

117TH CONGRESS
2D SESSION

H. R. 7666

IN THE SENATE OF THE UNITED STATES

JUNE 23, 2022

Received; read twice and referred to the Committee on Health, Education,
Labor, and Pensions

AN ACT

To amend the Public Health Service Act to reauthorize certain programs relating to mental health and substance use disorders, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the
 3 “Restoring Hope for Mental Health and Well-Being Act
 4 of 2022”.

5 (b) **TABLE OF CONTENTS.**—The table of contents for
 6 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MENTAL HEALTH AND CRISIS CARE NEEDS

Subtitle A—Crisis Care Services and 9–8–8 Implementation

Sec. 101. Behavioral Health Crisis Coordinating Office.

Sec. 102. Crisis response continuum of care.

Sec. 103. Suicide Prevention Lifeline Improvement.

Subtitle B—Into the Light for Maternal Mental Health and Substance Use
 Disorders

Sec. 111. Screening and treatment for maternal mental health and substance
 use disorders.

Sec. 112. Maternal mental health hotline.

Sec. 113. Task force on maternal mental health.

Subtitle C—Reaching Improved Mental Health Outcomes for Patients

Sec. 121. Innovation for mental health.

Sec. 122. Crisis care coordination.

Sec. 123. Treatment of serious mental illness.

Sec. 124. Study on the costs of serious mental illness.

Subtitle D—Anna Westin Legacy

Sec. 131. Maintaining education and training on eating disorders.

Subtitle E—Community Mental Health Services Block Grant Reauthorization

Sec. 141. Reauthorization of block grants for community mental health serv-
 ices.

Subtitle F—Peer-Supported Mental Health Services

Sec. 151. Peer-supported mental health services.

Subtitle G—Military Suicide Prevention in the 21st Century

Sec. 161. Pilot program on pre-programming of suicide prevention resources
 into smart devices issued to members of the Armed Forces.

**TITLE II—SUBSTANCE USE DISORDER PREVENTION,
 TREATMENT, AND RECOVERY SERVICES**

Subtitle A—Native Behavioral Health Access Improvement

Sec. 201. Behavioral health and substance use disorder services for Native Americans.

Subtitle B—Summer Barrow Prevention, Treatment, and Recovery

- Sec. 211. Grants for the benefit of homeless individuals.
 Sec. 212. Priority substance abuse treatment needs of regional and national significance.
 Sec. 213. Evidence-based prescription opioid and heroin treatment and interventions demonstration.
 Sec. 214. Priority substance use disorder prevention needs of regional and national significance.
 Sec. 215. Sober Truth on Preventing (STOP) Underage Drinking Reauthorization.
 Sec. 216. Grants for jail diversion programs.
 Sec. 217. Formula grants to States.
 Sec. 218. Projects for Assistance in Transition From Homelessness.
 Sec. 219. Grants for reducing overdose deaths.
 Sec. 220. Opioid overdose reversal medication access and education grant programs.
 Sec. 221. State demonstration grants for comprehensive opioid abuse response.
 Sec. 222. Emergency department alternatives to opioids.

Subtitle C—Excellence in Recovery Housing

- Sec. 231. Clarifying the role of SAMHSA in promoting the availability of high-quality recovery housing.
 Sec. 232. Developing guidelines for States to promote the availability of high-quality recovery housing.
 Sec. 233. Coordination of Federal activities to promote the availability of recovery housing.
 Sec. 234. NAS study and report.
 Sec. 235. Grants for States to promote the availability of recovery housing and services.
 Sec. 236. Funding.
 Sec. 237. Technical correction.

Subtitle D—Substance Use Prevention, Treatment, and Recovery Services
 Block Grant

- Sec. 241. Eliminating stigmatizing language relating to substance use.
 Sec. 242. Authorized activities.
 Sec. 243. Requirements relating to certain infectious diseases and human immunodeficiency virus.
 Sec. 244. State plan requirements.
 Sec. 245. Updating certain language relating to Tribes.
 Sec. 246. Block grants for substance use prevention, treatment, and recovery services.
 Sec. 247. Requirement of reports and audits by States.
 Sec. 248. Study on assessment for use in distribution of limited State resources.

Subtitle E—Timely Treatment for Opioid Use Disorder

- Sec. 251. Study on exemptions for treatment of opioid use disorder through opioid treatment programs during the COVID–19 public health emergency.
- Sec. 252. Changes to Federal opioid treatment standards.

Subtitle F—Additional Provisions Relating to Addiction Treatment

- Sec. 261. Prohibition.
- Sec. 262. Eliminating additional requirements for dispensing narcotic drugs in schedule III, IV, and V for maintenance or detoxification treatment.
- Sec. 263. Requiring prescribers of controlled substances to complete training.
- Sec. 264. Increase in number of days before which certain controlled substances must be administered.
- Sec. 265. Block, report, and suspend suspicious shipments.

Subtitle G—Opioid Epidemic Response

- Sec. 271. Opioid prescription verification.
- Sec. 272. Synthetic Opioid Danger Awareness.
- Sec. 273. Grant program for State and Tribal response to opioid and stimulant use and misuse.

TITLE III—ACCESS TO MENTAL HEALTH CARE AND COVERAGE

Subtitle A—Collaborate in an Orderly and Cohesive Manner

- Sec. 301. Increasing uptake of the collaborative care model.

Subtitle B—Helping Enable Access to Lifesaving Services

- Sec. 311. Reauthorization and provision of certain programs to strengthen the health care workforce.
- Sec. 312. Reauthorization of minority fellowship program.

Subtitle C—Eliminating the Opt-Out for Nonfederal Governmental Health Plans

- Sec. 321. Eliminating the opt-out for nonfederal governmental health plans.

Subtitle D—Mental Health and Substance Use Disorder Parity Implementation

- Sec. 331. Grants to support mental health and substance use disorder parity implementation.

Subtitle E—Improving Emergency Department Mental Health Access, Services, and Responders

- Sec. 341. Helping emergency responders overcome.

Subtitle F—Other Provisions

- Sec. 351. Report on Law Enforcement Mental Health and Wellness.

TITLE IV—CHILDREN AND YOUTH

Subtitle A—Supporting Children’s Mental Health Care Access

- Sec. 401. Pediatric mental health care access grants.

- Sec. 402. Infant and early childhood mental health promotion, intervention, and treatment.
- Sec. 403. School-based mental health; children and adolescents.
- Sec. 404. Co-occurring chronic conditions and mental health in youth study.
- Sec. 405. Best practices for behavioral intervention teams.

Subtitle B—Continuing Systems of Care for Children

- Sec. 411. Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances.
- Sec. 412. Substance Use Disorder Treatment and Early Intervention Services for Children and Adolescents.

Subtitle C—Garrett Lee Smith Memorial Reauthorization

- Sec. 421. Suicide prevention technical assistance center.
- Sec. 422. Youth suicide early intervention and prevention strategies.
- Sec. 423. Mental health and substance use disorder services for students in higher education.
- Sec. 424. Mental and behavioral health outreach and education at institutions of higher education.

Subtitle D—Media and Mental Health

- Sec. 431. Study on the effects of smartphone and social media use on adolescents.
- Sec. 432. Research on the health and development effects of media on infants, children, and adolescents.

TITLE V—MEDICAID AND CHIP

- Sec. 501. Medicaid and CHIP requirements for health screenings and referrals for eligible juveniles in public institutions.
- Sec. 502. Guidance on reducing administrative barriers to providing health care services in schools.
- Sec. 503. Guidance to States on supporting pediatric behavioral health services under Medicaid and CHIP.
- Sec. 504. Ensuring children receive timely access to care.
- Sec. 505. Strategies to increase access to telehealth under Medicaid and CHIP.
- Sec. 506. Removal of limitations on Federal financial participation for inmates who are eligible juveniles pending disposition of charges.

TITLE VI—MISCELLANEOUS PROVISIONS

- Sec. 601. Determination of budgetary effects.
- Sec. 602. Oversight of pharmacy benefit manager services.
- Sec. 603. Medicare Improvement Fund.
- Sec. 604. Limitations on authority.

1 **TITLE I—MENTAL HEALTH AND**
2 **CRISIS CARE NEEDS**
3 **Subtitle A—Crisis Care Services**
4 **and 9–8–8 Implementation**

5 **SEC. 101. BEHAVIORAL HEALTH CRISIS COORDINATING OF-**
6 **FICE.**

7 Part A of title V of the Public Health Service Act
8 (42 U.S.C. 290aa et seq.) is amended by adding at the
9 end the following:

10 **“SEC. 506B. BEHAVIORAL HEALTH CRISIS COORDINATING**
11 **OFFICE.**

12 “(a) IN GENERAL.—The Secretary shall establish,
13 within the Substance Abuse and Mental Health Services
14 Administration, an office to coordinate work relating to
15 behavioral health crisis care across the operating divisions
16 and agencies of the Department of Health and Human
17 Services, including the Substance Abuse and Mental
18 Health Services Administration, the Centers for Medicare
19 & Medicaid Services, and the Health Resources and Serv-
20 ices Administration, and external stakeholders.

21 “(b) DUTY.—The office established under subsection
22 (a) shall—

23 “(1) convene Federal, State, Tribal, local, and
24 private partners;

1 “(2) launch and manage Federal workgroups
2 charged with making recommendations regarding be-
3 havioral health crisis issues, including with respect
4 to health care best practices, workforce development,
5 mental health disparities, data collection, technology,
6 program oversight, public awareness, and engage-
7 ment; and

8 “(3) support technical assistance, data analysis,
9 and evaluation functions in order to assist States, lo-
10 calities, Territories, Tribes, and Tribal communities
11 to develop crisis care systems and establish nation-
12 wide best practices with the objective of expanding
13 the capacity of, and access to, local crisis call cen-
14 ters, mobile crisis care, crisis stabilization, psy-
15 chiatric emergency services, and rapid post-crisis fol-
16 low-up care provided by—

17 “(A) the National Suicide Prevention and
18 Mental Health Crisis Hotline and Response
19 System;

20 “(B) the Veterans Crisis Line;

21 “(C) community mental health centers (as
22 defined in section 1861(ff)(3)(B) of the Social
23 Security Act);

1 “(D) certified community behavioral health
2 clinics, as described in section 223 of the Pro-
3 tecting Access to Medicare Act of 2014; and

4 “(E) other community mental health and
5 substance use disorder providers.

6 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 \$5,000,000 for each of fiscal years 2023 through 2027.”.

9 **SEC. 102. CRISIS RESPONSE CONTINUUM OF CARE.**

10 Subpart 3 of part B of title V of the Public Health
11 Service Act (42 U.S.C. 290bb–31 et seq.) is amended by
12 adding at the end the following:

13 **“SEC. 520N. CRISIS RESPONSE CONTINUUM OF CARE.**

14 “(a) IN GENERAL.—The Secretary shall publish best
15 practices for a crisis response continuum of care for use
16 by health care providers, crisis services administrators,
17 and crisis services providers in responding to individuals
18 (including children and adolescents) experiencing mental
19 health crises, substance-related crises, and crises arising
20 from co-occurring disorders.

21 “(b) BEST PRACTICES.—

22 “(1) SCOPE OF BEST PRACTICES.—The best
23 practices published under subsection (a) shall de-
24 fine—

1 “(A) a minimum set of core crisis response
2 services, as determined by the Secretary, for
3 each entity that furnishes such services, that—

4 “(i) do not require prior authorization
5 from an insurance provider or group health
6 plan nor a referral from a health care pro-
7 vider prior to the delivery of services;

8 “(ii) provide for serving all individuals
9 regardless of age or ability to pay;

10 “(iii) provide for operating 24 hours a
11 day, 7 days a week; and

12 “(iv) provide for care and support
13 through resources described in paragraph
14 (2)(A) until the individual has been sta-
15 bilized or transferred to the next level of
16 crisis care; and

17 “(B) psychiatric stabilization, including the
18 point at which a case may be closed for—

19 “(i) individuals screened over the
20 phone; and

21 “(ii) individuals stabilized on the
22 scene by mobile teams.

23 “(2) IDENTIFICATION OF ESSENTIAL FUNC-
24 TIONS.—The best practices published under sub-
25 section (a) shall identify the essential functions of

1 each service in the crisis response continuum, which
2 shall include at least the following:

3 “(A) Identification of resources for referral
4 and enrollment in continuing mental health,
5 substance use, or other human services relevant
6 for the individual in crisis where necessary.

7 “(B) Delineation of access and entry
8 points to services within the crisis response con-
9 tinuum.

10 “(C) Development of protocols and agree-
11 ments for the transfer and receipt of individuals
12 to and from other segments of the crisis re-
13 sponse continuum segments as needed, and
14 from outside referrals including health care pro-
15 viders, first responders including law enforce-
16 ment, paramedics, and firefighters, education
17 institutions, and community-based organiza-
18 tions.

19 “(D) Description of the qualifications of
20 crisis services staff, including roles for physi-
21 cians, licensed clinicians, case managers, and
22 peers (in accordance with State licensing re-
23 quirements or requirements applicable to Tribal
24 health professionals).

1 “(E) The convening of collaborative meet-
2 ings of crisis response service providers, first
3 responders including law enforcement, para-
4 medics, and firefighters, and community part-
5 ners (including National Suicide Prevention
6 Lifeline or 9–8–8 call centers, 9–1–1 public
7 service answering points, and local mental
8 health and substance use disorder treatment
9 providers) operating in a common region for the
10 discussion of case management, best practices,
11 and general performance improvement.

12 “(3) SERVICE CAPACITY AND QUALITY BEST
13 PRACTICES.—The best practices under subsection
14 (a) shall include recommendations on—

15 “(A) adequate volume of services to meet
16 population need;

17 “(B) appropriate timely response; and

18 “(C) capacity to meet the needs of dif-
19 ferent patient populations that may experience
20 a mental health or substance use crisis, includ-
21 ing children, families, and all age groups, cul-
22 tural and linguistic minorities, veterans, individ-
23 uals with co-occurring mental health and sub-
24 stance use disorders, individuals with cognitive
25 disabilities, individuals with developmental

1 delays, and individuals with chronic medical
2 conditions and physical disabilities.

3 “(4) IMPLEMENTATION TIMEFRAME.—The Sec-
4 retary shall—

5 “(A) not later than 1 year after the date
6 of enactment of this section, publish and main-
7 tain the best practices required by subsection
8 (a); and

9 “(B) every two years thereafter, publish
10 updates.

11 “(5) DATA COLLECTION AND EVALUATIONS.—
12 The Secretary, directly or through grants, contracts,
13 or interagency agreements, shall collect data and
14 conduct evaluations with respect to the provision of
15 services and programs offered on the crisis response
16 continuum for purposes of assessing the extent to
17 which the provision of such services and programs
18 meet certain objectives and outcomes measures as
19 determined by the Secretary. Such objectives shall
20 include—

21 “(A) a reduction in reliance on law en-
22 forcement response, as appropriate, to individ-
23 uals in crisis who would be more appropriately
24 served by a mobile crisis team capable of re-

1 sponding to mental health and substance-re-
2 lated crises;

3 “(B) a reduction in boarding or extended
4 holding of patients in emergency room facilities
5 who require further psychiatric care, including
6 care for substance use disorders;

7 “(C) evidence of adequate access to crisis
8 care centers and crisis bed services; and

9 “(D) evidence of adequate linkage to ap-
10 propriate post-crisis care and longitudinal treat-
11 ment for mental health or substance use dis-
12 order when relevant.”.

13 **SEC. 103. SUICIDE PREVENTION LIFELINE IMPROVEMENT.**

14 (a) **SUICIDE PREVENTION LIFELINE.**—

15 (1) **PLAN.**—Section 520E–3 of the Public
16 Health Service Act (42 U.S.C. 290bb–36c) is
17 amended—

18 (A) by redesignating subsection (c) as sub-
19 section (e); and

20 (B) by inserting after subsection (b) the
21 following:

22 “(c) **PLAN.**—

23 “(1) **IN GENERAL.**—For purposes of maintain-
24 ing the suicide prevention hotline under subsection

1 (b)(2), the Secretary shall develop and implement a
2 plan to ensure the provision of high-quality service.

3 “(2) CONTENTS.—The plan required by para-
4 graph (1) shall include the following:

5 “(A) Quality assurance provisions, includ-
6 ing—

7 “(i) clearly defined and measurable
8 performance indicators and objectives to
9 improve the responsiveness and perform-
10 ance of the hotline, including at backup
11 call centers; and

12 “(ii) quantifiable timeframes to track
13 the progress of the hotline in meeting such
14 performance indicators and objectives.

15 “(B) Standards that crisis centers and
16 backup centers must meet—

17 “(i) to participate in the network
18 under subsection (b)(1); and

19 “(ii) to ensure that each telephone
20 call, online chat message, and other com-
21 munication received by the hotline, includ-
22 ing at backup call centers, is answered in
23 a timely manner by a person, consistent
24 with the guidance established by the Amer-
25 ican Association of Suicidology or other

1 guidance determined by the Secretary to be
2 appropriate.

3 “(C) Guidelines for crisis centers and
4 backup centers to implement evidence-based
5 practices including with respect to followup and
6 referral to other health and social services re-
7 sources.

8 “(D) Guidelines to ensure that resources
9 are available and distributed to individuals
10 using the hotline who are not personally in a
11 time of crisis but know of someone who is.

12 “(E) Guidelines to carry out periodic test-
13 ing of the hotline, including at crisis centers
14 and backup centers, during each fiscal year to
15 identify and correct any problems in a timely
16 manner.

17 “(F) Guidelines to operate in consultation
18 with the State department of health, local gov-
19 ernments, Indian tribes, and tribal organiza-
20 tions.

21 “(3) INITIAL PLAN; UPDATES.—The Secretary
22 shall—

23 “(A) not later than 6 months after the
24 date of enactment of the Restoring Hope for
25 Mental Health and Well-Being Act of 2022,

1 complete development of the initial version of
2 the plan required by paragraph (1), begin im-
3 plementation of such plan, and make such plan
4 publicly available; and

5 “(B) periodically thereafter, update such
6 plan and make the updated plan publicly avail-
7 able.”.

8 (2) TRANSMISSION OF DATA TO CDC.—Section
9 520E–3 of the Public Health Service Act (42 U.S.C.
10 290bb–36c) is amended by inserting after subsection
11 (c) of such section, as added by paragraph (1), the
12 following:

13 “(d) TRANSMISSION OF DATA TO CDC.—The Sec-
14 retary shall formalize and strengthen agreements between
15 the National Suicide Prevention Lifeline program and the
16 Centers for Disease Control and Prevention to transmit
17 any necessary epidemiological data from the program to
18 the Centers, including local call center data, to assist the
19 Centers in suicide prevention efforts.”.

20 (3) AUTHORIZATION OF APPROPRIATIONS.—
21 Subsection (e) of section 520E–3 of the Public
22 Health Service Act (42 U.S.C. 290bb–36c) is
23 amended to read as follows:

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) IN GENERAL.—To carry out this section,
2 there are authorized to be appropriated
3 \$101,621,000 for each of fiscal years 2023 through
4 2027.

5 “(2) ALLOCATION.—Of the amount authorized
6 to be appropriated by paragraph (1) for each of fis-
7 cal years 2023 through 2027—

8 “(A) at least 80 percent shall be made
9 available to crisis centers; and

10 “(B) not more than 10 percent may be
11 used for carrying out the pilot program in sec-
12 tion 103(b)(1) of the Restoring Hope for Men-
13 tal Health and Well-Being Act of 2022.”.

14 (b) PILOT PROGRAM ON INNOVATIVE TECH-
15 NOLOGIES.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services, acting through the Assistant Sec-
18 retary for Mental Health and Substance Use, shall
19 carry out a pilot program to research, analyze, and
20 employ various technologies and platforms of com-
21 munication (including social media platforms,
22 texting platforms, and email platforms) for suicide
23 prevention in addition to the telephone and online
24 chat service provided by the Suicide Prevention Life-
25 line.

1 (2) REPORT.—Not later than 24 months after
2 the date on which the pilot program under para-
3 graph (1) commences, the Secretary of Health and
4 Human Services, acting through the Assistant Sec-
5 retary for Mental Health and Substance Use, shall
6 submit to the Congress a report on the pilot pro-
7 gram. With respect to each platform of communica-
8 tion employed pursuant to the pilot program, the re-
9 port shall include—

10 (A) a full description of the program;

11 (B) the number of individuals served by
12 the program;

13 (C) the average wait time for each indi-
14 vidual to receive a response;

15 (D) the cost of the program, including the
16 cost per individual served; and

17 (E) any other information the Secretary
18 determines appropriate.

19 (c) HHS STUDY AND REPORT.—Not later than 24
20 months after the Secretary of Health and Human Services
21 begins implementation of the plan required by section
22 520E–3(c) of the Public Health Service Act, as added by
23 subsection (a)(1)(B), the Secretary shall—

24 (1) complete a study on—

1 (A) the implementation of such plan, in-
2 cluding the progress towards meeting the objec-
3 tives identified pursuant to paragraph (2)(A)(i)
4 of such section 520E-3(c) by the timeframes
5 identified pursuant to paragraph (2)(A)(ii) of
6 such section 520E-3(c); and

7 (B) in consultation with the Director of
8 the Centers for Disease Control and Prevention,
9 options to expand data gathering from calls to
10 the Suicide Prevention Lifeline in order to bet-
11 ter track aspects of usage such as repeat calls,
12 consistent with applicable Federal and State
13 privacy laws; and

14 (2) submit a report to the Congress on the re-
15 sults of such study, including recommendations on
16 whether additional legislation or appropriations are
17 needed.

18 (d) GAO STUDY AND REPORT.—

19 (1) IN GENERAL.—Not later than 24 months
20 after the Secretary of Health and Human Services
21 begins implementation of the plan required by sec-
22 tion 520E-3(c) of the Public Health Service Act, as
23 added by subsection (a)(1)(B), the Comptroller Gen-
24 eral of the United States shall—

1 (A) complete a study on the Suicide Pre-
2 vention Lifeline; and

3 (B) submit a report to the Congress on the
4 results of such study.

5 (2) ISSUES TO BE STUDIED.—The study re-
6 quired by paragraph (1) shall address—

7 (A) the feasibility of geolocating callers to
8 direct calls to the nearest crisis center;

9 (B) operation shortcomings of the Suicide
10 Prevention Lifeline;

11 (C) geographic coverage of each crisis call
12 center;

13 (D) the call answer rate of each crisis call
14 center;

15 (E) the call wait time of each crisis call
16 center;

17 (F) the hours of operation of each crisis
18 call center;

19 (G) funding avenues of each crisis call cen-
20 ter;

21 (H) the implementation of the plan under
22 section 520E–3(e) of the Public Health Service
23 Act, as added by subsection (a)(1)(B), including
24 the progress towards meeting the objectives
25 identified pursuant to paragraph (2)(A)(i) of

1 such section 520E–3(e) by the timeframes iden-
2 tified pursuant to paragraph (2)(A)(ii) of such
3 section 520E–3(e); and

4 (I) service to individuals requesting a for-
5 eign language speaker, including—

6 (i) the number of calls or chats the
7 Lifeline receives from individuals speaking
8 a foreign language;

9 (ii) the capacity of the Lifeline to han-
10 dle these calls or chats; and

11 (iii) the number of crisis centers with
12 the capacity to serve foreign language
13 speakers, in house.

14 (3) RECOMMENDATIONS.—The report required
15 by paragraph (1) shall include recommendations for
16 improving the Suicide Prevention Lifeline, including
17 recommendations for legislative and administrative
18 actions.

19 (e) DEFINITION.—In this section, the term “Suicide
20 Prevention Lifeline” means the suicide prevention hotline
21 maintained pursuant to section 520E–3 of the Public
22 Health Service Act (42 U.S.C. 290bb–36c).

1 **Subtitle B—Into the Light for Ma-**
2 **ternal Mental Health and Sub-**
3 **stance Use Disorders**

4 **SEC. 111. SCREENING AND TREATMENT FOR MATERNAL**
5 **MENTAL HEALTH AND SUBSTANCE USE DIS-**
6 **ORDERS.**

7 (a) IN GENERAL.—Section 317L–1 of the Public
8 Health Service Act (42 U.S.C. 247b–13a) is amended—

9 (1) in the section heading, by striking “**MA-**
10 **TERNAL DEPRESSION**” and inserting “**MATER-**
11 **NAL MENTAL HEALTH AND SUBSTANCE USE**
12 **DISORDERS**”; and

13 (2) in subsection (a)—

14 (A) by inserting “, Indian Tribes and Trib-
15 al organizations (as such terms are defined in
16 section 4 of the Indian Self-Determination and
17 Education Assistance Act), and Urban Indian
18 organizations (as such term is defined under
19 the Federally Recognized Indian Tribe List Act
20 of 1994)” after “States”; and

21 (B) by striking “for women who are preg-
22 nant, or who have given birth within the pre-
23 ceding 12 months, for maternal depression”
24 and inserting “for women who are postpartum,
25 pregnant, or have given birth within the pre-

1 ceding 12 months, for maternal mental health
2 and substance use disorders”.

3 (b) APPLICATION.—Subsection (b) of section 317L–
4 1 of the Public Health Service Act (42 U.S.C. 247b–13a)
5 is amended—

6 (1) by striking “a State shall submit” and in-
7 serting “an entity listed in subsection (a) shall sub-
8 mit”; and

9 (2) in paragraphs (1) and (2), by striking “ma-
10 ternal depression” each place it appears and insert-
11 ing “maternal mental health and substance use dis-
12 orders”.

13 (c) PRIORITY.—Subsection (c) of section 317L–1 of
14 the Public Health Service Act (42 U.S.C. 247b–13a) is
15 amended—

16 (1) by striking “may give priority to States pro-
17 posing to improve or enhance access to screening”
18 and inserting the following: “shall give priority to
19 entities listed in subsection (a) that—

20 “(1) are proposing to create, improve, or en-
21 hance screening, prevention, and treatment”;

22 (2) by striking “maternal depression” and in-
23 serting “maternal mental health and substance use
24 disorders”;

1 (3) by striking the period at the end of para-
2 graph (1), as so designated, and inserting a semi-
3 colon; and

4 (4) by inserting after such paragraph (1) the
5 following:

6 “(2) are currently partnered with, or will part-
7 ner with, a community-based organization to address
8 maternal mental health and substance use disorders;

9 “(3) are located in an area with high rates of
10 adverse maternal health outcomes or significant
11 health, economic, racial, or ethnic disparities in ma-
12 ternal health and substance use disorder outcomes;
13 and

14 “(4) operate in a health professional shortage
15 area designated under section 332.”.

16 (d) USE OF FUNDS.—Subsection (d) of section
17 317L–1 of the Public Health Service Act (42 U.S.C.
18 247b–13a) is amended—

19 (1) in paragraph (1)—

20 (A) in subparagraph (A), by striking “to
21 health care providers; and” and inserting “on
22 maternal mental health and substance use dis-
23 order screening, brief intervention, treatment
24 (as applicable for health care providers), and
25 referrals for treatment to health care providers

1 in the primary care setting and nonclinical
2 perinatal support workers;”;

3 (B) in subparagraph (B), by striking “to
4 health care providers, including information on
5 maternal depression screening, treatment, and
6 followup support services, and linkages to com-
7 munity-based resources; and” and inserting “on
8 maternal mental health and substance use dis-
9 order screening, brief intervention, treatment
10 (as applicable for health care providers) and re-
11 ferrals for treatment, follow-up support serv-
12 ices, and linkages to community-based resources
13 to health care providers in the primary care set-
14 ting and clinical perinatal support workers;
15 and”;

16 (C) by adding at the end the following:

17 “(C) enabling health care providers (such
18 as obstetrician-gynecologists, nurse practi-
19 tioners, nurse midwives, pediatricians, psychia-
20 trists, mental and other behavioral health care
21 providers, and adult primary care clinicians) to
22 provide or receive real-time psychiatric con-
23 sultation (in-person or remotely), including
24 through the use of technology-enabled collabo-
25 rative learning and capacity building models (as

1 defined in section 330N), to aid in the treat-
2 ment of pregnant and postpartum women;
3 and”; and

4 (2) in paragraph (2)—

5 (A) by striking subparagraph (A) and re-
6 designating subparagraphs (B) and (C) as sub-
7 paragraphs (A) and (B), respectively;

8 (B) in subparagraph (A), as redesignated,
9 by striking “and” at the end;

10 (C) in subparagraph (B), as redesign-
11 nated—

12 (i) by inserting “, including” before
13 “for rural areas”; and

14 (ii) by striking the period at the end
15 and inserting a semicolon; and

16 (D) by inserting after subparagraph (B),
17 as redesignated, the following:

18 “(C) providing assistance to pregnant and
19 postpartum women to receive maternal mental
20 health and substance use disorder treatment,
21 including patient consultation, care coordina-
22 tion, and navigation for such treatment;

23 “(D) coordinating with maternal and child
24 health programs of the Federal Government

1 and State, local, and Tribal governments, in-
2 cluding child psychiatric access programs;

3 “(E) conducting public outreach and
4 awareness regarding grants under subsection
5 (a);

6 “(F) creating multistate consortia to carry
7 out the activities required or authorized under
8 this subsection; and

9 “(G) training health care providers in the
10 primary care setting and nonclinical perinatal
11 support workers on trauma-informed care, cul-
12 turally and linguistically appropriate services,
13 and best practices related to training to im-
14 prove the provision of maternal mental health
15 and substance use disorder care for racial and
16 ethnic minority populations, including with re-
17 spect to perceptions and biases that may affect
18 the approach to, and provision of, care.”.

19 (e) ADDITIONAL PROVISIONS.—Section 317L–1 of
20 the Public Health Service Act (42 U.S.C. 247b–13a) is
21 amended—

22 (1) by redesignating subsection (e) as sub-
23 section (h); and

24 (2) by inserting after subsection (d) the fol-
25 lowing:

1 “(e) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide technical assistance to grantees and entities listed
3 in subsection (a) for carrying out activities pursuant to
4 this section.

5 “(f) DISSEMINATION OF BEST PRACTICES.—The
6 Secretary, based on evaluation of the activities funded
7 pursuant to this section, shall identify and disseminate
8 evidence-based or evidence-informed best practices for
9 screening, assessment, and treatment services for mater-
10 nal mental health and substance use disorders, including
11 culturally and linguistically appropriate services, for
12 women during pregnancy and 12 months following preg-
13 nancy.

14 “(g) MATCHING REQUIREMENT.—The Federal share
15 of the cost of the activities for which a grant is made to
16 an entity under subsection (a) shall not exceed 90 percent
17 of the total cost of such activities.”.

18 (f) AUTHORIZATION OF APPROPRIATIONS.—Sub-
19 section (h) of section 317L–1 (42 U.S.C. 247b–13a) of
20 the Public Health Service Act, as redesignated, is further
21 amended—

22 (1) by striking “\$5,000,000” and inserting
23 “\$24,000,000”; and

24 (2) by striking “2018 through 2022” and in-
25 serting “2023 through 2027”.

1 **SEC. 112. MATERNAL MENTAL HEALTH HOTLINE.**

2 Part P of title III of the Public Health Service Act
3 (42 U.S.C. 280g et seq.) is amended by adding at the end
4 the following:

5 **“SEC. 399V-7. MATERNAL MENTAL HEALTH HOTLINE.**

6 “(a) IN GENERAL.—The Secretary shall maintain, di-
7 rectly or by grant or contract, a national hotline to provide
8 emotional support, information, brief intervention, and
9 mental health and substance use disorder resources to
10 pregnant and postpartum women at risk of, or affected
11 by, maternal mental health and substance use disorders,
12 and to their families or household members.

13 “(b) REQUIREMENTS FOR HOTLINE.—The hotline
14 under subsection (a) shall—

15 “(1) be a 24/7 real-time hotline;

16 “(2) provide voice and text support;

17 “(3) be staffed by certified peer specialists, li-
18 censed health care professionals, or licensed mental
19 health professionals who are trained on—

20 “(A) maternal mental health and sub-
21 stance use disorder prevention, identification,
22 and intervention; and

23 “(B) providing culturally and linguistically
24 appropriate support; and

25 “(4) provide maternal mental health and sub-
26 stance use disorder assistance and referral services

1 to meet the needs of underserved populations, indi-
2 viduals with disabilities, and family and household
3 members of pregnant or postpartum women at risk
4 of experiencing maternal mental health and sub-
5 stance use disorders.

6 “(c) ADDITIONAL REQUIREMENTS.—In maintaining
7 the hotline under subsection (a), the Secretary shall—

8 “(1) consult with the Domestic Violence Hot-
9 line, National Suicide Prevention Lifeline, and Vet-
10 erans Crisis Line to ensure that pregnant and
11 postpartum women are connected in real-time to the
12 appropriate specialized hotline service, when applica-
13 ble;

14 “(2) conduct a public awareness campaign for
15 the hotline;

16 “(3) consult with Federal departments and
17 agencies, including the Centers of Excellence of the
18 Substance Abuse and Mental Health Services Ad-
19 ministration and the Department of Veterans Af-
20 fairs, to increase awareness regarding the hotline;
21 and

22 “(4) consult with appropriate State, local, and
23 Tribal public health officials, including officials that
24 administer programs that serve low-income pregnant
25 and postpartum individuals.

1 “(d) ANNUAL REPORT.—The Secretary shall submit
2 an annual report to the Congress on the hotline under sub-
3 section (a) and implementation of this section, including—

4 “(1) an evaluation of the effectiveness of activi-
5 ties conducted or supported under subsection (a);

6 “(2) a directory of entities or organizations to
7 which staff maintaining the hotline funded under
8 this section may make referrals; and

9 “(3) such additional information as the Sec-
10 retary determines appropriate.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this section, there are authorized to be appro-
13 priated \$10,000,000 for each of fiscal years 2023 through
14 2027.”.

15 **SEC. 113. TASK FORCE ON MATERNAL MENTAL HEALTH.**

16 Part B of title III of the Public Health Service Act
17 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
18 tion 317L-1 (42 U.S.C. 247b-13a) the following:

19 **“SEC. 317L-2. TASK FORCE ON MATERNAL MENTAL**
20 **HEALTH.**

21 “(a) ESTABLISHMENT.—Not later than 180 days
22 after the date of enactment of the Restoring Hope for the
23 Mental Health and Well-Being Act of 2022, the Secretary,
24 for purposes of identifying, evaluating, and making rec-

1 ommendations to coordinate and improve Federal re-
2 sponses to maternal mental health conditions, shall—

3 “(1) establish a task force to be known as the
4 Task Force on Maternal Mental Health (in this sec-
5 tion referred to as the ‘Task Force’); or

6 “(2) incorporate the duties, public meetings,
7 and reports specified in subsections (c) through (f)
8 into existing Federal policy forums, including the
9 Maternal Health Interagency Policy Committee and
10 the Maternal Health Working Group, as appro-
11 priate.

12 “(b) MEMBERSHIP.—

13 “(1) COMPOSITION.—The Task Force shall be
14 composed of—

15 “(A) the Federal members under para-
16 graph (2); and

17 “(B) the non-Federal members under
18 paragraph (3).

19 “(2) FEDERAL MEMBERS.—The Federal mem-
20 bers of the Task Force shall consist of the following
21 heads of Federal departments and agencies (or their
22 designees):

23 “(A) The Assistant Secretary for Health of
24 the Department of Health and Human Services,
25 who shall serve as Chair.

1 “(B) The Assistant Secretary for Planning
2 and Evaluation of the Department of Health
3 and Human Services.

4 “(C) The Assistant Secretary of the Ad-
5 ministration for Children and Families.

6 “(D) The Director of the Centers for Dis-
7 ease Control and Prevention.

8 “(E) The Administrator of the Centers for
9 Medicare & Medicaid Services.

10 “(F) The Administrator of the Health Re-
11 sources and Services Administration.

12 “(G) The Director of the Indian Health
13 Service.

14 “(H) The Assistant Secretary for Mental
15 Health and Substance Use.

16 “(I) Such other Federal departments and
17 agencies as the Secretary determines appro-
18 priate that serve individuals with maternal men-
19 tal health conditions.

20 “(3) NON-FEDERAL MEMBERS.—The non-Fed-
21 eral members of the Task Force shall—

22 “(A) compose not more than one-half, and
23 not less than one-third, of the total membership
24 of the Task Force;

25 “(B) be appointed by the Secretary; and

1 “(C) include—

2 “(i) representatives of medical soci-
3 eties with expertise in maternal or mental
4 health;

5 “(ii) representatives of nonprofit orga-
6 nizations with expertise in maternal or
7 mental health;

8 “(iii) relevant industry representa-
9 tives; and

10 “(iv) other representatives, as appro-
11 priate.

12 “(4) DEADLINE FOR DESIGNATING DES-
13 IGNEES.—If the Assistant Secretary for Health, or
14 the head of a Federal department or agency serving
15 as a member of the Task Force under paragraph
16 (2), chooses to be represented on the Task Force by
17 a designee, the Assistant Secretary or department or
18 agency head shall designate such designee not later
19 than 90 days after the date of the enactment of this
20 section.

21 “(c) DUTIES.—The Task Force shall—

22 “(1) prepare and regularly update a report that
23 analyzes and evaluates the state of national mater-
24 nal mental health policy and programs at the Fed-
25 eral, State, and local levels, and identifies best prac-

1 tices with respect to maternal mental health policy,
2 including—

3 “(A) a set of evidence-based, evidence-in-
4 formed, and promising practices with respect
5 to—

6 “(i) prevention strategies for individ-
7 uals at risk of experiencing a maternal
8 mental health condition, including strate-
9 gies and recommendations to address
10 health inequities;

11 “(ii) the identification, screening, di-
12 agnosis, intervention, and treatment of in-
13 dividuals and families affected by a mater-
14 nal mental health condition;

15 “(iii) the expeditious referral to, and
16 implementation of, practices and supports
17 that prevent and mitigate the effects of a
18 maternal mental health condition, includ-
19 ing strategies and recommendations to
20 eliminate the racial and ethnic disparities
21 that exist in maternal mental health; and

22 “(iv) community-based or
23 multigenerational practices that support
24 individuals and families affected by a ma-
25 ternal mental health condition; and

1 “(B) Federal and State programs and ac-
2 tivities to prevent, screen, diagnose, intervene,
3 and treat maternal mental health conditions;

4 “(2) develop and regularly update a national
5 strategy for maternal mental health, taking into con-
6 sideration the findings of the report under para-
7 graph (1), on how the Task Force and Federal de-
8 partments and agencies represented on the Task
9 Force may prioritize options for, and may implement
10 a coordinated approach to, addressing maternal
11 mental health conditions, including by—

12 “(A) increasing prevention, screening, di-
13 agnosis, intervention, treatment, and access to
14 care, including clinical and nonclinical care such
15 as peer-support and community health workers,
16 through the public and private sectors;

17 “(B) providing support for pregnant or
18 postpartum individuals who are at risk for or
19 experiencing a maternal mental health condi-
20 tion, and their families, as appropriate;

21 “(C) reducing racial, ethnic, geographic,
22 and other health disparities for prevention, di-
23 agnosis, intervention, treatment, and access to
24 care;

1 “(D) identifying options for modifying,
2 strengthening, and coordinating Federal pro-
3 grams and activities, such as the Medicaid pro-
4 gram under title XIX of the Social Security Act
5 and the State Children’s Health Insurance Pro-
6 gram under title XXI of such Act, including ex-
7 isting infant and maternity programs, in order
8 to increase research, prevention, identification,
9 intervention, and treatment with respect to ma-
10 ternal mental health; and

11 “(E) planning, data sharing, and commu-
12 nication within and across Federal depart-
13 ments, agencies, offices, and programs;

14 “(3) solicit public comments from stakeholders
15 for the report under paragraph (1) and the national
16 strategy under paragraph (2), including comments
17 from frontline service providers, mental health pro-
18 fessionals, researchers, experts in maternal mental
19 health, institutions of higher education, public health
20 agencies (including maternal and child health pro-
21 grams), and industry representatives, in order to in-
22 form the activities and reports of the Task Force;
23 and

24 “(4) disaggregate any data collected under this
25 section by race, ethnicity, geographical location, age,

1 marital status, socioeconomic level, and other fac-
2 tors, as the Secretary determines appropriate.

3 “(d) MEETINGS.—The Task Force shall—

4 “(1) meet not less than two times each year;
5 and

6 “(2) convene public meetings, as appropriate, to
7 fulfill its duties under this section.

8 “(e) REPORTS TO PUBLIC AND FEDERAL LEAD-
9 ERS.—The Task Force shall make publicly available and
10 submit to the heads of relevant Federal departments and
11 agencies, the Committee on Energy and Commerce of the
12 House of Representatives, the Committee on Health, Edu-
13 cation, Labor, and Pensions of the Senate, and other rel-
14 evant congressional committees, the following:

15 “(1) Not later than 1 year after the first meet-
16 ing of the Task Force, an initial report under sub-
17 section (c)(1).

18 “(2) Not later than 2 years after the first meet-
19 ing of the Task Force, an initial national strategy
20 under subsection (c)(2).

21 “(3) Each year thereafter—

22 “(A) an updated report under subsection
23 (c)(1);

24 “(B) an updated national strategy under
25 subsection (c)(2); or

1 “(C) if no update is made under subsection
2 (c)(1) or (c)(2), a report summarizing the ac-
3 tivities of the Task Force.

4 “(f) REPORTS TO GOVERNORS.—Upon finalizing the
5 initial national strategy under subsection (c)(2), and upon
6 making relevant updates to such strategy, the Task Force
7 shall submit a report to the Governors of all States de-
8 scribing opportunities for local- and State-level partner-
9 ships identified under subsection (c)(2)(D).

10 “(g) SUNSET.—The Task Force shall terminate on
11 September 30, 2027.

12 “(h) NONDUPLICATION OF FEDERAL EFFORTS.—
13 The Secretary may relieve the Task Force, in carrying out
14 subsections (c) through (f), from responsibility for car-
15 rying out such activities as may be specified by the Sec-
16 retary as duplicative with other activities carried out by
17 the Department of Health and Human Services.”.

18 **Subtitle C—Reaching Improved**
19 **Mental Health Outcomes for Pa-**
20 **tients**

21 **SEC. 121. INNOVATION FOR MENTAL HEALTH.**

22 (a) NATIONAL MENTAL HEALTH AND SUBSTANCE
23 USE POLICY LABORATORY.—Section 501A of the Public
24 Health Service Act (42 U.S.C. 290aa–0) is amended—

1 (1) in subsection (e)(1), by striking “Indian
2 tribes or tribal organizations” and inserting “Indian
3 Tribes or Tribal organizations”;

4 (2) by striking subsection (e)(3); and

5 (3) by adding at the end the following:

6 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there is authorized to be appro-
8 priated \$10,000,000 for each of fiscal years 2023 through
9 2027.”.

10 (b) INTERDEPARTMENTAL SERIOUS MENTAL ILL-
11 NESS COORDINATING COMMITTEE.—

12 (1) IN GENERAL.—Part A of title V of the Pub-
13 lic Health Service Act (42 U.S.C. 290aa et seq.) is
14 amended by inserting after section 501A (42 U.S.C.
15 290aa-0) the following:

16 **“SEC. 501B. INTERDEPARTMENTAL SERIOUS MENTAL ILL-
17 NESS COORDINATING COMMITTEE.**

18 **“(a) ESTABLISHMENT.—**

19 **“(1) IN GENERAL.—**The Secretary of Health
20 and Human Services, or the designee of the Sec-
21 retary, shall establish a committee to be known as
22 the Interdepartmental Serious Mental Illness Coordi-
23 nating Committee (in this section referred to as the
24 ‘Committee’).

1 “(2) FEDERAL ADVISORY COMMITTEE ACT.—

2 Except as provided in this section, the provisions of
3 the Federal Advisory Committee Act (5 U.S.C.
4 App.) shall apply to the Committee.

5 “(b) MEETINGS.—The Committee shall meet not
6 fewer than 2 times each year.

7 “(c) RESPONSIBILITIES.—The Committee shall sub-
8 mit, on a biannual basis, to Congress and any other rel-
9 evant Federal department or agency a report including—

10 “(1) a summary of advances in serious mental
11 illness and serious emotional disturbance research
12 related to the prevention of, diagnosis of, interven-
13 tion in, and treatment and recovery of serious men-
14 tal illnesses, serious emotional disturbances, and ad-
15 vances in access to services and support for adults
16 with a serious mental illness or children with a seri-
17 ous emotional disturbance;

18 “(2) an evaluation of the effect Federal pro-
19 grams related to serious mental illness have on pub-
20 lic health, including public health outcomes such
21 as—

22 “(A) rates of suicide, suicide attempts, in-
23 cidence and prevalence of serious mental ill-
24 nesses, serious emotional disturbances, and sub-
25 stance use disorders, overdose, overdose deaths,

1 emergency hospitalizations, emergency room
2 boarding, preventable emergency room visits,
3 interaction with the criminal justice system,
4 homelessness, and unemployment;

5 “(B) increased rates of employment and
6 enrollment in educational and vocational pro-
7 grams;

8 “(C) quality of mental and substance use
9 disorders treatment services; or

10 “(D) any other criteria as may be deter-
11 mined by the Secretary; and

12 “(3) specific recommendations for actions that
13 agencies can take to better coordinate the adminis-
14 tration of mental health services for adults with a
15 serious mental illness or children with a serious emo-
16 tional disturbance.

17 “(d) MEMBERSHIP.—

18 “(1) FEDERAL MEMBERS.—The Committee
19 shall be composed of the following Federal rep-
20 resentatives, or the designees of such representa-
21 tives—

22 “(A) the Secretary of Health and Human
23 Services, who shall serve as the Chair of the
24 Committee;

1 “(B) the Assistant Secretary for Mental
2 Health and Substance Use;

3 “(C) the Attorney General;

4 “(D) the Secretary of Veterans Affairs;

5 “(E) the Secretary of Defense;

6 “(F) the Secretary of Housing and Urban
7 Development;

8 “(G) the Secretary of Education;

9 “(H) the Secretary of Labor;

10 “(I) the Administrator of the Centers for
11 Medicare & Medicaid Services; and

12 “(J) the Commissioner of Social Security.

13 “(2) NON-FEDERAL MEMBERS.—The Com-
14 mittee shall also include not less than 14 non-Fed-
15 eral public members appointed by the Secretary of
16 Health and Human Services, of which—

17 “(A) at least 2 members shall be an indi-
18 vidual who has received treatment for a diag-
19 nosis of a serious mental illness;

20 “(B) at least 1 member shall be a parent
21 or legal guardian of an adult with a history of
22 a serious mental illness or a child with a history
23 of a serious emotional disturbance;

24 “(C) at least 1 member shall be a rep-
25 resentative of a leading research, advocacy, or

1 service organization for adults with a serious
2 mental illness;

3 “(D) at least 2 members shall be—

4 “(i) a licensed psychiatrist with expe-
5 rience in treating serious mental illnesses;

6 “(ii) a licensed psychologist with expe-
7 rience in treating serious mental illnesses
8 or serious emotional disturbances;

9 “(iii) a licensed clinical social worker
10 with experience treating serious mental ill-
11 nesses or serious emotional disturbances;
12 or

13 “(iv) a licensed psychiatric nurse,
14 nurse practitioner, or physician assistant
15 with experience in treating serious mental
16 illnesses or serious emotional disturbances;

17 “(E) at least 1 member shall be a licensed
18 mental health professional with a specialty in
19 treating children and adolescents with a serious
20 emotional disturbance;

21 “(F) at least 1 member shall be a mental
22 health professional who has research or clinical
23 mental health experience in working with mi-
24 norities;

1 “(G) at least 1 member shall be a mental
2 health professional who has research or clinical
3 mental health experience in working with medi-
4 cally underserved populations;

5 “(H) at least 1 member shall be a State
6 certified mental health peer support specialist;

7 “(I) at least 1 member shall be a judge
8 with experience in adjudicating cases related to
9 criminal justice or serious mental illness;

10 “(J) at least 1 member shall be a law en-
11 forcement officer or corrections officer with ex-
12 tensive experience in interfacing with adults
13 with a serious mental illness, children with a se-
14 rious emotional disturbance, or individuals in a
15 mental health crisis; and

16 “(K) at least 1 member shall have experi-
17 ence providing services for homeless individuals
18 and working with adults with a serious mental
19 illness, children with a serious emotional dis-
20 turbance, or individuals in a mental health cri-
21 sis.

22 “(3) TERMS.—A member of the Committee ap-
23 pointed under paragraph (2) shall serve for a term
24 of 3 years, and may be reappointed for 1 or more
25 additional 3-year terms. Any member appointed to

1 fill a vacancy for an unexpired term shall be ap-
2 pointed for the remainder of such term. A member
3 may serve after the expiration of the member’s term
4 until a successor has been appointed.

5 “(e) WORKING GROUPS.—In carrying out its func-
6 tions, the Committee may establish working groups. Such
7 working groups shall be composed of Committee members,
8 or their designees, and may hold such meetings as are nec-
9 essary.

10 “(f) SUNSET.—The Committee shall terminate on
11 September 30, 2027.”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) Section 501(l)(2) of the Public Health
14 Service Act (42 U.S.C. 290aa(l)(2)) is amended
15 by striking “section 6031 of such Act” and in-
16 serting “section 501B of this Act”.

17 (B) Section 6031 of the Helping Families
18 in Mental Health Crisis Reform Act of 2016
19 (Division B of Public Law 114–255) is repealed
20 (and by conforming the item relating to such
21 section in the table of contents in section 1(b)).

22 (c) PRIORITY MENTAL HEALTH NEEDS OF RE-
23 GIONAL AND NATIONAL SIGNIFICANCE.—Section 520A of
24 the Public Health Service Act (42 U.S.C. 290bb–32) is
25 amended—

1 (1) in subsection (a), by striking “Indian tribes
2 or tribal organizations” and inserting “Indian Tribes
3 or Tribal organizations”; and

4 (2) in subsection (f), by striking “\$394,550,000
5 for each of fiscal years 2018 through 2022” and in-
6 serting “\$599,036,000 for each of fiscal years 2023
7 through 2027”.

8 **SEC. 122. CRISIS CARE COORDINATION.**

9 (a) **STRENGTHENING COMMUNITY CRISIS RESPONSE**
10 **SYSTEMS.**—Section 520F of the Public Health Service Act
11 (42 U.S.C. 290bb–37) is amended to read as follows:

12 **“SEC. 520F. MENTAL HEALTH CRISIS RESPONSE PARTNER-**
13 **SHIP PILOT PROGRAM.**

14 “(a) **IN GENERAL.**—The Secretary shall establish a
15 pilot program under which the Secretary will award com-
16 petitive grants to States, localities, territories, Indian
17 Tribes, and Tribal organizations to establish new, or en-
18 hance existing, mobile crisis response teams that divert the
19 response for mental health and substance use crises from
20 law enforcement to mobile crisis teams, as described in
21 subsection (b).

22 “(b) **MOBILE CRISIS TEAMS DESCRIBED.**—A mobile
23 crisis team described in this subsection is a team of indi-
24 viduals—

1 “(1) that is available to respond to individuals
2 in crisis and provide immediate stabilization, refer-
3 rals to community-based mental health and sub-
4 stance use disorder services and supports, and triage
5 to a higher level of care if medically necessary;

6 “(2) which may include licensed counselors,
7 clinical social workers, physicians, paramedics, crisis
8 workers, peer support specialists, or other qualified
9 individuals; and

10 “(3) which may provide support to divert be-
11 havioral health crisis calls from the 9–1–1 system to
12 the 9–8–8 system.

13 “(c) PRIORITY.—In awarding grants under this sec-
14 tion, the Secretary shall prioritize applications which ac-
15 count for the specific needs of the communities to be
16 served, including children and families, veterans, rural and
17 underserved populations, and other groups at increased
18 risk of death from suicide or overdose.

19 “(d) REPORT.—

20 “(1) INITIAL REPORT.—Not later than Sep-
21 tember 30, 2024, the Secretary shall submit to Con-
22 gress a report on steps taken by the entities speci-
23 fied in subsection (a) as of such date of enactment
24 to strengthen the partnerships among mental health
25 providers, substance use disorder treatment pro-

1 viders, primary care physicians, mental health and
2 substance use crisis teams, paramedics, law enforce-
3 ment officers, and other first responders.

4 “(2) PROGRESS REPORTS.—Not later than one
5 year after the date on which the first grant is
6 awarded to carry out this section, and for each year
7 thereafter, the Secretary shall submit to Congress a
8 report on the grants made during the year covered
9 by the report, which shall include—

10 “(A) impact data on the teams and people
11 served by such programs, including demo-
12 graphic information of individuals served, vol-
13 ume, and types of service utilization;

14 “(B) outcomes of the number of linkages
15 to community-based resources, short-term crisis
16 receiving and stabilization facilities, and diver-
17 sion from law enforcement or hospital emer-
18 gency department settings;

19 “(C) data consistent with the State block
20 grant requirements for continuous evaluation
21 and quality improvement, and other relevant
22 data as determined by the Secretary; and

23 “(D) the Secretary’s recommendations and
24 best practices for—

1 “(i) States and localities providing
2 mobile crisis response and stabilization
3 services for youth and adults; and

4 “(ii) improvements to the program es-
5 tablished under this section.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section,
8 \$10,000,000 for each of fiscal years 2023 through 2027.”.

9 (b) MENTAL HEALTH AWARENESS TRAINING
10 GRANTS.—

11 (1) IN GENERAL.—Section 520J(b) of the Pub-
12 lic Health Service Act (42 U.S.C. 290bb–41(b)) is
13 amended—

14 (A) in paragraph (1), by striking “Indian
15 tribes, tribal organizations” and inserting “In-
16 dian Tribes, Tribal organizations”;

17 (B) in paragraph (4), by striking “Indian
18 tribe, tribal organization” and inserting “Indian
19 Tribe, Tribal organization”;

20 (C) in paragraph (5)—

21 (i) by striking “Indian tribe, tribal or-
22 ganization” and inserting “Indian Tribe,
23 Tribal organization”;

24 (ii) in subparagraph (A), by striking
25 “and” at the end;

1 (iii) in subparagraph (B)(ii), by strik-
2 ing the period at the end and inserting “;
3 and”; and

4 (iv) by adding at the end the fol-
5 lowing:

6 “(C) suicide intervention and prevention,
7 including recognizing warning signs and how to
8 refer someone for help.”;

9 (D) in paragraph (6), by striking “Indian
10 tribe, tribal organization” and inserting “Indian
11 Tribe, Tribal organization”; and

12 (E) in paragraph (7), by striking
13 “\$14,693,000 for each of fiscal years 2018
14 through 2022” and inserting “\$24,963,000 for
15 each of fiscal years 2023 through 2027”.

16 (2) TECHNICAL CORRECTIONS.—Section
17 520J(b) of the Public Health Service Act (42 U.S.C.
18 290bb–41(b)) is amended—

19 (A) in the heading of paragraph (2), by
20 striking “EMERGENCY SERVICES PERSONNEL”
21 and inserting “EMERGENCY SERVICES PER-
22 SONNEL”; and

23 (B) in the heading of paragraph (3), by
24 striking “DISTRIBUTION OF AWARDS” and in-
25 serting “DISTRIBUTION OF AWARDS”.

1 (c) ADULT SUICIDE PREVENTION.—Section 520L of
2 the Public Health Service Act (42 U.S.C. 290bb–43) is
3 amended—

4 (1) in subsection (a)—

5 (A) in paragraph (2)—

6 (i) by striking “Indian tribe” each
7 place it appears and inserting “Indian
8 Tribe”; and

9 (ii) by striking “tribal organization”
10 each place it appears and inserting “Tribal
11 organization”; and

12 (B) by amending paragraph (3)(C) to read
13 as follows:

14 “(C) Raising awareness of suicide preven-
15 tion resources, promoting help seeking among
16 those at risk for suicide.”; and

17 (2) in subsection (d), by striking “\$30,000,000
18 for the period of fiscal years 2018 through 2022”
19 and inserting “\$30,000,000 for each of fiscal years
20 2023 through 2027”.

21 **SEC. 123. TREATMENT OF SERIOUS MENTAL ILLNESS.**

22 (a) ASSERTIVE COMMUNITY TREATMENT GRANT
23 PROGRAM.—

24 (1) TECHNICAL AMENDMENT.—Section
25 520M(b) of the Public Health Service Act (42

1 U.S.C. 290bb–44(b)) is amended by striking “Indian
2 tribe or tribal organization” and inserting “Indian
3 Tribe or Tribal organization”.

4 (2) REPORT TO CONGRESS.—Section
5 520M(d)(1) of the Public Health Service Act (42
6 U.S.C. 290bb–44(d)(1)) is amended by striking “not
7 later than the end of fiscal year 2021” and inserting
8 “not later than the end of fiscal year 2026”.

9 (3) AUTHORIZATION OF APPROPRIATIONS.—
10 Section 520M(e)(1) of the Public Health Service Act
11 (42 U.S.C. 290bb–44(d)(1)) is amended by striking
12 “\$5,000,000 for the period of fiscal years 2018
13 through 2022” and inserting “\$9,000,000 for each
14 of fiscal years 2023 through 2027”.

15 (b) ASSISTED OUTPATIENT TREATMENT.—Section
16 224 of the Protecting Access to Medicare Act of 2014 (42
17 U.S.C. 290aa note) is amended to read as follows:

18 **“SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT**
19 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**
20 **MENTAL ILLNESS.**

21 “(a) IN GENERAL.—The Secretary shall carry out a
22 program to award grants to eligible entities for assisted
23 outpatient treatment programs for individuals with serious
24 mental illness.

1 “(b) CONSULTATION.—The Secretary shall carry out
2 this section in consultation with the Director of the Na-
3 tional Institute of Mental Health, the Attorney General
4 of the United States, the Administrator of the Administra-
5 tion for Community Living, and the Assistant Secretary
6 for Mental Health and Substance Use.

7 “(c) SELECTING AMONG APPLICANTS.—In awarding
8 grants under this section, the Secretary—

9 “(1) may give preference to applicants that
10 have not previously implemented an assisted out-
11 patient treatment program; and

12 “(2) shall evaluate applicants based on their po-
13 tential to reduce hospitalization, homelessness, incar-
14 ceration, and interaction with the criminal justice
15 system while improving the health and social out-
16 comes of the patient.

17 “(d) PROGRAM REQUIREMENTS.—An assisted out-
18 patient treatment program funded with a grant awarded
19 under this section shall include—

20 “(1) evaluating the medical and social needs of
21 the patients who are participating in the program;

22 “(2) preparing and executing treatment plans
23 for such patients that—

24 “(A) include criteria for completion of
25 court-ordered treatment if applicable; and

1 “(B) provide for monitoring of the pa-
2 tient’s compliance with the treatment plan, in-
3 cluding compliance with medication and other
4 treatment regimens;

5 “(3) providing for case management services
6 that support the treatment plan;

7 “(4) ensuring appropriate referrals to medical
8 and social services providers;

9 “(5) evaluating the process for implementing
10 the program to ensure consistency with the patient’s
11 needs and State law; and

12 “(6) measuring treatment outcomes, including
13 health and social outcomes such as rates of incarcer-
14 ation, health care utilization, and homelessness.

15 “(e) REPORT.—Not later than the end of fiscal year
16 2027, the Secretary shall submit a report to the appro-
17 priate congressional committees on the grant program
18 under this section. Such report shall include an evaluation
19 of the following:

20 “(1) Cost savings and public health outcomes
21 such as mortality, suicide, substance abuse, hos-
22 pitalization, and use of services.

23 “(2) Rates of incarceration of patients.

24 “(3) Rates of homelessness of patients.

1 “(4) Patient and family satisfaction with pro-
2 gram participation.

3 “(5) Demographic information regarding par-
4 ticipation of those served by the grant compared to
5 demographic information in the population of the
6 grant recipient.

7 “(f) DEFINITIONS.—In this section:

8 “(1) The term ‘assisted outpatient treatment’
9 means medically prescribed mental health treatment
10 that a patient receives while living in a community
11 under the terms of a law authorizing a State or local
12 civil court to order such treatment.

13 “(2) The term ‘eligible entity’ means a county,
14 city, mental health system, mental health court, or
15 any other entity with authority under the law of the
16 State in which the entity is located to implement,
17 monitor, and oversee an assisted outpatient treat-
18 ment program.

19 “(g) FUNDING.—

20 “(1) AMOUNT OF GRANTS.—

21 “(A) MAXIMUM AMOUNT.—The amount of
22 a grant under this section shall not exceed
23 \$1,000,000 for any fiscal year.

24 “(B) DETERMINATION.—Subject to sub-
25 paragraph (A), the Secretary shall determine

1 the amount of each grant under this section
2 based on the population of the area to be served
3 through the grant and an estimate of the num-
4 ber of patients to be served.

5 “(2) AUTHORIZATION OF APPROPRIATIONS.—

6 There is authorized to be appropriated to carry out
7 this section \$22,000,000 for each of fiscal years
8 2023 through 2027.”.

9 **SEC. 124. STUDY ON THE COSTS OF SERIOUS MENTAL ILL-**
10 **NESS.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services, in consultation with the Assistant Sec-
13 retary for Mental Health and Substance Use, the Assist-
14 ant Secretary for Planning and Evaluation, the Attorney
15 General of the United States, the Secretary of Labor, and
16 the Secretary of Housing and Urban Development, shall
17 conduct a study on the direct and indirect costs of serious
18 mental illness with respect to—

19 (1) nongovernmental entities; and

20 (2) the Federal Government and State, local,
21 and Tribal governments.

22 (b) CONTENT.—The study under subsection (a) shall
23 consider each of the following:

24 (1) The costs to the health care system for
25 health services, including with respect to—

- 1 (A) office-based physician visits;
- 2 (B) residential and inpatient treatment
- 3 programs;
- 4 (C) outpatient treatment programs;
- 5 (D) emergency room visits;
- 6 (E) crisis stabilization programs;
- 7 (F) home health care;
- 8 (G) skilled nursing and long-term care fa-
- 9 cilities;
- 10 (H) prescription drugs and digital thera-
- 11 peutics; and
- 12 (I) any other relevant health services.

13 (2) The costs of homelessness, including with
14 respect to—

- 15 (A) homeless shelters;
- 16 (B) street outreach activities;
- 17 (C) crisis response center visits; and
- 18 (D) other supportive services.

19 (3) The costs of structured residential facilities
20 and other supportive housing for residential and cus-
21 todial care services.

22 (4) The costs of law enforcement encounters
23 and encounters with the criminal justice system, in-
24 cluding with respect to—

1 (A) encounters that do and do not result
2 in an arrest;

3 (B) criminal and judicial proceedings;

4 (C) services provided by law enforcement
5 and judicial staff (including public defenders,
6 prosecutors, and private attorneys); and

7 (D) incarceration.

8 (5) The costs of serious mental illness on em-
9 ployment.

10 (6) With respect to family members and care-
11 givers, the costs of caring for an individual with a
12 serious mental illness.

13 (7) Any other relevant costs for programs and
14 services administered by the Federal Government or
15 State, Tribal, or local governments.

16 (c) DATA DISAGGREGATION.—In conducting the
17 study under subsection (a), the Secretary of Health and
18 Human Services shall (to the extent feasible)—

19 (1) disaggregate data by—

20 (A) costs to nongovernmental entities, the
21 Federal Government, and State, local, and
22 Tribal governments;

23 (B) types of serious mental illnesses and
24 medical chronic diseases common in patients
25 with a serious mental illness; and

1 (C) demographic characteristics, including
2 race, ethnicity, sex, age (including pediatric
3 subgroups), and other characteristics deter-
4 mined by the Secretary; and

5 (2) include an estimate of—

6 (A) the total number of individuals with a
7 serious mental illness in the United States, in-
8 cluding in traditional and nontraditional hous-
9 ing; and

10 (B) the percentage of such individuals in—

11 (i) homeless shelters;

12 (ii) penal facilities, including Federal
13 prisons, State prisons, and county and mu-
14 nicipal jails; and

15 (iii) nursing facilities.

16 (d) REPORT.—Not later than 2 years after the date
17 of the enactment of this Act, the Secretary of Health and
18 Human Services shall—

19 (1) submit to the Congress a report containing
20 the results of the study conducted under this sec-
21 tion; and

22 (2) make such report publicly available.

1 **Subtitle D—Anna Westin Legacy**

2 **SEC. 131. MAINTAINING EDUCATION AND TRAINING ON**
3 **EATING DISORDERS.**

4 Subpart 3 of part B of title V of the Public Health
5 Service Act (42 U.S.C. 290bb–31 et seq.), as amended by
6 section 102, is further amended by adding at the end the
7 following:

8 **“SEC. 5200. CENTER OF EXCELLENCE FOR EATING DIS-**
9 **ORDERS FOR EDUCATION AND TRAINING ON**
10 **EATING DISORDERS.**

11 “(a) IN GENERAL.—The Secretary, acting through
12 the Assistant Secretary, shall maintain, by competitive
13 grant or contract, a Center of Excellence for Eating Dis-
14 orders (referred to in this section as the ‘Center’) to im-
15 prove the identification of, interventions for, and treat-
16 ment of eating disorders in a manner that is develop-
17 mentally, culturally, and linguistically appropriate.

18 “(b) SUBGRANTS AND SUBCONTRACTS.—The Center
19 shall coordinate and implement the activities under sub-
20 section (c), in whole or in part, by awarding competitive
21 subgrants or subcontracts—

22 “(1) across geographical regions; and

23 “(2) in a manner that is not duplicative.

24 “(c) ACTIVITIES.—The Center—

25 “(1) shall—

1 “(A) provide training and technical assist-
2 ance for—

3 “(i) primary care and behavioral
4 health care providers to carry out screen-
5 ing, brief intervention, and referral to
6 treatment for individuals experiencing, or
7 at risk for, eating disorders; and

8 “(ii) nonclinical community support
9 workers to identify and support individuals
10 with, or at disproportionate risk for, eating
11 disorders;

12 “(B) develop and provide training mate-
13 rials to health care providers, including primary
14 care and behavioral health care providers, in
15 the effective treatment and ongoing support of
16 individuals with eating disorders, including chil-
17 dren and marginalized populations at dispropor-
18 tionate risk for eating disorders;

19 “(C) provide collaboration and coordina-
20 tion to other centers of excellence, technical as-
21 sistance centers, and psychiatric consultation
22 lines of the Substance Abuse and Mental
23 Health Services Administration and the Health
24 Resources and Services Administration on the
25 identification, effective treatment, and ongoing

1 support of individuals with eating disorders;
2 and

3 “(D) coordinate with the Director of the
4 Centers for Disease Control and Prevention and
5 the Administrator of the Health Resources and
6 Services Administration to disseminate training
7 to primary care and behavioral health care pro-
8 viders; and

9 “(2) may—

10 “(A) coordinate with electronic health
11 record systems for the integration of protocols
12 pertaining to screening, brief intervention, and
13 referral to treatment for individuals experi-
14 encing, or at risk for, eating disorders;

15 “(B) develop and provide training mate-
16 rials to health care providers, including primary
17 care and behavioral health care providers, in
18 the effective treatment and ongoing support for
19 members of the Armed Forces and veterans ex-
20 perienicing, or at risk for, eating disorders; and

21 “(C) consult with the Secretary of Defense
22 and the Secretary of Veterans Affairs on pre-
23 vention, identification, intervention for, and
24 treatment of eating disorders.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$1,000,000 for each of fiscal years 2023 through
4 2027.”.

5 **Subtitle E—Community Mental**
6 **Health Services Block Grant Re-**
7 **authorization**

8 **SEC. 141. REAUTHORIZATION OF BLOCK GRANTS FOR COM-**
9 **MUNITY MENTAL HEALTH SERVICES.**

10 (a) FUNDING.—Section 1920(a) of the Public Health
11 Service Act (42 U.S.C. 300x–9(a)) is amended by striking
12 “\$532,571,000 for each of fiscal years 2018 through
13 2022” and inserting “\$857,571,000 for each of fiscal
14 years 2023 through 2027”.

15 (b) SET-ASIDE FOR EVIDENCE-BASED CRISIS CARE
16 SERVICES.—Section 1920 of the Public Health Service
17 Act (42 U.S.C. 300x–9) is amended by adding at the end
18 the following:

19 “(d) CRISIS CARE.—

20 “(1) IN GENERAL.—Except as provided in para-
21 graph (3), a State shall expend at least 5 percent of
22 the amount the State receives pursuant to section
23 1911 for each fiscal year to support evidenced-based
24 programs that address the crisis care needs of—

1 “(A) individuals, including children and
2 adolescents, experiencing mental health crises,
3 substance-related crises, or crises arising from
4 co-occurring disorders; and

5 “(B) persons with intellectual and develop-
6 mental disabilities.

7 “(2) CORE ELEMENTS.—At the discretion of
8 the single State agency responsible for the adminis-
9 tration of the program of the State under a grant
10 under section 1911, funds expended pursuant to
11 paragraph (1) may be used to fund some or all of
12 the core crisis care service components, delivered ac-
13 cording to evidence-based principles, including the
14 following:

15 “(A) Crisis call centers.

16 “(B) 24/7 mobile crisis services.

17 “(C) Crisis stabilization programs offering
18 acute care or subacute care in a hospital or ap-
19 propriately licensed facility, as determined by
20 the Substance Abuse and Mental Health Serv-
21 ices Administration, with referrals to inpatient
22 or outpatient care.

23 “(3) STATE FLEXIBILITY.—In lieu of expending
24 5 percent of the amount the State receives pursuant
25 to section 1911 for a fiscal year to support evidence-

1 based programs as required by paragraph (1), a
2 State may elect to expend not less than 10 percent
3 of such amount to support such programs by the
4 end of two consecutive fiscal years.

5 “(4) RULE OF CONSTRUCTION.—With respect
6 to funds expended pursuant to the set-aside in para-
7 graph (1), section 1912(b)(1)(A)(vi) shall not
8 apply.”.

9 (c) EARLY INTERVENTION.—

10 (1) STATE PLAN OPTION.—Section
11 1912(b)(1)(A)(vii) of the Public Health Service Act
12 (42 U.S.C. 300x-1(b)(1)(A)(vii)) is amended—

13 (A) in subclause (III), by striking “and” at
14 the end;

15 (B) in subelause (IV), by striking the pe-
16 riod at the end and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(V) a description of any evi-
19 dence-based early intervention strate-
20 gies and programs the State provides
21 to prevent, delay, or reduce the sever-
22 ity and onset of mental illness and be-
23 havioral problems, including for chil-
24 dren and adolescents, irrespective of
25 experiencing a serious mental illness

1 or serious emotional disturbance, as
2 defined under subsection (c)(1).”.

3 (2) ALLOCATION ALLOWANCE; REPORTS.—Sec-
4 tion 1920 of the Public Health Service Act (42
5 U.S.C. 300x-9), as amended by subsection (c), is
6 further amended by adding at the end the following:
7 “(e) EARLY INTERVENTION SERVICES.—In the case
8 of a State with a State plan that provides for strategies
9 and programs specified in section 1912(b)(1)(A)(vii)(VI),
10 such State may expend not more than 5 percent of the
11 amount of the allotment of the State pursuant to a fund-
12 ing agreement under section 1911 for each fiscal year to
13 support such strategies and programs.

14 “(f) REPORTS TO CONGRESS.—Not later than Sep-
15 tember 30, 2025, and biennially thereafter, the Secretary
16 shall provide a report to the Congress on the crisis care
17 and early intervention strategies and programs pursued by
18 States pursuant to subsections (d) and (e). Each such re-
19 port shall include—

20 “(1) a description of the each State’s crisis care
21 and early intervention activities;

22 “(2) the population served, including informa-
23 tion on demographics, including age;

24 “(3) the outcomes of such activities, includ-
25 ing—

1 “(A) how such activities reduced hos-
2 pitalizations and hospital stays;

3 “(B) how such activities reduced incidents
4 of suicidal ideation and behaviors; and

5 “(C) how such activities reduced the sever-
6 ity of onset of serious mental illness and serious
7 emotional disturbance; and

8 “(4) any other relevant information the Sec-
9 retary deems necessary.”.

10 **Subtitle F—Peer-Supported Mental** 11 **Health Services**

12 **SEC. 151. PEER-SUPPORTED MENTAL HEALTH SERVICES.**

13 Subpart 3 of part B of title V of the Public Health
14 Service Act (42 U.S.C. 290bb—31 et seq.) is amended by
15 inserting after section 520G (42 U.S.C. 290bb—38) the
16 following:

17 **“SEC. 520H. PEER-SUPPORTED MENTAL HEALTH SERVICES.**

18 “(a) GRANTS AUTHORIZED.—The Secretary, acting
19 through the Director of the Center for Mental Health
20 Services, shall award grants to eligible entities to enable
21 such entities to develop, expand, and enhance access to
22 mental health peer-delivered services.

23 “(b) USE OF FUNDS.—Grants awarded under sub-
24 section (a) shall be used to develop, expand, and enhance
25 national, statewide, or community-focused programs, in-

1 cluding virtual peer-support services and infrastructure,
2 including by—

3 “(1) carrying out workforce development, re-
4 cruitment, and retention activities, to train, recruit,
5 and retain peer-support providers;

6 “(2) building connections between mental
7 health treatment programs, including between com-
8 munity organizations and peer-support networks, in-
9 cluding virtual peer-support networks, and with
10 other mental health support services;

11 “(3) reducing stigma associated with mental
12 health disorders;

13 “(4) expanding and improving virtual peer men-
14 tal health support services, including adoption of
15 technologies to expand access to virtual peer mental
16 health support services, including by acquiring—

17 “(A) appropriate physical hardware for
18 such virtual services;

19 “(B) software and programs to efficiently
20 run peer-support services virtually; and

21 “(C) other technology for establishing vir-
22 tual waiting rooms and virtual video platforms
23 for meetings; and

1 “(5) conducting research on issues relating to
2 mental illness and the impact peer-support has on
3 resiliency, including identifying—

4 “(A) the signs of mental illness;

5 “(B) the resources available to individuals
6 with mental illness and to their families; and

7 “(C) the resources available to help sup-
8 port individuals living with mental illness.

9 “(c) SPECIAL CONSIDERATION.—In carrying out this
10 section, the Secretary shall give special consideration to
11 the unique needs of rural areas.

12 “(d) DEFINITION.—In this section, the term ‘eligible
13 entity’ means—

14 “(1) a nonprofit consumer-run organization
15 that—

16 “(A) is principally governed by people liv-
17 ing with a mental health condition; and

18 “(B) mobilizes resources within and out-
19 side of the mental health community, which
20 may include through peer-support networks, to
21 increase the prevalence and quality of long-term
22 wellness of individuals living with a mental
23 health condition, including those with a co-oc-
24 curring substance use disorder; or

1 “(2) a Federally recognized Tribe, Tribal orga-
2 nization, Urban Indian organization, or consortium
3 of Tribes or Tribal organizations.

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 \$13,000,000 for each of fiscal years 2023 through 2027.”.

7 **Subtitle G—Military Suicide**
8 **Prevention in the 21st Century**

9 **SEC. 161. PILOT PROGRAM ON PRE-PROGRAMMING OF SUI-**
10 **CIDE PREVENTION RESOURCES INTO SMART**
11 **DEVICES ISSUED TO MEMBERS OF THE**
12 **ARMED FORCES.**

13 (a) IN GENERAL.—Commencing not later than 120
14 days after the date of the enactment of this Act, the Sec-
15 retary of Defense shall carry out a pilot program under
16 which the Secretary—

17 (1) pre-downloads the Virtual Hope Box appli-
18 cation of the Defense Health Agency, or such suc-
19 cessor application, on smart devices individually
20 issued to members of the Armed Forces;

21 (2) pre-programs the National Suicide Hotline
22 number and Veterans Crisis Line number into the
23 contacts for such devices; and

24 (3) provides training, as part of training on sui-
25 cide awareness and prevention conducted throughout

1 the Department of Defense, on the preventative re-
2 sources described in paragraphs (1) and (2).

3 (b) DURATION.—The Secretary shall carry out the
4 pilot program under this section for a two-year period.

5 (c) SCOPE.—The Secretary shall determine the ap-
6 propriate scope of individuals participating in the pilot
7 program under this section to best represent each Armed
8 Force and to ensure a relevant sample size.

9 (d) IDENTIFICATION OF OTHER RESOURCES.—In
10 carrying out the pilot program under this section, the Sec-
11 retary shall coordinate with the Director of the Defense
12 Health Agency and the Secretary of Veterans Affairs to
13 identify other useful technology-related resources for use
14 in the pilot program.

15 (e) REPORT.—Not later than 30 days after com-
16 pleting the pilot program under this section, the Secretary
17 shall submit to the Committee on Armed Services of the
18 Senate and the Committee on Armed Services of the
19 House of Representatives a report on the pilot program.

20 (f) VETERANS CRISIS LINE DEFINED.—In this sec-
21 tion, the term “Veterans Crisis Line” means the toll-free
22 hotline for veterans established under section 1720F(h) of
23 title 38, United States Code.

1 **TITLE II—SUBSTANCE USE DIS-**
2 **ORDER PREVENTION, TREAT-**
3 **MENT, AND RECOVERY SERV-**
4 **ICES**

5 **Subtitle A—Native Behavioral**
6 **Health Access Improvement**

7 **SEC. 201. BEHAVIORAL HEALTH AND SUBSTANCE USE DIS-**
8 **ORDER SERVICES FOR NATIVE AMERICANS.**

9 Section 506A of the Public Health Service Act (42
10 U.S.C. 290aa–5a) is amended to read as follows:

11 **“SEC. 506A. BEHAVIORAL HEALTH AND SUBSTANCE USE**
12 **DISORDER SERVICES FOR NATIVE AMERI-**
13 **CANS.**

14 “(a) DEFINITIONS.—In this section:

15 “(1) The term ‘eligible entity’ means an Indian
16 Tribe, a Tribal organization, an Urban Indian orga-
17 nization, and a Native Hawaiian health organization.

18 “(2) The terms ‘Indian Tribe’, ‘Tribal organiza-
19 tion’, and ‘Urban Indian organization’ have the
20 meanings given to the terms ‘Indian tribe’, ‘tribal
21 organization’, and ‘Urban Indian organization’ in
22 section 4 of the Indian Health Care Improvement
23 Act.

24 “(3) The term ‘Native Hawaiian health organi-
25 zation’ means ‘Papa Ola Lokahi’ as defined in sec-

1 tion 12 of the Native Hawaiian Health Care Im-
2 provement Act.

3 “(b) FORMULA FUNDS.—

4 “(1) IN GENERAL.—The Secretary, in consulta-
5 tion with the Director of the Indian Health Service,
6 as appropriate, shall award funds to eligible entities,
7 in amounts determined pursuant to the formula de-
8 scribed in paragraph (2), to be used by the eligible
9 entity to provide culturally appropriate mental
10 health and substance use disorder prevention, treat-
11 ment, and recovery services to American Indians,
12 Alaska Natives, and Native Hawaiians.

13 “(2) FORMULA.—The Secretary, using the
14 process described in subsection (d), shall develop a
15 formula to determine the amount of an award under
16 paragraph (1). Such formula shall take into account
17 the populations of eligible entities whose rates of
18 overdose deaths or suicide are substantially higher
19 relative to the populations of other Indian Tribes,
20 Tribal organizations, Urban Indian organizations, or
21 Native Hawaiian health organizations, as applicable.

22 “(c) TECHNICAL ASSISTANCE AND PROGRAM EVAL-
23 UATION.—

24 “(1) IN GENERAL.—The Secretary shall—

1 “(A) provide technical assistance to appli-
2 cants and awardees under this section; and

3 “(B) collect and evaluate information on
4 the program carried out under this section.

5 “(2) CONSULTATION ON EVALUATION MEAS-
6 URES, AND DATA SUBMISSION AND REPORTING RE-
7 QUIREMENTS.—The Secretary shall, using the proc-
8 ess described in subsection (d), develop evaluation
9 measures and data submission and reporting re-
10 quirements for purposes of the collection and evalua-
11 tion of information.

12 “(3) DATA SUBMISSION AND REPORTING.—As a
13 condition on receipt of funds under this section, an
14 applicant shall agree to submit data and reports in
15 a timely manner consistent with the evaluation
16 measures and data submission and reporting re-
17 quirements developed under subsection (d).

18 “(d) REGULATIONS.—

19 “(1) PROMULGATION.—Not later than 180 days
20 after the date of enactment of the Restoring Hope
21 for Mental Health and Well-Being Act of 2022, the
22 Secretary shall initiate procedures under subchapter
23 III of chapter 5 of title 5, United States Code, to
24 negotiate and promulgate such regulations as are
25 necessary to carry out this section, including devel-

1 opment of the funding formula described in sub-
2 section (b) and the program evaluation and report-
3 ing requirements under subsection (c).

4 “(2) PUBLICATION.—Not later than 18 months
5 after the date of enactment of the Restoring Hope
6 for Mental Health and Well-Being Act of 2022, the
7 Secretary shall publish in the Federal Register pro-
8 posed regulations to implement this section.

9 “(3) COMMITTEE.—A negotiated rulemaking
10 committee established pursuant to section 565 of
11 title 5, United States Code, to carry out this sub-
12 section shall have as its members only representa-
13 tives of the Federal Government, Tribal Govern-
14 ments, and Urban Indian organizations. For pur-
15 poses of such rulemaking, the Indian Health Service
16 shall be the lead agency for the Department.

17 “(4) ADAPTATION OF PROCEDURES.—In car-
18 rying out this subsection, the Secretary shall adapt
19 any negotiated rulemaking procedures to the unique
20 context of the government-to-government relation-
21 ship between the United States and Indian Tribes.

22 “(5) EFFECT.—The lack of promulgated regu-
23 lations under this subsection shall not limit the ef-
24 fect or implementation of this section.

1 “(e) APPLICATION.—An entity desiring an award
2 under subsection (b) shall submit an application to the
3 Secretary at such time, in such manner, and accompanied
4 by such information as the Secretary may reasonably re-
5 quire.

6 “(f) REPORT.—Not later than 3 years after the date
7 of the enactment of the Restoring Hope for Mental Health
8 and Well-Being Act of 2022, and annually thereafter, the
9 Secretary shall prepare and submit, to the Committee on
10 Health, Education, Labor, and Pensions of the Senate,
11 and the Committee on Energy and Commerce of the
12 House of Representatives, a report describing the services
13 provided pursuant to this section.

14 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section,
16 \$40,000,000 for each of fiscal years 2023 through 2027.”.

17 **Subtitle B—Summer Barrow Pre-**
18 **vention, Treatment, and Recov-**
19 **ery**

20 **SEC. 211. GRANTS FOR THE BENEFIT OF HOMELESS INDI-**
21 **VIDUALS.**

22 Section 506(e) of the Public Health Service Act (42
23 U.S.C. 290aa–5(e)) is amended by striking “2018 through
24 2022” and inserting “2023 through 2027”.

1 **SEC. 212. PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS**
2 **OF REGIONAL AND NATIONAL SIGNIFICANCE.**

3 Section 509 of the Public Health Service Act (42
4 U.S.C. 290bb–2) is amended—

5 (1) in the section heading, by striking
6 “**ABUSE**” and inserting “**USE DISORDER**”;

7 (2) in subsection (a)—

8 (A) by striking “tribes and tribal organiza-
9 tions (as the terms ‘Indian tribes’ and ‘tribal
10 organizations’ are defined” and inserting
11 “Tribes and Tribal organizations (as such
12 terms are defined”; and

13 (B) in paragraph (3), by striking “in sub-
14 stance abuse”;

15 (3) in subsection (b), in the subsection heading,
16 by striking “**ABUSE**” and inserting “**USE DIS-**
17 **ORDER**”; and

18 (4) in subsection (f), by striking “\$333,806,000
19 for each of fiscal years 2018 through 2022” and in-
20 serting “\$521,517,000 for each of fiscal years 2023
21 through 2027”.

22 **SEC. 213. EVIDENCE-BASED PRESCRIPTION OPIOID AND**
23 **HEROIN TREATMENT AND INTERVENTIONS**
24 **DEMONSTRATION.**

25 Section 514B of the Public Health Service Act (42
26 U.S.C. 290bb–10) is amended—

1 (1) in subsection (a)(1)—

2 (A) by striking “substance abuse” and in-
3 serting “substance use disorder”;

4 (B) by striking “tribes and tribal organiza-
5 tions” and inserting “Tribes and Tribal organi-
6 zations”; and

7 (C) by striking “addiction” and inserting
8 “substance use disorders”;

9 (2) in subsection (e)(3), by striking “tribes and
10 tribal organizations” and inserting “Tribes and
11 Tribal organizations”; and

12 (3) in subsection (f), by striking “2017 through
13 2021” and inserting “2023 through 2027”.

14 **SEC. 214. PRIORITY SUBSTANCE USE DISORDER PREVEN-**
15 **TION NEEDS OF REGIONAL AND NATIONAL**
16 **SIGNIFICANCE.**

17 Section 516 of the Public Health Service Act (42
18 U.S.C. 290bb–22) is amended—

19 (1) in subsection (a)—

20 (A) in paragraph (3), by striking “abuse”
21 and inserting “use”; and

22 (B) in the matter following paragraph (3),
23 by striking “tribes or tribal organizations” and
24 inserting “Tribes or Tribal organizations”;

1 (2) in subsection (b), in the subsection heading,
2 by striking “ABUSE” and inserting “USE DIS-
3 ORDER”; and

4 (3) in subsection (f), by striking “\$211,148,000
5 for each of fiscal years 2018 through 2022” and in-
6 serting “\$218,219,000 for each of fiscal years 2023
7 through 2027”.

8 **SEC. 215. SOBER TRUTH ON PREVENTING (STOP) UNDER-**
9 **AGE DRINKING REAUTHORIZATION.**

10 Section 519B of the Public Health Service Act (42
11 U.S.C. 290bb–25b) is amended—

12 (1) by amending subsection (a) to read as fol-
13 lows:

14 “(a) DEFINITIONS.—For purposes of this section:

15 “(1) The term ‘alcohol beverage industry’
16 means the brewers, vintners, distillers, importers,
17 distributors, and retail or online outlets that sell or
18 serve beer, wine, and distilled spirits.

19 “(2) The term ‘school-based prevention’ means
20 programs, which are institutionalized, and run by
21 staff members or school-designated persons or orga-
22 nizations in any grade of school, kindergarten
23 through 12th grade.

24 “(3) The term ‘youth’ means persons under the
25 age of 21.”; and

1 (2) by striking subsections (e) through (g) and
2 inserting the following:

3 “(c) INTERAGENCY COORDINATING COMMITTEE; AN-
4 NUAL REPORT ON STATE UNDERAGE DRINKING PREVEN-
5 TION AND ENFORCEMENT ACTIVITIES.—

6 “(1) INTERAGENCY COORDINATING COMMITTEE
7 ON THE PREVENTION OF UNDERAGE DRINKING.—

8 “(A) IN GENERAL.—The Secretary, in col-
9 laboration with the Federal officials specified in
10 subparagraph (B), shall continue to support
11 and enhance the efforts of the interagency co-
12 ordinating committee, that began operating in
13 2004, focusing on underage drinking (referred
14 to in this subsection as the ‘Committee’).

15 “(B) OTHER AGENCIES.—The officials re-
16 ferred to in subparagraph (A) are the Secretary
17 of Education, the Attorney General, the Sec-
18 retary of Transportation, the Secretary of the
19 Treasury, the Secretary of Defense, the Sur-
20 geon General, the Director of the Centers for
21 Disease Control and Prevention, the Director of
22 the National Institute on Alcohol Abuse and Al-
23 coholism, the Assistant Secretary for Mental
24 Health and Substance Use, the Director of the
25 National Institute on Drug Abuse, the Assist-

1 ant Secretary for Children and Families, the
2 Director of the Office of National Drug Control
3 Policy, the Administrator of the National High-
4 way Traffic Safety Administration, the Admin-
5 istrator of the Office of Juvenile Justice and
6 Delinquency Prevention, the Chairman of the
7 Federal Trade Commission, and such other
8 Federal officials as the Secretary of Health and
9 Human Services determines to be appropriate.

10 “(C) CHAIR.—The Secretary of Health
11 and Human Services shall serve as the chair of
12 the Committee.

13 “(D) DUTIES.—The Committee shall guide
14 policy and program development across the
15 Federal Government with respect to underage
16 drinking, provided, however, that nothing in
17 this section shall be construed as transferring
18 regulatory or program authority from an Agen-
19 cy to the Coordinating Committee.

20 “(E) CONSULTATIONS.—The Committee
21 shall actively seek the input of and shall consult
22 with all appropriate and interested parties, in-
23 cluding States, public health research and inter-
24 est groups, foundations, and alcohol beverage
25 industry trade associations and companies.

1 “(F) ANNUAL REPORT.—

2 “(i) IN GENERAL.—The Secretary, on
3 behalf of the Committee, shall annually
4 submit to the Congress a report that sum-
5 marizes—

6 “(I) all programs and policies of
7 Federal agencies designed to prevent
8 and reduce underage drinking, focus-
9 ing particularly on programs and poli-
10 cies that support the adoption and en-
11 forcement of State policies designed to
12 prevent and reduce underage drinking
13 as specified in paragraph (2);

14 “(II) the extent of progress in
15 preventing and reducing underage
16 drinking at State and national levels;

17 “(III) data that the Secretary
18 shall collect with respect to the infor-
19 mation specified in clause (ii); and

20 “(IV) such other information re-
21 garding underage drinking as the Sec-
22 retary determines to be appropriate.

23 “(ii) CERTAIN INFORMATION.—The
24 report under clause (i) shall include infor-
25 mation on the following:

1 “(I) Patterns and consequences
2 of underage drinking as reported in
3 research and surveys such as, but not
4 limited to, Monitoring the Future,
5 Youth Risk Behavior Surveillance
6 System, the National Survey on Drug
7 Use and Health, and the Fatality
8 Analysis Reporting System.

9 “(II) Measures of the availability
10 of alcohol from commercial and non-
11 commercial sources to underage popu-
12 lations.

13 “(III) Measures of the exposure
14 of underage populations to messages
15 regarding alcohol in advertising, social
16 media, and the entertainment media.

17 “(IV) Surveillance data, includ-
18 ing information on the onset and
19 prevalence of underage drinking, con-
20 sumption patterns, beverage pref-
21 erences, prevalence of drinking among
22 students at institutions of higher edu-
23 cation, correlations between adult and
24 youth drinking, and the means of un-
25 derage access, including trends over

1 time for these surveillance data. The
2 Secretary shall develop a plan to im-
3 prove the collection, measurement,
4 and consistency of reporting Federal
5 underage alcohol data.

6 “(V) Any additional findings re-
7 sulting from research conducted or
8 supported under subsection (f).

9 “(VI) Evidence-based best prac-
10 tices to prevent and reduce underage
11 drinking including a review of the re-
12 search literature related to State laws,
13 regulations, and policies designed to
14 prevent and reduce underage drink-
15 ing, as described in paragraph
16 (2)(B)(i).

17 “(2) ANNUAL REPORT ON STATE UNDERAGE
18 DRINKING PREVENTION AND ENFORCEMENT ACTIVI-
19 TIES.—

20 “(A) IN GENERAL.—The Secretary shall,
21 with input and collaboration from other appro-
22 priate Federal agencies, States, Indian Tribes,
23 territories, and public health, consumer, and al-
24 cohol beverage industry groups, annually issue
25 a report on each State’s performance in enact-

1 ing, enforcing, and creating laws, regulations,
2 and policies to prevent or reduce underage
3 drinking based on an assessment of best prac-
4 tices developed pursuant to paragraph
5 (1)(F)(ii)(VI) and subparagraph (B)(i). For
6 purposes of this paragraph, each such report,
7 with respect to a year, shall be referred to as
8 the ‘State Report’. Each State Report shall be
9 designed as a resource tool for Federal agencies
10 assisting States in the their underage drinking
11 prevention efforts, State public health and law
12 enforcement agencies, State and local policy-
13 makers, and underage drinking prevention coa-
14 litions including those receiving grants pursuant
15 to subsection (e).

16 “(B) STATE PERFORMANCE MEASURES.—

17 “(i) IN GENERAL.—The Secretary
18 shall develop, in consultation with the
19 Committee, a set of measures to be used in
20 preparing the State Report on best prac-
21 tices as they relate to State laws, regula-
22 tions, policies, and enforcement practices.

23 “(ii) STATE REPORT CONTENT.—The
24 State Report shall include updates on
25 State laws, regulations, and policies in-

1 cluded in previous reports to Congress, in-
2 cluding with respect to the following:

3 “(I) Whether or not the State
4 has comprehensive anti-underage
5 drinking laws such as for the illegal
6 sale, purchase, attempt to purchase,
7 consumption, or possession of alcohol;
8 illegal use of fraudulent ID; illegal
9 furnishing or obtaining of alcohol for
10 an individual under 21 years; the de-
11 gree of strictness of the penalties for
12 such offenses; and the prevalence of
13 the enforcement of each of these in-
14 fractions.

15 “(II) Whether or not the State
16 has comprehensive liability statutes
17 pertaining to underage access to alco-
18 hol such as dram shop, social host,
19 and house party laws, and the preva-
20 lence of enforcement of each of these
21 laws.

22 “(III) Whether or not the State
23 encourages and conducts comprehen-
24 sive enforcement efforts to prevent
25 underage access to alcohol at retail

1 outlets, such as random compliance
2 checks and shoulder tap programs,
3 and the number of compliance checks
4 within alcohol retail outlets measured
5 against the number of total alcohol re-
6 tail outlets in each State, and the re-
7 sult of such checks.

8 “(IV) Whether or not the State
9 encourages training on the proper
10 selling and serving of alcohol for all
11 sellers and servers of alcohol as a con-
12 dition of employment.

13 “(V) Whether or not the State
14 has policies and regulations with re-
15 gard to direct sales to consumers and
16 home delivery of alcoholic beverages.

17 “(VI) Whether or not the State
18 has programs or laws to deter adults
19 from purchasing alcohol for minors;
20 and the number of adults targeted by
21 these programs.

22 “(VII) Whether or not the State
23 has enacted graduated drivers licenses
24 and the extent of those provisions.

1 “(iii) ADDITIONAL CATEGORIES.—In
2 addition to the updates on State laws, reg-
3 ulations, and policies listed in clause (ii),
4 the Secretary shall consider the following:

5 “(I) Whether or not States have
6 adopted laws, regulations, and policies
7 that deter underage alcohol use, as
8 described in ‘The Surgeon General’s
9 Call to Action to Prevent and Reduce
10 Underage Drinking’ issued in 2007
11 and ‘Facing Addiction in America:
12 The Surgeon General’s Report on Al-
13 cohool, Drugs and Health’ issued in
14 2016, including restrictions on low-
15 price, high-volume drink specials, and
16 wholesaler pricing provisions.

17 “(II) Whether or not States have
18 adopted laws, regulations, and policies
19 designed to reduce alcohol advertising
20 messages attractive to youth and
21 youth exposure to alcohol advertising
22 and marketing in measured and
23 unmeasured media and digital and so-
24 cial media.

1 “(III) Whether or not States
2 have laws and policies that promote
3 underage drinking prevention policy
4 development by local jurisdictions.

5 “(IV) Whether or not States
6 have adopted laws, regulations, and
7 policies to restrict youth access to al-
8 coholic beverages that may pose spe-
9 cial risks to youth, including but not
10 limited to alcoholic mists, gelatins,
11 freezer pops, premixed caffeinated al-
12 coholic beverages, and flavored malt
13 beverages.

14 “(V) Whether or not States have
15 adopted uniform best practices proto-
16 cols for conducting compliance checks
17 and shoulder tap programs.

18 “(VI) Whether or not States
19 have adopted uniform best practices
20 penalty protocols for violations of laws
21 prohibiting retail licensees from sell-
22 ing or furnishing of alcohol to minors.

23 “(iv) UNIFORM DATA SYSTEM.—For
24 performance measures related to enforce-
25 ment of underage drinking laws as speci-

1 fied in clauses (ii) and (iii), the Secretary
2 shall develop and test a uniform data sys-
3 tem for reporting State enforcement data,
4 including the development of a pilot pro-
5 gram for this purpose. The pilot program
6 shall include procedures for collecting en-
7 forcement data from both State and local
8 law enforcement jurisdictions.

9 “(3) AUTHORIZATION OF APPROPRIATIONS.—
10 There is authorized to be appropriated to carry out
11 this subsection \$1,000,000 for each of fiscal years
12 2023 through 2027.

13 “(d) NATIONAL MEDIA CAMPAIGN TO PREVENT UN-
14 DERAGE DRINKING.—

15 “(1) IN GENERAL.—The Secretary, in consulta-
16 tion with the National Highway Traffic Safety Ad-
17 ministration, shall develop an intensive, multifaceted,
18 adult-oriented national media campaign to reduce
19 underage drinking by influencing attitudes regarding
20 underage drinking, increasing the willingness of
21 adults to take actions to reduce underage drinking,
22 and encouraging public policy changes known to de-
23 crease underage drinking rates.

1 “(2) PURPOSE.—The purpose of the national
2 media campaign described in this section shall be to
3 achieve the following objectives:

4 “(A) Instill a broad societal commitment to
5 reduce underage drinking.

6 “(B) Increase specific actions by adults
7 that are meant to discourage or inhibit under-
8 age drinking.

9 “(C) Decrease adult conduct that tends to
10 facilitate or condone underage drinking.

11 “(3) COMPONENTS.—When implementing the
12 national media campaign described in this section,
13 the Secretary shall—

14 “(A) educate the public about the public
15 health and safety benefits of evidence-based
16 policies to reduce underage drinking, including
17 minimum legal drinking age laws, and build
18 public and parental support for and cooperation
19 with enforcement of such policies;

20 “(B) educate the public about the negative
21 consequences of underage drinking;

22 “(C) promote specific actions by adults
23 that are meant to discourage or inhibit under-
24 age drinking, including positive behavior mod-

1 eling, general parental monitoring, and con-
2 sistent and appropriate discipline;

3 “(D) discourage adult conduct that tends
4 to facilitate underage drinking, including the
5 hosting of underage parties with alcohol and
6 the purchasing of alcoholic beverages on behalf
7 of underage youth;

8 “(E) establish collaborative relationships
9 with local and national organizations and insti-
10 tutions to further the goals of the campaign
11 and assure that the messages of the campaign
12 are disseminated from a variety of sources;

13 “(F) conduct the campaign through multi-
14 media sources; and

15 “(G) conduct the campaign with regard to
16 changing demographics and cultural and lin-
17 guistic factors.

18 “(4) CONSULTATION REQUIREMENT.—In devel-
19 oping and implementing the national media cam-
20 paign described in this section, the Secretary shall
21 consult recommendations for reducing underage
22 drinking published by the National Academy of
23 Sciences and the Surgeon General. The Secretary
24 shall also consult with interested parties including
25 medical, public health, and consumer and parent

1 groups, law enforcement, institutions of higher edu-
2 cation, community organizations and coalitions, and
3 other stakeholders supportive of the goals of the
4 campaign.

5 “(5) ANNUAL REPORT.—The Secretary shall
6 produce an annual report on the progress of the de-
7 velopment or implementation of the media campaign
8 described in this subsection, including expenses and
9 projected costs, and, as such information is avail-
10 able, report on the effectiveness of such campaign in
11 affecting adult attitudes toward underage drinking
12 and adult willingness to take actions to decrease un-
13 derage drinking.

14 “(6) RESEARCH ON YOUTH-ORIENTED CAM-
15 PAIGN.—The Secretary may, based on the avail-
16 ability of funds, conduct research on the potential
17 success of a youth-oriented national media campaign
18 to reduce underage drinking. The Secretary shall re-
19 port any such results to Congress with policy rec-
20 ommendations on establishing such a campaign.

21 “(7) ADMINISTRATION.—The Secretary may
22 enter into a subcontract with another Federal agen-
23 cy to delegate the authority for execution and ad-
24 ministration of the adult-oriented national media
25 campaign.

1 “(8) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this section \$2,500,000 for each of fiscal years 2023
4 through 2027.

5 “(e) COMMUNITY-BASED COALITION ENHANCEMENT
6 GRANTS TO PREVENT UNDERAGE DRINKING.—

7 “(1) AUTHORIZATION OF PROGRAM.—The As-
8 sistant Secretary for Mental Health and Substance
9 Use, in consultation with the Director of the Office
10 of National Drug Control Policy, shall award en-
11 hancement grants to eligible entities to design, im-
12 plement, evaluate, and disseminate comprehensive
13 strategies to maximize the effectiveness of commu-
14 nity-wide approaches to preventing and reducing un-
15 derage drinking. This subsection is subject to the
16 availability of appropriations.

17 “(2) PURPOSES.—The purposes of this sub-
18 section are to—

19 “(A) prevent and reduce alcohol use among
20 youth in communities throughout the United
21 States;

22 “(B) strengthen collaboration among com-
23 munities, the Federal Government, Tribal Gov-
24 ernments, and State and local governments;

1 “(C) enhance intergovernmental coopera-
2 tion and coordination on the issue of alcohol
3 use among youth;

4 “(D) serve as a catalyst for increased citi-
5 zen participation and greater collaboration
6 among all sectors and organizations of a com-
7 munity that first demonstrates a long-term
8 commitment to reducing alcohol use among
9 youth;

10 “(E) implement state-of-the-art science-
11 based strategies to prevent and reduce underage
12 drinking by changing local conditions in com-
13 munities; and

14 “(F) enhance, not supplant, effective local
15 community initiatives for preventing and reduc-
16 ing alcohol use among youth.

17 “(3) APPLICATION.—An eligible entity desiring
18 an enhancement grant under this subsection shall
19 submit an application to the Assistant Secretary at
20 such time, and in such manner, and accompanied by
21 such information and assurances, as the Assistant
22 Secretary may require. Each application shall in-
23 clude—

24 “(A) a complete description of the entity’s
25 current underage alcohol use prevention initia-

1 tives and how the grant will appropriately en-
2 hance the focus on underage drinking issues; or

3 “(B) a complete description of the entity’s
4 current initiatives, and how it will use this
5 grant to enhance those initiatives by adding a
6 focus on underage drinking prevention.

7 “(4) USES OF FUNDS.—Each eligible entity
8 that receives a grant under this subsection shall use
9 the grant funds to carry out the activities described
10 in such entity’s application submitted pursuant to
11 paragraph (3) and obtain specialized training and
12 technical assistance by the entity funded under sec-
13 tion 4 of Public Law 107–82, as amended (21
14 U.S.C. 1521 note). Grants under this subsection
15 shall not exceed \$60,000 per year and may not ex-
16 ceed four years.

17 “(5) SUPPLEMENT NOT SUPPLANT.—Grant
18 funds provided under this subsection shall be used to
19 supplement, not supplant, Federal and non-Federal
20 funds available for carrying out the activities de-
21 scribed in this subsection.

22 “(6) EVALUATION.—Grants under this sub-
23 section shall be subject to the same evaluation re-
24 quirements and procedures as the evaluation re-

1 requirements and procedures imposed on recipients of
2 drug-free community grants.

3 “(7) DEFINITIONS.—For purposes of this sub-
4 section, the term ‘eligible entity’ means an organiza-
5 tion that is currently receiving or has received grant
6 funds under the Drug-Free Communities Act of
7 1997.

8 “(8) ADMINISTRATIVE EXPENSES.—Not more
9 than 6 percent of a grant under this subsection may
10 be expended for administrative expenses.

11 “(9) AUTHORIZATION OF APPROPRIATIONS.—
12 There is authorized to be appropriated to carry out
13 this subsection \$11,500,000 for each of fiscal years
14 2023 through 2027.

15 “(f) GRANTS TO PROFESSIONAL PEDIATRIC PRO-
16 VIDER ORGANIZATIONS TO REDUCE UNDERAGE DRINK-
17 ING THROUGH SCREENING AND BRIEF INTERVEN-
18 TIONS.—

19 “(1) IN GENERAL.—The Secretary, acting
20 through the Assistant Secretary for Mental Health
21 and Substance Use, shall make one or more grants
22 to professional pediatric provider organizations to in-
23 crease among the members of such organizations ef-
24 fective practices to reduce the prevalence of alcohol

1 use among individuals under the age of 21, including
2 college students.

3 “(2) PURPOSES.—Grants under this subsection
4 shall be made to promote the practices of—

5 “(A) screening adolescents for alcohol use;

6 “(B) offering brief interventions to adoles-
7 cents to discourage such use;

8 “(C) educating parents about the dangers
9 of and methods of discouraging such use;

10 “(D) diagnosing and treating alcohol use
11 disorders; and

12 “(E) referring patients, when necessary, to
13 other appropriate care.

14 “(3) USE OF FUNDS.—A professional pediatric
15 provider organization receiving a grant under this
16 section may use the grant funding to promote the
17 practices specified in paragraph (2) among its mem-
18 bers by—

19 “(A) providing training to health care pro-
20 viders;

21 “(B) disseminating best practices, includ-
22 ing culturally and linguistically appropriate best
23 practices, and developing, printing, and distrib-
24 uting materials; and

1 “(C) supporting other activities approved
2 by the Assistant Secretary.

3 “(4) APPLICATION.—To be eligible to receive a
4 grant under this subsection, a professional pediatric
5 provider organization shall submit an application to
6 the Assistant Secretary at such time, and in such
7 manner, and accompanied by such information and
8 assurances as the Secretary may require. Each ap-
9 plication shall include—

10 “(A) a description of the pediatric provider
11 organization;

12 “(B) a description of the activities to be
13 completed that will promote the practices speci-
14 fied in paragraph (2);

15 “(C) a description of the organization’s
16 qualifications for performing such practices;
17 and

18 “(D) a timeline for the completion of such
19 activities.

20 “(5) DEFINITIONS.—For the purpose of this
21 subsection:

22 “(A) BRIEF INTERVENTION.—The term
23 ‘brief intervention’ means, after screening a pa-
24 tient, providing the patient with brief advice
25 and other brief motivational enhancement tech-

1 niques designed to increase the insight of the
2 patient regarding the patient’s alcohol use, and
3 any realized or potential consequences of such
4 use to effect the desired related behavioral
5 change.

6 “(B) ADOLESCENTS.—The term ‘adoles-
7 cents’ means individuals under 21 years of age.

8 “(C) PROFESSIONAL PEDIATRIC PROVIDER
9 ORGANIZATION.—The term ‘professional pedi-
10 atric provider organization’ means an organiza-
11 tion or association that—

12 “(i) consists of or represents pediatric
13 health care providers; and

14 “(ii) is qualified to promote the prac-
15 tices specified in paragraph (2).

16 “(D) SCREENING.—The term ‘screening’
17 means using validated patient interview tech-
18 niques to identify and assess the existence and
19 extent of alcohol use in a patient.

20 “(6) AUTHORIZATION OF APPROPRIATIONS.—
21 There is authorized to be appropriated to carry out
22 this subsection \$3,000,000 for each of fiscal years
23 2023 through 2027.

24 “(g) DATA COLLECTION AND RESEARCH.—

1 “(1) ADDITIONAL RESEARCH ON UNDERAGE
2 DRINKING.—

3 “(A) IN GENERAL.—The Secretary shall,
4 subject to the availability of appropriations, col-
5 lect data, and conduct or support research that
6 is not duplicative of research currently being
7 conducted or supported by the Department of
8 Health and Human Services, on underage
9 drinking, with respect to the following:

10 “(i) Improve data collection in sup-
11 port of evaluation of the effectiveness of
12 comprehensive community-based programs
13 or strategies and statewide systems to pre-
14 vent and reduce underage drinking, across
15 the underage years from early childhood to
16 age 21, such as programs funded and im-
17 plemented by governmental entities, public
18 health interest groups and foundations,
19 and alcohol beverage companies and trade
20 associations, through the development of
21 models of State-level epidemiological sur-
22 veillance of underage drinking by funding
23 in States or large metropolitan areas new
24 epidemiologists focused on excessive drink-
25 ing including underage alcohol use.

1 “(ii) Obtain and report more precise
2 information than is currently collected on
3 the scope of the underage drinking prob-
4 lem and patterns of underage alcohol con-
5 sumption, including improved knowledge
6 about the problem and progress in pre-
7 venting, reducing, and treating underage
8 drinking, as well as information on the
9 rate of exposure of youth to advertising
10 and other media messages encouraging and
11 discouraging alcohol consumption.

12 “(iii) Synthesize, expand on, and
13 widely disseminate existing research on ef-
14 fective strategies for reducing underage
15 drinking, including translational research,
16 and make this research easily accessible to
17 the general public.

18 “(iv) Improve and conduct public
19 health surveillance on alcohol use and alco-
20 hol-related conditions in States by increas-
21 ing the use of surveys, such as the Behav-
22 ioral Risk Factor Surveillance System, to
23 monitor binge and excessive drinking and
24 related harms among individuals who are
25 at least 18 years of age, but not more than

1 20 years of age, including harm caused to
2 self or others as a result of alcohol use
3 that is not duplicative of research currently
4 being conducted or supported by the De-
5 partment of Health and Human Services.

6 “(B) AUTHORIZATION OF APPROPRIA-
7 TIONS.—There is authorized to be appropriated
8 to carry out this paragraph \$5,000,000 for each
9 of fiscal years 2023 through 2027.

10 “(2) NATIONAL ACADEMY OF SCIENCES
11 STUDY.—

12 “(A) IN GENERAL.—Not later than 12
13 months after the enactment of the Restoring
14 Hope for Mental Health and Well-Being Act of
15 2022, the Secretary shall—

16 “(i) contract with the National Acad-
17 emy of Sciences to study developments in
18 research on underage drinking and the
19 public policy implications of these develop-
20 ments; and

21 “(ii) report to the Congress on the re-
22 sults of such review.

23 “(B) AUTHORIZATION OF APPROPRIA-
24 TIONS.—There is authorized to be appropriated

1 to carry out this paragraph \$500,000 for fiscal
2 year 2023.”.

3 **SEC. 216. GRANTS FOR JAIL DIVERSION PROGRAMS.**

4 Section 520G of the Public Health Service Act (42
5 U.S.C. 290bb–38) is amended—

6 (1) in subsection (a)—

7 (A) by striking “up to 125”; and

8 (B) by striking “tribes and tribal organiza-
9 tions” and inserting “Tribes and Tribal organi-
10 zations”;

11 (2) in subsection (b)(2), by striking “tribes, and
12 tribal organizations” and inserting “Tribes, and
13 Tribal organizations”;

14 (3) in subsection (c)—

15 (A) in paragraph (1), by striking “tribe or
16 tribal organization” and inserting “Tribe or
17 Tribal organization, health facility or program
18 described in subsection (a), or public or non-
19 profit entity referred to in subsection (a)”;

20 (B) in paragraph (2)(A)(iii), by striking
21 “tribe, or tribal organization” and inserting
22 “Tribe, or Tribal organization”;

23 (4) in subsection (e)—

1 (A) in the matter preceding paragraph (1),
2 by striking “tribe, or tribal organization” and
3 inserting “Tribe, or Tribal organization”; and

4 (B) in paragraph (5), by striking “or ar-
5 rest” and inserting “, arrest, or release”;

6 (5) in subsection (f), by striking “tribe, or trib-
7 al organization” each place it appears and inserting
8 “Tribe, or Tribal organization”;

9 (6) in subsection (h), by striking “tribe, or trib-
10 al organization” and inserting “Tribe, or Tribal or-
11 ganization”; and

12 (7) in subsection (j), by striking “\$4,269,000
13 for each of fiscal years 2018 through 2022” and in-
14 serting “\$14,000,000 for each of fiscal years 2023
15 through 2027”.

16 **SEC. 217. FORMULA GRANTS TO STATES.**

17 Section 521 of the Public Health Service Act (42
18 U.S.C. 290cc–21) is amended by striking “2018 through
19 2022” and inserting “2023 through 2027”.

20 **SEC. 218. PROJECTS FOR ASSISTANCE IN TRANSITION**
21 **FROM HOMELESSNESS.**

22 Section 535(a) of the Public Health Service Act (42
23 U.S.C. 290cc–35(a)) is amended by striking “2018
24 through 2022” and inserting “2023 through 2027”.

1 **SEC. 219. GRANTS FOR REDUCING OVERDOSE DEATHS.**

2 (a) GRANTS.—

3 (1) REPEAL OF MAXIMUM GRANT AMOUNT.—
4 Paragraph (2) of section 544(a) of the Public
5 Health Service Act (42 U.S.C. 290dd–3(a)) is here-
6 by repealed.

7 (2) ELIGIBLE ENTITY; SUBGRANTS.—Section
8 544(a) of the Public Health Service Act (42 U.S.C.
9 290dd–3(a)) is amended by striking paragraph (3)
10 and inserting the following:

11 “(2) ELIGIBLE ENTITY.—For purposes of this
12 section, the term ‘eligible entity’ means a State, Ter-
13 ritory, locality, Indian Tribe (as defined in the Fed-
14 erally Recognized Indian Tribe List Act of 1994),
15 Tribal organization, or Urban Indian organization
16 (as those terms are defined in section 4 of the In-
17 dian Health Care Improvement Act).

18 “(3) SUBGRANTS.—For the purposes for which
19 a grant is awarded under this section, the eligible
20 entity receiving the grant may award subgrants to a
21 Federally qualified health center (as defined in sec-
22 tion 1861(aa) of the Social Security Act), an opioid
23 treatment program (as defined in section 8.2 of title
24 42, Code of Federal Regulations (or any successor
25 regulations)), any practitioner dispensing narcotic
26 drugs pursuant to section 303(g) of the Controlled

1 Substances Act, or any nonprofit organization that
2 the Secretary deems appropriate.”.

3 (3) PRESCRIBING.—Section 544(a)(4) of the
4 Public Health Service Act (42 U.S.C. 290dd–
5 3(a)(4)) is amended—

6 (A) in subparagraph (A), by inserting “,
7 including patients prescribed with both an
8 opioid and a benzodiazepine” before the semi-
9 colon at the end; and

10 (B) in subparagraph (D), by striking
11 “drug overdose” and inserting “substance over-
12 dose”.

13 (4) USE OF FUNDS.—Paragraph (5) of section
14 544(c) of the Public Health Service Act (42 U.S.C.
15 290dd–3(c)) is amended to read as follows:

16 “(5) To establish protocols to connect patients
17 who have experienced an overdose with appropriate
18 treatment, including overdose reversal medications,
19 medication assisted treatment, and appropriate
20 counseling and behavioral therapies.”.

21 (5) IMPROVING ACCESS TO OVERDOSE TREAT-
22 MENT.—Section 544 of the Public Health Service
23 Act (42 U.S.C. 290dd–3) is amended—

1 (A) by redesignating subsections (d)
2 through (f) as subsections (e) through (g), re-
3 spectively;

4 (B) in subsection (f), as so redesignated,
5 by striking “subsection (d)” and inserting “sub-
6 section (e)”; and

7 (C) by inserting after subsection (c) the
8 following:

9 “(d) IMPROVING ACCESS TO OVERDOSE TREAT-
10 MENT.—

11 “(1) INFORMATION ON BEST PRACTICES.—

12 “(A) HEALTH AND HUMAN SERVICES.—

13 The Secretary of Health and Human Services
14 may provide information to States, localities,
15 Indian Tribes, Tribal organizations, and Urban
16 Indian organizations on best practices for pre-
17 scribing or co-prescribing a drug or device ap-
18 proved, cleared, or otherwise authorized under
19 the Federal Food, Drug, and Cosmetic Act for
20 emergency treatment of known or suspected
21 opioid overdose, including for patients receiving
22 chronic opioid therapy and patients being treat-
23 ed for opioid use disorders.

24 “(B) DEFENSE.—The Secretary of De-
25 fense may provide information to prescribers

1 within Department of Defense medical facilities
2 on best practices for prescribing or co-pre-
3 scribing a drug or device approved, cleared, or
4 otherwise authorized under the Federal Food,
5 Drug, and Cosmetic Act for emergency treat-
6 ment of known or suspected opioid overdose, in-
7 cluding for patients receiving chronic opioid
8 therapy and patients being treated for opioid
9 use disorders.

10 “(C) VETERANS AFFAIRS.—The Secretary
11 of Veterans Affairs may provide information to
12 prescribers within Department of Veterans Af-
13 fairs medical facilities on best practices for pre-
14 scribing or co-prescribing a drug or device ap-
15 proved, cleared, or otherwise authorized under
16 the Federal Food, Drug, and Cosmetic Act for
17 emergency treatment of known or suspected
18 opioid overdose, including for patients receiving
19 chronic opioid therapy and patients being treat-
20 ed for opioid use disorders.

21 “(2) RULE OF CONSTRUCTION.—Nothing in
22 this subsection shall be construed as establishing or
23 contributing to a medical standard of care.”.

24 (6) AUTHORIZATION OF APPROPRIATIONS.—
25 Section 544(g) of the Public Health Service Act (42

1 U.S.C. 290dd-3), as redesignated, is amended by
2 striking “fiscal years 2017 through 2021” and in-
3 serting “fiscal years 2023 through 2027”.

4 (7) TECHNICAL AMENDMENTS.—

5 (A) Section 544 of the Public Health Serv-
6 ice Act (42 U.S.C. 290dd-3), as amended, is
7 further amended by striking “approved or
8 cleared” each place it appears and inserting
9 “approved, cleared, or otherwise authorized”.

10 (B) Section 107 of the Comprehensive Ad-
11 diction and Recovery Act of 2016 (Public Law
12 114-198) is amended by striking subsection
13 (b).

14 **SEC. 220. OPIOID OVERDOSE REVERSAL MEDICATION AC-**
15 **CESS AND EDUCATION GRANT PROGRAMS.**

16 (a) GRANTS.—Section 545 of the Public Health Serv-
17 ice Act (42 U.S.C. 290ee) is amended—

18 (1) in the section heading, by striking “**AC-**
19 **CESS AND EDUCATION GRANT PROGRAMS**” and
20 inserting “**ACCESS, EDUCATION, AND CO-PRE-**
21 **SCRIBING GRANT PROGRAMS**”;

22 (2) in the heading of subsection (a), by striking
23 “GRANTS TO STATES” and inserting “GRANTS”;

24 (3) in subsection (a), by striking “shall make
25 grants to States” and inserting “shall make grants

1 to States, localities, Indian Tribes (as defined by the
2 Federally Recognized Indian Tribe List Act of
3 1994), Tribal organizations, and Urban Indian orga-
4 nizations (as those terms are defined in section 4 of
5 the Indian Health Care Improvement Act)”;

6 (4) in subsection (a)(1), by striking “implement
7 strategies for pharmacists to dispense a drug or de-
8 vice” and inserting “implement strategies that in-
9 crease access to drugs or devices”;

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

12 (6) by inserting after paragraph (2) the fol-
13 lowing:

14 “(3) encourage health care providers to co-pre-
15 scribe, as appropriate, drugs or devices approved,
16 cleared, or otherwise authorized under the Federal
17 Food, Drug, and Cosmetic Act for emergency treat-
18 ment of known or suspected opioid overdose;”.

19 (b) GRANT PERIOD.—Section 545(d)(2) of the Public
20 Health Service Act (42 U.S.C. 290ee(d)(2)) is amended
21 by striking “3 years” and inserting “5 years”.

22 (c) LIMITATION.—Paragraph (3) of section 545(d) of
23 the Public Health Service Act (42 U.S.C. 290ee(d)) is
24 amended to read as follows:

25 “(3) LIMITATIONS.—A State may—

1 “(A) use not more than 10 percent of a
2 grant under this section for educating the pub-
3 lic pursuant to subsection (a)(5); and

4 “(B) use not less than 20 percent of a
5 grant under this section to offset cost-sharing
6 for distribution and dispensing of drugs or de-
7 vices approved, cleared, or otherwise authorized
8 under the Federal Food, Drug, and Cosmetic
9 Act for emergency treatment of known or sus-
10 pected opioid overdose.”.

11 (d) **AUTHORIZATION OF APPROPRIATIONS.**—Section
12 545(h)(1) of the Public Health Service Act, is amended
13 by striking “fiscal years 2017 through 2019” and insert-
14 ing “fiscal years 2023 through 2027”.

15 (e) **TECHNICAL AMENDMENT.**—Section 545 of the
16 Public Health Service Act (42 U.S.C. 290ee), as amended,
17 is further amended by striking “approved or cleared” each
18 place it appears and inserting “approved, cleared, or oth-
19 erwise authorized”.

20 **SEC. 221. STATE DEMONSTRATION GRANTS FOR COM-**
21 **PREHENSIVE OPIOID ABUSE RESPONSE.**

22 Section 548 of the Public Health Service Act (42
23 U.S.C. 290ee–3) is amended—

24 (1) in the section heading, by striking
25 “**ABUSE**” and inserting “**USE DISORDER**”;

1 (2) in subsection (b)—

2 (A) in the subsection heading, by striking
3 “ABUSE” and inserting “USE DISORDER”;

4 (B) in paragraph (1), by striking “abuse”
5 and inserting “use disorder”;

6 (C) in paragraph (2)—

7 (i) in the matter preceding subpara-
8 graph (A), by striking “abuse” and insert-
9 ing “use disorder”;

10 (ii) in subparagraph (A), by striking
11 “opioid use, treatment, and addiction re-
12 covery” and inserting “opioid use dis-
13 orders, and treatment for, and recovery
14 from opioid use disorders”;

15 (iii) in subparagraph (C), by striking
16 “addiction” each place it appears and in-
17 serting “use disorder”;

18 (iv) by amending subparagraph (D) to
19 read as follows:

20 “(D) developing, implementing, and ex-
21 panding efforts to prevent overdose death from
22 opioid or other prescription medication use dis-
23 orders; and”;

1 (v) in subparagraph (E), by striking
2 “abuse” and inserting “use disorders”;
3 and
4 (D) in paragraph (4), by striking “abuse”
5 each place it appears and inserting “use dis-
6 orders”; and
7 (3) by striking “2017 through 2021” and in-
8 serting “2023 through 2027”.

9 **SEC. 222. EMERGENCY DEPARTMENT ALTERNATIVES TO**
10 **OPIOIDS.**

11 Section 7091 of the SUPPORT for Patients and
12 Communities Act (Public Law 115–271) is amended—

13 (1) in the section heading, by striking “**DEM-**
14 **ONSTRATION**” (and by conforming the item relat-
15 ing to such section in the table of contents in section
16 1(b));

17 (2) in subsection (a)—

18 (A) by amending the subsection heading to
19 read as follows: “GRANT PROGRAM”; and

20 (B) in paragraph (1), by striking “dem-
21 onstration”;

22 (3) in subsection (b), in the subsection heading,
23 by striking “DEMONSTRATION”;

24 (4) in subsection (d)(4), by striking “tribal”
25 and inserting “Tribal”;

1 (5) in subsection (f), by striking “Not later
2 than 1 year after completion of the demonstration
3 program under this section, the Secretary shall sub-
4 mit a report to the Congress on the results of the
5 demonstration program” and inserting “Not later
6 than the end of each of fiscal years 2024 and 2027,
7 the Secretary shall submit to the Congress a report
8 on the results of the program”; and

9 (6) in subsection (g), by striking “2019 through
10 2021” and inserting “2023 through 2027”.

11 **Subtitle C—Excellence in Recovery** 12 **Housing**

13 **SEC. 231. CLARIFYING THE ROLE OF SAMHSA IN PRO-** 14 **MOTING THE AVAILABILITY OF HIGH-QUAL-** 15 **ITY RECOVERY HOUSING.**

16 Section 501(d) of the Public Health Service Act (42
17 U.S.C. 290aa) is amended—

18 (1) in paragraph (24)(E), by striking “and” at
19 the end;

20 (2) in paragraph (25), by striking the period at
21 the end and inserting “; and”; and

22 (3) by adding at the end the following:

23 “(26) collaborate with national accrediting enti-
24 ties, reputable providers, organizations or individuals
25 with established expertise in delivery of recovery

1 housing services, States, Federal agencies (including
2 the Department of Health and Human Services, the
3 Department of Housing and Urban Development,
4 and the agencies listed in section 550(e)(2)(B)), and
5 other relevant stakeholders, to promote the avail-
6 ability of high-quality recovery housing and services
7 for individuals with a substance use disorder.”.

8 **SEC. 232. DEVELOPING GUIDELINES FOR STATES TO PRO-**
9 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
10 **RECOVERY HOUSING.**

11 Section 550(a) of the Public Health Service Act (42
12 U.S.C. 290ee–5(a)) (relating to national recovery housing
13 best practices) is amended—

14 (1) by amending paragraph (1) to read as fol-
15 lows:

16 “(1) IN GENERAL.—The Secretary, in consulta-
17 tion with the individuals and entities specified in
18 paragraph (2), shall build on existing best practices
19 and previously developed guidelines to develop and
20 periodically update consensus-based best practices,
21 which may include model laws for implementing sug-
22 gested minimum standards for operating, and pro-
23 moting the availability of, high-quality recovery
24 housing.”;

25 (2) in paragraph (2)—

1 (A) by striking subparagraphs (A) and (B)
2 and inserting the following:

3 “(A) Officials representing the agencies de-
4 scribed in subsection (e)(2).”; and

5 (B) by redesignating subparagraphs (C)
6 through (G) as subparagraphs (B) through (F),
7 respectively; and

8 (3) by adding at the end the following:

9 “(3) AVAILABILITY.—The best practices re-
10 ferred to in paragraph (1) shall be—

11 “(A) made publicly available; and

12 “(B) published on the public website of the
13 Substance Abuse and Mental Health Services
14 Administration.

15 “(4) EXCLUSION OF GUIDELINE ON TREAT-
16 MENT SERVICES.—In developing the guidelines
17 under paragraph (1), the Secretary may not include
18 any guidelines with respect to substance use disorder
19 treatment services.”.

20 **SEC. 233. COORDINATION OF FEDERAL ACTIVITIES TO PRO-**
21 **MOTE THE AVAILABILITY OF RECOVERY**
22 **HOUSING.**

23 Section 550 of the Public Health Service Act (42
24 U.S.C. 290ee–5) (relating to national recovery housing
25 best practices) is amended—

1 (1) by redesignating subsections (e), (f), and
2 (g) as subsections (g), (h), and (i), respectively; and

3 (2) by inserting after subsection (d) the fol-
4 lowing:

5 “(e) COORDINATION OF FEDERAL ACTIVITIES TO
6 PROMOTE THE AVAILABILITY OF HOUSING FOR INDIVID-
7 UALS EXPERIENCING HOMELESSNESS, INDIVIDUALS
8 WITH A MENTAL ILLNESS, AND INDIVIDUALS WITH A
9 SUBSTANCE USE DISORDER.—

10 “(1) IN GENERAL.—The Secretary, acting
11 through the Assistant Secretary, and the Secretary
12 of Housing and Urban Development shall convene
13 an interagency working group for the following pur-
14 poses:

15 “(A) To increase collaboration, coopera-
16 tion, and consultation among the Department
17 of Health and Human Services, the Department
18 of Housing and Urban Development, and the
19 Federal agencies listed in paragraph (2)(B),
20 with respect to promoting the availability of
21 housing, including recovery housing, for individ-
22 uals experiencing homelessness, individuals with
23 mental illnesses, and individuals with substance
24 use disorder.

1 “(B) To align the efforts of such agencies
2 and avoid duplication of such efforts by such
3 agencies.

4 “(C) To develop objectives, priorities, and
5 a long-term plan for supporting State, Tribal,
6 and local efforts with respect to the operation
7 of recovery housing that is consistent with the
8 best practices developed under this section.

9 “(D) To coordinate enforcement of fair
10 housing practices, as appropriate, among Fed-
11 eral and State agencies.

12 “(E) To coordinate data collection on the
13 quality of recovery housing.

14 “(2) COMPOSITION.—The interagency working
15 group under paragraph (1) shall be composed of—

16 “(A) the Secretary, acting through the As-
17 sistant Secretary, and the Secretary of Housing
18 and Urban Development, who shall serve as the
19 co-chairs; and

20 “(B) representatives of each of the fol-
21 lowing Federal agencies:

22 “(i) The Centers for Medicare & Med-
23 icaid Services.

24 “(ii) The Substance Abuse and Men-
25 tal Health Services Administration.

1 “(iii) The Health Resources and Serv-
2 ices Administration.

3 “(iv) The Office of Inspector General.

4 “(v) The Indian Health Service.

5 “(vi) The Department of Agriculture.

6 “(vii) The Department of Justice.

7 “(viii) The Office of National Drug
8 Control Policy.

9 “(ix) The Bureau of Indian Affairs.

10 “(x) The Department of Labor.

11 “(xi) The Department of Veterans Af-
12 fairs.

13 “(xii) Any other Federal agency as
14 the co-chairs determine appropriate.

15 “(3) MEETINGS.—The working group shall
16 meet on a quarterly basis.

17 “(4) REPORTS TO CONGRESS.—Not later than
18 4 years after the date of the enactment of this sec-
19 tion, the working group shall submit to the Com-
20 mittee on Energy and Commerce, the Committee on
21 Ways and Means, the Committee on Agriculture,
22 and the Committee on Financial Services of the
23 House of Representatives and the Committee on
24 Health, Education, Labor, and Pensions, the Com-
25 mittee on Agriculture, Nutrition, and Forestry, and

1 the Committee on Finance of the Senate a report
2 describing the work of the working group and any
3 recommendations of the working group to improve
4 Federal, State, and local coordination with respect
5 to recovery housing and other housing resources and
6 operations for individuals experiencing homelessness,
7 individuals with a mental illness, and individuals
8 with a substance use disorder.”.

9 **SEC. 234. NAS STUDY AND REPORT.**

10 (a) IN GENERAL.—Not later than 60 days after the
11 date of enactment of this Act, the Secretary of Health and
12 Human Services, acting through the Assistant Secretary
13 for Mental Health and Substance Use shall—

14 (1) contract with the National Academies of
15 Sciences, Engineering, and Medicine—

16 (A) to study the quality and effectiveness
17 of recovery housing in the United States and
18 whether the availability of such housing meets
19 demand; and

20 (B) to identify recommendations to pro-
21 mote the availability of high-quality recovery
22 housing; and

23 (2) report to the Congress on the results of
24 such review.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section there is authorized to be appropriated
3 \$1,500,000 for fiscal year 2023.

4 **SEC. 235. GRANTS FOR STATES TO PROMOTE THE AVAIL-**
5 **ABILITY OF RECOVERY HOUSING AND SERV-**
6 **ICES.**

7 Section 550 of the Public Health Service Act (42
8 U.S.C. 290ee–5) (relating to national recovery housing
9 best practices), as amended by sections 232 and 233, is
10 further amended by inserting after subsection (e) (as in-
11 serted by section 233) the following:

12 “(f) GRANTS FOR IMPLEMENTING NATIONAL RECOV-
13 ERY HOUSING BEST PRACTICES.—

14 “(1) IN GENERAL.—The Secretary shall award
15 grants to States (and political subdivisions thereof),
16 Tribes, and territories—

17 “(A) for the provision of technical assist-
18 ance to implement the guidelines and rec-
19 ommendations developed under subsection (a);
20 and

21 “(B) to promote—

22 “(i) the availability of recovery hous-
23 ing for individuals with a substance use
24 disorder; and

1 “(ii) the maintenance of recovery
2 housing in accordance with best practices
3 developed under this section.

4 “(2) STATE PROMOTION PLANS.—Not later
5 than 90 days after receipt of a grant under para-
6 graph (1), and every 2 years thereafter, each State
7 (or political subdivisions thereof,) Tribe, or territory
8 receiving a grant under paragraph (1) shall submit
9 to the Secretary, and publish on a publicly accessible
10 internet website of the State (or political subdivi-
11 sions thereof), Tribe, or territory—

12 “(A) the plan of the State (or political sub-
13 divisions thereof), Tribe, or territory, with re-
14 spect to the promotion of recovery housing for
15 individuals with a substance use disorder lo-
16 cated within the jurisdiction of such State (or
17 political subdivisions thereof), Tribe, or terri-
18 tory; and

19 “(B) a description of how such plan is con-
20 sistent with the best practices developed under
21 this section.”.

22 **SEC. 236. FUNDING.**

23 Subsection (i) of section 550 of the Public Health
24 Service Act (42 U.S.C. 290ee–5) (relating to national re-
25 covery housing best practices), as redesignated by section

1 233, is amended by striking “\$3,000,000 for the period
2 of fiscal years 2019 through 2021” and inserting
3 “\$5,000,000 for the period of fiscal years 2023 through
4 2027”.

5 **SEC. 237. TECHNICAL CORRECTION.**

6 Title V of the Public Health Service Act (42 U.S.C.
7 290aa et seq.) is amended—

8 (1) by redesignating section 550 (relating to
9 Sobriety Treatment and Recovery Teams) (42
10 U.S.C. 290ee–10), as added by section 8214 of Pub-
11 lic Law 115–271, as section 550A; and

12 (2) by moving such section so it appears after
13 section 550 (relating to national recovery housing
14 best practices).

15 **Subtitle D—Substance Use Preven-**
16 **tion, Treatment, and Recovery**
17 **Services Block Grant**

18 **SEC. 241. ELIMINATING STIGMATIZING LANGUAGE RELAT-**
19 **ING TO SUBSTANCE USE.**

20 (a) BLOCK GRANTS FOR PREVENTION AND TREAT-
21 MENT OF SUBSTANCE USE.—Part B of title XIX of the
22 Public Health Service Act (42 U.S.C. 300x et seq.) is
23 amended—

1 (1) in the part heading, by striking “**SUB-**
2 **STANCE ABUSE**” and inserting “**SUBSTANCE**
3 **USE**”;

4 (2) in subpart II, by amending the subpart
5 heading to read as follows: “**Block Grants for**
6 **Substance Use Prevention, Treatment,**
7 **and Recovery Services**”;

8 (3) in section 1922(a) (42 U.S.C. 300x-
9 22(a))—

10 (A) in paragraph (1), in the matter pre-
11 ceeding subparagraph (A), by striking “sub-
12 stance abuse” and inserting “substance use dis-
13 orders”; and

14 (B) by striking “such abuse” each place it
15 appears in paragraphs (1) and (2) and insert-
16 ing “such disorders”;

17 (4) in section 1923 (42 U.S.C. 300x-23)—

18 (A) in the section heading, by striking
19 “**SUBSTANCE ABUSE**” and inserting “**SUB-**
20 **STANCE USE**”; and

21 (B) in subsection (a), by striking “drug
22 abuse” and inserting “substance use disorders”;

23 (5) in section 1925(a)(1) (42 U.S.C. 300x-
24 25(a)(1)), by striking “alcohol or drug abuse” and
25 inserting “alcohol or other substance use disorders”;

1 (6) in section 1926(b)(2)(B) (42 U.S.C. 300x–
2 26(b)(2)(B)), by striking “substance abuse”;

3 (7) in section 1931(b)(2) (42 U.S.C. 300x–
4 31(b)(2)), by striking “substance abuse” and insert-
5 ing “substance use disorders”;

6 (8) in section 1933(d)(1) (42 U.S.C. 300x–
7 33(d)), in the matter following subparagraph (B), by
8 striking “abuse of alcohol and other drugs” and in-
9 serting “use of substances”;

10 (9) by amending paragraph (4) of section 1934
11 (42 U.S.C. 300x–34) to read as follows:

12 “(4) The term ‘substance use disorder’ means
13 the recurrent use of alcohol or other drugs that
14 causes clinically significant impairment.”;

15 (10) in section 1935 (42 U.S.C. 300x–35)—

16 (A) in subsection (a), by striking “sub-
17 stance abuse” and inserting “substance use dis-
18 orders”; and

19 (B) in subsection (b)(1), by striking “sub-
20 stance abuse” each place it appears and insert-
21 ing “substance use disorders”;

22 (11) in section 1949 (42 U.S.C. 300x–59), by
23 striking “substance abuse” each place it appears in
24 subsections (a) and (d) and inserting “substance use
25 disorders”;

1 (12) in section 1954(b)(4) (42 U.S.C. 300x–
2 64(b)(4))—

3 (A) by striking “substance abuse” and in-
4 serting “substance use disorders”; and

5 (B) by striking “such abuse” and inserting
6 “such disorders”;

7 (13) in section 1955 (42 U.S.C. 300x–65), by
8 striking “substance abuse” each place it appears
9 and inserting “substance use disorder”; and

10 (14) in section 1956 (42 U.S.C. 300x–66), by
11 striking “substance abuse” and inserting “substance
12 use disorders”.

13 (b) CERTAIN PROGRAMS REGARDING MENTAL
14 HEALTH AND SUBSTANCE ABUSE.—Part C of title XIX
15 of the Public Health Service Act (42 U.S.C. 300y et seq.)
16 is amended—

17 (1) in the part heading, by striking “**SUB-**
18 **STANCE ABUSE**” and inserting “**SUBSTANCE**
19 **USE**”;

20 (2) in section 1971 (42 U.S.C. 300y), by strik-
21 ing “substance abuse” each place it appears in sub-
22 sections (a), (b), and (f) and inserting “substance
23 use”; and

1 (3) in section 1976 (42 U.S.C. 300y–11), by
2 striking “intravenous abuse” each place it appears
3 and inserting “intravenous use”.

4 **SEC. 242. AUTHORIZED ACTIVITIES.**

5 Section 1921(b) of the Public Health Service Act (42
6 U.S.C. 300x–21(b)) is amended by striking “prevent and
7 treat substance use disorders” and inserting “prevent,
8 treat, and provide recovery support services for substance
9 use disorders”.

10 **SEC. 243. REQUIREMENTS RELATING TO CERTAIN INFEC-**
11 **TIOUS DISEASES AND HUMAN IMMUNO-**
12 **DEFICIENCY VIRUS.**

13 Section 1924 of the Public Health Service Act (42
14 U.S.C. 300x–24) is amended—

15 (1) in the section heading, by striking “**TUBER-**
16 **CULOSIS AND HUMAN IMMUNODEFICIENCY**
17 **VIRUS**” and inserting “**TUBERCULOSIS, VIRAL**
18 **HEPATITIS, AND HUMAN IMMUNODEFICIENCY**
19 **VIRUS**”;

20 (2) by amending subsection (a)(2) to read as
21 follows:

22 “(2) DESIGNATED STATES.—

23 “(A) FISCAL YEARS THROUGH FISCAL
24 YEAR 2024.—For purposes of this subsection,
25 through September 30, 2024, a State described

1 in this paragraph is any State whose rate of
2 cases of acquired immune deficiency syndrome
3 is 10 or more such cases per 100,000 individ-
4 uals (as indicated by the number of such cases
5 reported to and confirmed by the Director of
6 the Centers for Disease Control and Prevention
7 for the most recent calendar year for which
8 such data are available).

9 “(B) FISCAL YEAR 2025 AND SUCCEEDING
10 FISCAL YEARS.—

11 “(i) IN GENERAL.—Beginning with
12 fiscal year 2025, for purposes of this sub-
13 section, a State described in this para-
14 graph is any State whose rate of cases of
15 human immunodeficiency virus is 10 or
16 more such cases per 100,000 individuals
17 (as indicated by the number of such cases
18 newly reported to and confirmed by the Di-
19 rector of the Centers for Disease Control
20 and Prevention for the most recent cal-
21 endar year for which such data are avail-
22 able).

23 “(ii) CONTINUATION OF DESIGNATED
24 STATE STATUS.—In the case of a State
25 whose rate of cases of human immuno-

1 deficiency virus falls below the threshold
2 specified in clause (i) for a calendar year,
3 such State shall, notwithstanding clause
4 (i), continue to be described in this para-
5 graph unless the rate of cases falls below
6 such threshold for three consecutive cal-
7 endar years.”.

8 (3) by redesignating subsections (c) and (d) as
9 subsections (d) and (e), respectively; and

10 (4) by inserting after subsection (b) the fol-
11 lowing:

12 “(c) VIRAL HEPATITIS.—

13 “(1) IN GENERAL.—A funding agreement for a
14 grant under section 1921 is that the State involved
15 will require that any entity receiving amounts from
16 the grant for operating a program of treatment for
17 substance use disorders—

18 “(A) will, directly or through arrangements
19 with other public or nonprofit private entities,
20 routinely make available viral hepatitis services
21 to each individual receiving treatment for such
22 disorders; and

23 “(B) in the case of an individual in need
24 of such treatment who is denied admission to
25 the program on the basis of the lack of the ca-

1 capacity of the program to admit the individual,
2 will refer the individual to another provider of
3 viral hepatitis services.

4 “(2) VIRAL HEPATITIS SERVICES.—For pur-
5 poses of paragraph (1), the term ‘viral hepatitis
6 services’, with respect to an individual, means—

7 “(A) screening the individual for viral hep-
8 atitis; and

9 “(B) referring the individual to a provider
10 whose practice includes viral hepatitis vaccina-
11 tion and treatment.”.

12 **SEC. 244. STATE PLAN REQUIREMENTS.**

13 Section 1932(b)(1)(A) of the Public Health Service
14 Act (42 U.S.C. 300x–32(b)(1)(A)) is amended—

15 (1) by redesignating clauses (vi) through (ix) as
16 clauses (vii) through (x), respectively; and

17 (2) by inserting after clause (v) the following:

18 “(vi) provides a description of—

19 “(I) the State’s comprehensive
20 statewide recovery support services ac-
21 tivities, including the number of indi-
22 viduals being served, target popu-
23 lations, and priority needs; and

24 “(II) the amount of funds re-
25 ceived under this subpart expended on

1 recovery support services,
2 disaggregated by the amount ex-
3 pended for type of service activity;”.

4 **SEC. 245. UPDATING CERTAIN LANGUAGE RELATING TO**
5 **TRIBES.**

6 Section 1933(d) of the Public Health Service Act (42
7 U.S.C. 300x-33(d)) is amended—

8 (1) in paragraph (1)—

9 (A) in subparagraph (A)—

10 (i) by striking “of an Indian tribe or
11 tribal organization” and inserting “of an
12 Indian Tribe or Tribal organization”; and

13 (ii) by striking “such tribe” and in-
14 serting “such Tribe”;

15 (B) in subparagraph (B)—

16 (i) by striking “tribe or tribal organi-
17 zation” and inserting “Tribe or Tribal or-
18 ganization”; and

19 (ii) by striking “Secretary under this”
20 and inserting “Secretary under this sub-
21 part”; and

22 (C) in the matter following subparagraph
23 (B), by striking “tribe or tribal organization”
24 and inserting “Tribe or Tribal organization”;

1 (2) by amending paragraph (2) to read as fol-
2 lows:

3 “(2) INDIAN TRIBE OR TRIBAL ORGANIZATION
4 AS GRANTEE.—The amount reserved by the Sec-
5 retary on the basis of a determination under this
6 subsection shall be granted to the Indian Tribe or
7 Tribal organization serving the individuals for whom
8 such a determination has been made.”;

9 (3) in paragraph (3), by striking “tribe or trib-
10 al organization” and inserting “Tribe or Tribal or-
11 ganization”; and

12 (4) in paragraph (4)—

13 (A) in the paragraph heading, by striking
14 “DEFINITION” and inserting “DEFINITIONS”;
15 and

16 (B) by striking “The terms” and all that
17 follows through “given such terms” and insert-
18 ing the following: “The terms ‘Indian Tribe’
19 and ‘Tribal organization’ have the meanings
20 given the terms ‘Indian tribe’ and ‘tribal orga-
21 nization’ ”.

1 **SEC. 246. BLOCK GRANTS FOR SUBSTANCE USE PREVEN-**
2 **TION, TREATMENT, AND RECOVERY SERV-**
3 **ICES.**

4 (a) IN GENERAL.—Section 1935(a) of the Public
5 Health Service Act (42 U.S.C. 300x–35(a)), as amended
6 by section 241, is further amended by striking “appro-
7 priated” and all that follows through “2022..” and insert-
8 ing the following: “appropriated \$1,908,079,000 for each
9 of fiscal years 2023 through 2027.”.

10 (b) TECHNICAL CORRECTIONS.—Section
11 1935(b)(1)(B) of the Public Health Service Act (42
12 U.S.C. 300x–35(b)(1)(B)) is amended by striking “the
13 collection of data in this paragraph is”.

14 **SEC. 247. REQUIREMENT OF REPORTS AND AUDITS BY**
15 **STATES.**

16 Section 1942(a) of the Public Health Service Act (42
17 U.S.C. 300x–52(a)) is amended—

18 (1) in paragraph (1), by striking “and” at the
19 end;

20 (2) in paragraph (2), by striking the period at
21 the end and inserting “; and”; and

22 (3) by adding at the end the following:

23 “(3) the amount provided to each recipient in
24 the previous fiscal year.”.

1 **SEC. 248. STUDY ON ASSESSMENT FOR USE IN DISTRIBUTION OF LIMITED STATE RESOURCES.**
2

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services, acting through the Assistant Secretary
5 for Mental Health and Substance Use (in this section re-
6 ferred to as the “Secretary”), shall, in consultation with
7 States and other local entities providing prevention, treat-
8 ment, or recovery support services related to substance
9 use, conduct a study to develop a model needs assessment
10 process for States to consider to help determine how best
11 to allocate block grant funding received under subpart II
12 of part B of title XIX of the Public Health Service Act
13 (42 U.S.C. 300x–21) to provide services to substance use
14 disorder prevention, treatment, and recovery support. The
15 study shall include cost estimates with each model needs
16 assessment process.

17 (b) REPORT.—Not later than 2 years after the date
18 of the enactment of this Act, the Secretary shall submit
19 to the Committee on Energy and Commerce of the House
20 of Representatives and the Committee on Health, Edu-
21 cation, Labor, and Pensions of the Senate a report on the
22 results of the study conducted under paragraph (1).

1 **Subtitle E—Timely Treatment for**
2 **Opioid Use Disorder**

3 **SEC. 251. STUDY ON EXEMPTIONS FOR TREATMENT OF**
4 **OPIOID USE DISORDER THROUGH OPIOID**
5 **TREATMENT PROGRAMS DURING THE COVID–**
6 **19 PUBLIC HEALTH EMERGENCY.**

7 (a) STUDY.—The Assistant Secretary for Mental
8 Health and Substance Use shall conduct a study, in con-
9 sultation with patients and other stakeholders, on activi-
10 ties carried out pursuant to exemptions granted—

11 (1) to a State (including the District of Colum-
12 bia or any territory of the United States) or an
13 opioid treatment program;

14 (2) pursuant to section 8.11(h) of title 42, Code
15 of Federal Regulations; and

16 (3) during the period—

17 (A) beginning on the declaration of the
18 public health emergency for the COVID–19
19 pandemic under section 319 of the Public
20 Health Service Act (42 U.S.C. 247d); and

21 (B) ending on the earlier of—

22 (i) the termination of such public
23 health emergency, including extensions
24 thereof pursuant to such section 319; and

25 (ii) the end of calendar year 2022.

1 (b) PRIVACY.—The section does not authorize the
2 disclosure by the Department of Health and Human Serv-
3 ices of individually identifiable information about patients.

4 (c) FEEDBACK.—In conducting the study under sub-
5 section (a), the Assistant Secretary for Mental Health and
6 Substance Use shall gather feedback from the States and
7 opioid treatment programs on their experiences in imple-
8 menting exemptions described in subsection (a).

9 (d) REPORT.—Not later than 180 days after the end
10 of the period described in subsection (a)(3)(B), and sub-
11 ject to subsection (c), the Assistant Secretary for Mental
12 Health and Substance Use shall publish a report on the
13 results of the study under this section.

14 **SEC. 252. CHANGES TO FEDERAL OPIOID TREATMENT**
15 **STANDARDS.**

16 (a) MOBILE MEDICATION UNITS.—Section 302(e) of
17 the Controlled Substances Act (21 U.S.C. 822(e)) is
18 amended by adding at the end the following:

19 “(3) Notwithstanding paragraph (1), a registrant
20 that is dispensing pursuant to section 303(g) narcotic
21 drugs to individuals for maintenance treatment or detoxi-
22 fication treatment shall not be required to have a separate
23 registration to incorporate one or more mobile medication
24 units into the registrant’s practice to dispense such nar-
25 cotics at locations other than the registrant’s principal

1 place of business or professional practice described in
2 paragraph (1), so long as the registrant meets such stand-
3 ards for operation of a mobile medication unit as the At-
4 torney General may establish.”.

5 (b) REVISE OPIOID TREATMENT PROGRAM ADMIS-
6 SION CRITERIA TO ELIMINATE REQUIREMENT THAT PA-
7 TIENTS HAVE AN OPIOID USE DISORDER FOR AT LEAST
8 1 YEAR.—Not later than 18 months after the date of en-
9 actment of this Act, the Secretary of Health and Human
10 Services shall revise section 8.12(e)(1) of title 42, Code
11 of Federal Regulations (or successor regulations), to elimi-
12 nate the requirement that an opioid treatment program
13 only admit an individual for treatment under the program
14 if the individual has been addicted to opioids for at least
15 1 year before being so admitted for treatment.

16 (c) FINAL REGULATION ON PERIODS FOR TAKE-
17 HOME SUPPLY REQUIREMENTS.—

18 (1) IN GENERAL.—Not later than 18 months
19 after the date of enactment of this Act, the Sec-
20 retary of Health and Human Services shall promul-
21 gate a final regulation amending paragraphs (i)(3)(i)
22 through (i)(3)(vi) of section 8.12 of title 42, Code of
23 Federal Regulations, as appropriate based on the
24 findings of the study under section 251 of this Act.

1 (2) CRITERIA.—The regulation under para-
2 graph (1) shall establish relevant criteria for the
3 medical director or an appropriately licensed practi-
4 tioner of an opioid treatment program, to determine
5 whether a patient is stable and may qualify for un-
6 supervised use, which criteria may allow for consid-
7 eration of each of the following:

8 (A) Whether the benefits of providing un-
9 supervised doses to a patient outweigh the
10 risks.

11 (B) The patient’s demonstrated adherence
12 to their treatment plan.

13 (C) The patient’s history of negative toxico-
14 logy tests.

15 (D) Whether there is an absence of serious
16 behavioral problems.

17 (E) The patient’s stability in living ar-
18 rangements and social relationships.

19 (F) Whether there is an absence of sub-
20 stance misuse-related behaviors.

21 (G) Whether there is an absence of recent
22 diversion activity.

23 (H) Whether there is an assurance that
24 the medication can be safely stored by the pa-
25 tient.

1 (I) Any other criterion the Secretary of
2 Health and Human Services determines appro-
3 priate.

4 (3) PROHIBITED SOLE CONSIDERATION.—The
5 regulation under paragraph (1) shall prohibit the
6 medical director of an opioid treatment program
7 from considering, as the sole consideration in deter-
8 mining whether a patient is sufficiently responsible
9 in handling opioid drugs for unsupervised use,
10 whether the patient has an absence of recent misuse
11 of drugs (whether narcotic or nonnarcotic), including
12 alcohol.

13 **Subtitle F—Additional Provisions**
14 **Relating to Addiction Treatment**

15 **SEC. 261. PROHIBITION.**

16 Notwithstanding any provision of this Act and the
17 amendments made by this Act, no funds made available
18 to carry out this Act or any amendment made by this Act
19 shall be used to purchase, procure, or distribute pipes or
20 cylindrical objects intended to be used to smoke or inhale
21 illegal scheduled substances.

1 **SEC. 262. ELIMINATING ADDITIONAL REQUIREMENTS FOR**
2 **DISPENSING NARCOTIC DRUGS IN SCHEDULE**
3 **III, IV, AND V FOR MAINTENANCE OR DETOXI-**
4 **FICATION TREATMENT.**

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

7 (1) by striking paragraph (2);

8 (2) by striking “(g)(1) Except as provided in
9 paragraph (2), practitioners who dispense narcotic
10 drugs to individuals for maintenance treatment or
11 detoxification treatment” and inserting “(g) Practi-
12 tioners who dispense narcotic drugs (other than nar-
13 cotic drugs in schedule III, IV, or V) to individuals
14 for maintenance treatment or detoxification treat-
15 ment”;

16 (3) by redesignating subparagraphs (A), (B),
17 and (C) as paragraphs (1), (2), and (3), respectively;
18 and

19 (4) in paragraph (2), as so redesignated—

20 (A) by striking “(i) security of stocks” and
21 inserting “(A) security of stocks”; and

22 (B) by striking “(ii) the maintenance of
23 records” and inserting “(B) the maintenance of
24 records”.

25 (b) CONFORMING CHANGES.—

1 (1) Subsections (a) and (d)(1) of section 304 of
2 the Controlled Substances Act (21 U.S.C. 824) are
3 each amended by striking “303(g)(1)” each place it
4 appears and inserting “303(g)”.

5 (2) Section 309A(a)(2) of the Controlled Sub-
6 stances Act (21 U.S.C. 829a) is amended—

7 (A) in the matter preceding subparagraph

8 (A), by striking “the controlled substance is to
9 be administered for the purpose of maintenance
10 or detoxification treatment under section
11 303(g)(2)” and inserting “the controlled sub-
12 stance is a narcotic drug in schedule III, IV, or
13 V to be administered for the purpose of mainte-
14 nance or detoxification treatment”; and

15 (B) by striking “and—” and all that fol-
16 lows through “is to be administered by injection
17 or implantation;” and inserting “and is to be
18 administered by injection or implantation;”.

19 (3) Section 520E–4(c) of the Public Health
20 Service Act (42 U.S.C. 290bb–36d(c)) is amended
21 by striking “information on any qualified practi-
22 tioner that is certified to prescribe medication for
23 opioid dependency under section 303(g)(2)(B) of the
24 Controlled Substances Act” and inserting “informa-
25 tion on any practitioner who prescribes narcotic

1 drugs in schedule III, IV, or V of section 202 of the
2 Controlled Substances Act for the purpose of main-
3 tenance or detoxification treatment”.

4 (4) Section 544(a)(3) of the Public Health
5 Service Act (42 U.S.C. 290dd-3), as added by sec-
6 tion 219(a)(2), is amended by striking “any practi-
7 tioner dispensing narcotic drugs pursuant to section
8 303(g) of the Controlled Substances Act” and in-
9 serting “any practitioner dispensing narcotic drugs
10 for the purpose of maintenance or detoxification
11 treatment”.

12 (5) Section 1833(bb)(3)(B) of the Social Secu-
13 rity Act (42 U.S.C. 1395l(bb)(3)(B)) is amended by
14 striking “first receives a waiver under section 303(g)
15 of the Controlled Substances Act on or after Janu-
16 ary 1, 2019” and inserting “first begins prescribing
17 narcotic drugs in schedule III, IV, or V of section
18 202 of the Controlled Substances Act for the pur-
19 pose of maintenance or detoxification treatment on
20 or after January 1, 2021”.

21 (6) Section 1834(o)(3)(C)(ii) of the Social Se-
22 curity Act (42 U.S.C. 1395m(o)(3)(C)(ii)) is amend-
23 ed by striking “first receives a waiver under section
24 303(g) of the Controlled Substances Act on or after
25 January 1, 2019” and inserting “first begins pre-

1 scribing narcotic drugs in schedule III, IV, or V of
2 section 202 of the Controlled Substances Act for the
3 purpose of maintenance or detoxification treatment
4 on or after January 1, 2021”.

5 (7) Section 1866F(c)(3) of the Social Security
6 Act (42 U.S.C. 1395cc–6(c)(3)) is amended—

7 (A) in subparagraph (A), by adding “and”
8 at the end;

9 (B) in subparagraph (B), by striking “;
10 and” and inserting a period; and

11 (C) by striking subparagraph (C).

12 (8) Section 1903(aa)(2)(C) of the Social Secu-
13 rity Act (42 U.S.C. 1396b(aa)(2)(C)) is amended—

14 (A) in clause (i), by adding “and” at the
15 end;

16 (B) by striking clause (ii); and

17 (C) by redesignating clause (iii) as clause
18 (ii).

19 **SEC. 263. REQUIRING PRESCRIBERS OF CONTROLLED SUB-**
20 **STANCES TO COMPLETE TRAINING.**

21 Section 303 of the Controlled Substances Act (21
22 U.S.C. 823) is amended by adding at the end the fol-
23 lowing:

24 “(l) **REQUIRED TRAINING FOR PRESCRIBERS.**—

1 “(1) TRAINING REQUIRED.—As a condition on
2 registration under this section to dispense controlled
3 substances in schedule II, III, IV, or V, the Attorney
4 General shall require any qualified practitioner, be-
5 ginning with the first applicable registration for the
6 practitioner, to meet the following:

7 “(A) If the practitioner is a physician (as
8 defined under section 1861(r) of the Social Se-
9 curity Act), the practitioner meets one or more
10 of the following conditions:

11 “(i) The physician holds a board cer-
12 tification in addiction psychiatry or addic-
13 tion medicine from the American Board of
14 Medical Specialties.

15 “(ii) The physician holds a board cer-
16 tification from the American Board of Ad-
17 diction Medicine.

18 “(iii) The physician holds a board cer-
19 tification in addiction medicine from the
20 American Osteopathic Association.

21 “(iv) The physician has, with respect
22 to the treatment and management of pa-
23 tients with opioid or other substance use
24 disorders, or the safe pharmacological
25 management of dental pain and screening,

1 brief intervention, and referral for appro-
2 priate treatment of patients with or at risk
3 of developing opioid or other substance use
4 disorders, completed not less than 8 hours
5 of training (through classroom situations,
6 seminars at professional society meetings,
7 electronic communications, or otherwise)
8 that is provided by—

9 “(I) the American Society of Ad-
10 diction Medicine, the American Acad-
11 emy of Addiction Psychiatry, the
12 American Medical Association, the
13 American Osteopathic Association, the
14 American Dental Association, the
15 American Association of Oral and
16 Maxillofacial Surgeons, the American
17 Psychiatric Association, or any other
18 organization accredited by the Accred-
19 itation Council for Continuing Medical
20 Education (commonly known as the
21 ‘ACCME’) or the Commission on
22 Dental Accreditation;

23 “(II) any organization accredited
24 by a State medical society accreditor
25 that is recognized by the ACCME or

1 the Commission on Dental Accredita-
2 tion;

3 “(III) any organization accred-
4 ited by the American Osteopathic As-
5 sociation to provide continuing med-
6 ical education; or

7 “(IV) any organization approved
8 by the Assistant Secretary for Mental
9 Health and Substance Abuse, the
10 ACCME, or the Commission on Den-
11 tal Accreditation.

12 “(v) The physician graduated in good
13 standing from an accredited school of
14 allopathic medicine, osteopathic medicine,
15 dental surgery, or dental medicine in the
16 United States during the 5-year period im-
17 mediately preceding the date on which the
18 physician first registers or renews under
19 this section and has successfully completed
20 a comprehensive allopathic or osteopathic
21 medicine curriculum or accredited medical
22 residency or dental surgery or dental medi-
23 cine curriculum that included not less than
24 8 hours of training on—

1 “(I) treating and managing pa-
2 tients with opioid and other substance
3 use disorders, including the appro-
4 priate clinical use of all drugs ap-
5 proved by the Food and Drug Admin-
6 istration for the treatment of a sub-
7 stance use disorder; or

8 “(II) the safe pharmacological
9 management of dental pain and
10 screening, brief intervention, and re-
11 ferral for appropriate treatment of pa-
12 tients with or at risk of developing
13 opioid and other substance use dis-
14 orders.

15 “(B) If the practitioner is not a physician
16 (as defined under section 1861(r) of the Social
17 Security Act), the practitioner meets one or
18 more of the following conditions:

19 “(i) The practitioner has completed
20 not fewer than 8 hours of training with re-
21 spect to the treatment and management of
22 patients with opioid or other substance use
23 disorders (through classroom situations,
24 seminars at professional society meetings,
25 electronic communications, or otherwise)

1 provided by the American Society of Addic-
2 tion Medicine, the American Academy of
3 Addiction Psychiatry, the American Med-
4 ical Association, the American Osteopathic
5 Association, the American Nurses
6 Credentialing Center, the American Psy-
7 chiatric Association, the American Associa-
8 tion of Nurse Practitioners, the American
9 Academy of Physician Associates, or any
10 other organization approved or accredited
11 by the Assistant Secretary for Mental
12 Health and Substance Abuse or the Ac-
13 creditation Council for Continuing Medical
14 Education.

15 “(ii) The practitioner has graduated
16 in good standing from an accredited physi-
17 cian assistant school or accredited school
18 of advanced practice nursing in the United
19 States during the 5-year period imme-
20 diately preceding the date on which the
21 practitioner first registers or renews under
22 this section and has successfully completed
23 a comprehensive physician assistant or ad-
24 vanced practice nursing curriculum that
25 included not fewer than 8 hours of training

1 on treating and managing patients with
2 opioid and other substance use disorders,
3 including the appropriate clinical use of all
4 drugs approved by the Food and Drug Ad-
5 ministration for the treatment of a sub-
6 stance use disorder.

7 “(2) ONE-TIME TRAINING.—

8 “(A) IN GENERAL.—The Attorney General
9 shall not require any qualified practitioner to
10 complete the training described in clause (iv) or
11 (v) of paragraph (1)(A) or clause (i) or (ii) of
12 paragraph (1)(B) more than once.

13 “(B) NOTIFICATION.—Not later than 90
14 days after the date of the enactment of the Re-
15 storing Hope for Mental Health and Well-Being
16 Act of 2022, the Attorney General shall provide
17 to qualified practitioners a single written, elec-
18 tronic notification of the training described in
19 clauses (iv) and (v) of paragraph (1)(A) or
20 clauses (i) and (ii) of paragraph (1)(B).

21 “(3) RULE OF CONSTRUCTION.—Nothing in
22 this subsection shall be construed to preclude the
23 use, by a qualified practitioner, of training received
24 pursuant to this subsection to satisfy registration re-

1 requirements of a State or for some other lawful pur-
2 pose.

3 “(4) DEFINITIONS.—In this section:

4 “(A) FIRST APPLICABLE REGISTRATION.—

5 The term ‘first applicable registration’ means
6 the first registration or renewal of registration
7 by a qualified practitioner under this section
8 that occurs on or after the date that is 180
9 days after the date of enactment of the Restor-
10 ing Hope for Mental Health and Well-Being
11 Act of 2022.

12 “(B) QUALIFIED PRACTITIONER.—In this
13 subsection, the term ‘qualified practitioner’
14 means a practitioner who—

15 “(i) is licensed under State law to pre-
16 scribe controlled substances; and

17 “(ii) is not solely a veterinarian.”.

18 **SEC. 264. INCREASE IN NUMBER OF DAYS BEFORE WHICH**
19 **CERTAIN CONTROLLED SUBSTANCES MUST**
20 **BE ADMINISTERED.**

21 Section 309A(a)(5) of the Controlled Substances Act
22 (21 U.S.C. 829a(a)(5)) is amended by striking “14 days”
23 and inserting “60 days”.

1 **SEC. 265. BLOCK, REPORT, AND SUSPEND SUSPICIOUS**
2 **SHIPMENTS.**

3 (a) CLARIFICATION OF PROCESS FOR REGISTRANTS
4 TO EXERCISE DUE DILIGENCE UPON DISCOVERING A
5 SUSPICIOUS ORDER.—Paragraph (3) of section 312(a) of
6 the Controlled Substances Act (21 U.S.C. 832(a)) is
7 amended to read as follows:

8 “(3) upon discovering a suspicious order or se-
9 ries of orders, and in a manner consistent with the
10 other requirements of this section—

11 “(A) exercise due diligence as appropriate;

12 “(B) establish and maintain (for not less
13 than a period to be determined by the Adminis-
14 trator of the Drug Enforcement Administra-
15 tion) a record of the due diligence that was per-
16 formed;

17 “(C) decline to fill the order or series of
18 orders if the due diligence fails to dispel all of
19 the indicators that give rise to the suspicion
20 that, if the order or series of orders is filled, the
21 drugs that are the subject of the order or series
22 of orders are likely to be diverted; and

23 “(D) notify the Administrator of the Drug
24 Enforcement Administration and the Special
25 Agent in Charge of the Division Office of the
26 Drug Enforcement Administration for the area

1 in which the registrant is located or conducts
2 business of—

3 “(i) each suspicious order or series of
4 orders discovered by the registrant; and

5 “(ii) the indicators giving rise to the
6 suspicion that, if the order or series of or-
7 ders is filled, the drugs that are the sub-
8 ject of the order or series of orders are
9 likely to be diverted.”.

10 (b) RESOLUTION OF SUSPICIOUS INDICATORS.—Sec-
11 tion 312 of the Controlled Substances Act (21 U.S.C. 832)
12 is amended—

13 (1) by redesignating subsection (b) and (c) as
14 subsections (c) and (d), respectively; and

15 (2) by inserting after subsection (a) the fol-
16 lowing:

17 “(b) RESOLUTION OF SUSPICIOUS INDICATORS.—If
18 a registrant resolves all of the indicators giving rise to sus-
19 picion about an order or series of orders under subsection
20 (a)(3)—

21 “(1) notwithstanding subsection (a)(3)(C), the
22 registrant may choose to fill the order or series of
23 orders; and

1 “(2) notwithstanding subsection (a)(3)(D), the
2 registrant may choose not to make the notification
3 otherwise required by such subsection.”.

4 (c) REGULATIONS.—Not later than 1 year after the
5 date of enactment of this Act, for purposes of subsections
6 (a)(3) and (b) of section 312 of the Controlled Substances
7 Act, as amended or inserted by subsection (a), the Attor-
8 ney General of the United States shall promulgate a final
9 regulation specifying the indicators that give rise to a sus-
10 picion that, if an order or series of orders is filled, the
11 drugs that are the subject of the order or series of orders
12 are likely to be diverted.

13 (d) APPLICABILITY.—Subsections (a)(3) and (b) of
14 section 312 of the Controlled Substances Act, as amended
15 or inserted by subsection (a), shall apply beginning on the
16 day that is 1 year after the date of enactment of this Act.
17 Until such day, section 312(a)(3) of the Controlled Sub-
18 stances Act shall apply as such section 312(a)(3) was in
19 effect on the day before the date of enactment of this Act.

20 **Subtitle G—Opioid Epidemic**
21 **Response**

22 **SEC. 271. OPIOID PRESCRIPTION VERIFICATION.**

23 (a) MATERIALS FOR TRAINING PHARMACISTS ON
24 CERTAIN CIRCUMSTANCES UNDER WHICH A PHARMACIST
25 MAY DECLINE TO FILL A PRESCRIPTION.—

1 (1) UPDATES TO MATERIALS.—Section 3212(a)
2 of the SUPPORT for Patients and Communities Act
3 (21 U.S.C. 829 note) is amended by striking “Not
4 later than 1 year after the date of enactment of this
5 Act, the Secretary of Health and Human Services,
6 in consultation with the Administrator of the Drug
7 Enforcement Administration, Commissioner of Food
8 and Drugs, Director of the Centers for Disease Con-
9 trol and Prevention, and Assistant Secretary for
10 Mental Health and Substance Use, shall develop and
11 disseminate” and inserting “The Secretary of
12 Health and Human Services, in consultation with
13 the Administrator of the Drug Enforcement Admin-
14 istration, Commissioner of Food and Drugs, Direc-
15 tor of the Centers for Disease Control and Preven-
16 tion, and Assistant Secretary for Mental Health and
17 Substance Use, shall develop and disseminate not
18 later than 1 year after the date of enactment of this
19 Act, and update periodically thereafter”.

20 (2) MATERIALS INCLUDED.—Section 3212(b) of
21 the SUPPORT for Patients and Communities Act
22 (21 U.S.C. 829 note) is amended—

23 (A) by redesignating paragraphs (1) and
24 (2) as paragraphs (2) and (3), respectively; and

1 (B) by inserting before paragraph (2), as
2 so redesignated, the following new paragraph:

3 “(1) pharmacists on how to verify the identity
4 of the patient;”.

5 (3) MATERIALS FOR TRAINING ON PATIENT
6 VERIFICATION.—Section 3212 of the SUPPORT
7 for Patients and Communities Act (21 U.S.C. 829
8 note) is amended by adding at the end the following
9 new subsection:

10 “(d) MATERIALS FOR TRAINING ON VERIFICATION
11 OF IDENTITY.—Not later than 1 year after the date of
12 enactment of this subsection, the Secretary of Health and
13 Human Services, after seeking stakeholder input in ac-
14 cordance with subsection (c), shall—

15 “(1) update the materials developed under sub-
16 section (a) to include information for pharmacists on
17 how to verify the identity the patient; and

18 “(2) disseminate, as appropriate, the updated
19 materials.”.

20 (b) INCENTIVIZING STATES TO FACILITATE RESPON-
21 SIBLE, INFORMED DISPENSING OF CONTROLLED SUB-
22 STANCES.—

23 (1) IN GENERAL.—Section 392A of the Public
24 Health Service Act (42 U.S.C. 280b–1) is amend-
25 ed—

1 (A) by redesignating subsections (c) and
2 (d) as subsections (d) and (e), respectively; and
3 (B) by inserting after subsection (b) the
4 following new subsection:

5 “(c) PREFERENCE.—In determining the amounts of
6 grants awarded to States under subsections (a) and (b),
7 the Director of the Centers for Disease Control and Pre-
8 vention may give preference to States in accordance with
9 such criteria as the Director may specify and may choose
10 to give preference to States that—

11 “(1) maintain a prescription drug monitoring
12 program;

13 “(2) require prescribers of controlled substances
14 in schedule II, III, or IV to issue such prescriptions
15 electronically, and make such requirement subject to
16 exceptions in the cases listed in section 1860D-
17 4(e)(7)(B) of the Social Security Act; and

18 “(3) require dispensers of such controlled sub-
19 stances to enter certain information about the pur-
20 chase of such controlled substances into the respec-
21 tive State’s prescription drug monitoring program,
22 including—

23 “(A) the National Drug Code or, in the
24 case of compounded medications, compound
25 identifier;

1 “(B) the quantity dispensed;
2 “(C) the patient identifier; and
3 “(D) the date filled.”.

4 (2) DEFINITIONS.—

5 (A) IN GENERAL.—Subsection (d) of sec-
6 tion 392A of the Public Health Service Act (42
7 U.S.C. 280b–1), as redesignated by paragraph
8 (1)(A), is amended to read as follows:

9 “(d) DEFINITIONS.—In this section:

10 “(1) CONTROLLED SUBSTANCE.—The term
11 ‘controlled substance’ has the meaning given that
12 term in section 102 of the Controlled Substances
13 Act.

14 “(2) DISPENSER.—The term ‘dispenser’ means
15 a physician, pharmacist, or other person that dis-
16 penses a controlled substance to an ultimate user.

17 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
18 has the meaning given that term in section 4 of the
19 Indian Self-Determination and Education Assistance
20 Act.”.

21 (B) CONFORMING CHANGE.—Section 392A
22 of the Public Health Service Act (42 U.S.C.
23 280b–1) is amended by striking “Indian tribes”
24 each place it appears and inserting “Indian
25 Tribes”.

1 **SEC. 272. SYNTHETIC OPIOID DANGER AWARENESS.**

2 (a) SYNTHETIC OPIOIDS PUBLIC AWARENESS CAM-
3 PAIGN.—Part B of title III of the Public Health Service
4 Act is amended by inserting after section 317U (42 U.S.C.
5 247b–23) the following new section:

6 **“SEC. 317V. SYNTHETIC OPIOIDS PUBLIC AWARENESS CAM-**
7 **PAIGN.**

8 “(a) IN GENERAL.—Not later than one year after the
9 date of the enactment of this section, the Secretary shall
10 provide for the planning and implementation of a public
11 education campaign to raise public awareness of synthetic
12 opioids (including fentanyl and its analogues). Such cam-
13 paign shall include the dissemination of information
14 that—

15 “(1) promotes awareness about the potency and
16 dangers of fentanyl and its analogues and other syn-
17 thetic opioids;

18 “(2) explains services provided by the Sub-
19 stance Abuse and Mental Health Services Adminis-
20 tration and the Centers for Disease Control and
21 Prevention (and any entity providing such services
22 under a contract entered into with such agencies)
23 with respect to the misuse of opioids, particularly as
24 such services relate to the provision of alternative,
25 non-opioid pain management treatments; and

1 “(3) relates generally to opioid use and pain
2 management.

3 “(b) USE OF MEDIA.—The campaign under sub-
4 section (a) may be implemented through the use of tele-
5 vision, radio, internet, in-person public communications,
6 and other commercial marketing venues and may be tar-
7 geted to specific age groups.

8 “(c) CONSIDERATION OF REPORT FINDINGS.—In
9 planning and implementing the public education campaign
10 under subsection (a), the Secretary shall take into consid-
11 eration the findings of the report required under section
12 7001 of the SUPPORT for Patients and Communities Act
13 (Public Law 115–271).

14 “(d) CONSULTATION.—In coordinating the campaign
15 under subsection (a), the Secretary shall consult with the
16 Assistant Secretary for Mental Health and Substance Use
17 to provide ongoing advice on the effectiveness of informa-
18 tion disseminated through the campaign.

19 “(e) REQUIREMENT OF CAMPAIGN.—The campaign
20 implemented under subsection (a) shall not be duplicative
21 of any other Federal efforts relating to eliminating the
22 misuse of opioids.

23 “(f) EVALUATION.—

24 “(1) IN GENERAL.—The Secretary shall ensure
25 that the campaign implemented under subsection (a)

1 is subject to an independent evaluation, beginning 2
2 years after the date of the enactment of this section,
3 and every 2 years thereafter.

4 “(2) MEASURES AND BENCHMARKS.—For pur-
5 poses of an evaluation conducted pursuant to para-
6 graph (1), the Secretary shall—

7 “(A) establish baseline measures and
8 benchmarks to quantitatively evaluate the im-
9 pact of the campaign under this section; and

10 “(B) conduct qualitative assessments re-
11 garding the effectiveness of strategies employed
12 under this section.

13 “(g) REPORT.—The Secretary shall, beginning 2
14 years after the date of the enactment of this section, and
15 every 2 years thereafter, submit to Congress a report on
16 the effectiveness of the campaign implemented under sub-
17 section (a) towards meeting the measures and benchmarks
18 established under subsection (e)(2).

19 “(h) DISSEMINATION OF INFORMATION THROUGH
20 PROVIDERS.—The Secretary shall develop and implement
21 a plan for the dissemination of information related to syn-
22 thetic opioids, to health care providers who participate in
23 Federal programs, including programs administered by
24 the Department of Health and Human Services, the In-
25 dian Health Service, the Department of Veterans Affairs,

1 the Department of Defense, and the Health Resources and
2 Services Administration, the Medicare program under title
3 XVIII of the Social Security Act, and the Medicaid pro-
4 gram under title XIX of such Act.”.

5 (b) TRAINING GUIDE AND OUTREACH ON SYNTHETIC
6 OPIOID EXPOSURE PREVENTION.—

7 (1) TRAINING GUIDE.—Not later than 18
8 months after the date of the enactment of this Act,
9 the Secretary of Health and Human Services shall
10 design, publish, and make publicly available on the
11 internet website of the Department of Health and
12 Human Services, a training guide and webinar for
13 first responders and other individuals who also may
14 be at high risk of exposure to synthetic opioids that
15 details measures to prevent that exposure.

16 (2) OUTREACH.—Not later than 18 months
17 after the date of the enactment of this Act, the Sec-
18 retary of Health and Human Services shall also con-
19 duct outreach about the availability of the training
20 guide and webinar published under paragraph (1)
21 to—

22 (A) police and fire managements;

23 (B) sheriff deputies in city and county
24 jails;

- 1 (C) ambulance transport and hospital
2 emergency room personnel;
- 3 (D) clinicians; and
- 4 (E) other high-risk occupations, as identi-
5 fied by the Assistant Secretary for Mental
6 Health and Substance Use.

7 **SEC. 273. GRANT PROGRAM FOR STATE AND TRIBAL RE-**
8 **SPONSE TO OPIOID AND STIMULANT USE AND**
9 **MISUSE.**

10 Section 1003 of the 21st Century Cures Act (42
11 U.S.C. 290ee–3 note) is amended to read as follows:

12 **“SEC. 1003. GRANT PROGRAM FOR STATE AND TRIBAL RE-**
13 **SPONSE TO OPIOID AND STIMULANT USE AND**
14 **MISUSE.**

15 “(a) IN GENERAL.—The Secretary of Health and
16 Human Services (referred to in this section as the ‘Sec-
17 retary’) shall carry out the grant program described in
18 subsection (b) for purposes of addressing opioid and stim-
19 ulant use and misuse, within States, Indian Tribes, and
20 populations served by Tribal organizations and Urban In-
21 dian organizations.

22 “(b) GRANTS PROGRAM.—

23 “(1) IN GENERAL.—Subject to the availability
24 of appropriations, the Secretary shall award grants
25 to States, Indian Tribes, Tribal organizations, and

1 Urban Indian organizations for the purpose of ad-
2 dressing opioid and stimulant use and misuse, within
3 such States, such Indian Tribes, and populations
4 served by such Tribal organizations and Urban In-
5 dian organizations, in accordance with paragraph
6 (2).

7 “(2) MINIMUM ALLOCATIONS; PREFERENCE.—

8 In determining grant amounts for each recipient of
9 a grant under paragraph (1), the Secretary shall—

10 “(A) ensure that each State receives not
11 less than \$4,000,000; and

12 “(B) give preference to States, Indian
13 Tribes, Tribal organizations, and Urban Indian
14 organizations whose populations have an inci-
15 dence or prevalence of opioid use disorders or
16 stimulant use or misuse that is substantially
17 higher relative to the populations of other
18 States, other Indian Tribes, Tribal organiza-
19 tions, or Urban Indian organizations, as appli-
20 cable.

21 “(3) FORMULA METHODOLOGY.—

22 “(A) IN GENERAL.—Before publishing a
23 funding opportunity announcement with respect
24 to grants under this section, the Secretary
25 shall—

1 “(i) develop a formula methodology to
2 be followed in allocating grant funds
3 awarded under this section among grant-
4 ees, which includes performance assess-
5 ments for continuation awards; and

6 “(ii) not later than 30 days after de-
7 veloping the formula methodology under
8 clause (i), submit the formula methodology
9 to—

10 “(I) the Committee on Energy
11 and Commerce and the Committee on
12 Appropriations of the House of Rep-
13 resentatives; and

14 “(II) the Committee on Health,
15 Education, Labor, and Pensions and
16 the Committee on Appropriations of
17 the Senate.

18 “(B) REPORT.—Not later than two years
19 after the date of the enactment of the Restoring
20 Hope for Mental Health and Well-Being Act of
21 2022, the Comptroller General of the United
22 States shall submit to the Committee on
23 Health, Education, Labor, and Pensions of the
24 Senate and the Committee on Energy and Com-

1 merce of the House of Representatives a report
2 that—

3 “(i) assesses how grant funding is al-
4 located to States under this section and
5 how such allocations have changed over
6 time;

7 “(ii) assesses how any changes in
8 funding under this section have affected
9 the efforts of States to address opioid or
10 stimulant use or misuse; and

11 “(iii) assesses the use of funding pro-
12 vided through the grant program under
13 this section and other similar grant pro-
14 grams administered by the Substance
15 Abuse and Mental Health Services Admin-
16 istration.

17 “(4) USE OF FUNDS.—Grants awarded under
18 this subsection shall be used for carrying out activi-
19 ties that supplement activities pertaining to opioid
20 and stimulant use and misuse, undertaken by the
21 State agency responsible for administering the sub-
22 stance abuse prevention and treatment block grant
23 under subpart II of part B of title XIX of the Public
24 Health Service Act (42 U.S.C. 300x–21 et seq.),

1 which may include public health-related activities
2 such as the following:

3 “(A) Implementing prevention activities,
4 and evaluating such activities to identify effective
5 strategies to prevent substance use disorders.
6 orders.

7 “(B) Establishing or improving prescription
8 drug monitoring programs.

9 “(C) Training for health care practitioners,
10 such as best practices for prescribing opioids,
11 pain management, recognizing potential cases
12 of substance use disorders, referral of patients
13 to treatment programs, preventing diversion of
14 controlled substances, and overdose prevention.

15 “(D) Supporting access to health care
16 services, including—

17 “(i) services provided by federally certified
18 opioid treatment programs;

19 “(ii) outpatient and residential substance
20 use disorder treatment services that
21 utilize medication-assisted treatment, as
22 appropriate; or

23 “(iii) other appropriate health care
24 providers to treat substance use disorders.

1 “(E) Recovery support services, includ-
2 ing—

3 “(i) community-based services that in-
4 clude peer supports;

5 “(ii) mutual aid recovery programs
6 that support medication-assisted treat-
7 ment; or

8 “(iii) services to address housing
9 needs and family issues.

10 “(F) Other public health-related activities,
11 as the State, Indian Tribe, Tribal organization,
12 or Urban Indian organization determines appro-
13 priate, related to addressing substance use dis-
14 orders within the State, Indian Tribe, Tribal or-
15 ganization, or Urban Indian organization, in-
16 cluding directing resources in accordance with
17 local needs related to substance use disorders.

18 “(c) ACCOUNTABILITY AND OVERSIGHT.—A State re-
19 ceiving a grant under subsection (b) shall include in re-
20 porting related to substance use disorders submitted to the
21 Secretary pursuant to section 1942 of the Public Health
22 Service Act (42 U.S.C. 300x–52), a description of—

23 “(1) the purposes for which the grant funds re-
24 ceived by the State under such subsection for the

1 preceding fiscal year were expended and a descrip-
2 tion of the activities of the State under the grant;

3 “(2) the ultimate recipients of amounts pro-
4 vided to the State; and

5 “(3) the number of individuals served through
6 the grant.

7 “(d) LIMITATIONS.—Any funds made available pur-
8 suant to subsection (i)—

9 “(1) shall not be used for any purpose other
10 than the grant program under subsection (b); and

11 “(2) shall be subject to the same requirements
12 as substance use disorders prevention and treatment
13 programs under titles V and XIX of the Public
14 Health Service Act (42 U.S.C. 290aa et seq., 300w
15 et seq.).

16 “(e) INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND
17 URBAN INDIAN ORGANIZATIONS.—The Secretary, in con-
18 sultation with Indian Tribes, Tribal organizations, and
19 Urban Indian organizations, shall identify and establish
20 appropriate mechanisms for Indian Tribes, Tribal organi-
21 zations, and Urban Indian organizations to demonstrate
22 or report the information as required under subsections
23 (b), (c), and (d).

24 “(f) REPORT TO CONGRESS.—Not later than Sep-
25 tember 30, 2024, and biennially thereafter, the Secretary

1 shall submit to the Committee on Health, Education,
2 Labor, and Pensions of the Senate and the Committee on
3 Energy and Commerce of the House of Representatives,
4 and the Committees on Appropriations of the House of
5 Representatives and the Senate, a report that includes a
6 summary of the information provided to the Secretary in
7 reports made pursuant to subsections (c) and (e), includ-
8 ing—

9 “(1) the purposes for which grant funds are
10 awarded under this section;

11 “(2) the activities of the grant recipients; and

12 “(3) for each State, Indian Tribe, Tribal orga-
13 nization, and Urban Indian organization that re-
14 ceives a grant under this section, the funding level
15 provided to such recipient.

16 “(g) TECHNICAL ASSISTANCE.—The Secretary, in-
17 cluding through the Tribal Training and Technical Assist-
18 ance Center of the Substance Abuse and Mental Health
19 Services Administration, shall provide States, Indian
20 Tribes, Tribal organizations, and Urban Indian organiza-
21 tions, as applicable, with technical assistance concerning
22 grant application and submission procedures under this
23 section, award management activities, and enhancing out-
24 reach and direct support to rural and underserved commu-
25 nities and providers in addressing substance use disorders.

1 “(h) DEFINITIONS.—In this section:

2 “(1) INDIAN TRIBE.—The term ‘Indian Tribe’
3 has the meaning given the term ‘Indian tribe’ in sec-
4 tion 4 of the Indian Self-Determination and Edu-
5 cation Assistance Act (25 U.S.C. 5304).

6 “(2) TRIBAL ORGANIZATION.—The term ‘Tribal
7 organization’ has the meaning given the term ‘tribal
8 organization’ in such section 4.

9 “(3) STATE.—The term ‘State’ has the mean-
10 ing given such term in section 1954(b) of the Public
11 Health Service Act (42 U.S.C. 300x–64(b)).

12 “(4) URBAN INDIAN ORGANIZATION.—The term
13 ‘Urban Indian organization’ has the meaning given
14 such term in section 4 of the Indian Health Care
15 Improvement Act.

16 “(i) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—For purposes of carrying
18 out the grant program under subsection (b), there is
19 authorized to be appropriated \$1,750,000,000 for
20 each of fiscal years 2023 through 2027, to remain
21 available until expended.

22 “(2) FEDERAL ADMINISTRATIVE EXPENSES.—
23 Of the amounts made available for each fiscal year
24 to award grants under subsection (b), the Secretary
25 shall not use more than 20 percent for Federal ad-

1 ministrative expenses, training, technical assistance,
2 and evaluation.

3 “(3) SET ASIDE.—Of the amounts made avail-
4 able for each fiscal year to award grants under sub-
5 section (b) for a fiscal year, the Secretary shall—

6 “(A) award 5 percent to Indian Tribes,
7 Tribal organizations, and Urban Indian organi-
8 zations; and

9 “(B) of the amount remaining after appli-
10 cation of subparagraph (A), set aside up to 15
11 percent for awards to States with the highest
12 age-adjusted rate of drug overdose death based
13 on the ordinal ranking of States according to
14 the Director of the Centers for Disease Control
15 and Prevention.”.

16 **TITLE III—ACCESS TO MENTAL**
17 **HEALTH CARE AND COVERAGE**

18 **Subtitle A—Collaborate in an**
19 **Orderly and Cohesive Manner**

20 **SEC. 301. INCREASING UPTAKE OF THE COLLABORATIVE**
21 **CARE MODEL.**

22 Section 520K of the Public Health Service Act (42
23 U.S.C. 290bb–42) is amended to read as follows:

1 **“SEC. 520K. INTEGRATION INCENTIVE GRANTS AND COOP-**
2 **ERATIVE AGREEMENTS.**

3 “(a) DEFINITIONS.—In this section:

4 “(1) COLLABORATIVE CARE MODEL.—The term
5 ‘collaborative care model’ means the evidence-based,
6 integrated behavioral health service delivery method
7 that includes—

8 “(A) care directed by the primary care
9 team;

10 “(B) structured care management;

11 “(C) regular assessments of clinical status
12 using developmentally appropriate, validated
13 tools; and

14 “(D) modification of treatment as appro-
15 priate.

16 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
17 tity’ means a State, or an appropriate State agency,
18 in collaboration with—

19 “(A) 1 or more qualified community pro-
20 grams as described in section 1913(b)(1);

21 “(B) 1 or more health centers (as defined
22 in section 330(a)), a rural health clinic (as de-
23 fined in section 1961(aa) of the Social Security
24 Act), or a Federally qualified health center (as
25 defined in such section); or

1 “(C) 1 or more primary health care prac-
2 tices.

3 “(3) INTEGRATED CARE; BIDIRECTIONAL INTE-
4 GRATED CARE.—

5 “(A) The term ‘integrated care’ means
6 models or practices for coordinating and jointly
7 delivering behavioral and physical health serv-
8 ices, which may include practices that share the
9 same space in the same facility.

10 “(B) The term ‘bidirectional integrated
11 care’ means the integration of behavioral health
12 care and specialty physical health care, as well
13 as the integration of primary and physical
14 health care with specialty behavioral health set-
15 tings, including within primary health care set-
16 tings.

17 “(4) PRIMARY HEALTH CARE PROVIDER.—The
18 term ‘primary health care provider’ means a pro-
19 vider who—

20 “(A) provides health services related to
21 family medicine, internal medicine, pediatrics,
22 obstetrics, gynecology, or geriatrics; or

23 “(B) is a doctor of medicine or osteopathy,
24 physician assistant, or nurse practitioner, who
25 is licensed to practice medicine by the State in

1 which such physician, assistant, or practitioner
2 primarily practices, including within primary
3 health care settings.

4 “(5) PRIMARY HEALTH CARE PRACTICE.—The
5 term ‘primary health care practice’ means a medical
6 practice of primary health care providers, including
7 a practice within a larger health care system.

8 “(6) SPECIAL POPULATION.—The term ‘special
9 population’, for an eligible entity that is collabo-
10 rating with an entity described in subparagraph (A)
11 or (B) of paragraph (3), means—

12 “(A) adults with a serious mental illness
13 who have a co-occurring physical health condi-
14 tion or chronic disease;

15 “(B) children and adolescents with a men-
16 tal illness who have a co-occurring physical
17 health condition or chronic disease;

18 “(C) individuals with a substance use dis-
19 order; or

20 “(D) individuals with a mental illness who
21 have a co-occurring substance use disorder.

22 “(b) GRANTS AND COOPERATIVE AGREEMENTS.—

23 “(1) IN GENERAL.—The Secretary may award
24 grants and cooperative agreements to eligible entities
25 to support the improvement of integrated care for

1 physical and behavioral health care in accordance
2 with paragraph (2).

3 “(2) USE OF FUNDS.—A grant or cooperative
4 agreement awarded under this section shall be
5 used—

6 “(A) in the case of an eligible entity that
7 is collaborating with an entity described in sub-
8 paragraph (A) or (B) of subsection (a)(2)—

9 “(i) to promote full integration and
10 collaboration in clinical practices between
11 physical and behavioral health care for spe-
12 cial populations including each population
13 listed in subsection (a)(7);

14 “(ii) to support the improvement of
15 integrated care models for physical and be-
16 havioral health care to improve the overall
17 wellness and physical health status of—

18 “(I) adults with a serious mental
19 illness or children with a serious emo-
20 tional disturbance; and

21 “(II) individuals with a substance
22 use disorder; and

23 “(iii) to promote bidirectional inte-
24 grated care services including screening,
25 diagnosis, prevention, treatment, and re-

1 covery of mental and substance use dis-
2 orders, and co-occurring physical health
3 conditions and chronic diseases; and

4 “(B) in the case of an eligible entity that
5 is collaborating with a primary health care
6 practice, to support the uptake of the collabo-
7 rative care model, including by—

8 “(i) hiring staff;

9 “(ii) identifying and formalizing con-
10 tractual relationships with other health
11 care providers, including providers who will
12 function as psychiatric consultants and be-
13 havioral health care managers in providing
14 behavioral health integration services
15 through the collaborative care model;

16 “(iii) purchasing or upgrading soft-
17 ware and other resources needed to appro-
18 priately provide behavioral health integra-
19 tion services through the collaborative care
20 model, including resources needed to estab-
21 lish a patient registry and implement
22 measurement-based care; and

23 “(iv) for such other purposes as the
24 Secretary determines to be necessary.

25 “(c) APPLICATIONS.—

1 “(1) IN GENERAL.—An eligible entity that is
2 collaborating with an entity described in subpara-
3 graph (A) or (B) of subsection (a)(2) seeking a
4 grant or cooperative agreement under subsection
5 (b)(2)(A) shall submit an application to the Sec-
6 retary at such time, in such manner, and accom-
7 panied by such information as the Secretary may re-
8 quire, including the contents described in paragraph
9 (2).

10 “(2) CONTENTS.—Any such application of an
11 eligible entity described in subparagraph (A) or (B)
12 of subsection (a)(2) shall include—

13 “(A) a description of a plan to achieve
14 fully collaborative agreements to provide
15 bidirectional integrated care to special popu-
16 lations;

17 “(B) a document that summarizes the poli-
18 cies, if any, that are barriers to the provision of
19 integrated care, and the specific steps, if appli-
20 cable, that will be taken to address such bar-
21 riers;

22 “(C) a description of partnerships or other
23 arrangements with local health care providers
24 to provide services to special populations;

1 “(D) an agreement and plan to report to
2 the Secretary performance measures necessary
3 to evaluate patient outcomes and facilitate eval-
4 uations across participating projects;

5 “(E) a description of how validated rating
6 scales will be implemented to support the im-
7 provement of patient outcomes using measure-
8 ment-based care, including those related to de-
9 pression screening, patient follow-up, and symp-
10 tom remission; and

11 “(F) a plan for sustainability beyond the
12 grant or cooperative agreement period under
13 subsection (e).

14 “(3) COLLABORATIVE CARE MODEL GRANTS.—
15 An eligible entity that is collaborating with a pri-
16 mary health care practice seeking a grant pursuant
17 to subsection (b)(2)(B) shall submit an application
18 to the Secretary at such time, in such manner, and
19 accompanied by such information as the Secretary
20 may require.

21 “(d) GRANT AND COOPERATIVE AGREEMENT
22 AMOUNTS.—

23 “(1) TARGET AMOUNT.—The target amount
24 that an eligible entity may receive for a year through

1 a grant or cooperative agreement under this section
2 shall be—

3 “(A) \$2,000,000 for an eligible entity de-
4 scribed in subparagraph (A) or (B) of sub-
5 section (a)(2); or

6 “(B) \$100,000 or less for an eligible entity
7 described in subparagraph (C) of subsection
8 (a)(2).

9 “(2) ADJUSTMENT PERMITTED.—The Sec-
10 retary, taking into consideration the quality of an el-
11 igible entity’s application and the number of eligible
12 entities that received grants under this section prior
13 to the date of enactment of the Restoring Hope for
14 Mental Health and Well-Being Act of 2022, may ad-
15 just the target amount that an eligible entity may
16 receive for a year through a grant or cooperative
17 agreement under this section.

18 “(3) LIMITATION.—An eligible entity that is
19 collaborating with an entity described in subpara-
20 graph (A) or (B) of subsection (a)(2) receiving fund-
21 ing under this section—

22 “(A) may not allocate more than 20 per-
23 cent of the funds awarded to such eligible entity
24 under this section to administrative functions;
25 and

1 “(B) shall allocate the remainder of such
2 funding to health facilities that provide inte-
3 grated care.

4 “(e) DURATION.—A grant or cooperative agreement
5 under this section shall be for a period not to exceed 5
6 years.

7 “(f) REPORT ON PROGRAM OUTCOMES.—An eligible
8 entity receiving a grant or cooperative agreement under
9 this section—

10 “(1) that is collaborating with an entity de-
11 scribed in subparagraph (A) or (B) of subsection
12 (a)(2) shall submit an annual report to the Sec-
13 retary that includes—

14 “(A) the progress made to reduce barriers
15 to integrated care as described in the entity’s
16 application under subsection (e); and

17 “(B) a description of outcomes with re-
18 spect to each special population listed in sub-
19 section (a)(7), including outcomes related to
20 education, employment, and housing; or

21 “(2) that is collaborating with a primary health
22 care practice shall submit an annual report to the
23 Secretary that includes—

24 “(A) the progress made to improve access;

1 “(B) the progress made to improve patient
2 outcomes; and

3 “(C) the progress made to reduce referrals
4 to specialty care.

5 “(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAV-
6 IORAL HEALTH CARE INTEGRATION.—

7 “(1) CERTAIN RECIPIENTS.—The Secretary
8 may provide appropriate information, training, and
9 technical assistance to eligible entities that are col-
10 laborating with an entity described in subparagraph
11 (A) or (B) of subsection (a)(2) that receive a grant
12 or cooperative agreement under this section, in order
13 to help such entities meet the requirements of this
14 section, including assistance with—

15 “(A) development and selection of inte-
16 grated care models;

17 “(B) dissemination of evidence-based inter-
18 ventions in integrated care;

19 “(C) establishment of organizational prac-
20 tices to support operational and administrative
21 success; and

22 “(D) other activities, as the Secretary de-
23 termines appropriate.

24 “(2) COLLABORATIVE CARE MODEL RECIPI-
25 ENTS.—The Secretary shall provide appropriate in-

1 formation, training, and technical assistance to eligi-
2 ble entities that are collaborating with primary
3 health care practices that receive funds under this
4 section to help such entities implement the collabo-
5 rative care model, including—

6 “(A) developing financial models and budg-
7 ets for implementing and maintaining a collabo-
8 rative care model, based on practice size;

9 “(B) developing staffing models for essen-
10 tial staff roles;

11 “(C) providing strategic advice to assist
12 practices seeking to utilize other clinicians for
13 additional psychotherapeutic interventions;

14 “(D) providing information technology ex-
15 pertise to assist with building the collaborative
16 care model into electronic health records, in-
17 cluding assistance with care manager tools, pa-
18 tient registry, ongoing patient monitoring, and
19 patient records;

20 “(E) training support for all key staff and
21 operational consultation to develop practice
22 workflows;

23 “(F) establishing methods to ensure the
24 sharing of best practices and operational knowl-
25 edge among primary health care physicians and

1 primary health care practices that provide be-
2 havioral health integration services through the
3 collaborative care model; and

4 “(G) providing guidance and instruction to
5 primary health care physicians and primary
6 health care practices on developing and main-
7 taining relationships with community-based
8 mental health and substance use disorder facili-
9 ties for referral and treatment of patients
10 whose clinical presentation or diagnosis is best
11 suited for treatment at such facilities.

12 “(3) ADDITIONAL DISSEMINATION OF TECH-
13 NICAL INFORMATION.—In addition to providing the
14 assistance described in paragraphs (1) and (2) to re-
15 cipients of a grant or cooperative agreement under
16 this section, the Secretary may also provide such as-
17 sistance to other States and political subdivisions of
18 States, Indian Tribes and Tribal organizations (as
19 defined under the Federally Recognized Indian Tribe
20 List Act of 1994), outpatient mental health and ad-
21 diction treatment centers, community mental health
22 centers that meet the criteria under section 1913(c),
23 certified community behavioral health clinics de-
24 scribed in section 223 of the Protecting Access to
25 Medicare Act of 2014, primary care organizations

1 such as Federally qualified health centers or rural
2 health clinics as defined in section 1861(aa) of the
3 Social Security Act, primary health care practices,
4 other community-based organizations, and other en-
5 tities engaging in integrated care activities, as the
6 Secretary determines appropriate.

7 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this section, there is authorized to be appro-
9 priated \$60,000,000 for each of fiscal years 2023 through
10 2027.”.

11 **Subtitle B—Helping Enable Access**
12 **to Lifesaving Services**

13 **SEC. 311. REAUTHORIZATION AND PROVISION OF CERTAIN**
14 **PROGRAMS TO STRENGTHEN THE HEALTH**
15 **CARE WORKFORCE.**

16 (a) LIABILITY PROTECTIONS FOR HEALTH PROFES-
17 SIONAL VOLUNTEERS.—Section 224(q)(6) of the Public
18 Health Service Act (42 U.S.C. 233(q)(6)) is amended by
19 striking “October 1, 2022” and inserting “October 1,
20 2027”.

21 (b) MINORITY FELLOWSHIPS IN CRISIS CARE MAN-
22 AGEMENT.—Section 597(b) of the Public Health Service
23 Act (42 U.S.C. 2901l(b)) is amended by striking “in the
24 fields of psychiatry,” and inserting “in the fields of crisis
25 care management, psychiatry,”.

1 (c) MENTAL AND BEHAVIORAL HEALTH EDUCATION
2 AND TRAINING GRANTS.—Section 756 of the Public
3 Health Service Act (42 U.S.C. 294e–1) is amended—

4 (1) in subsection (a)(1), by inserting “(which
5 may include master’s and doctoral level programs)”
6 after “occupational therapy”; and

7 (2) in subsection (f), by striking “For each of
8 fiscal years 2019 through 2023” and inserting “For
9 each of fiscal years 2023 through 2027”.

10 (d) TRAINING DEMONSTRATION PROGRAM.—Section
11 760(g) of the Public Health Service Act (42 U.S.C.
12 294k(g)) is amended by inserting “and \$31,700,000 for
13 each of fiscal years 2023 through 2027” before the period
14 at the end.

15 **SEC. 312. REAUTHORIZATION OF MINORITY FELLOWSHIP**
16 **PROGRAM.**

17 Section 597(c) of the Public Health Service Act (42
18 U.S.C. 290ll(c)) is amended by striking “\$12,669,000 for
19 each of fiscal years 2018 through 2022” and inserting
20 “\$25,000,000 for each of fiscal years 2023 through
21 2027”.

1 **Subtitle C—Eliminating the Opt-**
2 **Out for Nonfederal Govern-**
3 **mental Health Plans**

4 **SEC. 321. ELIMINATING THE OPT-OUT FOR NONFEDERAL**
5 **GOVERNMENTAL HEALTH PLANS.**

6 Section 2722(a)(2) of the Public Health Service Act
7 (42 U.S.C. 300gg–21(a)(2)) is amended by adding at the
8 end the following new subparagraph:

9 “(F) SUNSET OF ELECTION OPTION.—

10 “(i) IN GENERAL.—Notwithstanding
11 the preceding provisions of this para-
12 graph—

13 “(I) no election described in sub-
14 paragraph (A) with respect to section
15 2726 may be made on or after the
16 date of the enactment of this subpara-
17 graph; and

18 “(II) except as provided in clause
19 (ii), no such election with respect to
20 section 2726 expiring on or after the
21 date that is 180 days after the date of
22 such enactment may be renewed.

23 “(ii) EXCEPTION FOR CERTAIN COL-
24 LECTIVELY BARGAINED PLANS.—Notwith-
25 standing clause (i)(II), a plan described in

1 subparagraph (B)(ii) that is subject to
2 multiple agreements described in such sub-
3 paragraph of varying lengths and that has
4 an election described in subparagraph (A)
5 with respect to section 2726 in effect as of
6 the date of the enactment of this subpara-
7 graph that expires on or after the date
8 that is 180 days after the date of such en-
9 actment may extend such election until the
10 date on which the term of the last such
11 agreement expires.”.

12 **Subtitle D—Mental Health and**
13 **Substance Use Disorder Parity**
14 **Implementation**

15 **SEC. 331. GRANTS TO SUPPORT MENTAL HEALTH AND SUB-**
16 **STANCE USE DISORDER PARITY IMPLEMEN-**
17 **TATION.**

18 (a) IN GENERAL.—Section 2794(c) of the Public
19 Health Service Act (42 U.S.C. 300gg–94(c)) (as added by
20 section 1003 of the Patient Protection and Affordable
21 Care Act (Public Law 111–148)) is amended by adding
22 at the end the following:

23 “(3) PARITY IMPLEMENTATION.—

24 “(A) IN GENERAL.—Beginning during the
25 first fiscal year that begins after the date of en-

1 actment of this paragraph, the Secretary shall,
2 out of funds made available pursuant to sub-
3 paragraph (C), award grants to eligible States
4 to enforce and ensure compliance with the men-
5 tal health and substance use disorder parity
6 provisions of section 2726.

7 “(B) ELIGIBLE STATE.—A State shall be
8 eligible for a grant awarded under this para-
9 graph only if such State—

10 “(i) submits to the Secretary an appli-
11 cation for such grant at such time, in such
12 manner, and containing such information
13 as specified by the Secretary; and

14 “(ii) agrees to request and review
15 from health insurance issuers offering
16 group or individual health insurance cov-
17 erage the comparative analyses and other
18 information required of such health insur-
19 ance issuers under subsection (a)(8)(A) of
20 section 2726 relating to the design and ap-
21 plication of nonquantitative treatment limi-
22 tations imposed on mental health or sub-
23 stance use disorder benefits.

24 “(C) AUTHORIZATION OF APPROPRIA-
25 TIONS.—There are authorized to be appro-

1 priedated \$10,000,000 for each of the first five
2 fiscal years beginning after the date of the en-
3 actment of this paragraph, to remain available
4 until expended, for purposes of awarding grants
5 under subparagraph (A).”.

6 (b) TECHNICAL AMENDMENT.—Section 2794 of the
7 Public Health Service Act (42 U.S.C. 300gg–95), as
8 added by section 6603 of the Patient Protection and Af-
9 fordable Care Act (Public Law 111–148) is redesignated
10 as section 2795.

11 **Subtitle E—Improving Emergency**
12 **Department Mental Health Ac-**
13 **cess, Services, and Responders**

14 **SEC. 341. HELPING EMERGENCY RESPONDERS OVERCOME.**

15 (a) DATA SYSTEM TO CAPTURE NATIONAL PUBLIC
16 SAFETY OFFICER SUICIDE INCIDENCE.—The Public
17 Health Service Act is amended by inserting before section
18 318 of such Act (42 U.S.C. 247c) the following:

19 **“SEC. 317V. DATA SYSTEM TO CAPTURE NATIONAL PUBLIC**
20 **SAFETY OFFICER SUICIDE INCIDENCE.**

21 “(a) IN GENERAL.—The Secretary, in coordination
22 with the Director of the Centers for Disease Control and
23 Prevention and other agencies as the Secretary determines
24 appropriate, may—

1 “(1) develop and maintain a data system, to be
2 known as the Public Safety Officer Suicide Report-
3 ing System, for the purposes of—

4 “(A) collecting data on the suicide inci-
5 dence among public safety officers; and

6 “(B) facilitating the study of successful
7 interventions to reduce suicide among public
8 safety officers; and

9 “(2) integrate such system into the National
10 Violent Death Reporting System, so long as the Sec-
11 retary determines such integration to be consistent
12 with the purposes described in paragraph (1).

13 “(b) DATA COLLECTION.—In collecting data for the
14 Public Safety Officer Suicide Reporting System, the Sec-
15 retary shall, at a minimum, collect the following informa-
16 tion:

17 “(1) The total number of suicides in the United
18 States among all public safety officers in a given cal-
19 endar year.

20 “(2) Suicide rates for public safety officers in
21 a given calendar year, disaggregated by—

22 “(A) age and gender of the public safety
23 officer;

24 “(B) State;

1 “(C) occupation; including both the indi-
2 vidual’s role in their public safety agency and
3 their primary occupation in the case of volun-
4 teer public safety officers;

5 “(D) where available, the status of the
6 public safety officer as volunteer, paid-on-call,
7 or career; and

8 “(E) status of the public safety officer as
9 active or retired.

10 “(c) CONSULTATION DURING DEVELOPMENT.—In
11 developing the Public Safety Officer Suicide Reporting
12 System, the Secretary shall consult with non-Federal ex-
13 perts to determine the best means to collect data regard-
14 ing suicide incidence in a safe, sensitive, anonymous, and
15 effective manner. Such non-Federal experts shall include,
16 as appropriate, the following:

17 “(1) Public health experts with experience in
18 developing and maintaining suicide registries.

19 “(2) Organizations that track suicide among
20 public safety officers.

21 “(3) Mental health experts with experience in
22 studying suicide and other profession-related trau-
23 matic stress.

24 “(4) Clinicians with experience in diagnosing
25 and treating mental health issues.

1 “(5) Active and retired volunteer, paid-on-call,
2 and career public safety officers.

3 “(6) Relevant national police, and fire and
4 emergency medical services, organizations.

5 “(d) DATA PRIVACY AND SECURITY.—In developing
6 and maintaining the Public Safety Officer Suicide Report-
7 ing System, the Secretary shall ensure that all applicable
8 Federal privacy and security protections are followed to
9 ensure that—

10 “(1) the confidentiality and anonymity of sui-
11 cide victims and their families are protected, includ-
12 ing so as to ensure that data cannot be used to deny
13 benefits; and

14 “(2) data is sufficiently secure to prevent unau-
15 thorized access.

16 “(e) REPORTING.—

17 “(1) ANNUAL REPORT.—Not later than 2 years
18 after the date of enactment of the Restoring Hope
19 for Mental Health and Well-Being Act of 2022, and
20 biannually thereafter, the Secretary shall submit a
21 report to the Congress on the suicide incidence
22 among public safety officers. Each such report
23 shall—

1 “(A) include the number and rate of such
2 suicide incidence, disaggregated by age, gender,
3 and State of employment;

4 “(B) identify characteristics and contrib-
5 uting circumstances for suicide among public
6 safety officers;

7 “(C) disaggregate rates of suicide by—

8 “(i) occupation;

9 “(ii) status as volunteer, paid-on-call,
10 or career; and

11 “(iii) status as active or retired;

12 “(D) include recommendations for further
13 study regarding the suicide incidence among
14 public safety officers;

15 “(E) specify in detail, if found, any obsta-
16 cles in collecting suicide rates for volunteers
17 and include recommended improvements to
18 overcome such obstacles;

19 “(F) identify options for interventions to
20 reduce suicide among public safety officers; and

21 “(G) describe procedures to ensure the
22 confidentiality and anonymity of suicide victims
23 and their families, as described in subsection
24 (d)(1).

1 “(2) PUBLIC AVAILABILITY.—Upon the submis-
2 sion of each report to the Congress under paragraph
3 (1), the Secretary shall make the full report publicly
4 available on the website of the Centers for Disease
5 Control and Prevention.

6 “(f) DEFINITION.—In this section, the term ‘public
7 safety officer’ means—

8 “(1) a public safety officer as defined in section
9 1204 of the Omnibus Crime Control and Safe
10 Streets Act of 1968; or

11 “(2) a public safety telecommunicator as de-
12 scribed in detailed occupation 43–5031 in the Stand-
13 ard Occupational Classification Manual of the Office
14 of Management and Budget (2018).

15 “(g) PROHIBITED USE OF INFORMATION.—Notwith-
16 standing any other provision of law, if an individual is
17 identified as deceased based on information contained in
18 the Public Safety Officer Suicide Reporting System, such
19 information may not be used to deny or rescind life insur-
20 ance payments or other benefits to a survivor of the de-
21 ceased individual.”.

22 (b) PEER-SUPPORT BEHAVIORAL HEALTH AND
23 WELLNESS PROGRAMS WITHIN FIRE DEPARTMENTS AND
24 EMERGENCY MEDICAL SERVICE AGENCIES.—

1 (1) IN GENERAL.—Part B of title III of the
2 Public Health Service Act (42 U.S.C. 243 et seq.)
3 is amended by adding at the end the following:

4 **“SEC. 320C. PEER-SUPPORT BEHAVIORAL HEALTH AND**
5 **WELLNESS PROGRAMS WITHIN FIRE DEPART-**
6 **MENTS AND EMERGENCY MEDICAL SERVICE**
7 **AGENCIES.**

8 “(a) IN GENERAL.—The Secretary may award grants
9 to eligible entities for the purpose of establishing or en-
10 hancing peer-support behavioral health and wellness pro-
11 grams within fire departments and emergency medical
12 services agencies.

13 “(b) PROGRAM DESCRIPTION.—A peer-support be-
14 havioral health and wellness program funded under this
15 section shall—

16 “(1) use career and volunteer members of fire
17 departments or emergency medical services agencies
18 to serve as peer counselors;

19 “(2) provide training to members of career, vol-
20 unteer, and combination fire departments or emer-
21 gency medical service agencies to serve as such peer
22 counselors;

23 “(3) purchase materials to be used exclusively
24 to provide such training; and

1 “(4) disseminate such information and mate-
2 rials as are necessary to conduct the program.

3 “(c) DEFINITION.—In this section:

4 “(1) The term ‘eligible entity’ means a non-
5 profit organization with expertise and experience
6 with respect to the health and life safety of members
7 of fire and emergency medical services agencies.

8 “(2) The term ‘member’—

9 “(A) with respect to an emergency medical
10 services agency, means an employee, regardless
11 of rank or whether the employee receives com-
12 pensation (as defined in section 1204(7) of the
13 Omnibus Crime Control and Safe Streets Act of
14 1968); and

15 “(B) with respect to a fire department,
16 means any employee, regardless of rank or
17 whether the employee receives compensation, of
18 a Federal, State, Tribal, or local fire depart-
19 ment who is responsible for responding to calls
20 for emergency service.”.

21 (2) TECHNICAL CORRECTION.—Effective as if
22 included in the enactment of the Children’s Health
23 Act of 2000 (Public Law 106–310), the amendment
24 instruction in section 1603 of such Act is amended
25 by striking “Part B of the Public Health Service

1 Act” and inserting “Part B of title III of the Public
2 Health Service Act”.

3 (c) HEALTH CARE PROVIDER BEHAVIORAL HEALTH
4 AND WELLNESS PROGRAMS.—Part B of title III of the
5 Public Health Service Act (42 U.S.C. 243 et seq.), as
6 amended by subsection (b)(1), is further amended by add-
7 ing at the end the following:

8 **“SEC. 320D. HEALTH CARE PROVIDER BEHAVIORAL**
9 **HEALTH AND WELLNESS PROGRAMS.**

10 “(a) IN GENERAL.—The Secretary may award grants
11 to eligible entities for the purpose of establishing or en-
12 hancing behavioral health and wellness programs for
13 health care providers.

14 “(b) PROGRAM DESCRIPTION.—A behavioral health
15 and wellness program funded under this section shall—

16 “(1) provide confidential support services for
17 health care providers to help handle stressful or
18 traumatic patient-related events, including coun-
19 seling services and wellness seminars;

20 “(2) provide training to health care providers to
21 serve as peer counselors to other health care pro-
22 viders;

23 “(3) purchase materials to be used exclusively
24 to provide such training; and

1 “(4) disseminate such information and mate-
2 rials as are necessary to conduct such training and
3 provide such peer counseling.

4 “(c) DEFINITIONS.—In this section, the term ‘eligible
5 entity’ means a hospital, including a critical access hos-
6 pital (as defined in section 1861(mm)(1) of the Social Se-
7 curity Act) or a disproportionate share hospital (as defined
8 under section 1923(a)(1)(A) of such Act), a Federally-
9 qualified health center (as defined in section
10 1905(1)(2)(B) of such Act), or any other health care facil-
11 ity.”.

12 (d) DEVELOPMENT OF RESOURCES FOR EDUCATING
13 MENTAL HEALTH PROFESSIONALS ABOUT TREATING
14 FIRE FIGHTERS AND EMERGENCY MEDICAL SERVICES
15 PERSONNEL.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services shall develop and make publicly
18 available resources that may be used by the Federal
19 Government and other entities to educate mental
20 health professionals about—

21 (A) the culture of Federal, State, Tribal,
22 and local career, volunteer, and combination
23 fire departments and emergency medical serv-
24 ices agencies;

1 (B) the different stressors experienced by
2 firefighters and emergency medical services per-
3 sonnel, supervisory firefighters and emergency
4 medical services personnel, and chief officers of
5 fire departments and emergency medical serv-
6 ices agencies;

7 (C) challenges encountered by retired fire-
8 fighters and emergency medical services per-
9 sonnel; and

10 (D) evidence-based therapies for mental
11 health issues common to firefighters and emer-
12 gency medical services personnel within such
13 departments and agencies.

14 (2) CONSULTATION.—In developing resources
15 under paragraph (1), the Secretary of Health and
16 Human Services shall consult with national fire and
17 emergency medical services organizations.

18 (3) DEFINITIONS.—In this subsection:

19 (A) The term “firefighter” means any em-
20 ployee, regardless of rank or whether the em-
21 ployee receives compensation, of a Federal,
22 State, Tribal, or local fire department who is
23 responsible for responding to calls for emer-
24 gency service.

1 (B) The term “emergency medical services
2 personnel” means any employee, regardless of
3 rank or whether the employee receives com-
4 pensation, as defined in section 1204(7) of the
5 Omnibus Crime Control and Safe Streets Act of
6 1968 (34 U.S.C. 10284(7)).

7 (C) The term “chief officer” means any in-
8 dividual who is responsible for the overall oper-
9 ation of a fire department or an emergency
10 medical services agency, irrespective of whether
11 such individual also serves as a firefighter or
12 emergency medical services personnel.

13 (e) BEST PRACTICES AND OTHER RESOURCES FOR
14 ADDRESSING POSTTRAUMATIC STRESS DISORDER IN
15 PUBLIC SAFETY OFFICERS.—

16 (1) DEVELOPMENT; UPDATES.—The Secretary
17 of Health and Human Services shall—

18 (A) develop and assemble evidence-based
19 best practices and other resources to identify,
20 prevent, and treat posttraumatic stress disorder
21 and co-occurring disorders in public safety offi-
22 cers; and

23 (B) reassess and update, as the Secretary
24 determines necessary, such best practices and
25 resources, including based upon the options for

1 interventions to reduce suicide among public
2 safety officers identified in the annual reports
3 required by section 317V(e)(1)(F) of the Public
4 Health Service Act, as added by subsection (a).

5 (2) CONSULTATION.—In developing, assembling,
6 and updating the best practices and resources
7 under paragraph (1), the Secretary of Health and
8 Human Services shall consult with, at a minimum,
9 the following:

10 (A) Public health experts.

11 (B) Mental health experts with experience
12 in studying suicide and other profession-related
13 traumatic stress.

14 (C) Clinicians with experience in diagnosing
15 and treating mental health issues.

16 (D) Relevant national police, fire, and
17 emergency medical services organizations.

18 (3) AVAILABILITY.—The Secretary of Health
19 and Human Services shall make the best practices
20 and resources under paragraph (1) available to Federal,
21 State, and local fire, law enforcement, and
22 emergency medical services agencies.

23 (4) FEDERAL TRAINING AND DEVELOPMENT
24 PROGRAMS.—The Secretary of Health and Human
25 Services shall work with Federal departments and

1 agencies, including the United States Fire Adminis-
2 tration, to incorporate education and training on the
3 best practices and resources under paragraph (1)
4 into Federal training and development programs for
5 public safety officers.

6 (5) DEFINITION.—In this subsection, the term
7 “public safety officer” means—

8 (A) a public safety officer as defined in
9 section 1204 of the Omnibus Crime Control and
10 Safe Streets Act of 1968 (34 U.S.C. 10284); or

11 (B) a public safety telecommunicator as
12 described in detailed occupation 43–5031 in the
13 Standard Occupational Classification Manual of
14 the Office of Management and Budget (2018).

15 **Subtitle F—Other Provisions**

16 **SEC. 351. REPORT ON LAW ENFORCEMENT MENTAL** 17 **HEALTH AND WELLNESS.**

18 (a) IN GENERAL.—Not later than 270 days after the
19 date of enactment of this Act, the Attorney General, in
20 consultation with the Director of the Federal Bureau of
21 Investigation, the Director of the National Institute for
22 Justice, and the Assistant Secretary for Mental Health
23 and Substance Abuse, shall submit to the Committee on
24 Health, Education, Labor, and Pensions and the Com-
25 mittee on the Judiciary of the Senate and the Committee

1 on Energy and Commerce and the Committee on the Judi-
2 ciary of the House of Representatives a report on—

3 (1) the types, frequency, and severity of mental
4 health and stress-related responses of law enforce-
5 ment officers to aggressive actions or other trauma-
6 inducing incidents against law enforcement officers;

7 (2) mental health and stress-related resources
8 or programs that are available to law enforcement
9 officers at the Federal, State, and local level, includ-
10 ing peer-to-peer programs;

11 (3) the extent to which law enforcement officers
12 use the resources or programs described in para-
13 graph (2);

14 (4) the availability of, or need for, mental
15 health screening within Federal, State, and local law
16 enforcement agencies; and

17 (5) recommendations for Federal, State, and
18 local law enforcement agencies to improve the men-
19 tal health and wellness of their officers.

20 (b) DEVELOPMENT.—In developing the report re-
21 quired under subsection (a), the Attorney General, the Di-
22 rector of the Federal Bureau of Investigation, the Director
23 of the National Institute of Justice, and the Assistant Sec-
24 retary for Mental Health and Substance Abuse shall con-
25 sult relevant stakeholders, including—

1 (1) Federal, State, Tribal and local law enforce-
2 ment agencies; and

3 (2) nongovernmental organizations, inter-
4 national organizations, academies, or other entities.

5 **TITLE IV—CHILDREN AND** 6 **YOUTH**

7 **Subtitle A—Supporting Children’s** 8 **Mental Health Care Access**

9 **SEC. 401. PEDIATRIC MENTAL HEALTH CARE ACCESS** 10 **GRANTS.**

11 Section 330M of the Public Health Service Act (42
12 U.S.C. 254e-19) is amended—

13 (1) in the section enumerator, by striking
14 “**330M**” and inserting “**330M.**”;

15 (2) in subsection (a)—

16 (A) by striking “Indian tribes and tribal
17 organizations” and inserting “Indian Tribes
18 and Tribal organizations”; and

19 (B) by inserting “or, in the case of a State
20 that does not submit an application, a nonprofit
21 entity that has the support of the State” after
22 “450b))”;

23 (3) in subsection (b)—

24 (A) in paragraph (1)—

1 (i) in subparagraph (G), by inserting
2 “developmental-behavioral pediatricians,”
3 after “adolescent psychiatrists,”;

4 (ii) in subparagraph (H), by striking
5 “; and” at the end and inserting a semi-
6 colon;

7 (iii) by redesignating subparagraph
8 (I) as subparagraph (J); and

9 (iv) by inserting after subparagraph
10 (H) the following:

11 “(I) maintain an up-to-date list of commu-
12 nity-based supports for children with mental
13 health problems; and”;

14 (B) by redesignating paragraph (2) as
15 paragraph (4);

16 (C) by inserting after paragraph (1) the
17 following:

18 “(2) SUPPORT TO SCHOOLS AND EMERGENCY
19 DEPARTMENTS.—In addition to the activities re-
20 quired by paragraph (1), a pediatric mental health
21 care telehealth access program referred to in sub-
22 section (a), with respect to which a grant under such
23 subsection may be used, may provide support to
24 schools and emergency departments.

1 “(3) PRIORITY.—In awarding grants under this
2 section, the Secretary shall give priority to appli-
3 cants proposing to—

4 “(A) continue existing programs that meet
5 the requirements of paragraph (1);

6 “(B) establish a pediatric mental health
7 care telehealth access program in the jurisdic-
8 tion of a State, Territory, Indian Tribe, or
9 Tribal organization that does not yet have such
10 a program; or

11 “(C) expand a pediatric mental health care
12 telehealth access program to include one or
13 more new sites of care, such as a school or
14 emergency department.”; and

15 (D) in paragraph (4), as redesignated by
16 subparagraph (B), by inserting “Such a team
17 may include a developmental-behavioral pedia-
18 trician.” after “mental health counselor.”;

19 (4) in subsections (c), (d), and (f), by striking
20 “Indian tribe, or tribal organization” each place it
21 appears and inserting “Indian Tribe, Tribal organi-
22 zation, or nonprofit entity”; and

23 (5) by striking subsection (g) and inserting the
24 following:

1 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
2 award grants or contracts to one or more eligible entities
3 (as defined by the Secretary) for the purposes of providing
4 technical assistance and evaluation support to grantees
5 under subsection (a).

6 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there are authorized to be appro-
8 priated—

9 “(1) \$14,000,000 for each of fiscal years 2023
10 through 2025; and

11 “(2) \$30,000,000 for each of fiscal years 2026
12 through 2027.”.

13 **SEC. 402. INFANT AND EARLY CHILDHOOD MENTAL**
14 **HEALTH PROMOTION, INTERVENTION, AND**
15 **TREATMENT.**

16 Section 399Z–2(f) of the Public Health Service Act
17 (42 U.S.C. 280h–6(f)) is amended by striking
18 “\$20,000,000 for the period of fiscal years 2018 through
19 2022” and inserting “\$50,000,000 for the period of fiscal
20 years 2023 through 2027”.

21 **SEC. 403. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND**
22 **ADOLESCENTS.**

23 (a) TECHNICAL AMENDMENTS.—The second part G
24 (relating to services provided through religious organiza-

1 tions) of title V of the Public Health Service Act (42
2 U.S.C. 290kk et seq.) is amended—

3 (1) by redesignating such part as part J; and

4 (2) by redesignating sections 581 through 584
5 as sections 596 through 596C, respectively.

6 (b) SCHOOL-BASED MENTAL HEALTH AND CHIL-
7 DREN.—Section 581 of the Public Health Service Act (42
8 U.S.C. 290hh) (relating to children and violence) is
9 amended to read as follows:

10 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**
11 **AND ADOLESCENTS.**

12 “(a) IN GENERAL.—The Secretary, in consultation
13 with the Secretary of Education, shall, through grants,
14 contracts, or cooperative agreements awarded to eligible
15 entities described in subsection (c), provide comprehensive
16 school-based mental health services and supports to assist
17 children in local communities and schools (including
18 schools funded by the Bureau of Indian Education) deal-
19 ing with traumatic experiences, grief, bereavement, risk of
20 suicide, and violence. Such services and supports shall
21 be—

22 “(1) developmentally, linguistically, and cul-
23 turally appropriate;

24 “(2) trauma-informed; and

1 “(3) incorporate positive behavioral interven-
2 tions and supports.

3 “(b) ACTIVITIES.—Grants, contracts, or cooperative
4 agreements awarded under subsection (a), shall, as appro-
5 priate, be used for—

6 “(1) implementation of school and community-
7 based mental health programs that—

8 “(A) build awareness of individual trauma
9 and the intergenerational, continuum of impacts
10 of trauma on populations;

11 “(B) train appropriate staff to identify,
12 and screen for, signs of trauma exposure, men-
13 tal health disorders, or risk of suicide; and

14 “(C) incorporate positive behavioral inter-
15 ventions, family engagement, student treatment,
16 and multigenerational supports to foster the
17 health and development of children, prevent
18 mental health disorders, and ameliorate the im-
19 pact of trauma;

20 “(2) technical assistance to local communities
21 with respect to the development of programs de-
22 scribed in paragraph (1);

23 “(3) facilitating community partnerships among
24 families, students, law enforcement agencies, edu-
25 cation agencies, mental health and substance use

1 disorder service systems, family-based mental health
2 service systems, child welfare agencies, health care
3 providers (including primary care physicians, mental
4 health professionals, and other professionals who
5 specialize in children’s mental health such as child
6 and adolescent psychiatrists), institutions of higher
7 education, faith-based programs, trauma networks,
8 and other community-based systems to address child
9 and adolescent trauma, mental health issues, and vi-
10 olence; and

11 “(4) establishing mechanisms for children and
12 adolescents to report incidents of violence or plans
13 by other children, adolescents, or adults to commit
14 violence.

15 “(c) REQUIREMENTS.—

16 “(1) IN GENERAL.—To be eligible for a grant,
17 contract, or cooperative agreement under subsection
18 (a), an entity shall be a partnership that includes—

19 “(A) a State educational agency, as de-
20 fined in section 8101 of the Elementary and
21 Secondary Education Act of 1965, in coordina-
22 tion with one or more local educational agen-
23 cies, as defined in section 8101 of the Elemen-
24 tary and Secondary Education Act of 1965, or
25 a consortium of any entities described in sub-

1 paragraph (B), (C), (D), or (E) of section
2 8101(30) of such Act; and

3 “(B) at least 1 community-based mental
4 health provider, including a public or private
5 mental health entity, health care entity, family-
6 based mental health entity, trauma network, or
7 other community-based entity, as determined by
8 the Secretary (and which may include addi-
9 tional entities such as a human services agency,
10 law enforcement or juvenile justice entity, child
11 welfare agency, agency, an institution of higher
12 education, or another entity, as determined by
13 the Secretary).

14 “(2) COMPLIANCE WITH HIPAA.—Any patient
15 records developed by covered entities through activi-
16 ties under the grant shall meet the regulations pro-
17 mulgated under section 264(c) of the Health Insur-
18 ance Portability and Accountability Act of 1996.

19 “(3) COMPLIANCE WITH FERPA.—Section 444
20 of the General Education Provisions Act (commonly
21 known as the ‘Family Educational Rights and Pri-
22 vacy Act of 1974’) shall apply to any entity that is
23 a member of the partnership in the same manner
24 that such section applies to an educational agency or
25 institution (as that term is defined in such section).

1 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
2 shall ensure that grants, contracts, or cooperative agree-
3 ments under subsection (a) will be distributed equitably
4 among the regions of the country and among urban and
5 rural areas.

6 “(e) DURATION OF AWARDS.—With respect to a
7 grant, contract, or cooperative agreement under sub-
8 section (a), the period during which payments under such
9 an award will be made to the recipient shall be 5 years,
10 with options for renewal.

11 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

12 “(1) DEVELOPMENT OF PROCESS.—The Assist-
13 ant Secretary shall develop a fiscally appropriate
14 process for evaluating activities carried out under
15 this section. Such process shall include—

16 “(A) the development of guidelines for the
17 submission of program data by grant, contract,
18 or cooperative agreement recipients;

19 “(B) the development of measures of out-
20 comes (in accordance with paragraph (2)) to be
21 applied by such recipients in evaluating pro-
22 grams carried out under this section; and

23 “(C) the submission of annual reports by
24 such recipients concerning the effectiveness of
25 programs carried out under this section.

1 “(2) MEASURES OF OUTCOMES.—The Assistant
2 Secretary shall develop measures of outcomes to be
3 applied by recipients of assistance under this section
4 to evaluate the effectiveness of programs carried out
5 under this section, including outcomes related to the
6 student, family, and local educational systems sup-
7 ported by this Act.

8 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
9 ble entity described in subsection (c) that receives a
10 grant, contract, or cooperative agreement under this
11 section shall annually submit to the Assistant Sec-
12 retary a report that includes data to evaluate the
13 success of the program carried out by the entity
14 based on whether such program is achieving the pur-
15 poses of the program. Such reports shall utilize the
16 measures of outcomes under paragraph (2) in a rea-
17 sonable manner to demonstrate the progress of the
18 program in achieving such purposes.

19 “(4) EVALUATION BY ASSISTANT SECRETARY.—
20 Based on the data submitted under paragraph (3),
21 the Assistant Secretary shall annually submit to
22 Congress a report concerning the results and effec-
23 tiveness of the programs carried out with assistance
24 received under this section.

1 “(5) LIMITATION.—An eligible entity shall use
2 not more than 20 percent of amounts received under
3 a grant under this section to carry out evaluation
4 activities under this subsection.

5 “(g) INFORMATION AND EDUCATION.—The Sec-
6 retary shall disseminate best practices based on the find-
7 ings of the knowledge development and application under
8 this section.

9 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
10 APPROPRIATIONS.—

11 “(1) AMOUNT OF GRANTS.—A grant under this
12 section shall be in an amount that is not more than
13 \$2,000,000 for each of the first 5 fiscal years fol-
14 lowing the date of enactment of the Restoring Hope
15 for Mental Health and Well-Being Act of 2022. The
16 Secretary shall determine the amount of each such
17 grant based on the population of children up to age
18 21 of the area to be served under the grant.

19 “(2) AUTHORIZATION OF APPROPRIATIONS.—
20 There is authorized to be appropriated to carry out
21 this section, \$130,000,000 for each of fiscal years
22 2023 through 2027.”.

23 “(c) CONFORMING AMENDMENT.—Part G of title V of
24 the Public Health Service Act (42 U.S.C. 290hh et seq.),
25 as amended by subsection (b), is further amended by strik-

1 ing the part designation and heading and inserting the
2 following:

3 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

4 **SEC. 404. CO-OCCURRING CHRONIC CONDITIONS AND MEN-**
5 **TAL HEALTH IN YOUTH STUDY.**

6 Not later than 12 months after the date of enactment
7 of this Act, the Secretary of Health and Human Services
8 shall—

9 (1) complete a study on the rates of suicidal be-
10 haviors among children and adolescents with chronic
11 illnesses, including substance use disorders, auto-
12 immune disorders, and heritable blood disorders; and

13 (2) submit a report to the Congress on the re-
14 sults of such study, including recommendations for
15 early intervention services for such children and ado-
16 lescents at risk of suicide, the dissemination of best
17 practices to support the emotional and mental health
18 needs of youth, and strategies to lower the rates of
19 suicidal behaviors in children and adolescents de-
20 scribed in paragraph (1) to reduce any demographic
21 disparities in such rates.

1 **SEC. 405. BEST PRACTICES FOR BEHAVIORAL INTERVEN-**
2 **TION TEAMS.**

3 The Public Health Service Act is amended by insert-
4 ing after section 520H of such Act, as added by section
5 151, the following new section:

6 **“SEC. 520I. BEST PRACTICES FOR BEHAVIORAL INTERVEN-**
7 **TION TEAMS.**

8 “(a) IN GENERAL.—The Secretary shall identify and
9 facilitate the development of best practices to assist ele-
10 mentary schools, secondary schools, and institutions of
11 higher education in establishing and using behavioral
12 intervention teams.

13 “(b) ELEMENTS.—The best practices under sub-
14 section (a)(1) shall include guidance on the following:

15 “(1) How behavioral intervention teams can op-
16 erate effectively from an evidence-based, objective
17 perspective while protecting the constitutional and
18 civil rights of individuals.

19 “(2) The use of behavioral intervention teams
20 to identify concerning behaviors, implement interven-
21 tions, and manage risk through the framework of
22 the school’s or institution’s rules or code of conduct,
23 as applicable.

24 “(3) How behavioral intervention teams can,
25 when assessing an individual—

1 “(A) access training on evidence-based,
2 threat-assessment rubrics;

3 “(B) ensure that such teams—

4 “(i) have trained, diverse stakeholders
5 with varied expertise; and

6 “(ii) use cross validation by a wide-
7 range of individual perspectives on the
8 team; and

9 “(C) use violence risk assessment.

10 “(4) How behavioral intervention teams can
11 help mitigate—

12 “(A) inappropriate use of a mental health
13 assessment;

14 “(B) inappropriate limitations or restric-
15 tions on law enforcement’s jurisdiction over
16 criminal matters;

17 “(C) attempts to substitute the behavioral
18 intervention process in place of a criminal proc-
19 ess, or impede a criminal process, when an indi-
20 vidual’s behavior has potential criminal implica-
21 tions;

22 “(D) endangerment of an individual’s pri-
23 vacy by failing to ensure that all applicable
24 Federal and State privacy laws are fully com-
25 plied with; or

1 “(E) inappropriate referrals to, or involve-
2 ment of, law enforcement when an individual’s
3 behavior does not warrant a criminal response.

4 “(c) CONSULTATION.—In carrying out subsection
5 (a)(1), the Secretary shall consult with—

6 “(1) the Secretary of Education;

7 “(2) the Director of the National Threat As-
8 sessment Center of the United States Secretary
9 Service;

10 “(3) the Attorney General and the Director of
11 the Bureau of Justice Assistance;

12 “(4) teachers and other educators, principals,
13 school administrators, school board members, school
14 psychologists, mental health professionals, and par-
15 ents of students;

16 “(5) local law enforcement agencies and campus
17 law enforcement administrators;

18 “(6) privacy experts; and

19 “(7) other education and mental health profes-
20 sionals as the Secretary deems appropriate.

21 “(d) PUBLICATION.—Not later than 2 years after the
22 date of enactment of this section, the Secretary shall pub-
23 lish the best practices under subsection (a)(1) on the inter-
24 net website of the Department of Health and Human
25 Services.

1 “(e) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide technical assistance to institutions of higher edu-
3 cation, elementary schools, and secondary schools to assist
4 such institutions and schools in implementing the best
5 practices under subsection (a).

6 “(f) DEFINITIONS.—In this section:

7 “(1) The term ‘behavioral intervention team’
8 means a team of qualified individuals who—

9 “(A) are responsible for identifying and as-
10 sessing individuals exhibiting concerning behav-
11 iors, experiencing distress, or who are at risk of
12 harm to self or others;

13 “(B) develop and facilitate implementation
14 of evidence-based interventions to mitigate the
15 threat of harm to self or others posed by an in-
16 dividual and address the mental and behavioral
17 health needs of individuals to reduce risk; and

18 “(C) provide information to students, par-
19 ents, and school employees on recognizing be-
20 havior described in this subsection.

21 “(2) The terms ‘elementary school’, ‘parent’,
22 and ‘secondary school’ have the meanings given to
23 such terms in section 8101 of the Elementary and
24 Secondary Education Act of 1965.

1 “(3) The term ‘institution of higher education’
2 has the meaning given to such term in section 102
3 of the Higher Education Act of 1965.

4 “(4) The term ‘mental health assessment’
5 means an evaluation, primarily focused on diagnosis,
6 determining the need for involuntary commitment,
7 medication management, and on-going treatment
8 recommendations.

9 “(5) The term ‘violence risk assessment’ means
10 a broad determination of the potential risk of vio-
11 lence based on evidence-based literature.”.

12 **Subtitle B—Continuing Systems of** 13 **Care for Children**

14 **SEC. 411. COMPREHENSIVE COMMUNITY MENTAL HEALTH** 15 **SERVICES FOR CHILDREN WITH SERIOUS** 16 **EMOTIONAL DISTURBANCES.**

17 (a) DEFINITION OF FAMILY.—Section 565(d)(2)(B)
18 of the Public Health Service Act (42 U.S.C. 290ff–
19 4(d)(2)(B)) is amended by striking “as appropriate re-
20 garding mental health services for the child, the parents
21 of the child (biological or adoptive, as the case may be)
22 and any foster parents of the child” and inserting “as ap-
23 propriate regarding mental health services for the child
24 and the parents or kinship caregivers of the child”.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—Para-
2 graph (1) of section 565(f) of the Public Health Service
3 Act (42 U.S.C. 290ff–4(f)) is amended—

4 (1) by moving the margin of such paragraph 2
5 ems to the right; and

6 (2) by striking “\$119,026,000 for each of fiscal
7 years 2018 through 2022” and inserting
8 “\$125,000,000 for each of fiscal years 2023 through
9 2027”.

10 **SEC. 412. SUBSTANCE USE DISORDER TREATMENT AND**
11 **EARLY INTERVENTION SERVICES FOR CHIL-**
12 **DREN AND ADOLESCENTS.**

13 Section 514 of the Public Health Service Act (42
14 U.S.C. 290bb–7) is amended—

15 (1) in subsection (a), by striking “Indian tribes
16 or tribal organizations” and inserting “Indian Tribes
17 or Tribal organizations”; and

18 (2) in subsection (f), by striking “2018 through
19 2022” and inserting “2023 through 2027”.

1 **Subtitle C—Garrett Lee Smith**
2 **Memorial Reauthorization**

3 **SEC. 421. SUICIDE PREVENTION TECHNICAL ASSISTANCE**
4 **CENTER.**

5 (a) TECHNICAL AMENDMENT.—Section 520C of the
6 Public Health Service Act (42 U.S.C. 290bb–34) is
7 amended—

8 (1) by striking “tribes” and inserting “Tribes”;
9 and

10 (2) by striking “tribal” each place it appears
11 and inserting “Tribal”.

12 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
13 520C(c) of the Public Health Service Act (42 U.S.C.
14 290bb–34(e)) is amended by striking “\$5,988,000 for
15 each of fiscal years 2018 through 2022” and inserting
16 “\$9,000,000 for each of fiscal years 2023 through 2027”.

17 (c) ANNUAL REPORT.—Section 520C(d) of the Public
18 Health Service Act (42 U.S.C. 290bb–34(d)) is amended
19 by striking “Not later than 2 years after the date of enact-
20 ment of this subsection” and inserting “Not later than
21 2 years after the date of enactment of the Restoring Hope
22 for Mental Health and Well-Being Act of 2022”.

1 **SEC. 422. YOUTH SUICIDE EARLY INTERVENTION AND PRE-**
2 **VENTION STRATEGIES.**

3 Section 520E of the Public Health Service Act (42
4 U.S.C. 290bb–36) is amended—

5 (1) by striking “tribe” and inserting “Tribe”;

6 (2) by striking “tribal” each place it appears
7 and inserting “Tribal”;

8 (3) in subsection (a)(1), by inserting “pediatric
9 health programs,” after “foster care systems,”;

10 (4) by amending subsection (b)(1)(B) to read
11 as follows:

12 “(B) a public organization or private non-
13 profit organization designated by a State or In-
14 dian Tribe (as defined under the Federally Rec-
15 ognized Indian Tribe List Act of 1994) to de-
16 velop or direct the State-sponsored statewide or
17 Tribal youth suicide early intervention and pre-
18 vention strategy; or”;

19 (5) in subsection (c)—

20 (A) in paragraph (1), by inserting “pedi-
21 atric health programs,” after “foster care sys-
22 tems,”;

23 (B) in paragraph (7), by inserting “pedi-
24 atric health programs,” after “foster care sys-
25 tems,”;

1 (C) in paragraph (9), by inserting “pedi-
2 atric health programs,” after “educational insti-
3 tutions,”;

4 (D) in paragraph (13), by striking “and”
5 at the end;

6 (E) in paragraph (14), by striking the pe-
7 riod at the end and inserting “; and”; and

8 (F) by adding at the end the following:

9 “(15) provide to parents, legal guardians, and
10 family members of youth, supplies to securely store
11 means commonly used in suicide, if applicable, with-
12 in the household.”;

13 (6) in subsection (d)—

14 (A) in the heading, by striking “DIRECT
15 SERVICES” and inserting “SUICIDE PREVEN-
16 TION ACTIVITIES”; and

17 (B) by striking “direct services, of which
18 not less than 5 percent shall be used for activi-
19 ties authorized under subsection (a)(3)” and in-
20 serting “suicide prevention activities”;

21 (7) in subsection (e)(3)(A), by inserting “and
22 Department of Education” after “Department of
23 Health and Human Services”;

24 (8) in subsection (g)—

1 (A) in paragraph (1), by striking “18” and
2 inserting “24”; and

3 (B) in paragraph (2), by striking “2 years
4 after the date of enactment of Helping Families
5 in Mental Health Crisis Reform Act of 2016”
6 and inserting “3 years after December 31,
7 2022”;

8 (9) in subsection (l)(4), by striking “between 10
9 and 24 years of age” and inserting “up to 24 years
10 of age”; and

11 (10) in subsection (m), by striking
12 “\$30,000,000 for each of fiscal years 2018 through
13 2022” and inserting “\$40,000,000 for each of fiscal
14 years 2023 through 2027”.

15 **SEC. 423. MENTAL HEALTH AND SUBSTANCE USE DIS-**
16 **ORDER SERVICES FOR STUDENTS IN HIGHER**
17 **EDUCATION.**

18 Section 520E–2 of the Public Health Service Act (42
19 U.S.C. 290bb–36b) is amended—

20 (1) in the heading, by striking “**ON CAMPUS**”
21 and inserting “**FOR STUDENTS IN HIGHER EDU-**
22 **CATION**”; and

23 (2) in subsection (i), by striking “2018 through
24 2022” and inserting “2023 through 2027”.

1 **SEC. 424. MENTAL AND BEHAVIORAL HEALTH OUTREACH**
2 **AND EDUCATION AT INSTITUTIONS OF HIGH-**
3 **ER EDUCATION.**

4 Section 549 of the Public Health Service Act (42
5 U.S.C. 290ee-4) is amended—

6 (1) in the heading, by striking “**ON COLLEGE**
7 **CAMPUSES**” and inserting “**AT INSTITUTIONS OF**
8 **HIGHER EDUCATION**”;

9 (2) in subsection (c)(2), by inserting “, includ-
10 ing minority-serving institutions as described in sec-
11 tion 371(a) of the Higher Education Act of 1965
12 (20 U.S.C. 1067q) and community colleges” after
13 “higher education”; and

14 (3) in subsection (f), by striking “2018 through
15 2022” and inserting “2023 through 2027”.

16 **Subtitle D—Media and Mental**
17 **Health**

18 **SEC. 431. STUDY ON THE EFFECTS OF SMARTPHONE AND**
19 **SOCIAL MEDIA USE ON ADOLESCENTS.**

20 (a) **IN GENERAL.**—Not later than 1 year after the
21 date of enactment of this Act, the Secretary of Health and
22 Human Services shall conduct or support research on—

23 (1) smartphone and social media use by adoles-
24 cents; and

25 (2) the effects of such use on—

1 (A) emotional, behavioral, and physical
2 health and development; and

3 (B) any disparities in the mental health
4 outcomes of rural, minority, and other under-
5 served populations.

6 (b) REPORT.—Not later than 5 years after the date
7 of enactment of this Act, the Secretary of Health and
8 Human Services shall submit to the Congress, and make
9 publicly available, a report on the findings of research
10 under this section.

11 **SEC. 432. RESEARCH ON THE HEALTH AND DEVELOPMENT**
12 **EFFECTS OF MEDIA ON INFANTS, CHILDREN,**
13 **AND ADOLESCENTS.**

14 Subpart 7 of part C of title IV of the Public Health
15 Service Act (42 U.S.C. 285g et seq.) is amended by adding
16 at the end the following:

17 **“SEC. 452H. RESEARCH ON THE HEALTH AND DEVELOP-**
18 **MENT EFFECTS OF MEDIA ON INFANTS, CHIL-**
19 **DREN, AND ADOLESCENTS.**

20 “(a) IN GENERAL.—The Director of the National In-
21 stitutes of Health, in coordination with or acting through
22 the Director of the Institute, shall conduct and support
23 research and related activities concerning the health and
24 developmental effects of media on infants, children, and
25 adolescents, which may include the positive and negative

1 effects of exposure to and use of media, such as social
2 media, applications, websites, television, motion pictures,
3 artificial intelligence, mobile devices, computers, video
4 games, virtual and augmented reality, and other media
5 formats as they become available. Such research shall at-
6 tempt to better understand the relationships between
7 media and technology use and individual differences and
8 characteristics of children and shall include longitudinally
9 designed studies to assess the impact of media on youth
10 over time. Such research shall include consideration of
11 core areas of child and adolescent health and development
12 including the following:

13 “(1) COGNITIVE.—The role and impact of
14 media use and exposure in the development of chil-
15 dren and adolescents within such cognitive areas as
16 language development, executive functioning, atten-
17 tion, creative problem solving skills, visual and spa-
18 tial skills, literacy, critical thinking, and other learn-
19 ing abilities, and the impact of early technology use
20 on developmental trajectories.

21 “(2) PHYSICAL.—The role and impact of media
22 use and exposure on children’s and adolescent’s
23 physical development and health behaviors, including
24 diet, exercise, sleeping and eating routines, and
25 other areas of physical development.

1 “(3) SOCIO-EMOTIONAL.—The role and impact
2 of media use and exposure on children’s and adoles-
3 cents’ social-emotional competencies, including self-
4 awareness, self-regulation, social awareness, relation-
5 ship skills, empathy, distress tolerance, perception of
6 social cues, awareness of one’s relationship with the
7 media, and decision-making, as well as outcomes
8 such as violations of privacy, perpetration of or ex-
9 posure to violence, bullying or other forms of aggres-
10 sion, depression, anxiety, substance use, misuse or
11 disorder, and suicidal ideation/behavior and self-
12 harm.

13 “(b) DEVELOPING RESEARCH AGENDA.—The Direc-
14 tor of the National Institutes of Health, in consultation
15 with the Director of the Institute, other appropriate na-
16 tional research institutes, academies, and centers, the
17 Trans-NIH Pediatric Research Consortium, and non-Fed-
18 eral experts as needed, shall develop a research agenda
19 on the health and developmental effects of media on in-
20 fants, children, and adolescents to inform research activi-
21 ties under subsection (a). In developing such research
22 agenda, the Director may use whatever means necessary
23 (such as scientific workshops and literature reviews) to as-
24 sess current knowledge and research gaps in this area.

1 “(c) RESEARCH PROGRAM.—In coordination with the
2 Institute and other national research institutes and cen-
3 ters, and utilizing the National Institutes of Health’s proc-
4 ess of scientific peer review, the Director of the National
5 Institutes of Health shall fund an expanded research pro-
6 gram on the health and developmental effects of media
7 on infants, children, and adolescents.

8 “(d) REPORT TO CONGRESS.—Not later than 1 year
9 after the date of enactment of this Act, the Director of
10 the National Institutes of Health shall submit a report to
11 Congress on the progress made in gathering data and ex-
12 panding research on the health and developmental effects
13 of media on infants, children, and adolescents in accord-
14 ance with this section. Such report shall summarize the
15 grants and research funded, by year, under this section.”.

16 **TITLE V—MEDICAID AND CHIP**

17 **SEC. 501. MEDICAID AND CHIP REQUIREMENTS FOR** 18 **HEALTH SCREENINGS AND REFERRALS FOR** 19 **ELIGIBLE JUVENILES IN PUBLIC INSTITU-** 20 **TIONS.**

21 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
22 1902 of the Social Security Act (42 U.S.C. 1396a) is
23 amended—

24 (1) in subsection (a)(84)—

1 (A) in subparagraph (A), by inserting “,
2 subject to subparagraph (D),” after “but”;

3 (B) in subparagraph (B), by striking
4 “and” at the end;

5 (C) in subparagraph (C), by adding “and”
6 at the end; and

7 (D) by adding at the end the following new
8 subparagraph:

9 “(D) beginning on the first day of the first
10 calendar quarter that begins two years after the
11 date of enactment of this subparagraph, in the
12 case of individuals who are eligible juveniles de-
13 scribed in subsection (nn)(2), are within 30
14 days of the date on which such eligible juvenile
15 is scheduled to be released from a public insti-
16 tution following adjudication, the State shall
17 have in place a plan to ensure, and in accord-
18 ance with such plan, provide—

19 “(i) for, in the 30 days prior to the
20 release of such an eligible juvenile from
21 such public institution (or not later than
22 one week after release from the public in-
23 stitution), and in coordination with such
24 institution—

1 “(I) any screening or diagnostic
2 service which meets reasonable stand-
3 ards of medical and dental practice,
4 as determined by the State, or as in-
5 dicated as medically necessary, in ac-
6 cordance with paragraphs (1)(A) and
7 (5) of section 1905(r); and

8 “(II) a mental health or other be-
9 havioral health screening that is a
10 screening service described under sec-
11 tion 1905(r)(1), or a diagnostic serv-
12 ice described under paragraph (5) of
13 such section, if such screening or di-
14 agnostic service was not otherwise
15 conducted pursuant to this clause;

16 “(ii) for, not later than one week after
17 release from the public institution, refer-
18 rals for such eligible juvenile to the appro-
19 priate care and services available under the
20 State plan (or waiver of such plan) in the
21 geographic region of the home or residence
22 of such eligible juvenile, based on such
23 screenings; and

24 “(iii) for, following the release of such
25 eligible juvenile from such institution, not

1 less than 30 days of targeted case manage-
2 ment services furnished by a provider in
3 the geographic region of the home or resi-
4 dence of such eligible juvenile.”; and

5 (2) in subsection (nn)(3), by striking “(30)”
6 and inserting “(31)”.

7 (b) AUTHORIZATION OF FEDERAL FINANCIAL PAR-
8 TICIPATION.—The subdivision (A) of section 1905(a) of
9 the Social Security Act (42 U.S.C. 1396d(a)) following
10 paragraph (31) of such section is amended by inserting
11 “, or in the case of an eligible juvenile described in section
12 1902(a)(84)(D) with respect to the screenings, diagnostic
13 services, referrals, and case management required under
14 such subparagraph (D)” after “(except as a patient in a
15 medical institution”.

16 (c) CHIP CONFORMING AMENDMENTS.—

17 (1) Section 2103(c) of the Social Security Act
18 (42 U.S.C. 1397cc(c)) is amended by adding at the
19 end the following new paragraph:

20 “(12) REQUIRED COVERAGE OF SCREENINGS,
21 DIAGNOSTIC SERVICES, REFERRALS, AND CASE MAN-
22 AGEMENT FOR CERTAIN INMATES PRE-RELEASE.—

23 With respect to individuals described in section
24 2110(b)(7), the State shall provide screenings, diag-
25 nostic services, referrals, and case management oth-

1 otherwise covered under the State child health plan (or
2 waiver of such plan) during the period described in
3 such section with respect to such screenings, serv-
4 ices, referrals, and case management.”.

5 (2) Section 2110(b) of the Social Security Act
6 (42 U.S.C. 1397jj(b)) is amended—

7 (A) in paragraph (2)(A), by inserting “ex-
8 cept as provided in paragraph (7),” before “a
9 child who is an inmate of a public institution”;
10 and

11 (B) by adding at the end the following new
12 paragraph:

13 “(7) EXCEPTION TO EXCLUSION OF CHILDREN
14 WHO ARE INMATES OF A PUBLIC INSTITUTION.—A
15 child shall not be considered to be described in para-
16 graph (2)(A) if such child is an eligible juvenile (as
17 described in section 1902(a)(84)(D)) with respect to
18 the screenings, diagnostic services, referrals, and
19 case management otherwise covered under the State
20 child health plan (or waiver of such plan) during the
21 period with respect to which such screenings, serv-
22 ices, referrals, and case management is respectively
23 required under such section.”.

1 **SEC. 502. GUIDANCE ON REDUCING ADMINISTRATIVE BAR-**
2 **RIERS TO PROVIDING HEALTH CARE SERV-**
3 **ICES IN SCHOOLS.**

4 (a) IN GENERAL.—Not later than 12 months after
5 the date of enactment of this Act, the Secretary of Health
6 and Human Services shall issue guidance to State Med-
7 icaid agencies, elementary and secondary schools, and
8 school-based health centers on reducing administrative
9 barriers to such schools and centers furnishing medical as-
10 sistance and obtaining payment for such assistance under
11 titles XIX and XXI of the Social Security Act (42 U.S.C.
12 1396 et seq., 1397aa et seq.).

13 (b) CONTENTS OF GUIDANCE.—The guidance issued
14 pursuant to subsection (a) shall—

15 (1) include revisions to the May 2003 Medicaid
16 School-Based Administrative Claiming Guide, the
17 1997 Medicaid and Schools Technical Assistance
18 Guide, and other relevant guidance in effect on the
19 date of enactment of this Act;

20 (2) provide information on payment under titles
21 XIX and XXI of the Social Security Act (42 U.S.C.
22 1396 et seq., 1397aa et seq.) for the provision of
23 medical assistance, including such assistance pro-
24 vided in accordance with an individualized education
25 program or under the policy described in the State

1 Medicaid Director letter on payment for services
2 issued on December 15, 2014 (#14-006);

3 (3) take into account reasons why small and
4 rural local education agencies may not provide med-
5 ical assistance and provide information on best prac-
6 tices to encourage such agencies to provide such as-
7 sistance; and

8 (4) include best practices and examples of
9 methods that State Medicaid agencies and local edu-
10 cation agencies have used to pay for, and increase
11 the availability of, medical assistance.

12 (c) DEFINITIONS.—In this Act:

13 (1) INDIVIDUALIZED EDUCATION PROGRAM.—
14 The term “individualized education program” has
15 the meaning given such term in section 602(14) of
16 the Individuals with Disabilities Education Act (20
17 U.S.C. 1401(14)).

18 (2) SCHOOL-BASED HEALTH CENTER.—The
19 term “school-based health center” has the meaning
20 given such term in section 2110(c)(9) of the Social
21 Security Act (42 U.S.C. 1397jj(c)(9)), and includes
22 an entity that provides Medicaid-covered services in
23 school-based settings for which Federal financial
24 participation is permitted.

1 **SEC. 503. GUIDANCE TO STATES ON SUPPORTING PEDI-**
2 **ATRIC BEHAVIORAL HEALTH SERVICES**
3 **UNDER MEDICAID AND CHIP.**

4 Not later than 18 months after the date of enactment
5 of this Act, the Secretary of Health and Human Services
6 shall issue guidance to States on how to expand the provi-
7 sion of, and access to, behavioral health services, including
8 mental health services, for children covered under State
9 plans (or waivers of such plans) under title XIX of the
10 Social Security Act (42 U.S.C. 1396 et seq.), or State
11 child health plans (or waivers of such plans) under title
12 XXI of such Act (42 U.S.C. 1397aa et seq.), including
13 a description of best practices for—

- 14 (1) expanding access to such services;
- 15 (2) expanding access to such services in under-
16 served communities;
- 17 (3) flexibilities that States may offer for pedi-
18 atric hospitals and other pediatric behavioral health
19 providers to expand access to services; and
- 20 (4) recruitment and retention of providers of
21 such services.

22 **SEC. 504. ENSURING CHILDREN RECEIVE TIMELY ACCESS**
23 **TO CARE.**

24 (a) **GUIDANCE TO STATES ON FLEXIBILITIES TO EN-**
25 **SURE PROVIDER CAPACITY TO PROVIDE PEDIATRIC BE-**
26 **HAVIORAL HEALTH, INCLUDING MENTAL HEALTH, CRI-**

1 SIS CARE.—Not later than 18 months after the date of
2 enactment of this Act, the Secretary of Health and
3 Human Services shall provide guidance to States on exist-
4 ing flexibilities under State plans (or waivers of such
5 plans) under title XIX of the Social Security Act (42
6 U.S.C. 1396 et seq.), or State child health plans under
7 title XXI of such Act (42 U.S.C. 1397aa et seq.), to sup-
8 port children experiencing a behavioral health crisis or in
9 need of intensive behavioral health, including mental
10 health, services.

11 (b) ENSURING CONSISTENT REVIEW AND STATE IM-
12 PLEMENTATION OF EARLY AND PERIODIC SCREENING,
13 DIAGNOSTIC, AND TREATMENT SERVICES.—Section
14 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))
15 is amended by adding at the end the following: “Not later
16 than January 1, 2025, and every 5 years thereafter, the
17 Secretary shall review implementation of the requirements
18 of this subsection by States, including such requirements
19 relating to services provided by managed care organiza-
20 tions, prepaid inpatient health plans, prepaid ambulatory
21 health plans, and primary care case managers, to identify
22 and disseminate best practices for ensuring comprehensive
23 coverage of services, to identify gaps and deficiencies in
24 meeting Federal requirements, and to provide guidance to
25 States on addressing identified gaps and disparities and

1 meeting Federal coverage requirements in order to ensure
2 children have access to health services.”.

3 **SEC. 505. STRATEGIES TO INCREASE ACCESS TO TELE-**
4 **HEALTH UNDER MEDICAID AND CHIP.**

5 Not later than 1 year after the date of the enactment
6 of this Act, and in the event updates are available, once
7 every five years thereafter, the Secretary of Health and
8 Human Services shall update guidance issued by the Cen-
9 ters for Medicare & Medicaid Services to States, the State
10 Medicaid & CHIP Telehealth Toolkit, or any successor
11 guidance, to describe strategies States may use to over-
12 come existing barriers and increase access to telehealth
13 services under the Medicaid program under title XIX of
14 the Social Security Act (42 U.S.C. 1396 et seq.) and the
15 Children’s Health Insurance Program under title XXI of
16 such Act (42 U.S.C. 1397aa et seq.). Such updated guid-
17 ance shall include examples of and promising practices re-
18 garding—

- 19 (1) telehealth delivery of covered services;
- 20 (2) recommended voluntary billing codes, modi-
21 fiers, and place-of-service designations for telehealth
22 and other virtual health care services;
- 23 (3) strategies States can use for the simplifica-
24 tion or alignment of provider credentialing and en-
25 rollment protocols with respect to telehealth across

1 States, State Medicaid plans under title XIX, State
2 child health plans under title XXI, Medicaid man-
3 aged care organizations, prepaid inpatient health
4 plans, prepaid ambulatory health plans, and primary
5 care case managers, including during national public
6 health emergencies; and

7 (4) strategies States can use to integrate tele-
8 health and other virtual health care services into
9 value-based health care models.

10 **SEC. 506. REMOVAL OF LIMITATIONS ON FEDERAL FINAN-**
11 **CIAL PARTICIPATION FOR INMATES WHO ARE**
12 **ELIGIBLE JUVENILES PENDING DISPOSITION**
13 **OF CHARGES.**

14 (a) MEDICAID.—

15 (1) IN GENERAL.—The subdivision (A) of sec-
16 tion 1905(a) of the Social Security Act (42 U.S.C.
17 1396d(a)) following paragraph (31) of such section,
18 as amended by section 501(b), is further amended
19 by inserting “, or, at the option of the State, for an
20 individual who is an eligible juvenile (as defined in
21 section 1902(nn)(2)), while such individual is an in-
22 mate of a public institution (as defined in section
23 1902(nn)(3)) pending disposition of charges” after
24 “or in the case of an eligible juvenile described in
25 section 1902(a)(84)(D) with respect to the

1 screenings, diagnostic services, referrals, and case
2 management required under such subparagraph
3 (D)”.

4 (2) CONFORMING.—Section 1902(a)(84)(A) of
5 the Social Security Act (42 U.S.C. 1396a(a)(84)(A))
6 is amended by inserting “(or in the case of a State
7 electing the option described in the subdivision (A)
8 following paragraph (31) of section 1905(a), during
9 such period beginning after the disposition of
10 charges with respect to such individual)” after “is
11 such an inmate”.

12 (b) CHIP.—Section 2110(b)(7) of the Social Security
13 Act (42 U.S.C. 13977jj(b)(7)), as added by section
14 501(c)(2)(B), is further amended by inserting “or, at the
15 option of the State, for an individual who is a juvenile,
16 while such individual is an inmate of a public institution
17 pending disposition of charges” after “if such child is an
18 eligible juvenile (as described in section 1902(a)(84)(D))
19 with respect to screenings, diagnostic services, referrals,
20 and case management otherwise covered under the State
21 child health plan (or waiver of such plan)”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect on the first day of the first
24 calendar quarter that begins after the date that is 18
25 months after the date of enactment of this Act and shall

1 apply to items and services furnished for periods beginning
2 on or after such date.

3 **TITLE VI—MISCELLANEOUS**
4 **PROVISIONS**

5 **SEC. 601. DETERMINATION OF BUDGETARY EFFECTS.**

6 The budgetary effects of this Act, for the purpose of
7 complying with the Statutory Pay-As-You-Go Act of 2010,
8 shall be determined by reference to the latest statement
9 titled “Budgetary Effects of PAYGO Legislation” for this
10 Act, submitted for printing in the Congressional Record
11 by the Chairman of the House Budget Committee, pro-
12 vided that such statement has been submitted prior to the
13 vote on passage.

14 **SEC. 602. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
15 **SERVICES.**

16 (a) PHSA.—Title XXVII of the Public Health Serv-
17 ice Act (42 U.S.C. 300gg et seq.) is amended—

18 (1) in part D (42 U.S.C. 300gg–111 et seq.),
19 by adding at the end the following new section:

20 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFIT MAN-**
21 **AGER SERVICES.**

22 “(a) IN GENERAL.—For plan years beginning on or
23 after January 1, 2024, a group health plan or health in-
24 surance issuer offering group health insurance coverage
25 or an entity or subsidiary providing pharmacy benefits

1 management services on behalf of such a plan or issuer
2 shall not enter into a contract with a drug manufacturer,
3 distributor, wholesaler, subcontractor, rebate aggregator,
4 or any associated third party that limits the disclosure of
5 information to plan sponsors in such a manner that pre-
6 vents the plan or issuer, or an entity or subsidiary pro-
7 viding pharmacy benefits management services on behalf
8 of a plan or issuer, from making the reports described in
9 subsection (b).

10 “(b) REPORTS.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after January 1, 2024, not less frequently
13 than once every 6 months, a health insurance issuer
14 offering group health insurance coverage or an enti-
15 ty providing pharmacy benefits management services
16 on behalf of a group health plan or an issuer pro-
17 viding group health insurance coverage shall submit
18 to the plan sponsor (as defined in section 3(16)(B)
19 of the Employee Retirement Income Security Act of
20 1974) of such group health plan or health insurance
21 coverage a report in accordance with this subsection
22 and make such report available to the plan sponsor
23 in a machine-readable format. Each such report
24 shall include, with respect to the applicable group
25 health plan or health insurance coverage—

1 “(A) as applicable, information collected
2 from drug manufacturers by such issuer or en-
3 tity on the total amount of copayment assist-
4 ance dollars paid, or copayment cards applied,
5 that were funded by the drug manufacturer
6 with respect to the participants and bene-
7 ficiaries in such plan or coverage;

8 “(B) a list of each drug covered by such
9 plan, issuer, or entity providing pharmacy ben-
10 efit management services that was dispensed
11 during the reporting period, including, with re-
12 spect to each such drug during the reporting
13 period—

14 “(i) the brand name, chemical entity,
15 and National Drug Code;

16 “(ii) the number of participants and
17 beneficiaries for whom the drug was filled
18 during the plan year, the total number of
19 prescription fills for the drug (including
20 original prescriptions and refills), and the
21 total number of dosage units of the drug
22 dispensed across the plan year, including
23 whether the dispensing channel was by re-
24 tail, mail order, or specialty pharmacy;

1 “(iii) the wholesale acquisition cost,
2 listed as cost per days supply and cost per
3 pill, or in the case of a drug in another
4 form, per dose;

5 “(iv) the total out-of-pocket spending
6 by participants and beneficiaries on such
7 drug, including participant and beneficiary
8 spending through copayments, coinsurance,
9 and deductibles; and

10 “(v) for any drug for which gross
11 spending of the group health plan or
12 health insurance coverage exceeded
13 \$10,000 during the reporting period—

14 “(I) a list of all other drugs in
15 the same therapeutic category or
16 class, including brand name drugs
17 and biological products and generic
18 drugs or biosimilar biological products
19 that are in the same therapeutic cat-
20 egory or class as such drug; and

21 “(II) the rationale for preferred
22 formulary placement of such drug in
23 that therapeutic category or class, if
24 applicable;

1 “(C) a list of each therapeutic category or
2 class of drugs that were dispensed under the
3 health plan or health insurance coverage during
4 the reporting period, and, with respect to each
5 such therapeutic category or class of drugs,
6 during the reporting period—

7 “(i) total gross spending by the plan,
8 before manufacturer rebates, fees, or other
9 manufacturer remuneration;

10 “(ii) the number of participants and
11 beneficiaries who filled a prescription for a
12 drug in that category or class;

13 “(iii) if applicable to that category or
14 class, a description of the formulary tiers
15 and utilization mechanisms (such as prior
16 authorization or step therapy) employed
17 for drugs in that category or class;

18 “(iv) the total out-of-pocket spending
19 by participants and beneficiaries, including
20 participant and beneficiary spending
21 through copayments, coinsurance, and
22 deductibles; and

23 “(v) for each therapeutic category or
24 class under which 3 or more drugs are in-

1 cluded on the formulary of such plan or
2 coverage—

3 “(I) the amount received, or ex-
4 pected to be received, from drug man-
5 ufacturers in rebates, fees, alternative
6 discounts, or other remuneration—

7 “(aa) that has been paid, or
8 is to be paid, by drug manufac-
9 turers for claims incurred during
10 the reporting period; or

11 “(bb) that is related to utili-
12 zation of drugs, in such thera-
13 peutic category or class;

14 “(II) the total net spending, after
15 deducting rebates, price concessions,
16 alternative discounts or other remu-
17 neration from drug manufacturers, by
18 the health plan or health insurance
19 coverage on that category or class of
20 drugs; and

21 “(III) the net price per course of
22 treatment or single fill, such as a 30-
23 day supply or 90-day supply, incurred
24 by the health plan or health insurance
25 coverage and its participants and

1 beneficiaries, after manufacturer re-
2 bates, fees, and other remuneration
3 for drugs dispensed within such thera-
4 peutic category or class during the re-
5 porting period;

6 “(D) total gross spending on prescription
7 drugs by the plan or coverage during the re-
8 porting period, before rebates and other manu-
9 facturer fees or remuneration;

10 “(E) total amount received, or expected to
11 be received, by the health plan or health insur-
12 ance coverage in drug manufacturer rebates,
13 fees, alternative discounts, and all other remu-
14 neration received from the manufacturer or any
15 third party, other than the plan sponsor, re-
16 lated to utilization of drug or drug spending
17 under that health plan or health insurance cov-
18 erage during the reporting period;

19 “(F) the total net spending on prescription
20 drugs by the health plan or health insurance
21 coverage during the reporting period; and

22 “(G) amounts paid directly or indirectly in
23 rebates, fees, or any other type of remuneration
24 to brokers, consultants, advisors, or any other
25 individual or firm who referred the group health

1 plan’s or health insurance issuer’s business to
2 the pharmacy benefit manager.

3 “(2) PRIVACY REQUIREMENTS.—Health insur-
4 ance issuers offering group health insurance cov-
5 erage and entities providing pharmacy benefits man-
6 agement services on behalf of a group health plan
7 shall provide information under paragraph (1) in a
8 manner consistent with the privacy, security, and
9 breach notification regulations promulgated under
10 section 264(c) of the Health Insurance Portability
11 and Accountability Act of 1996, and shall restrict
12 the use and disclosure of such information according
13 to such privacy regulations.

14 “(3) DISCLOSURE AND REDISCLOSURE.—

15 “(A) LIMITATION TO BUSINESS ASSOCI-
16 ATES.—A group health plan receiving a report
17 under paragraph (1) may disclose such informa-
18 tion only to business associates of such plan as
19 defined in section 160.103 of title 45, Code of
20 Federal Regulations (or successor regulations).

21 “(B) CLARIFICATION REGARDING PUBLIC
22 DISCLOSURE OF INFORMATION.—Nothing in
23 this section prevents a health insurance issuer
24 offering group health insurance coverage or an
25 entity providing pharmacy benefits management

1 services on behalf of a group health plan from
2 placing reasonable restrictions on the public dis-
3 closure of the information contained in a report
4 described in paragraph (1), except that such
5 issuer or entity may not restrict disclosure of
6 such report to the Department of Health and
7 Human Services, the Department of Labor, the
8 Department of the Treasury, or applicable
9 State agencies.

10 “(C) LIMITED FORM OF REPORT.—The
11 Secretary shall define through rulemaking a
12 limited form of the report under paragraph (1)
13 required of plan sponsors who are drug manu-
14 facturers, drug wholesalers, or other direct par-
15 ticipants in the drug supply chain, in order to
16 prevent anti-competitive behavior.

17 “(4) REPORT TO GAO.—A health insurance
18 issuer offering group health insurance coverage or
19 an entity providing pharmacy benefits management
20 services on behalf of a group health plan shall sub-
21 mit to the Comptroller General of the United States
22 each of the first 4 reports submitted to a plan spon-
23 sor under paragraph (1) with respect to such cov-
24 erage or plan, and other such reports as requested,
25 in accordance with the privacy requirements under

1 paragraph (2), the disclosure and redisclosure stand-
2 ards under paragraph (3), the standards specified
3 pursuant to paragraph (5), and such other informa-
4 tion that the Comptroller General determines nec-
5 essary to carry out the study under section 602(d)
6 of the Restoring Hope for Mental Health and Well-
7 Being Act of 2022.

8 “(5) STANDARD FORMAT.—Not later than June
9 1, 2023, the Secretary shall specify through rule-
10 making standards for health insurance issuers and
11 entities required to submit reports under paragraph
12 (4) to submit such reports in a standard format.

13 “(c) ENFORCEMENT.—

14 “(1) IN GENERAL.—The Secretary, in consulta-
15 tion with the Secretary of Labor and the Secretary
16 of the Treasury, shall enforce this section.

17 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
18 TION.—A health insurance issuer or an entity pro-
19 viding pharmacy benefit management services that
20 violates subsection (a) or fails to provide information
21 required under subsection (b), or a drug manufac-
22 turer that fails to provide information under sub-
23 section (b)(1)(A) in a timely manner, shall be sub-
24 ject to a civil monetary penalty in the amount of
25 \$10,000 for each day during which such violation

1 continues or such information is not disclosed or re-
2 ported.

3 “(3) FALSE INFORMATION.—A health insurance
4 issuer, entity providing pharmacy benefit manage-
5 ment services, or drug manufacturer that knowingly
6 provides false information under this section shall be
7 subject to a civil money penalty in an amount not
8 to exceed \$100,000 for each item of false informa-
9 tion. Such civil money penalty shall be in addition to
10 other penalties as may be prescribed by law.

11 “(4) PROCEDURE.—The provisions of section
12 1128A of the Social Security Act, other than sub-
13 section (a) and (b) and the first sentence of sub-
14 section (c)(1) of such section shall apply to civil
15 monetary penalties under this subsection in the
16 same manner as such provisions apply to a penalty
17 or proceeding under section 1128A of the Social Se-
18 curity Act.

19 “(5) WAIVERS.—The Secretary may waive pen-
20 alties under paragraph (2), or extend the period of
21 time for compliance with a requirement of this sec-
22 tion, for an entity in violation of this section that
23 has made a good-faith effort to comply with this sec-
24 tion.

1 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed to permit a health insurance issuer,
3 group health plan, or other entity to restrict disclosure to,
4 or otherwise limit the access of, the Department of Health
5 and Human Services to a report described in subsection
6 (b)(1) or information related to compliance with sub-
7 section (a) by such issuer, plan, or entity.

8 “(e) DEFINITION.—In this section, the term ‘whole-
9 sale acquisition cost’ has the meaning given such term in
10 section 1847A(c)(6)(B) of the Social Security Act.”; and

11 (2) in section 2723 (42 U.S.C. 300gg-22)—

12 (A) in subsection (a)—

13 (i) in paragraph (1), by inserting
14 “(other than subsections (a) and (b) of
15 section 2799A-11)” after “part D”; and

16 (ii) in paragraph (2), by inserting
17 “(other than subsections (a) and (b) of
18 section 2799A-11)” after “part D”; and

19 (B) in subsection (b)—

20 (i) in paragraph (1), by inserting
21 “(other than subsections (a) and (b) of
22 section 2799A-11)” after “part D”;

23 (ii) in paragraph (2)(A), by inserting
24 “(other than subsections (a) and (b) of
25 section 2799A-11)” after “part D”; and

1 (iii) in paragraph (2)(C)(ii), by insert-
2 ing “(other than subsections (a) and (b) of
3 section 2799A–11)” after “part D”.

4 (b) ERISA.—

5 (1) IN GENERAL.—Subtitle B of title I of the
6 Employee Retirement Income Security Act of 1974
7 (29 U.S.C. 1021 et seq.) is amended—

8 (A) in subpart B of part 7 (29 U.S.C.
9 1185 et seq.), by adding at the end the fol-
10 lowing:

11 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
12 **SERVICES.**

13 “(a) IN GENERAL.—For plan years beginning on or
14 after January 1, 2024, a group health plan (or health in-
15 surance issuer offering group health insurance coverage
16 in connection with such a plan) or an entity or subsidiary
17 providing pharmacy benefits management services on be-
18 half of such a plan or issuer shall not enter into a contract
19 with a drug manufacturer, distributor, wholesaler, subcon-
20 tractor, rebate aggregator, or any associated third party
21 that limits the disclosure of information to plan sponsors
22 in such a manner that prevents the plan or issuer, or an
23 entity or subsidiary providing pharmacy benefits manage-
24 ment services on behalf of a plan or issuer, from making
25 the reports described in subsection (b).

1 “(b) REPORTS.—

2 “(1) IN GENERAL.—For plan years beginning
3 on or after January 1, 2024, not less frequently
4 than once every 6 months, a health insurance issuer
5 offering group health insurance coverage or an enti-
6 ty providing pharmacy benefits management services
7 on behalf of a group health plan or an issuer pro-
8 viding group health insurance coverage shall submit
9 to the plan sponsor (as defined in section 3(16)(B))
10 of such group health plan or group health insurance
11 coverage a report in accordance with this subsection
12 and make such report available to the plan sponsor
13 in a machine-readable format. Each such report
14 shall include, with respect to the applicable group
15 health plan or health insurance coverage—

16 “(A) as applicable, information collected
17 from drug manufacturers by such issuer or en-
18 tity on the total amount of copayment assist-
19 ance dollars paid, or copayment cards applied,
20 that were funded by the drug manufacturer
21 with respect to the participants and bene-
22 ficiaries in such plan or coverage;

23 “(B) a list of each drug covered by such
24 plan, issuer, or entity providing pharmacy ben-
25 efit management services that was dispensed

1 during the reporting period, including, with re-
2 spect to each such drug during the reporting
3 period—

4 “(i) the brand name, chemical entity,
5 and National Drug Code;

6 “(ii) the number of participants and
7 beneficiaries for whom the drug was filled
8 during the plan year, the total number of
9 prescription fills for the drug (including
10 original prescriptions and refills), and the
11 total number of dosage units of the drug
12 dispensed across the plan year, including
13 whether the dispensing channel was by re-
14 tail, mail order, or specialty pharmacy;

15 “(iii) the wholesale acquisition cost,
16 listed as cost per days supply and cost per
17 pill, or in the case of a drug in another
18 form, per dose;

19 “(iv) the total out-of-pocket spending
20 by participants and beneficiaries on such
21 drug, including participant and beneficiary
22 spending through copayments, coinsurance,
23 and deductibles; and

24 “(v) for any drug for which gross
25 spending of the group health plan or

1 health insurance coverage exceeded
2 \$10,000 during the reporting period—

3 “(I) a list of all other drugs in
4 the same therapeutic category or
5 class, including brand name drugs
6 and biological products and generic
7 drugs or biosimilar biological products
8 that are in the same therapeutic cat-
9 egory or class as such drug; and

10 “(II) the rationale for preferred
11 formulary placement of such drug in
12 that therapeutic category or class, if
13 applicable;

14 “(C) a list of each therapeutic category or
15 class of drugs that were dispensed under the
16 health plan or health insurance coverage during
17 the reporting period, and, with respect to each
18 such therapeutic category or class of drugs,
19 during the reporting period—

20 “(i) total gross spending by the plan,
21 before manufacturer rebates, fees, or other
22 manufacturer remuneration;

23 “(ii) the number of participants and
24 beneficiaries who filled a prescription for a
25 drug in that category or class;

1 “(iii) if applicable to that category or
2 class, a description of the formulary tiers
3 and utilization mechanisms (such as prior
4 authorization or step therapy) employed
5 for drugs in that category or class;

6 “(iv) the total out-of-pocket spending
7 by participants and beneficiaries, including
8 participant and beneficiary spending
9 through copayments, coinsurance, and
10 deductibles; and

11 “(v) for each therapeutic category or
12 class under which 3 or more drugs are in-
13 cluded on the formulary of such plan or
14 coverage—

15 “(I) the amount received, or ex-
16 pected to be received, from drug man-
17 ufacturers in rebates, fees, alternative
18 discounts, or other remuneration—

19 “(aa) that has been paid, or
20 is to be paid, by drug manufac-
21 turers for claims incurred during
22 the reporting period; or

23 “(bb) that is related to utili-
24 zation of drugs, in such thera-
25 peutic category or class;

1 “(II) the total net spending, after
2 deducting rebates, price concessions,
3 alternative discounts or other remun-
4 eration from drug manufacturers, by
5 the health plan or health insurance
6 coverage on that category or class of
7 drugs; and

8 “(III) the net price per course of
9 treatment or single fill, such as a 30-
10 day supply or 90-day supply, incurred
11 by the health plan or health insurance
12 coverage and its participants and
13 beneficiaries, after manufacturer re-
14 bates, fees, and other remuneration
15 for drugs dispensed within such thera-
16 peutic category or class during the re-
17 porting period;

18 “(D) total gross spending on prescription
19 drugs by the plan or coverage during the re-
20 porting period, before rebates and other manu-
21 facturer fees or remuneration;

22 “(E) total amount received, or expected to
23 be received, by the health plan or health insur-
24 ance coverage in drug manufacturer rebates,
25 fees, alternative discounts, and all other remun-

1 neration received from the manufacturer or any
2 third party, other than the plan sponsor, re-
3 lated to utilization of drug or drug spending
4 under that health plan or health insurance cov-
5 erage during the reporting period;

6 “(F) the total net spending on prescription
7 drugs by the health plan or health insurance
8 coverage during the reporting period; and

9 “(G) amounts paid directly or indirectly in
10 rebates, fees, or any other type of remuneration
11 to brokers, consultants, advisors, or any other
12 individual or firm who referred the group health
13 plan’s or health insurance issuer’s business to
14 the pharmacy benefit manager.

15 “(2) PRIVACY REQUIREMENTS.—Health insur-
16 ance issuers offering group health insurance cov-
17 erage and entities providing pharmacy benefits man-
18 agement services on behalf of a group health plan
19 shall provide information under paragraph (1) in a
20 manner consistent with the privacy, security, and
21 breach notification regulations promulgated under
22 section 264(c) of the Health Insurance Portability
23 and Accountability Act of 1996, and shall restrict
24 the use and disclosure of such information according
25 to such privacy regulations.

1 “(3) DISCLOSURE AND REDISCLOSURE.—

2 “(A) LIMITATION TO BUSINESS ASSOCI-
3 ATES.—A group health plan receiving a report
4 under paragraph (1) may disclose such informa-
5 tion only to business associates of such plan as
6 defined in section 160.103 of title 45, Code of
7 Federal Regulations (or successor regulations).

8 “(B) CLARIFICATION REGARDING PUBLIC
9 DISCLOSURE OF INFORMATION.—Nothing in
10 this section prevents a health insurance issuer
11 offering group health insurance coverage or an
12 entity providing pharmacy benefits management
13 services on behalf of a group health plan from
14 placing reasonable restrictions on the public dis-
15 closure of the information contained in a report
16 described in paragraph (1), except that such
17 issuer or entity may not restrict disclosure of
18 such report to the Department of Health and
19 Human Services, the Department of Labor, the
20 Department of the Treasury, or applicable
21 State agencies.

22 “(C) LIMITED FORM OF REPORT.—The
23 Secretary shall define through rulemaking a
24 limited form of the report under paragraph (1)
25 required of plan sponsors who are drug manu-

1 facturers, drug wholesalers, or other direct par-
2 ticipants in the drug supply chain, in order to
3 prevent anti-competitive behavior.

4 “(4) REPORT TO GAO.—A health insurance
5 issuer offering group health insurance coverage or
6 an entity providing pharmacy benefits management
7 services on behalf of a group health plan shall sub-
8 mit to the Comptroller General of the United States
9 each of the first 4 reports submitted to a plan spon-
10 sor under paragraph (1) with respect to such cov-
11 erage or plan, and other such reports as requested,
12 in accordance with the privacy requirements under
13 paragraph (2), the disclosure and redisclosure stand-
14 ards under paragraph (3), the standards specified
15 pursuant to paragraph (5), and such other informa-
16 tion that the Comptroller General determines nec-
17 essary to carry out the study under section 602(d)
18 of the Restoring Hope for Mental Health and Well-
19 Being Act of 2022.

20 “(5) STANDARD FORMAT.—Not later than June
21 1, 2023, the Secretary shall specify through rule-
22 making standards for health insurance issuers and
23 entities required to submit reports under paragraph
24 (4) to submit such reports in a standard format.

25 “(c) ENFORCEMENT.—

1 “(1) IN GENERAL.—The Secretary, in consulta-
2 tion with the Secretary of Health and Human Serv-
3 ices and the Secretary of the Treasury, shall enforce
4 this section.

5 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
6 TION.—A health insurance issuer or an entity pro-
7 viding pharmacy benefit management services that
8 violates subsection (a) or fails to provide information
9 required under subsection (b), or a drug manufac-
10 turer that fails to provide information under sub-
11 section (b)(1)(A) in a timely manner, shall be sub-
12 ject to a civil monetary penalty in the amount of
13 \$10,000 for each day during which such violation
14 continues or such information is not disclosed or re-
15 ported.

16 “(3) FALSE INFORMATION.—A health insurance
17 issuer, entity providing pharmacy benefit manage-
18 ment services, or drug manufacturer that knowingly
19 provides false information under this section shall be
20 subject to a civil money penalty in an amount not
21 to exceed \$100,000 for each item of false informa-
22 tion. Such civil money penalty shall be in addition to
23 other penalties as may be prescribed by law.

24 “(4) PROCEDURE.—The provisions of section
25 1128A of the Social Security Act, other than sub-

1 section (a) and (b) and the first sentence of sub-
2 section (c)(1) of such section shall apply to civil
3 monetary penalties under this subsection in the
4 same manner as such provisions apply to a penalty
5 or proceeding under section 1128A of the Social Se-
6 curity Act.

7 “(5) WAIVERS.—The Secretary may waive pen-
8 alties under paragraph (2), or extend the period of
9 time for compliance with a requirement of this sec-
10 tion, for an entity in violation of this section that
11 has made a good-faith effort to comply with this sec-
12 tion.

13 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
14 tion shall be construed to permit a health insurance issuer,
15 group health plan, or other entity to restrict disclosure to,
16 or otherwise limit the access of, the Department of Labor
17 to a report described in subsection (b)(1) or information
18 related to compliance with subsection (a) by such issuer,
19 plan, or entity.

20 “(e) DEFINITION.—In this section, the term ‘whole-
21 sale acquisition cost’ has the meaning given such term in
22 section 1847A(c)(6)(B) of the Social Security Act.”; and

23 (B) in section 502(b)(3) (29 U.S.C.
24 1132(b)(3)), by inserting “(other than section
25 726)” after “part 7”.

1 (2) CLERICAL AMENDMENT.—The table of con-
2 tents in section 1 of the Employee Retirement In-
3 come Security Act of 1974 (29 U.S.C. 1001 et seq.)
4 is amended by inserting after the item relating to
5 section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefit manager services.”.

6 (c) IRC.—

7 (1) IN GENERAL.—Subchapter B of chapter
8 100 of the Internal Revenue Code of 1986 is amend-
9 ed by adding at the end the following:

10 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
11 **SERVICES.**

12 “(a) IN GENERAL.—For plan years beginning on or
13 after January 1, 2024, a group health plan or an entity
14 or subsidiary providing pharmacy benefits management
15 services on behalf of such a plan shall not enter into a
16 contract with a drug manufacturer, distributor, whole-
17 saler, subcontractor, rebate aggregator, or any associated
18 third party that limits the disclosure of information to
19 plan sponsors in such a manner that prevents the plan,
20 or an entity or subsidiary providing pharmacy benefits
21 management services on behalf of a plan, from making
22 the reports described in subsection (b).

23 “(b) REPORTS.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after January 1, 2024, not less frequently

1 than once every 6 months, an entity providing phar-
2 macy benefits management services on behalf of a
3 group health plan shall submit to the plan sponsor
4 (as defined in section 3(16)(B) of the Employee Re-
5 tirement Income Security Act of 1974) of such
6 group health plan a report in accordance with this
7 subsection and make such report available to the
8 plan sponsor in a machine-readable format. Each
9 such report shall include, with respect to the applica-
10 ble group health plan—

11 “(A) as applicable, information collected
12 from drug manufacturers by such entity on the
13 total amount of copayment assistance dollars
14 paid, or copayment cards applied, that were
15 funded by the drug manufacturer with respect
16 to the participants and beneficiaries in such
17 plan;

18 “(B) a list of each drug covered by such
19 plan or entity providing pharmacy benefit man-
20 agement services that was dispensed during the
21 reporting period, including, with respect to each
22 such drug during the reporting period—

23 “(i) the brand name, chemical entity,
24 and National Drug Code;

1 “(ii) the number of participants and
2 beneficiaries for whom the drug was filled
3 during the plan year, the total number of
4 prescription fills for the drug (including
5 original prescriptions and refills), and the
6 total number of dosage units of the drug
7 dispensed across the plan year, including
8 whether the dispensing channel was by re-
9 tail, mail order, or specialty pharmacy;

10 “(iii) the wholesale acquisition cost,
11 listed as cost per days supply and cost per
12 pill, or in the case of a drug in another
13 form, per dose;

14 “(iv) the total out-of-pocket spending
15 by participants and beneficiaries on such
16 drug, including participant and beneficiary
17 spending through copayments, coinsurance,
18 and deductibles; and

19 “(v) for any drug for which gross
20 spending of the group health plan exceeded
21 \$10,000 during the reporting period—

22 “(I) a list of all other drugs in
23 the same therapeutic category or
24 class, including brand name drugs
25 and biological products and generic

1 drugs or biosimilar biological products
2 that are in the same therapeutic cat-
3 egory or class as such drug; and

4 “(II) the rationale for preferred
5 formulary placement of such drug in
6 that therapeutic category or class, if
7 applicable;

8 “(C) a list of each therapeutic category or
9 class of drugs that were dispensed under the
10 health plan during the reporting period, and,
11 with respect to each such therapeutic category
12 or class of drugs, during the reporting period—

13 “(i) total gross spending by the plan,
14 before manufacturer rebates, fees, or other
15 manufacturer remuneration;

16 “(ii) the number of participants and
17 beneficiaries who filled a prescription for a
18 drug in that category or class;

19 “(iii) if applicable to that category or
20 class, a description of the formulary tiers
21 and utilization mechanisms (such as prior
22 authorization or step therapy) employed
23 for drugs in that category or class;

24 “(iv) the total out-of-pocket spending
25 by participants and beneficiaries, including

1 participant and beneficiary spending
2 through copayments, coinsurance, and
3 deductibles; and

4 “(v) for each therapeutic category or
5 class under which 3 or more drugs are in-
6 cluded on the formulary of such plan—

7 “(I) the amount received, or ex-
8 pected to be received, from drug man-
9 ufacturers in rebates, fees, alternative
10 discounts, or other remuneration—

11 “(aa) that has been paid, or
12 is to be paid, by drug manufac-
13 turers for claims incurred during
14 the reporting period; or

15 “(bb) that is related to utili-
16 zation of drugs, in such thera-
17 peutic category or class;

18 “(II) the total net spending, after
19 deducting rebates, price concessions,
20 alternative discounts or other remu-
21 nation from drug manufacturers, by
22 the health plan on that category or
23 class of drugs; and

24 “(III) the net price per course of
25 treatment or single fill, such as a 30-

1 day supply or 90-day supply, incurred
2 by the health plan and its participants
3 and beneficiaries, after manufacturer
4 rebates, fees, and other remuneration
5 for drugs dispensed within such thera-
6 peutic category or class during the re-
7 porting period;

8 “(D) total gross spending on prescription
9 drugs by the plan during the reporting period,
10 before rebates and other manufacturer fees or
11 remuneration;

12 “(E) total amount received, or expected to
13 be received, by the health plan in drug manu-
14 facturer rebates, fees, alternative discounts, and
15 all other remuneration received from the manu-
16 facturer or any third party, other than the plan
17 sponsor, related to utilization of drug or drug
18 spending under that health plan during the re-
19 porting period;

20 “(F) the total net spending on prescription
21 drugs by the health plan during the reporting
22 period; and

23 “(G) amounts paid directly or indirectly in
24 rebates, fees, or any other type of remuneration
25 to brokers, consultants, advisors, or any other

1 individual or firm who referred the group health
2 plan's business to the pharmacy benefit man-
3 ager.

4 “(2) PRIVACY REQUIREMENTS.—Entities pro-
5 viding pharmacy benefits management services on
6 behalf of a group health plan shall provide informa-
7 tion under paragraph (1) in a manner consistent
8 with the privacy, security, and breach notification
9 regulations promulgated under section 264(c) of the
10 Health Insurance Portability and Accountability Act
11 of 1996, and shall restrict the use and disclosure of
12 such information according to such privacy regula-
13 tions.

14 “(3) DISCLOSURE AND REDISCLOSURE.—

15 “(A) LIMITATION TO BUSINESS ASSOCI-
16 ATES.—A group health plan receiving a report
17 under paragraph (1) may disclose such informa-
18 tion only to business associates of such plan as
19 defined in section 160.103 of title 45, Code of
20 Federal Regulations (or successor regulations).

21 “(B) CLARIFICATION REGARDING PUBLIC
22 DISCLOSURE OF INFORMATION.—Nothing in
23 this section prevents an entity providing phar-
24 macy benefits management services on behalf of
25 a group health plan from placing reasonable re-

1 restrictions on the public disclosure of the infor-
2 mation contained in a report described in para-
3 graph (1), except that such entity may not re-
4 strict disclosure of such report to the Depart-
5 ment of Health and Human Services, the De-
6 partment of Labor, the Department of the
7 Treasury, or applicable State agencies.

8 “(C) LIMITED FORM OF REPORT.—The
9 Secretary shall define through rulemaking a
10 limited form of the report under paragraph (1)
11 required of plan sponsors who are drug manu-
12 facturers, drug wholesalers, or other direct par-
13 ticipants in the drug supply chain, in order to
14 prevent anti-competitive behavior.

15 “(4) REPORT TO GAO.—An entity providing
16 pharmacy benefits management services on behalf of
17 a group health plan shall submit to the Comptroller
18 General of the United States each of the first 4 re-
19 ports submitted to a plan sponsor under paragraph
20 (1) with respect to such plan, and other such reports
21 as requested, in accordance with the privacy require-
22 ments under paragraph (2), the disclosure and re-
23 disclosure standards under paragraph (3), the stand-
24 ards specified pursuant to paragraph (5), and such
25 other information that the Comptroller General de-

1 termines necessary to carry out the study under sec-
2 tion 602(d) of the Restoring Hope for Mental
3 Health and Well-Being Act of 2022.

4 “(5) STANDARD FORMAT.—Not later than June
5 1, 2023, the Secretary shall specify through rule-
6 making standards for entities required to submit re-
7 ports under paragraph (4) to submit such reports in
8 a standard format.

9 “(c) ENFORCEMENT.—

10 “(1) IN GENERAL.—The Secretary, in consulta-
11 tion with the Secretary of Labor and the Secretary
12 of Health and Human Services, shall enforce this
13 section.

14 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
15 TION.—An entity providing pharmacy benefit man-
16 agement services that violates subsection (a) or fails
17 to provide information required under subsection
18 (b), or a drug manufacturer that fails to provide in-
19 formation under subsection (b)(1)(A) in a timely
20 manner, shall be subject to a civil monetary penalty
21 in the amount of \$10,000 for each day during which
22 such violation continues or such information is not
23 disclosed or reported.

24 “(3) FALSE INFORMATION.—An entity pro-
25 viding pharmacy benefit management services, or

1 drug manufacturer that knowingly provides false in-
2 formation under this section shall be subject to a
3 civil money penalty in an amount not to exceed
4 \$100,000 for each item of false information. Such
5 civil money penalty shall be in addition to other pen-
6 alties as may be prescribed by law.

7 “(4) PROCEDURE.—The provisions of section
8 1128A of the Social Security Act, other than sub-
9 section (a) and (b) and the first sentence of sub-
10 section (c)(1) of such section shall apply to civil
11 monetary penalties under this subsection in the
12 same manner as such provisions apply to a penalty
13 or proceeding under section 1128A of the Social Se-
14 curity Act.

15 “(5) WAIVERS.—The Secretary may waive pen-
16 alties under paragraph (2), or extend the period of
17 time for compliance with a requirement of this sec-
18 tion, for an entity in violation of this section that
19 has made a good-faith effort to comply with this sec-
20 tion.

21 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
22 tion shall be construed to permit a group health plan or
23 other entity to restrict disclosure to, or otherwise limit the
24 access of, the Department of the Treasury to a report de-

1 scribed in subsection (b)(1) or information related to com-
2 pliance with subsection (a) by such plan or entity.

3 “(e) DEFINITION.—In this section, the term ‘whole-
4 sale acquisition cost’ has the meaning given such term in
5 section 1847A(e)(6)(B) of the Social Security Act.”.

6 (2) CLERICAL AMENDMENT.—The table of sec-
7 tions for subchapter B of chapter 100 of the Inter-
8 nal Revenue Code of 1986 is amended by adding at
9 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefit manager services.”.

10 (d) GAO STUDY.—

11 (1) IN GENERAL.—Not later than 3 years after
12 the date of enactment of this Act, the Comptroller
13 General of the United States shall submit to Con-
14 gress a report on—

15 (A) pharmacy networks of group health
16 plans, health insurance issuers, and entities
17 providing pharmacy benefit management serv-
18 ices under such group health plan or group or
19 individual health insurance coverage, including
20 networks that have pharmacies that are under
21 common ownership (in whole or part) with
22 group health plans, health insurance issuers, or
23 entities providing pharmacy benefit manage-
24 ment services or pharmacy benefit administra-

1 tive services under group health plan or group
2 or individual health insurance coverage;

3 (B) as it relates to pharmacy networks
4 that include pharmacies under common owner-
5 ship described in subparagraph (A)—

6 (i) whether such networks are de-
7 signed to encourage enrollees of a plan or
8 coverage to use such pharmacies over other
9 network pharmacies for specific services or
10 drugs, and if so, the reasons the networks
11 give for encouraging use of such phar-
12 macies; and

13 (ii) whether such pharmacies are used
14 by enrollees disproportionately more in the
15 aggregate or for specific services or drugs
16 compared to other network pharmacies;

17 (C) whether group health plans and health
18 insurance issuers offering group or individual
19 health insurance coverage have options to elect
20 different network pricing arrangements in the
21 marketplace with entities that provide phar-
22 macy benefit management services, the preva-
23 lence of electing such different network pricing
24 arrangements;

1 (D) pharmacy network design parameters
2 that encourage enrollees in the plan or coverage
3 to fill prescriptions at mail order, specialty, or
4 retail pharmacies that are wholly or partially-
5 owned by that issuer or entity; and

6 (E) the degree to which mail order, spe-
7 cialty, or retail pharmacies that dispense pre-
8 scription drugs to an enrollee in a group health
9 plan or health insurance coverage that are
10 under common ownership (in whole or part)
11 with group health plans, health insurance
12 issuers, or entities providing pharmacy benefit
13 management services or pharmacy benefit ad-
14 ministrative services under group health plan or
15 group or individual health insurance coverage
16 receive reimbursement that is greater than the
17 median price charged to the group health plan
18 or health insurance issuer when the same drug
19 is dispensed to enrollees in the plan or coverage
20 by other pharmacies included in the pharmacy
21 network of that plan, issuer, or entity that are
22 not wholly or partially owned by the health in-
23 surance issuer or entity providing pharmacy
24 benefit management services.

1 (2) REQUIREMENT.—The Comptroller General
2 of the United States shall ensure that the report
3 under paragraph (1) does not contain information
4 that would allow a reader to identify a specific plan
5 or entity providing pharmacy benefits management
6 services or otherwise contain commercial or financial
7 information that is privileged or confidential.

8 (3) DEFINITIONS.—In this subsection, the
9 terms “group health plan”, “health insurance cov-
10 erage”, and “health insurance issuer” have the
11 meanings given such terms in section 2791 of the
12 Public Health Service Act (42 U.S.C. 300gg–91).

13 **SEC. 603. MEDICARE IMPROVEMENT FUND.**

14 Section 1898(b)(1) of the Social Security Act (42
15 U.S.C. 1395iii(b)(1)) is amended by striking
16 “\$5,000,000” and inserting “\$1,029,000,000”.

17 **SEC. 604. LIMITATIONS ON AUTHORITY.**

18 In carrying out any program of the Substance Abuse
19 and Mental Health Services Administration whose statu-
20 tory authorization is enacted or amended by this Act, the
21 Secretary of Health and Human Services shall not allocate
22 funding, or require award recipients to prioritize, dedicate,
23 or allocate funding, without consideration of the incidence,
24 prevalence, or determinants of mental health or substance

1 use issues, unless such allocation or requirement is con-
2 sistent with statute, regulation, or other Federal law.

Passed the House of Representatives June 22, 2022.

Attest: CHERYL L. JOHNSON,
Clerk.

By KEVIN MCCUMBER,
Deputy Clerk.