is vital in fighting the U.S. drug abuse epidemic.

H.R. 4982 requires the Government Accountability Office to report on inpatient and outpatient treatment capacities, detoxification programs, rehabilitation programs, and treatment programs for pregnant women and adolescents.

Inpatient and outpatient treatment centers are usually one of the biggest obstacles communities face when trying to help people who are fighting addiction. Unfortunately, for most communities, local treatment facilities are few and far between and many of them are full.

As a lifelong healthcare professional, I believe the only way we will be able to adequately fight this opioid abuse epidemic is if we work together.

□ 1830

We need to adequately understand the treatment services that are available to people with addiction across the country so we can use these tools to their fullest extent. That is why I am supporting H.R. 4982. By understanding all the tools the community can use, we can begin to fight this epidemic.

I encourage my colleagues to support this bill so we can begin to leverage our resources to help our communities fight opioid abuse.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. FOSTER), a cosponsor of the bill.

Mr. FOSTER. Mr. Speaker, I thank Mr. GREEN for yielding me the time.

My bill, H.R. 4982, the Examining Opioid Treatment Infrastructure Act of 2016, is straightforward, and it is bipartisan.

If we are ever going to get a handle on the heroin and opioid epidemic tearing through our communities, we have to know what we are dealing with. We need data, and we need to know what capacity we have in place and what capacity we need to treat this epidemic so that we can make smart and adequate investments, which is why we need this bill.

This important bill directs a study of the inpatient and outpatient addiction treatment capacity and availability throughout the U.S., as well as an assessment of the needed types and numbers of treatment options.

It seems simple, but there is no better place to start than at the beginning, with an understanding of the addiction treatment infrastructure that we have versus the need for that infrastructure.

When I was first elected to Congress, I was not prepared to hear the stories from family members who had lost a loved one due to substance abuse. My office often gets calls from parents wanting to share their stories of the children they have lost to addiction.

While opioid addiction may start in many ways, it ends with a scientifically understood, increasingly treatable medical condition in which the biochemical pathways necessary to normal decisionmaking in the brain have been hijacked, and the chemistry of the brain permanently altered.

The more we learn about the science of addiction, the more convinced we become that the best path forward is treating addiction like the medical, biochemical condition that it is. To do this successfully, we need the correct number and types of addiction treatment facilities.

That is why I introduced the Examining Opioid Treatment Infrastructure Act of 2016, with my friend from New Jersey (Mr. PALLONE).

We know that opioid use and abuse has become an epidemic, and now let's make sure that we know the real numbers we are dealing with so we can allocate the necessary resources.

I urge support of the Examining Opioid Treatment Infrastructure Act of 2016.

Mr. GENE GREEN of Texas. Mr. Speaker, having no further speakers, I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I encourage my colleagues to vote for H.R. 4982.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 4982, 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.

OPIOID USE DISORDER TREATMENT EXPANSION AND MODERNIZATION ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4981) to amend the Controlled Substances Act to improve access to opioid use disorder treatment, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4981

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 ''Opioid Use Disorder Treatment Expansion and Modernization Act''.

SEC. 2. FINDING.

The Congress finds that opioid use disorder has become a public health epidemic that must be addressed by increasing awareness and access to all treatment options for opioid use disorder, overdose reversal, and relapse prevention.

SEC. 3. OPIOID USE DISORDER TREATMENT MODERNIZATION.

(a) IN GENERAL.—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended—

(1) in subparagraph (B), by striking clauses (i), (ii), and (iii) and inserting the following:

''(i) The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

''(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary—

''(I) all schedule III, IV, and V drugs, as well as unscheduled medications approved by the Food and Drug Administration, for the treatment of opioid use disorder, including such drugs and medications for maintenance, detoxification, overdose reversal, and relapse prevention, as available; and

''(II) appropriate counseling and other appropriate ancillary services.

''(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclause (II), the applicable number is 30.

''(II) The applicable number is 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients.

''(III) The Secretary may by regulation change such total number.

''(IV) The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.

''(iv) If the Secretary by regulation increases the total number of patients which a qualifying practitioner is permitted to treat pursuant to clause (iii)(II), the Secretary shall require such a practitioner to obtain a written agreement from each patient, including the patient's signature, that the patient—

''(I) will receive an initial assessment and treatment plan and periodic assessments and treatment plans thereafter;

''(II) will be subject to medication adherence and substance use monitoring;

''(III) understands available treatment options, including all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including their potential risks and benefits; and

''(IV) understands that receiving regular counseling services is critical to recovery.

''(v) The practitioner will comply with the reporting requirements of subparagraph (D)(i)(IV).'';

(2) in subparagraph (D)—

(A) in clause (i), by adding at the end the following:

''(IV) The practitioner reports to the Secretary, at such times and in such manner as specified by the Secretary, such information and assurances as the Secretary determines necessary to assess whether the practitioner continues to meet the requirements for a waiver under this paragraph.'';

(B) in clause (ii), by striking ''Upon receiving a notification under subparagraph (B)'' and inserting ''Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B)''; and

(C) in clause (iii)—

(i) by inserting ''and shall forward such determination to the Attorney General'' before the period at the end of the first sentence; and

(ii) by striking ''physician'' and inserting ''practitioner'';

(3) in subparagraph (G)—

(A) by amending clause (ii)(IV) to read as follows:

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall address—

''(aa) opioid maintenance and detoxification;

''(bb) appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

''(cc) initial and periodic patient assessments (including substance use monitoring);

''(dd) individualized treatment planning; overdose reversal; relapse prevention;

''(ee) counseling and recovery support services;

''(ff) staffing roles and considerations;

''(gg) diversion control; and

''(hh) other best practices, as identified by the Secretary.''; and

(B) by adding at the end the following:

''(iii) The term 'qualifying practitioner' means—

''(I) a qualifying physician, as defined in clause (ii); or

''(II) during the period beginning on the date of the enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act and ending on the date that is three years after such date of enactment, a qualifying other practitioner, as defined in clause (iv).

''(iv) The term 'qualifying other practitioner' means a nurse practitioner or physician assistant who satisfies each of the following:

''(I) The nurse practitioner or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

''(II) The nurse practitioner or physician assistant satisfies 1 or more of the following:

''(aa) Has completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

''(bb) Has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

''(III) The nurse practitioner or physician assistant is supervised by or works in collaboration with a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may review and update the requirements for being a qualifying other practitioner under this clause.''; and

(4) in subparagraph (H)—

(A) in clause (i), by inserting after subclause (II) the following:

''(III) Such other elements of the requirements under this paragraph as the Secretary determines necessary for purposes of implementing such requirements.''; and

(B) by amending clause (ii) to read as follows:

''(ii) Not later than one year after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.''.

(b) RECOMMENDATION OF REVOCATION OR SUSPENSION OF REGISTRATION IN CASE OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary of Health and Human Services may recommend to the Attorney General that the registration of a practitioner be revoked or suspended if the Secretary determines, according to such criteria as the Secretary establishes by regulation, that a practitioner who is registered under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is not in substantial compliance with the requirements of such section, as amended by this Act.

(c) OPIOID DEFINED.—Section 102(18) of the Controlled Substances Act (21 U.S.C. 802(18)) is amended by inserting ''or 'opioid' '' after ''The term 'opiate' ''.

(d) REPORTS TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and not less than over every 5 years thereafter, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration and experts in opioid use disorder research and treatment, shall—

(A) perform a thorough review of the provision of opioid use disorder treatment services in the United States, including services provided in opioid treatment programs and other specialty and nonspecialty settings; and

(B) submit a report to the Congress on the findings and conclusions of such review.

(2) CONTENTS.—Each report under paragraph (1) shall include an assessment of—

(A) compliance with the requirements of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), as amended by this Act;

(B) the measures taken by the Secretary of Health and Human Services to ensure such compliance;

(C) whether there is further need to increase or decrease the number of patients a waivered practitioner is permitted to treat, as provided for by the amendment made by subsection (a)(1);

(D) the extent to which, and proportions with which, the full range of Food and Drug Administration-approved treatments for opioid use disorder are used in routine health care settings and specialty substance use disorder treatment settings;

(E) access to, and use of, counseling and recovery support services, including the percentage of patients receiving such services;

(F) changes in State or local policies and legislation relating to opioid use disorder treatment;

(G) the use of prescription drug monitoring programs by practitioners who are permitted to dispense narcotic drugs to individuals pursuant to a waiver under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2));

(H) the findings resulting from inspections by the Drug Enforcement Administration of practitioners described in subparagraph (G); and

(I) the effectiveness of cross-agency collaboration between Department of Health and Human Services and the Drug Enforcement Administration for expanding effective opioid use disorder treatment.

SEC. 4. SENSE OF CONGRESS.

It is the Sense of Congress that, with respect to the total number of patients that a qualifying physician (as defined in subparagraph (G)(iii) of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) can treat at any one time pursuant to such section, the Secretary of Health and Human Services should consider raising such total number to 250 patients following a third notification to the Secretary of the need and intent of the physician to treat up to 250 patients that is submitted to the Secretary not sooner than 1 year after the date on which the physician submitted to the Secretary a second notification to treat up to 100 patients.

SEC. 5. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

''(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.—

''(1) PARTIAL FILLS.—

''(A) IN GENERAL.—A prescription for a controlled substance in schedule II may be partially filled if—

''(i) it is not prohibited by State law;

''(ii) the prescription is written and filled in accordance with the Controlled Substances Act (21 U.S.C. 801 et seq.), regulations prescribed by the Attorney General, and State law;

''(iii) the partial fill is requested by the patient or the practitioner that wrote the prescription; and

''(iv) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

''(B) OTHER CIRCUMSTANCES.—A prescription for a controlled substance in schedule II may be partially filled in accordance with section 1306.13 of title 21, Code of Federal Regulations (as in effect on the date of enactment of the Reducing Unused Medications Act of 2016).

''(2) REMAINING PORTIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 30 days after the date on which the prescription is written.

''(B) EMERGENCY SITUATIONS.—In emergency situations, as described in subsection (a), the remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 72 hours after the prescription is issued.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Attorney General to allow a prescription for a controlled substance in schedule III, IV, or V of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) to be partially filled.

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

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members

have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

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

There was no objection.

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

Mr. Speaker, I rise in support of H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, introduced by the gentleman from Indiana (Mr. BUCSHON) and the gentleman from New York (Mr. TONKO).

More than 2 million Americans are living with a substance use disorder. Evidence strongly suggests that medication-assisted treatment can have a significant impact on combating this epidemic.

H.R. 4981 would amend the Controlled Substance Act to expand access to medication-assisted treatment for patients with substance use disorders while improving the quality of care provided and minimizing the potential for drug diversion.

For the first time, this bill would authorize nurse practitioners and physician assistants to prescribe maintenance treatment in an office-based setting after meeting certain training requirements.

H.R. 4981 would improve the training that all qualifying practitioners receive, and it would maintain the critical role counseling and other recovery support services play in the provision of quality medication-assisted treatment.

Further, the bill would require HHS to perform a thorough review of opioid use disorder so we know what is working well and where there is a need for further improvement.

H.R. 4981 is the product of extensive bipartisan discussion at the Energy and Commerce Committee, and I urge my colleagues to join me in supporting it.

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 H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act.

Despite the fact that we are in the middle of an unprecedented opioid and heroin crisis, we know that treatment gaps continue to limit our ability to address the growing crisis. Only 1 in 10 people struggling with addiction receive any form of treatment, despite the fact that we have evidence-based, medication-assisted treatment for those struggling with prescription drug or heroin addiction.

One available treatment is buprenorphine. The medication is safely prescribed from an office setting similar to any other medication a patient might take.

Unfortunately, in the midst of our current opioid epidemic, currently, physicians are restricted to how many patients they are allowed to treat with this medication, and nurse practitioners and physician assistants are not allowed to treat patients with this medication at all.

As a result, many patients are placed on prolonged waiting lists with addiction specialists as they await access to this treatment. This is not acceptable.

We must significantly increase the cap of the number of patients a physician can treat, as well as permanently allow nurse practitioners and physician assistants to treat patients with this medication.

Today's legislation is not perfect, but it is the first step toward reaching bicameral, bipartisan agreement on a package that meets these goals. I remain committed to working with my colleagues to expand access to this important evidence-based treatment as we move to conference with the Senate.

I want to thank the bill's sponsors, fellow members of the Committee on Energy and Commerce, Representative PAUL TONKO and Representative LARRY BUCSHON, for introducing this legislation. I urge my colleagues to support the Opioid Use Disorder Treatment Expansion and Modernization Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 5 minutes to the gentleman from Indiana (Mr. BUCSHON), a cosponsor of this piece of legislation.

Mr. BUCSHON. Mr. Speaker, H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, is the product of months of stakeholder engagement, expert input, and bipartisan negotiation.

The opioid epidemic has left no area of this Nation untouched. Day in and day out, we hear from our constituents and see in the news the direct impact this has on the everyday lives of our fellow citizens.

The evidence is clear that this epidemic is growing and it will continue to grow unless immediate action is taken.

As a doctor, a father, and a public policymaker, I want to do my part to help our communities overcome this challenge. That is why I am proud to offer H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act today with my colleague from New York (Mr. TONKO).

We have worked together over the past several months to find common ground and move forward with a well-crafted policy solution. Our final bill represents months of stakeholder engagement and bipartisan work to improve access and quality treatment for opioid use disorder while limiting diversion of treatment medications for abuse themselves.

H.R. 4981 targets four main areas:

Increase access to opioid use disorder treatment where it is most needed;

Empower physicians through education, training, and quality-of-care measures;

Encourage a multi-pronged approach to opioid use disorder treatment;

Deter bad actors and reduce diversion, as previously was mentioned.

This is a positive step toward increasing access for treatment for opioid use disorder while raising the quality of care and reducing diversion.

Again, I want to thank Mr. TONKO and all those who have worked with us throughout this process. I urge my colleagues to support H.R. 4981's passage, and I look forward to productive discussions with the Senate to get critical opioid legislation to the President's desk.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentleman from New York (Mr. TONKO), a fellow member on the Committee on Energy and Commerce.

Mr. TONKO. Mr. Speaker, I thank the gentleman from Texas for yielding.

I rise in support of H.R. 4981, Opioid Use Disorder Treatment Expansion and Modernization Act, which I have had the honor of working on with my colleague and friend, Representative LARRY BUCSHON, in introducing.

At the outset, I would like to thank Representative BUCSHON and his staff, as well as the hard work of individuals on the committee staff, and our committee leaders, Chairman UPTON and Ranking Member PALLONE, to get this bill to this point.

I would also like to praise my colleague and fellow New Yorker, Representative BRIAN HIGGINS, for his introduction and leadership on the TREAT Act, without which we would not be making this progress today.

It is no hyperbole to announce that we are in a crisis when it comes to the opioid epidemic sweeping our Nation. More than 47,000 people have died of drug overdoses in 2014—family members, friends, and neighbors within that 47,000, for each and every one of us—a vast majority of which were opioid-related.

It is a sign of the times that when you drive down the thruway in my district in upstate New York, instead of billboards advertising for McDonald's or Taco Bell, you see billboards advising to you call 911 in case of an opioid overdose.

It is disturbing how quickly this has become the new normal. This crisis has affected our neighbors, our families, and our beloved communities.

Having worked with the addiction recovery community, I know that one of the most important things we can do as policymakers is to ensure that when an individual struggling with addiction cries out for help, that there is someone there to answer the call. That is what this bill endeavors to do.

Right now, treatment capacity for those seeking help for opioid use disorder in an office-based setting is artificially capped at 100 patients. What this means in reality is that if you are patient 101 or 102, you get a closed door and have to wait weeks, if not months, for treatment. Expectedly, these delays can be deadly.

The legislation before us will support the goal of raising the caps for qualified physicians to 250, expanding existing opioid treatment capacity by some 150 percent, all while ensuring the care that individuals receive is high quality and minimizes the risk of diversion.

In addition, this legislation will, for the first time, expand buprenorphine-prescribing authority to nurse practitioners and physician assistants who meet certain training requirements and comply with applicable State laws.

By bringing these practitioners into the fold, we can expand treatment capacity, especially in rural areas where physicians oftentimes might be few and far between.

Importantly, this bill expands access to high-quality addiction treatment, promoting the full range of psychosocial services that makes recovery possible, and providing HHS with new tools to remove bad actors from the system.

Any Member interested in decreasing the unlawful diversion of buprenorphine should support this legislation.

This legislation is not perfect, and I would still like to see a higher patient limit for the top class of physicians.

In the midst of this crisis, ensuring access for all needs to be our utmost top priority. No matter where we ultimately land on this arbitrary number, we will still be closing the door on someone who needs our help. We would not accept this in any other field of medicine, so we all need to think long and hard about why we are allowing this situation to persist in the field of addiction.

In addition, I would like to draw attention to two changes made to this bill before floor consideration. First, instead of statutorily lifting the DATA 2000 caps, this legislation includes a sense of Congress, if you will, that the caps should be lifted.

Secondly, this legislation would time-limit the expansion of prescribing authority to nurse practitioners and physician assistants to some 3 years.

Both of these temporary changes were made to bring the bill into compliance with PAYGO procedures for floor consideration and must be fixed as we move this bill into conference.

□ 1845

I would just ask, Mr. Speaker, are we firm in our commitment to combat the addiction to heroin? Are we firm in our efforts to assist those who struggle with the illness of addiction? Do we stand for providing true hope to individuals who count on us to provide the resources along with the legislation to make life available to them?

I would suggest that this House and the Senate look hard and fast at providing resources that are real and that provide for an effective outcome. If we fail to find a path forward for a meaningful expansion of the physician caps and certainly the nurse practitioners' and physician assistants' prescribing authority, then we are rationing care, pure and simple.

The starting point for any conference discussion should be the bill as reported out of the House Energy and Commerce Committee. In any final legislation, we must include a statutory lifting of the DATA 2000 caps as well as full authority for our NPs and PAs. I would ask for the commitment of my colleagues on the other side of the aisle in continuing to work toward these goals.

Notwithstanding these issues, I believe it is critically important to keep up the momentum and to pass this bill. Even in its imperfect form, this bill will make a huge difference in the lives of those who struggle with this disease. If we cannot find a way to get a bill to the President's desk that will provide needed relief in the midst of this epidemic, shame on us.

While this legislation is not a cure-all for the opioid epidemic, I believe the Opioid Use Disorder Treatment Expansion and Modernization Act will go far in helping to alleviate our acute treatment capacity issues and put more people on the path to recovery. I ask my colleagues in this House and down the hall in the Senate to support a bill—this bill—so that we can bring hope, truly bring hope into the lives of those individuals, those families, and those communities who grapple with this crisis on a daily basis.

Mr. GUTHRIE. Mr. Speaker, as I said earlier, people come here to the people's House from all walks of life. We are blessed to have a pharmacist amongst us. The only pharmacist here. These are difficult issues. Legal prescription drugs are diverted and abused, and heroin is illegal. It is great to have his expertise.

Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. I thank the gentleman from Kentucky for yielding and for his efforts, along with Dr. BUCSHON and others across the aisle, Congressman GENE GREEN and all those who have been involved in this. This is a very important subject.

Mr. Speaker, I rise today in support of H.R. 4981 because making sure modern treatments are available for opioid addiction should be one of our top priorities in the fight against opioid drug abuse.

H.R. 4981 makes reforms to the Controlled Substances Act that would modernize the way doctors approach opioid addiction and how patients obtain treatment. These reforms, which make treatment tools more available to patients, are one more step we can take to improve treatment services for patients. With these reforms, more patients will receive higher quality care, increasing the success of overall treatment.

As a lifelong healthcare professional, I have witnessed patients firsthand who have struggled with receiving care for their addiction. We must stop the cycle of failing to provide patients with proper care because the system is not adequately structured to provide it.

The only way we are able to provide the appropriate care is if we continue to support the evolution of treatment and care for this ever-changing opioid abuse epidemic. That is why I am supporting H.R. 4981. By reforming the way treatment is provided, we can begin to truly help all patients with opioid addiction.

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

Mr. GENE GREEN of Texas. Mr. Speaker, I have no further speakers.

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

Mr. GUTHRIE. Mr. Speaker, I encourage and urge my colleagues to support this very important bill, H.R. 4981.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4981 the "Opioid Use Disorder Treatment Expansion and Modernization Act".

This bill highlights the abuse of opioids that has become a public health epidemic.

Opioids are drugs with effects similar to opium, such as heroin and certain pain medications.

H.R. 4981 would encourage and train health care providers to prescribe overdose reversal drugs, such as Naloxone, when they prescribe common opioids-like pain medication to patients at risk of addiction.

The plague of opioid overdose deaths across the nation is disturbing, but there are ways to combat this trend.

Any party receiving treatment assessments under this legislation will be privy to the following.

1. A treatment plan and periodic assessments.

2. Will also be subject to medication adherence and substance use monitoring.

3. Treatment options, including all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including their potential risks and benefits.

4. Receiving regular counseling services is critical to recovery.

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

Enacting this legislation will implement a diversion control plan that contains specific measures to reduce the likelihood of the diversion of controlled substances prescribed by the physician for the treatment of opioid use disorder.

In 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

Both states and the federal government have begun responding to this growing public health crisis.

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

Mr. Speaker, the mounting number of people adversely affected and the over 25,000 lives lost expressly demonstrates the need for this type of legislation.

H.R. 4981 is a positive step in the right direction and I urge all members to support this important legislation.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 4981, 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.

VICTIMS OF GUN VIOLENCE

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

Mr. PETERS. Mr. Speaker, Akron, Ohio, April 18, 2013:

Kem Delaney, 23 years old.
Kiana Welch, 19.
Maria Nash, 19.

Kalamazoo, Michigan, February 20, 2016:

Dorothy Brown, 74 years old.
Barbara Hawthorne, 68.
Mary Lou Nye, 62.
Mary Jo Nye, 60.
Richard Smith, 53.
Tyler Smith, 17.

Lakeland, Florida, January 6, 2016:

Eneida Branch, 31 years old.
David Washington, 24.
Angelica Guadalupe Castro, 23.

Pelzer, South Carolina, March 5, 2014:

Victor Vandegrift, 48 years old.
Wanda Renee Anderson, 43.
Hank Eaton, 32.

Kansas City, Kansas, March 7, 2016:

Randy J. Nordman, 49 years old.
Mike Capps, 41.
Austin Harter, 29.
Clint Harter, 27.

Jackson, Tennessee, April 28, 2016:

Dartalin Pharmer, 32 years old.
Delandis Cortez Clark, 31.
Brian Jontez Banes, 31.
Tashonda Davis, 22.

Wilmington, Delaware, February 11, 2016:

Steven Rinehart, 50 years old.
Laura Elizabeth Mulford, 47.
Officer Michael Manley, 42.
Christine Belford, 39.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 1252. An act to authorize a comprehensive strategic approach for United States foreign assistance to developing countries to reduce global poverty and hunger, achieve food and nutrition security, promote inclusive, sustainable, agricultural-led economic growth, improve nutritional outcomes, especially for women and children, build resilience among vulnerable populations, and for other purposes; to the Committee on Foreign Affairs.

S. 1352. An act to increase Federal Pell Grants for the children of fallen public safety officers, and for other purposes; to the Committee on Education and the Workforce; in addition, to the Committee on the Budget; and to the Committee on the Judiciary for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

Mr. PETERS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 6 o'clock and 52 minutes p.m.), under its previous order, the House adjourned until tomorrow, Thursday, May 12, 2016, at 10 a.m. for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XIV, executive communications were taken from the Speaker's table and referred as follows:

5322. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's direct final rule — Standard Preparations, Limits of Potency, and Dating Period Limitations for Biological Products [Docket No.: FDA-2016-N-1170] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5323. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule — Standards for the Growing, Harvesting, Packing, and Holding of Produce for Human Consumption; Technical Amendment [Docket No.: FDA-2011-N-0921] (RIN: 0910-AG35) received May 9, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5324. A letter from the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, Department of Justice, transmitting the Department's final order — Schedules of Controlled Substances: Temporary Placement of Butyryl Fentanyl and Beta-Hydroxythiofentanyl into Schedule I [Docket No.: DEA-434F] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5325. A letter from the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, Department of Justice, transmitting the Department's interim final rule — Schedules of Controlled Substances: Placement of Brivaracetam into Schedule V [Docket No.: DEA-435] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5326. A letter from the Secretary, Department of the Treasury, transmitting a six-month periodic report on the national emergency with respect to Sudan that was declared in Executive Order 13067 of November 3, 1997, pursuant to 50 U.S.C. 1641(c); Public Law 94-412, Sec. 401(c); (90 Stat. 1257) and 50 U.S.C. 1703(c); Public Law 95-223, Sec 204(c); (91 Stat. 1627); to the Committee on Foreign Affairs.

5327. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a report to Congress on the status of the Government of Cuba's compliance with the United States-Cuba September 1994 ''Joint Communique'' and the treatment by the Government of Cuba of persons returned to Cuba in accordance with the United States-Cuba May 1995 ''Joint Statement'', together known as the Migration Accords, pursuant to Public Law 105-277, Sec. 2245; (112 Stat. 2681-824); to the Committee on Foreign Affairs.

5328. A letter from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting the FY 2015 No FEAR Act report, pursuant to Public Law 107-174, 203(a); (116 Stat. 569); to the Committee on Oversight and Government Reform.

5329. A letter from the Regulations Coordinator, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting the Department's interim final rule — Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program [CMS-9933-IFC] (RIN: 0938-AS87) received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); jointly to the Committees on Energy and Commerce and Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BISHOP of Utah: Committee on Natural Resources. H.R. 1621. A bill to modify the boundary of Petersburg National Battlefield in the Commonwealth of Virginia, and for other purposes; with an amendment (Rept. 114–562, Pt. 1). Referred to the Committee of the Whole House on the state of the Union.

Mr. BISHOP of Utah: Committee on Natural Resources. H.R. 3211. A bill to provide for the addition of certain real property to the reservation of the Siletz Tribe in the State of Oregon (Rept. 114–563). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEE

Pursuant to clause 2 of rule XIII, the Committee on Armed Services discharged from further consideration H.R. 1621 referred to the Committee of the Whole House on the state of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mrs. LOVE:

H.R. 5188. A bill to amend title XVIII of the Social Security Act to promote physician training in newly recognized primary medical specialties, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. KUSTER:

H.R. 5189. A bill to address the opioid abuse crisis; to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Veterans' Affairs, Education and the Workforce, Ways and Means, Armed Services, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.