of title 38, United States Code, as added by subsection (a).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania (Mr. COSTELLO) and the gentlewoman from Florida (Ms. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and to add extraneous material on H.R. 1384.

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

There was no objection.

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I yield myself such time as I may consume.

I urge all Members to support H.R. 1384, the Honor America's Guard-Reserve Retirees Act, which was introduced by the gentleman from Minnesota (Mr. WALZ).

The National Guard and Reserve are vital to our Nation's defense. These brave men and women enlist while knowing they can be deployed with little notice, just like America's Active Duty servicemembers.

Despite the invaluable contributions of National Guard and Reserve personnel to our national security, Members may be surprised to learn that many of the men and women who served in the National Guard or Reserve for 20 years may not legally be considered ''veterans'' if they were never called up for Active Duty. This is not fair to these brave men and women who have demonstrated their patriotism through their willingness to wear the uniform and defend our Nation whenever and wherever they are needed.

H.R. 1384 would not provide any monetary benefit. It would simply honor the service and sacrifice of retired National Guard and Reserve personnel by giving them the prestigious title of ''veteran''—in my opinion, the most prestigious title that Congress can bestow.

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

Ms. BROWN of Florida. Mr. Speaker, I yield myself such time as I may consume.

I stand before this body to support legislation introduced by my friend and colleague from Minnesota, TIM WALZ. As a retired guardsman himself and as the highest ranking enlisted soldier to serve in Congress, I know this bill is near and dear to his heart.

The Honor America's Guard-Reserve Retirees Act closes a long-existing gap. Federal law has neglected to acknowledge our guardsmen and -women and reservists who have served fewer than 180 days of Active Duty service as ''veterans.'' This law would remedy this longstanding oversight by legally recognizing Guard and Reserve retirees as American veterans.

Our military is more dependent on Reserve components than they have been since the dawn of modern warfare. These are men and women who have stood ready and trained to serve our Nation at war. They have served a dedicated 20 years of service. At the very least, we should acknowledge the dedication of these servicemembers by legally recognizing them as American veterans.

I urge my colleagues to support this commonsense legislation.

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

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I reserve the balance of my time.

Ms. BROWN of Florida. Mr. Speaker, I yield such time as he may consume to the gentleman from Minnesota (Mr. WALZ).

Mr. WALZ. I thank the subcommittee chairman and the ranking member for the time. More importantly, I thank both of them and their respective staffs for the bipartisan and continuously exceptional effort to serve our veterans. I thank them for the opportunity to move this forward.

Mr. Speaker, this bill has passed the House multiple times over the last 8 years. It is very simple. It is less than 150 words, and it is very rare in that it costs nothing, but I would argue that it is very important. The men and women of the Reserve component, as you so eloquently heard by my colleagues who spoke prior, take the exact same oath of office and are held to the exact same standards as the Active component. They sacrifice their time and energy. They stand at the ready if called upon, whether it is assisting flood victims in Minnesota, fighting wildfires across the Western United States, or fighting overseas in the protection of our freedoms.

For those who have completed 20 years or more in the Guard or Reserve but who have not served a qualifying period of Title X Active Duty, we honor their service with health care benefits and monetary benefits, with one notable exception—they must call themselves ''military retirees'' and not ''veterans.'' As the gentleman from Pennsylvania noted, I think most Americans, when I talk to them, are unaware of this. Once they find out, they are appalled that we don't do it. This bill closes the loophole.

There are about 280,000 Americans who fall into this category. They have devoted their lives to our Nation—they have served honorably for 20 or 20-plus years—and this bill will recognize their service. It might be as simple as buying a hat that reads ''Army veteran'' or getting a license place for your car. It bestows no monetary benefits to these brave men and women, merely the title. Again, my colleague from Pennsylvania, I think, said it right in that it is a pretty important title—a veteran of the United States military.

It also does something else very important. In doing so, we recognize the integral role our National Guard and Reserve play in our Nation's defense. There is nothing quite so unifying or quintessentially American as the citizen soldier. Dating back to the founding of our Nation or serving overseas at a time of fighting terrorism, it is the mother who leaves her family and her law firm to serve her Nation, and it is the father who leaves his teaching job and his family to serve his Nation.

□ 1715

It is about recognizing that our All Volunteer Force would be unsustainable if it were not for the men and women who dedicated 20 years of their lives. And one of the most important things they did, most of those are cold war warriors who were responsible for the training of the current force that protects us.

So I thank the gentleman and the ranking member again for their commitment to our veterans.

I ask my colleagues—we are on the heels of Veterans Day here—to add these 280,000. Let's do what is right. Let's call them veterans and honor their service.

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I reserve the balance of my time.

Ms. BROWN of Florida. Mr. Speaker, I have no further speakers. I urge my colleagues to support passage of H.R. 1384.

I yield back the balance of my time.

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I also urge Members to support H.R. 1384.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. COSTELLO) that the House suspend the rules and pass the bill, H.R. 1384.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. COSTELLO of Pennsylvania. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

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

IMPROVING ACCESS TO EMERGENCY PSYCHIATRIC CARE ACT

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (S. 599) to extend and expand the Medicaid emergency psychiatric demonstration project, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 599

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Access to Emergency Psychiatric Care Act''.

SEC. 2. EXTENSION AND EXPANSION OF MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) IN GENERAL.—Subsection (d) of section 2707 of Public Law 111–148 (42 U.S.C. 1396a note) is amended to read as follows:

''(d) LENGTH OF DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the demonstration project established under this section shall be conducted for a period of 3 consecutive years.

''(2) TEMPORARY EXTENSION OF PARTICIPATION ELIGIBILITY FOR SELECTED STATES.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (4), a State selected as an eligible State to participate in the demonstration project on or prior to March 13, 2012, shall, upon the request of the State, be permitted to continue to participate in the demonstration project through September 30, 2016, if—

''(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such extension for that State is projected not to increase net program spending under title XIX of the Social Security Act.

''(B) NOTICE OF PROJECTIONS.—The Secretary shall provide each State selected to participate in the demonstration project on or prior to March 13, 2012, with notice of the determination and certification made under subparagraph (A) for the State.

''(3) EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—

''(A) ADDITIONAL EXTENSION.—Taking into account the recommendations submitted to Congress under subsection (f)(3), the Secretary may permit an eligible State participating in the demonstration project as of the date such recommendations are submitted to continue to participate in the project through December 31, 2019, if, with respect to the State—

''(i) the Secretary determines that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the continued participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

''(B) OPTION FOR EXPANSION TO ADDITIONAL STATES.—Taking into account the recommendations submitted to Congress pursuant to subsection (f)(3), the Secretary may expand the number of eligible States participating in the demonstration project through December 31, 2019, if, with respect to any new eligible State—

''(i) the Secretary determines that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the participation of the State in the demonstration project is projected not to increase net program spending under title XIX of the Social Security Act.

''(C) NOTICE OF PROJECTIONS.—The Secretary shall provide each State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), and any additional State that applies to be added to the demonstration project, with notice of the determination and certification made for the State under subparagraphs (A) and (B), respectively, and the standards used to make such determination and certification—

''(i) in the case of a State participating in the demonstration project as of the date the Secretary submits recommendations to Congress under subsection (f)(3), not later than August 31, 2016; and

''(ii) in the case of an additional State that applies to be added to the demonstration project, prior to the State making a final election to participate in the project.

''(4) AUTHORITY TO ENSURE BUDGET NEUTRALITY.—The Secretary annually shall review each participating State's demonstration project expenditures to ensure compliance with the requirements of paragraphs (2)(A)(i), (2)(A)(ii), (3)(A)(i), (3)(A)(ii), (3)(B)(i), and (3)(B)(ii) (as applicable). If the Secretary determines with respect to a State's participation in the demonstration project that the State's net program spending under title XIX of the Social Security Act has increased as a result of the State's participation in the project, the Secretary shall treat the demonstration project excess expenditures of the State as an overpayment under title XIX of the Social Security Act.''.

(b) FUNDING.—Subsection (e) of section 2707 of such Act (42 U.S.C. 1396a note) is amended—

(1) in the subsection heading, by striking ''LIMITATIONS ON FEDERAL'';

(2) in paragraph (2)—

(A) in the paragraph heading, by striking ''5-YEAR''; and

(B) by striking ''through December 31, 2015'' and inserting ''until expended'';

(3) by striking paragraph (3);

(4) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively;

(5) in paragraph (3) (as so redesignated), by striking ''and the availability of funds'' and inserting ''(other than States deemed to be eligible States through the application of subsection (c)(4))''; and

(6) in paragraph (4) (as so redesignated)—

(A) in the first sentence—

(i) by inserting ''(other than a State deemed to be an eligible State through the application of subsection (c)(4))'' after ''eligible State''; and

(ii) by striking ''paragraph (4)'' and inserting ''paragraph (3)''; and

(B) by inserting after the first sentence the following: ''In addition to any payments made to an eligible State under the preceding sentence, the Secretary shall, during any period in effect under paragraph (2) or (3) of subsection (d), or during any period in which a law described in subsection (f)(4)(C) is in effect, pay each eligible State (including any State deemed to be an eligible State through the application of subsection (c)(4)), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter during such period for medical assistance described in subsection (a). Payments made to a State for emergency psychiatric demonstration services under this section during the extension period shall be treated as medical assistance under the State plan for purposes of section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)).''.

(c) RECOMMENDATIONS TO CONGRESS.—Subsection (f) of section 2707 of such Act (42 U.S.C. 1396a note) is amended by adding at the end the following:

''(3) RECOMMENDATION TO CONGRESS REGARDING EXTENSION AND EXPANSION OF PROJECT.—Not later than September 30, 2016, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(A) whether the demonstration project should be continued after September 30, 2016; and

''(B) whether the demonstration project should be expanded to additional States.

''(4) RECOMMENDATION TO CONGRESS REGARDING PERMANENT EXTENSION AND NATIONWIDE EXPANSION.—

''(A) IN GENERAL.—Not later than April 1, 2019, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(i) whether the demonstration project should be permanently continued after December 31, 2019, in 1 or more States; and

''(ii) whether the demonstration project should be expanded (including on a nationwide basis).

''(B) REQUIREMENTS.—Any recommendation submitted under subparagraph (A) to permanently continue the project in a State, or to expand the project to 1 or more other States (including on a nationwide basis) shall include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that permanently continuing the project in a particular State, or expanding the project to a particular State (or all States) is projected not to increase net program spending under title XIX of the Social Security Act.

''(C) CONGRESSIONAL APPROVAL REQUIRED.—The Secretary shall not permanently continue the demonstration project in any State after December 31, 2019, or expand the demonstration project to any additional State after December 31, 2019, unless Congress enacts a law approving either or both such actions and the law includes provisions that—

''(i) ensure that each State's participation in the project complies with budget neutrality requirements; and

''(ii) require the Secretary to treat any expenditures of a State participating in the demonstration project that are excess of the expenditures projected under the budget neutrality standard for the State as an overpayment under title XIX of the Social Security Act.

''(5) FUNDING.—Of the unobligated balances of amounts available in the Centers for Medicare & Medicaid Services Program Management account, $100,000 shall be available to carry out this subsection and shall remain available until expended.''.

(d) CONFORMING AMENDMENTS.—Section 2707 of such Act (42 U.S.C. 1396a note) is amended—

(1) in subsection (a), in the matter before paragraph (1), by inserting ''publicly or'' after ''institution for mental diseases that is'';

(2) in subsection (c)—

(A) in paragraph (1), by striking ''An eligible State'' and inserting ''Except as otherwise provided in paragraph (4), an eligible State'';

(B) in paragraph (3), by striking ''A State shall'' and inserting ''Except as otherwise provided in paragraph (4), a State shall''; and

(C) by adding at the end the following:

''(4) NATIONWIDE AVAILABILITY.—In the event that the Secretary makes a recommendation pursuant to subsection (f)(4) that the demonstration project be expanded on a national basis, any State that has submitted or submits an application pursuant to paragraph (2) shall be deemed to have been selected to be an eligible State to participate in the demonstration project.''; and

(3) in the heading for subsection (f), by striking ''AND REPORT'' and inserting '', REPORT, AND RECOMMENDATIONS''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

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

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

There was no objection.

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

Mr. Speaker, the bill before us today extends and expands the Medicaid emergency psychiatric demonstration project.

A longstanding policy under Medicaid, called the institutions for mental diseases, IMD, exclusion, prohibits the Federal Government from providing Federal Medicaid matching funds to States for services rendered to Medicaid-eligible individuals aged 21 to 64 who are patients in IMDs. IMDs are inpatient facilities with more than 16 beds that primarily treat people with mental health and substance abuse disorders. The original IMD exclusion is consistent with the goal of treating severe mental illness in the least restrictive setting feasible.

The IMD exclusion provided an incentive to shift the cost of care for mental illness to other care modalities and facilities where Medicaid matching funds were available. However, since the IMD exclusion was included with the creation of the Medicaid program in 1965, our mental healthcare system and overall healthcare system have evolved notably.

In recent years, we have seen a significant decrease in the number of publicly funded inpatient psychiatric beds available for emergency services. This has contributed to patients in need of critical mental health services facing psychiatric boarding in general hospital emergency departments.

Psychiatric boarding occurs when an individual with a mental health condition is kept in a hospital emergency department for several hours or admitted to medical wards or skilled nursing facilities without psychiatric expertise because appropriate mental health services were unavailable. This leads to potential serious consequences for psychiatric patients and unnecessary hospital costs.

The Patient Protection and Affordable Care Act authorized a 3-year demonstration program to study the effects of allowing Federal Medicaid matching funds to pay for emergency psychiatric treatment for adults that is otherwise prohibited by the Medicaid IMD exclusion. The demonstration was funded with $75 million in FY 2011, and these funds were available for obligation through December 31, 2015.

The HHS Secretary selected 11 States and the District of Columbia to participate in the demonstration program in March of 2012, and the demonstration program began July 1, 2012. Due to significant State interest, patient need, and other factors, the demonstration project exhausted its Federal funding in April and was forced to terminate early.

S. 599 would temporarily extend the Medicaid emergency psychiatric demonstration for States already participating in the demonstration through September 30, 2016, if the chief actuary of CMS certifies that this extension would not increase net Medicaid spending.

The bill also requires that, not later than September 30, 2016, the HHS Secretary report to Congress on whether the demonstration should be continued after such date and whether the demonstration should be expanded to additional States. If the chief actuary of CMS certifies that this extension would not increase net Medicaid spending, then the demonstration may continue not beyond 2019.

While I have strong concerns with the President's healthcare law, S. 599 would let States and CMS continue to test the provision of critical mental health services for patients in a manner that is responsible for the Federal budget.

Mr. Speaker, I encourage my colleagues to support this commonsense, bipartisan bill.

I reserve the balance of my time.

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

Mr. Speaker, I rise in support of S. 599, the Improving Access to Emergency Psychiatric Care Act.

This legislation, sponsored by Senator BEN CARDIN and championed in the House by Representative JOHN SARBANES, will extend and expand the Medicaid emergency psychiatric demonstration protect. Since the creation of Medicaid 50 years ago, the program has excluded payment for institutions for mental diseases, IMDs, a designation that includes most residential treatment facilities for mental health and substance use disorders with more than 16 beds.

The original IMD exclusion is consistent with the goal of treating severe mental illness in the least restrictive setting possible. However, there have been some unintended consequences of this longstanding policy. States have an incentive to shift the cost of treating mental illness to other care settings where Medicaid matching funds are available. This contributed to a decrease in the number of publicly funded beds available for inpatient psychiatric emergency services. It also contributed to a rise in psychiatric boarding and recidivism in hospital emergency departments.

To develop data on whether modifying an IMD exclusion can improve health care for mental illness, the Affordable Care Act authorized $75 million over 3 years for the Medicare emergency psychiatric demonstration project. Administered by the CMS Innovation Center, the initiative aims to test whether the Medicaid program could provide higher quality care at a lower total cost by reimbursing private psychiatric hospitals for emergency care otherwise prohibited by the Medicaid IMD exclusion. The demonstration project is currently operating in 11 States and the District of Columbia.

This legislation extends the demonstration in a budget-neutral manner so that the Secretary of Health and Human Services can complete an evaluation and make an informed recommendation regarding its continuation and expansion.

Medicaid plays a central and critical role in covering treatment for individuals with mental illness. S. 599 holds promise for improving access to quality psychiatric care for this underserved and vulnerable population and the overall success of our mental healthcare system.

I urge my colleagues to support S. 599, and I thank the sponsors for their commitment to this important issue.

I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Indiana (Mrs. BROOKS), a prime sponsor of the House companion bill and a member of the Energy and Commerce Subcommittee on Health.

Mrs. BROOKS of Indiana. Mr. Speaker, I rise today to speak in support of S. 599, the Improving Access to Emergency Psychiatric Care Act. The bill is the companion to H.R. 3681, which I proudly introduced with my colleague, Congressman SARBANES from Maryland.

With the passage of this bill today, I am pleased that this meaningful mental health reform will head to the President's desk. Fortunately, this bipartisan, bicameral, and commonsense legislation is a great step toward enacting meaningful reforms to an incredibly challenging system.

Currently, CMS does not reimburse private psychiatric institutions or institutions for mental diseases for the services provided to Medicaid enrollees aged 21 to 64. Yet often serious mental illness manifests itself in those in their twenties, and they are not allowed to go with a severe psychiatric break to a psychiatric hospital.

Instead, they go and present at our ERs; and our ERs are already overburdened. Many of them often lack the resources and sometimes the expertise to deal with people who are suffering from a true mental crisis. When they find themselves in the ERs, it is not uncommon for them to have to sit for hours and for far too long while they are suffering.

This commonsense legislation extends the existing demonstration grant that lifts the IMD exclusion and will allow these important psychiatric clinics to receive Medicaid reimbursement

while giving people access to short-term direct care in psychiatric hospitals when they need it most.

I am proud to support the extension of this legislation that allows people to get the treatment that they need. As a lawyer, I have dealt with people who have been in a psychiatric crisis. Many of us have family members who have dealt with a psychiatric crisis. They need the help from the right experts at the right time.

I thank the gentleman for carrying this in the House, and I urge my colleagues to support this legislation.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield such time as he may consume to the gentleman from Maryland (Mr. SARBANES). He is also a member of the Energy and Commerce Committee and a member of our Health Subcommittee. I personally appreciate his commitment to mental health.

Mr. SARBANES. Mr. Speaker, I thank the gentleman for yielding and for his leadership on the Health Subcommittee and on the Energy and Commerce Committee.

I rise today in strong support of the Improving Access to Emergency Psychiatric Care Act. I thank Representative BROOKS of Indiana for her support of this measure and certainly welcome the fact that this is a bipartisan piece of legislation.

What this bill would do is it would extend a demonstration project, as indicated, that ends the Federal prohibition on Medicaid matching payments to community psychiatric hospitals for emergency psychiatric cases. This demonstration project allows individuals with severe mental illness who are a threat to themselves or to others, including those with substance abuse disorders who have experienced overdoses, to get emergency inpatient treatment.

The background of this is as follows:

There has been a longstanding Medicaid provision, dating back to 1965, called the institutions for mental diseases, IMD, exclusion. Under that, the Federal Government is prohibited from providing Medicaid matching funds and reimbursement for the care of eligible individuals aged 21 to 64 if that care is provided in an inpatient facility that primarily treats people with mental health and substance abuse disorders and if that facility has more than 16 beds.

As was indicated, the effect of this exclusion has been to decrease the number of inpatient psychiatric beds that are available for emergency services. It has also been cited by the Government Accountability Office as a factor in emergency department overcrowding, which Congresswoman BROOKS just indicated.

Community-based psychiatric hospitals could help relieve these backups and provide much-needed emergency psychiatric care, but these hospitals cannot receive Federal matching payments for these services.

In 2010, Congress authorized a 3-year pilot called the Medicaid emergency psychiatric demonstration project, which expanded the number of emergency inpatient psychiatric beds available in communities by allowing Federal Medicaid matching payments to freestanding psychiatric hospitals for emergency psychiatric cases.

□ 1730

Eleven States, including my home State of Maryland, are participating in this demonstration, and the preliminary data is very promising. Of the total number of Medicaid beneficiaries admitted to these community-based psychiatric hospitals, fully 84 percent had just one admission during the entire first year of the demonstration. The average length of stay was only 8.2 days, and in 88 percent of the admissions, the beneficiaries were discharged to their homes or to self-care.

The demonstration project is set to end on December 31, 2015, but the final evaluation of the project is not expected to be completed until a year later.

In closing, Mr. Speaker, this bill would build upon the success of the current demonstration project, which is providing timely and cost-effective care. It would also extend the current demonstration project by 1 year.

It would ensure budget neutrality by certifying that the extension is not projected to result in an increase in net Medicaid program spending, and it would allow the Secretary of HHS to extend the demonstration project for an additional 3 years, provided that the requirements regarding Medicaid spending are met.

The bill has already been passed in the Senate by unanimous consent. While I am a little bit disappointed that a very small change was made that is going to require it to go back to the Senate for reconsideration, I am confident that it will be supported there again with Senator CARDIN's leadership.

I urge support of this bipartisan effort to extend a demonstration project that allows individuals with severe mental illness and substance abuse disorders to get emergency inpatient treatment at community psychiatric hospitals.

Mr. PITTS. Mr. Speaker, I am prepared to close. I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield the balance of my time to the gentlewoman from California (Ms. MATSUI), who is also a member of the Committee on Energy and Commerce, a member of the Subcommittee on Health, and, again, a champion of mental health.

Ms. MATSUI. Mr. Speaker, I rise today in support of the Improving Access to Emergency Psychiatric Care Act.

As we work to reform our broken mental healthcare system, it is critical that we build upon programs that provide resources to underserved and vulnerable populations at all points along the spectrum of care.

Today, with the passage of this bill, we have the opportunity to extend the vital Medicaid emergency psychiatric demonstration project. This demonstration project, which recently expired, ensures greater access to essential emergency psychiatric care for Medicaid patients.

This bipartisan bill will ensure that hospitals across our Nation will be able to provide community members in need with inpatient psychiatric beds.

In my home district in Sacramento County, this demonstration project has provided great benefits to our system of care. Medi-Cal beneficiaries have greater access to mental health services, and there has been a reduction in readmission rates at local hospitals.

In fact, by the final year of the 3-year demonstration project, the number of individuals rehospitalized within 30 days of their initial stay decreased by 20 percent in Sacramento County.

The project has improved coordination of care for mental health patients by streamlining planning efforts between inpatient and outpatient providers. In addition, Sacramento County has been able to reinvest savings generated by the project into programs that build greater community alternatives for patients identified as high utilizers of inpatient and emergency departments.

All of these improvements add up to a community mental health system in California that is better able to focus on the whole spectrum of care for underserved patients, from prevention to treatment to the crisis stage.

There is still much more work to do to improve the mental health system, but we must not reverse our significant progress by failing to renew this demonstration project.

I urge my colleagues to vote ''yes'' on S. 599, the Improving Access to Emergency Psychiatric Care Act.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, I encourage my colleagues to support this commonsense, bipartisan bill.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I rise today in support of extending and expanding the Improving Access to Emergency Psychiatric Care Act, which has already passed the Senate and for which identical legislation, H.R. 3681 has been introduced in the House with bipartisan support.

This legislation would extend, and expand if appropriate, the Medicaid Emergency Psychiatric Demonstration that was created by the Affordable Care Act.

While I will not oppose this legislation based on process, I must mention that I am not pleased that this legislation did not go through regular order here in the House as it should have, and as it did in the Senate. I also do not support a change made to require the $100,000 in administrative costs in the bill to come out of unobligated funds at CMS. To delay this legislation, slow it down even further and force the Senate to reconsider the bill for a one word change and an amount of money

that is less than the annual salary of any Member of Congress is a waste of time. However, despite these reservations, I support this legislation moving forward.

Since the enactment of Medicaid in 1965, so-called ''Institutions of Mental Disease'', or IMDs, have been prohibited by statute from receiving federal Medicaid matching funds for inpatient treatment provided to adults ages 21 to 64. This prohibition was rooted in the desirability of community-based care as an alternative to mass institutionalization of the mentally ill, often in horrific conditions.

However, as our healthcare system has grown and changed, there has been increasing concern about the perverse incentives created by the wholesale exclusion of IMDs from treatment for Medicaid beneficiaries; for instance, frequent boarding of psychiatric patients in emergency rooms and non-psychiatric beds of general hospitals has been reported to occur when specialized inpatient psychiatric beds are not available.

The days of mass institutionalization are over and we can never go back to those days—at the same time, so-called ''boarding'' of the seriously mentally ill in general hospitals, because the beds simply aren't available, is not an acceptable alternative.

Those Medicaid beneficiaries that are seriously mentally ill need the right treatment, at the right time. The demonstration project that we are extending here today allows states to test incorporation of IMD services for Medicaid beneficiaries in a way that insures other community-based services do not suffer. This legislation, which also aligns with CMS's recent proposal to allow for short-term IMD stays in Medicaid managed care plans, is the appropriate way to responsibly address the Medicaid IMD exclusion.

We've had immense success with this project thus far, and we can still learn more from it, which is exactly why this demonstration project must be extended and as appropriate, expanded. This legislation will allow the Secretary to do just that, and I urge my colleagues to support its swift passage.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. PITTS) that the House suspend the rules and pass the bill, S. 599, as amended.

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

A motion to reconsider was laid on the table.

PROTECTING OUR INFANTS ACT OF 2015

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (S. 799) to address problems related to prenatal opioid use.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 799

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Protecting Our Infants Act of 2015''.

SEC. 2. ADDRESSING PROBLEMS RELATED TO PRENATAL OPIOID USE.

(a) REVIEW OF PROGRAMS.—The Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') shall conduct a review of planning and coordination related to prenatal opioid use, including neonatal abstinence syndrome, within the agencies of the Department of Health and Human Services.

(b) STRATEGY.—In carrying out subsection (a), the Secretary shall develop a strategy to address gaps in research and gaps, overlap, and duplication among Federal programs, including those identified in findings made by reports of the Government Accountability Office. Such strategy shall address—

(1) gaps in research, including with respect to—

(A) the most appropriate treatment of pregnant women with opioid use disorders;

(B) the most appropriate treatment and management of infants with neonatal abstinence syndrome; and

(C) the long-term effects of prenatal opioid exposure on children;

(2) gaps, overlap, or duplication in—

(A) substance use disorder treatment programs for pregnant and postpartum women; and

(B) treatment program options for newborns with neonatal abstinence syndrome;

(3) gaps, overlap, or duplication in Federal efforts related to education about, and prevention of, neonatal abstinence syndrome; and

(4) coordination of Federal efforts to address neonatal abstinence syndrome.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary 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 concerning the findings of the review conducted under subsection (a) and the strategy developed under subsection (b).

SEC. 3. DEVELOPING RECOMMENDATIONS FOR PREVENTING AND TREATING PRENATAL OPIOID USE DISORDERS.

(a) IN GENERAL.—The Secretary shall conduct a study and develop recommendations for preventing and treating prenatal opioid use disorders, including the effects of such disorders on infants. In carrying out this subsection the Secretary shall—

(1) take into consideration—

(A) the review and strategy conducted and developed under section 2; and

(B) the lessons learned from previous opioid epidemics; and

(2) solicit input from States, localities, and Federally recognized Indian tribes or tribal organizations (as defined in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)), and nongovernmental entities, including organizations representing patients, health care providers, hospitals, other treatment facilities, and other entities, as appropriate.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall make available on the appropriate Internet Website of the Department of Health and Human Services a report on the recommendations under subsection (a). Such report shall address each of the issues described in subsection (c).

(c) CONTENTS.—The recommendations described in subsection (a) and the report under subsection (b) shall include—

(1) a comprehensive assessment of existing research with respect to the prevention, identification, treatment, and long-term outcomes of neonatal abstinence syndrome, including the identification and treatment of pregnant women or women who may become pregnant who use opioids or have opioid use disorders;

(2) an evaluation of—

(A) the causes of, and risk factors for, opioid use disorders among women of reproductive age, including pregnant women;

(B) the barriers to identifying and treating opioid use disorders among women of reproductive age, including pregnant and postpartum women and women with young children;

(C) current practices in the health care system to respond to, and treat, pregnant women with opioid use disorders and infants affected by such disorders;

(D) medically indicated uses of opioids during pregnancy;

(E) access to treatment for opioid use disorders in pregnant and postpartum women; and

(F) access to treatment for infants with neonatal abstinence syndrome; and

(G) differences in prenatal opioid use and use disorders in pregnant women between demographic groups; and

(3) recommendations on—

(A) preventing, identifying, and treating the effects of prenatal opioid use on infants;

(B) treating pregnant women who have opioid use disorders;

(C) preventing opioid use disorders among women of reproductive age, including pregnant women, who may be at risk of developing opioid use disorders; and

(D) reducing disparities in opioid use disorders among pregnant women.

SEC. 4. IMPROVING DATA AND THE PUBLIC HEALTH RESPONSE.

The Secretary may continue activities, as appropriate, related to—

(1) providing technical assistance to support States and Federally recognized Indian Tribes in collecting information on neonatal abstinence syndrome through the utilization of existing surveillance systems and collaborating with States and Federally recognized Indian Tribes to improve the quality, consistency, and collection of such data; and

(2) providing technical assistance to support States in implementing effective public health measures, such as disseminating information to educate the public, health care providers, and other stakeholders on prenatal opioid use and neonatal abstinence syndrome.

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

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

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

There was no objection.

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

Mr. Speaker, the bill before us today begins to combat the rise of prenatal opioid abuse and neonatal abstinence syndrome.

Over the past several years, opioid addiction has risen dramatically in the United States, reaching epidemic proportions. The death rate for heroin overdose doubled in just 2 years from 2010 to 2012.