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.

One of the issues resulting from this epidemic is neonatal abstinence syndrome, known as NAS. Babies born with NAS are infants that are addicted to opioids and that suffer medical issues associated with drug withdrawal. Symptoms can last for weeks, keeping otherwise healthy infants confined to the hospital at the start of their lives.

NAS can result from the use of prescription drugs or from the use of illegal opioids. Sadly, over the past 15 years, the incidence of NAS has tripled in the United States. This is a rapidly growing problem that needs to be addressed for the safety of our mothers and children.

S. 799, Protecting Our Infants Act of 2015, introduced in the Senate by Majority Leader MCCONNELL and led in the House by my colleagues, Ms. CLARK of Massachusetts and Mr. STIVERS, would address the increasing problem of prenatal opioid abuse and neonatal abstinence syndrome.

Preventing opioid abuse among pregnant women and women of childbearing age is crucial in addressing NAS. The Government Accountability Office has identified that more research is needed in this area to help treat babies born with NAS and mothers addicted to opioids.

This legislation would help fill this research gap by directing the Agency for Healthcare Research and Quality, AHRQ, to conduct a study and develop recommendations for preventing and treating prenatal opioid abuse and neonatal abstinence syndrome.

Mr. Speaker, the House companion to S. 799 was approved by a voice vote in the Subcommittee on Health and the full Committee on Energy and Commerce. Today we have a chance to approve this important bipartisan and bicameral legislation. I urge my colleagues to support the bill.

Mr. Speaker, 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. 799, Protecting Our Infants Act of 2015. This legislation, sponsored by Senator MITCH MCCONNELL and championed in the House by Representative KATHERINE CLARK, would help combat prenatal opioid abuse epidemic.

The Centers for Disease Control and Prevention, CDC, has found drug overdose to be the leading cause of injury death in the United States and declared prescription drug abuse to be an epidemic.

Prescription opioid use in pregnancy is strongly associated with neonatal complications. According to a recent study in the New England Journal of Medicine, the incidence rate of neonatal abstinence syndrome, NAS, quadrupled from 2004 to 2013, a fourfold increase in less than a decade.

NAS is a group of problems that occur in newborns who have been exposed to opioids while in the womb. The symptoms are often severe. Newborns with NAS require specialized care, typically in a neonatal intensive care unit.

In February 2015, the Government Accountability Office, the GAO, released a report entitled ''Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination.'' The report identified a number of different research gaps in the treatment of opioid use during pregnancy and in the treatment of infants with NAS.

S. 799 will help combat prenatal opioid abuse and neonatal abstinence syndrome. Addressing these issues is a critical part of our effort to fight the ongoing prescription drug abuse epidemic.

The legislation will facilitate the development and recommendations for the treatment of prenatal opioid abuse and NAS and coordinate a national strategy to close research program gaps. It will also require CDC to help States improve data collection and surveillance activities related to prenatal opioid abuse and NAS.

I urge my colleagues to support S. 799, the Protecting Our Infants Act, and I thank the sponsors for their commitment to this important issue.

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

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from West Virginia (Mr. JENKINS), a leader on this issue.

Mr. JENKINS of West Virginia. Mr. Speaker, every day in hospitals across my district and the country, tragically, babies begin their lives suffering through drug withdrawal because they were exposed during pregnancy.

Sadly, the rates of babies with NAS have skyrocketed. NAS is a nationwide crisis. The Protecting Our Infants Act addresses the many gaps in the care and treatment of NAS babies.

How do I know there are gaps? Today, in a facility in my hometown that I helped start, Lily's Place is caring for 10—10—babies suffering the ravages of withdrawal.

It took years of working through the regulatory burdens and certification limitations just to do what is right for our most innocent. The gaps in care are real and so are the obstacles treating NAS babies.

This legislation will pave the way to consider new models of care, like Lily's Place, for our NAS babies.

I commend my colleagues, Leader MITCH MCCONNELL and Representatives KATHERINE CLARK and STEVE STIVERS, for helping to give every child a chance at a healthy start in life.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 4 minutes to the gentlewoman from Massachusetts (Ms. CLARK), the House Democratic sponsor.

Ms. CLARK of Massachusetts. Mr. Speaker, today 58 babies, 1 baby every 25 minutes, will be born suffering from the same pain adults describe as the worst pain of their lives, the pain of drug withdrawal.

Over the last decade, the number of infants born experiencing withdrawal from powerful drugs has grown nearly fivefold. It is a condition called neonatal abstinence syndrome. It results from prenatal exposure to opioids like heroin and prescription painkillers. In States like Massachusetts, we are seeing this happen at a rate three times the national average.

In addition to the human suffering, the costs associated with NAS births are staggering. They are five times more expensive than healthy births, totaling $1.5 billion for hospitals in 2012, with 80 percent being paid by Medicaid.

But despite the best efforts of doctors, nurses, and others, there is no coordinated response to this crisis. There are no clear best practices for treating these infants, and more research is needed to help understand the problem. That is why I have worked with my colleagues, researchers, doctors, and advocates to introduce the Protecting Our Infants Act, the first Federal bill to take proactive steps in addressing the rise of NAS births.

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We were able to pass this bill in the House in September, thanks to the help of my partner on this bill, Representative STEVE STIVERS. A slightly modified version was passed a few weeks ago, due to the hard work of our Senate sponsors, Majority Leader MCCONNELL and Senator CASEY. With broad support in both Chambers, this is an opportunity for Congress to make a difference for moms and babies suffering because of the opioid epidemic.

The Protecting Our Infants Act will require the Department of Health and Human Services to develop recommendations to prevent and treat prenatal opioid abuse and NAS, and to develop a strategy in the Department to coordinate programs and research. This will help ease the suffering of the smallest victims of the opioid crisis. It will help hospitals and Medicaid save money, and ease the burden on doctors and nurses that are overwhelmed by this problem.

This is not controversial, partisan, or political. It is just good policy. I thank my Republican partner in the House, STEVE STIVERS, for his leadership in getting this bill to where it is today.

I ask the House to come together and help the thousands of babies and mothers who are fighting this epidemic, and I urge my colleagues to pass the bipartisan Protecting Our Infants Act and send this legislation to the President for his signature.

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

Mr. PITTS. Mr. Speaker, I urge all Members to support this important bipartisan, bicameral legislation.

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

Mr. PALLONE. Mr. Speaker, I rise in support of S. 799—the Protecting Our Infants Act of 2015. This legislation addresses a sad reality of our country's opioid epidemic: prenatal

opioid abuse and the steep increase in the incidence of neonatal abstinence syndrome or NAS.

NAS occurs in newborns who were exposed to opiates while in their mother's womb and is associated with negative health outcomes such as preterm births, low birthweight, and respiratory distress. A recent study found the incidence of NAS quadrupled between 2004 and 2013. This legislation would respond to that dramatic increase by requiring HHS to create a comprehensive national strategy to address prenatal opioid abuse and NAS. That strategy would include a coordinated research and programming strategy to address the public health challenge of NAS and prenatal opioid abuse as well as develop a comprehensive set of recommendations for preventing and treating prenatal opioid use disorders and NAS.

I want to thank Rep. KATHERINE CLARK for her leadership on this critical and timely issue. I urge my colleagues to support this legislation.

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. 799.

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

A motion to reconsider was laid on the table.

FEDERAL COMMUNICATIONS COMMISSION PROCESS REFORM ACT OF 2015

Mr. WALDEN. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2583) to amend the Communications Act of 1934 to provide for greater transparency and efficiency in the procedures followed by the Federal Communications Commission, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2583

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 ''Federal Communications Commission Process Reform Act of 2015''.

SEC. 2. FCC PROCESS REFORM.

(a) IN GENERAL.—Title I of the Communications Act of 1934 (47 U.S.C. 151 et seq.) is amended by adding at the end the following:

''SEC. 13. TRANSPARENCY AND EFFICIENCY.

''(a) INITIAL RULEMAKING AND INQUIRY.—

''(1) RULEMAKING.—Not later than 1 year after the date of the enactment of the Federal Communications Commission Process Reform Act of 2015, the Commission shall complete a rulemaking proceeding and adopt procedural changes to its rules to maximize opportunities for public participation and efficient decisionmaking.

''(2) REQUIREMENTS FOR RULEMAKING.—The rules adopted under paragraph (1) shall—

''(A) set minimum comment periods for comment and reply comment, subject to a determination by the Commission that good cause exists for departing from such minimum comment periods, for—

''(i) significant regulatory actions, as defined in Executive Order No. 12866; and

''(ii) all other rulemaking proceedings;

''(B) establish policies concerning the submission of extensive new comments, data, or reports towards the end of the comment period;

''(C) establish policies regarding treatment of comments, ex parte communications, and data or reports (including statistical reports and reports to Congress) submitted after the comment period to ensure that the public has adequate notice of and opportunity to respond to such submissions before the Commission relies on such submissions in any order, decision, report, or action;

''(D) establish procedures for, not later than 14 days after the end of each quarter of a calendar year (or more frequently, as the Commission considers appropriate), publishing on the Internet website of the Commission and submitting to Congress a report that contains—

''(i) the status of open rulemaking proceedings and proposed orders, decisions, reports, or actions on circulation for review by the Commissioners, including which Commissioners have not cast a vote on an order, decision, report, or action that has been on circulation for more than 60 days;

''(ii) for the petitions, applications, complaints, and other requests for action by the Commission that were pending at the Commission on the last day of such quarter (or more frequent period, as the case may be)—

''(I) the number of such requests, broken down by the bureau primarily responsible for action and, for each bureau, the type of request (such as a petition, application, or complaint); and

''(II) information regarding the amount of time for which such requests have been pending, broken down as described in subclause (I); and

''(iii) a list of the congressional investigations of the Commission that were pending on the last day of such quarter (or more frequent period, as the case may be) and the cost of such investigations, individually and in the aggregate;

''(E) establish deadlines (relative to the date of filing) for—

''(i) in the case of a petition for a declaratory ruling under section 1.2 of title 47, Code of Federal Regulations, issuing a public notice of such petition;

''(ii) in the case of a petition for rulemaking under section 1.401 of such title, issuing a public notice of such petition; and

''(iii) in the case of a petition for reconsideration under section 1.106 or 1.429 of such title or an application for review under section 1.115 of such title, issuing a public notice of a decision on the petition or application by the Commission or under delegated authority (as the case may be);

''(F) establish guidelines (relative to the date of filing) for the disposition of petitions filed under section 1.2 of such title;

''(G) establish procedures for the inclusion of the specific language of the proposed rule or the proposed amendment of an existing rule in a notice of proposed rulemaking; and

''(H) require notices of proposed rulemaking and orders adopting a rule or amending an existing rule that—

''(i) create (or propose to create) a program activity to contain performance measures for evaluating the effectiveness of the program activity; and

''(ii) substantially change (or propose to substantially change) a program activity to contain—

''(I) performance measures for evaluating the effectiveness of the program activity as changed (or proposed to be changed); or

''(II) a finding that existing performance measures will effectively evaluate the program activity as changed (or proposed to be changed).

''(3) INQUIRY.—Not later than 1 year after the date of the enactment of the Federal Communications Commission Process Reform Act of 2015, the Commission shall complete an inquiry to seek public comment on whether and how the Commission should—

''(A) establish procedures for allowing a bipartisan majority of Commissioners to place an order, decision, report, or action on the agenda of an open meeting;

''(B) establish procedures for informing all Commissioners of a reasonable number of options available to the Commission for resolving a petition, complaint, application, rulemaking, or other proceeding;

''(C) establish procedures for ensuring that all Commissioners have adequate time, prior to being required to decide a petition, complaint, application, rulemaking, or other proceeding (including at a meeting held pursuant to section 5(d)), to review the proposed Commission decision document, including the specific language of any proposed rule or any proposed amendment of an existing rule;

''(D) establish procedures for publishing the text of agenda items to be voted on at an open meeting in advance of such meeting so that the public has the opportunity to read the text before a vote is taken;

''(E) establish deadlines (relative to the date of filing) for disposition of applications for a license under section 1.913 of title 47, Code of Federal Regulations;

''(F) assign resources needed in order to meet the deadlines described in subparagraph (E), including whether the Commission's ability to meet such deadlines would be enhanced by assessing a fee from applicants for such a license; and

''(G) publish each order, decision, report, or action not later than 30 days after the date of the adoption of such order, decision, report, or action.

''(4) DATA FOR PERFORMANCE MEASURES.—The Commission shall develop a performance measure or proposed performance measure required by this subsection to rely, where possible, on data already collected by the Commission.

''(5) GAO AUDIT.—Not less frequently than every 6 months, the Comptroller General of the United States shall audit the cost estimates provided by the Commission under paragraph (2)(D)(iii) during the preceding 6-month period.

''(b) PERIODIC REVIEW.—On the date that is 5 years after the completion of the rulemaking proceeding under subsection (a)(1), and every 5 years thereafter, the Commission shall initiate a new rulemaking proceeding to continue to consider such procedural changes to its rules as may be in the public interest to maximize opportunities for public participation and efficient decisionmaking.

''(c) NONPUBLIC COLLABORATIVE DISCUSSIONS.—

''(1) IN GENERAL.—Notwithstanding section 552b of title 5, United States Code, a bipartisan majority of Commissioners may hold a meeting that is closed to the public to discuss official business if—

''(A) a vote or any other agency action is not taken at such meeting;

''(B) each person present at such meeting is a Commissioner, an employee of the Commission, a member of a joint board or conference established under section 410, or a person on the staff of such a joint board or conference or of a member of such a joint board or conference; and

''(C) an attorney from the Office of General Counsel of the Commission is present at such meeting.

''(2) DISCLOSURE OF NONPUBLIC COLLABORATIVE DISCUSSIONS.—Not later than 2 business days after the conclusion of a meeting held under paragraph (1), the Commission