or today dealing with DACA and dealing with the children, who are an object of great concern by all the country, is not mentioned in the gentleman's remarks for legislation that will be considered next week.

The DACA bill was supposed to be voted in the second immigration bill pursuant to the rule that we adopted this week. That vote, I thought, had been postponed until next week. Now, however, I do not see it being announced as a bill that is going to be considered.

It is disappointing that, after months of committing to working together on a solution to the DACA crisis, Mr. Speaker, this week, the House considered two partisan bills.

I would like to point out that Speaker RYAN, on September 5, 2017, some 8 months ago, said: ''It is my hope that the House and Senate, with the President's leadership, will be able to find consensus on a permanent legislative solution that includes ensuring that those who have done nothing wrong can still contribute as a valued part of this country.''

Speaker RYAN said more recently, on February 8, 2018, when he urged people to support the caps bill—that is, setting the limits of expenditures—''my commitment to working together,'' and he looked at our side of the aisle when he said that. But, Mr. Speaker, the only persons who apparently will be included in ''working together'' are between the Freedom Caucus and others on the Republican side of the aisle.

He went on to say: ''My commitment to working together on an immigration measure that we can make law is a sincere commitment. Let me repeat,'' the Speaker said, ''my commitment to working together on an immigration measure that we can make law is a sincere commitment. We will solve this DACA problem.''

He said that February 8, 2018, from that rostrum on the floor of this House. There has been no ''together.''

Now, my friend, the majority leader, Mr. Speaker, said this: ''This all started when I was at Camp David with the President this weekend.''

We know that the majority leader is probably the closest ally that the President has in the Congress of the United States.

''He was telling me how, earlier last week, he was with some Republican Senators talking about DACA. They all agreed, but he said we can't solve that unless we bring Democrats into the room, too.''

That was Majority Leader KEVIN MCCARTHY on FOX News on January 10, 2018.

So I ask my friend, the majority leader, can the gentleman clarify whether or not changes will be made to H.R. 6136—that is, the Ryan-Trump so-called compromise that, from our perspective, ''together'' meant simply together among Republicans trying to decide what the Republicans wanted to do. Can you tell me whether there will be changes to that so-called compromise bill and whether or not that

bill may be brought to the floor anytime soon?

I yield to my friend.

□ 1215

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding, and I appreciate him watching me on TV.

Mr. Speaker, if I could just restate, so maybe I could speak more clearly.

The House is also expected to consider legislation relating to border security immigration. So the answer is yes.

As I said before, we are bringing that bill to the floor. We have been working very closely with the entire Conference, taking all ideas in. We had a very productive conference last night. We will work through the weekend, and you will see that bill on the floor next week. And I look forward to Mr. HOYER's support as well.

Mr. HOYER. Mr. Speaker, together, working with their Conference, not with us, not, frankly, with a bipartisan group that has support on this floor of 240 Members. 240 Members of the House of Representatives, and you need 218 for a majority, support an option and have been asking for that option for a long period of time.

Now, the majority leader is looking somewhat quizzical, Mr. Speaker, and he wants to know how you get to 240; 193 plus 47.

There were 54 Republicans who asked for the rule putting four bills on the floor, but 7 were, apparently, encouraged to take their name off of that, so only 47 Republicans remain. All 193, that is 240. That is a majority of the House.

What was asked for was to put four options, giving everybody a chance to put the option that they liked on the floor. Notwithstanding Speaker RYAN's commitment and notwithstanding the comments that Mr. MCCARTHY made following his meeting at Camp David with the President of the United States where they needed to bring Democrats in, all we have seen is a deeply divided Republican Party negotiating with itself.

They brought a bill to the floor, and they passed the rule. The only real effect of the rule, because the bill lost, was to negate the 216 signatures—and we believe there would have been more but for arm-twisting—to bring those compromised bills to the floor, which had both Republicans and Democrats working together and supporting. Two of those bills, the principal sponsors were a Republican and a Democrat.

Mr. Speaker, I would ask the gentleman, he says he is going to bring a bill to the floor—I presume he is talking about the bill that was going to be brought to the floor yesterday then changed to today, and then changed to next week—whether there will be amendments in that bill and, if so, will they be discussed with us and will we have input into that process?

The gentleman concluded, Mr. Speaker, his comments with he hopes he could have our support. We are not included. We are shut out. The compromise has been rejected and undermined, and the Speaker ignored 216 people who asked for those bills to be brought to the floor, and he said no: no openness, no transparency, closed rules, consistent with the policies that have been followed in this, the most closed Congress in which I have served.

So I would ask my friend again, Mr. Speaker: What changes will be affected in the bill that would be brought to the floor, or are we going to be told when they are brought to the floor what those changes are?

Mr. Speaker, I yield to my friend.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, it is quite interesting to me to listen to my friend. He is complaining that somehow he is not involved. Mr. Speaker, he is complaining about the number of hours that he sat in my office, not just himself—Senator DURBIN, the chief of staff to the President, the Secretary of Homeland Security as well, and Senator CORNYN—and we worked time and again. But every time, we tried to find compromise. We even went to the point of their number one issue, and the President went beyond what they even asked.

But they said: No, we can't do anything else. They said all they wanted to do was go do a discharge petition. That is all they wanted. They didn't want to work through the system.

But that was not unusual, because my friend, Mr. Speaker, likes to quote people—I don't have it written. I just have it by memory, the number of times my friend told me he would never vote to shut down the government. He doesn't care about politics; he would never do that. But we found it was a different year and a different time.

Then we talked about children's health, CHIP. A number of times, Mr. Speaker, we would go to the other side, we would go to the ranking member, and we would go to those individuals on the committee, but they were told not to work with us. So we would run a bill, Mr. Speaker, with everything that they had ever said they would want in it, and yet they would get to the day and they would vote against it.

Mr. HOYER. Mr. Speaker, I reclaim my time just to remind the majority leader of what I asked.

The majority leader likes to talk about what we did in the past. His party shut down the government, and he says I voted to shut down the government. That is absurd that he could cite a vote of mine against some sort of proposal that they put forward.

The question is: He refuses to put on a bipartisan, to give even the House the opportunity to consider a bill that is supported by 240 Members of this House. And, frankly, my perception—and I am not bad at counting, Mr. Speaker, which is why I am standing at this podium and why the majority leader is standing at his podium. We understand counting.

I dare him, Mr. Speaker, I dare him to put the Hurd-Aguilar bill on the floor, and I guarantee him it will get 240 votes. The people's House will be allowed to speak. But they are afraid to do that, Mr. Speaker.

All of this stuff about we had meetings in his office, we had meetings in his office and he knew, from the start, that the two things they were asking for were nonstarters. Very frankly, I have had discussions with the Secretary, who said: Well, we will just stick with border security and DACA.

But that is all in the past. What we are talking about is today. And what they did was shut down the people who wanted to vote on their option, on our option, and on two other options in this, the most transparent House that would take issues one by one and would face the tough issues head-on. While people are twisting in the wind and while children are being separated from their parents, ripped from the arms of their moms and their dads, we fiddle while Rome is burning, and we talk about shutting down government.

Their party shut down government a number of times since I have been here. They did it intentionally. And, very frankly, their Speaker and the head of the OMB voted ''no'' and to shut it down; they voted not to open it up.

That is not the issue, Mr. Speaker. The issue is: What are we going to do to solve a problem the President of the United States said we ought to solve?

Now, the President of the United States, of course, this morning, says: No, forget it. Go deal with it.

His tweet at 7:06 a.m. this morning: ''Republicans should stop wasting their time on immigration until after we elect more Senators and Congressmen/women in November''—in other words, until we take over.

This President who said: Well, you know, I met with Kim Jong-un. He is loved by his people. And, boy, when he says stand up, his people stand up.

Perhaps, that is what he wants us to do, Mr. Speaker, but we are not North Korea. We are a democracy, and, very frankly, they don't have the courage, Mr. Speaker, to bring bills to the floor and allow this House to work its will. What they do is they negotiate with themselves and bring bills to the floor, neither of which would have passed yesterday.

After all of their compromise, after all of their talk, and after all of their commitments to solve the problem, neither one of their bills would have passed yesterday. They have 240-plus Members. They don't need us, but they took the bill off the floor because they couldn't get their own party to come to agreement.

So, Mr. Speaker, my question is, and I will reiterate my question: What changes are going to be effected in the bill that would have been considered yesterday, had it not been pulled from the floor, that we will have to consider next week?

Mr. Speaker, I yield to my friend.

Mr. MCCARTHY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I just asked the gentleman if he would allow me the opportunity to answer questions.

Mr. HOYER. Certainly.

Mr. MCCARTHY. I know he likes to make long speeches before he gets to a question, and I know he likes to go back in decades for the decades that he has served, but I was only referring to this Congress. I was moving to the answer, but I was building and explaining why the answer is what it is.

He doesn't think the actions prior don't take place until now. We have sat in those rooms and we talked about border security. The interesting part, though, Mr. Speaker: The other side of the aisle that said they were for border security, they were going to perpetuate the problem we currently have because they did not want to end this catch and release. They are going to put families in harm's way.

They question whether you could actually have a border of a wall. That is really the philosophical debate that we are talking about.

Now, we will work through this bill. There are some other parts of the bill that we are working on this weekend. Any changes that come to a conclusion, of course, we will let you know.

But much of what this bill is is the same thing that we talked down at the White House about and we talked for those numbers of hours inside my office about.

But, Mr. Speaker, the gentleman on the other side said that he was never going to shut down the government, but he voted to do it this time. They said that they were concerned about CHIP, but they would vote against it when we bring it to the floor.

Do you know what we had to do? We had to carry it on our own.

And do you know what happened for the American children? The longest it has ever been renewed: 10 years.

So, yes, we want to work with them. But if the idea is to stop anything from happening for the American public, do not expect me to stop. It is too important. If we have to push through on our own, we will.

And my friend made a statement that this body is one-sided. Don't take my word for it. Let's go to Quorum, a company that only focuses on data, that only focuses on measurements. Do you know what they said about this Congress? Seventy percent of the bills signed into law this Congress have one Republican and one Democratic cosponsor, the highest rate in the past 20 years for bipartisanship.

The bills that we bring to the floor, despite the leadership's push, every week, Mr. Speaker, we can see the actions. What was the action that they held everybody until the last minute for those 23 people who wanted to vote for the appropriations bill? They had to wait until the Republicans carried it, then they released them to vote for it.

Or we talk about the farm bill.

Every day, Mr. Speaker, I come back here, I see the ranking member on the other side put a letter out to her Members to not vote for whatever comes.

And, yes, we on this side of the aisle want to solve DACA. But I know. I read your tweets just as well: Dreamers can still apply to renew DACA protections.

But, do you know what? In our bill, we deal with the DACA situation.

Do you know what else we also deal with? We deal with the border, and we deal with security, because we do not want to be back here in another 2 or 5 years with the same problem we have today.

□ 1230

Even if you won't work with us from the children's health insurance, from funding of government, from appropriations for our veterans, you want to hold those votes back, I don't think the public wants to hold those back.

And you know what? If we have to push forward, we will. And I will not apologize for it. This country is too important, the problems are too big.

And I can listen, Mr. Speaker, to every argument we make, but I will just think the American public can look at the data.

Do you know what today is, Mr. Speaker? The 6-month anniversary of the tax bill passing. You know what else it is? One million new jobs. You know what else it is? Unemployment below 4 percent. And in the last 49 years of this country, unemployment below 4 percent has only been 7 months in 49 years, but two of those 7 months were April and May of this year. Unemployment claims, 44-year low. And for the first time in the history of this Nation, there are more jobs being offered than there are people looking for them.

So all that rhetoric, all those arguments you made building up to that tax bill, the Armageddon, the crumbs, how terrible this is going to be, 6 months later, history proves different.

And you know what, Mr. Speaker? If we had waited and waited for the Democrats, there would not be a million new jobs, there would not be unemployment where it is, because, Mr. Speaker, there wasn't one Democrat to vote for it, even though a number of them privately told me on this floor they wanted to, but their leadership told them no.

So if we have to solve the economy and we have to solve immigration on our own, we will.

Mr. HOYER. Mr. Speaker, he didn't answer the question, of course. He hardly ever does.

400,000 more jobs created in 2016 than 2017. He doesn't say that. They inherited a growing economy. We inherited, when President Obama took office, a receding economy, hemorrhaging 787,000 jobs in January of 2009. He doesn't talk about that. That was after the two tax cuts that they passed in 2001 and 2003 that they said would create the greatest economy we have ever seen. It didn't. He didn't say that.

Mr. Speaker, he didn't say that the only time we balanced the budget for 4 years was under President Clinton, and we created jobs and had the best economy he has experienced and I have experienced. He didn't say that.

And, Mr. Speaker, what he didn't say is why we are not bringing to this floor four pieces of legislation, giving everybody on the floor the opportunity to express their opinion and say to the American people how they think we can address, yes, border security, which we want to address.

But what the President asked us to do and the Speaker said he would do, and the Speaker has not done, and that is to address in a rational way, in a way that can get the majority of votes—the two bills they brought to the floor, they knew they couldn't get the votes.

The farm bill that he just talked about that is going to the Senate, it is dead on arrival. He knows it, Mr. Speaker. The 69 times they tried to repeal the Affordable Care Act, wasted time. He knows it.

And he mentions, by the way, how bipartisan this Congress is. Let me tell you why it is bipartisan: we don't control it, but we cooperate when we can. When we were in charge, it wasn't nearly as bipartisan, because the Republicans did not cooperate when they could.

And, Mr. Speaker, he talks about fiscal bills. Ninety percent of the fiscal bills could not have passed this House, kept the government open, opened the government up, give relief to those who were suffering from natural disasters without substantial Democratic help, and in many instances with the majority of Democrats and the minority of Republicans.

But the answer I looked for, Mr. Speaker, what are we going to consider next week in terms of an issue that the Speaker said some 8 months ago we were going to solve and promised us in February 2018 he was going to address to solve DACA? And now we have this crisis in the country created by the President of the United States with children being wrenched from the arms of their moms and dads. That is what we ought to be discussing.

The majority leader is a good friend of the President's. I understand that. All the President has to do is pick up the phone and call and say to the Attorney General and the Secretary of the Department of Homeland Security: stop wrenching those children from the hands of their parents.

We don't need legislation, but now we have legislation. And I would ask him if he would bring the Nadler bill to the floor, which will prevent children from being wrenched from the hands of their families simply because they have committed a misdemeanor of wanting to seek opportunity in the land of opportunity that we call America.

Mr. Speaker, I yield to my friend for his response, but we need to know what is going to be considered next week.

Apparently, they haven't decided. So the majority leader says they will let us know as soon as they have decided what they are going to do—who they have to deal with to cobble the votes together on their side of the aisle. We have 240-plus votes for an option, but they are being muzzled. They are being prevented to express the will of this House.

Mr. Speaker, I ask the majority leader, does he believe that my representation that Hurd-Aguilar has 240 votes on this floor inaccurate?

Mr. Speaker, I yield to my friend.

Mr. MCCARTHY. Mr. Speaker, I thank my friend for yielding. My friend made a lot of points. Sometimes facts get caught up in them.

So, Mr. Speaker, the gentleman talked about the floor and the willingness of this side to allow Democratic amendments, or bipartisanship.

As of June 7, Republicans in the 115th Congress—and we are not done with this Congress yet—have provided for the consideration of over 1,200 amendments on the House floor. Now, that includes 570 Democrat amendments.

And I don't want to compare apples to oranges, so let's do apples to apples.

So in the entire 111th Congress—that was their entire Congress when my friend was majority leader—Speaker Pelosi allowed less than 1,000 amendments to be considered on the floor.

Now, despite the unified Democratic opposition, Republicans are still getting the work done, and we will continue to do that.

Now, my friend made a few statements, said there are things I did not say. Maybe there were some things I did not say about the economy, but they are different than what he would, because there is some really good news, and it is not far from here.

Mr. Speaker, you could go to my friend's district. Each of the counties that make up Maryland's Fifth Congressional District has seen a drop in unemployment since 2016. St. Mary's County is down over a full percent to 3.7, Calvert County down to 3.5, Charles County down to 3.8, Prince George's down to 4.1, and Anne Arundel County down to 3.2 percent.

Now, the other point I did not make—and I thank the gentleman for bringing it up to me that I missed points—do you realize in America today, if you are African American, this is the lowest unemployment has ever been; if you are Hispanic, the lowest it has ever been.

Yes, there are things we had to do on our own, but the numbers prove it is worth it.

And what is even more telling about this and something that makes me prouder, it doesn't just help Republican districts, it helps everybody's districts. It helps all Americans. And that is what we are here for.

My friend brought up that there are issues. Yes, there are. That is why we want to pass the immigration bill. We think there should be a border and the border should be protected. We think children should be with their parents, and that is what we are working on.

So I look forward to next week, to us passing an immigration bill that solves a lot of these problems.

And, Mr. Speaker, I hope my friend from the other side of the aisle would look at the bill and understand not everybody gets what they want, because in that bill there won't be everything that I want, not one person in this room will get everything they want. But will America be safer? Will America be better in the future? Will we have a system that works? Those answers will be yes, and that is how I will cast my vote.

Mr. HOYER. Mr. Speaker, we will close now.

Neither of the questions that I posed were answered. And certainly the fact that there are 240 votes on this floor was not disputed, by the majority leader, for the Hurd-Aguilar, which addresses security at the border. By the way, cosponsored by Mr. HURD, a Member of the majority leader's party. A Member from Texas who knows about the border and who, I presume, wants to keep it secure. The bill he has cosponsored has at least 240 votes on this floor.

This is the most closed Congress in which I have served, the most closed rules. That is a fact. And apparently it is closed to the majority, who want to move ahead on a bill and just have the opportunity to vote on it and to give the Speaker the opportunity to put something on the floor and have the House consider it, and have Ms. ROYBAL-ALLARD and Ms. ROS-LEHTINEN, Republican from Florida, have a bill on the floor and have it considered, and have Mr. GOODLATTE, who did, in fact, have his bill on the floor, and it lost.

So, Mr. Speaker, I regret that I don't know what there is going to be next week, because we need to take action. And we need to take action not by compromising with one side of the aisle and seeing only capitulation by some. We do need compromise, we do need action, and we need action that can pass the Senate.

Mr. Speaker, I yield back the balance of my time.

ADJOURNMENT FROM FRIDAY, JUNE 22, 2018, TO MONDAY, JUNE 25, 2018

Mr. MCCARTHY. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet on Monday, June 25, 2018, when it shall convene at noon for morning-hour debate and 2 p.m. for legislative business.

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

There was no objection.

TAX CUTS AND JOBS ACT IS GETTING RESULTS

(Mr. PAULSEN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PAULSEN. Mr. Speaker, today is the 6-month anniversary of the Tax Cuts and Jobs Act. And few would have thought that 6 months ago we would have seen such progress so fast because of tax reform, and the results are significant: bigger paychecks and employers giving workers pay raises; we have got faster economic growth; we have got 1 million new jobs that have now been created since the beginning of the year already; unemployment is at one of its lowest rates ever, under 4 percent; and we actually now, for the first time in history, have more job openings than jobseekers.

This is a good thing, with more business investment, record optimism among small businesses and manufacturers, and consumer confidence nearly at an all-time high.

Mr. Speaker, tax reform was just the shot in the arm that our economy needed to put Americans back to work and get our economy back on track.

HONORING RON PLUMMER

(Mrs. DEMINGS asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. DEMINGS. Mr. Speaker, I rise today to honor the life of Mr. Ron Plummer, Manager of Orange County, Florida, Office of Emergency Management, who passed away last week.

Ron was a dedicated public servant, husband, and father. Ron served in the Army and the Marine Corps for 27 years.

Since 2002, he has helped our community through countless storms and disasters. As every Floridian knows, getting through hurricanes and other emergencies requires calm leadership and deep compassion.

Ron lifted the spirit of storm-stricken neighbors, brought kindness to those with special needs, and made hope a tangible presence.

Ron united peers and partners to keep us safe, and shared his vast expertise throughout the State and the Nation.

Ron Plummer will be greatly missed by all who knew him, and we owe him a debt of gratitude for a life well lived.

□ 1245

RECOGNIZING THE NORTH PLATTE CANTEEN

(Mr. SMITH of Nebraska asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Nebraska. Mr. Speaker, I rise today to recognize the community of North Platte, Nebraska, for its many decades of service to our men and women in uniform.

Earlier this week, the North Platte Canteen came together once again to host more than 700 Army National

Guard soldiers based in Arkansas who were returning from a training mission in Wyoming, not having eaten a hot meal in days.

The North Platte Canteen traces its history to World War II, when the community came together to feed more than 6 million servicemen and -women as they traveled by train across the country.

The North Platte Canteen was organized this time to feed more than 700 soldiers, like I said. They were transported on 21 buses over 2 days, and these experiences included homemade birthday cakes for those celebrating, which is that time-honored tradition at the Canteen.

I would like to thank Lisa Burke, Muriel Clark, Amanda Connick, Courtney Fegter, and Michelle Thomas at the North Platte/Lincoln County Visitors Bureau, who coordinated what became a whole-community effort with just a few days' notice.

This is really what Nebraska's support for our troops is all about.

MOMENT OF SILENCE FOR DEPUTY THERESA SUE KING, DEPUTY PATRICK THOMAS ROHRER, AND ALL FALLEN POLICE OFFICERS

(Mr. YODER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. YODER. Mr. Speaker, there are no words to describe the tragedy that occurred in my district in Kansas last week. Two Wyandotte County deputies, Theresa Sue King and Patrick Thomas Rohrer, lost their lives while transporting an inmate for a court hearing on Friday.

This is, tragically, not the first time in recent history that law enforcement men and women in our community have made the ultimate sacrifice to keep the peace. We are reminded that we owe our police force, their deputies, and their loved ones a debt of great gratitude that we will never be able to repay.

We pray for their families at this time, and we pray for Sheriff Ash, Kelli Bailiff, and Chief Ziegler as they lead their departments through this tragedy.

Mr. Speaker, may God bless Deputy King and Deputy Rohrer. May they rest in peace.

Mr. Speaker, along with our colleagues from Kansas, RON ESTES and I ask for a moment of silence for Deputy King and Deputy Rohrer and all of our fallen police officers.

RECOGNIZING THE 150TH ANNIVERSARY OF THE UTICA CURLING CLUB

(Ms. TENNEY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. TENNEY. Mr. Speaker, remember the Miracurl on Ice, the stunning victory earlier this year when Team USA defeated Sweden to win the first-ever gold medal for the U.S. Olympic curling team? It was a milestone for the support of curling around the Nation.

I am a longtime fan of the sport of curling and a member of the team that won the 1975 Teenage Curling Championship held at the Utica Curling Club in Utica, New York.

I rise today to recognize the Utica Curling Club, which recently celebrated its 150th anniversary. Established in 1868, the Utica Curling Club is one of the oldest rinks in the country.

This ice sport was first played on open-air rinks on Ballou Creek near Rutger Street in Utica. In 1916, the indoor club was built on Francis Street in downtown Utica, where I was able to hold my title as the 1975 Teenage Curling Champion.

Tragically, the club was destroyed by fire in 1995. In 1996, a brand-new facility was built on Clark Mills Road in nearby Whitesboro.

Today, the club hosts novice and competitive curlers from across the country and the world. Members range from 7 years old to 90 years old. The official curling season runs from October through March.

This past winter, the Utica Curling Club held the Olympic Open House, which it has held every year for 4 years, and doubled its attendance to watch the U.S. curling team bring home their very first Olympic Gold Medal.

The sport of curling has experienced many changes in Utica over the last 150 years, but the spirit of curling remains strong.

Mr. Speaker, please join me in wishing a hearty congratulations to the Utica Curling Club for 150 years and many more Miracurls on Ice.

CONTINUATION OF THE NATIONAL EMERGENCY WITH RESPECT TO NORTH KOREA—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 115–136)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, referred to the Committee on Foreign Affairs and ordered to be printed:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, within 90 days before the anniversary date of its declaration, the President publishes in the *Federal Register* and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent to the *Federal Register* for publication the enclosed notice stating that the national emergency with respect to North Korea declared in Executive Order 13466 of June 26, 2008, expanded in scope in Executive Order 13551 of August 30, 2010, addressed further in Executive Order 13570 of April 18, 2011, further expanded in scope in Executive Order 13687 of January 2, 2015, and under which additional steps were taken in Executive Order 13722 of March 15, 2016, and Executive Order 13810 of September 20, 2017, is to continue in effect beyond June 26, 2018.

The existence and risk of proliferation of weapons-usable fissile material on the Korean Peninsula; the actions and policies of the Government of North Korea that destabilize the Korean Peninsula and imperil United States Armed Forces, allies, and trading partners in the region, including its pursuit of nuclear and missile programs; and other provocative, destabilizing, and repressive actions and policies of the Government of North Korea continue to constitute an unusual and extraordinary threat to the national security, foreign policy, and economy of the United States. For this reason, I have determined that it is necessary to continue the national emergency declared in Executive Order 13466 with respect to North Korea.

DONALD J. TRUMP.

THE WHITE HOUSE, *June 22, 2018.*

CONTINUATION OF THE NATIONAL EMERGENCY WITH RESPECT TO THE WESTERN BALKANS—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 115–137)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, referred to the Committee on Foreign Affairs and ordered to be printed:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act (50 U.S.C. 1622(d)) provides for the automatic termination of a national emergency unless, within 90 days before the anniversary date of its declaration, the President publishes in the *Federal Register* and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent to the *Federal Register* for publication the enclosed notice stating that the national emergency with respect to the Western Balkans that was declared in Executive Order 13219 of June 26, 2001, is to continue in effect beyond June 26, 2018.

The threat constituted by the actions of persons engaged in, or assisting, sponsoring, or supporting (i) extremist violence in the Republic of Macedonia and elsewhere in the Western Balkans region, or (ii) acts obstructing implementation of the Dayton Accords in Bosnia or United Nations Security Council Resolution 1244 of June 10, 1999,

in Kosovo, has not been resolved. In addition, Executive Order 13219 was amended by Executive Order 13304 of May 28, 2003, to take additional steps with respect to acts obstructing implementation of the Ohrid Framework Agreement of 2001 relating to Macedonia.

The acts of extremist violence and obstructionist activity outlined in these Executive Orders are hostile to United States interests and continue to pose an unusual and extraordinary threat to the national security and foreign policy of the United States. For this reason, I have determined that it is necessary to continue the national emergency with respect to the Western Balkans.

DONALD J. TRUMP.

THE WHITE HOUSE, *June 22, 2018.*

IMMIGRATION

The SPEAKER pro tempore (Mrs. HANDEL). Under the Speaker's announced policy of January 3, 2013, the gentleman from California (Mr. TED LIEU) is recognized for 60 minutes as the designee of the minority leader.

Mr. TED LIEU of California. Madam Speaker, if the Statue of Liberty could cry, she would be crying today. As I stand here, there are 2,300 babies and kids who were ripped away from their parents by our government and are in detention facilities across America.

America was a country founded by people fleeing persecution. We are a land of immigrants. President Ronald Reagan called us ''that shining city upon the hill.''

Unfortunately, Donald Trump and Homeland Security Secretary Nielsen have perverted that grand legacy and have now engaged in the functional equivalent of kidnapping.

You can believe in any God or no God at all and conclude that ripping kids away from their parents is immoral. I believe in Jesus Christ. Every single thing in the Gospels and what Christ taught goes against the policy of family separation.

Imagine being a mother and father and losing your child to the government and not knowing if you are ever going to see your child again, the horror of that.

Imagine being a child; when you are young, your parents are likely the most important people in your life. Imagine being ripped away from your mother or father and not knowing if you are ever going to see them again, and then being placed in a detention facility with strangers. Imagine the horror and fear you will see doing that. What must that sound like?

(Audio being played.)

The SPEAKER pro tempore. The gentleman will suspend.

Mr. TED LIEU of California. For what reason, Madam Speaker?

The SPEAKER pro tempore. The gentleman is in breach of decorum.

Mr. TED LIEU of California. Cite the rule, Madam Speaker.

The SPEAKER pro tempore. Rule XVII of the rules of the House prohibits——

Mr. TED LIEU of California. There is no rule that says I can't play sounds.

The SPEAKER pro tempore. The gentleman will suspend.

Mr. TED LIEU of California. Why are you trying to prevent the American people from listening to what it sounds like in a detention facility?

The SPEAKER pro tempore. Rule XVII of the rules of the House prohibits the use of that device.

Mr. TED LIEU of California. These are babies and kids in a detention facility. Why do you not let the American people hear what they are saying?

The SPEAKER pro tempore. The gentleman will suspend.

Mr. TED LIEU of California. There is no rule in the House that says I cannot play sounds from a detention facility.

The SPEAKER pro tempore. The gentleman will suspend the use of the device. It is in violation of rule XVII.

Mr. TED LIEU of California. Read the rule. It does not say I cannot play sounds from a detention facility.

Why are we hiding this from the American people?

The SPEAKER pro tempore. Rule XVII prohibits the use of an electronic device to produce sound in the Chamber.

Mr. TED LIEU of California. Why are we hiding it from the American people?

The SPEAKER pro tempore. The gentleman will suspend.

Mr. TED LIEU of California. Why are we hiding it from the American people?

The SPEAKER pro tempore. The gentleman will suspend, per rule XVII of the rules of the House.

Mr. TED LIEU of California. We have 2,300 babies and kids——

The SPEAKER pro tempore. The gentleman will suspend. Per rule XVII of the rules of the House, that prohibits the use of a device to produce sound in the Chamber.

Mr. TED LIEU of California. We have 2,300 babies and kids in detention facilities who were ripped away from their parents. I think the American people need to hear this.

□ 1300

The SPEAKER pro tempore. The gentleman will suspend per rule XVII of the rules of the House.

Mr. TED LIEU of California. Madam Speaker, I think the American people need to hear this ProPublica tape of a detention facility of babies and children who were ripped away from their parents.

The SPEAKER pro tempore. The Sergeant at Arms will enforce the rules of decorum.

Mr. TED LIEU of California. Madam Speaker, I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. PAYNE (at the request of Ms. PELOSI) for June 21 and today on account of medical care.

ADJOURNMENT

The SPEAKER pro tempore. Without objection, the House stands adjourned until noon on Monday next for morning-hour debate.

There was no objection.

Thereupon (at 1 o'clock and 2 minutes p.m.), under its previous order, the House adjourned until Monday, June 25, 2018, at noon for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XIV, executive communications were taken from the Speaker's table and referred as follows:

5263. A letter from the Secretary, Department of Commerce, transmitting a report of a series of violations of the Antideficiency Act, pursuant to 31 U.S.C. 1351; Public Law 97-258; (96 Stat. 926); to the Committee on Appropriations.

5264. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Air Plan Approval; KY; Fine Particulate Matter and Ozone NAAQS Revisions [EPA-R04-OAR-2017-0550; FRL-9977-93-Region 4] received June 21, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5265. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Extension of Deadline for Action on the Section 126(b) Petition From New York [EPA-HQ-OAR-2018-0170; FRL-9977-90-OAR] (RIN: 2060-AU02) received June 21, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5266. A letter from the Secretary, Department of the Treasury, transmitting a six-month periodic report on the national emergency with respect to North Korea that was declared in Executive Order 13466 of June 26, 2008, pursuant to 50 U.S.C. 1641(c); Public Law 94-412, Sec. 401(c); (90 Stat. 1257) and 50 U.S.C. 1703(c); Public Law 95-223, Sec 204(c); (91 Stat. 1627); to the Committee on Foreign Affairs.

5267. A letter from the Secretary, Department of the Treasury, transmitting a six-month periodic report on the national emergency with respect to serious human rights abuse or corruption that was declared in Executive Order 13818 of December 20, 2017, pursuant to 50 U.S.C. 1641(c); Public Law 94-412, Sec. 401(c); (90 Stat. 1257) and 50 U.S.C. 1703(c); Public Law 95-223, Sec 204(c); (91 Stat. 1627); to the Committee on Foreign Affairs.

5268. A letter from the Chief Financial Officer, Department of Housing and Urban Development, transmitting a report to Congress stating that HUD has not conducted any competitions during FY 2017, pursuant to 31 U.S.C. 501 note; Public Law 108-199, Sec. 647(b); (118 Stat. 361); to the Committee on Oversight and Government Reform.

5269. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting the Department's FY 2017 No FEAR Act report, pursuant to 5 U.S.C. 2301 note; Public Law 107-174, 203(a) (as amended by Public Law 109-435, Sec. 604(f)); (120 Stat. 3242); to the Committee on Oversight and Government Reform.

5270. A letter from the President and Chief Executive Officer, Federal Home Loan Bank of Indianapolis, transmitting the 2017 management report of the Federal Home Loan Bank of Indianapolis, pursuant to 31 U.S.C. 9106(a)(1); Public Law 97-258 (as amended by Public Law 101-576, Sec. 306(a)) (104 Stat. 2854); to the Committee on Oversight and Government Reform.

5271. A letter from the Senior Vice President and Chief Financial Officer, Federal Home Loan Bank of New York, transmitting the 2017 management report of the Federal Home Loan Bank of New York, pursuant to 31 U.S.C. 9106(a)(1); Public Law 97-258 (as amended by Public Law 101-576, Sec. 306(a)) (104 Stat. 2854); to the Committee on Oversight and Government Reform.

5272. A letter from the Senior Vice President and Chief Financial Officer, Federal Home Loan Bank of San Francisco, transmitting the 2017 management report of the Federal Home Loan Bank of San Francisco, pursuant to 31 U.S.C. 9106(a)(1); Public Law 97-258 (as amended by Public Law 101-576, Sec. 306(a)) (104 Stat. 2854); to the Committee on Oversight and Government Reform.

5273. A letter from the Director, Peace Corps, transmitting the Corps' semiannual report of the Office of the Inspector General covering the period from October 1, 2017, through March 31, 2018, pursuant to Sec. 5 of the Inspector General Act of 1978; to the Committee on Oversight and Government Reform.

5274. A letter from the Director, Office of Regulatory Affairs and Collaborative Action, Bureau of Indian Affairs, Department of the Interior, transmitting the Department's final rule — Tribal Transportation Program; Delay of Compliance Date [Docket No.: 189D0102DRDS5A300000DR.5A311.IA000118] (RIN: 1076-AF38) received June 19, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5275. A letter from the Director, Office of Regulatory Affairs and Collaborative Action, Bureau of Indian Affairs, Department of the Interior, transmitting the Department's final rule — Addition of the Wind River Indian Reservation to the List of Courts of Indian Offenses [Docket No.: 189A2100DD/AAKC001030/A0A501010.999900] (RIN: 1076-AF39) received June 19, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5276. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod in the Bering Sea and Aleutian Islands Management Area [Docket No.: 161020985-7181-02] (RIN: 0648-XF675) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5277. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Magnuson-Stevens Act Provisions; Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; 2017-2018 Biennial Specifications and Management Measures; Inseason Adjustments [Docket No.: 160808696-7010-02] (RIN: 0648-BH20) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5278. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Ocean Perch in the West Yakutat District of the Gulf of Alaska [Docket No.: 160920866-7167-02] (RIN: 0648-XF572) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5279. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — International Fisheries; Pacific Tuna Fisheries; 2017 Commercial Pacific Bluefin Tuna Fishery Closure in the Eastern Pacific Ocean [Docket No.: 160422356-7283-02] (RIN: 0648-XF630) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5280. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — International Fisheries; Pacific Tuna Fisheries; 2017 Bigeye Tuna Longline Fishery Closure in the Eastern Pacific Ocean [Docket No.: 170223197-7311-01] (RIN: 0648-XF605) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5281. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Reallocation of Pacific Cod in the Bering Sea and Aleutian Islands Management Area; Correction [Docket No.: 161020985-7181-02] (RIN: 0648-XF654) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5282. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Atka Mackerel in the Bering Sea and Aleutian Islands Management Area [Docket No.: 161020985-7181-02] (RIN: 0648-XF655) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5283. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Coastal Migratory Pelagic Resources of the Gulf of Mexico and Atlantic Region; 2017-2018 Commercial Closure for King Mackerel in the Gulf of Mexico Northern Zone [Docket No.: 160426363-7275-02] (RIN: 0648-XF920) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5284. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Ocean Perch in the Central Regulatory Area of the Gulf of Alaska [Docket No.: 160920866-7167-02] (RIN: 0648-XF671) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5285. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Ocean Perch in the Bering Sea and Aleutian Islands Management Area [Docket No.: 161020985-7181-02] (RIN: 0648-XF656) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5286. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Longnose Skate in the Western Regulatory Area of the Gulf of Alaska [Docket No.: 161020985-7181-02] (RIN: 0648-XF707) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5287. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Snapper-Grouper Fishery of the South Atlantic; 2017 Recreational and Commercial Closures for the Florida Keys/East Florida Stock of Hogfish in the South Atlantic and Gulf of Mexico [Docket No.: 160906822-7547-02] (RIN: 0648-XF602) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5288. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Sablefish in the West Yakutat District of the Gulf of Alaska [Docket No.: 160920866-7167-02] (RIN: 0648-XF573) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5289. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Snapper-Grouper Resources of the South Atlantic; Commercial Trip Limit Reduction for Vermilion Snapper [Docket No.: 130312235-3658-02] (RIN: 0648-XF683) received June 20, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

5290. A letter from the Director, Office of Regulatory Affairs and Collaborative Action, Bureau of Indian Affairs, Department of the Interior, transmitting the Department's final rule — Civil Penalties Inflation Adjustments; Annual Adjustments [Docket No.: 189A2100DD/AAKC001030/A0A501010.999900253G] (RIN: 1076-AF40) received June 19, 2018, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on the Judiciary.

5291. A letter from the Assistant Secretary for Legislation, Department of Health and Human Services, transmitting the Department's report entitled ''Annual Report to Congress on the Medicare and Medicaid Integrity Programs for FY 2016'', pursuant to 42 U.S.C. 1395ddd(i)(2); Aug. 14, 1935, ch. 531, title XVIII, Sec. 1893(i)(2) (as amended by Public Law 111-148, Sec. 6402(j)(1)(B)); (124 Stat. 762) and 42 U.S.C. 1936(e)(5); Public Law 109-171, Sec. 6034(a)(2); (120 Stat. 76); jointly to the Committees on Energy and Commerce and Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk

for printing and reference to the proper calendar, as follows:

Mr. BISHOP of Utah: Committee on Natural Resources. H.R. 4528. A bill to make technical amendments to certain marine fish conservation statutes, and for other purposes (Rept. 115–775). Referred to the Committee of the Whole House on the state of the Union.

Mr. MCCAUL: Committee on Homeland Security. H.R. 5730. A bill to require testing and evaluation of advanced transportation security screening technologies related to the mission of the Transportation Security Administration, and for other purposes; with an amendment (Rept. 115–776). Referred to the Committee of the Whole House on the state of the Union.

Mr. MCCAUL: Committee on Homeland Security. H.R. 5733. A bill to amend the Homeland Security Act of 2002 to provide for the responsibility of the National Cybersecurity and Communications Integration Center to maintain capabilities to identify threats to industrial control systems, and for other purposes, with an amendment (Rept. 115–777). Referred to the Committee of the Whole House on the state of the Union.

Mr. MCCAUL: Committee on Homeland Security. H.R. 5766. A bill to improve the security of public areas of transportation facilities, and for other purposes (Rept. 115–778). Referred to the Committee of the Whole House on the state of the Union.

Mr. FRELINGHUYSEN: Committee on Appropriations. Revised Suballocation of Budget Allocations for Fiscal Year 2019 (Rept. 115–779). Referred to the Committee of the Whole House on the state of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. ROYCE of California:

H.R. 6192. A bill to amend the Credit Repair Organizations Act to facilitate the development of consumer credit services, and for other purposes; to the Committee on Financial Services, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ENGEL (for himself, Mrs. TORRES, Mr. ESPAILLAT, Mr. SIRES, Mr. CROWLEY, Mr. GUTIÉRREZ, Ms. WASSERMAN SCHULTZ, Ms. NORTON, Mr. RASKIN, Mr. MEEKS, Mr. HUFFMAN, Mr. DEUTCH, Mr. CORREA, Mr. KHANNA, Ms. LEE, Mr. SOTO, Mr. LEWIS of Georgia, Mr. PALLONE, Ms. VELÁZQUEZ, Mr. GONZALEZ of Texas, Mrs. NAPOLITANO, Ms. TITUS, Mr. BLUMENAUER, Ms. ROSEN, Mr. GOMEZ, Mr. SEAN PATRICK MALONEY of New York, Mr. WELCH, Mr. VEASEY, Mr. CASTRO of Texas, Mrs. LOWEY, Mr. SERRANO, Mr. GALLEGO, Mr. MCGOVERN, Ms. BARRAGÁN, Mr. PASCRELL, Ms. JAYAPAL, Mr. KIHUEN, Ms. ROYBAL-ALLARD, Mr. CICILLINE, Ms. DEGETTE, Mr. AGUILAR, Mr. DANNY K. DAVIS of Illinois, Mr. WALZ, Ms. CLARKE of New York, Mr. PAYNE, Mr. VELA, Ms. FRANKEL of Florida, Ms. LOFGREN, Mr. SMITH of Washington, Ms. SHEA-PORTER, Ms. MATSUI, Mr. KEATING, and Mr. VARGAS):

H.R. 6193. A bill to direct the Secretary of State to help keep Central American families together, and for other purposes; to the Committee on Foreign Affairs, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BARLETTA:

H.R. 6194. A bill to reduce costs of Federal real estate, improve building security, and for other purposes; to the Committee on Transportation and Infrastructure, and in addition to the Committee on Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BRAT:

H.R. 6195. A bill to limit the separation of families seeking asylum in the United States and expedite the asylum process for individuals arriving in the United States with children; to the Committee on the Judiciary.

By Mr. CARTWRIGHT:

H.R. 6196. A bill to amend the Elementary and Secondary Education Act of 1965 to require local educational agencies to implement a policy on allergy bullying in schools; to the Committee on Education and the Workforce.

By Mr. DONOVAN (for himself and Mr. CASTRO of Texas):

H.R. 6197. A bill to amend the State Department Basic Authorities Act of 1956 to authorize rewards for thwarting wildlife trafficking linked to transnational organized crime, and for other purposes; to the Committee on Foreign Affairs.

By Mr. DONOVAN (for himself and Mr. MCCAUL):

H.R. 6198. A bill to amend the Homeland Security Act of 2002 to establish the Countering Weapons of Mass Destruction Office, and for other purposes; to the Committee on Homeland Security, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. JENKINS of Kansas (for herself, Ms. MENG, Mr. KIND, and Mr. PAULSEN):

H.R. 6199. A bill to amend the Internal Revenue Code of 1986 to include certain over-the-counter medical products as qualified medical expenses; to the Committee on Ways and Means.

By Ms. EDDIE BERNICE JOHNSON of Texas (for herself, Mr. BARTON, Mr. VEASEY, Mr. ELLISON, and Mr. CAPUANO):

H.R. 6200. A bill to allow the Secretary of Transportation to provide grants to retrain transportation workers; to the Committee on Transportation and Infrastructure.

By Mr. LANGEVIN (for himself, Mr. THOMPSON of Mississippi, and Mr. KING of New York):

H.R. 6201. A bill to require the Secretary of Health and Human Services to establish a National Advisory Committee on Individuals with Disabilities in All-Hazards Emergencies; to the Committee on Energy and Commerce.

By Mr. ROGERS of Alabama:

H.R. 6202. A bill to allow States to elect to observe year-round daylight saving time, and for other purposes; to the Committee on Energy and Commerce.

By Mr. DAVID SCOTT of Georgia (for himself and Ms. NORTON):

H.R. 6203. A bill to amend the Public Health Service Act to expand research and education with respect to endometrial cancer, and for other purposes; to the Committee on Energy and Commerce.

By Mr. SESSIONS (for himself, Mr. MEADOWS, Mr. GRIFFITH, Mr. FLORES, and Mr. POE of Texas):

H.R. 6204. A bill to clarify standards of family detention and the treatment of unaccompanied alien children, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Foreign Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska:

H.R. 6205. A bill to amend the Controlled Substances Act to authorize hospitals to dispose of controlled substances on behalf of patients who die at the hospital, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. AMASH:

H. Res. 957. A resolution disapproving of the request of the President for the extension, under section 103(c)(1)(B)(i) of the Bipartisan Congressional Trade Priorities and Accountability Act of 2015, of the trade authorities procedures under that Act to any implementing bill submitted with respect to any trade agreement entered into under section 103(b) of that Act after June 30, 2018; to the Committee on Ways and Means, and in addition to the Committee on Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HASTINGS (for himself, Ms. WASSERMAN SCHULTZ, Ms. WILSON of Florida, Mr. DEUTCH, and Ms. FRANKEL of Florida):

H. Res. 958. A resolution expressing support for the recognition of the Dillard Center for the Arts Jazz Band for winning first place in the 2018 Essentially Ellington Competition, one of the most prestigious national high school jazz band competitions in the country; to the Committee on Education and the Workforce.

By Mr. HECK (for himself, Mr. KILMER, Ms. DELBENE, Mr. SMITH of Washington, Mr. LARSEN of Washington, Ms. JAYAPAL, Mr. BLUMENAUER, and Ms. LEE):

H. Res. 959. A resolution to express support for recognition of June 2018 as National Orca Protection Month; to the Committee on Oversight and Government Reform.

MEMORIALS

Under clause 3 of rule XII,

215. The SPEAKER presented a memorial of the General Assembly of the State of New Jersey, relative to Assembly Resolution No. 45, urging the President and Congress of the United States to enact the ''Transparent Summer Flounder Quotas Act''; which was referred to the Committee on Natural Resources.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of rule XII of the Rules of the House of Representatives, the following statements are submitted regarding the specific powers granted to Congress in the Constitution to enact the accompanying bill or joint resolution.

By Mr. ROYCE of California:

H.R. 6192.

Congress has the power to enact this legislation pursuant to the following:

Under Article I, Section 8, Clause 3 of the U.S. Constitution to regulate commerce.

By Mr. ENGEL:

H.R. 6193.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause 18 of the Constitution

By Mr. BARLETTA:

H.R. 6194.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8 of the United States Constitution, specifically Clause 1 (relating to providing for the general welfare of the United States) and Clause 18 (relating to the power to make all laws necessary and proper for carrying out the powers vested in Congress) and clause 17 (relating to authority over the district as the seat of government), and Article IV, Section 3, Clause 2 (relating to the power of Congress to dispose of and make all needful rules and regulations respecting the territory or other property belonging to the United States).

By Mr. BRAT:

H.R. 6195.

Congress has the power to enact this legislation pursuant to the following:

Article I, Sec. 8, Cl. 4: ''To establish an uniform Rule of Naturalization . . .''

By Mr. CARTWRIGHT:

H.R. 6196.

Congress has the power to enact this legislation pursuant to the following:

Article I; Section 8; Clause 1 of the Constitution states The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . .

By Mr. DONOVAN:

H.R. 6197.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8 of the Constitution of the United States

By Mr. DONOVAN:

H.R. 6198.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause 18—To make all laws which shall be necessary and proper for carrying into execution the foregoing powers, and all other powers vested by this Constitution in the government of the United States, or in any department or officer thereof.

By Ms. JENKINS of Kansas:

H.R. 6199.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States.

By Ms. EDDIE BERNICE JOHNSON of Texas:

H.R. 6200.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8 of the Constitution of the United States.

By Mr. LANGEVIN:

H.R. 6201.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8, Clause 3

By Mr. ROGERS of Alabama:

H.R. 6202.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, clause 3 provides Congress with the power to ''regulate commerce with foreign nations, and among the several states, and with the Indian tribes.''

By Mr. DAVID SCOTT of Georgia:

H.R. 6203.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section VIII of the U.S. Constitution

By Mr. SESSIONS:

H.R. 6204.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8, Clause 4

By Mr. YOUNG of Alaska:

H.R. 6205.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause I and Article I, Section 8, Clause 3 of the U.S. Constitution

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions, as follows:

H.R. 120: Mr. GOHMERT.
H.R. 173: Mr. MCNERNEY.
H.R. 398: Ms. PINGREE.
H.R. 525: Mr. O'ROURKE.
H.R. 1150: Mr. COLLINS of Georgia.
H.R. 1298: Mr. REED.
H.R. 1377: Mr. COHEN and Mr. SERRANO.
H.R. 1437: Mr. O'ROURKE.
H.R. 1676: Mrs. TORRES.
H.R. 1781: Mr. BUDD.
H.R. 1939: Mr. ABRAHAM.
H.R. 1953: Mr. CARBAJAL.
H.R. 2077: Mr. KRISHNAMOORTHI.
H.R. 2150: Mr. BROWN of Maryland and Mrs. DINGELL.
H.R. 2160: Mr. PASCRELL.
H.R. 2315: Mr. RODNEY DAVIS of Illinois.
H.R. 2598: Mr. LAWSON of Florida.
H.R. 2976: Mr. MICHAEL F. DOYLE of Pennsylvania.
H.R. 2995: Mr. MCGOVERN and Ms. LOFGREN.
H.R. 3032: Mr. SIMPSON, Mr. WELCH, and Mr. POCAN.
H.R. 3272: Mr. KILMER.
H.R. 3380: Mr. SCHIFF.
H.R. 3601: Mr. BARR.
H.R. 3626: Mr. GONZALEZ of Texas.
H.R. 3682: Mr. HUFFMAN.
H.R. 3913: Mrs. LAWRENCE.
H.R. 4382: Ms. JACKSON LEE and Mr. SIMPSON.
H.R. 4647: Mr. DONOVAN, Mr. POCAN, and Mr. QUIGLEY.
H.R. 4721: Ms. NORTON.
H.R. 4775: Ms. ESHOO.
H.R. 4940: Mrs. DINGELL.
H.R. 4969: Ms. KELLY of Illinois.
H.R. 5003: Mr. KRISHNAMOORTHI, Mr. CORREA, Mr. MCGOVERN, Mr. GARAMENDI, and Ms. NORTON.
H.R. 5052: Mr. SCHRADER.
H.R. 5105: Mr. WEBSTER of Florida.
H.R. 5114: Mr. HUFFMAN.
H.R. 5138: Mr. FASO.
H.R. 5485: Ms. PINGREE, Mr. RASKIN, Mr. BUTTERFIELD, Mr. YOUNG of Iowa, Mr. TIPTON, and Mr. COURTNEY.
H.R. 5507: Mr. NEWHOUSE.
H.R. 5534: Mr. COFFMAN.
H.R. 5545: Mr. SCHIFF, Ms. JUDY CHU of California, Mr. VISCLOSKY, Ms. MOORE, Mr. POCAN, Ms. BARRAGÁN, and Mr. CROWLEY.
H.R. 5595: Mr. NOLAN.
H.R. 5634: Mr. HUNTER.
H.R. 5658: Mr. ROE of Tennessee.
H.R. 5671: Ms. SINEMA, Mr. RUSH, Mr. BISHOP of Michigan, Mr. BERGMAN, Mr. MACARTHUR, and Mrs. HARTZLER.
H.R. 5697: Ms. NORTON.
H.R. 5749: Mr. FOSTER.
H.R. 5780: Mr. QUIGLEY and Mr. BARLETTA.
H.R. 5908: Mr. ELLISON.
H.R. 5963: Mr. BILIRAKIS.
H.R. 5986: Mr. GONZALEZ of Texas, Mr. KATKO, and Mr. COOK.
H.R. 5988: Mr. SMUCKER.
H.R. 6014: Mrs. BROOKS of Indiana.
H.R. 6031: Mr. ADERHOLT and Mr. PETERSON.
H.R. 6033: Mr. PERLMUTTER, Ms. SÁNCHEZ, Mr. CÁRDENAS, Mr. POLIS, Mr. NORCROSS, and Mr. KEATING.
H.R. 6075: Mr. MCGOVERN.
H.R. 6080: Mr. BLUMENAUER.
H.R. 6084: Mr. REICHERT.
H.R. 6090: Mr. LIPINSKI.
H.R. 6101: Mr. BRENDAN F. BOYLE of Pennsylvania.
H.R. 6134: Mr. SANFORD.
H.R. 6137: Mr. MACARTHUR.
H.R. 6172: Mr. DESAULNIER, Ms. DEGETTE, and Mr. KENNEDY.
H.R. 6174: Mr. SERRANO.
H.R. 6180: Mr. TAKANO, Mr. DESAULNIER, and Ms. TITUS.
H.R. 6190: Mr. HUIZENGA.
H. Res. 395: Mr. LOWENTHAL, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. KENNEDY, Ms. BROWNLEY of California, Ms. HANABUSA, Mr. GARAMENDI, Mr. COURTNEY, Mr. LARSON of Connecticut, Mr. YARMUTH, Ms. CASTOR of Florida, Mrs. LAWRENCE, Mr. HECK, and Mr. MCNERNEY.
H. Res. 745: Mr. SESSIONS and Mr. MAST.
H. Res. 785: Mr. KATKO and Mrs. WALORSKI.
H. Res. 869: Mr. COURTNEY.
H. Res. 926: Mr. BLUMENAUER.
H. Res. 927: Ms. ADAMS, Mrs. BEATTY, Mr. BLUMENAUER, Mr. PERLMUTTER, Mr. RICHMOND, Mr. SWALWELL of California, Mr. THOMPSON of Mississippi, Mr. VARGAS, and Mr. YARMUTH.

EXTENSIONS OF REMARKS

JAMES AND JANE LONG

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. POE of Texas. Mr. Speaker, Texas has a proud history, and the names of Texas heroes—Sam Houston, Juan Seguin, and, my hero, William Barrett Travis—are still remembered and venerated by Texans. Two names that are often unjustifiably left out of this group are James and Jane Long.

A veteran of the War of 1812, Dr. James Long was a doctor living in Natchez, Mississippi, in 1819. In that year, the United States and Spain agreed on the Adams-Onis treaty, in which Spain relinquished control over Florida and the United States rescinded claims to the land west of the Sabine River in Texas.

Long and his friends didn't like that they no longer had access to a land they considered their birthright. They decided to take action.

Dr. Long proposed the establishment of Texas as an independent and sovereign nation. Together with eighty of his friends, as well as his wife, Jane, and their newborn infant, Long rode to Nacogdoches. By the time his group reached the Texas settlement, they were over 300 strong. Internal resistance and uncertainty had plagued Spanish Texas, and so Long's party easily took control of Nacogdoches.

They then gathered for a solemn convention. On June 23, 1819, under the heat of the Texas sun, the group proclaimed Texas a free and independent nation and elected Dr. Long as its first president. They became the first to champion the Lone Star. Indeed, the Lone Star featured prominently on their flag, which adopted the 13 red and white stripes of the American flag and placed a single star in the top left-hand corner.

The fate of Long's new Texas Republic was cruel and short-lived. Spanish forces, upon hearing of Long's presence in Nacogdoches, marched east from Bexar (modern-day San Antonio) and drove Long's forces out, killing his brother in the process. Long traveled with his young family to New Orleans, and, determined not to give up on his dream, attempted to stir up support for a second expedition. He found a willing partner in Don Felix Trespalacios, and in 1829, the two departed by sea, bound for the Texas coast.

After landing at a place they named Point Bolivar, in honor of the South American revolutionary, Long took forces inland while Trespalacios sailed onward to spread revolution elsewhere. When his forces took La Bahia, however, Spanish troops struck back and forced their surrender. Long became a captive and traveled to Mexico City to await his fate. Amid mysterious circumstances, Long was shot and killed while in Mexico City, leaving his young wife and two children alone to fend for themselves at Point Bolivar.

Texas women are fiercely courageous, and Mrs. Long was no different. Though she was just twenty-one years old, she was determined not to become a victim of her own circumstances. She fended off would-be Indian assailants while wintering in Galveston Bay, and in the spring, she traveled on horseback with her two young children and an enslaved woman to Bexar and then to Monterrey, hundreds of miles across the open, rugged Texas landscape. She was determined to bring her husband's murderer to justice, but even her indomitable spirit could not overcome a turbulent political climate. Unsuccessful but not unbowed, she rode back to Mississippi with her children. She later made her way back to Texas, settling at Richmond near the coast, and died on Texas soil in 1880.

Mr. Speaker, James and Jane Long are vital to the history of Texas. These two individuals helped sow the seeds of independence in the minds of Texans. Members of Long's expedition, in particular Ben Miram and Jim Bowie, later played integral roles in winning Texas independence from Mexico. While their contribution has often been overlooked by history, their names should live beside those of Houston, Seguin, and Travis as true Texas heroes.

And that is just the way it is.

CELEBRATING THE RISE OF BLACK WOMEN IN POLITICS

HON. TERRI A. SEWELL

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. SEWELL of Alabama. Mr. Speaker, I stand before you today to address a new wave sweeping the state of Alabama and the nation. In response to the Trump administration's continued attack on women as well as the #MeToo movement, at least 70 African-American women ran for office in the Alabama primary on June 5th. These women ran for their local school boards, for county judgeships, for state lawmakers, and for Congress.

Black women have been the backbone of families and communities for generations, providing an unwavering source of strength. I know I stand on the shoulders of such women of strength, like Shirley Chisholm, Harriett Tubman, and Amelia Boynton Robinson. Moreover, I am inspired every day by my mother, Nancy Garner Sewell, who was the first African American female elected to the City Council of Selma, Alabama. These dynamic black women gave all they had to create a more just and free America. Yet, the fight is long from over.

As the first African-American woman elected to Congress from the State of Alabama in 2010, I am overjoyed to see so many others enthusiastic to serve their communities by running for office. Black women are refusing to sit idly on the sidelines. Whether it is on issues of access to quality healthcare, education, equal pay for equal work, or engagement in the political arena, we have women from around the country that are joining the fight to let the world know that we will hold our elected officials accountable on issues that affect us, our families, and our communities.

As more black women continue to speak out and run for office, I look forward to welcoming them to the table.

HONORING DR. JAMES BOK WONG

HON. JUDY CHU

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. JUDY CHU of California. Mr. Speaker, I rise today to honor the life of Dr. James Bok Wong, who passed away on May 25, 2018 at the age of 96. Dr. Wong was a lifelong leader in his community, an immigrant, a businessman, and a veteran.

Dr. Wong was born in Canton, China in 1922. After immigrating to the United States in 1938, he served with the famous Flying Tigers Air Corps, the first American Volunteer Group of the Chinese Air Force during World War II. Following his service, he earned a Bachelor of Science in Agriculture and Chemical Engineering from the University of Maryland under the G.I. bill, and went on to earn both a Master of Science and PhD in Chemical Engineering from the University of Illinois. An entrepreneur and businessman, Dr. Wong rose to become a distinguished figure in the biochemical industry. He served as chief economist and director of international technologies for Dart Industries, and founded his own company, James B. Wong Associates, Inc., through which he licensed U.S. technologies to spearhead the dairy industry in China.

In 1971, Dr. Wong founded the Chinese American Citizens Alliance Foundation to support the growing Chinese American community in Los Angeles. The foundation has provided educational and leadership opportunities to countless young people and played a key role in encouraging civic engagement. Dr. Wong was also a longtime leader in the Chinese American Citizens Alliance, serving as national marshal, president, and a member of the board of directors. Recognized with an L.A. Outstanding Volunteer Service Award in 1977, Dr. Wong later received a History Makers Leadership Award by the Chinese American Museum in 2014.

Dr. Wong leaves behind an enduring legacy of dedication and service to his country and his community. He is an inspiration to all those who knew him and it is my honor to commemorate his life.

RECOGNIZING MARGOT JAMES COPELAND

HON. MARCIA L. FUDGE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. FUDGE. Mr. Speaker, I rise today to honor Margot James Copeland and acknowledge her achievements. She is known for her commitment to improve the local economy and foster inclusive multicultural and multiracial relations in Cleveland, Ohio. Mrs. Copeland is an integral force for change in shaping an inclusive urban community that welcomes constructive change by means of intercultural dialogue and cooperation.

A native of Richmond, Virginia, Mrs. Copeland graduated from Hampton University with a Bachelor of Science degree in physics. She went on to receive her Master of Arts in Educational Research and Statistics from the Ohio State University.

Mrs. Copeland began her corporate career at Xerox Corporation, Polaroid, and Picker International. She later served as Executive Director for Leadership Cleveland before becoming President and CEO of the Greater Cleveland Roundtable.

Currently, Mrs. Copeland is Executive Vice President and Director of Philanthropy and Civic Engagement at KeyBank, one of the nation's largest bank-based multi-line financial services companies. In her role, Mrs. Copeland also serves as Chair and CEO of the KeyBank Foundation, where she guides strategic philanthropic investments promoting affordable home ownership, high quality education, and small business growth. By supporting organizations and programs, she helps make dreams become reality. Mrs. Copeland has been a proven leader in a number of community organizations and sits on several boards. She is the 15th National President of The Links, Inc., serving from 2010 to 2014. She served as President of the Junior League of Cleveland, sat on the Kent State University Board of Trustees, acted as a Protege Program Advisor for Morehouse College, and was a member of the Business School Advisory Board at Hampton University. Mrs. Copeland's public service is marked by her appointment as Vice Chairperson of the Cleveland Bicentennial Commission and, subsequently, the Cleveland Millennium Commission by former Mayor Michael R. White, whose second term Inaugural Committee she chaired. She also served on the Transition Committee for current Cleveland Mayor Frank Jackson.

Mrs. Copeland's extensive record of excellence in service to her community makes it truly an honor to know her, and it gives me great pleasure, Mr. Speaker, to celebrate her today.

HONORING THE LIFE OF GERALD 'JERRY' EIGHMY

HON. MIKE KELLY

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. KELLY of Pennsylvania. Mr. Speaker, I rise today to honor the life of Gerald 'Jerry' Eighmy, who passed away on Tuesday, May 15, 2018 after a lengthy illness. Jerry is survived by his wife of 56 years—Mary, his sons Scott and Harry (both of Erie) and eight beloved grandchildren who will proudly carry on the legacy of their admirable grandfather.

Jerry was born on December 17, 1940 in Cleveland, Ohio. He moved to Conneaut early in life and has been a lifelong resident ever since. After graduating from Conneaut High School, Jerry worked on the ore boats for US Steel to gather up the money needed to go to college.

He attended Heidelberg College in Tiffin, OH getting a degree in chemistry. Shortly after graduating, Jerry started working for his father at the family machining company, the Eighmy Corporation in Conneaut. Over the years, Jerry was instrumental in growing and advancing the company.

In 1984, Jerry started American Turned Products in Erie, PA. American Turned Products has grown into a thriving manufacturing company, with two plants in Erie County that serve the automotive, appliance, military and hydraulics industries.

During his time in the machining industry, Jerry became very involved with the National Screw Machine Products Association, now called the Precision Machined Products Association (PMPA). PMPA is an international trade association that represents the interests of the precision machined products industry and provides programs and services to ensure members stay ahead of the curve and ready to compete on a global scale.

Jerry was actively involved in many PMPA committees over the years and also served on the PMPA's Finance, Executive, and Pension Committees. Jerry served a five year term as Association Treasurer before transitioning to Association Second Vice President, First Vice President, and eventually President elect. In order to acknowledge his service to the association and industry in general, Jerry was presented with the merit award, the association's highest honor.

Jerry continuously strived to make a difference and better the lives of those around him, which he did through a number of capacities. He was a board member and past President of the NWPA Manufacturers and business association and served on the board of Brown Memorial Hospital for 25 years until becoming the chairman. In addition, Jerry was instrumental in the creation of the sports complex for the Conneaut School System, where he was not only the major monetary donor for the project but also donated the land for the track and soccer field, which bears his name today.

In serving his family and community, Jerry was a leader in the truest sense of the word and a role model for those who were privileged to know him. He set a standard of excellence and generosity that is both admirable and praiseworthy. Furthermore, Jerry was a class act that will be remembered for his distinguished career and selfless personality.

Mr. Speaker, please join me in honoring the memory of Jerry Eighmy, a service-minded individual who leaves behind a legacy of compassion and integrity that will positively impact the Conneaut community for years to come.

RATIFICATION OF THE CONSTITUTION

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. POE of Texas. Mr. Speaker, the year was 1787. The American experiment was in trouble. After the Revolution, the colonies came together to draft the Articles of Confederation, which enumerated the powers of the new government. This document, however, left the government unable to regulate interstate commerce, raise revenue through taxes, or support a national defense. Many of the colonists had become restless, and some like Daniel Shays even began openly revolting against the newly founded government.

It was time to act. Fifty-five men from around the colonies made the arduous trek to Philadelphia, where they crammed inside Independence Hall, the same venue where, just eleven years before, many of the individuals present hammered out and ratified the Declaration of Independence. Under the leadership of the gentleman from Virginia, Mr. George Washington, the delegates debated a new direction for the fledgling government. The document that was finally agreed upon by the delegates was what we know today as the United States Constitution. The document outlined a federal government made up of three branches that could each check and balance the powers of the others.

After much debate, it was up to the delegates to gain the ratification of their respective states. They returned home and attempted to whip up support for the Constitution, needing nine states out of thirteen to successfully bring the Constitution into law. Some went to great lengths to promote the Constitution. Alexander Hamilton, James Madison, and John Jay published the Federalist Papers under pseudonyms, a series of essays that highlighted the advantages of the document.

Slowly but surely, the ratifications trickled in. Delaware, Pennsylvania, New Jersey, Georgia, and Connecticut were the first to support the document. Massachusetts, Maryland, and South Carolina followed suit, and finally on June 21, 1788, New Hampshire provided the ninth and decisive ratification. The Constitution was adopted by the U.S. government on March 4, 1789, and the other colonies soon ratified the document, successfully uniting the nation.

More than any individual or group, the documents drafted and adopted by our Founding Fathers shaped who we are as a nation. The Constitution provides us the structure to defend, govern, and implement the beliefs and freedoms enshrined in the Declaration of Independence and the Bill of Rights. It establishes that we the people, not a king or tyrant, would govern our nation.

Mr. Speaker, George Washington hailed the Constitution as ''the guide in which I will never abandon.'' Today, on the occasion of the 230th anniversary of the ratification of this document, let us remember the oath that we took before taking office to support and defend this guide, the very essence of our democracy.

And that is just the way it is.

RECOGNIZING HEALTH SERVICES INCOPORATED FOR 50 YEARS OF OUTSTANDING HEALTHCARE SERVICE

HON. TERRI A. SEWELL

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. SEWELL of Alabama. Mr. Speaker, today I am honored to congratulate Health Services Incorporated on its 50th anniversary of providing affordable health and wellness services to residents of Alabama's 7th Congressional District.

Throughout its 50-year history, Health Services has provided extraordinary healthcare service to the City of Montgomery and its surrounding communities. As a participant in the Federal Health Center Program, Health Services has worked tirelessly to improve the health of the underserved by delivering primary care, pediatric services, dentistry, optometry, family planning, counseling services, veteran benefits, WIC services, and healthcare enrollment services.

Health Services traces its origin back to the late Senator J. Lister Hill, an innovator in his own right who pioneered healthcare legislation such as the Hill-Burton Act. This act was instrumental in providing federal funds to construct medical facilities such as Health Services with the goal of expanding quality health coverage to all Americans, especially those in rural or lower income areas.

Beginning as a small clinic in the basement of Montgomery City Hall in 1968, Health Services used funds made available by the Hill-Burton Act to construct their first clinic in the early 1970s. The building was renamed the Lister Hill Health Center in 1973 to honor Senator Hill. After the renaming, Health Services began expanding its operation, opening its second clinic in 1981 to serve Montgomery County's rural population.

In 1995 Health Services opened its first school-based center and began expanding into other rural Alabama counties, including its Lowndes County office in 1998. Since then, the doctors and providers at Health Services have expanded to 10 locations across 5 counties. Health Services has grown to be the number one healthcare provider to the underserved in South Central Alabama.

All of Health Services' locations operate on a sliding fee schedule to ensure the availability of quality health care to all of those who need medical attention. In addition to helping patients register for federal healthcare programs, Health Services also pioneers programs to bring health information to the communities it serves.

Presently, Health Services Women's Pavilion sees an average of 450 obstetrical patients and another 300 women seeking gynecological services each month. For low-income families without health insurance, Health Services' low fees and accessible healthcare are invaluable. In Montgomery County, Alabama, 15.8 percent of the population is uninsured, and in Lowndes County, 17 percent of Alabamians are uninsured. Without groups like Health Services, it would be extremely difficult for underserved residents in Montgomery, Lowndes, and other counties across Central Alabama to have access to quality healthcare.

On behalf of the 7th Congressional District, the State of Alabama and this nation, I ask my colleagues to join me in celebrating the tremendous accomplishments and extraordinary contributions of Health Services Incorporated—an organization that has worked tirelessly to provide quality and innovative healthcare to the citizens of Alabama for more than 50 years.

RUSSIAN AND CHINESE NUCLEAR ARSENALS: POSTURE, PROLIFERATION, AND THE FUTURE OF ARMS CONTROL

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. POE of Texas. Mr. Speaker, the world today is in a new era of great power rivalry. Resurgent Russia and China are challenging U.S. interests across the globe. Both are rapidly modernizing their militaries to directly challenge America's dominance on the battlefield and to undermine our alliances around the world. The potential for major conflict is closer now than it has been since the Cold War.

China and Russia's rising power has huge implications for how we trade, how we target rogue regimes, and how the entire international system works. While we often focus on Iran and North Korea's nuclear programs, we tend to overlook the two atomic arsenals that pose the greatest danger to our security. But with Russia and China's aggressive behavior in places like Ukraine, Georgia, and the South China Sea, we are forced to rethink our deterrence against such threats.

Comparing our nuclear arsenals, it's clear China and Russia have been intent on challenging U.S. dominance and coercing our friends for some time. While we have barely upgraded some of our nuclear systems since they were first deployed in the early 1980s, China and Russia have introduced new weapons. We may be reluctant to maintain and upgrade such devastating weapons, but our strategic rivals are not. If we allow Russia or China to achieve nuclear superiority over us, the results will be dire for our allies and for the international order we have spent decades building.

Just in March, Vladimir Putin unveiled several new nuclear weapons intended to make our missile defenses ''useless.'' They include a new heavy ICBM, a nuclear-powered cruise missile with ''unlimited range,'' and a nuclear-powered unmanned submarine designed to sneak into coastal cities and explode. Such a heavy investment in nuclear arms is concerning and demonstrates Putin's priority is not disarmament but strategic dominance.

However, Putin left something out of his threatening display. He did not include the new ground-launched cruise missile which the State Department has said for years is violating the INF Treaty. This missile undermines years of arms control negotiations and the good faith we have hoped to build with the Russians since the end of the Cold War. With the New START treaty expiring in 2021, the INF violation casts real doubt on continued strategic arms limitations with the Russians going forward. If the START treaty expires, the Russians will be completely free to expand their nuclear stockpile to what it was during the darkest days of the Cold War. This will likely force others—including ourselves—to also build more bombs.

Worse, now that China is a major rival, we could be pushed into a situation more dangerous than the Cold War. We have been fortunate that China has kept its nuclear stockpile relatively small, focusing on minimal deterrence. But China is building new delivery systems to match our own and is not restrained to arms control agreements like those between the U.S. and Russia. China is rapidly building new ballistic missile submarines and mobile ICBMs which will further strain our military's ability to track. Beijing is also making advances in hypersonic missiles that will make early warning systems ineffective.

Yet, the major concern with China is its willingness to proliferate nuclear technology to rogue regimes. Iran, North Korea, and Pakistan have all benefited from Chinese assistance. In many cases, China has directly sold nuclear and missile technology to these terrorist regimes. China's low regard for non-proliferation standards has been irresponsible and created increased instability around the globe.

For too long we have not addressed the source of these rising threats. North Korea and Iran are major problems, but they would be far more isolated and far less dangerous if they did not have backing from Russia and China. Even our need for missile defense—which China and Russia claim is so destabilizing—would be unnecessary if these rogue regimes did not have help from Moscow and Beijing.

As we think about the future of our nuclear forces and the future of arms control, we must have a clear view of the threats we face. China and Russia are capable adversaries. Left unchecked they will surpass us and make the world less safe. Therefore, we must continue to engage them to restrict the number and capability of these terrible weapons while making clear we will not allow them to gain the nuclear advantage.

Ronald Reagan once said, ''a nuclear war cannot be won and must never be fought.'' We must continue his legacy by seeking a world without nuclear arms.

And that's just the way it is.

RECOGNIZING THE BAY AREA CLIMATE ACTION FORUM

HON. JERRY McNERNEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. MCNERNEY. Mr. Speaker, I rise, along with my colleagues from the Bay Area, Representatives MARK DESAULNIER, ANNA ESHOO, JOHN GARAMENDI, JARED HUFFMAN, BARBARA LEE, JACKIE SPEIER, ERIC SWALWELL and MIKE THOMPSON.

As members who represent Bay Area communities, we are proud to stand in support of the Bay Area Climate Action Forum, which will be held both before and after the Global Climate Action Summit in San Francisco.

Science continues to produce overwhelming evidence that climate change is accelerating and bringing increasingly negative impacts around the globe. The devastating, and in some cases irreversible, costs impact our economy, health and the general wellbeing of all residents in the San Francisco Bay Area and around the globe.

The United States was one of the original United Nations member countries to vote to adopt the historic Paris Climate Accord, which commits to a global initiative to combat climate change and its effects. Unfortunately, this administration has withdrawn the U.S. from this vital global agreement.

Many American cities and states, especially the San Francisco Bay Area and throughout California, are committed to meeting the objectives laid out in the Paris Climate Accord. As their representatives in Congress, we are dedicated to maintaining the United States' role as a global leader and will continue to advocate for the U.S. to be an active participant in fulfilling the principles and objectives of the Paris Climate Accord.

Mitigating the effects of rapid climate change is a global imperative that requires participation from all levels of government, as well as private industry, non-governmental organizations and individuals in our global community.

We applaud the collaboration of those stakeholders in the San Francisco Bay Area who have joined together to hold the Bay Area Climate Action Forum. They are leading by example to show that a regional commitment to climate action is a critical component to finding sustainable solutions.

HONORING THE UNC CHARLOTTE MEN'S RUGBY TEAM

HON. RICHARD HUDSON

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. HUDSON. Mr. Speaker, I rise today to honor the UNC Charlotte 49ers Men's Rugby Team and congratulate them on their National Men's DII 7s Championship. The 49ers defeated the University of Wisconsin Whitewater on May 20, 2018.

Led by Coach Brent "Bo" Pasko, UNC Charlotte capped off an impressive undefeated 2018 season and won its third straight Southern Rugby Conference championship. In the quarterfinals, the team defeated Principia College and moved on to eliminate Bloomsburg University in the semifinals. In the championship game, the Niners bested the University of Wisconsin Whitewater (38–10) to secure a perfect record during the tournament.

The 49ers jumpstarted the championship game with fly half and MVP Michael Basnett scoring the first two tries in rapid succession. Wisconsin Whitewater responded by drawing the game within two points before Basnett crossed once more—advancing the score to 19–10. In the second half, the 49ers opened the flood gates and tries were scored swiftly. Basnett dominated the second half, scoring at will and orchestrating the 49ers' offense to perfection.

It was an immense victory for UNC Charlotte. In defeating the University of Wisconsin Whitewater, the 49ers upset the reigning Division II Rugby 15s and 7s champions. As a proud UNC Charlotte Rugby Alumnus, it brings me great pride to recognize these extraordinary young men as well as all of the coaches and support staff that made this Championship possible. The hard work and dedication exhibited by each member of the team during the season will continue to serve them well in life. They are a source of pride to both UNC Charlotte as well as the surrounding community. I already can't wait to see what 2019 has in store for the 49ers.

Mr. Speaker, please join me today in congratulating the UNC Charlotte 49ers Men's Rugby Team on their national title. Go mean green.

COMMEMORATING THE 55TH ANNIVERSARY OF THE INTEGRATION OF THE UNIVERSITY OF ALABAMA

HON. TERRI A. SEWELL

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. SEWELL of Alabama. Mr. Speaker, I rise today to honor the countless brave men and women who worked to achieve integration on the campus of the University of Alabama (UA). This battle was finally won on June 11, 1963, nearly a decade after the U.S. Supreme Court declared segregation unconstitutional in the 1954 landmark case of Brown v. Board of Education. On that day, school officials attempted to allow black students to enter the University of Alabama, while then-Governor George C. Wallace took his infamous "Stand in the Schoolhouse Door."

During the stand, Governor Wallace stood at the doors of Foster Auditorium at the University of Alabama to physically, and symbolically, block the entry of two black students: Vivian Malone and James Hood.

While Hood and Malone's attempt to desegregate the University of Alabama was historic, they were not the first black students to apply or attend the school. Autherine Lucy, a graduate student from Shiloh, had been accepted to the University and attended for three days in 1956. In response to her attendance, mob violence broke out on UA's campus, and university officials said the school could no longer protect Lucy. She filed an unsuccessful lawsuit against the University, which was used as an excuse to expel her.

Five years later, with the help of the NAACP Legal Defense and Educational Fund of Alabama, Hood and Malone applied to enroll at the University of Alabama. Their applications were denied and the two students faced threats for even applying, but Hood and Malone persisted. After two years of court proceedings, District Court Judge Harlan Grooms granted Hood and Malone permission to enroll at the University of Alabama, ruling that the University was in violation of the U.S. Supreme Court's ruling in Brown v. Board of Education.

Despite the ruling, Governor Wallace blocked the school doors, even as federal authorities demanded he step aside. When Wallace refused to budge, President John F. Kennedy called for 100 troops from the Alabama National Guard to assist federal marshals in helping Hood and Malone enter campus. At that point, Governor Wallace stepped aside.

In 1965, Malone received a Bachelor of Arts in Business Management and became the first African American to graduate from the University of Alabama. Hood left the University after only two months, but returned in 1995 to begin earning his doctorate degree. On May 17, 1997, he received his Ph.D. in Interdisciplinary Studies.

The legacy of Wallace's stand in the schoolhouse door is twofold. Although it is a reminder of the sacrifices made by African American students seeking a higher education, it also served as a turning point for the first steps toward racial equality at the University and within the State of Alabama.

We commend the bravery and determination of the students who continued to fight for their rights and for equal access to education despite facing resistance from all levels of society. We also recognize the importance of continuing to work towards creating a more fair and just society for all citizens.

In the years since the "Stand in the Schoolhouse Doors," Malone, Hood, and countless others have been able to rightfully enroll at the University of Alabama. To this day, students of all ethnicities and backgrounds, including those involved in UA's Black Alumni Association, have gone on to earn undergraduate, graduate, and professional degrees from the University of Alabama. As Malone reflected on her time at the University, she hoped that her impact would be lasting. "I was just one person, but I think of the thousands of people who came after me, and I would just like to think their road might have been a little bit easier, [because of us]" Malone said.

It is because of the courage shown by Vivian Malone and James Hood that students from the University of Alabama have since been able to create a Black Alumni Association dedicated to alumni engagement, scholarship support, mentoring, and networking. Since it was established in 2016, the group has contributed more than $16,000 in donations towards the AAAN Endowed Scholarship Fund.

Since 1963, the University of Alabama has continued to solidify its legacy by exemplifying its continued commitment to inclusion and equality for all persons willing to learn and grow on their campus. Regardless of race, the University of Alabama promises to welcome all students through its doors.

I ask my colleagues to join me in celebrating diversity and inclusion at the University of Alabama on the 55th anniversary of its integration.

RECOGNIZING MR. NATHAN CHITTENDEN OF DUTCH HOLLOW FARM IN SCHODACK LANDING, NEW YORK

HON. JOHN J. FASO

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. FASO. Mr. Speaker, it is with great respect and admiration that I rise today to recognize the many achievements of Mr. Nathan Chittenden of Dutch Hollow Farm in Schodack Landing, New York. Nate has been named the recipient of Cornell University's prestigious Hometown Alumni Award. This designation recognizes Cornell graduates who have returned to their hometown to start or develop a business while also being active and engaged members of their communities.

Nate is a third-generation farmer, carrying on his family's rich dairy farming tradition. Following his graduation from Cornell in 2000 with a degree in dairy science, he returned to the family farm. Since then, he has grown

Dutch Hollow Farm and has become an esteemed advocate and clarion voice for the dairy farming industry across New York State.

Dairy farming is a vitally important part of our identity in Upstate New York, and Nate has worked tirelessly to ensure it remains the engine of our local economy. Through his active participation in the Columbia-Greene Cornell Extension Board, the Agri-Mark Young Cooperators Board, and as a local 4–H dairy leader for over two decades, Nate has become a fixture within the farming community as well as the greater Rensselaer County community.

This Hometown Alumni Award is a true testament to Nate's steadfast commitment to his community and to dairy farming. I cannot think of anyone more deserving of this honor. Mr. Speaker, I ask that my colleagues join me in congratulating Nate on receiving this award. His lifetime of hard work is inspirational, and I am grateful for his many contributions to New York State and to our robust dairy industry.

PERSONAL EXPLANATION

HON. JASON LEWIS

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. LEWIS of Minnesota. Mr. Speaker, on June 20, 2018, during roll call vote No. 276 and No. 278 on the passage of H.R. 5797, the IMD CARE Act, and H.R. 6082, the Overdose Prevention and Patient Safety Act, I was not present on the floor to cast my vote. I fully intended to vote ''yes'' on both pieces of legislation which will help address the opioid crisis facing our nation.

HONORING WALTER J. CORTER

HON. THOMAS MacARTHUR

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. MACARTHUR. Mr. Speaker, I rise today to honor the career and community contributions of Walter J. Corter, of the Third Congressional District, who will retire on July 1, 2018, after over thirty four years of public service to Burlington Township.

Walter has dedicated his career to serving the public. He was hired as a Burlington Township Police Officer in 1974 and held various assignments in the Patrol Division and Investigation Division. He was then appointed as the Public Safety Director in 1983 , and remained in that position until 1994. From 1995 to 2003, he served as the Chief of Investigations for the Burlington County Prosecutor's Office. He additionally served 12 years as Burlington Township's Emergency Management Coordinator. In 2004, he returned to the role of Public Safety Director where he remained until 2011. He was ultimately appointed as the Township Administrator in 2012 and has served in that position ever since.

Walter has received numerous recognitions throughout his career, including several lifetime achievements from the Jewish Relations Council of South Jersey, the Burlington County Prosecutor's Office, the FBI National Academy Associates, and the Burlington County Police Chiefs Association. He has served on FBI Director Mueller's National Law Enforcement Advisory Committee and is a lifetime member of the International Association of Chiefs of Police and the FBI National Academy Associates. Through his efforts, several partnerships have been formed with various agencies and organizations, which continue to benefit the residents of Burlington Township.

Walter is a highly respected individual whose leadership abilities, perseverance, and integrity are widely recognized and demonstrate his commitment to public service. He has continued to further initiatives and programs within Burlington Township that benefit the community as a whole.

Mr. Speaker, the people of New Jersey's Third Congressional District are tremendously honored to have Walter J. Corter as a member of their community. Walter has shown a desire to serve the public and to give back to his community, and has worked continuously to do so at the best of his ability. I am honored to recognize his career of public service and to commend him for all that he has contributed to his community.

RECOGNIZING JUNE AS SCLERODERMA AWARENESS MONTH

HON. PETER T. KING

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. KING of New York. Mr. Speaker, I rise today to recognize June as Scleroderma Awareness Month.

Scleroderma is a chronic connective tissue disease generally classified as one of the autoimmune rheumatic diseases. Hardening of the skin is one of the most visible manifestations of the disease. The disease is also known as ''systemic sclerosis,'' a subset of the disease in which internal organ systems (such as kidneys, lungs, heart, and gastrointestinal track) and skin, or internal organ systems only, are affected. It is estimated that about 300,000 Americans have scleroderma with one-third of those having the systemic form of the disease.

Scleroderma varies from patient to patient and often presents with symptoms similar to other autoimmune diseases, making diagnosis and treatment extremely complicated. There may be many misdiagnosed or undiagnosed cases. Currently, there is no cure for scleroderma.

On behalf of the scleroderma community, I am proud to be the lead sponsor of H.R. 4638, the National Commission on Scleroderma and Fibrotic Diseases Act. This bill would establish a National Commission on Fibrotic Diseases within the National Institutes of Health (NIH) to evaluate and make recommendations regarding improvements to the coordination and advancement of NIH-supported research activities related to fibrosis and fibrotic diseases.

I call on my colleagues to join me in supporting this important legislation by becoming a cosponsor of H.R. 4638, which will increase research and treatments for the fibrotic community.

COMMEMORATING THE GROUNDBREAKING FOR THE STEPHEN D. ''STEVE'' HOGAN PARKWAY

HON. MIKE COFFMAN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. COFFMAN. Mr. Speaker, I rise today to commemorate the groundbreaking for the Stephen D. ''Steve'' Hogan Parkway in Aurora, Colorado. Named in honor of Aurora's Mayor Steve Hogan, who sadly passed away on May 13, 2018, this parkway represents a long awaited major improvement and expansion of Aurora, Colorado's Sixth Avenue. The parkway is fittingly named to honor the life of this well-loved public servant, who I was fortunate enough to call a friend.

The parkway's design was finalized in February of 2017, and completion is scheduled to occur prior to the end of 2019. This expansion of Sixth Avenue will greatly facilitate east/west mobility in Aurora and provide substantial safety and congestion improvements at the 6th Avenue entrance to Buckley Air Force Base.

Throughout his time serving the citizens of Aurora as a state legislator, as a member of Aurora City Council, and as its Mayor, Steve Hogan tirelessly worked on behalf of the citizens of the City of Aurora. During his time in elected office, Aurora has grown from a medium sized suburb of Denver to become Colorado's third largest city with a full range of amenities, services, and its own distinct identity.

The Stephen D. Hogan parkway will symbolize his lasting legacy as a public servant. I am pleased that this vital transportation project will do so much for Aurora, the wonderful city that Mayor Hogan loved, by bringing it new growth and economic opportunities.

Steve Hogan was truly a model citizen and a great mayor of my hometown. It is my honor to take this opportunity to commemorate, here on the floor of the U.S. House of Representatives, this important event in the legacy and the life of Mayor Steve Hogan.

IN HONOR OF MR. JERRY C. GRIMSLEY

HON. SANFORD D. BISHOP, JR.

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. BISHOP of Georgia. Mr. Speaker, it is with a heavy heart and solemn remembrance that I pay tribute to a devoted and hard-working businessman, Mr. Jerry C. Grimsley. Mr. Grimsley passed away on Monday, June 11, 2018. A funeral service was held on Friday, June 15, 2018, at First Baptist Church in Colquitt, Georgia.

A Georgia man through and through, Jerry was born on July 19, 1939, to Clarence E. Grimsley and Julia Tassie Odom Grimsley on their family farm in Miller County, Georgia. After graduating from Miller County High School in 1957, he attended Abraham Baldwin Agricultural College in Tifton, Georgia.

Mr. Grimsley was a highly trusted leader in the agriculture and financial services industries. He built quite an impressive career

which began in 1962 at Farmers Fertilizer and Milling Company as Vice-President and Co-Owner with his father-in-law. He became the President of Farmers Fertilizer and Milling Company in 1974 and helped it to grow from a small feed and fertilizer manufacturer into an internationally recognized leader in the peanut shelling industry. Mr. Grimsley also was the Founding Director of Peoples Bank, now Peoples South, when it was chartered on March 16, 1973. During his tenure as Founding Director, the bank grew from one small branch in Colquitt to twenty-nine branches across Georgia, Alabama, and Florida. He served in this capacity for 45 years until early 2018, when his health started to decline. Upon his retirement, he became the Director Emeritus of Peoples Bank and the owner of a local golf course which he named ''Clydesdale Meadows''.

Throughout his career, Mr. Grimsley served on a number of boards and was affiliated with several associations. He was President and Chairman of the Board for the Southeastern Peanut Sheller's Association (1975 to 1976); the Board of the National Peanut Council (1985 to 1987); and President of American Peanut Sheller's Association (1990 to 1991). In addition to these roles, he also served as the Chairman of several peanut-based committees. In 2000, Birdsong Peanuts purchased Farmer Fertilizer and Milling Company, and Jerry served as a consultant in the Southeast Division.

George Washington Carver once said, ''No individual has any right to come into the world and go out of it without leaving behind distinct and legitimate reasons for having passed through it.'' We are all so blessed that Mr. Jerry C. Grimsley passed this way and during his life's journey did so much for so many for so long. He leaves behind a great legacy in public service to the countless residents of Colquitt whose lives he touched and brightened.

He is survived by his sons, Gerry and Scott; and a host of family and friends who will miss him dearly.

Mr. Speaker, I ask my colleagues to join me, along with my wife, Vivian, and the more than 730,000 residents of Georgia's Second Congressional District in paying tribute to Mr. Jerry C. Grimsley for his remarkable leadership in our great State of Georgia. We extend our deepest condolences to his family, friends and the Colquitt, Georgia community during this difficult time and pray that they will be comforted by an abiding faith and the Holy Spirit in the days, weeks, and months ahead.

IN RECOGNITION OF MAJOR GENERAL WAYNE P. JACKSON (RETIRED), UNITED STATES ARMY

HON. BRIAN J. MAST

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. MAST. Mr. Speaker, I rise today to recognize Major General Wayne P. Jackson, Retired, a true patriot and fellow veteran who I had the honor of joining in throwing out the first pitch earlier this month at Roger Dean Stadium.

Born in Chicago in 1929, General Jackson was commissioned in 1951 as a Second Lieutenant after several years of enlisted service in the U.S. Army Air Force and U.S. Navy. His 37 years in the service was defined by profound courage and many accomplishments.

He served in various overseas theaters of operation and has commanded Signal Corps, Military Intelligence and Civil Affairs units. As a General Officer he served as the Director of Counter Intelligence and Security, the Assistant to the Chief of Staff for Intelligence at the Department of the Army Headquarters, the Commanding General of the 352nd Civil Affairs Command, and the Deputy and Commanding General of the 97th Army Reserve Command.

General Jackson has also been awarded the Expert Infantry Badge, the Parachute Badge, and the Master Aviator Badge. His decorations include the Distinguished Service Medal, the Meritorious Service Medal, the Army Commendation Medal and several other military awards and decorations.

However, General Jackson's life of excellence extends not only to his military service, but to his academic work as well. He received his Bachelor of Arts and Masters of Arts degrees in psychology at the University of Tulsa. He did post graduate work at the Illinois Institute of Technology and the University of Southern California. His military education includes the basic and advanced officer courses at the Signal and Military Intelligence Schools. He has also completed the advanced courses at the Civil Affairs and Infantry Schools. He is a graduate of the U.S. Army Command and General Staff College and the U.S. Army War College.

General Jackson and his wife, Lahoma reside in Jupiter, Florida. His son Wayne Jr. and two daughters, Jacky and Jennifer, four grandchildren and 2 great grandchildren also reside in Jupiter. In the tradition of his father, his son Wayne Jr., is also retired from the U.S. Army.

General Jackson has lived a life of excellence and of many great accomplishments both in the military and as a civilian. Mr. Speaker, that is why I am honoring General Jackson and thank him for his many years of service to our country. I have no doubt that he will continue to accomplish great things in the years to come.

IN RECOGNITION OF MRS. LILIA GIACOMAZZI

HON. DAVID G. VALADAO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. VALADAO. Mr. Speaker, I rise today to recognize Mrs. Lilia Elizabeth Giacomazzi as the 2018 Distinguished Dairyperson by the June Dairy Month Committee of Kings County, California.

Mrs. Giacomazzi was born Lilia Elizabeth Curti on July 23, 1913 in Fresno, California to her parents Miro and Domenica Curti, immigrants from the small town of Albonico in the northern Italian Alps. The oldest of five siblings, Lilia graduated from Tulare Union High School in 1927.

On July 12, 1936 Lilia married Fred Giacomazzi and the newlyweds moved to a home on the Hanford-based Giacomazzi Dairy, Kings County's longest-continuously-operating dairy. Their initial home now houses the Giacomazzi Dairy offices.

In October 1937, Lilia and Fred had their first child, their son Donald and three years later, in March 1940, welcomed their daughter, Patricia. Mrs. Giacomazzi was actively involved in her children's education, serving as a room mother and president of the Hanford High School Parent-Teachers Association. Additionally, she helped many Kings County 4–H participants learn to cook, sew, and garden.

Her love of gardening led to her work establishing the LaCasa Garden Club and, eventually, LaCasa Park in Hanford, California. Her love and passion for gardening has remained a constant during her 105 years.

On July 12, 1998, Mrs. Giacomazzi lost her beloved husband of sixty-two years, Fred. However, she has found comfort from her seven grandchildren and to eight great-grandchildren to whom she is known as ''Nonna.''

Mrs. Giacomazzi also served as President of the Kings County Dairywomen and Western United Dairy Women of California. This year marks Mrs. Giacomazzi's fifty fith year of service to the Kings County Dairywomen. She has also been actively involved in the Sons of Italy Lodge, the Central Valley Hospital Auxiliary, the Kings County Republican Women Federated, the Kings County Historical Society, the American Theater Organ Society, the Kings Symphony Orchestra, and the Young Ladies Institute.

Mr. Speaker, I ask my colleagues in the United States House of Representatives to join me in commending Mrs. Lilia Elizabeth Giacomazzi on her lifetime of service to the Central Valley and on receiving the 2018 Distinguished Dairyperson Award.

HONORING WORLD WAR II HEROES

HON. TIM RYAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. RYAN of Ohio. Mr. Speaker, today I rise to honor deceased Trumbull County, Ohio resident 1st Lt. Olof M. Ballinger, pilot of the 42–299–28 B–17 Flying Fortress that was shot down over Normandy, France during WWII 75 years ago on July 4, 1943. 2nd Lt. George C. Williams, Bombardier of Warren, Ohio, was also aboard the aircraft.

Pilot Olof Maximilian Ballinger of Newton Falls, Trumbull County, Ohio evaded capture and walked alone, with no compass, over the Pyrenees Mountains during the winter. He reached safety in Spain in November 1943 and returned to the U.S. He eventually moved to California.

George C. Williams, bombardier from Warren, Trumbull County, Ohio, was killed in action. While assisting the nose gunner, his chute accidentally opened inside the aircraft. Pilot Olof Ballinger offered up his own parachute, but George Williams refused. It is thought that George Williams attempted to fly the plane after all the crew had evacuated.

Also aboard the aircraft was Harry W. Basucher Jr. of Cincinnati, Ohio and Albert Wackerman of Salinas, California who were killed in action by enemy cannon fire. Bryon J. Gronstall, of Van Nuys, California and John K. Lane, a radio operator from Deland, Florida, were captured by German patrol and were Prisoners of War at Stalag 7A. William C. Howell, of Goldsboro, North Carolina and Paul

McConnell, the navigator from Montgomery, Alabama both evaded capture. Francis E. Owens, of Pittsburgh Pennsylvania, also evaded capture, but he died of exposure in the Pyrenees Mountains while trying to assist other crewmen through the dangerous passage. He was awarded the Soldiers Medal for dragging wounded men out of harm's way. Co-pilot, John Marshall Carrah, from Chico, California, evaded capture and escaped to Switzerland, to Spain, and then returned to the U.S. in March 1944. He continued to assist in the war effort. He was a career United States Air Force Officer, retiring as a Lt. Colonel.

A documentary was created about these seven brave American aviators and will be featured at an event in Warren, Ohio on July 2, 2018. The son of co-pilot John M. Carrah will also be at the event to share his firsthand knowledge about his father's experience.

I am inspired by the stories of these brave Americans, and I'm so proud of the individuals who are keeping this history alive for younger generations.

PROVIDING FOR CONSIDERATION OF H.R. 6, SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT; PROVIDING FOR CONSIDERATION OF H.R. 5797, INDIVIDUALS IN MEDICAID DESERVE CARE THAT IS APPROPRIATE AND RESPONSIBLE IN ITS EXECUTION ACT; AND PROVIDING FOR CONSIDERATION OF H.R. 6082, OVERDOSE PREVENTION AND PATIENT SAFETY ACT

SPEECH OF

HON. PETE SESSIONS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 20, 2018

Mr. SESSIONS. Mr. Speaker, the Rules Committee report (H. Rept. 115–766) to accompany House Resolution 949 should have included in its waiver of all points of order against consideration of H.R. 6 a disclosure of the following violation:

Clause 12(a)(1) of rule XXI, requiring a comparative print to be made publicly available prior to consideration of a bill amending or repealing statutes to show, by typographical device, parts of statute affected. While the waiver is necessary because the document was not available prior to consideration of the bill, it is important to note that it was available before the vote on final passage.

IN RECOGNITION OF JACK MEINKE ON HIS OFFER OF APPOINTMENT TO ATTEND THE UNITED STATES NAVAL ACADEMY

HON. ROBERT E. LATTA

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. LATTA. Mr. Speaker, it is my great pleasure to pay special tribute to an outstanding student from Ohio's Fifth Congressional District. I am pleased to announce that Jack Meinke of Millbury, Ohio has been offered an appointment to the United States Naval Academy in Annapolis, Maryland.

Jack's offer of appointment permits him to attend the United States Naval Academy this fall with the incoming Class of 2022. Attending one of our nation's military academies not only offers the opportunity to serve our country, but also guarantees a world-class education while undertaking one of the most challenging and rewarding experiences of a lifetime.

Jack brings a tremendous amount of leadership, service, and dedication to the incoming Class of 2022. While attending St. John's Jesuit High School in Toledo, Ohio, Jack was active in the National Honor Society, National Spanish Honor Society, and was an Honor Roll student. Additionally, he participated in Buckeye Boys State, Ignatian Guild Scholars, and various leadership and mentoring programs.

Throughout high school, Jack excelled on the football and wrestling teams, earning varsity letters and diligently serving as captain of the wrestling team. I am confident that Jack will carry the lessons of his student and athletic leadership to the Naval Academy.

Mr. Speaker, I ask my colleagues to join me in congratulating Jack Meinke on his offer of appointment to the United States Naval Academy. Our service academies offer the finest military training and education available. I am positive that Jack will excel during his career at the Naval Academy, and I ask my colleagues to join me in extending their best wishes to him as he begins his service to our Nation.

PERSONAL EXPLANATION

HON. MICHAEL R. TURNER

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. TURNER. Mr. Speaker, on June 20, I was unable to vote on Roll Call votes 272, 273, and 274. Had I been present, I would have voted as follows:

Roll Call 272—Yes.
Roll Call 273—Yes.
Roll Call 274—Yes.

IN RECOGNITION OF DEPUTY CHIEF OF POLICE BETTY MILLER STOCKS RECEIVING THE ROBERT JACKSON EURY MEMORIAL AWARD

HON. RICHARD HUDSON

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. HUDSON. Mr. Speaker, I rise today to honor Concord Deputy Chief of Police Betty Miller Stocks for receiving the Robert Jackson Eury Memorial Award. Deputy Chief Stocks has now become the first African American recipient of this award.

A native of Concord, North Carolina, Deputy Chief Stocks has served with the Concord Police Department in North Carolina's 8th Congressional District for 27 years. Education was of the utmost importance to Deputy Chief Stocks—graduating from Concord High School before earning an Associate's Degree in Criminal Justice from Rowan-Cabarrus Community College, a Bachelor's Degree in Criminal Justice from Barber-Scotia College and a Master's Degree in Public Administration from the University of North Carolina at Charlotte.

Throughout her career, Deputy Chief Stocks has served as a Patrol Officer, Sergeant, Captain, and now Deputy Chief of Police. Deputy Chief Stock's outstanding leadership and commitment in these roles for the Concord Police Department made her stand out in our community.

The Robert Jackson Eury Memorial Award is presented in memory of Robert Jackson Eury, a man who lost his life in the line of duty while serving as a Cabarrus County law enforcement officer. This award keeps Mr. Eury's legacy alive through officers who share his same admirable and commendable spirit in Cabarrus County. Based on her career of service, I would say Deputy Chief Stocks fits the mold of esteemed law enforcement officers in our community set by Robert Eury.

There is no doubt in my mind that Deputy Chief Stocks will continue her outstanding leadership and maintain her unwavering values while protecting the people of Cabarrus County; I am excited to see what the future holds for such a dedicated law enforcement professional.

Mr. Speaker, please join me today in congratulating Deputy Chief of Police Betty Miller Stocks for receiving the Robert Jackson Eury Memorial Award. We all wish her well as she continues to make a positive impact on our community.

PERSONAL EXPLANATION

HON. ROBERT B. ADERHOLT

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. ADERHOLT. Mr. Speaker, I would like to go on the record as fully supporting H.R. 2, the Agriculture and Nutrition Act of 2018. I was detained off the floor and missed the opportunity to cast my vote on a bill that indeed supports our farmers and rural America. I would like to reflect that I voted in favor of this bill, H.R. 2, the first time it came to the floor on May 18, 2018. I commend Chairman CONAWAY on passage of the bill on the House floor. This new Farm Bill will benefit consumers and producers, and all those who make our food supply chain abundant and secure.

H.R. 5788

HON. SUZANNE BONAMICI

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. BONAMICI. Mr. Speaker, I rise today in support of H.R. 5788, the Synthetics Trafficking and Overdose Prevention Act. The STOP Act requires the U.S. Postal Service to collect Advanced Electronic Data on international shipments, making it easier for U.S. Customs to target high-risk shipments for inspection and seizure. This is particularly important to stem the deadly flow of fentanyl

coming from China. I understand the concerns about potential civil penalties that could be imposed if USPS fails to meet terms of compliance. But with the updated language added to the final version, I am confident this legislation provides sufficient flexibility allowing USPS to avoid those penalties as long as it is making a good faith effort to institute AED collection in a meaningful way. I will closely follow the implementation of this policy and will work to make sure USPS can comply without leading to cost-saving actions such as reductions of service, consolidation or closing of post offices, or cuts to the employee workforce. We must stop these dangerous shipments to help save the lives of those who are addicted to opioids. Although there is more to be done to tackle the opioid crisis, this is one step forward that I support.

IN RECOGNITION OF MR. JOHN CARLOS MARTINS

HON. DAVID G. VALADAO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. VALADAO. Mr. Speaker, I rise today, along with my colleagues, Representatives DEVIN NUNES and JIM COSTA, to honor the life of Mr. John Carlos Martins, who sadly passed away on June 16, 2018.

Mr. John Carlos Martins was born on April 21, 1964 in the parish of Altares, on the Portuguese island of Terceira. Just two years later, in 1966, John and his family immigrated to the United States and settled in Artesia, California. At a young age, John developed an interest in carpentry. After graduating from Cerritos High School in 1982, Mr. Martins attended Los Angeles Trade-Technical College where he advanced and honed his craft further, enabling him to build a successful development company with his father and brother.

In 1997, Mr. Martins was appointed to the City of Artesia Planning Commission and in 2001, he was elected to serve on the Artesia City Council. Following his service as city councilman, John continued working for the people of Artesia as Mayor of the city from 2004 until his retirement in 2010.

Although John and his family left the Azores Islands of Portugal early in his childhood, he remained deeply connected to his roots, as seen through his steadfast involvement in the Portuguese-American community. John participated in, and held positions on, many local and statewide Portuguese-American organizations. Mr. Martins was a Board Member of the California Portuguese American Coalition, President of the Artesia DES Portuguese Center in 2006 and 2013, Board Director of the Luso-American Fraternal Federation for eight years, and in 2000, he became President of that same Federation. Additionally, in 2015, Mr. Martins was appointed Honorary Consul of Portugal in Los Angeles.

While John dedicated the majority of his free time to his community, he also pursued his musical passions. John began playing guitar when he was only ten years old, and throughout his time in school he learned to play various other instruments. In 1979, he and his siblings formed the group Aquarious and travelled the world playing music for over twenty-five years. In 2012, John teamed up with his son Cole and his old bandmate David to establish the band 562. The talented group performed throughout California at various events and festivals and to many sold out shows.

Mr. Martins' tireless and selfless dedication to his community was truly inspiring. Although he left us too soon, John made a lasting, positive impact on the people he met. John is survived by his wife Karen and their three children.

Mr. Speaker, today we ask our colleagues in the United States House of Representatives to join us in honoring the life of Mr. John Carlos Martins. Our thoughts and prayers are with his family, friends, and community during this difficult time.

HORNORING THE DILLARD CENTER FOR THE ARTS JAZZ BAND IN WINNING THE 2018 ESSENTIALLY ELLINGTON HIGH SCHOOL JAZZ BAND COMPETITION

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. HASTINGS. Mr. Speaker, I am honored to rise today and recognize the Dillard Center for the Arts Jazz Band on their May 12, 2018 first place win at the 2018 Essentially Ellington High School Jazz Band Competition in New York City.

Dillard High School, located in Fort Lauderdale, Florida has a long history of excellence in the arts. In 1948, Dillard's well-known jazz program attracted one of the greatest musicians in history, Julian Edwin ''Cannonball'' Adderley.

Under the leadership of Director Christopher Dorsey, Dillard's Jazz Band performed on stage at Lincoln Center for the Essentially Ellington Competition. They were judged by an esteemed panel of jazz musicians, lead by composer and trumpeter Mr. Wynton Marsalis, and deemed to be worthy of the first place prize out of fifteen band finalists. Additionally, Ms. Summer Camargo, a member of the band, won the Composition/Arranger Contest.

Mr. Speaker, I am so proud of the Dillard Center for the Arts Jazz band. I wish Director Dorsey and the entire jazz band ensemble a hearty congratulations.

PERSONAL EXPLANATION

HON. JARED POLIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. POLIS. Mr. Speaker, I was absent for the vote on passage of H.R. 6082, the Overdose Prevention and Patient Safety Act (Roll Call vote No. 278), had I been present I would have voted NO.

I was absent for the vote on passage of H.R. 5797, the Individuals in Medicaid Deserve Care that is Appropriate and Responsible in its Execution Act (Roll Call vote No. 276), had I been present I would have voted NO.

PERSONAL EXPLANATION

HON. JOYCE BEATTY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mrs. BEATTY. Mr. Speaker, I was absent from the House Chamber between June 5, 2018, and June 19, 2018, during my medical recovery. Had I been present, I would have voted: Yes on Roll Call No. 231, Yes on Roll Call No. 232, Yes on Roll Call No. 233, No on Roll Call No. 234, No on Roll Call No. 235, No on Roll Call No. 236, No on Roll Call No. 237, Yes on Roll Call No. 238, Yes on Roll Call No. 239, No on Roll Call No. 240, No on Roll Call No. 241, No on Roll Call No. 242, No on Roll Call No. 243, Yes on Roll Call No. 244, Yes on Roll Call No. 245, No on Roll Call No. 246, Yes on Roll Call No. 247, Yes on Roll Call No. 248, No on Roll Call No. 249, Yes on Roll Call No. 250, No on Roll Call No. 251, No on Roll Call No. 252, No on Roll Call No. 253, No on Roll Call No. 254, Yes on Roll Call No. 255, Yes on Roll Call No. 256, No on Roll Call No. 257, Yes on Roll Call No. 258, Yes on Roll Call No. 259, No on Roll Call No. 260, No on Roll Call No. 261, No on Roll Call No. 262, Yes on Roll Call No. 263, Yes on Roll Call No. 264, Yes on Roll Call No. 265, No on Roll Call No. 266, No on Roll Call No. 267, No on Roll Call No. 268, Yes on Roll Call No. 269, Yes on Roll Call No. 270, No on Roll Call No. 271.

PERSONAL EXPLANATION

HON. JACK BERGMAN

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. BERGMAN. Mr. Speaker, on Roll Call Votes No. 269, No. 270 and No. 271 I am not recorded because I was absent from the House of Representatives. Had I been present, I would have voted in the following manner.

On Roll Call No. 269. Had I been present, I would have voted YEA.

On Roll Call No. 270. Had I been present, I would have voted YEA.

On Roll Call No. 271. Had I been present, I would have voted NO.

SUPPORTING PASSAGE OF H.R. 6 AND URGING FURTHER ACTION TO PREVENT ADDICTION

HON. TERRI A. SEWELL

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. SEWELL of Alabama. Mr. Speaker, I rise today to thank all of the Members who have worked across the aisle on the opioid bills we've passed over the past two weeks. The bipartisan work that has gone into these bills is exactly what our constituents sent us to Congress to do. I have enjoyed working with Rep. PETER ROSKAM on H.R. 5773, the Preventing Addiction for Susceptible Seniors Act, which passed on Tuesday as a suspension. Since our committee has jurisdiction over the Medicare program, we found it necessary to

work on legislation that helps the seniors impacted by the opioid crisis across this country.

The bill included another bill I worked on with Rep. RENACCI, H.R. 5715, the Strengthening Partnerships to Prevent Opioid Abuse Act. The bill encourages greater data sharing between CMS and insurers.

All the bills passed in recent weeks represent the first step in addressing a crisis that has impacted millions of Americans and their families. In 2016, we lost 64,000 American lives from drug overdoses. Drug overdoses are now the leading cause of death among Americans under the age of 50.

After today, we must continue to focus on policies that lift our constituents out of the conditions that lead to addiction. Whether that results from social isolation, financial anxiety, emotional or physical trauma, inadequate access to primary or mental health care, we should consider how all of the policies we advance in this body will impact our constituents.

The lessons from past drug crises and the evidence supporting the public health approach we are taking today can guide us as we seek an end to the current opioid crisis—without revamping the failed and costly War on Drugs.

Opioid addiction is a disease that has spread to millions of Americans across the country, from our young students to our parents and grandparents, from our rural communities to our big cities. Alabama, which has the highest rate of opioid prescriptions in the country, is a battleground in our fight against this epidemic.

Millions of Americans become addicted to opioids after being prescribed opioids after surgery or to manage pain. My congressional district and state is home to many retired coal miners and men and women who have spent their lives working in physically intensive jobs in manufacturing. I have no doubt that the chronic pain they have sustained from years in physically taxing work environments is real and requires pain medication.

I also have heard from constituents with sickle cell disease and cancer, who require pain management to treat the pain that results from their conditions.

Moving forward, I am committed to working on policies that advance and encourage the development and adoption of non-opioid alternatives for pain management. From increased access to physical therapy and chiropractic care to post-surgical non-opioid alternatives, I urge CMS to take the steps they can today to change reimbursement policies that discourage providers to prescribe non-opioid alternatives.

The preventative action necessary for a crisis as such can be observed in the case of Jessica Kilpatrick, an Alabama woman in a small town in Northwest Alabama. As stated in the Washington Post, ''for as long as she could remember, pills made the intolerable possible. Now, without them, she was a poor woman in a poor town with a swollen right foot from a 10-hour shift [at Burger King] and a new key tag from Narcotics Anonymous that said ''Clean and Serene for Eighteen months.''

Susceptibility to relapse on this road to recovery is fueled by the lack of access to adequate treatment for both pain and addiction. I am deeply concerned about Alabamians who work hard every day but yet fall into the Medicaid gap. Workers who make more than 18 percent of the poverty line but less than the federal poverty line do not qualify for any assistance, making prevention and treatment more expensive in non-expansion states and unaffordable for Alabamians in minimum wage jobs.

I urge all Members of Congress to support H.R. 6 today because it marks a positive step in the right direction as we work to improve the lives of the millions of Americans impacted by the opioid and addiction crisis.

HONORING THE CAREER OF LEGENDARY SPECIAL FORCES VETERAN MAJOR GENERAL MICHAEL D. HEALY

HON. RICHARD HUDSON

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. HUDSON. Mr. Speaker, I rise today to recognize the life and legacy of Major General Michael D. Healy who passed away on April 15, 2018 at the age of 91. During his 35 years of dedicated service, Maj. Gen. Healy served valiantly, made history and showed us all how to be a family man.

After enlisting in the United States Army in 1945, Maj. Gen. Healy began an illustrious career with deployments in both the Korean and Vietnam Wars. After evading enemy machine gun fire in the Korean War, Maj. Gen. Healy was given the nickname ''Iron Mike'' and it has stuck with him throughout his entire life. His nerves of steel and unparalleled courage led him to become one of the first Green Berets to achieve the rank of General.

Deployed on numerous operational assignments all over the globe and through some of our nation's toughest times, Maj. Gen. Healy stood ready to answer the call to serve our nation. Throughout these operations, he delivered on the promise to keep America safe and confront our enemies under the most difficult conditions. Maj. Gen. Healy received numerous medals and recognitions for his service, including the Distinguished Service Cross, Bronze Star Medal, Distinguished Service Medal, two awards of the Silver Star, four awards of the Legion of Merit, and the Distinguished Flying Cross. He was truly a man of humility, bravery, and dignity.

While fighting our nation's battles overseas, Maj. Gen. Healy most important commitment remained to his family back home. He was married to his lovely wife, Jacklyn, for 69 years, and they raised six sons, ten grandchildren and eight great grandchildren. This country cannot repay the debt we owe to Maj. Gen. Healy and his family—the Healys are true American heroes.

Mr. Speaker, please join me today in commemorating the career of the Major General Michael D. Healy.

IN RECOGNITION OF GIACOMAZZI DAIRY

HON. DAVID G. VALADAO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. VALADAO. Mr. Speaker, I rise today to recognize Giacomazzi Dairy as it celebrates its 125th year of continuous operations producing milk in Kings County, California.

Founded by Luigi Giacomazzi, an immigrant from Moghegno, Ticino, Switzerland, Giacomazzi Dairy opened on property acquired from Southern Pacific Rail Road Company in 1893, the same year Kings County was formed. Mr. Giacomazzi developed the land and founded the dairy with just ten cows producing butter and cheese that he sold to locals and Chinese railroad workers.

After marrying his wife, the former Gilia Pincini, Mr. Giacomazzi built their farm and dairy with the help of their four children: Florinda, Louis, Jr., Stephen, and Fred.

In 1923, Giacomazzi Dairy became the first dairy to install milking machines in the region. These revolutionary machines simultaneously milked four cows. By 1937, Giacomazzi Dairy constructed their third Grade A barn in Kings County. Technological advances enabled the Giacomazzis to milk forty-two cows at a time.

Louis, Jr., Stephen, and Fred formed a new partnership—Giacomazzi Brothers—with each sibling handling a distinct aspect of operations. Once considered the largest dairy operation in the southern Central Valley region, Giacomazzi Brothers dissolved the partnership in 1969, however, Fred Giacomazzi continued to operate the dairy, purchasing land from the partnership.

Joined by his son, Donald in 1974, Fred increased the dairy's herd to 350 cows with approximately 300 acres of farmland. In 1985, the Giacomazzi Dairy herd grew to 600 cows and its farming operation expanded to 500 acres.

Don and his wife Jackie, had four children: Gina, Dino, Cara, and Mia. In 2003, Dino returned to the farm after working thirteen years in the music and internet industries. Two years later, Dino married his wife, the former Julie Friebe, and took over day-to-day management and operations of the farm. Since assuming operations, Dino has expanded the herd to 1,000 cows on 1,000 acres, including 375 acres planted with almond trees.

Beginning with its first milking machine in 1923, Giacomazzi Dairy has established itself as a leader in agriculture innovation.

Mr. Speaker, I ask my colleagues in the United States House of Representatives to join me in congratulating the Giacomazzi Dairy, Kings County's longest, continuously-operating dairy, on its 125th year of producing milk.

HONORING DAVID FOUNTAIN AND LEADERSHIP NORTH CAROLINA

HON. DAVID E. PRICE

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Mr. PRICE of North Carolina. Mr. Speaker, I rise today to honor the leadership of David Fountain, North Carolina President of Duke Energy, as he completes his successful term of service as chair of the Leadership North Carolina Board of Directors.

Leadership North Carolina is an independent, nonpartisan, nonprofit organization that engages current and emerging leaders from across the state. Its mission is to inform, develop, and engage committed leaders by broadening their understanding of and involvement in issues and opportunities facing the

state. Each year LNC recruits committed individuals interested in learning more about North Carolina and connecting with fellow leaders. Through innovative programming, LNC teaches these engaged citizens about the challenges and opportunities facing North Carolina and offers tools to turn their knowledge into action for the benefit of the state.

David Fountain has been an energetic and visionary chair of LNC's board since 2016, as one might have expected from his successful rise through the ranks at Duke Energy. He holds BA, JD, and MBA degrees from the University of North Carolina at Chapel Hill, where he was a Morehead-Cain Scholar. He practiced law at McGuire Woods in Raleigh from 1994 to 2000, after which he joined what was then called Carolina Power & Light as associate general counsel. From 2009 to 2012, Mr. Fountain served as general counsel and vice president of Progress Energy Inc. From there, he went on to serve as senior vice president of Enterprise Legal Support at Duke Energy and rose to the role of President in 2015.

David was elected chair of Leadership North Carolina in 2016. He knew and believed in the program as an alumnus and has given it full benefit of his experience and dedication. He has helped position the program for sustainability for years to come and has strengthened its reputation among leaders in business, government, education, and the nonprofit sectors. The measure of a good leader is the legacy he or she leaves behind. Mr. Fountain leaves North Carolina with 1,157 informed and engaged leaders and has challenged them to exercise their influence for the benefit of our state and nation.

I want to join David Fountain's many friends and admirers in thanking him for the time and effort he has dedicated to Leadership North Carolina and to congratulate him for a job well done. He leaves the organization stronger than he found it, better equipped to nurture future generations of conscientious and effective leaders. For that, all North Carolinians are in his debt.

PERSONAL EXPLANATION

HON. SUZANNE BONAMICI

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Friday, June 22, 2018

Ms. BONAMICI. Mr. Speaker, I was unable to be on the House floor on June 19, 2018 because my flight from Oregon was delayed because of weather. If I had been present, I would have voted in favor of H.R. 5676, the Stop Excessive Narcotics in our Retirement Communities Protection Act, and H.R. 5687, the Securing Opioids and Unused Narcotics with Deliberate Disposal and Packaging Act of 2018. These bills take important steps to stem the tide of opioid abuse in this country, and I will continue to work with my colleagues on both sides of the aisle to combat this crisis.

Daily Digest

Senate

Chamber Action

The Senate was not in session and stands adjourned until 3 p.m., on Monday, June 25, 2018.

Committee Meetings

No committee meetings were held.

House of Representatives

Chamber Action

Public Bills and Resolutions Introduced: 14 public bills, H.R. 6192–6205; and 3 resolutions, H. Res. 957–959 were introduced. **Page H5580**

Additional Cosponsors: **Page H5581**

Reports Filed: Reports were filed today as follows:

H.R. 4528, to make technical amendments to certain marine fish conservation statutes , and for other purposes (H. Rept. 115–775);

H.R. 5730, to require testing and evaluation of advanced transportation security screening technologies related to the mission of the Transportation Security Administration, and for other purposes, with an amendment (H. Rept. 115–776);

H.R. 5733, to amend the Homeland Security Act of 2002 to provide for the responsibility of the National Cybersecurity and Communications Integration Center to maintain capabilities to identify threats to industrial control systems, and for other purposes, with an amendment (H. Rept. 115–777); and

H.R. 5766, to improve the security of public areas of transportation facilities, and for other purposes (H. Rept. 115–778). **Pages H5579–80**

Speaker: Read a letter from the Speaker wherein he appointed Representative Bacon to act as Speaker pro tempore for today. **Page H5509**

Journal: The House agreed to the Speaker's approval of the Journal by voice vote. **Pages H5509, H5572**

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act: The House passed H.R. 6, to provide for opioid use disorder prevention, recovery, and treatment, by a yea-and-nay vote of 396 yeas to 14 nays, Roll No. 288. **Pages H5511–72**

Rejected the Tonko motion to recommit the bill to the Committee on Energy and Commerce and the Committee on Ways and Means with instructions to report the same back to the House forthwith with an amendment, by a yea-and-nay vote of 185 yeas to 226 nays, Roll No. 287. **Pages H5567–71**

Pursuant to the Rule, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–76, modified by Rules Committee Print 115–78 and the amendment printed in part A of H. Rept. 115–766, shall be considered as adopted in the House and in the Committee of the Whole. **Page H5522**

Agreed to:

Walden amendment (No. 1 printed in part B of H. Rept. 115–766) that calls for Medicaid, Medicare, and public health reforms to help combat the opioid crisis; **Pages H5560–61**

Barton amendment (No. 3 printed in part B of H. Rept. 115–766) that directs the Commissioner of Food and Drugs to develop high-quality, evidence-based opioid analgesic prescribing guidelines for the indication-specific treatment of acute pain; in developing such guidelines, it would require the Commissioner of Food and Drugs to gather input through a public workshop and comment period, and to provide a report to Congress on how such guidelines will be used to protect the public health; **Pages H5562–64**

Curtis amendment (No. 4 printed in part B of H. Rept. 115–766) that requires a report from HHS on

opioid prescribing practices and opioid misuse during pregnancy, and evaluating non-opiate pain management practices during pregnancy; **Pages H5564–65**

Keating amendment (No. 5 printed in part B of H. Rept. 115–766) that directs HHS to issue guidelines for prescribing naloxone in situations involving any type of prescription or illicit opioid use; and **Pages H5565–66**

Maxine Waters (CA) amendment (No. 7 printed in part B of H. Rept. 115–766) that directs the Secretary of Health and Human Services (HHS) to conduct a survey of organizations that provide substance abuse treatment services; under the amendment, HHS is required to develop, and submit to Congress, a plan to direct appropriate resources to address inadequacies in services or funding for specific types of drug addictions identified through the survey. **Pages H5566–67**

Withdrawn:

Dunn amendment (No. 2 printed in part B of H. Rept. 115–766) that was offered and subsequently withdrawn that would have struck language expanding the classes of health care workers who are authorized to dispense narcotics for narcotic treatment. **Pages H5561–62**

H. Res. 949, the rule providing for consideration of the bills (H.R. 6), (H.R. 5797), and (H.R. 6082) was agreed to Wednesday, June 20th.

Firefighter Cancer Registry Act: The House agreed to take from the Speaker's table and concur in the Senate amendment to H.R. 931, to require the Secretary of Health and Human Services to develop a voluntary registry to collect data on cancer incidence among firefighters. **Pages H5572–73**

All Circuit Review Act: The House agreed to take from the Speaker's table and concur in the Senate amendment to H.R. 2229, to amend title 5, United States Code, to provide permanent authority for judicial review of certain Merit Systems Protection Board decisions relating to whistleblowers. **Page H5573**

Meeting Hour: Agreed by unanimous consent that when the House adjourns today, it adjourn to meet at 12 noon on Monday, June 25th for Morning Hour debate. **Page H5576**

Presidential Messages: Read a message from the President wherein he notified Congress that the national emergency declared with respect to North Korea is to continue in effect beyond June 26, 2018—referred to the Committee on Foreign Affairs and ordered to be printed (H. Doc. 115–136). **Page H5577**

Read a message from the President wherein he notified Congress that the national emergency declared with respect to the Western Balkans is to continue in effect beyond June 26, 2018—referred to the Committee on Foreign Affairs and ordered to be printed (H. Doc. 115–137). **Pages H5577–78**

Quorum Calls—Votes: Two yea-and-nay votes developed during the proceedings of today and appear on pages H5570–71 and H5571–72. There were no quorum calls.

Adjournment: The House met at 9 a.m. and adjourned at 1:02 p.m.

Committee Meetings

SPACE SITUATIONAL AWARENESS: WHOLE OF GOVERNMENT PERSPECTIVES ON ROLES AND RESPONSIBILITIES

Committee on Armed Services: Subcommittee on Strategic Forces; and Subcommittee on Space of the House Committee on Science, Space, and Technology held a joint hearing entitled "Space Situational Awareness: Whole of Government Perspectives on Roles and Responsibilities". Testimony was heard from Jim Bridenstine, Administrator, National Aeronautics and Space Administration; General John Hyten, Commander, U.S. Strategic Command; and Wilbur Ross, Secretary, Department of Commerce.

LEGISLATIVE HEARING

Committee on Energy and Commerce: Subcommittee on Digital Commerce and Consumer Protection held a hearing on H.R. 2651, the "Horseracing Integrity Act of 2017". Testimony was heard from Representatives Tonko and Barr; and public witnesses.

ADVANCED BIOFUELS UNDER THE RENEWABLE FUEL STANDARD: CURRENT STATUS AND FUTURE PROSPECTS

Committee on Energy and Commerce: Subcommittee on Environment held a hearing entitled "Advanced Biofuels Under the Renewable Fuel Standard: Current Status and Future Prospects". Testimony was heard from public witnesses.

Joint Meetings

No joint committee meetings were held.

COMMITTEE MEETINGS FOR MONDAY, JUNE 25, 2018

(Committee meetings are open unless otherwise indicated)

Senate

No meetings/hearings scheduled.

House

Committee on Rules, Full Committee, hearing on H.R. 200, the "Strengthening Fishing Communities and Increasing Flexibility in Fisheries Management Act"; H.R. 2083, the "Endangered Salmon and Fisheries Predation Prevention Act"; and H.R. 6157, the "Department of Defense Appropriations Act, 2019" [General Debate], 5 p.m., H–313 Capitol.

Next Meeting of the **SENATE**

3 p.m., Monday, June 25

Senate Chamber

Program for Monday: Senate will resume consideration of H.R. 5895, Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act, as amended, and vote on passage of the bill at 5:30 p.m.

Following disposition of H.R. 5895, Senate will vote on the motion to invoke cloture on the motion to proceed to consideration of H.R. 2, Agriculture and Nutrition Act.

Next Meeting of the **HOUSE OF REPRESENTATIVES**

12 noon, Monday, June 25

House Chamber

Program for Monday: To be announced.

Extensions of Remarks, as inserted in this issue

HOUSE

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