Mr. BURGESS. Mr. Speaker, I claim the time in opposition to the motion.

The SPEAKER pro tempore. The gentleman from Texas is recognized for 5 minutes.

Mr. BURGESS. Mr. Speaker, I urge a ''no'' vote on the motion to recommit as it will destroy the intent of the bill.

Eliminating the sharing of records for the purposes of treatment, payment, and healthcare operations completely negates the entire purpose of this initiative.

Aligning 42 CFR part 2 with HIPAA for purposes of treatment, payment, and healthcare operations is the entire purpose of the legislation.

Opponents of this bill have offered no evidence or findings to back up their claim that HIPAA is inadequate to protect sensitive data contained in substance use disorder treatment records.

HIPAA is currently functioning well in protecting sensitive patient information in a number of areas.

Real integration of behavioral health and primary care simply cannot happen until we align 42 CFR part 2 with HIPAA.

The opposition of H.R. 6082 is not based on protecting privacy. It is based on very specific distrust of the healthcare community to properly provide care to people with substance use disorder—the very people whom we are asking to help us with this.

Yet, the ranking member is strongly in favor of numerous bills that seek to expand access to evidence-based medication-assisted treatment, telehealth and integration with mainstream medicine—the very things that demand alignment with HIPAA. So the thinking, Mr. Speaker, to be kind, is incongruous.

Prohibiting the sharing of addiction medical records for treatment, payment, and healthcare operations makes it impossible to prescribe the latest substance use treatment medications safely.

Like most pharmaceuticals, buprenorphine and methadone have drug interactions and interact with other medicines. Adverse events from drug interactions can lead to emergency hospital visits, serious injuries, or death.

We must amend part 2 so we can safely prescribe medication-assisted treatment for patients. Put simply, standard clinical practices like medication reconciliation are not feasible under the current Federal law. For that reason, I urge my colleagues to vote ''no'' on the motion to recommit. Vote ''yes'' on the underlying motion.

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

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

Mr. PALLONE. 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 question will be postponed.

INDIVIDUALS IN MEDICAID DESERVE CARE THAT IS APPROPRIATE AND RESPONSIBLE IN ITS EXECUTION ACT

GENERAL LEAVE

Mrs. MIMI WALTERS of California. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on the bill, H.R. 5797.

The SPEAKER pro tempore (Mr. SHIMKUS). Is there objection to the request of the gentlewoman from California?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 949 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 5797.

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

□ 1345

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 5797) to amend title XIX of the Social Security Act to allow States to provide under Medicaid services for certain individuals with opioid use disorders in institutions for mental diseases, with Mr. BOST in the chair.

The Clerk read the title of the bill.

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

The gentlewoman from California (Mrs. MIMI WALTERS) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes.

The Chair recognizes the gentlewoman from California.

Mrs. MIMI WALTERS of California. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the opioid epidemic is ravaging this Nation. Families have been torn apart; lives have been destroyed; and communities are endangered.

This crisis does not discriminate. Americans from all walks of life in all 50 States are being held hostage by the scourge of opioids.

Tragically, the opioid epidemic claims the lives of 115 Americans on average each day. In my home of Orange County, California, 361 people died from opioid overdoses in 2015. That accounts for a 50 percent increase in overdose deaths since 2006.

According to the OC Health Care Agency's 2017 ''Opioid Overdose and Death in Orange County'' report, the rate of opioid-related emergency room visits increased by more than 140 percent since 2005. Between 2011 and 2015, Orange County emergency rooms treated nearly 7,500 opioid overdose and abuse cases.

We can put an end to these tragic statistics by providing full access to various treatment options to those seeking help with their addictions. While many of these patients may benefit from outpatient help, others need highly specialized inpatient treatment to ensure they are receiving the most clinically appropriate care.

The IMD CARE Act will increase access to care for certain Medicaid beneficiaries with opioid use disorder who need the most intensive care possible: inpatient care.

Current law prohibits the Federal Government from providing Federal Medicaid matching funds to States to provide mental disease care to Medicaid-eligible patients aged 21 to 64 in facilities defined as institutes of mental diseases, commonly known as IMDs. This IMD exclusion means that Federal dollars may not be provided for the care of Medicaid-eligible patients in this age group for substance use disorder treatments at hospitals, nursing facilities, or other institutions with more than 16 beds.

It is time to repeal the IMD exclusion and remove this outdated barrier to inpatient treatment. The IMD CARE Act would allow States to repeal for 5 years the IMD exclusion for adult Medicaid beneficiaries who have an opioid use disorder, which includes heroin and fentanyl.

These beneficiaries would receive treatment in an IMD for up to 30 days over a 12-month period, during which time the beneficiary would be regularly assessed to ensure their treatment and health needs require inpatient care. The bill would also require the IMD to develop an outpatient plan for the individual's ongoing treatment upon discharge.

Throughout the Energy and Commerce Committee's work on the opioid crisis, the IMD exclusion is consistently identified as a significant barrier to care for Medicaid patients. Not every patient needs treatment in an IMD, but those who do are often among the most vulnerable. What once was a well-intended exclusion on Federal Medicaid spending has since prevented individuals from seeking treatment.

In the light of the opioid epidemic, I believe my legislation strikes the right balance. I know some have suggested States continue to seek CMS waivers to allow Medicaid to pay for IMD care. Waivers can be a good option for some States, but not all States want a waiver. In fact, less than half of the States have applied for a waiver. Additionally, a waiver can take a substantial amount of time to develop, review, and approve.

We are losing too many friends and family members to force States to navigate a lengthy and uncertain waiver process. The IMD CARE Act allows

States to act now to ensure patients who are suffering from addiction get the care they need.

The National Governors Association and the American Hospital Association have endorsed this legislation. Other organizations, such as the National Association of State Medicaid Directors and the National Association of State Mental Health Directors, have supported the idea of Congress addressing the IMD.

While the repeal of the IMD exclusion would increase mandatory outlays and add costs to the Medicaid system, the IMD CARE Act is fully paid for by curbing unnecessary Federal and State Medicaid outlays.

I want to thank Chairman WALDEN and my colleagues on the House Energy and Commerce Committee for their support of this bill, which will provide much needed care to Americans suffering from opioid use disorder. Through the IMD CARE Act, Congress has a unique opportunity to remove a barrier to care and bring specialized treatment to Medicaid patients who desperately need it.

Mr. Chairman, I urge all Members to support this important bill today, and I reserve the balance of my time.

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

Mr. Chair, I stand in opposition to H.R. 5797, the IMD CARE Act.

I think we all agree that we need all the tools available to us to address the opioid crisis. Inpatient treatment centers that focus on the treatment of behavioral health needs of patients with substance use disorder are part of that. Congress must do what we can to ease access to care.

But I believe this legislation, as drafted, is misguided. It is also counterproductive and an ineffective use of scarce Medicaid dollars. But more importantly, it may undermine the ongoing efforts to improve the full continuum of care for people with substance use disorders.

This policy spends more than $1 billion in Medicaid to pay for a policy that is far narrower in both scope and flexibility than what many of our States already have and any State could do through Medicaid substance use disorder waivers.

In addition, as countless data has indicated, there are many gaps in treatment for Medicaid beneficiaries with substance use disorder. Yet this bill does nothing to incentivize States to provide the full continuum of care.

Community-based services are necessary for both people not treated in residential inpatient facilities and also for people who leave residential inpatient treatment and need community-based services to continue their treatment and recovery.

We already face a shortage of community-based care for substance use disorder and should be working with States to increase this capacity. Yet this bill doesn't tie Federal funds for IMD care to improvements in community-based services. Without that connection, States simply will not pursue these needed improvements.

Without incentives to improve access to treatment more broadly, repealing the IMD exclusion to only a narrow population—in this case, opioid use—through legislation may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.

We can't push a system where people cycle in and out of institutions. People with substance use disorders need a range of supports to stay well and sober long term, not just a limited stay in an IMD.

Existing guidance from both the Obama and Trump administrations allows States to waive the IMD exclusions if the States also take steps to ensure that people with substance use disorder have access to other care they need, including preventive, treatment and recovery services.

So far, there are 22 States, Mr. Chair, that have waivers approved or pending before the administration. I think these waivers are important to support.

My home State of New Jersey has approval for a waiver right now. Under that waiver, they expanded access to all substance use disorder services in their Medicaid program. We should build on that policy, which emphasizes the full continuum of care, with any bills that repeal the IMD exclusion.

In addition, I have concerns about creating a system in States whereby only some of our Medicaid beneficiaries with substance use disorder have access to the full continuum of care they need.

This bill specifically limits residential treatment to adults with opioid use disorders, with the possible addition of an amendment for cocaine use disorders. But it doesn't help the overwhelming majority of individuals with other substance use disorders, such as alcohol, which is far more commonly abused.

Treatment for substance use disorder, especially in the midst of our opioid crisis, must include a comprehensive approach that addresses the entirety of a patient's medical and psychological conditions. This legislation creates a perverse incentive toward individuals reporting opioid abuse or going out and getting addicted to opioids, for instance, in the hopes of gaining access to the treatment they need.

Expanding access to inpatient residential treatment in a vacuum I think would undermine State efforts to ensure the availability of substance use disorder treatment that meets the needs of all patients in the most appropriate environment.

In the short time this legislation has been publicly available, countless stakeholders have weighed in vehemently on particulars of this bill, echoing my concerns today. In fact, coalitions with more than 300 groups as well as other mental health, substance use, and disability groups have sent letters in opposition. I think we need to work with stakeholders. This issue is too important to get wrong.

For these reasons, Mr. Chair, I oppose H.R. 5797. I urge my colleagues to vote ''no,'' and I reserve the balance of my time.

Mrs. MIMI WALTERS of California. Mr. Chairman, I yield 3 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Chair, I want to thank Mrs. WALTERS for introducing this legislation.

Throughout this committee's and subcommittee's work on opioids, the IMD exclusion has been consistently identified by many stakeholders in conversations not only in my office but with the subcommittee as a barrier to care for Medicaid patients who need inpatient treatment.

In the face of an epidemic that is taking the lives of 115 Americans on average every day, I believe this policy strikes the right balance. The IMD CARE Act targets limited resources to remove a barrier to care by allowing States to repeal the IMD exclusion for 5 years for Medicaid beneficiaries between the ages of 21 and 64 who have an opioid use disorder. This approach will provide States the flexibility to increase access to institutional care for those who truly need it.

While getting a waiver from CMS for the IMD exclusion is a good option for many States, less than half the States have applied for a waiver. We are losing too many of our friends and neighbors each day to this crisis to ask States to go through what can be a lengthy and uncertain process to secure a waiver.

The IMD CARE Act allows States to act now to ensure their patients who are suffering now from a terrible disease can get the care that they need and get it now.

I ask my fellow Members to join me in support of Mrs. WALTERS' bill.

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

Mr. Chair, I want to speak briefly on a point that I think is being lost here.

This bill presumes that expanding access to residential treatment is the answer, and it is not necessarily. Without any requirement that States address gaps in Medicaid community-based services, I think there is a possibility that we risk more harm than good.

The former director of national drug control policy has reminded us that most of these IMD facilities provide detoxification services. But detoxification is only the first stage of addiction treatment. Indeed, it may increase the potential for overdose if patients do not remain or have any support when released, since, with detoxification, their tolerance for opioids is significantly reduced.

The proposal before the House will likely create an overreliance on institutional treatment and may exacerbate

the dearth of community-based health services.

□ 1400

People with substance use disorder often find themselves unable to access intensive community-based behavioral health services when they need it. Likewise, many cannot access services in the community when they are discharged following a crisis.

Incentivizing inpatient care may actually increase opioid overdose, the very harm that Congress is seeking to prevent. Experts have raised serious concerns with this bill's institutional focus because recent data suggests that inpatient detoxification is an important predictor of overdose, largely because many who receive inpatient care aren't then connected to community-based treatment programs or put on medication, leaving them extremely vulnerable.

Again, I am concerned that we may be contributing to this crisis with this legislation.

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

Mrs. MIMI WALTERS of California. Mr. Chair, I yield 5 minutes to the gentleman from Oregon (Mr. WALDEN), chairman of the Committee on Energy and Commerce.

Mr. WALDEN. Mr. Chair, I want to thank my colleague MIMI WALTERS and those who have worked so closely with her on this really, really important legislation. That is why I am here to support it, H.R. 5797, the IMD CARE Act.

This is really commonsense legislation, and it will make a meaningful change to the way Medicaid covers opioid use disorder for its beneficiaries. In other words, low-income people in America who get their medical assistance through Medicaid are going to get another option and more help to deal with their addiction.

We are discussing this bill because a severely outdated policy limits Medicaid's coverage in an institution for mental disease—that is what an IMD is, institution for mental disease—for just 30 days. It is old. It is antiquated. It doesn't work with today's treatment regimens.

This exclusion has been in place for decades—decades—certainly long before the opioid crisis ever hit our country, and it is now a barrier to critical care for low-income people on Medicaid when this vulnerable population needs help with their addiction the most.

Representative WALTERS' thoughtful bill will allow State Medicaid programs, from 2019 through 2023, to remove this antiquated Federal barrier to treatment for those on Medicaid, age 21 to 64, with an opioid use disorder, through a State plan amendment. In doing so, Medicaid would pay for up to 30 total days of a beneficiary's care in an IMD during a 12-month period, year.

So this is limited in scope. It is in partnership with the States. It is low-income people getting more help from Medicaid to pay for this extraordinarily important treatment.

This bill also collects much-needed data on the process. After taking up this option, States will have to report on the number of individuals with opioid use disorder under this plan, their length of stay, and the type of treatment received upon discharge. This will help inform better programs down the line.

As a Congress, we have been focused on combating the opioid crisis for quite some time. This is not our first legislative attempt to help people not only avoid this addiction, but overcome it. It will not be our last. We will legislate; we will evaluate; we will legislate; we will evaluate, as Republicans and Democrats have been doing for some time.

It is an important step, this bill, that can help get people a vital treatment to which they now don't have access. The American Hospital Association, the National Governors Association, Republicans and Democrats, hospitals and Governors across the country, have said: Please do this. This is a need that is unmet. Please help us change this antiquated Federal law.

Many stakeholder groups, including the National Association of State Medicaid Directors, the people who run the Medicaid programs in States; the National Association of State Mental Health Program Directors, the people who know what is needed most to overcome these situations; and many others have talked to us in the committee. They have talked to me personally. They are pleading with Congress to get rid of this barrier to care, this outdated law, and to help people get treatment, especially the low-income among us.

We have an opportunity to deliver, to help. We have an opportunity to save lives. It is our responsibility, and we need to pass this legislation.

Mr. Chair, I commend the gentlewoman from California for bringing this issue to the committee and shepherding it through. It is so important to pass this legislation. Let's help these people get the care they need and want.

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

Mr. Chair, in closing and in urging opposition to this bill from my colleagues, the reason the IMD exclusion was put in place in the beginning was because of the fear that people who had overdosed, who had opiate problems, would be put into institutions, if you will, and then throw away the key. In other words, they put them in there, maybe they get detoxed, and then they come out. But without any treatment or any followup, community-based treatment, they would just go back to the same thing again; they would overdose again and end up back in the facility.

So the fear was that we would have these large facilities where they go in and, without any kind of continuum of care, the cycle just keeps repeating itself. I just want my colleagues to be mindful of that.

What happened was, during the Obama administration, States had asked for waivers from the IMD exclusion, and the Obama administration decided they would do that if they provided a continuum of care and community-based services so that the problem that led to the IMD exclusion would not repeat itself.

I guess my fear is, today, that this seems like such a simple solution: Okay. We will get rid of the 16-bed exclusion because we need people to go into these institutions.

However, since we are not providing any continuum of care or community care in eliminating this exclusion, it goes back to the same problem, which is we don't want people to just be warehoused to detox, come out again, overdose again, and go back in without any kind of community services.

That is why I am making the argument that the actual waivers that exist now, which I think almost half of the States have, is a much better alternative than just lifting and getting rid of the exclusion. That is why I believe that this bill is misplaced and why I would urge my colleagues to oppose it, because I think it may actually go back to the days where we were just warehousing people and we are not actually giving them the kind of treatment that they need.

Mr. Chair, I would urge my colleagues to vote against the bill, and I yield back the balance of my time.

Mrs. MIMI WALTERS of California. Mr. Chair, I yield myself the balance of my time.

Mr. Chair, the opioid crisis requires us to act now. The IMD exclusion is consistently identified as a significant barrier to care by State Medicaid directors and numerous other stakeholder groups. We need to pass this bill in order to increase access to acute, short-term inpatient treatment. I urge my colleagues to support this bill and help individuals suffering with opioid addiction.

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

Ms. MAXINE WATERS of California. Mr. Chair, I rise to oppose H.R. 5797, also known as the "IMD CARE Act."

H.R. 5797 allows states to use Medicaid funds to treat adult patients ages 21–64 with opioid abuse disorders in Institutions for Mental Disease (IMDs) with more than 16 beds. While expanding access to treatment for substance abuse disorders is an admirable goal, H.R. 5797 is not the way to accomplish this goal.

One obvious limitation of H.R. 5797 is that it only applies to opioid and heroin use disorders. It does nothing to expand access to treatment for other types of substance abuse disorders, including alcoholism and the abuse of other illegal drugs like methamphetamine, crack, and other forms of cocaine.

A second problem with this bill is that it only expands access to treatment in inpatient IMD

facilities. It does not provide Medicaid funding for substance abuse treatment services in an outpatient setting, nor does it require states to make such services available. Not all substance abuse patients need to be treated in an institution, and those that do will also need outpatient recovery services after they are released from an IMD.

Currently, states can already use Medicaid funds to treat patients in IMD facilities by means of a waiver from the Centers for Medicare and Medicaid Services (CMS). In order to qualify for a waiver, states must take steps to ensure that patients are able to obtain substance abuse treatment and services in the community, as well as in institutions. Eleven states already have a waiver for this purpose, and eleven other states have waiver applications pending. Expanding access to inpatient treatment in states that do not provide outpatient services risks forcing patients into treatment that is ineffective and inappropriate for their situation.

Another option that is already available for states that want to expand access to substance abuse treatment services is to expand Medicaid under the Affordable Care Act. Medicaid expansion would ensure that all low-income people, including those with substance abuse disorders, are able to obtain treatment for their medical conditions.

I submitted an amendment that would have required states to expand Medicaid pursuant to the Affordable Care Act as a condition for using Medicaid funds to treat people with opioid abuse disorders in IMD facilities. This amendment would have provided an additional incentive for states to expand Medicaid, which in turn would have expanded access to a broad range of treatment and services for patients with substance abuse disorders.

Expanding access to Medicaid will benefit patients with substance abuse disorders, regardless of the type of addiction from which they suffer and regardless of whether they would be best served by inpatient treatment, outpatient treatment, or a combination of the two.

It is especially ironic that this bill is being considered on the House floor the day after House Republicans unveiled their fiscal year 2019 budget proposal, which would cut $1.5 trillion from Medicaid. If the majority party cares about Americans suffering from an opioid abuse disorder, they would not rob them of the health care services thiey already have.

I urge my colleagues to oppose H.R. 5797 and support a comprehensive solution to substance abuse disorders that will meet the needs of all people suffering from these tragic medical conditions.

The Acting CHAIR (Mr. MITCHELL). All time for general debate has expired.

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

The amendment in the nature of a substitute recommended by the Committee on Energy and Commerce, printed in the bill, modified by the amendment printed in part C of House Report 115–766, shall be considered as adopted. The bill, as amended, shall be considered as an original bill for purpose of further amendment under the 5-minute rule, and shall be considered read.

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

H.R. 5797

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 ''Individuals in Medicaid Deserve Care that is Appropriate and Responsible in its Execution Act'' or the ''IMD CARE Act''.

SEC. 2. MEDICAID STATE PLAN OPTION TO PROVIDE SERVICES FOR CERTAIN INDIVIDUALS WITH OPIOID USE DISORDERS IN INSTITUTIONS FOR MENTAL DISEASES.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

''(l) STATE PLAN OPTION TO PROVIDE SERVICES FOR CERTAIN INDIVIDUALS IN INSTITUTIONS FOR MENTAL DISEASES.—

''(1) IN GENERAL.—With respect to calendar quarters beginning during the period beginning January 1, 2019, and ending December 31, 2023, a State may elect, through a State plan amendment, to, notwithstanding section 1905(a), provide medical assistance for services furnished in institutions for mental diseases and for other medically necessary services furnished to eligible individuals with opioid use disorders, in accordance with the requirements of this subsection.

''(2) PAYMENTS.—

''(A) IN GENERAL.—Amounts expended under a State plan amendment under paragraph (1) for services described in such paragraph furnished, with respect to a 12-month period, to an eligible individual with an opioid use disorder who is a patient in an institution for mental diseases shall be treated as medical assistance for which payment is made under section 1903(a) but only to the extent that such services are furnished for not more than a period of 30 days (whether or not consecutive) during such 12-month period.

''(B) CLARIFICATION.—Payment made under this paragraph for expenditures under a State plan amendment under this subsection with respect to services described in paragraph (1) furnished to an eligible individual with an opioid use disorder shall not affect payment that would otherwise be made under section 1903(a) for expenditures under the State plan (or waiver of such plan) for medical assistance for such individual.

''(3) INFORMATION REQUIRED IN STATE PLAN AMENDMENT.—

''(A) IN GENERAL.—A State electing to provide medical assistance pursuant to this subsection shall include with the submission of the State plan amendment under paragraph (1) to the Secretary—

''(i) a plan on how the State will improve access to outpatient care during the period of the State plan amendment, including a description of—

''(I) the process by which eligible individuals with opioid use disorders will make the transition from receiving inpatient services in an institution for mental diseases to appropriate outpatient care; and

''(II) the process the State will undertake to ensure individuals with opioid use disorder are provided care in the most integrated setting appropriate to the needs of the individuals; and

''(ii) a description of how the State plan amendment ensures an appropriate clinical screening of eligible individuals with an opioid use disorder, including assessments to determine level of care and length of stay recommendations based upon the multidimensional assessment criteria of the American Society of Addiction Medicine.

''(B) REPORT.—Not later than the sooner of December 31, 2024, or one year after the date of the termination of a State plan amendment under this subsection, the State shall submit to the Secretary a report that includes at least—

''(i) the number of eligible individuals with opioid use disorders who received services pursuant to such State plan amendment;

''(ii) the length of the stay of each such individual in an institution for mental diseases; and

''(iii) the type of outpatient treatment, including medication-assisted treatment, each such individual received after being discharged from such institution.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE INDIVIDUAL WITH AN OPIOID USE DISORDER.—The term 'eligible individual with an opioid use disorder' means an individual who—

''(i) with respect to a State, is enrolled for medical assistance under the State plan (or a waiver of such plan);

''(ii) is at least 21 years of age;

''(iii) has not attained 65 years of age; and

''(iv) has been diagnosed with at least one opioid use disorder.

''(B) INSTITUTION FOR MENTAL DISEASES.—The term 'institution for mental diseases' has the meaning given such term in section 1905(i).

''(C) OPIOID PRESCRIPTION PAIN RELIEVER.—The term 'opioid prescription pain reliever' includes hydrocodone products, oxycodone products, tramadol products, codeine products, morphine products, fentanyl products, buprenorphine products, oxymorphone products, meperidine products, hydromorphone products, methadone, and any other prescription pain reliever identified by the Assistant Secretary for Mental Health and Substance Use.

''(D) OPIOID USE DISORDER.—The term 'opioid use disorder' means a disorder that meets the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (or a successor edition), for heroin use disorder or pain reliever use disorder (including with respect to opioid prescription pain relievers).

''(E) OTHER MEDICALLY NECESSARY SERVICES.—The term 'other medically necessary services' means, with respect to an eligible individual with an opioid use disorder who is a patient in an institution for mental diseases, items and services that are provided to such individual outside of such institution to the extent that such items and services would be treated as medical assistance for such individual if such individual were not a patient in such institution.''.

SEC. 3. PROMOTING VALUE IN MEDICAID MANAGED CARE.

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

''(7)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020 (and before fiscal year 2025), in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1905(b) (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1905(y).

''(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

''(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

''(I) in the case of a State described in subparagraph (C), to apply a minimum medical

loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

''(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

''(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

''(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this title (or a waiver of the plan) that is equal to or greater than 85 percent.

''(D) For purposes of this paragraph:

''(i) The term 'managed care entity' means a medicaid managed care organization described in section 1932(a)(1)(B)(i).

''(ii) The term 'minimum medical loss ratio' means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this title (or a waiver of the plan).

''(iii) The term 'other specified entity' means—

''(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

''(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).''.

The Acting CHAIR. No further amendment to the bill, as amended, shall be in order except those printed in part D of House Report 115–766. Each such further amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENT NO. 1 OFFERED BY MR. RUSH

The Acting CHAIR. It is now in order to consider amendment No. 1 printed in part D of House Report 115–766.

Mr. RUSH. Mr. Chair, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

In section 2, strike ''**INDIVIDUALS WITH OPIOID USE DISORDERS**'' and insert ''**INDIVIDUALS WITH TARGETED SUDS**''.

In the subsection (l) proposed to be added by section 2 of the bill to section 1915 of the Social Security Act, strike ''eligible individuals with opioid use disorders'' each place it appears and insert ''eligible individuals with targeted SUDs'' each such place.

In the subsection (l) proposed to be added by section 2 of the bill to section 1915 of the Social Security Act, strike ''eligible individual with an opioid use disorder'' each place it appears and insert ''eligible individual with a targeted SUD'' each such place.

Page 5, beginning on line 19, strike ''individuals with opioid use disorder'' and insert ''eligible individuals with targeted SUDs''.

Page 6, beginning on line 1, strike ''eligible individuals with an opioid use disorder'' and insert ''eligible individuals with targeted SUDs''.

Page 6, line 7, insert before the period the following: ''and to determine the appropriate setting for such care''.

Page 7, line 12, strike ''opioid use disorder'' and insert ''targeted SUD''.

In the subsection (l)(4) proposed to be added by section 2 of the bill to section 1915 of the Social Security Act, strike subparagraph (D), redesignate subparagraph (E) as subparagraph (D), and add at the end the following:

''(E) TARGETED SUD.—

''(i) IN GENERAL.—The term 'targeted SUD' means an opioid use disorder or a cocaine use disorder.

''(ii) COCAINE USE DISORDER.—The term 'cocaine use disorder' means a disorder that meets the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (or a successor edition), for either dependence or abuse for cocaine, including cocaine base (commonly referred to as 'crack cocaine').

''(iii) OPIOID USE DISORDER.—The term 'opioid use disorder' means a disorder that meets the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (or a successor edition), for heroin use disorder or pain reliever use disorder (including with respect to opioid prescription pain relievers).''.

Strike all that follows after section 2 and insert the following:

SEC. 3. PROMOTING VALUE IN MEDICAID MANAGED CARE.

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

''(7)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020 (and before fiscal year 2024), in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1905(b) (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1905(y).

''(B) Expenditures described in this subparagraph, with respect to a fiscal year to which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

''(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

''(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

''(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

''(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

''(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this title (or a waiver of the plan) that is equal to or greater than 85 percent.

''(D) For purposes of this paragraph:

''(i) The term 'managed care entity' means a medicaid managed care organization described in section 1932(a)(1)(B)(i).

''(ii) The term 'minimum medical loss ratio' means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this title (or a waiver of the plan).

''(iii) The term 'other specified entity' means—

''(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

''(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).''.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Illinois (Mr. RUSH) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Illinois.

Mr. RUSH. Mr. Chair, I yield myself such time as I may consume.

Mr. Chair, I rise today to offer my amendment that finally addresses a longstanding and discriminatory gap in coverage and expands treatment options for those suffering from addiction.

This House, Mr. Chairman, should be commended for its work on opioid addiction, but let us not forget that we have insidiously ignored another pervasive and catastrophically destructive addiction that is known as crack cocaine.

To remedy this, Mr. Chairman, my amendment would expand the bill to include those individuals suffering from cocaine use disorder and explicitly clarifies the inclusion of cocaine base, more commonly known as crack cocaine, which, along with opiates, is a double-barrel cause of drug-related deaths in communities like mine all across this Nation.

Too often, Mr. Chairman, this House seems to only have focused on issues when they have affected the majority, the White population. This leaves vulnerable, non-White, minority Americans without any chance to escape from their illness and their resulting suffering.

Too often, Mr. Chairman, the government's response to minority Americans has been mass incarceration instead of treatment. Too often, Mr. Chairman, crises that impact the African American communities are seen as a criminal justice problem, while those that affect the White community are seen as a public health problem. That phenomenon changes today.

I know opponents of this amendment will say that we should be expanding coverage to all those suffering from addiction. I wholeheartedly agree, Mr. Chairman, with that statement. However, while more remains to be done, today's action is a step in the right direction.

This is an important moment for those who have been addicted to crack and have been denied such access to treatment. Today they will finally get relief as we make historic progress in the fight against addiction and the injustice that continues to tear communities apart.

For this reason, I urge all my colleagues on both sides of the aisle to join me in supporting this worthwhile and meaningful amendment.

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

Mr. WALDEN. Mr. Chair, I claim the time in opposition to the amendment, though I am not opposed to the amendment.

The Acting CHAIR. Without objection, the gentleman from Oregon is recognized for 5 minutes.

There was no objection.

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

Mr. Chair, I rise today in support of the Rush amendment to H.R. 5797, the IMD CARE Act. Earlier today, I spoke in support of the underlying bill. It will make a meaningful change to the way Medicaid covers opioid use disorder for its beneficiaries.

The amendment offered by my friend and colleague from Illinois, Representative BOBBY RUSH, will expand on that definition. It will allow Medicaid to provide coverage for individuals seeking treatment from cocaine and crack cocaine usage.

Looking at just 2016, opioids and cocaine caused 82 percent of all drug overdose deaths in the United States. Cocaine alone kills more than 10,000 Americans a year. News outlets have also reported fentanyl being mixed in with cocaine, further complicating this tragic opioid crisis.

This is an issue that Mr. RUSH has passionately led on in the committee, on the floor, and at home in his community.

□ 1415

We discussed it in the hearing room and at length in private while working to fine-tune this legislation so that the best possible version can become law.

So I want to thank Mr. RUSH for this amendment, and I want people to know that it really will improve and expand the scope of this bill.

Mr. Chairman, I urge my colleagues to adopt this amendment and support the underlying bill, which will dramatically aid in our response to the opioid epidemic for all Americans, wherever they live.

Mr. Chairman, how much time do I have remaining?

The Acting CHAIR. The gentleman from Oregon has 3½ minutes remaining.

Mr. WALDEN. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. PALLONE), the ranking Democrat on the committee.

Mr. PALLONE. Mr. Chairman, I thank the chairman for yielding.

Mr. Chairman, I support Mr. RUSH's amendment, but I remain in strong opposition to the underlying bill. I support my colleague's, Mr. RUSH's, work to add cocaine use disorder.

As Mr. RUSH noted in our committee, cocaine use claims more African American lives than opioid use and has been a larger problem than opioid use disorder for more than 20 years, yet incarceration, not treatment, is far too often the response.

Unfortunately, adding a single additional drug does not make this legislation whole. Nearly half of all States already reimburse for IMDs for all individuals with substance use disorder. We can and should build on that policy and strengthen the full continuum of care with any IMD policy this body passes.

There is no good reason, policy or otherwise, for us to leave the overwhelming majority of Medicaid beneficiaries out in the cold because they have the misfortunate to be addicted to, for instance, alcohol or meth instead of cocaine or opioids.

So, again, I support the amendment, but I remain in strong opposition to the underlying bill.

Mr. WALDEN. Mr. Chairman, I conclude my comments by expressing my disappointment that I have yet to persuade my friend from New Jersey to support the underlying bill, although I appreciate his support of the Rush amendment.

We know that our Governors, we know that our State Medicaid directors, and we know those most involved in helping those with addiction have pled with us to change this antiquated law so that people of all colors, of all backgrounds, from anywhere in this country, especially the low-income, can get access to meaningful, modern, and helpful assistance to overcome their addiction. That is what this bill does.

Mr. Chairman, I encourage my colleagues to support the amendment, and I encourage them to support the underlying bill.

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

Mr. RUSH. Mr. Chairman, may I inquire as to how much time I have remaining.

The Acting CHAIR. The gentleman from Illinois has 1½ minutes remaining.

Mr. RUSH. Mr. Chairman, before I close, I want to, in a most sincere and humble way, thank Chairman WALDEN for his outstanding leadership on this matter, and for his breadth of understanding of the difficulties that my constituents have as a result of the omission from treatments for crack cocaine and other similar addictions.

I do understand the ranking member on the full committee's problems and concerns. I do understand, and I accept it. But, Mr. Chairman, we have to go forward on this particular amendment and on final passage.

Mr. Chairman, I thank Congressman WALDEN, and all of the staffs, for working with my staff on this critically important issue.

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

The Acting CHAIR. The question is on the amendment offered by the gentleman from Illinois (Mr. RUSH).

The amendment was agreed to.

AMENDMENT NO. 2 OFFERED BY MR. KILDEE

The Acting CHAIR. It is now in order to consider amendment No. 2 printed in part D of House Report 115–766.

Mr. KILDEE. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 19, strike ''and''.

Page 6, line 23, strike the period at the end and insert ''; and''.

Page 6, after line 23, insert the following:

''(iv) the number of eligible individuals with any co-occuring disorders who received services pursuant to such State plan amendment and the co-occuring disorders from which they suffer; and

''(v) information regarding the effects of a State plan amendment on access to community care for individuals suffering from a mental disease other than substance use disorder.''.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Michigan (Mr. KILDEE) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Michigan.

Mr. KILDEE. Mr. Chairman, this legislation requires States to submit a report on the number of patients served for opioid use disorder at institutions for mental diseases, their length of stay, and the care they received after they were discharged. My amendment would add two requirements to that report.

The first additional element addresses co-occurring disorders. My amendment would require that States include information on the number of individuals suffering from these disorders, as well as the type of specific disorders from which they suffer.

Co-occurring disorders are a terrible situation in which a person is simultaneously experiencing a mental illness and a substance use issue. This is especially prevalent in our veteran population, with the VA estimating that about one-third of veterans seeking treatment for substance use disorder also meet the criteria for post-traumatic stress disorder.

Co-occurring disorders can be especially difficult for doctors to diagnose because of how complex symptoms can be, with one often masking the symptoms of the other.

As of 2016, the Substance Abuse and Mental Health Services Administration estimates that more than 8 million

adults in the U.S. had co-occurring disorders. Half of them did not receive proper treatment, and around one-third received no care for mental illness or substance use disorder.

If we are going to get these individuals the help they need and deserve, we are going to need to know what care is needed and how large the existing treatment gap really is. My amendment will help to provide that data.

The second element of my amendment requires information on access to community care for individuals suffering from a mental illness other than substance use disorder.

For decades, our country has shifted mental healthcare services away from institutional care into community health providers. That is substantial progress that we certainly don't want to reverse or endanger.

Make no mistake, passing this legislation will have a direct effect on access to community care for people with mental diseases. We should know how much and to what extent that is the case. My amendment will provide Congress with the data on whether that access is increasing or, as a result of this potential legislation, decreasing.

We should not, in efforts to combat this epidemic, inadvertently create uncertainty or greater harm for other groups of people, especially such vulnerable groups as those with mental illness. My amendment will provide Congress with greater information for us to know if we are doing just that.

Mr. Chairman, I urge my colleagues to support this amendment, and I reserve the balance of my time.

Mrs. MIMI WALTERS of California. Mr. Chairman, I claim the time in opposition, but I am not opposed to the amendment.

The Acting CHAIR. Without objection, the gentlewoman is recognized for 5 minutes.

There was no objection.

Mrs. MIMI WALTERS of California. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I thank the gentleman from Michigan (Mr. KILDEE), my colleague, for offering this amendment to H.R. 5797.

This amendment seeks to add several components to a State report that is included in H.R. 5797. I appreciate Mr. KILDEE's work on this amendment. I think that this information would be valuable, and I am happy to accept the amendment. However, I want to note that we will need to talk to States about the information this amendment would have, and then report. Changes may have to be made, depending on that feedback.

I am committed to working out the technical details of the amendment as we move into conference.

Mr. Chairman, I yield to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Chairman, I thank the gentlewoman for yielding.

Mr. Chairman, I support my colleague's, Representative KILDEE's, amendment to this legislation. It is certainly important to require States to report information on individuals with co-occurring disorders and what disorders are suffered, and it is equally important to have information on access to community care for individuals suffering from a behavioral health issue other than a substance use disorder.

Mr. Chairman, I want to stress that this information is important, but the underlying problem with the IMD CARE Act continues. I believe this bill is, at best, an ineffective use of scarce Medicaid dollars. More importantly, it may undermine ongoing efforts to improve the full continuum of care for people with substance use disorders.

Mrs. MIMI WALTERS of California. Mr. Chairman, I yield back the balance of my time.

Mr. KILDEE. Mr. Chairman, I appreciate the comments of both of my colleagues.

This is an effort to make sure that, as we take on this epidemic, whatever path we may take, we do so in a way that gets us the best information we can to determine whether or not we are making the progress that this intends. We have our thoughts about that. This legislation, and this particular amendment, would ensure that Congress has the information it needs.

I encourage my colleagues to support the amendment, and I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Michigan (Mr. KILDEE).

The amendment was agreed to.

AMENDMENT NO. 3 OFFERED BY MR. FITZPATRICK

The Acting CHAIR. It is now in order to consider amendment No. 3 printed in part D of House Report 115–766.

Mr. FITZPATRICK. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 7, insert before the period the following: ''or criteria established or endorsed by the State agency identified by the State pursuant to section 1932(b)(1)(A)(i) of the Public Health Service Act''.

The Acting CHAIR. Pursuant to House Resolution 949, the gentleman from Pennsylvania (Mr. FITZPATRICK) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Pennsylvania.

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

Mr. Chairman, I intend to withdraw the amendment, but I want to take a moment to highlight an issue of critical importance to my home State of Pennsylvania where communities across the Commonwealth have been suffering from the scourge of the opioid crisis.

First, I want to thank the committee for tackling the IMD exclusion problem. We must ensure access to treatment to get people suffering with addiction on the road to recovery. Going forward, we must ensure that States have the flexibility that they need to provide access to treatment and not unintentionally create obstacles or bureaucratic barriers to care.

This is exactly what I had in mind when I introduced my Road to Recovery Act last year. I worked with various stakeholders across the Nation and in Pennsylvania, including Pennsylvania State Representative Gene DiGirolamo and Deb Beck, the head of the Drug and Alcohol Service Providers Organization of Pennsylvania.

I determined that States deliberately tailoring criteria to meet their unique situation, whether it be specific local realities or socioeconomic factors, need flexibility and should not be bound solely to the proprietary criteria of one organization—which, in fact, endorsed my Road to Recovery Act that included this same State flexibility criteria provision.

I am concerned for Pennsylvania and other similarly situated States that could be left behind, especially in the public patient and residential treatment context.

For instance, in Pennsylvania, we currently use the Pennsylvania client placement criteria tool for determining the appropriate level of care for an individual seeking treatment or already within Pennsylvania's treatment system. And there are simply differences between the ASAM standard specified in this bill and the criteria used by my home State of Pennsylvania.

Additionally, in States that may be transitioning to the ASAM guidelines, much work is needed to implement these changes. So, States need the flexibility and assurances to be able to address facility needs during this transition period. This would ensure access to care if the State sees a necessity for it.

Furthermore, the CMS guidance for the States applying for 1115 waivers already gives the ability to use either the ASAM criteria or other patient placement assessment tools.

A manual published by SAMHSA discusses the ASAM criteria and notes the following: ''. . . The ASAM criteria were not as applicable to publicly funded programs as to hospitals, practices of private practitioners, group practices, or other medical settings. Therefore, some States supplemented or adapted ASAM criteria.''

The same manual goes on to say that several States have adopted variations of the ASAM criteria to fit their systems and that many States have made significant improvements in the ASAM criteria to make them more appropriate to their systems and easier to use.

□ 1430

So as you can see, Mr. Chairman, one size, or, in this case, one criteria, might not fit all for States that need

to tailor their criteria for their specific public health needs.

I look forward to working with the committee and with the Senate in conference to ensure that States have the flexibility that they need to provide access to care.

Mr. Chair, I yield such time as he may consume to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN. Mr. Chair, I thank Mr. FITZPATRICK and his team for agreeing to work with us on this issue. Unfortunately, this well-thought-out amendment would significantly alter the quality standards we have built into the base bill, and such a change would require more substantial vetting with key stakeholders than we have time for at this point.

Because of that, we are not in position of being able to accept the amendment at this time. However, we do feel that Mr. FITZPATRICK has made a good start, so I will have our team do a comprehensive vetting of the language and work with stakeholders to see if this is something we could add as we move into conference with the Senate.

Mr. Chair, I thank the gentleman for his work and I look forward to continuing to work with him on this and other issues and with the Senate as we continue work on this legislation.

Mr. FITZPATRICK. Mr. Chair, I appreciate the remarks from the chairman.

I yield back the balance of my time.

Mr. Chair, I ask unanimous consent to withdraw the amendment.

The Acting CHAIR. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

The Acting CHAIR. The amendment is withdrawn.

There being no further amendments, under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. POE of Texas) having assumed the chair, Mr. MITCHELL, Acting Chair of the Committee of the Whole House on the state of the Union, reported that that Committee, having had under consideration the bill (H.R. 5797) to amend title XIX of the Social Security Act to allow States to provide under Medicaid services for certain individuals with opioid use disorders in institutions for mental diseases, and, pursuant to House Resolution 949, he reported the bill, as amended by that resolution, back to the House with sundry further amendments adopted in the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any further amendment reported from the Committee of the Whole? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Ms. CASTOR of Florida. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentlewoman opposed to the bill?

Ms. CASTOR of Florida. I am opposed in its current form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Ms. Castor of Florida moves to recommit the bill H.R. 5797 to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all that follows after section 1 and insert the following:

SEC. 2. MEDICAID STATE PLAN OPTION TO PROVIDE SERVICES FOR CERTAIN INDIVIDUALS WITH SUBSTANCE USE DISORDERS IN QUALIFIED INSTITUTIONS FOR MENTAL DISEASES.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

''(l) STATE PLAN OPTION TO PROVIDE SERVICES FOR CERTAIN INDIVIDUALS IN QUALIFIED INSTITUTIONS FOR MENTAL DISEASES.—

''(1) IN GENERAL.—With respect to calendar quarters beginning during the period beginning January 1, 2019, and ending December 31, 2023, a State may elect, through a State plan amendment, to, notwithstanding section 1905(a), provide medical assistance for addiction treatment services and other medically necessary services furnished to eligible individuals with substance use disorders who are patients in qualified institutions for mental diseases, in accordance with the requirements of this subsection.

''(2) PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), amounts expended under a State plan amendment under paragraph (1) for services described in such paragraph furnished, with respect to a 12-month period, to an eligible individual with a substance use disorder who is a patient in a qualified institution for mental diseases shall be treated as medical assistance for which payment is made under section 1903(a) but only to the extent that such services are furnished for not more than a period of 30 days (whether or not consecutive) during such 12-month period.

''(B) CONDITIONS.—As a condition of receiving payment under this paragraph, a State shall satisfy each of the following:

''(i) COVERAGE OF CONTINUUM OF CARE RECOMMENDED BY ASAM.—Provide medical assistance under the State plan for all nine levels of the continuum of care recommended, as of the date of the enactment of this section, by the American Society of Addiction Medicine.

''(ii) COVERAGE OF NEWLY ELIGIBLE INDIVIDUALS.—Provide for making medical assistance available under the State plan to all individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

''(C) CLARIFICATION.—Payment made under this paragraph for expenditures under a State plan amendment under this subsection with respect to services described in paragraph (1) furnished to an eligible individual with a substance use disorder shall not affect payment that would otherwise be made under section 1903(a) for expenditures under the State plan (or waiver of such plan) for medical assistance for such individual.

''(3) DEFINITIONS.—In this subsection:

''(A) ADDICTION TREATMENT SERVICES.—The term 'addiction treatment services' means, with respect to a State and eligible individuals with substance use disorders who are patients in qualified institutions for mental diseases, services that are offered as part of a full continuum of evidence-based treatment services under the State plan (or a waiver of such plan), including residential, non-residential, and community-based care, for such individuals.

''(B) ELIGIBLE INDIVIDUAL WITH A SUBSTANCE USE DISORDER.—The term 'eligible individual with a substance use disorder' means an individual who—

''(i) with respect to a State, is enrolled for medical assistance under the State plan (or a waiver of such plan);

''(ii) is at least 21 years of age;

''(iii) has not attained 65 years of age; and

''(iv) has been diagnosed with at least one substance use disorder.

''(C) QUALIFIED INSTITUTION FOR MENTAL DISEASES.—

''(i) IN GENERAL.—The term 'qualified institution for mental diseases' means an institution described in section 1905(i) that—

''(I) has fewer than 40 beds;

''(II) is accredited for the treatment of substance use disorders by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or any other accrediting agency that the Secretary deems appropriate as necessary to ensure nationwide applicability, including qualified national organizations and State-level accrediting agencies; and

''(III) employs at least one provider who, for purposes of treating eligible individuals with a substance use disorder—

''(aa) is licensed to prescribe at least one form of each type of medication-assisted treatment specified in clause (ii);

''(bb) provides, with respect to the prescription of any such medication-assisted treatment, counseling services and behavioral therapy; and

''(cc) can discuss with any such individual the risks, benefits, and alternatives of any such medication-assisted treatment so prescribed.

''(ii) TYPES OF MEDICATION-ASSISTED TREATMENT SPECIFIED.—For purposes of clause (i), the types of medication-assisted treatment specified in this clause are each of the following:

''(I) Methadone.

''(II) Buprenorphine.

''(III) Naltrexone.

''(D) OTHER MEDICALLY NECESSARY SERVICES.—The term 'other medically necessary services' means, with respect to an eligible individual with a substance use disorder who is a patient in a qualified institution for mental diseases, items and services that are provided to such individual outside of such institution to the extent that such items and services would be treated as medical assistance for such individual if such individual were not a patient in such institution.''.

SEC. 3. PROMOTING VALUE IN MEDICAID MANAGED CARE.

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

''(7)(A) With respect to expenditures described in subparagraph (B) that are incurred by a State for any fiscal year after fiscal year 2020 (and before fiscal year 2025), in determining the pro rata share to which the United States is equitably entitled under subsection (d)(3), the Secretary shall substitute the Federal medical assistance percentage that applies for such fiscal year to the State under section 1905(b) (without regard to any adjustments to such percentage applicable under such section or any other provision of law) for the percentage that applies to such expenditures under section 1905(y).

''(B) Expenditures described in this subparagraph, with respect to a fiscal year to

which subparagraph (A) applies, are expenditures incurred by a State for payment for medical assistance provided to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) by a managed care entity, or other specified entity (as defined in subparagraph (D)(iii)), that are treated as remittances because the State—

''(i) has satisfied the requirement of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation), by electing—

''(I) in the case of a State described in subparagraph (C), to apply a minimum medical loss ratio (as defined in subparagraph (D)(ii)) that is at least 85 percent but not greater than the minimum medical loss ratio (as so defined) that such State applied as of May 31, 2018; or

''(II) in the case of a State not described in subparagraph (C), to apply a minimum medical loss ratio that is equal to 85 percent; and

''(ii) recovered all or a portion of the expenditures as a result of the entity's failure to meet such ratio.

''(C) For purposes of subparagraph (B), a State described in this subparagraph is a State that as of May 31, 2018, applied a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in such subparagraph under the State plan under this title (or a waiver of the plan) that is equal to or greater than 85 percent.

''(D) For purposes of this paragraph:

''(i) The term 'managed care entity' means a medicaid managed care organization described in section 1932(a)(1)(B)(i).

''(ii) The term 'minimum medical loss ratio' means, with respect to a State, a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (as in effect on June 1, 2018)) for payment for services provided by entities described in subparagraph (B) under the State plan under this title (or a waiver of the plan).

''(iii) The term 'other specified entity' means—

''(I) a prepaid inpatient health plan, as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation); and

''(II) a prepaid ambulatory health plan, as defined in such section (or any successor regulation).''.

Mrs. MIMI WALTERS of California (during the reading). Mr. Speaker, I reserve a point of order on the motion to recommit.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will continue to read.

The Clerk continued to read.

Ms. CASTOR of Florida (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

The SPEAKER pro tempore. The gentlewoman from Florida is recognized for 5 minutes in support of her motion.

Ms. CASTOR of Florida. Mr. Speaker, this is the final amendment to the bill. It will not kill the bill or send it back to committee. If adopted, the bill will immediately proceed to passage, as amended.

Mr. Speaker, the House has been debating legislation to combat the opioid epidemic. While many of the bills we heard last week and this week are fine, together they fail to meet the challenge of this very serious public health crisis where in America today, we are losing about 40,000 lives a year due to opioid addiction.

Now, in the Energy and Commerce Committee over the past few months, we have had numerous hearings and heard from all sorts of experts and families and the DEA and health providers. And then back home, families have been educating us on the challenges of dealing with opioid addiction.

Families and public health experts and the medical community, they have reached a consensus that we need a more comprehensive approach to tackle the opioid epidemic that includes prevention, community-based treatment, and integrated recovery plans. But it is very difficult for us to be proactive in a meaningful way on the opioid crisis when the Republicans and the White House continue to press us backwards when it comes to access to affordable healthcare.

Just last week, the Trump administration launched a new attack on Americans with preexisting conditions, and that includes families struggling with opioid addiction. President Trump and the GOP asked a Federal court to strike down the protection that prevents insurance companies from denying coverage or charging more for a preexisting condition.

This would be a devastating blow to those suffering from addiction, not to mention cancer or diabetes or a heart condition or more. This would leave more families without insurance and more families without addiction treatment.

President Trump and the GOP were not successful last year in ripping health coverage away from families across this country through legislation, so now they are trying to do this through the court system: take away the guarantee of health coverage for millions of Americans with preexisting conditions. This is wrong and it will make the opioid epidemic worse. Instead, we should be working together to develop and fund a comprehensive robust plan to combat and treat addiction.

Mr. Speaker, this is why I am proposing an amendment to strengthen the underlying bill. My amendment, most importantly, makes the 5-year limited repeal of the IMD exclusion for individuals with substance use disorders contingent on the State expanding Medicaid. It is based on the most up-to-date research and everything we know about how important Medicaid and Medicaid expansion is to treating opioid addiction.

Mr. Speaker, Medicaid is central to treating addiction, because families can get early intervention and treatment, including the important medical-assisted treatment. In fact, Medicaid serves four out of ten of nonelderly adults with opioid addiction.

According to a 2016 study by the National Council on Behavioral Health, about 1.6 million people with substance use disorders now have coverage because they live in one of the 31 States at the time that expanded Medicaid. So they are more likely to receive treatment, including access to naloxone and other drugs that help them stay off the opioids.

The Agency for Healthcare Research and Quality highlighted the importance of Medicaid expansion in increasing insurance coverage among people with opioid use disorders just recently. They found that the share of hospitalizations in which the patient was uninsured fell dramatically in States that had expanded Medicaid, from over 13 percent in 2013 to just 2.9 percent 2 years later after those States expanded Medicaid. The steep decline indicates that many uninsured people coping with opioid addiction gained coverage through Medicaid expansion.

Medicaid is part of the solution to the opioid crisis, and Republicans should not irresponsibly press to cut millions of Americans, take away their lifeline as they propose massive cuts again to Medicaid.

The Republican budget came out just yesterday. Surprise, surprise. Again, they go after families who rely on Medicaid, not just Medicaid expansion that has been so important to treating folks who suffer from addiction, but families, children, our neighbors with disabilities, folks that rely on skilled nursing care, the Republican budget released yesterday says $1.5 trillion in cuts to those families. That is not going to help solve the opioid epidemic.

Republicans in Congress cannot, on one hand, say we are facing up to the addiction crisis, and on the other say we are taking away your healthcare, whether it is Medicaid or preexisting conditions.

Mr. Speaker, I urge approval of my motion, and I yield back the balance of my time.

Mrs. MIMI WALTERS of California. Mr. Speaker, I withdraw my point of order.

The SPEAKER pro tempore (Mr. MITCHELL). The reservation of a point of order is withdrawn.

Mrs. MIMI WALTERS of California. Mr. Speaker, I claim the time in opposition to the motion.

The SPEAKER pro tempore. The gentlewoman from California is recognized for 5 minutes.

Mrs. MIMI WALTERS of California. Mr. Speaker, the Energy and Commerce Committee has worked hard to make this monumental first step in removing a decades-old barrier.

Currently the law prohibits Medicaid beneficiaries aged 21 to 64 from receiving care in an institution for mental disease, or IMD. This prohibition was set into law in the 1960s, long before the opioid crisis, and the time to repeal it in a targeted manner is now.

Now is the time, because 115 Americans are dying each day from opioid-related deaths. Now is the time, because

on average, 1,000 people are treated in emergency rooms for opioid misuse.

I am happy to work with my colleagues on expanding addiction treatment services, but that should not distract from what we are considering today: increasing access to specialized inpatient treatment for the most vulnerable in society who are struggling with an opioid addiction.

We are helping to ensure that people get the care they need in the midst of this crisis, and most importantly, it will save lives.

A recent MACPAC report clearly stated that the Medicaid IMD exclusion acts as a barrier for individuals with an opioid use disorder and is one of the few instances in Medicaid where Federal financial participation cannot be used for medically necessary and otherwise covered services for a specific Medicaid enrollee population receiving treatment in a specific setting.

The IMD CARE Act is vital to helping our communities end the opioid epidemic by removing that barrier. This bill provides for a targeted repeal of the IMD prohibition. The bill gives States a quicker alternative than Medicaid waivers to provide this much needed care. This bill was carefully crafted to ensure that patients are not being held in IMDs for longer than necessary and the bill also includes an offset.

For these reasons, the National Governors Association and the American Hospital Association support the bill.

Numerous stakeholder groups have identified the IMD exclusion repeal as one of the most significant reforms we can make to end the opioid crisis.

This is such a critical first step.

Mr. Speaker, I urge my colleagues to oppose this motion to recommit and to vote ''yes'' on final passage.

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

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

Ms. CASTOR of Florida. 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 question will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 2 o'clock and 42 minutes p.m.), the House stood in recess.

□ 1545

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. DUNCAN of Tennessee) at 3 o'clock and 45 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on questions previously postponed.

Votes will be taken in the following order:

The motion to recommit on H.R. 5797;

The question on passage of H.R. 5797, if ordered;

The motion to recommit on H.R. 6082;

The question on passage of H.R. 6082, if ordered; and

Agreeing to the Speaker's approval of the Journal, if ordered.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

INDIVIDUALS IN MEDICAID DESERVE CARE THAT IS APPROPRIATE AND RESPONSIBLE IN ITS EXECUTION ACT

The SPEAKER pro tempore. The unfinished business is the vote on the motion to recommit on the bill (H.R. 5797) to amend title XIX of the Social Security Act to allow States to provide under Medicaid services for certain individuals with opioid use disorders in institutions for mental diseases, offered by the gentlewoman from Florida (Ms. CASTOR), on which the yeas and nays were ordered.

The Clerk will redesignate the motion.

The Clerk redesignated the motion.

The SPEAKER pro tempore. The question is on the motion to recommit.

The vote was taken by electronic device, and there were—yeas 190, nays 226, not voting 11, as follows:

[Roll No. 275]

YEAS—190

Adams
Aguilar
Barragán
Bass
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Cooper
Correa
Costa
Courtney
Crist
Crowley
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Engel
Eshoo
Espaillat
Esty (CT)
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gomez
Gonzalez (TX)
Gottheimer
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hanabusa
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Lamb
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lieu, Ted
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Murphy (FL)
Nadler
Napolitano
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Payne
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Tsongas
Vargas
Veasey
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NAYS—226

Abraham
Aderholt
Allen
Amash
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bergman
Biggs
Bilirakis
Bishop (MI)
Bishop (UT)
Blackburn
Bost
Brady (TX)
Brat
Brooks (AL)
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Cheney
Coffman
Cole
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Curtis
Davidson
Davis, Rodney
Denham
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duncan (SC)
Duncan (TN)
Dunn
Estes (KS)
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Frelinghuysen
Gaetz
Gallagher
Garrett
Gianforte
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Griffith
Grothman
Guthrie
Handel
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lesko
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Massie
Mast
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Newhouse
Noem
Norman
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin