114TH CONGRESS
*2d Session*
HOUSE OF REPRESENTATIVES
REPORT
114–555

# LALI'S LAW

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

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

# R E P O R T

[To accompany H.R. 4586]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4586) to amend the Public Health Service Act to authorize grants to States for developing standing orders and educating health care professionals regarding the dispensing of opioid overdose reversal medication without person-specific prescriptions, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as "Lali's Law".

**SEC. 2. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.**

(a) TECHNICAL CLARIFICATION.—Effective as if included in the enactment of the Children's Health Act of 2000 (Public Law 106–310), section 3405(a) of such Act (114 Stat. 1221) is amended by striking "Part E of title III" and inserting "Part E of title III of the Public Health Service Act".

(b) AMENDMENT.—Title III of the Public Health Service Act is amended by inserting after part D of such title (42 U.S.C. 254b et seq.) the following new part E:

## "PART E—OPIOID USE DISORDER

**"SEC. 341. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.**

"(a) GRANTS TO STATES.—The Secretary may make grants to States for—

"(1) developing standing orders for pharmacies regarding opioid overdose reversal medication;

"(2) encouraging pharmacies to dispense opioid overdose reversal medication pursuant to a standing order;

"(3) implementing best practices for persons authorized to prescribe medication regarding—

"(A) prescribing opioids for the treatment of chronic pain;

"(B) co-prescribing opioid overdose reversal medication with opioids; and

"(C) discussing the purpose and administration of opioid overdose reversal medication with patients;

"(4) developing or adapting training materials and methods for persons authorized to prescribe or dispense medication to use in educating the public regarding—

"(A) when and how to administer opioid overdose reversal medication; and

"(B) steps to be taken after administering opioid overdose reversal medication; and

"(5) educating the public regarding—

"(A) the public health benefits of opioid overdose reversal medication; and

"(B) the availability of opioid overdose reversal medication without a person-specific prescription.

"(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders regarding opioid overdose reversal medication.

"(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary shall give preference to States that—

"(1) have not issued standing orders regarding opioid overdose reversal medication;

"(2) authorize standing orders that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer opioid overdose reversal medication;

"(3) authorize standing orders that permit police, fire, or emergency medical services agencies to acquire and administer opioid overdose reversal medication;

"(4) have a higher per capita rate of opioid overdoses than other applicant States; or

"(5) meet any other criteria deemed appropriate by the Secretary.

"(d) GRANT TERMS.—

"(1) NUMBER.—A State may not receive more than 1 grant under this section.

"(2) PERIOD.—A grant under this section shall be for a period of 3 years.

"(3) AMOUNT.—A grant under this section may not exceed $500,000.

"(4) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(5).

"(e) APPLICATIONS.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may require, including detailed proposed expenditures of grant funds.

"(f) REPORTING.—Not later than 3 months after the Secretary disburses the first grant payment to any State under this section and every 6 months thereafter for

3 years, such State shall submit a report to the Secretary that includes the following:

"(1) The name and ZIP Code of each pharmacy in the State that dispenses opioid overdose reversal medication under a standing order.

"(2) The total number of opioid overdose reversal medication doses dispensed by each such pharmacy, specifying how many were dispensed with or without a person-specific prescription.

"(3) The number of pharmacists in the State who have participated in training pursuant to subsection (a)(4).

"(g) DEFINITIONS.—In this section:

"(1) OPIOID OVERDOSE REVERSAL MEDICATION.—The term 'opioid overdose reversal medication' means any drug, including naloxone, that—

"(A) blocks opioids from attaching to, but does not itself activate, opioid receptors; or

"(B) inhibits the effects of opioids on opioid receptors.

"(2) STANDING ORDER.—The term 'standing order' means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.

"(h) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $5,000,000 for the period of fiscal years 2017 through 2019.

"(2) ADMINISTRATIVE COSTS.—Not more than 3 percent of the amounts made available to carry out this section may be used by the Secretary for administrative expenses of carrying out this section.".

**SEC. 3. CUT-GO COMPLIANCE.**

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by inserting before the period at the end the following: "(except such dollar amount shall be reduced by $5,000,000 for fiscal year 2017)".

## PURPOSE AND SUMMARY

H.R. 4586, "Lali's Law," was introduced by Rep. Bob Dold (R–IL) and Rep. Katherine Clark (D–MA) on February 23, 2016. This legislation amends the Public Health Service Act to authorize grants to states for developing standing orders and educating health care professionals regarding the dispensing of opioid overdose reversal medication without person-specific prescriptions.

## BACKGROUND AND NEED FOR LEGISLATION

In 1999, there were 6.1 overdose deaths per 100,000 Americans involving opioid analgesics and heroin. By 2014, that number more than doubled to 14.7 overdose deaths. The rate of overdose for individuals aged 24 to 34 nearly tripled, going from 8.1 overdose deaths per 100,000 to 23.1 overdose deaths.[1] Naloxone is an opioid antagonist that can prevent opioid overdose deaths by binding to the opioid receptors in the body and preventing the overdose. The World Health Organization estimated that if naloxone was more widely available in the United States, 20,000 overdose deaths could be prevented annually.[2] This legislation is a first step in promoting wider access of naloxone or other opioid overdose reversal drugs that may come to market. Standing orders are prescriptions that are not person-specific. If a pharmacy has a standing order, anyone needing the medication may come and fill a prescription for it. Naloxone, while incredibly effective at stopping opioid overdose, does have severe side effects if used incorrectly or if used when not needed. Many states have standing order laws in place, but need

[1] *http://www.cdc.gov/nchs/data/hus/hus15.pdf.*
[2] *http://www.reuters.com/article/us-health-who-naloxone-idUSKBN0IO12420141104.*

help bridging the gap between law and a functioning program. The grants funded by this legislation will help aid that process.

## HEARINGS

The Committee on Energy and Commerce has not held hearings on the legislation.

## COMMITTEE CONSIDERATION

On April 20, 2016, the Subcommittee on Health met in open markup session and forwarded H.R. 4586, as amended, to the full Committee, by a voice vote. On April 26, 27, and 28, 2016, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 4586 reported to the House, as amended, by a voice vote.

## COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 4586 reported.

## COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has not held hearings on this legislation.

## STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of this legislation is to authorize grants to states for developing standing orders and educating health care professionals regarding the dispensing of opioid overdose reversal medication without person-specific prescriptions.

## NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4586 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

## EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 4586 contains no earmarks, limited tax benefits, or limited tariff benefits.

## COMMITTEE COST ESTIMATE

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

## CONGRESSIONAL BUDGET OFFICE ESTIMATE

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, DC, May 9, 2016.*

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4586, Lali's Law.

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

Sincerely,

KEITH HALL.

Enclosure.

*H.R. 4586—Lali's Law*

H.R. 4586 would allow the Centers for Disease Control and Prevention (CDC) to provide grants to states to enable and encourage pharmacies to dispense medications that reverse opioid overdoses pursuant to a standing order. A standing order is a prescription that permits another person to acquire, dispense, or administer medication without the prescription specifying who will be treated with the medication. The grants would be limited to $500,000 per state. The bill also would allow states to use the grant funds to implement best practices and to develop training materials on the purpose, administration, and availability of those medications. H.R. 4586 would authorize the appropriation of a total of $5 million of fiscal years 2017 through 2019 to carry out these activities. Assuming the availability of appropriated funds, CBO estimates those funds would be spent over the 2017–2021 period.

Under current law, an authorization of appropriations totaling $138 million exists for 2017 for CDC for activities related to bioterrorism and public health emergencies. H.R. 4586 would reduce the amount authorized by $5 million in 2017. Assuming appropriation actions consistent with the bill, CBO estimates that implementing this provision would result in $5 million less in discretionary outlays for that program over the 2017–2021 period.

On net, CBO estimates that implementing H.R. 4586 would not affect discretionary costs over the 2017–2021 period. Enacting H.R. 4586 would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply. CBO estimates that enacting H.R. 4586 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

H.R. 4586 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. Any costs incurred by states that apply for grants authorized by the bill would be incurred voluntarily as a condition of assistance.

The CBO staff contact for this estimate is Rebecca Yip. The estimate was approved by Holly Harvey, Deputy Assistant Director for Budget Analysis.

## FEDERAL MANDATES STATEMENT

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

## DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 4586 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

## DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 4586 specifically directs to be completed 0 rule makings within the meaning of 5 U.S.C. 551.

## ADVISORY COMMITTEE STATEMENT

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

## APPLICABILITY TO LEGISLATIVE BRANCH

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

## SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

*Section 1. Short title*

Section 1 states that the legislation may be cited as "Lali's Law."

*Section 2. Opioid overdose reversal medication access and education grant programs*

Under section 2, the Secretary of Health and Human Services is authorized to make grants for: developing standing orders for pharmacies regarding opioid overdose reversal medication; encouraging pharmacies to dispense opioid overdose reversal medication pursuant to a standing order; implementing best practices; and developing or adapting training materials.

Grantees must report on a number of metrics including: the name and ZIP codes of each pharmacy dispensing opioid overdose reversal drugs under a standing order, the total number of opioid overdose reversal medication doses dispensed by each pharmacy, and the number of pharmacists in the State who have participated in training also funded by the grant.

Finally, this section authorizes an appropriation of $5 million over the period of fiscal years 2017 through 2019.

*Section 3. Cut-go compliance*

Section 3 reduces the authorization of Section 319D of the Public Health Service Act for $5,000,000 for fiscal year 2017 to bring the legislation into compliance with Cut-Go. This reduction in authorization is equal to the authorization of appropriations in section 2.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

**CHILDREN'S HEALTH ACT OF 2000**

* * * * * * *

# DIVISION B—YOUTH DRUG AND MENTAL HEALTH SERVICES

* * * * * * *

# TITLE XXXIV—PROVISIONS RELATING TO FLEXIBILITY AND ACCOUNTABILITY

* * * * * * *

**SEC. 3405. REPEAL OF OBSOLETE ADDICT REFERRAL PROVISIONS.**

(a) REPEAL OF OBSOLETE PUBLIC HEALTH SERVICE ACT AUTHORITIES.—**[**Part E of title III**]** *Part E of title III of the Public Health Service Act* (42 U.S.C. 257 et seq.) is repealed.

(b) REPEAL OF OBSOLETE NARA AUTHORITIES.—Titles III and IV of the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89-793) are repealed.

(c) REPEAL OF OBSOLETE TITLE 28 AUTHORITIES.—

(1) IN GENERAL.—Chapter 175 of title 28, United States Code, is repealed.

(2) TABLE OF CONTENTS.—The table of contents to part VI of title 28, United States Code, is amended by striking the items relating to chapter 175.

* * * * * * *

---

**PUBLIC HEALTH SERVICE ACT**

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

PART B—FEDERAL-STATE COOPERATION

* * * * * * *

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

(a) FACILITIES; CAPACITIES.—

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

(2) FACILITIES.—

(A) IN GENERAL.—The Director of the Centers for Disease Control and Prevention may design, construct, and equip new facilities, renovate existing facilities (including laboratories, laboratory support buildings, scientific communication facilities, transshipment complexes, secured and isolated parking structures, office buildings, and other facilities and infrastructure), and upgrade security of such facilities, in order to better conduct the capacities described in section 319A, and for supporting public health activities.

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

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

(A) expanding or enhancing the training of personnel;

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

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

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

(b) NATIONAL COMMUNICATIONS AND SURVEILLANCE NETWORKS.—

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

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

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

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

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

(3) STANDARDS.—Not later than one year after the date of the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the Secretary, in cooperation with health care providers and State and local public health officials, shall establish any additional technical and reporting standards (including standards for interoperability) for networks under paragraph (1) and update such standards as necessary.

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

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

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

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

(B) modernize and enhance biosurveillance activities; and

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

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

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

(B) Federal health agencies;

(C) zoonotic disease monitoring systems;

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

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

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

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

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

(B) define minimal data elements for such network;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the operation of the system described in subparagraph (A); and

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

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

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

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

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

(e) TELEHEALTH ENHANCEMENTS FOR EMERGENCY RESPONSE.—

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

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

(i) the specific location of network components;

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

(iii) the functionality of such components; and

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

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

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

(D) identify methods for reducing legal barriers that deter health care professionals from providing telemedicine services, such as by utilizing State emergency health care

professional credentialing verification systems, encouraging States to establish and implement mechanisms to improve interstate medical licensure cooperation, facilitating the exchange of information among States regarding investigations and adverse actions, and encouraging States to waive the application of licensing requirements during a public health emergency;

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

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

(2) REPORT.—Not later than 12 months after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall prepare and submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives regarding the findings and recommendations pursuant to subparagraphs (A) through (F) of paragraph (1).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $138,300,000 for each of fiscal years 2014 through 2018 *(except such dollar amount shall be reduced by $5,000,000 for fiscal year 2017)*.

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

* * * * * * *

## [PART E—NARCOTIC ADDICTS AND OTHER DRUG ABUSERS

### [CARE AND TREATMENT

[SEC. 341. (a) The Surgeon General is authorized to provide for the confinement, care, protection, treatment, and discipline of persons addicted to the use of habit-forming narcotic drugs who are civilly committed to treatment under the Narcotic Addict Rehabilitation Act of 1966, addicts and other persons with drug abuse and drug dependence problems who voluntarily submit themselves for treatment, and addicts convicted of offenses against the United States, including persons convicted by general courts-martial and consular courts. Such care and treatment shall be provided at hospitals of the Service especially equipped for the accommodation of such patients or elsewhere where authorized under other provisions of law, and shall be designed to rehabilitate such persons, to restore them to health, and, where necessary, to train them to be self-supporting and self-reliant; but nothing in this section or in this part shall be construed to limit the authority of the Surgeon General under other provisions of law to provide for the conditional release of patients and for aftercare under supervision. In carrying out this subsection, the Secretary shall establish in each hospital

and other appropriate medical facility of the Service a treatment and rehabilitation program for drug addicts and other persons with drug abuse and drug dependence problems who are in the area served by such hospital or other facility; except that the requirement of this sentence shall not apply in the case of any such hospital or other facility with respect to which the Secretary determines that there is not sufficient need for such a program in such hospital or other facility.

[(b) Upon the admittance to, and departure from, a hospital of the Service of a person who voluntarily submitted himself for treatment pursuant to the provisions of this section, and who at the time of his admittance to such hospital was a resident of the District of Columbia, the Surgeon General shall furnish to the Commissioners of the District of Columbia or their designated agent, the name, address, and such other pertinent information as may be useful in the rehabilitation to society of such person.

[(c) The Secretary may enter into agreements with the Secretary of Veterans Affairs, the Secretary of Defense, and the head of any other department or agency of the Government under which agreements hospitals and other appropriate medical facilities of the Service may be used in treatment and rehabilitation programs provided by such department or agency for drug addicts and other persons with drug abuse and other drug dependence problems who are in areas served by such hospitals or other facilities.

[EMPLOYMENT OF ADDICTS OR OTHER PERSONS WITH DRUG ABUSE AND DRUG DEPENDENCE PROBLEMS

[SEC. 342. Narcotic addicts or other persons with drug abuse and drug dependence problems in hospitals of the Service designated for their care shall be employed in such manner and under such conditions as the Surgeon General may direct. In such hospitals the Surgeon General may, in his discretion, establish industries, plants, factories, or shops for the production and manufacture of articles, commodities, and supplies for the United States Government. The Secretary of the Treasury may require any Government department, establishment, or other institution, for whom appropriations are made directly or indirectly by the Congress of the United States, to purchase at current market prices, as determined by him or his authorized representative, such of the articles, commodities, or supplies so produced or manufactured as meet their specifications; and the Surgeon General shall provide for payment to the inmates or their dependents of such pecuniary earnings as he may deem proper. The Secretary shall establish a working-capital fund for such industries, plants, factories, and shops out of any funds appropriated for Public Health Service hospitals at which addicts or other persons with drug abuse and drug dependence problems are treated and cared for; and such fund shall be available for the purchase, repair, or replacement of machinery or equipment, for the purchase of raw materials and supplies, for the purchase of uniforms and other distinctive wearing apparel of employees in the performance of their official duties, and for the employment of necessary civilian officers and employees. The Surgeon General may provide for the disposal of products of the industrial activities conducted pursuant to this section, and the proceeds of any sales

thereof shall be covered into the Treasury of the United States to the credit of the working-capital fund.

[CONVICTS

[SEC. 343. (a) The authority vested with the power to designate the place of confinement of a prisoner shall transfer to hospitals of the Service especially equipped for the accommodation of addicts or other persons with drug abuse and drug dependence problems, if accommodations are available, all addicts or other persons with drug abuse and drug dependence problems who have been or are hereafter sentenced to confinement, or who are now or shall hereafter be confined, in any penal, correctional, disciplinary, or reformatory institution of the United States, including those addicts or other persons with drug abuse and drug dependence problems convicted of offenses against the United States who are confined in State and Territorial prisons, penitentiaries, and reformatories, except that no addict or other person with a drug abuse or other drug dependence problem shall be transferred to a hospital of the Service who, in the opinion of the officer authorized to direct the transfer, is not a proper subject for confinement in such an institution either because of the nature of the crime he has committed or because of his apparent incorrigibility. The authority vested with the power to designate the place of confinement of a prisoner shall transfer from a hospital of the Service to the institution from which he was received, or to such other institution as may be designated by the proper authority, any addict or other person with a drug abuse or other drug dependence problem whose presence at a hospital of the Service is detrimental to the well-being of the hospital or who does not continue to be a narcotic addict or other person with a drug abuse or other drug dependence problem. All transfers of such prisoners to or from a hospital of the Service shall be accompanied by necessary attendants as directed by the officer in charge of such hospital and the actual and necessary expenses incident to such transfers shall be paid from the appropriation for the maintenance of such Service hospital except to the extent that other Federal agencies are authorized or required by law to pay expenses incident to such transfers. When sentence is pronounced against any person whom the prosecuting officer believes to be an addict or other person with a drug abuse or other drug dependence problem such officer shall report to the authority vested with the power to designate the place of confinement, the name of such person, the reasons for his belief, all pertinent facts bearing on such addiction, drug abuse, or drug dependence and the nature of the offense committed. Whenever an alien addict or other person with a drug abuse or other drug dependence problem transferred to a Service hospital pursuant to this subsection is entitled to his discharge but is subject to deportation, in lieu of being returned to the penal institution from which he came he shall be deported by the authority vested by law with power over deportation.

[(c) Not later than one month prior to the expiration of the sentence of any addict or other person with a drug abuse or other drug dependence problem confined in a Service hospital, he shall be examined by the Surgeon General or his authorized representative. If the Surgeon General believes the person to be discharged is still an addict or other person with a drug abuse or other drug depend-

ence problem and that he may by further treatment in a Service hospital be cured of his addiction, drug abuse, or drug dependence the addict or other person with a drug abuse or other drug dependence problem shall be informed, in accordance with regulations, of the advisability of his submitting himself to further treatment. The addict or other person with a drug abuse or other drug dependence problem may then apply in writing to the Surgeon General for further treatment in a Service hospital for a period not exceeding the maximum length of time considered necessary by the Surgeon General. Upon approval of the application by the Surgeon General or his authorized agent, the addict or other person with a drug abuse or other drug dependence problem may be given such further treatment as is necessary to cure him of his addiction, drug abuse, or drug dependence.

[(d) Every person convicted of an offense against the United States, upon discharge, or upon release on parole or supervised release from a hospital of the Service, shall be furnished with the gratuities and transportation authorized by law to be furnished to prisoners upon release from a penal, correctional, disciplinary, or reformatory institution.

[(e) Any court of the United States having the power to suspend the imposition or execution of sentence and to place a defendant on probation under any existing laws may impose as one of the conditions of such probation that the defendant, if an addict, or other person with a drug abuse or other drug dependence problem shall submit himself for treatment at a hospital of the Service especially equipped for the accommodation of addicts or other persons with drug abuse and drug dependence problems until discharged therefrom as cured and that he shall be admitted thereto for such purpose. Upon the discharge of any such probationer from a hospital of the Service, he shall be furnished with the gratuities and transportation authorized by law to be furnished to prisoners upon release from a penal, correctional, disciplinary, or reformatory institution. The actual and necessary expense incident to transporting such probationer to such hospital and to furnishing such transportation and gratuities shall be paid from the appropriation for the maintenance of such hospital except to the extent that other Federal agencies are authorized or required by law to pay the cost of such transportation: *Provided,* That where existing law vests a discretion in any officer as to the place to which transportation shall be furnished or as to the amount of clothing and gratuities to be furnished, such discretion shall be exercised by the Surgeon General with respect to addicts or other persons with drug abuse and drug dependence problems discharged from hospitals of the Service.

[VOLUNTARY PATIENTS

[SEC. 344. (a) Any addict, or other person with a drug abuse or other drug dependence problem whether or not he shall have been convicted of an offense against the United States, may apply to the Surgeon General for admission to a hospital of the Service especially equipped for the accommodation of addicts or other persons with drug abuse and drug dependence problems.

[(b) Any applicant shall be examined by the Surgeon General who shall determine whether the applicant is an addict, or other person with a drug abuse or other drug dependence problem

whether by treatment in a hospital of the Service he may probably be cured of his addiction, drug abuse, or drug dependence and the estimated length of time necessary to effect his cure. The Surgeon General may, in his discretion, admit the applicant to a Service hospital. No such addict or other person with drug abuse or other drug dependence problem shall be admitted unless he agrees to submit to treatment for the maximum amount of time estimated by the Surgeon General to be necessary to effect a cure, and unless suitable accommodations are available after all eligible addicts or other persons with drug abuse and drug dependence problems convicted of offenses against the United States have been admitted. Any such addict or other person with a drug abuse or other drug dependence problem may be required to pay for his subsistence, care, and treatment at rates fixed by the Surgeon General and amounts so paid shall be covered into the Treasury of the United States to the credit of the appropriation from which the expenditure for his subsistence, care, and treatment was made. Appropriations available for the care and treatment of addicts or other persons with drug abuse and drug dependence problems admitted to a hospital of the Service under this section shall be available, subject to regulations, for paying the cost of transportation to any place within the continental United States, including subsistence allowance while traveling, for any indigent addict or other person with a drug abuse or other drug dependence problem who is discharged as cured.

[(c) Any addict or other person with a drug abuse or other drug dependence problem admitted for treatment under this section, including any addict, or other person with a drug abuse or other drug dependence problem not convicted of an offense, who voluntarily submits himself for treatment, may be confined in a hospital of the Service for a period not exceeding the maximum amount of time estimated by the Surgeon General as necessary to effect a cure of the addiction, drug abuse, or drug dependence or until such time as he ceases to be an addict or other person with a drug abuse or other drug dependence problem.

[(d) Any addict or other person with a drug abuse or other drug dependence problem admitted for treatment under this section shall not thereby forfeit or abridge any of his rights as a citizen of the United States; nor shall such admission or treatment be used against him in any proceeding in any court; and the record of his voluntary commitment shall, except as otherwise provided by this Act, be confidential and shall not be divulged.

[PERSONS COMMITTED FROM DISTRICT OF COLUMBIA

[SEC. 345. (a) The Surgeon General is authorized to admit for care and treatment in any hospital of the Service suitably equipped therefor, and thereafter to transfer between hospitals of the Service in accordance with section 321(b), any addict who is committed, under the provisions of the Act of June 24, 1953 (Public Law 76, Eighty-third Congress), to the Service or to a hospital thereof for care and treatment and who the Surgeon General determines is a proper subject for care and treatment. No such addict shall be admitted unless (1) committed prior to July 1, 1958; and (2) at the time of commitment, the number of persons in hospitals of the Service who have been admitted pursuant to this subsection is less

than 100; and (3) suitable accommodations are available after all eligible addicts convicted of offenses against the United States have been admitted.

[(b) Any person admitted to a hospital of the Service pursuant to subsection (a) shall be discharged therefrom (1) upon order of the Superior Court of the District of Columbia, or (2) when he is found by the Surgeon General to be cured and rehabilitated. When any such person is so discharged, the Surgeon General shall give notice thereof to the Superior Court of the District of Columbia and shall deliver such person to such court for such further action as such court may deem necessary and proper under the provisions of the Act of June 24, 1953 (Public Law 76, Eighty-third Congress).

[(c) With respect to the detention, transfer, parole, or discharge of any person committed to a hospital of the Service in accordance with subsection (a), the Surgeon General and the officer in charge of the hospital, in addition to authority otherwise vested in them, shall have such authority as may be conferred upon them, respectively, by the order of the committing court.

[(d) The cost of providing care and treatment for persons admitted to a hospital of the Service pursuant to subsection (a) shall be a charge upon the District of Columbia and shall be paid by the District of Columbia to the Public Health Service, either in advance or otherwise, as may be determined by the Surgeon General. Such cost may be determined for each addict or on the basis of rates established for all or particular classes of patients, and shall include the cost of transportation to and from facilities of the Public Health Service. Moneys so paid to the Public Health Service shall be covered into the Treasury of the United States as miscellaneous receipts. Appropriations available for the care and treatment of addicts admitted to a hospital of the Service under this section shall be available, subject to regulations, for paying the cost of transportation to the District of Columbia, including subsistence allowance while traveling, for any such addict who is discharged.

[PENALTIES

[SEC. 346. (a) Any person not authorized by law or by the Surgeon General who introduces or attempts to introduce into or upon the grounds of any hospital of the Service at which addicts or other persons with drug abuse and drug dependence problems are treated and cared for, any habit-forming narcotic drug, or substance controlled under the Controlled Substances Act, weapon, or any other contraband article or thing, or any contraband letter or message intended to be received by an inmate thereof, shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not more than ten years.

[(b) It shall be unlawful for any person properly committed thereto to escape or attempt to escape from a hospital of the Service at which addicts or other persons with drug abuse and drug dependence problems are treated and cared for, and any such person upon apprehension and conviction in a United States court shall be punished by imprisonment for not more than five years, such sentence to begin upon the expiration of the sentence for which such person was originally confined.

[(c) Any person who procures the escape of any person admitted to a hospital of the Service at which addicts or other persons with

drug abuse and drug dependence problems are treated and cared for, or who advises, connives at, aids, or assists in such escape, or who conceals any such inmate after such escape, shall be punished upon conviction in a United States court by imprisonment in the penitentiary for not more than three years.

[RELEASE OF PATIENTS

[SEC. 347. For purposes of this Act, an individual shall be deemed cured of his addiction, drug abuse, or drug dependence, and rehabilitated if the Surgeon General determines that he has received the maximum benefits of treatment and care by the Service for his addiction, drug abuse, or drug dependence, or if the Surgeon General determines that his further treatment and care for such purpose would be detrimental to the interests of the Service.]

## *PART E—OPIOID USE DISORDER*

***SEC. 341. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.***

*(a) GRANTS TO STATES.—The Secretary may make grants to States for—*

*(1) developing standing orders for pharmacies regarding opioid overdose reversal medication;*

*(2) encouraging pharmacies to dispense opioid overdose reversal medication pursuant to a standing order;*

*(3) implementing best practices for persons authorized to prescribe medication regarding—*

*(A) prescribing opioids for the treatment of chronic pain;*

*(B) co-prescribing opioid overdose reversal medication with opioids; and*

*(C) discussing the purpose and administration of opioid overdose reversal medication with patients;*

*(4) developing or adapting training materials and methods for persons authorized to prescribe or dispense medication to use in educating the public regarding—*

*(A) when and how to administer opioid overdose reversal medication; and*

*(B) steps to be taken after administering opioid overdose reversal medication; and*

*(5) educating the public regarding—*

*(A) the public health benefits of opioid overdose reversal medication; and*

*(B) the availability of opioid overdose reversal medication without a person-specific prescription.*

*(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders regarding opioid overdose reversal medication.*

*(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary shall give preference to States that—*

*(1) have not issued standing orders regarding opioid overdose reversal medication;*

*(2) authorize standing orders that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer opioid overdose reversal medication;*

*(3) authorize standing orders that permit police, fire, or emergency medical services agencies to acquire and administer opioid overdose reversal medication;*

*(4) have a higher per capita rate of opioid overdoses than other applicant States; or*

*(5) meet any other criteria deemed appropriate by the Secretary.*

*(d) GRANT TERMS.—*

*(1) NUMBER.—A State may not receive more than 1 grant under this section.*

*(2) PERIOD.—A grant under this section shall be for a period of 3 years.*

*(3) AMOUNT.—A grant under this section may not exceed $500,000.*

*(4) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(5).*

*(e) APPLICATIONS.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may require, including detailed proposed expenditures of grant funds.*

*(f) REPORTING.—Not later than 3 months after the Secretary disburses the first grant payment to any State under this section and every 6 months thereafter for 3 years, such State shall submit a report to the Secretary that includes the following:*

*(1) The name and ZIP Code of each pharmacy in the State that dispenses opioid overdose reversal medication under a standing order.*

*(2) The total number of opioid overdose reversal medication doses dispensed by each such pharmacy, specifying how many were dispensed with or without a person-specific prescription.*

*(3) The number of pharmacists in the State who have participated in training pursuant to subsection (a)(4).*

*(g) DEFINITIONS.—In this section:*

*(1) OPIOID OVERDOSE REVERSAL MEDICATION.—The term "opioid overdose reversal medication" means any drug, including naloxone, that—*

*(A) blocks opioids from attaching to, but does not itself activate, opioid receptors; or*

*(B) inhibits the effects of opioids on opioid receptors.*

*(2) STANDING ORDER.—The term "standing order" means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.*

*(h) AUTHORIZATION OF APPROPRIATIONS.—*

*(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $5,000,000 for the period of fiscal years 2017 through 2019.*

*(2) ADMINISTRATIVE COSTS.—Not more than 3 percent of the amounts made available to carry out this section may be used*

*by the Secretary for administrative expenses of carrying out this section.*

* * * * * * *

○