Roskam	Simpson	Velázquez
Ross	Sinema	Visclosky
Rothfus	Sires	Wagner
Rouzer	Slaughter	Walberg
Roybal-Allard	Smith (MO)	Walden
Royce	Smith (NE)	Walker
Ruiz	Smith (NJ)	Walorski
Ruppersberger	Smith (TX)	Walters, Mimi
Rush	Speier	Walz
Russell	Stefanik	Wasserman Schultz
Ryan (OH)	Stewart	Waters, Maxine
Salmon	Stivers	Watson Coleman
Sánchez, Linda T.	Stutzman	Weber (TX)
Sanchez, Loretta	Swalwell (CA)	Webster (FL)
Sanford	Takano	Welch
Sarbanes	Thompson (CA)	Wenstrup
Scalise	Thompson (MS)	Westerman
Schakowsky	Thompson (PA)	Wilson (FL)
Schiff	Thornberry	Wilson (SC)
Schrader	Tiberi	Wittman
Schweikert	Tipton	Womack
Scott (VA)	Titus	Woodall
Scott, Austin	Tonko	Yarmuth
Scott, David	Torres	Yoder
Sensenbrenner	Trott	Yoho
Serrano	Tsongas	Young (AK)
Sessions	Turner	Young (IA)
Sewell (AL)	Upton	Young (IN)
Sherman	Valadao	Zeldin
Shimkus	Vargas	Zinke
Shuster	Veasey	
	Vela	

NAYS—3

Bass	Perlmutter	Smith (WA)

NOT VOTING—20

Barletta	Hurt (VA)	Nugent
Brown (FL)	Jolly	Poe (TX)
Clawson (FL)	Jones	Renacci
Crenshaw	Kirkpatrick	Van Hollen
Farr	McCaul	Westmoreland
Fincher	McDermott	Williams
Hahn	Nolan	

□ 1340

So (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RENACCI. Mr. Speaker, I was unavoidably detained on rollcalls 590 and 591. Had I been present, I would have voted "yea" on rollcall No. 590 and "yea" on rollcall No. 591.

PERMISSION TO POSTPONE PROCEEDINGS ON MOTION TO CONCUR ON SENATE AMENDMENT TO H.R. 34, TSUNAMI WARNING, EDUCATION, AND RESEARCH ACT OF 2015

Mr. UPTON. Mr. Speaker, I ask unanimous consent that the question of adopting a motion to concur in the Senate amendment to H.R. 34 with an amendment may be subject to postponement as though under clause 8 of rule XX.

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

There was no objection.

TSUNAMI WARNING, EDUCATION, AND RESEARCH ACT OF 2015

Mr. UPTON. Mr. Speaker, pursuant to House Resolution 934, I call up the bill (H.R. 34) to authorize and strengthen the tsunami detection, forecast, warning, research, and mitigation program of the National Oceanic and Atmospheric Administration, and for other purposes, with the Senate amendment thereto, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will designate the Senate amendment.

Senate amendment:

In lieu of the matter proposed to be inserted, add the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Tsunami Warning, Education, and Research Act of 2015''.

SEC. 2. REFERENCES TO THE TSUNAMI WARNING AND EDUCATION ACT.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Tsunami Warning and Education Act (Public Law 109–424; 33 U.S.C. 3201 et seq.).

SEC. 3. EXPANSION OF PURPOSES OF TSUNAMI WARNING AND EDUCATION ACT.

Section 3 (33 U.S.C. 3202) is amended—

(1) in paragraph (1), by inserting ''research,'' after ''warnings,'';

(2) by amending paragraph (2) to read as follows:

''(2) to enhance and modernize the existing United States Tsunami Warning System to increase the accuracy of forecasts and warnings, to ensure full coverage of tsunami threats to the United States with a network of detection assets, and to reduce false alarms;'';

(3) by amending paragraph (3) to read as follows:

''(3) to improve and develop standards and guidelines for mapping, modeling, and assessment efforts to improve tsunami detection, forecasting, warnings, notification, mitigation, resiliency, response, outreach, and recovery;'';

(4) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (8), respectively;

(5) by inserting after paragraph (3) the following:

''(4) to improve research efforts related to improving tsunami detection, forecasting, warnings, notification, mitigation, resiliency, response, outreach, and recovery;'';

(6) in paragraph (5), as redesignated—

(A) by striking ''and increase'' and inserting '', increase, and develop uniform standards and guidelines for''; and

(B) by inserting '', including the warning signs of locally generated tsunami'' after ''approaching'';

(7) in paragraph (6), as redesignated, by striking '', including the Indian Ocean; and'' and inserting a semicolon; and

(8) by inserting after paragraph (6), as redesignated, the following:

''(7) to foster resilient communities in the face of tsunami and other similar coastal hazards; and''.

SEC. 4. MODIFICATION OF TSUNAMI FORECASTING AND WARNING PROGRAM.

(a) IN GENERAL.—Subsection (a) of section 4 (33 U.S.C. 3203(a)) is amended by striking ''Atlantic Ocean, Caribbean Sea, and Gulf of Mexico region'' and inserting ''Atlantic Ocean region, including the Caribbean Sea and the Gulf of Mexico''.

(b) COMPONENTS.—Subsection (b) of section 4 (33 U.S.C. 3203(b)) is amended—

(1) in paragraph (1), by striking ''established'' and inserting ''supported or maintained'';

(2) by redesignating paragraphs (7) through (9) as paragraphs (8) through (10), respectively;

(3) by redesignating paragraphs (2) through (6) as paragraphs (3) through (7), respectively;

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

''(2) to the degree practicable, maintain not less than 80 percent of the Deep-ocean Assessment and Reporting of Tsunamis buoy array at operational capacity to optimize data reliability;''.

(5) by amending paragraph (5), as redesignated by paragraph (3), to read as follows:

''(5) provide tsunami forecasting capability based on models and measurements, including tsunami inundation models and maps for use in increasing the preparedness of communities and safeguarding port and harbor operations, that incorporate inputs, including—

''(A) the United States and global ocean and coastal observing system;

''(B) the global Earth observing system;

''(C) the global seismic network;

''(D) the Advanced National Seismic system;

''(E) tsunami model validation using historical and paleotsunami data;

''(F) digital elevation models and bathymetry;

''(G) newly developing tsunami detection methodologies using satellites and airborne remote sensing; and

''(H) any other data the Administrator determines is necessary;'';

(6) by amending paragraph (7), as redesignated by paragraph (3), to read as follows:

''(7) include a cooperative effort among the Administration, the United States Geological Survey, and the National Science Foundation under which the Director of the United States Geological Survey and the Director of the National Science Foundation shall—

''(A) provide rapid and reliable seismic information to the Administrator from international and domestic seismic networks; and

''(B) support seismic stations installed before the date of the enactment of the Tsunami Warning, Education, and Research Act of 2015 to supplement coverage in areas of sparse instrumentation;'';

(7) in paragraph (8), as redesignated by paragraph (2)—

(A) by inserting '', including graphical warning products,'' after ''warnings'';

(B) by inserting '', territories,'' after ''States''; and

(C) by inserting ''and Wireless Emergency Alerts'' after ''Hazards Program''; and

(8) in paragraph (9), as redesignated by paragraph (2)—

(A) by inserting ''provide and'' before ''allow''; and

(B) by inserting ''and commercial and Federal undersea communications cables'' after ''observing technologies''.

(c) TSUNAMI WARNING SYSTEM.—Subsection (c) of section 4 (33 U.S.C. 3203(c)) is amended to read as follows:

''(c) TSUNAMI WARNING SYSTEM.—The program under this section shall operate a tsunami warning system that—

''(1) is capable of forecasting tsunami, including forecasting tsunami arrival time and inundation estimates, anywhere in the Pacific and Arctic Ocean regions and providing adequate warnings;

''(2) is capable of forecasting and providing adequate warnings, including tsunami arrival time and inundation models where applicable, in areas of the Atlantic Ocean, including the Caribbean Sea and Gulf of Mexico, that are determined—

''(A) to be geologically active, or to have significant potential for geological activity; and

''(B) to pose significant risks of tsunami for States along the coastal areas of the Atlantic Ocean, Caribbean Sea, or Gulf of Mexico; and

''(3) supports other international tsunami forecasting and warning efforts.''.

(d) TSUNAMI WARNING CENTERS.—Subsection (d) of section 4 (33 U.S.C. 3203(d)) is amended to read as follows:

''(d) TSUNAMI WARNING CENTERS.—

''(1) IN GENERAL.—The Administrator shall support or maintain centers to support the tsunami warning system required by subsection (c). The Centers shall include—

''(A) the National Tsunami Warning Center, located in Alaska, which is primarily responsible for Alaska and the continental United States;

''(B) the Pacific Tsunami Warning Center, located in Hawaii, which is primarily responsible for Hawaii, the Caribbean, and other areas of the Pacific not covered by the National Center; and

''(C) any additional forecast and warning centers determined by the National Weather Service to be necessary.

''(2) RESPONSIBILITIES.—The responsibilities of the centers supported or maintained under paragraph (1) shall include the following:

''(A) Continuously monitoring data from seismological, deep ocean, coastal sea level, and tidal monitoring stations and other data sources as may be developed and deployed.

''(B) Evaluating earthquakes, landslides, and volcanic eruptions that have the potential to generate tsunami.

''(C) Evaluating deep ocean buoy data and tidal monitoring stations for indications of tsunami resulting from earthquakes and other sources.

''(D) To the extent practicable, utilizing a range of models, including ensemble models, to predict tsunami, including arrival times, flooding estimates, coastal and harbor currents, and duration.

''(E) Using data from the Integrated Ocean Observing System of the Administration in coordination with regional associations to calculate new inundation estimates and periodically update existing inundation estimates.

''(F) Disseminating forecasts and tsunami warning bulletins to Federal, State, tribal, and local government officials and the public.

''(G) Coordinating with the tsunami hazard mitigation program conducted under section 5 to ensure ongoing sharing of information between forecasters and emergency management officials.

''(H) In coordination with the Coast Guard, evaluating and recommending procedures for ports and harbors at risk of tsunami inundation, including review of readiness, response, and communication strategies, and data sharing policies.

''(I) Making data gathered under this Act and post-warning analyses conducted by the National Weather Service or other relevant Administration offices available to the public.

''(J) Integrating and modernizing the program operated under this section with advances in tsunami science to improve performance without compromising service.

''(3) FAIL-SAFE WARNING CAPABILITY.—The tsunami warning centers supported or maintained under paragraph (1) shall maintain a fail-safe warning capability and perform backup duties for each other.

''(4) COORDINATION WITH NATIONAL WEATHER SERVICE.—The Administrator shall coordinate with the forecast offices of the National Weather Service, the centers supported or maintained under paragraph (1), and such program offices of the Administration as the Administrator or the coordinating committee, as established in section 5(d), consider appropriate to ensure that regional and local forecast offices—

''(A) have the technical knowledge and capability to disseminate tsunami warnings for the communities they serve;

''(B) leverage connections with local emergency management officials for optimally disseminating tsunami warnings and forecasts; and

''(C) implement mass communication tools in effect on the day before the date of the enactment of the Tsunami Warning, Education, and Research Act of 2015 used by the National Weather Service on such date and newer mass communication technologies as they are developed as a part of the Weather-Ready Nation program of the Administration, or otherwise, for the purpose of timely and effective delivery of tsunami warnings.

''(5) UNIFORM OPERATING PROCEDURES.—The Administrator shall—

''(A) develop uniform operational procedures for the centers supported or maintained under paragraph (1), including the use of software applications, checklists, decision support tools, and tsunami warning products that have been standardized across the program supported under this section;

''(B) ensure that processes and products of the warning system operated under subsection (c)—

''(i) reflect industry best practices when practicable;

''(ii) conform to the maximum extent practicable with internationally recognized standards for information technology; and

''(iii) conform to the maximum extent practicable with other warning products and practices of the National Weather Service;

''(C) ensure that future adjustments to operational protocols, processes, and warning products—

''(i) are made consistently across the warning system operated under subsection (c); and

''(ii) are applied in a uniform manner across such warning system;

''(D) establish a systematic method for information technology product development to improve long-term technology planning efforts; and

''(E) disseminate guidelines and metrics for evaluating and improving tsunami forecast models.

''(6) AVAILABLE RESOURCES.—The Administrator, through the National Weather Service, shall ensure that resources are available to fulfill the obligations of this Act. This includes ensuring supercomputing resources are available to run, as rapidly as possible, such computer models as are needed for purposes of the tsunami warning system operated under subsection (c).''.

(e) TRANSFER OF TECHNOLOGY; MAINTENANCE AND UPGRADES.—Subsection (e) of section 4 (33 U.S.C. 3203(e)) is amended to read as follows:

''(e) TRANSFER OF TECHNOLOGY; MAINTENANCE AND UPGRADES.—In carrying out this section, the Administrator shall—

''(1) develop requirements for the equipment used to forecast tsunami, including—

''(A) provisions for multipurpose detection platforms;

''(B) reliability and performance metrics; and

''(C) to the maximum extent practicable, requirements for the integration of equipment with other United States and global ocean and coastal observation systems, the global Earth observing system of systems, the global seismic networks, and the Advanced National Seismic System;

''(2) develop and execute a plan for the transfer of technology from ongoing research conducted as part of the program supported or maintained under section 6 into the program under this section; and

''(3) ensure that the Administration's operational tsunami detection equipment is properly maintained.''.

(f) FEDERAL COOPERATION.—Subsection (f) of section 4 (33 U.S.C. 3203(f)) is amended to read as follows:

''(f) FEDERAL COOPERATION.—When deploying and maintaining tsunami detection technologies under the program under this section, the Administrator shall—

''(1) identify which assets of other Federal agencies are necessary to support such program; and

''(2) work with each agency identified under paragraph (1)—

''(A) to acquire the agency's assistance; and

''(B) to prioritize the necessary assets in support of the tsunami forecast and warning program.''.

(g) UNNECESSARY PROVISIONS.—Section 4 (33 U.S.C. 3203) is further amended—

(1) by striking subsection (g);

(2) by striking subsections (i) through (k); and

(3) by redesignating subsection (h) as subsection (g).

(h) CONGRESSIONAL NOTIFICATIONS.—Subsection (g) of section 4 (33 U.S.C. 3203(g)), as redesignated by subsection (g)(3), is amended—

(1) in the matter before paragraph (1), by striking ''30'' and inserting ''90'';

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs 2 ems to the right;

(3) in the matter before subparagraph (A), as redesignated by paragraph (2), by striking ''The Administrator'' and inserting the following:

''(1) IN GENERAL.—The Administrator'';

(4) in paragraph (1), as redesignated by paragraph (3)—

(A) in subparagraph (A), as redesignated by paragraph (2), by striking ''and'' at the end;

(B) in subparagraph (B), as redesignated by paragraph (2), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) the occurrence of a significant tsunami warning.''; and

(5) by adding at the end the following:

''(2) CONTENTS.—In a case in which notice is submitted under paragraph (1) within 90 days of a significant tsunami warning described in subparagraph (C) of such paragraph, such notice shall include, as appropriate, brief information and analysis of—

''(A) the accuracy of the tsunami model used;

''(B) the specific deep ocean or other monitoring equipment that detected the incident, as well as the deep ocean or other monitoring equipment that did not detect the incident due to malfunction or other reasons;

''(C) the effectiveness of the warning communication, including the dissemination of warnings with State, territory, local, and tribal partners in the affected area under the jurisdiction of the National Weather Service; and

''(D) such other findings as the Administrator considers appropriate.''.

SEC. 5. MODIFICATION OF NATIONAL TSUNAMI HAZARD MITIGATION PROGRAM.

(a) IN GENERAL.—Section 5 (33 U.S.C. 3204) is amended by striking subsections (a) through (d) and inserting the following:

''(a) PROGRAM REQUIRED.—The Administrator, in coordination with the Administrator of the Federal Emergency Management Agency and the heads of such other agencies as the Administrator considers relevant, shall conduct a community-based tsunami hazard mitigation program to improve tsunami preparedness and resiliency of at-risk areas in the United States and the territories of the United States.

''(b) PROGRAM COMPONENTS.—The Program conducted under subsection (a) shall include the following:

''(1) Technical and financial assistance to coastal States, territories, tribes, and local governments to develop and implement activities under this section.

''(2) Integration of tsunami preparedness and mitigation programs into ongoing State-based hazard warning, resilience planning, and risk management activities, including predisaster planning, emergency response, evacuation planning, disaster recovery, hazard mitigation, and community development and redevelopment planning programs in affected areas.

''(3) Activities to promote the adoption of tsunami resilience, preparedness, warning, and mitigation measures by Federal, State, territorial, tribal, and local governments and nongovernmental entities, including educational and risk communication programs to discourage development in high-risk areas.

''(4) Activities to support the development of regional tsunami hazard and risk assessments. Such regional risk assessments may include the following:

''(A) The sources, sizes, and other relevant historical data of tsunami in the region, including paleotsunami data.

''(B) Inundation models and maps of critical infrastructure and socioeconomic vulnerability in areas subject to tsunami inundation.

''(C) Maps of evacuation areas and evacuation routes, including, when appropriate, traffic studies that evaluate the viability of evacuation routes.

''(D) Evaluations of the size of populations that will require evacuation, including populations with special evacuation needs.

''(E) Evaluations and technical assistance for vertical evacuation structure planning for communities where models indicate limited or no ability for timely evacuation, especially in areas at risk of near shore generated tsunami.

''(F) Evaluation of at-risk ports and harbors.

''(G) Evaluation of the effect of tsunami currents on the foundations of closely-spaced, coastal high-rise structures.

''(5) Activities to promote preparedness in at-risk ports and harbors, including the following:

''(A) Evaluation and recommendation of procedures for ports and harbors in the event of a distant or near-field tsunami.

''(B) A review of readiness, response, and communication strategies to ensure coordination and data sharing with the Coast Guard.

''(6) Activities to support the development of community-based outreach and education programs to ensure community readiness and resilience, including the following:

''(A) The development, implementation, and assessment of technical training and public education programs, including education programs that address unique characteristics of distant and near-field tsunami.

''(B) The development of decision support tools.

''(C) The incorporation of social science research into community readiness and resilience efforts.

''(D) The development of evidence-based education guidelines.

''(7) Dissemination of guidelines and standards for community planning, education, and training products, programs, and tools, including—

''(A) standards for—

''(i) mapping products;

''(ii) inundation models; and

''(iii) effective emergency exercises; and

''(B) recommended guidance for at-risk port and harbor tsunami warning, evacuation, and response procedures in coordination with the Coast Guard.

''(c) AUTHORIZED ACTIVITIES.—In addition to activities conducted under subsection (b), the program conducted under subsection (a) may include the following:

''(1) Multidisciplinary vulnerability assessment research, education, and training to help integrate risk management and resilience objectives with community development planning and policies.

''(2) Risk management training for local officials and community organizations to enhance understanding and preparedness.

''(3) Interagency, Federal, State, tribal, and territorial intergovernmental tsunami response exercise planning and implementation in high risk areas.

''(4) Development of practical applications for existing or emerging technologies, such as modeling, remote sensing, geospatial technology, engineering, and observing systems, including the integration of tsunami sensors into Federal and commercial submarine telecommunication cables if practicable.

''(5) Risk management, risk assessment, and resilience data and information services, including—

''(A) access to data and products derived from observing and detection systems; and

''(B) development and maintenance of new integrated data products to support risk management, risk assessment, and resilience programs.

''(6) Risk notification systems that coordinate with and build upon existing systems and actively engage decisionmakers, State, local, tribal, and territorial governments and agencies, business communities, nongovernmental organizations, and the media.

''(d) COORDINATING COMMITTEE.—

''(1) IN GENERAL.—The Administrator shall maintain a coordinating committee to assist the Administrator in the conduct of the program required by subsection (a).

''(2) COMPOSITION.—The coordinating committee shall be composed of members as follows:

''(A) Representatives from each of the States and territories most at risk from tsunami, including Alaska, Washington, Oregon, California, Hawaii, Puerto Rico, Guam, American Samoa, and the Northern Marianas Islands.

''(B) Such other members as the Administrator considers appropriate to represent Federal, State, tribal, territorial, and local governments.

''(3) SUBCOMMITTEES.—The Administrator may approve the formation of subcommittees to address specific program components or regional issues.

''(4) RESPONSIBILITIES.—The coordinating committee shall—

''(A) provide feedback on how funds should be prioritized to carry out the program required by subsection (a);

''(B) ensure that areas described in section 4(c) in the United States and its territories have the opportunity to participate in the program;

''(C) provide recommendations to the Administrator on how to improve and continuously advance the TsunamiReady program of the National Weather Service, particularly on ways to make communities more tsunami resilient through the use of inundation maps and models and other hazard mitigation practices;

''(D) ensure that all components of the program required by subsection (a) are integrated with ongoing State based hazard warning, risk management, and resilience activities, including—

''(i) integrating activities with emergency response plans, disaster recovery, hazard mitigation, and community development programs in affected areas; and

''(ii) integrating information to assist in tsunami evacuation route planning.

''(5) EXEMPTION FROM FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the committee established and maintained under paragraph (1).

''(e) NO PREEMPTION WITH RESPECT TO DESIGNATION OF AT-RISK AREAS.—The establishment of national standards for inundation models under this section shall not prevent States, territories, tribes, and local governments from designating additional areas as being at risk based on knowledge of local conditions.

''(f) NO NEW REGULATORY AUTHORITY.—Nothing in this Act may be construed as establishing new regulatory authority for any Federal agency.''.

(b) REPORT ON ACCREDITATION OF TSUNAMIREADY PROGRAM.—Not later than 180 days after the date of enactment of this Act, the Administrator of the National Oceanic and Atmospheric Administration shall submit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Science, Space, and Technology of the House of Representatives a report on which authorities and activities would be needed to have the TsunamiReady program of the National Weather Service accredited by the Emergency Management Accreditation Program.

SEC. 6. MODIFICATION OF TSUNAMI RESEARCH PROGRAM.

Section 6 (33 U.S.C. 3205) is amended—

(1) in the matter before paragraph (1), by striking ''The Administrator shall'' and all that follows through ''establish or maintain'' and inserting the following:

''(a) IN GENERAL.—The Administrator shall, in consultation with such other Federal agencies, State, tribal, and territorial governments, and academic institutions as the Administrator considers appropriate, the coordinating committee under section 5(d), and the panel under section 8(a), support or maintain'';

(2) in subsection (a), as designated by paragraph (1), by striking ''and assessment for tsunami tracking and numerical forecast modeling. Such research program shall—'' and inserting the following: ''assessment for tsunami tracking and numerical forecast modeling, and standards development.

''(b) RESPONSIBILITIES.—The research program supported or maintained under subsection (a) shall—''; and

(3) in subsection (b), as designated by paragraph (2)—

(A) by amending paragraph (1) to read as follows:

''(1) consider other appropriate and cost effective solutions to mitigate the impact of tsunami, including the improvement of near-field and distant tsunami detection and forecasting capabilities, which may include use of a new generation of the Deep-ocean Assessment and Reporting of Tsunamis array, integration of tsunami sensors into commercial and Federal telecommunications cables, and other real-time tsunami monitoring systems and supercomputer capacity of the Administration to develop a rapid tsunami forecast for all United States coastlines;'';

(B) in paragraph (3)—

(i) by striking ''include'' and inserting ''conduct''; and

(ii) by striking ''and'' at the end;

(C) by redesignating paragraph (4) as paragraph (5);

(D) by inserting after paragraph (3) the following:

''(4) develop the technical basis for validation of tsunami maps, numerical tsunami models, digital elevation models, and forecasts; and''; and

(E) in paragraph (5), as redesignated by subparagraph (C), by striking ''to the scientific community'' and inserting ''to the public and the scientific community''.

SEC. 7. GLOBAL TSUNAMI WARNING AND MITIGATION NETWORK.

Section 7 (33 U.S.C. 3206) is amended—

(1) by amending subsection (a) to read as follows:

''(a) SUPPORT FOR DEVELOPMENT OF AN INTERNATIONAL TSUNAMI WARNING SYSTEM.—The Administrator shall, in coordination with the Secretary of State and in consultation with such other agencies as the Administrator considers relevant, provide technical assistance, operational support, and training to the Intergovernmental Oceanographic Commission of the United Nations Educational, Scientific, and Cultural Organization, the World Meteorological Organization of the United Nations, and such other international entities as the Administrator considers appropriate, as part of the international efforts to develop a fully functional global tsunami forecast and warning system comprised of regional tsunami warning networks.'';

(2) in subsection (b), by striking ''shall'' each place it appears and inserting ''may''; and

(3) in subsection (c)—

(A) in paragraph (1), by striking ''establishing'' and inserting ''supporting''; and

(B) in paragraph (2)—

(i) by striking ''establish'' and inserting ''support''; and

(ii) by striking ''establishing'' and inserting ''supporting''.

SEC. 8. TSUNAMI SCIENCE AND TECHNOLOGY ADVISORY PANEL.

(a) IN GENERAL.—The Act is further amended—

(1) by redesignating section 8 (33 U.S.C. 3207) as section 9; and

(2) by inserting after section 7 (33 U.S.C. 3206) the following:

''SEC. 8. TSUNAMI SCIENCE AND TECHNOLOGY ADVISORY PANEL.

''(a) DESIGNATION.—The Administrator shall designate an existing working group within the Science Advisory Board of the Administration to manage the Tsunami Science and Technology Advisory Panel to provide advice to the Administrator on matters regarding tsunami science, technology, and regional preparedness.

''(b) MEMBERSHIP.—

''(1) COMPOSITION.—The Panel shall be composed of no fewer than 7 members selected by the Administrator from among individuals from academia or State agencies who have academic or practical expertise in physical sciences, social sciences, information technology, coastal resilience, emergency management, or such other disciplines as the Administrator considers appropriate.

''(2) FEDERAL EMPLOYMENT.—No member of the Panel may be a Federal employee.

''(c) RESPONSIBILITIES.—Not less frequently than once every 4 years, the Panel shall—

''(1) review the activities of the Administration, and other Federal activities as appropriate, relating to tsunami research, detection, forecasting, warning, mitigation, resiliency, and preparation; and

''(2) submit to the Administrator and such others as the Administrator considers appropriate—

''(A) the findings of the working group with respect to the most recent review conducted under paragraph (1); and

''(B) such recommendations for legislative or administrative action as the working group considers appropriate to improve Federal tsunami research, detection, forecasting, warning, mitigation, resiliency, and preparation.

''(d) REPORTS TO CONGRESS.—Not less frequently than once every 4 years, the Administrator shall submit to the Committee on Commerce, Science, and Transportation of the Senate, and the Committee on Science, Space, and Technology of the House of Representatives a report on the findings and recommendations received by the Administrator under subsection (c)(2).''.

SEC. 9. REPORTS.

(a) REPORT ON IMPLEMENTATION OF TSUNAMI WARNING AND EDUCATION ACT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Administrator of the National Oceanic and Atmospheric Administration shall submit to Congress a report on the implementation of the Tsunami Warning and Education Act (33 U.S.C. 3201 et seq.).

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A detailed description of the progress made in implementing sections 4(d)(6), 5(b)(6), and 6(b)(4) of the Tsunami Warning and Education Act.

(B) A description of the ways that tsunami warnings and warning products issued by the Tsunami Forecasting and Warning Program established under section 4 of the Tsunami Warning and Education Act (33 U.S.C. 3203) can be standardized and streamlined with warnings and warning products for hurricanes, coastal storms, and other coastal flooding events.

(b) REPORT ON NATIONAL EFFORTS THAT SUPPORT RAPID RESPONSE FOLLOWING NEAR-SHORE TSUNAMI EVENTS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Administrator and the Secretary of Homeland Security shall jointly, in coordination with the Director of the United States Geological Survey, Administrator of the Federal Emergency Management Agency, the Chief of the National Guard Bureau, and the heads of such other Federal agencies as the Administrator considers appropriate, submit to the appropriate committees of Congress a report on the national efforts in effect on the day before the date of the enactment of this Act that support and facilitate rapid emergency response following a domestic near-shore tsunami event to better understand domestic effects of earthquake derived tsunami on people, infrastructure, and communities in the United States.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A description of scientific or other measurements collected on the day before the date of the enactment of this Act to quickly identify and quantify lost or degraded infrastructure or terrestrial formations.

(B) A description of scientific or other measurements that would be necessary to collect to quickly identify and quantify lost or degraded infrastructure or terrestrial formations.

(C) Identification and evaluation of Federal, State, local, tribal, territorial, and military first responder and search and rescue operation centers, bases, and other facilities as well as other critical response assets and infrastructure, including search and rescue aircraft, located within near-shore and distant tsunami inundation areas on the day before the date of the enactment of this Act.

(D) An evaluation of near-shore tsunami response plans in areas described in subparagraph (C) in effect on the day before the date of the enactment of this Act, and how those response plans would be affected by the loss of search and rescue and first responder infrastructure described in such subparagraph.

(E) A description of redevelopment plans and reports in effect on the day before the date of the enactment of this Act for communities in areas that are at high-risk for near-shore tsunami, as well identification of States or communities that do not have redevelopment plans.

(F) Recommendations to enhance near-shore tsunami preparedness and response plans, including recommended responder exercises, predisaster planning, and mitigation needs.

(G) Such other data and analysis information as the Administrator and the Secretary of Homeland Security consider appropriate.

(3) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term ''appropriate committees of Congress'' means—

(A) the Committee on Commerce, Science, and Transportation and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(B) the Committee on Science, Space, and Technology and the Committee on Homeland Security of the House of Representatives.

SEC. 10. AUTHORIZATION OF APPROPRIATIONS.

Section 9 of the Act, as redesignated by section 8(a)(1) of this Act, is amended—

(1) in paragraph (4)(B), by striking ''and'' at the end;

(2) in paragraph (5)(B), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(6) $27,000,000 for each of fiscal years 2016 through 2021, of which—

''(A) not less than 27 percent of the amount appropriated for each fiscal year shall be for activities conducted at the State level under the tsunami hazard mitigation program under section 5; and

''(B) not less than 8 percent of the amount appropriated shall be for the tsunami research program under section 6.''.

SEC. 11. OUTREACH RESPONSIBILITIES.

The Administrator of the National Oceanic and Atmospheric Administration, in coordination with State and local emergency managers, shall develop and carry out formal outreach activities to improve tsunami education and awareness and foster the development of resilient communities. Outreach activities may include—

(1) the development of outreach plans to ensure the close integration of tsunami warning centers supported or maintained under section 4(d) of the Tsunami Warning and Education Act (33 U.S.C. 3203(d)) with local Weather Forecast Offices of the National Weather Service and emergency managers;

(2) working with appropriate local Weather Forecast Offices to ensure they have the technical knowledge and capability to disseminate tsunami warnings to the communities they serve; and

(3) evaluating the effectiveness of warnings and of coordination with local Weather Forecast Offices after significant tsunami events.

SEC. 12. MODIFICATION OF COASTAL OCEAN PROGRAM.

Section 201(c) of the National Oceanic and Atmospheric Administration Authorization Act of 1992 (Public Law 102–567; 106 Stat. 4280) is amended—

(1) by inserting ''(1) IN GENERAL.—'' before ''Of the sums'' and indenting appropriately; and

(2) by adding at the end the following:

''(2) REGIONAL COASTAL RISK MANAGEMENT COALITIONS.—The Administrator of the National Oceanic and Atmospheric Administration may form regional coastal risk management coalitions comprised of representatives of Federal, State, local, and tribal governments, community groups, academic institutions, and nongovernmental groups to advance the goals of this section for communities facing common coastal hazards and risks. Such coalitions may enter into an agreement with an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 to establish a nonprofit foundation in order to accept gifts and donations to support the goals of this subsection.''.

SEC. 13. REPEAL OF DUPLICATE PROVISIONS OF LAW.

(a) REPEAL.—The Magnuson-Stevens Fishery Conservation and Management Reauthorization Act of 2006 (Public Law 109–479) is amended by striking title VIII (relating to tsunami warning and education).

(b) CONSTRUCTION.—Nothing in this section shall be construed to repeal, or affect in any way, Public Law 109–424.

MOTION OFFERED BY MR. UPTON

Mr. UPTON. Mr. Speaker, I have a motion at the desk.

The SPEAKER pro tempore. The Clerk will designate the motion.

The text of the motion is as follows:

Mr. Upton moves that the House concur in the Senate amendment to H.R. 34 with an amendment inserting the text of Rules Committee Print 114–67, modified by the amendment printed in part A of House Report 114–839, in lieu of the matter proposed to be added by the Senate.

The text of the House amendment to the Senate amendment to the text is as follows:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''21st Century Cures Act''.

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

DIVISION A—21ST CENTURY CURES

SEC. 1000. SHORT TITLE.

This Division may be cited as the ''21st Century Cures Act''.

TITLE I—INNOVATION PROJECTS AND STATE RESPONSES TO OPIOID ABUSE

SEC. 1001. NIH INNOVATION PROJECTS.

(a) IN GENERAL.—The Director of the National Institutes of Health (referred to in this section as the ''Director of NIH'') shall use any funds appropriated pursuant to the authorization of appropriations in subsection (b)(3) to carry out the National Institutes of Health innovation projects described in subsection (b)(4) (referred to in this section as the ''NIH Innovation Projects'').

(b) NATIONAL INSTITUTES OF HEALTH INNOVATION ACCOUNT.—

(1) ESTABLISHMENT OF NIH INNOVATION ACCOUNT.—There is established in the Treasury an account, to be known as the ''NIH Innovation Account'' (referred to in this subsection as the ''Account''), for purposes of carrying out the NIH Innovation Projects described in paragraph (4).

(2) TRANSFER OF DIRECT SPENDING SAVINGS.—

(A) IN GENERAL.—The following amounts shall be transferred to the Account from the general fund of the Treasury:

(i) For fiscal year 2017, $352,000,000.
(ii) For fiscal year 2018, $496,000,000.
(iii) For fiscal year 2019, $711,000,000.
(iv) For fiscal year 2020, $492,000,000.
(v) For fiscal year 2021, $404,000,000.
(vi) For fiscal year 2022, $496,000,000.
(vii) For fiscal year 2023, $1,085,000,000.
(viii) For fiscal year 2024, $407,000,000.
(ix) For fiscal year 2025, $127,000,000.
(x) For fiscal year 2026, $226,000,000.

(B) AMOUNTS DEPOSITED.—Any amounts transferred under subparagraph (A) shall remain unavailable in the Account until such amounts are appropriated pursuant to paragraph (3).

(3) APPROPRIATIONS.—

(A) AUTHORIZATION OF APPROPRIATIONS.—For each of the fiscal years 2017 through 2026, there is authorized to be appropriated from the Account to the Director of NIH, for the purpose of carrying out the NIH Innovation Projects, an amount not to exceed the total amount transferred to the Account under paragraph (2)(A), to remain available until expended.

(B) OFFSETTING FUTURE APPROPRIATIONS.—For any of fiscal years 2017 through 2026, for any discretionary appropriation under the heading ''NIH Innovation Account'' provided to the Director of NIH pursuant to the authorization of appropriations under subparagraph (A) for the purpose of carrying out the NIH Innovation Projects, the total amount of such appropriations for the applicable fiscal year (not to exceed the total amount remaining in the Account) shall be subtracted from the estimate of discretionary budget authority and the resulting outlays for any estimate under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985, and the amount transferred to the Account shall be reduced by the same amount.

(4) NIH INNOVATION PROJECTS.—NIH Innovation Projects authorized to be funded under this section shall consist of the following and, of the total amounts authorized to be appropriated under paragraph (3), there are authorized to be appropriated to each such project a total amount not to exceed the following, over the period of fiscal years 2017 through 2026:

(A) For the Precision Medicine Initiative, including for the advancement of a cohort of individuals to support the goals of the Precision Medicine Initiative, not to exceed a total of $1,455,000,000, as follows:

(i) For fiscal year 2017, $40,000,000.
(ii) For fiscal year 2018, $100,000,000.
(iii) For fiscal year 2019, $186,000,000.
(iv) For fiscal year 2020, $149,000,000.
(v) For fiscal year 2021, $109,000,000.
(vi) For fiscal year 2022, $150,000,000.
(vii) For fiscal year 2023, $419,000,000.
(viii) For fiscal year 2024, $235,000,000.
(ix) For fiscal year 2025, $36,000,000.
(x) For fiscal year 2026, $31,000,000.

(B) For the Brain Research through Advancing Innovative Neurotechnologies Initiative (known as the ''BRAIN Initiative''), not to exceed a total of $1,511,000,000, as follows:

(i) For fiscal year 2017, $10,000,000.
(ii) For fiscal year 2018, $86,000,000.
(iii) For fiscal year 2019, $115,000,000.
(iv) For fiscal year 2020, $140,000,000.
(v) For fiscal year 2021, $100,000,000.
(vi) For fiscal year 2022, $152,000,000.
(vii) For fiscal year 2023, $450,000,000.
(viii) For fiscal year 2024, $172,000,000.
(ix) For fiscal year 2025, $91,000,000.
(x) For fiscal year 2026, $195,000,000.

(C) To support cancer research, such as the development of cancer vaccines, the development of more sensitive diagnostic tests for cancer, immunotherapy and the development of

combination therapies, and research that has the potential to transform the scientific field, that has inherently higher risk, and that seeks to address major challenges related to cancer, not to exceed a total of $1,800,000,000, as follows:

(i) For fiscal year 2017, $300,000,000.

(ii) For fiscal year 2018, $300,000,000.

(iii) For fiscal year 2019, $400,000,000.

(iv) For fiscal year 2020, $195,000,000.

(v) For fiscal year 2021, $195,000,000.

(vi) For fiscal year 2022, $194,000,000.

(vii) For fiscal year 2023, $216,000,000.

(D) For the National Institutes of Health, in coordination with the Food and Drug Administration, to award grants and contracts for clinical research to further the field of regenerative medicine using adult stem cells, including autologous stem cells, for which grants and contracts shall be contingent upon the recipient making available non-Federal contributions toward the costs of such research in an amount not less than $1 for each $1 of Federal funds provided in the award, not to exceed a total of $30,000,000, as follows:

(i) For fiscal year 2017, $2,000,000.

(ii) For each of fiscal years 2018 and 2019, $10,000,000.

(iii) For fiscal year 2020, $8,000,000.

(iv) For each of fiscal years 2021 through 2026, $0.

(c) ACCOUNTABILITY AND OVERSIGHT.—

(1) WORK PLAN.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Director of NIH shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a work plan including the proposed allocation of funds authorized to be appropriated pursuant to subsection (b)(3) for each of fiscal years 2017 through 2026 for the NIH Innovation Projects and the contents described in subparagraph (B).

(B) CONTENTS.—The work plan submitted under subparagraph (A) shall include—

(i) recommendations from the Advisory Committee described in subparagraph (C);

(ii) the amount of money to be obligated or expended in each fiscal year for each NIH Innovation Project;

(iii) a description and justification of each such project; and

(iv) a description of how each such project supports the strategic research priorities identified in the NIH Strategic Plan under subsection (m) of section 402 of the Public Health Service Act (42 U.S.C. 282), as added by section 2031.

(C) RECOMMENDATIONS.—Prior to submitting the work plan under this paragraph, the Director of NIH shall seek recommendations from the Advisory Committee to the Director of NIH appointed under section 222 of the Public Health Service Act (42 U.S.C. 217a) on—

(i) the allocations of funds appropriated pursuant to the authorization of appropriations under subsection (b)(3) for each of fiscal years 2017 through 2026; and

(ii) on the contents of the proposed work plan.

(2) REPORTS.—

(A) ANNUAL REPORTS.—Not later than October 1 of each of fiscal years 2018 through 2027, the Director of NIH shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a report including—

(i) the amount of money obligated or expended in the prior fiscal year for each NIH Innovation Project;

(ii) a description of any such project using funds provided pursuant to the authorization of appropriations under subsection (b)(3); and

(iii) whether such projects are advancing the strategic research priorities identified in the NIH Strategic Plan under subsection (m) of section 402 of the Public Health Service Act (42 U.S.C. 282), as added by section 2031.

(B) ADDITIONAL REPORTS.—At the request of the Committee on Health, Education, Labor, and Pensions or the Committee on Appropriations of the Senate, or the Committee on Energy and Commerce or the Committee on Appropriations of the House of Representatives, the Director of NIH shall provide an update in the form of testimony and any additional reports to the respective congressional committee regarding the allocation of funding under this section or the description of the NIH Innovation Projects.

(d) LIMITATIONS.—Notwithstanding any transfer authority authorized by this Act or any appropriations Act, any funds made available pursuant to the authorization of appropriations under subsection (b)(3) may not be used for any purpose other than a NIH Innovation Project.

(e) SUNSET.—This section shall expire on September 30, 2026.

SEC. 1002. FDA INNOVATION PROJECTS.

(a) IN GENERAL.—The Commissioner of Food and Drugs (referred to in this section as the ''Commissioner'') shall use any funds appropriated pursuant to the authorization of appropriations under subsection (b)(3) to carry out the activities described in subsection (b)(4).

(b) FDA INNOVATION ACCOUNT.—

(1) ESTABLISHMENT OF FDA INNOVATION ACCOUNT.—There is established in the Treasury an account, to be known as the ''FDA Innovation Account'' (referred to in this subsection as the ''Account''), for purposes of carrying out the activities described in paragraph (4).

(2) TRANSFER OF DIRECT SPENDING SAVINGS.—

(A) IN GENERAL.—For each of fiscal years 2017 through 2025, the following amounts shall be transferred to the Account from the general fund of the Treasury:

(i) For fiscal year 2017, $20,000,000.

(ii) For fiscal year 2018, $60,000,000.

(iii) For fiscal year 2019, $70,000,000.

(iv) For fiscal year 2020, $75,000,000.

(v) For fiscal year 2021, $70,000,000.

(vi) For fiscal year 2022, $50,000,000.

(vii) For fiscal year 2023, $50,000,000.

(viii) For fiscal year 2024, $50,000,000.

(ix) For fiscal year 2025, $55,000,000.

(B) AMOUNTS DEPOSITED.—Any amounts transferred under subparagraph (A) shall remain unavailable in the Account until such amounts are appropriated pursuant to paragraph (3).

(3) APPROPRIATIONS.—

(A) AUTHORIZATION OF APPROPRIATIONS.—For each of the fiscal years 2017 through 2025, there is authorized to be appropriated from the Account to the Commissioner, for the purpose of carrying out the activities described in paragraph (5), an amount not to exceed the total amount transferred to the Account under paragraph (2)(A), to remain available until expended.

(B) OFFSETTING FUTURE APPROPRIATIONS.—For any of fiscal years 2017 through 2025, for any discretionary appropriation under the heading ''FDA Innovation Account'' provided to the Commissioner pursuant to the authorization of appropriations under subparagraph (A) for the purpose of carrying out the projects activities described in paragraph (4), the total amount of such appropriations in the applicable fiscal year (not to exceed the total amount remaining in the Account) shall be subtracted from the estimate of discretionary budget authority and the resulting outlays for any estimate under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985, and the amount transferred to the Account shall be reduced by the same amount.

(4) FDA ACTIVITIES.—The activities authorized to be funded under this section are the activities under subtitles A through F (including the amendments made by such subtitles) of title III of this Act and section 1014 of the Federal Food, Drug, and Cosmetic Act, as added by section 3073 of this Act.

(c) ACCOUNTABILITY AND OVERSIGHT.—

(1) WORK PLAN.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Commissioner shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a work plan including the proposed allocation of funds appropriated pursuant to the authorization of appropriations under subsection (b)(3) for each of fiscal years 2017 through 2025 and the contents described in subparagraph (B).

(B) CONTENTS.—The work plan submitted under subparagraph (A) shall include—

(i) recommendations from the Advisory Committee described in subparagraph (C);

(ii) the amount of money to be obligated or expended in each fiscal year for each activity described in subsection (b)(4); and

(iii) a description and justification of each such project activity.

(C) RECOMMENDATIONS.—Prior to submitting the work plan under this paragraph, the Commissioner shall seek recommendations from the Science Board to the Food and Drug Administration, on the proposed allocation of funds appropriated pursuant to the authorization of appropriations under subsection (b)(3) for each of fiscal years 2017 through 2025 and on the contents of the proposed work plan.

(2) REPORTS.—

(A) ANNUAL REPORTS.—Not later than October 1 of each of fiscal years 2018 through 2026, the Commissioner shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a report including—

(i) the amount of money obligated or expended in the prior fiscal year for each activity described in subsection (b)(4);

(ii) a description of all such activities using funds provided pursuant to the authorization of appropriations under subsection (b)(3); and

(iii) how the activities are advancing public health.

(B) ADDITIONAL REPORTS.—At the request of the Committee on Health, Education, Labor, and Pensions or the Committee on Appropriations of the Senate, or the Committee on Energy and Commerce or the Committee on Appropriations of the House of Representatives, the Commissioner shall provide an update in the form of testimony and any additional reports to the respective congressional committee regarding the allocation of funding under this section or the description of the activities undertaken with such funding.

(d) LIMITATIONS.—Notwithstanding any transfer authority authorized by this Act or any appropriations Act, any funds made available pursuant to the authorization of appropriations in subsection (b)(3) shall not be used for any purpose other than an activity described in subsection (b)(4).

(e) SUNSET.—This section shall expire on September 30, 2025.

SEC. 1003. ACCOUNT FOR THE STATE RESPONSE TO THE OPIOID ABUSE CRISIS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall use any funds appropriated pursuant to the authorization of appropriations under subsection (b) to carry out the grant program described in subsection (c) for purposes of addressing the opioid abuse crisis within the States.

(b) ACCOUNT FOR THE STATE RESPONSE TO THE OPIOID ABUSE CRISIS.—

(1) ESTABLISHMENT.—There is established in the Treasury an account, to be known as the ''Account For the State Response to the Opioid

Abuse Crisis'' (referred to in this subsection as the ''Account''), to carry out the opioid grant program described in subsection (c).

(2) TRANSFER OF DIRECT SPENDING SAVINGS.—

(A) IN GENERAL.—The following amounts shall be transferred to the Account from the general fund of the Treasury:

(i) For fiscal year 2017, $500,000,000.

(ii) For fiscal year 2018, $500,000,000.

(B) AMOUNTS DEPOSITED.—Any amounts transferred under subparagraph (A) shall remain unavailable in the Account until such amounts are appropriated pursuant to paragraph (3).

(3) APPROPRIATIONS.—

(A) AUTHORIZATION OF APPROPRIATIONS.—In each of the fiscal years 2017 and 2018, there is authorized to be appropriated from the Account to the Secretary, for the grant program described in subsection (c), an amount not to exceed the total amount transferred to the Account under paragraph (2)(A), to remain available until expended.

(B) OFFSETTING FUTURE APPROPRIATIONS.—In each of fiscal years 2017 and 2018, for any discretionary appropriation under the heading ''Account For the State Response to the Opioid Abuse Crisis'' for the grant program described in subsection (c), the total amount of such appropriations in the applicable fiscal year (not to exceed the total amount remaining in the Account) shall be subtracted from the estimate of discretionary budget authority and the resulting outlays for any estimate under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985, and the amount transferred to the Account shall be reduced by the same amount.

(c) OPIOID GRANT PROGRAM.—

(1) STATE RESPONSE TO THE OPIOID ABUSE CRISIS.—Subject to the availability of appropriations, the Secretary shall award grants to States for the purpose of addressing the opioid abuse crisis within such States, in accordance with subparagraph (B). In awarding such grants, the Secretary shall give preference to States with an incidence or prevalence of opioid use disorders that is substantially higher relative to other States.

(2) OPIOID GRANTS.—Grants awarded to a State under this subsection shall be used for carrying out activities that supplement activities pertaining to opioids undertaken by the State agency responsible for administering the substance abuse prevention and treatment block grant under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.), which may include public health-related activities such as the following:

(A) Improving State prescription drug monitoring programs.

(B) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent opioid abuse.

(C) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.

(D) Supporting access to health care services, including those services provided by Federally certified opioid treatment programs or other appropriate health care providers to treat substance use disorders.

(E) Other public health-related activities, as the State determines appropriate, related to addressing the opioid abuse crisis within the State.

(d) ACCOUNTABILITY AND OVERSIGHT.—A State receiving a grant under subsection (c) shall include in a report related to substance abuse submitted to the Secretary pursuant to section 1942 of the Public Health Service Act (42 U.S.C. 300x–52), a description of—

(1) the purposes for which the grant funds received by the State under such subsection for the preceding fiscal year were expended and a description of the activities of the State under the program; and

(2) the ultimate recipients of amounts provided to the State in the grant.

(e) LIMITATIONS.—Any funds made available pursuant to the authorization of appropriations under subsection (b)—

(1) notwithstanding any transfer authority in any appropriations Act, shall not be used for any purpose other than the grant program in subsection (c); and

(2) shall be subject to the same requirements as substance abuse prevention and treatment programs under titles V and XIX of the Public Health Service Act (42 U.S.C. 290aa et seq., 300w et seq.).

(f) SUNSET.—This section shall expire on September 30, 2026.

SEC. 1004. BUDGETARY TREATMENT.

(a) STATUTORY PAYGO SCORECARDS.—The budgetary effects of division A of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) SENATE PAYGO SCORECARDS.—The budgetary effects of division A of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 201 of S. Con. Res. 21 (110th Congress).

(c) RESERVATION OF SAVINGS.—None of the funds in the NIH Innovation Account, the FDA Innovation Account, or the Account For the State Response to the Opioid Abuse Crisis established by this title shall be made available except to the extent provided in advance in appropriations Acts, and legislation or an Act that rescinds or reduces amounts in such accounts shall not be estimated as a reduction in direct spending under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

TITLE II—DISCOVERY

Subtitle A—National Institutes of Health Reauthorization

SEC. 2001. NATIONAL INSTITUTES OF HEALTH REAUTHORIZATION.

Section 402A(a)(1) of the Public Health Service Act (42 U.S.C. 282a(a)(1)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subparagraphs:

''(D) $34,851,000,000 for fiscal year 2018;

''(E) $35,585,871,000 for fiscal year 2019; and

''(F) $36,472,442,775 for fiscal year 2020.''.

SEC. 2002. EUREKA PRIZE COMPETITIONS.

(a) IN GENERAL.—Pursuant to the authorities and processes established under section 24 of the Stevenson-Wydler Technology Innovation Act of 1980 (15 U.S.C. 3719), the Director of the National Institutes of Health shall support prize competitions for one or both of the following goals:

(1) Identifying and funding areas of biomedical science that could realize significant advancements through a prize competition.

(2) Improving health outcomes, particularly with respect to human diseases and conditions—

(A) for which public and private investment in research is disproportionately small relative to Federal Government expenditures on prevention and treatment activities with respect to such diseases and conditions, such that Federal expenditures on health programs would be reduced;

(B) that are serious and represent a significant disease burden in the United States; or

(C) for which there is potential for significant return on investment to the United States.

(b) TRACKING; REPORTING.—The Director of the National Institutes of Health shall—

(1) collect information on—

(A) the effect of innovations funded through the prize competitions under this section in advancing biomedical science or improving health outcomes pursuant to subsection (a); and

(B) the effect of the innovations on Federal expenditures; and

(2) include the information collected under paragraph (1) in the triennial report under section 403 of the Public Health Service Act (42 U.S.C. 283) (as amended by section 2032).

Subtitle B—Advancing Precision Medicine

SEC. 2011. PRECISION MEDICINE INITIATIVE.

Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by adding at the end the following:

''SEC. 498E. PRECISION MEDICINE INITIATIVE.

''(a) IN GENERAL.—The Secretary is encouraged to establish and carry out an initiative, to be known as the 'Precision Medicine Initiative' (in this section referred to as the 'Initiative'), to augment efforts to address disease prevention, diagnosis, and treatment.

''(b) COMPONENTS.—The Initiative described under subsection (a) may include—

''(1) developing a network of scientists to assist in carrying out the purposes of the Initiative;

''(2) developing new approaches for addressing scientific, medical, public health, and regulatory science issues;

''(3) applying genomic technologies, such as whole genomic sequencing, to provide data on the molecular basis of disease;

''(4) collecting information voluntarily provided by a diverse cohort of individuals that can be used to better understand health and disease; and

''(5) other activities to advance the goals of the Initiative, as the Secretary determines appropriate.

''(c) AUTHORITY OF THE SECRETARY.—In carrying out this section, the Secretary may—

''(1) coordinate with the Secretary of Energy, private industry, and others, as the Secretary determines appropriate, to identify and address the advanced supercomputing and other advanced technology needs for the Initiative;

''(2) develop and utilize public-private partnerships; and

''(3) leverage existing data sources.

''(d) REQUIREMENTS.—In the implementation of the Initiative under subsection (a), the Secretary shall—

''(1) ensure the collaboration of the National Institutes of Health, the Food and Drug Administration, the Office of the National Coordinator for Health Information Technology, and the Office for Civil Rights of the Department of Health and Human Services;

''(2) comply with existing laws and regulations for the protection of human subjects involved in research, including the protection of participant privacy;

''(3) implement policies and mechanisms for appropriate secure data sharing across systems that include protections for privacy and security of data;

''(4) consider the diversity of the cohort to ensure inclusion of a broad range of participants, including consideration of biological, social, and other determinants of health that contribute to health disparities;

''(5) ensure that only authorized individuals may access controlled or sensitive, identifiable biological material and associated information collected or stored in connection with the Initiative; and

''(6) on the appropriate Internet website of the Department of Health and Human Services, identify any entities with access to such information and provide information with respect to the purpose of such access, a summary of the research project for which such access is granted, as applicable, and a description of the biological material and associated information to which the entity has access.

''(e) REPORT.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary shall submit a report on the relevant data access policies and procedures to the Committee on Health, Education, Labor, and

Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include steps the Secretary has taken to consult with experts or other heads of departments or agencies of the Federal Government in the development of such policies.''.

SEC. 2012. PRIVACY PROTECTION FOR HUMAN RESEARCH SUBJECTS.

(a) IN GENERAL.—Subsection (d) of section 301 of the Public Health Service Act (42 U.S.C. 241) is amended to read as follows:

''(d)(1)(A) If a person is engaged in biomedical, behavioral, clinical, or other research, in which identifiable, sensitive information is collected (including research on mental health and research on the use and effect of alcohol and other psychoactive drugs), the Secretary, in coordination with other agencies, as applicable—

''(i) shall issue to such person a certificate of confidentiality to protect the privacy of individuals who are the subjects of such research if the research is funded wholly or in part by the Federal Government; and

''(ii) may, upon application by a person engaged in research, issue to such person a certificate of confidentiality to protect the privacy of such individuals if the research is not so funded.

''(B) Except as provided in subparagraph (C), any person to whom a certificate is issued under subparagraph (A) to protect the privacy of individuals described in such subparagraph shall not disclose or provide to any other person not connected with the research the name of such an individual or any information, document, or biospecimen that contains identifiable, sensitive information about such an individual and that was created or compiled for purposes of the research.

''(C) The disclosure prohibition in subparagraph (B) shall not apply to disclosure or use that is—

''(i) required by Federal, State, or local laws, excluding instances described in subparagraph (D);

''(ii) necessary for the medical treatment of the individual to whom the information, document, or biospecimen pertains and made with the consent of such individual;

''(iii) made with the consent of the individual to whom the information, document, or biospecimen pertains; or

''(iv) made for the purposes of other scientific research that is in compliance with applicable Federal regulations governing the protection of human subjects in research.

''(D) Any person to whom a certificate is issued under subparagraph (A) to protect the privacy of an individual described in such subparagraph shall not, in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding, disclose or provide the name of such individual or any such information, document, or biospecimen that contains identifiable, sensitive information about the individual and that was created or compiled for purposes of the research, except in the circumstance described in subparagraph (C)(iii).

''(E) Identifiable, sensitive information protected under subparagraph (A), and all copies thereof, shall be immune from the legal process, and shall not, without the consent of the individual to whom the information pertains, be admissible as evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceeding.

''(F) Identifiable, sensitive information collected by a person to whom a certificate has been issued under subparagraph (A), and all copies thereof, shall be subject to the protections afforded by this section for perpetuity.

''(G) The Secretary shall take steps to minimize the burden to researchers, streamline the process, and reduce the time it takes to comply with the requirements of this subsection.

''(2) The Secretary shall coordinate with the heads of other applicable Federal agencies to ensure that such departments have policies in place with respect to the issuance of a certificate of confidentiality pursuant to paragraph (1) and other requirements of this subsection.

''(3) Nothing in this subsection shall be construed to limit the access of an individual who is a subject of research to information about himself or herself collected during such individual's participation in the research.

''(4) For purposes of this subsection, the term 'identifiable, sensitive information' means information that is about an individual and that is gathered or used during the course of research described in paragraph (1)(A) and—

''(A) through which an individual is identified; or

''(B) for which there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual.''.

(b) APPLICABILITY.—Beginning 180 days after the date of enactment of this Act, all persons engaged in research and authorized by the Secretary of Health and Human Services to protect information under section 301(d) of the Public Health Service Act (42 U.S.C. 241(d)) prior to the date of enactment of this Act shall be subject to the requirements of such section (as amended by this Act).

SEC. 2013. PROTECTION OF IDENTIFIABLE AND SENSITIVE INFORMATION.

Section 301 of the Public Health Service Act (42 U.S.C. 241) is amended by adding at the end the following:

''(f)(1) The Secretary may exempt from disclosure under section 552(b)(3) of title 5, United States Code, biomedical information that is about an individual and that is gathered or used during the course of biomedical research if—

''(A) an individual is identified; or

''(B) there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, the request, and other available data sources could be used to deduce the identity of an individual.

''(2)(A) Each determination of the Secretary under paragraph (1) to exempt information from disclosure shall be made in writing and accompanied by a statement of the basis for the determination.

''(B) Each such determination and statement of basis shall be available to the public, upon request, through the Office of the Chief FOIA Officer of the Department of Health and Human Services.

''(3) Nothing in this subsection shall be construed to limit a research participant's access to information about such participant collected during the participant's participation in the research.''.

SEC. 2014. DATA SHARING.

(a) IN GENERAL.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (23), by striking ''and'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (24) the following:

''(25) may require recipients of National Institutes of Health awards to share scientific data, to the extent feasible, generated from such National Institutes of Health awards in a manner that is consistent with all applicable Federal laws and regulations, including such laws and regulations for the protection of—

''(A) human research participants, including with respect to privacy, security, informed consent, and protected health information; and

''(B) proprietary interests, confidential commercial information, and the intellectual property rights of the funding recipient.''.

(b) CONFIDENTIALITY.—Nothing in the amendments made by subsection (a) authorizes the Secretary of Health and Human Services to disclose any information that is a trade secret, or other privileged or confidential information, described in section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code, or be construed to require recipients of grants or cooperative agreements through the National Institutes of Health to share such information.

Subtitle C—Supporting Young Emerging Scientists

SEC. 2021. INVESTING IN THE NEXT GENERATION OF RESEARCHERS.

(a) IN GENERAL.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end the following:

''SEC. 404M. NEXT GENERATION OF RESEARCHERS.

''(a) NEXT GENERATION OF RESEARCHERS INITIATIVE.—There shall be established within the Office of the Director of the National Institutes of Health, the Next Generation of Researchers Initiative (referred to in this section as the 'Initiative'), through which the Director shall coordinate all policies and programs within the National Institutes of Health that are focused on promoting and providing opportunities for new researchers and earlier research independence.

''(b) ACTIVITIES.—The Director of the National Institutes of Health, through the Initiative shall—

''(1) promote policies and programs within the National Institutes of Health that are focused on improving opportunities for new researchers and promoting earlier research independence, including existing policies and programs, as appropriate;

''(2) develop, modify, or prioritize policies, as needed, within the National Institutes of Health to promote opportunities for new researchers and earlier research independence, such as policies to increase opportunities for new researchers to receive funding, enhance training and mentorship programs for researchers, and enhance workforce diversity;

''(3) coordinate, as appropriate, with relevant agencies, professional and academic associations, academic institutions, and others, to improve and update existing information on the biomedical research workforce in order to inform programs related to the training, recruitment, and retention of biomedical researchers; and

''(4) carry out other activities, including evaluation and oversight of existing programs, as appropriate, to promote the development of the next generation of researchers and earlier research independence.''.

(b) CONSIDERATION OF RECOMMENDATIONS.—In carrying out activities under section 404M(b) of the Public Health Service Act, the Director of the National Institutes of Health shall take into consideration the recommendations made by the National Academies of Sciences, Engineering, and Medicine as part of the comprehensive study on policies affecting the next generation of researchers under the Department of Health and Human Services Appropriations Act, 2016 (Public Law 114–113), and submit a report to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate, and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, with respect to any actions taken by the National Institutes of Health based on the recommendations not later than 2 years after the completion of the study required pursuant to the Department of Health and Human Services Appropriations Act, 2016.

SEC. 2022. IMPROVEMENT OF LOAN REPAYMENT PROGRAM.

(a) INTRAMURAL LOAN REPAYMENT PROGRAM.—Section 487A of the Public Health Service Act (42 U.S.C. 288–1) is amended—

*(1) by amending the section heading to read as follows: ''**INTRAMURAL LOAN REPAYMENT PROGRAM**'';*

(2) in subsection (a)—

(A) by striking ''The Secretary shall carry out a program'' and inserting ''The Director of the National Institutes of Health shall, as appropriate and based on workforce and scientific priorities, carry out a program through the subcategories listed in subsection (b)(1) (or modified subcategories as provided for in subsection (b)(2))'';

(B) by striking ''conduct'' and inserting ''conduct research'';

(C) by striking ''research with respect to acquired immune deficiency syndrome''; and

(D) by striking ''$35,000'' and inserting ''$50,000'';

(3) by redesignating subsection (b) as subsection (d);

(4) by inserting after subsection (a), the following:

''(b) SUBCATEGORIES OF RESEARCH.—

''(1) IN GENERAL.—In carrying out the program under subsection (a), the Director of the National Institutes of Health—

''(A) shall continue to focus on—

''(i) general research;

''(ii) research on acquired immune deficiency syndrome; and

''(iii) clinical research conducted by appropriately qualified health professional who are from disadvantaged backgrounds; and

''(B) may focus on an area of emerging scientific or workforce need.

''(2) ELIMINATION OR ESTABLISHMENT OF SUBCATEGORIES.—The Director of the National Institutes of Health may eliminate one or more subcategories provided for in paragraph (1) due to changes in workforce or scientific needs related to biomedical research. The Director may establish other subcategory areas based on workforce and scientific priorities if the total number of subcategories does not exceed the number of subcategories listed in paragraph (1).

''(c) LIMITATION.—The Director of the National Institutes of Health may not enter into a contract with a health professional pursuant to subsection (a) unless such professional has a substantial amount of education loans relative to income (as determined pursuant to guidelines issued by the Director).''; and

(5) by adding at the end the following:

''(e) AVAILABILITY OF APPROPRIATIONS.—Amounts available for carrying out this section shall remain available until the expiration of the second fiscal year beginning after the fiscal year for which such amounts are made available.''.

(b) EXTRAMURAL LOAN REPAYMENT PROGRAM.—Section 487B of the Public Health Service Act (42 U.S.C. 288–2) is amended—

*(1) by amending the section heading to read as follows: ''**EXTRAMURAL LOAN REPAYMENT PROGRAM**'';*

(2) in subsection (a)—

(A) by striking ''The Secretary, in consultation with the Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, shall establish a program'' and inserting ''IN GENERAL.—The Director of the National Institutes of Health shall, as appropriate and based on workforce and scientific priorities, carry out a program through the subcategories listed in subsection (b)(1) (or modified subcategories as provided for in subsection (b)(2)),'';

(B) by striking ''(including graduate students)'';

(C) by striking ''with respect to contraception, or with respect to infertility,''; and

(D) by striking ''service, not more than $35,000'' and inserting ''research, not more than $50,000'';

(3) by redesignating subsections (b) and (c) as subsections (d) and (e), respectively;

(4) by inserting after subsection (a), the following:

''(b) SUBCATEGORIES OF RESEARCH.—

''(1) IN GENERAL.—In carrying out the program under subsection (a), the Director of the National Institutes of Health—

''(A) shall continue to focus on—

''(i) contraception or infertility research;

''(ii) pediatric research, including pediatric pharmacological research;

''(iii) minority health disparities research;

''(iv) clinical research; and

''(v) clinical research conducted by appropriately qualified health professional who are from disadvantaged backgrounds; and

''(B) may focus on an area of emerging scientific or workforce need.

''(2) ELIMINATION OR ESTABLISHMENT OF SUBCATEGORIES.—The Director of the National Institutes of Health may eliminate one or more subcategories provided for in paragraph (1) due to changes in workforce or scientific needs related to biomedical research. The Director may establish other subcategory areas based on workforce and scientific priorities if the total number of subcategories does not exceed the number of subcategories listed in paragraph (1).

''(c) LIMITATION.—The Director of the National Institutes of Health may not enter into a contract with a health professional pursuant to subsection (a) unless such professional has a substantial amount of education loans relative to income (as determined pursuant to guidelines issued by the Director).''; and

(5) in subsection (d) (as so redesignated), by striking ''The provisions'' and inserting ''APPLICABILITY OF CERTAIN PROVISIONS REGARDING OBLIGATED SERVICE.—The provisions''; and

(6) in subsection (e) (as so redesignated), by striking ''Amounts'' and inserting ''AVAILABILITY OF APPROPRIATIONS.—Amounts''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title IV of the Public Health Service Act is amended—

(1) by striking section 464z–5 (42 U.S.C. 285t–2);

(2) by striking section 487C (42 U.S.C. 288–3);

(3) by striking section 487E (42 U.S.C. 288–5);

(4) by striking section 487F (42 U.S.C. 288–5a), as added by section 205 of Public Law 106–505, relating to loan repayment for clinical researchers; and

(5) by striking section 487F (42 U.S.C. 288–6), as added by section 1002(b) of Public Law 106–310 relating to pediatric research loan repayment.

(d) GAO REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the efforts of the National Institutes of Health to attract, retain, and develop emerging scientists, including underrepresented individuals in the sciences, such as women, racial and ethnic minorities, and other groups. Such report shall include an analysis of the impact of the additional authority provided to the Secretary of Health and Human Services under this Act to address workforce shortages and gaps in priority research areas, including which centers and research areas offered loan repayment program participants the increased award amount.

Subtitle D—National Institutes of Health Planning and Administration

SEC. 2031. NATIONAL INSTITUTES OF HEALTH STRATEGIC PLAN.

(a) STRATEGIC PLAN.—Section 402 of the Public Health Service Act (42 U.S.C. 282) is amended—

(1) in subsection (b)(5), by inserting before the semicolon the following: '', and through the development, implementation, and updating of the strategic plan developed under subsection (m)''; and

(2) by adding at the end the following:

''(m) NATIONAL INSTITUTES OF HEALTH STRATEGIC PLAN.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of the 21st Century Cures Act, and at least every 6 years thereafter, the Director of the National Institutes of Health shall develop and submit to the appropriate committees of Congress and post on the Internet website of the National Institutes of Health, a coordinated strategy (to be known as the 'National Institutes of Health Strategic Plan') to provide direction to the biomedical research investments made by the National Institutes of Health, to facilitate collaboration across the institutes and centers, to leverage scientific opportunity, and to advance biomedicine.

''(2) REQUIREMENTS.—The strategy under paragraph (1) shall—

''(A) identify strategic research priorities and objectives across biomedical research, including—

''(i) an assessment of the state of biomedical and behavioral research, including areas of opportunity with respect to basic, clinical, and translational research;

''(ii) priorities and objectives to advance the treatment, cure, and prevention of health conditions;

''(iii) emerging scientific opportunities, rising public health challenges, and scientific knowledge gaps; and

''(iv) the identification of near-, mid-, and long-term scientific needs;

''(B) consider, in carrying out subparagraph (A)—

''(i) disease burden in the United States and the potential for return on investment to the United States;

''(ii) rare diseases and conditions;

''(iii) biological, social, and other determinants of health that contribute to health disparities; and

''(iv) other factors the Director of National Institutes of Health determines appropriate;

''(C) include multi-institute priorities, including coordination of research among institutes and centers;

''(D) include strategic priorities for funding research through the Common Fund, in accordance with section 402A(c)(1)(C);

''(E) address the National Institutes of Health's proposed and ongoing activities related to training and the biomedical workforce; and

''(F) describe opportunities for collaboration with other agencies and departments, as appropriate.

''(3) USE OF PLANS.—Strategic plans developed and updated by the national research institutes and national centers of the National Institutes of Health shall be prepared regularly and in such a manner that such plans will be informed by the strategic plans developed and updated under this subsection. Such plans developed by and updated by the national research institutes and national centers shall have a common template.

''(4) CONSULTATION.—The Director of National Institutes of Health shall develop the strategic plan under paragraph (1) in consultation with the directors of the national research institutes and national centers, researchers, patient advocacy groups, and industry leaders.''.

(b) CONFORMING AMENDMENT.—Section 402A(c)(1)(C) of the Public Health Service Act (42 U.S.C. 282a(c)(1)(C)) is amended by striking ''Not later than June 1, 2007, and every 2 years thereafter,'' and inserting ''As part of the National Institutes of Health Strategic Plan required under section 402(m),''.

(c) STRATEGIC PLAN.—Section 492B(a) of the Public Health Service Act (42 U.S.C. 289a–2(a)) is amended by adding at the end the following:

''(3) STRATEGIC PLANNING.—

''(A) IN GENERAL.—The directors of the national institutes and national centers shall consult at least once annually with the Director of the National Institute on Minority Health and Health Disparities and the Director of the Office of Research on Women's Health regarding objectives of the national institutes and national centers to ensure that future activities by such institutes and centers take into account women

and minorities and are focused on reducing health disparities.

''(B) STRATEGIC PLANS.—Any strategic plan issued by a national institute or national center shall include details on the objectives described in subparagraph (A).''.

SEC. 2032. TRIENNIAL REPORTS.

Section 403 of the Public Health Service Act (42 U.S.C. 283) is amended—

(1) in the section heading, by striking ''**BIENNIAL**'' and inserting ''**TRIENNIAL**'' ; and

(2) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking ''biennial'' and inserting ''triennial'';

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

''(3) A description of intra-National Institutes of Health activities, including—

''(A) identification of the percentage of funds made available by each national research institute and national center with respect to each applicable fiscal year for conducting or supporting research that involves collaboration between the institute or center and 1 or more other national research institutes or national centers; and

''(B) recommendations for promoting coordination of information among the centers of excellence.'';

(C) in paragraph (4)—

(i) in subparagraph (B), by striking ''demographic variables and other variables'' and inserting ''demographic variables, including biological and social variables and relevant age categories (such as pediatric subgroups), and determinants of health,''; and

(ii) in subparagraph (C)(v)—

(I) by striking ''demographic variables and such'' and inserting ''demographic variables, including relevant age categories (such as pediatric subgroups), information submitted by each national research institute and national center to the Director of National Institutes of Health under section 492B(f), and such''; and

(II) by striking ''(regarding inclusion of women and minorities in clinical research)'' and inserting ''and other applicable requirements regarding inclusion of demographic groups''; and

(D) in paragraph (6)—

(i) in the matter preceding subparagraph (A), by striking ''the following:'' and inserting ''the following—'';

(ii) in subparagraph (A)—

(I) by striking ''An evaluation'' and inserting ''an evaluation''; and

(II) by striking the period and inserting ''; and'';

(iii) by striking subparagraphs (B) and (D);

(iv) by redesignating subparagraph (C) as subparagraph (B); and

(v) in subparagraph (B), as redesignated by clause (iv), by striking ''Recommendations'' and inserting ''recommendations''.

SEC. 2033. INCREASING ACCOUNTABILITY AT THE NATIONAL INSTITUTES OF HEALTH.

(a) APPOINTMENT AND TERMS OF DIRECTORS OF NATIONAL RESEARCH INSTITUTES AND NATIONAL CENTERS.—Subsection (a) of section 405 of the Public Health Service Act (42 U.S.C. 284) is amended to read as follows:

''(a) APPOINTMENT.—

''(1) IN GENERAL.—The Director of the National Cancer Institute shall be appointed by the President, and the Directors of the other national research institutes and national centers shall be appointed by the Secretary, acting through the Director of National Institutes of Health. Each Director of a national research institute or national center shall report directly to the Director of National Institutes of Health.

''(2) APPOINTMENT.—

''(A) TERM.—A Director of a national research institute or national center who is appointed by the Secretary, acting through the Director of National Institutes of Health, shall be appointed for 5 years.

''(B) REAPPOINTMENT.—At the end of the term of a Director of a national research institute or national center, the Director may be reappointed in accordance with standards applicable to the relevant appointment mechanism. There shall be no limit on the number of terms that a Director may serve.

''(C) VACANCIES.—If the office of a Director of a national research institute or national center becomes vacant before the end of such Director's term, the Director appointed to fill the vacancy shall be appointed for a 5-year term starting on the date of such appointment.

''(D) CURRENT DIRECTORS.—Each Director of a national research institute or national center who is serving on the date of enactment of the 21st Century Cures Act shall be deemed to be appointed for a 5-year term under this subsection beginning on such date of enactment.

''(E) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of the Secretary or the Director of National Institutes of Health to terminate the appointment of a director referred to in subparagraph (A) before the expiration of such director's 5-year term.

''(F) NATURE OF APPOINTMENT.—Appointments and reappointments under this subsection shall be made on the basis of ability and experience as it relates to the mission of the National Institutes of Health and its components, including compliance with any legal requirement that the Secretary or Director of National Institutes of Health determines relevant.

''(3) NONAPPLICATION OF CERTAIN PROVISION.—The restrictions contained in section 202 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1993 (Public Law 102–394; 42 U.S.C. 238f note) related to consultants and individual scientists appointed for limited periods of time shall not apply to Directors appointed under this subsection.''.

(b) REVIEW OF CERTAIN AWARDS BY DIRECTORS.—Section 405(b) of the Public Health Service Act (42 U.S.C. 284(b)) is amended by adding at the end the following:

''(3) Before an award is made by a national research institute or by a national center for a grant for a research program or project (commonly referred to as an 'R-series grant'), other than an award constituting a noncompetitive renewal of such a grant, or a noncompetitive administrative supplement to such a grant, the Director of such national research institute or national center shall, consistent with the peer review process—

''(A) review and make the final decision with respect to making the award; and

''(B) take into consideration, as appropriate—

''(i) the mission of the national research institute or national center and the scientific priorities identified in the strategic plan under section 402(m);

''(ii) programs or projects funded by other agencies on similar research topics; and

''(iii) advice by staff and the advisory council or board of such national research institute or national center.''.

(c) REPORT ON DUPLICATION IN FEDERAL BIOMEDICAL RESEARCH.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), shall, not later than 2 years after the date of enactment of this Act, submit a report to Congress on efforts to prevent and eliminate duplicative biomedical research that is not necessary for scientific purposes. Such report shall—

(1) describe the procedures in place to identify such duplicative research, including procedures for monitoring research applications and funded research awards to prevent unnecessary duplication;

(2) describe the steps taken to improve the procedures described in paragraph (1), in response to relevant recommendations made by the Comptroller General of the United States;

(3) describe how the Secretary operationally distinguishes necessary and appropriate scientific replication from unnecessary duplication; and

(4) provide examples of instances where the Secretary has identified unnecessarily duplicative research and the steps taken to eliminate the unnecessary duplication.

SEC. 2034. REDUCING ADMINISTRATIVE BURDEN FOR RESEARCHERS.

(a) PLAN PREPARATION AND IMPLEMENTATION OF MEASURES TO REDUCE ADMINISTRATIVE BURDENS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall—

(A) lead a review by research funding agencies of all regulations and policies related to the disclosure of financial conflicts of interest, including the minimum threshold for reporting financial conflicts of interest;

(B) make revisions, as appropriate, to harmonize existing policies and reduce administrative burden on researchers while maintaining the integrity and credibility of research findings and protections of human participants; and

(C) confer with the Office of the Inspector General about the activities of such office related to financial conflicts of interest involving research funding agencies.

(2) CONSIDERATIONS.—In updating policies under paragraph (1)(B), the Secretary shall consider—

(A) modifying the timelines for the reporting of financial conflicts of interest to just-in-time information by institutions receiving grant or cooperative agreement funding from the National Institutes of Health;

(B) ensuring that financial interest disclosure reporting requirements are appropriate for, and relevant to, awards that will directly fund research, which may include modification of the definition of the term ''investigator'' for purposes of the regulations and policies described in subparagraphs (A) and (B) of paragraph (1); and

(C) updating any applicable training modules of the National Institutes of Health related to Federal financial interest disclosure.

(b) MONITORING OF SUBRECIPIENTS OF FUNDING FROM THE NATIONAL INSTITUTES OF HEALTH.—The Director of the National Institutes of Health (referred to in this section as the ''Director of National Institutes of Health'') shall implement measures to reduce the administrative burdens related to monitoring of subrecipients of grants by primary awardees of funding from the National Institutes of Health, which may incorporate findings and recommendations from existing and ongoing activities. Such measures may include, as appropriate—

(1) an exemption from subrecipient monitoring requirements, upon request from the primary awardees, provided that—

(A) the subrecipient is subject to Federal audit requirements pursuant to the Uniform Guidance of the Office of Management and Budget;

(B) the primary awardee conducts, pursuant to guidance of the National Institutes of Health, a pre-award evaluation of each subrecipient's risk of noncompliance with Federal statutes and regulations, the conditions of the subaward, and any recurring audit findings; and

(C) such exemption does not absolve the primary awardee of liability for misconduct by subrecipients; and

(2) the implementation of alternative grant structures that obviate the need for subrecipient monitoring, which may include collaborative grant models allowing for multiple primary awardees.

(c) REPORTING OF FINANCIAL EXPENDITURES.—The Secretary, in consultation with the Director of National Institutes of Health, shall evaluate financial expenditure reporting procedures and requirements for recipients of funding from the National Institutes of Health and take action, as appropriate, to avoid duplication between department and agency procedures and requirements and minimize burden to funding recipients.

(d) ANIMAL CARE AND USE IN RESEARCH.—Not later than 2 years after the date of enactment of this Act, the Director of National Institutes of Health, in collaboration with the Secretary of Agriculture and the Commissioner of Food and Drugs, shall complete a review of applicable regulations and policies for the care and use of laboratory animals and make revisions, as appropriate, to reduce administrative burden on investigators while maintaining the integrity and credibility of research findings and protection of research animals. In carrying out this effort, the Director of the National Institutes of Health shall seek the input of experts, as appropriate. The Director of the National Institutes of Health shall—

(1) identify ways to ensure such regulations and policies are not inconsistent, overlapping, or unnecessarily duplicative, including with respect to inspection and review requirements by Federal agencies and accrediting associations;

(2) take steps to eliminate or reduce identified inconsistencies, overlap, or duplication among such regulations and policies; and

(3) take other actions, as appropriate, to improve the coordination of regulations and policies with respect to research with laboratory animals.

(e) DOCUMENTATION OF PERSONNEL EXPENSES.—The Secretary shall clarify the applicability of the requirements under the Office of Management and Budget Uniform Guidance for management and certification systems adopted by entities receiving Federal research grants through the Department of Health and Human Services regarding documentation of personnel expenses, including clarification of the extent to which any flexibility to such requirements specified in such Uniform Guidance applies to entities receiving grants through the Department of Health and Human Services.

(f) RESEARCH POLICY BOARD.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Director of the Office of Management and Budget shall establish an advisory committee, to be known as the ''Research Policy Board'' (referred to in this subsection as the ''Board''), to provide Federal Government officials with information on the effects of regulations related to Federal research requirements.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Board shall include not more than 10 Federal members, including each of the following Federal members or their designees:

(i) The Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget.

(ii) The Director of the Office of Science and Technology Policy.

(iii) The Secretary of Health and Human Services.

(iv) The Director of the National Science Foundation.

(v) The secretaries and directors of other departments and agencies that support or regulate scientific research, as determined by the Director of the Office of Management and Budget.

(B) NON-FEDERAL MEMBERS.—The Board shall be comprised of not less than 9 and not more than 12 representatives of academic research institutions, other private, nonprofit research institutions, or other nonprofit organizations with relevant expertise. Such members shall be appointed by a formal process, to be established by the Director of the Office of Management and Budget, in consultation with the Federal membership, and that incorporates—

(i) nomination by members of the nonprofit scientific research community, including academic research institutions; and

(ii) procedures to fill membership positions vacated before the end of a member's term.

(3) PURPOSE AND RESPONSIBILITIES.—The Board shall make recommendations regarding the modification and harmonization of regulations and policies having similar purposes across research funding agencies to ensure that the administrative burden of such research policy and regulation is minimized to the greatest extent possible and consistent with maintaining responsible oversight of federally funded research. Activities of the Board may include—

(A) providing thorough and informed analysis of regulations and policies;

(B) identifying negative or adverse consequences of existing policies and making actionable recommendations regarding possible improvement of such policies;

(C) making recommendations with respect to efforts within the Federal Government to improve coordination of regulation and policy related to research;

(D) creating a forum for the discussion of research policy or regulatory gaps, challenges, clarification, or harmonization of such policies or regulation, and best practices; and

(E) conducting ongoing assessment and evaluation of regulatory burden, including development of metrics, periodic measurement, and identification of process improvements and policy changes.

(4) EXPERT SUBCOMMITTEES.—The Board may form temporary expert subcommittees, as appropriate, to develop timely analysis on pressing issues and assist the Board in anticipating future regulatory challenges, including challenges emerging from new scientific advances.

(5) REPORTING REQUIREMENTS.—Not later than 2 years after the date of enactment of this Act, and once thereafter, the Board shall submit a report to the Director of the Office of Management and Budget, the Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget, the Director of the Office of Science and Technology Policy, the heads of relevant Federal departments and agencies, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives containing formal recommendations on the conceptualization, development, harmonization, and reconsideration of scientific research policy, including the regulatory benefits and burdens.

(6) SUNSET.—The Board shall terminate on September 30, 2021.

(7) GAO REPORT.—Not later than 4 years after the date of enactment of this Act, the Comptroller General of the United States shall conduct an independent evaluation of the activities carried out by the Board pursuant to this subsection and submit to the appropriate committees of Congress a report regarding the results of the independent evaluation. Such report shall review and assess the Board's activities with respect to the responsibilities described in paragraph (3).

SEC. 2035. EXEMPTION FOR THE NATIONAL INSTITUTES OF HEALTH FROM THE PAPERWORK REDUCTION ACT REQUIREMENTS.

Section 301 of the Public Health Service Act (42 U.S.C. 241), as amended by section 2013, is further amended by adding at the end the following:

''(g) Subchapter I of chapter 35 of title 44, United States Code, shall not apply to the voluntary collection of information during the conduct of research by the National Institutes of Health.''.

SEC. 2036. HIGH-RISK, HIGH-REWARD RESEARCH.

(a) IN GENERAL.—Section 402 of the Public Health Service Act (42 U.S.C. 282), as amended by section 2031, is further amended by adding at the end the following:

''(n) UNIQUE RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH may approve, after consideration of a proposal under paragraph (2)(A), requests by the national research institutes and centers, or program officers within the Office of the Director to engage in transactions other than a contract, grant, or cooperative agreement with respect to projects that carry out—

''(A) the Precision Medicine Initiative under section 498E; or

''(B) section 402(b)(7), except that not more than 50 percent of the funds available for a fiscal year through the Common Fund under section 402A(c)(1) for purposes of carrying out such section 402(b)(7) may be used to engage in such other transactions.

''(2) REQUIREMENTS.—The authority provided under this subsection may be used to conduct or support high impact cutting-edge research described in paragraph (1) using the other transactions authority described in such paragraph if the institute, center, or office—

''(A) submits a proposal to the Director of NIH for the use of such authority before conducting or supporting the research, including why the use of such authority is essential to promoting the success of the project;

''(B) receives approval for the use of such authority from the Director of NIH; and

''(C) for each year in which the institute, center, or office has used such authority in accordance with this subsection, submits a report to the Director of NIH on the activities of the institute, center, or office relating to such research.''.

(b) REPORT TO CONGRESS.—Not later than September 30, 2020, the Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall conduct an evaluation of the activities under subsection (n) of section 402 of the Public Health Service Act (42 U.S.C. 282), as added by subsection (a), and submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives on the results of such evaluation.

(c) DUTIES OF DIRECTORS OF INSTITUTES.—Section 405(b)(1) of the Public Health Service Act (42 U.S.C. 284(b)(1)) is amended—

(1) by redesignating subparagraphs (C) through (L) as subparagraphs (D) through (M), respectively; and

(2) by inserting after subparagraph (B), the following:

''(C) shall, as appropriate, conduct and support research that has the potential to transform the scientific field, has inherently higher risk, and that seeks to address major current challenges;''.

SEC. 2037. NATIONAL CENTER FOR ADVANCING TRANSLATIONAL SCIENCES.

(a) IN GENERAL.—Section 479(b) of the Public Health Service Act (42 U.S.C. 287(b)) is amended—

(1) in paragraph (1), by striking ''phase IIA'' and inserting ''phase IIB''; and

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by striking ''phase IIB'' and inserting ''phase III'';

(B) in subparagraph (A), by striking ''phase IIB'' and inserting ''phase III'';

(C) in subparagraph (B), by striking ''phase IIA'' and inserting ''phase IIB''; and

(D) in subparagraph (C), by striking ''phase IIB'' and inserting ''phase III''.

(b) INCREASED TRANSPARENCY.—Section 479 of the Public Health Service Act (42 U.S.C. 287) is amended—

(1) in subsection (c)—

(A) in paragraph (4)(D), by striking ''and'' at the end;

(B) in paragraph (5), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(6) the methods and tools, if any, that have been developed since the last biennial report was prepared; and

''(7) the methods and tools, if any, that have been developed and are being utilized by the Food and Drug Administration to support medical product reviews.''; and

(2) by adding at the end the following:

''(d) INCLUSION OF LIST.—The first biennial report submitted under this section after the

date of enactment of the 21st Century Cures Act shall include a complete list of all of the methods and tools, if any, which have been developed by research supported by the Center.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing the Secretary to disclose any information that is a trade secret, or other privileged or confidential information subject to section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code.''.

SEC. 2038. COLLABORATION AND COORDINATION TO ENHANCE RESEARCH.

(a) RESEARCH PRIORITIES; COLLABORATIVE RESEARCH PROJECTS.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) by amending paragraph (4) to read as follows:

''(4) shall assemble accurate data to be used to assess research priorities, including—

''(A) information to better evaluate scientific opportunity, public health burdens, and progress in reducing health disparities; and

''(B) data on study populations of clinical research, funded by or conducted at each national research institute and national center, which—

''(i) specifies the inclusion of—

''(I) women;

''(II) members of minority groups;

''(III) relevant age categories, including pediatric subgroups; and

''(IV) other demographic variables as the Director of the National Institutes of Health determines appropriate;

''(ii) is disaggregated by research area, condition, and disease categories; and

''(iii) is to be made publicly available on the Internet website of the National Institutes of Health;''; and

(2) in paragraph (8)—

(A) in subparagraph (A), by striking ''and'' at the end; and

(B) by adding at the end the following:

''(C) foster collaboration between clinical research projects funded by the respective national research institutes and national centers that—

''(i) conduct research involving human subjects; and

''(ii) collect similar data; and

''(D) encourage the collaboration described in subparagraph (C) to—

''(i) allow for an increase in the number of subjects studied; and

''(ii) utilize diverse study populations, with special consideration to biological, social, and other determinants of health that contribute to health disparities;''.

(b) REPORTING.—Section 492B(f) of the Public Health Service Act (42 U.S.C. 289a–2(f)) is amended—

(1) by striking ''biennial'' each place such term appears and inserting ''triennial'';

(2) by striking ''The advisory council'' and inserting the following:

''(1) IN GENERAL.—The advisory council''; and

(3) by adding at the end the following:

''(2) CONTENTS.—Each triennial report prepared by an advisory council of each national research institute as described in paragraph (1) shall include each of the following:

''(A) The number of women included as subjects, and the proportion of subjects that are women, in any project of clinical research conducted during the applicable reporting period, disaggregated by categories of research area, condition, or disease, and accounting for single-sex studies.

''(B) The number of members of minority groups included as subjects, and the proportion of subjects that are members of minority groups, in any project of clinical research conducted during the applicable reporting period, disaggregated by categories of research area, condition, or disease and accounting for single-race and single-ethnicity studies.

''(C) For the applicable reporting period, the number of projects of clinical research that include women and members of minority groups and that—

''(i) have been completed during such reporting period; and

''(ii) are being carried out during such reporting period and have not been completed.

''(D) The number of studies completed during the applicable reporting period for which reporting has been submitted in accordance with subsection (c)(2)(A).''.

(c) COORDINATION.—Section 486(c)(2) of the Public Health Service Act (42 U.S.C. 287d(c)(2)) is amended by striking ''designees'' and inserting ''senior-level staff designees''.

(d) IN GENERAL.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.), as amended by section 2021, is further amended by adding at the end the following:

''SEC. 404N. POPULATION FOCUSED RESEARCH.

''The Director of the National Institutes of Health shall, as appropriate, encourage efforts to improve research related to the health of sexual and gender minority populations, including by—

''(1) facilitating increased participation of sexual and gender minority populations in clinical research supported by the National Institutes of Health, and reporting on such participation, as applicable;

''(2) facilitating the development of valid and reliable methods for research relevant to sexual and gender minority populations; and

''(3) addressing methodological challenges.''.

(e) REPORTING.—

(1) IN GENERAL.—The Secretary, in collaboration with the Director of the National Institutes of Health, shall as appropriate—

(A) continue to support research for the development of appropriate measures related to reporting health information about sexual and gender minority populations; and

(B) not later than 2 years after the date of enactment of this Act, disseminate and make public such measures.

(2) NATIONAL ACADEMY OF MEDICINE RECOMMENDATIONS.—In developing the measures described in paragraph (1)(A), the Secretary shall take into account recommendations made by the National Academy of Medicine.

(f) IMPROVING COORDINATION RELATED TO MINORITY HEALTH AND HEALTH DISPARITIES.—Section 464z–3 of the Public Health Service Act (42 U.S.C. 285t) is amended—

(1) by redesignating subsection (h), relating to interagency coordination, that follows subsection (j) as subsection (k); and

(2) in subsection (k) (as so redesignated)—

(A) in the subsection heading, by striking ''INTERAGENCY'' and inserting ''INTRA-NATIONAL INSTITUTES OF HEALTH'';

(B) by striking ''as the primary Federal officials'' and inserting ''as the primary Federal official'';

(C) by inserting a comma after ''review'';

(D) by striking ''Institutes and Centers of the National Institutes of Health'' and inserting ''national research institutes and national centers''; and

(E) by adding at the end the following: ''The Director of the Institute may foster partnerships between the national research institutes and national centers and may encourage the funding of collaborative research projects to achieve the goals of the National Institutes of Health that are related to minority health and health disparities.''.

(g) BASIC RESEARCH.—

(1) DEVELOPING POLICIES.—Not later than 2 years after the date of enactment of this Act, the Director of the National Institutes of Health (referred to in this section as the ''Director of the National Institutes of Health''), taking into consideration the recommendations developed under section 2039, shall develop policies for projects of basic research funded by National Institutes of Health to assess—

(A) relevant biological variables including sex, as appropriate; and

(B) how differences between male and female cells, tissues, or animals may be examined and analyzed.

(2) REVISING POLICIES.—The Director of the National Institutes of Health may update or revise the policies developed under paragraph (1) as appropriate.

(3) CONSULTATION AND OUTREACH.—In developing, updating, or revising the policies under this section, the Director of the National Institutes of Health shall—

(A) consult with—

(i) the Office of Research on Women's Health;

(ii) the Office of Laboratory Animal Welfare; and

(iii) appropriate members of the scientific and academic communities; and

(B) conduct outreach to solicit feedback from members of the scientific and academic communities on the influence of sex as a variable in basic research, including feedback on when it is appropriate for projects of basic research involving cells, tissues, or animals to include both male and female cells, tissues, or animals.

(4) ADDITIONAL REQUIREMENTS.—The Director of the National Institutes of Health shall—

(A) ensure that projects of basic research funded by the National Institutes of Health are conducted in accordance with the policies developed, updated, or revised under this section, as applicable; and

(B) encourage that the results of such research, when published or reported, be disaggregated as appropriate with respect to the analysis of any sex differences.

(h) CLINICAL RESEARCH.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Director of the National Institutes of Health, in consultation with the Director of the Office of Research on Women's Health and the Director of the National Institute on Minority Health and Health Disparities, shall update the guidelines established under section 492B(d) of Public Health Service Act (42 U.S.C. 289a–2(d)) in accordance with paragraph (2).

(2) REQUIREMENTS.—The updated guidelines described in paragraph (1) shall—

(A) reflect the science regarding sex differences;

(B) improve adherence to the requirements under section 492B of the Public Health Service Act (42 U.S.C. 289a–2), including the reporting requirements under subsection (f) of such section; and

(C) clarify the circumstances under which studies should be designed to support the conduct of analyses to detect significant differences in the intervention effect due to demographic factors related to section 492B of the Public Health Service Act, including in the absence of prior studies that demonstrate a difference in study outcomes on the basis of such factors and considering the effects of the absence of such analyses on the availability of data related to demographic differences.

(i) APPROPRIATE AGE GROUPINGS IN CLINICAL RESEARCH.—

(1) INPUT FROM EXPERTS.—Not later than 180 days after the date of enactment of this Act, the Director of the National Institutes of Health shall convene a workshop of experts on pediatric and older populations to provide input on—

(A) appropriate age groups to be included in research studies involving human subjects; and

(B) acceptable justifications for excluding participants from a range of age groups from human subjects research studies.

(2) POLICY UPDATES.—Not later than 180 days after the conclusion of the workshop under paragraph (1), the Director of the National Institutes of Health shall make a determination with respect to whether the policies of the National Institutes of Health on the inclusion of relevant age groups in clinical studies need to be updated, and shall update such policies as appropriate. In making the determination, the Director of the National Institutes of Health shall take into consideration whether such policies—

(A) address the consideration of age as an inclusion variable in research involving human subjects; and

(B) identify the criteria for justification for any age-related exclusions in such research.

(3) PUBLIC AVAILABILITY OF FINDINGS AND CONCLUSIONS.—The Director of the National Institutes of Health shall—

(A) make the findings and conclusions resulting from the workshop under paragraph (1) and updates to policies in accordance with paragraph (2), as applicable, available to the public on the Internet website of the National Institutes of Health; and

(B) ensure that age-related data reported in the triennial report under section 403 of the Public Health Service Act (42 U.S.C. 283) (as amended by section 2032) are made available to the public on the Internet website of the National Institutes of Health.

SEC. 2039. ENHANCING THE RIGOR AND REPRODUCIBILITY OF SCIENTIFIC RESEARCH.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall convene a working group under the Advisory Committee to the Director of the National Institutes of Health (referred to in this section as the ''Advisory Committee''), appointed under section 222 of the Public Health Service Act (42 U.S.C. 217a), to develop and issue recommendations through the Advisory Committee for a formal policy, which may incorporate or be informed by relevant existing and ongoing activities, to enhance rigor and reproducibility of scientific research funded by the National Institutes of Health.

(b) CONSIDERATIONS.—In developing and issuing recommendations through the Advisory Committee under subsection (a), the working group established under such subsection shall consider, as appropriate—

(1) preclinical experiment design, including analysis of sex as a biological variable;

(2) clinical experiment design, including—

(A) the diversity of populations studied for clinical research, with respect to biological, social, and other determinants of health that contribute to health disparities;

(B) the circumstances under which summary information regarding biological, social, and other factors that contribute to health disparities should be reported; and

(C) the circumstances under which clinical studies, including clinical trials, should conduct an analysis of the data collected during the study on the basis of biological, social, and other factors that contribute to health disparities;

(3) applicable levels of rigor in statistical methods, methodology, and analysis;

(4) data and information sharing in accordance with applicable privacy laws and regulations; and

(5) any other matter the working group determines relevant.

(c) POLICIES.—Not later than 18 months after the date of enactment of this Act, the Director of the National Institutes of Health shall consider the recommendations developed by the working group and issued by the Advisory Committee under subsection (a) and develop or update policies as appropriate.

(d) REPORT.—Not later than 2 years after the date of enactment of this Act, the Director of the National Institutes of Health shall issue a report to the Secretary of Health and Human Services, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives regarding recommendations developed under subsection (a) and any subsequent policy changes implemented, to enhance rigor and reproducibility in scientific research funded by the National Institutes of Health.

(e) CONFIDENTIALITY.—Nothing in this section authorizes the Secretary of Health and Human Services to disclose any information that is a trade secret, or other privileged or confidential information, described in section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code.

SEC. 2040. IMPROVING MEDICAL REHABILITATION RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH.

(a) IN GENERAL.—Section 452 of the Public Health Service Act (42 U.S.C. 285g–4) is amended—

(1) in subsection (b), by striking ''conduct and support'' and inserting ''conduct, support, and coordination'';

(2) in subsection (c)(1)(C), by striking ''of the Center'' and inserting ''within the Center'';

(3) in subsection (d)—

(A) by striking ''(d)(1) In consultation'' and all that follows through the end of paragraph (1) and inserting the following:

''(d)(1) The Director of the Center, in consultation with the Director of the Institute, the coordinating committee established under subsection (e), and the advisory board established under subsection (f), shall develop a comprehensive plan (referred to in this section as the 'Research Plan') for the conduct, support, and coordination of medical rehabilitation research.'';

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''; and'' and inserting a semicolon;

(ii) in subparagraph (B), by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(C) include goals and objectives for conducting, supporting, and coordinating medical rehabilitation research, consistent with the purpose described in subsection (b).'';

(C) by striking paragraph (4) and inserting the following:

''(4) The Director of the Center, in consultation with the Director of the Institute, the coordinating committee established under subsection (e), and the advisory board established under subsection (f), shall revise and update the Research Plan periodically, as appropriate, or not less than every 5 years. Not later than 30 days after the Research Plan is so revised and updated, the Director of the Center shall transmit the revised and updated Research Plan to the President, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives.''; and

(D) by adding at the end the following:

''(5) The Director of the Center, in consultation with the Director of the Institute, shall, prior to revising and updating the Research Plan, prepare a report for the coordinating committee established under subsection (e) and the advisory board established under subsection (f) that describes and analyzes the progress during the preceding fiscal year in achieving the goals and objectives described in paragraph (2)(C) and includes expenditures for rehabilitation research at the National Institutes of Health. The report shall include recommendations for revising and updating the Research Plan, and such initiatives as the Director of the Center and the Director of the Institute determine appropriate. In preparing the report, the Director of the Center and the Director of the Institute shall consult with the Director of the National Institutes of Health.'';

(4) in subsection (e)—

(A) in paragraph (2), by inserting ''periodically host a scientific conference or workshop on medical rehabilitation research and'' after ''The Coordinating Committee shall''; and

(B) in paragraph (3), by inserting ''the Director of the Division of Program Coordination, Planning, and Strategic Initiatives within the Office of the Director of the National Institutes of Health,'' after ''shall be composed of'';

(5) in subsection (f)(3)(B)—

(A) by redesignating clauses (ix) through (xi) as clauses (x) through (xii), respectively; and

(B) by inserting after clause (viii) the following:

''(ix) The Director of the Division of Program Coordination, Planning, and Strategic Initiatives.''; and

(6) by adding at the end the following:

''(g)(1) The Secretary and the heads of other Federal agencies shall jointly review the programs carried out (or proposed to be carried out) by each such official with respect to medical rehabilitation research and, as appropriate, enter into agreements preventing duplication among such programs.

''(2) The Secretary shall, as appropriate, enter into interagency agreements relating to the coordination of medical rehabilitation research conducted by agencies of the National Institutes of Health and other agencies of the Federal Government.

''(h) For purposes of this section, the term 'medical rehabilitation research' means the science of mechanisms and interventions that prevent, improve, restore, or replace lost, underdeveloped, or deteriorating function.''.

(b) CONFORMING AMENDMENT.—Section 3 of the National Institutes of Health Amendments of 1990 (42 U.S.C. 285g–4 note) is amended—

(1) in subsection (a), by striking ''IN GENERAL.—''; and

(2) by striking subsection (b).

SEC. 2041. TASK FORCE ON RESEARCH SPECIFIC TO PREGNANT WOMEN AND LACTATING WOMEN.

(a) TASK FORCE ON RESEARCH SPECIFIC TO PREGNANT WOMEN AND LACTATING WOMEN.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a task force, in accordance with the Federal Advisory Committee Act (5 U.S.C. App.), to be known as the ''Task Force on Research Specific to Pregnant Women and Lactating Women'' (in this section referred to as the ''Task Force'').

(2) DUTIES.—The Task Force shall provide advice and guidance to the Secretary regarding Federal activities related to identifying and addressing gaps in knowledge and research regarding safe and effective therapies for pregnant women and lactating women, including the development of such therapies and the collaboration on and coordination of such activities.

(3) MEMBERSHIP.—

(A) FEDERAL MEMBERS.—The Task Force shall be composed of each of the following Federal members, or the designees of such members:

(i) The Director of the Centers for Disease Control and Prevention.

(ii) The Director of the National Institutes of Health, the Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the directors of such other appropriate national research institutes.

(iii) The Commissioner of Food and Drugs.

(iv) The Director of the Office on Women's Health.

(v) The Director of the National Vaccine Program Office.

(vi) The head of any other research-related agency or department not described in clauses (i) through (v) that the Secretary determines appropriate, which may include the Department of Veterans Affairs and the Department of Defense.

(B) NON-FEDERAL MEMBERS.—The Task Force shall be composed of each of the following non-Federal members, including—

(i) representatives from relevant medical societies with subject matter expertise on pregnant women, lactating women, or children;

(ii) nonprofit organizations with expertise related to the health of women and children;

(iii) relevant industry representatives; and

(iv) other representatives, as appropriate.

(C) LIMITATIONS.—The non-Federal members described in subparagraph (B) shall—

(i) compose not more than one-half, and not less than one-third, of the total membership of the Task Force; and

(ii) be appointed by the Secretary.

(4) TERMINATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the Task Force shall terminate on the date that is 2 years after the date on which the Task Force is established under paragraph (1).

(B) EXTENSION.—The Secretary may extend the operation of the Task Force for one additional 2-year period following the 2-year period described in subparagraph (A), if the Secretary determines that the extension is appropriate for carrying out the purpose of this section.

(5) MEETINGS.—The Task Force shall meet not less than 2 times each year and shall convene public meetings, as appropriate, to fulfill its duties under paragraph (2).

(6) TASK FORCE REPORT TO CONGRESS.—Not later than 18 months after the date on which the Task Force is established under paragraph (1), the Task Force shall prepare and submit to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives a report that includes each of the following:

(A) A plan to identify and address gaps in knowledge and research regarding safe and effective therapies for pregnant women and lactating women, including the development of such therapies.

(B) Ethical issues surrounding the inclusion of pregnant women and lactating women in clinical research.

(C) Effective communication strategies with health care providers and the public on information relevant to pregnant women and lactating women.

(D) Identification of Federal activities, including—

(i) the state of research on pregnancy and lactation;

(ii) recommendations for the coordination of, and collaboration on research related to pregnant women and lactating women;

(iii) dissemination of research findings and information relevant to pregnant women and lactating women to providers and the public; and

(iv) existing Federal efforts and programs to improve the scientific understanding of the health impacts on pregnant women, lactating women, and related birth and pediatric outcomes, including with respect to pharmacokinetics, pharmacodynamics, and toxicities.

(E) Recommendations to improve the development of safe and effective therapies for pregnant women and lactating women.

(b) CONFIDENTIALITY.—Nothing in this section shall authorize the Secretary of Health and Human Services to disclose any information that is a trade secret, or other privileged or confidential information, described in section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code.

(c) UPDATING PROTECTIONS FOR PREGNANT WOMEN AND LACTATING WOMEN IN RESEARCH.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary, considering any recommendations of the Task Force available at such time and in consultation with the heads of relevant agencies of the Department of Health and Human Services, shall, as appropriate, update regulations and guidance, as applicable, regarding the inclusion of pregnant women and lactating women in clinical research.

(2) CRITERIA FOR EXCLUDING PREGNANT OR LACTATING WOMEN.—In updating any regulations or guidance described in paragraph (1), the Secretary shall consider any appropriate criteria to be used by institutional review boards and individuals reviewing grant proposals for excluding pregnant women or lactating women as a study population requiring additional protections from participating in human subject research.

SEC. 2042. STREAMLINING NATIONAL INSTITUTES OF HEALTH REPORTING REQUIREMENTS.

(a) TRANS-NATIONAL INSTITUTES OF HEALTH RESEARCH REPORTING.—Section 402A(c)(2) of the Public Health Service Act (42 U.S.C. 282a(c)(2)) is amended—

(1) by amending subparagraph (B) to read as follows:

''(B) REPORTING.—Not later than 2 years after the date of enactment of 21st Century Cures Act, the head of each national research institute or national center shall submit to the Director of the National Institutes of Health a report, to be included in the triennial report under section 403, on the amount made available by the institute or center for conducting or supporting research that involves collaboration between the institute or center and 1 or more other national research institutes or national centers.''; and

(2) in subparagraphs (D) and (E) by striking ''(B)(i)'' each place it appears and inserting ''(B)''.

(b) FRAUD AND ABUSE REPORTING.—Section 403B of the Public Health Service Act (42 U.S.C. 283a–1) is amended—

(1) by striking subsection (b);

(2) by redesignating subsection (c) as subsection (b); and

(3) in subsection (b) (as so redesignated), by striking ''subsections (a) and (b)'' and inserting ''subsection (a)''.

(c) DOCTORAL DEGREES REPORTING.—Section 403C(a)(2) of the Public Health Service Act (42 U.S.C. 283a–2(a)(2)) is amended by striking ''(not including any leaves of absence)''.

(d) VACCINE REPORTING.—Section 404B of the Public Health Service Act (42 U.S.C. 283d) is amended—

(1) by striking subsection (b); and

(2) by striking ''(a) DEVELOPMENT OF NEW VACCINES.—The Secretary'' and inserting ''The Secretary''.

(e) NATIONAL CENTER FOR ADVANCING TRANSLATIONAL SCIENCES.—Section 479(c) of the Public Health Service Act (42 U.S.C. 287(c)) is amended—

(1) in the subsection heading, by striking ''ANNUAL'' and inserting ''BIENNIAL''; and

(2) in the matter preceding paragraph (1), by striking ''an annual report'' and inserting ''a report on a biennial basis''.

(f) REVIEW OF CENTERS OF EXCELLENCE.—

(1) REPEAL.—Section 404H of the Public Health Service Act (42 U.S.C. 283j) is repealed.

(2) CONFORMING AMENDMENT.—Section 399EE(c) of the Public Health Service Act (42 U.S.C. 280–4(c)) is amended by striking ''399CC, 404H,'' and inserting ''399CC''.

(g) RAPID HIV TEST REPORT.—Section 502(a) of the Ryan White CARE Act Amendments of 2000 (42 U.S.C. 300cc note) is amended—

(1) by striking paragraph (2); and

(2) by redesignating paragraph (3) as paragraph (2).

(h) NATIONAL INSTITUTE OF NURSING RESEARCH.—

(1) REPEAL.—Section 464Y of the Public Health Service Act (42 U.S.C. 285q–3) is repealed.

(2) CONFORMING AMENDMENT.—Section 464X(g) of the Public Health Service Act (42 U.S.C. 285q–2(g)) is amended by striking ''biennial report made under section 464Y,'' and inserting ''triennial report made under section 403''.

SEC. 2043. REIMBURSEMENT FOR RESEARCH SUBSTANCES AND LIVING ORGANISMS.

Section 301 of the Public Health Service Act (42 U.S.C. 241), as amended by section 2035, is further amended—

(1) in the flush matter at the end of subsection (a)—

(A) by redesignating such matter as subsection (h)(1); and

(B) by moving such matter so as to appear at the end of such section; and

(2) in subsection (h) (as so redesignated), by adding at the end the following:

''(2) Where research substances and living organisms are made available under paragraph (1) through contractors, the Secretary may direct such contractors to collect payments on behalf of the Secretary for the costs incurred to make available such substances and organisms and to forward amounts so collected to the Secretary, in the time and manner specified by the Secretary.

''(3) Amounts collected under paragraph (2) shall be credited to the appropriations accounts that incurred the costs to make available the research substances and living organisms involved, and shall remain available until expended for carrying out activities under such accounts.''.

SEC. 2044. SENSE OF CONGRESS ON INCREASED INCLUSION OF UNDERREPRESENTED POPULATIONS IN CLINICAL TRIALS.

It is the sense of Congress that the National Institute on Minority Health and Health Disparities should include within its strategic plan under section 402(m) of the Public Health Service Act (42 U.S.C. 282(m)) ways to increase representation of underrepresented populations in clinical trials.

Subtitle E—Advancement of the National Institutes of Health Research and Data Access

SEC. 2051. TECHNICAL UPDATES TO CLINICAL TRIALS DATABASE.

Section 402(j)(2)(D) of the Public Health Service Act (42 U.S.C. 282(j)(2)(D)) is amended—

(1) in clause (ii)(I), by inserting before the semicolon '', unless the responsible party affirmatively requests that the Director of the National Institutes of Health publicly post such clinical trial information for an applicable device clinical trial prior to such date of clearance or approval''; and

(2) by adding at the end the following:

''(iii) OPTION TO MAKE CERTAIN CLINICAL TRIAL INFORMATION AVAILABLE EARLIER.—The Director of the National Institutes of Health shall inform responsible parties of the option to request that clinical trial information for an applicable device clinical trial be publicly posted prior to the date of clearance or approval, in accordance with clause (ii)(I).

''(iv) COMBINATION PRODUCTS.—An applicable clinical trial for a product that is a combination of drug, device, or biological product shall be considered—

''(I) an applicable drug clinical trial, if the Secretary determines under section 503(g) of the Federal Food, Drug, and Cosmetic Act that the primary mode of action of such product is that of a drug or biological product; or

''(II) an applicable device clinical trial, if the Secretary determines under such section that the primary mode of action of such product is that of a device.''.

SEC. 2052. COMPLIANCE ACTIVITIES REPORTS.

(a) DEFINITIONS.—In this section:

(1) APPLICABLE CLINICAL TRIAL.—The term ''applicable clinical trial'' has the meaning given the term in section 402(j) of the Public Health Service Act (42 U.S.C. 282(j)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(b) REPORT ON ACTIVITIES TO ENCOURAGE COMPLIANCE.—Not later than 2 years after the date of enactment of this Act, the Secretary, acting through the Director of the National Institutes of Health and in collaboration with the Commissioner of Food and Drugs, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report that describes education and outreach, guidance, enforcement, and other activities undertaken to encourage compliance with section 402(j) of the Public Health Service Act (42 U.S.C. 282(j)).

(c) REPORTS ON CLINICAL TRIALS.—

(1) IN GENERAL.—Not later than 2 years after the final compliance date under the final rule implementing section 402(j) of the Public Health Service Act, and every 2 years thereafter for the next 4 years, the Secretary, acting through the Director of the National Institutes of Health

and in collaboration with the Commissioner of Food and Drugs, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report describing—

(A) the total number of applicable clinical trials with complete data bank registration information registered during the period for which the report is being prepared (broken down by each year of such reporting period);

(B) the total number of applicable clinical trials registered during the period for which the report is being prepared for which results have been submitted to the data bank (broken down by each year of such reporting period);

(C) the activities undertaken by the Secretary to educate responsible persons about data bank registration and results submission requirements, including through issuance of guidance documents, informational meetings, and training sessions; and

(D) the activities described in the report submitted under subsection (b).

(2) ACTIONS TO ENFORCE COMPLIANCE.—After the Secretary has undertaken the educational activities described in paragraph (1)(C), the Secretary shall include in subsequent reports submitted under paragraph (1) the number of actions taken by the Secretary during the period for which the report is being prepared to enforce compliance with data bank registration and results submission requirements.

SEC. 2053. UPDATES TO POLICIES TO IMPROVE DATA.

Section 492B(c) of the Public Health Service Act (42 U.S.C. 289a–2(c)) is amended—

(1) by striking ''In the case'' and inserting the following:

''(1) IN GENERAL.—In the case''; and

(2) by adding at the end the following:

''(2) REPORTING REQUIREMENTS.—For any new and competing project of clinical research subject to the requirements under this section that receives a grant award 1 year after the date of enactment of the 21st Century Cures Act, or any date thereafter, for which a valid analysis is provided under paragraph (1)—

''(A) and which is an applicable clinical trial as defined in section 402(j), the entity conducting such clinical research shall submit the results of such valid analysis to the clinical trial registry data bank expanded under section 402(j)(3), and the Director of the National Institutes of Health shall, as appropriate, consider whether such entity has complied with the reporting requirement described in this subparagraph in awarding any future grant to such entity, including pursuant to section 402(j)(5)(A)(ii) when applicable; and

''(B) the Director of the National Institutes of Health shall encourage the reporting of the results of such valid analysis described in paragraph (1) through any additional means determined appropriate by the Director.''.

SEC. 2054. CONSULTATION.

Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall consult with relevant Federal agencies, including the Food and Drug Administration, the Office of the National Coordinator for Health Information Technology, and the National Institutes of Health, as well as other stakeholders (including patients, researchers, physicians, industry representatives, and developers of health information technology) to receive recommendations with respect to enhancements to the clinical trial registry data bank under section 402(j) of the Public Health Service Act (42 U.S.C. 282(j)), including with respect to usability, functionality, and search capability.

Subtitle F—Facilitating Collaborative Research

SEC. 2061. NATIONAL NEUROLOGICAL CONDITIONS SURVEILLANCE SYSTEM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by inserting after section 399S the following:

''SEC. 399S–1. SURVEILLANCE OF NEUROLOGICAL DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other agencies as the Secretary determines, shall, as appropriate—

''(1) enhance and expand infrastructure and activities to track the epidemiology of neurological diseases; and

''(2) incorporate information obtained through such activities into an integrated surveillance system, which may consist of or include a registry, to be known as the National Neurological Conditions Surveillance System.

''(b) RESEARCH.—The Secretary shall ensure that the National Neurological Conditions Surveillance System is designed in a manner that facilitates further research on neurological diseases.

''(c) CONTENT.—In carrying out subsection (a), the Secretary—

''(1) shall provide for the collection and storage of information on the incidence and prevalence of neurological diseases in the United States;

''(2) to the extent practicable, shall provide for the collection and storage of other available information on neurological diseases, including information related to persons living with neurological diseases who choose to participate, such as—

''(A) demographics, such as age, race, ethnicity, sex, geographic location, family history, and other information, as appropriate;

''(B) risk factors that may be associated with neurological diseases, such as genetic and environmental risk factors and other information, as appropriate; and

''(C) diagnosis and progression markers;

''(3) may provide for the collection and storage of information relevant to analysis on neurological diseases, such as information concerning—

''(A) the natural history of the diseases;

''(B) the prevention of the diseases;

''(C) the detection, management, and treatment approaches for the diseases; and

''(D) the development of outcomes measures;

''(4) may address issues identified during the consultation process under subsection (d); and

''(5) initially may address a limited number of neurological diseases.

''(d) CONSULTATION.—In carrying out this section, the Secretary shall consult with individuals with appropriate expertise, which may include—

''(1) epidemiologists with experience in disease surveillance or registries;

''(2) representatives of national voluntary health associations that—

''(A) focus on neurological diseases; and

''(B) have demonstrated experience in research, care, or patient services;

''(3) health information technology experts or other information management specialists;

''(4) clinicians with expertise in neurological diseases; and

''(5) research scientists with experience conducting translational research or utilizing surveillance systems for scientific research purposes.

''(e) GRANTS.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, public or private nonprofit entities to carry out activities under this section.

''(f) COORDINATION WITH OTHER FEDERAL, STATE, AND LOCAL AGENCIES.—Subject to subsection (h), the Secretary shall—

''(1) make information and analysis in the National Neurological Conditions Surveillance System available, as appropriate—

''(A) to Federal departments and agencies, such as the National Institutes of Health and the Department of Veterans Affairs; and

''(B) to State and local agencies; and

''(2) identify, build upon, leverage, and coordinate among existing data and surveillance systems, surveys, registries, and other Federal public health infrastructure, wherever practicable.

''(g) PUBLIC ACCESS.—Subject to subsection (h), the Secretary shall ensure that information and analysis in the National Neurological Conditions Surveillance System are available, as appropriate, to the public, including researchers.

''(h) PRIVACY.—The Secretary shall ensure that information and analysis in the National Neurological Conditions Surveillance System are made available only to the extent permitted by applicable Federal and State law, and in a manner that protects personal privacy, to the extent required by applicable Federal and State privacy law, at a minimum.

''(i) REPORTS.—

''(1) REPORT ON INFORMATION AND ANALYSES.—Not later than 1 year after the date on which any system is established under this section, the Secretary shall submit an interim report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives regarding aggregate information collected pursuant to this section and epidemiological analyses, as appropriate. Such report shall be posted on the Internet website of the Department of Health and Human Services and shall be updated biennially.

''(2) IMPLEMENTATION REPORT.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit a report to the Congress concerning the implementation of this section. Such report shall include information on—

''(A) the development and maintenance of the National Neurological Conditions Surveillance System;

''(B) the type of information collected and stored in the surveillance system;

''(C) the use and availability of such information, including guidelines for such use; and

''(D) the use and coordination of databases that collect or maintain information on neurological diseases.

''(j) DEFINITION.—In this section, the term 'national voluntary health association' means a national nonprofit organization with chapters, other affiliated organizations, or networks in States throughout the United States with experience serving the population of individuals with neurological disease and have demonstrated experience in neurological disease research, care, and patient services.

''(k) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2018 through 2022.''.

SEC. 2062. TICK-BORNE DISEASES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as ''the Secretary'') shall continue to conduct or support epidemiological, basic, translational, and clinical research related to vector-borne diseases, including tick-borne diseases.

(b) REPORTS.—The Secretary shall ensure that each triennial report under section 403 of the Public Health Service Act (42 U.S.C. 283) (as amended by section 2032) includes information on actions undertaken by the National Institutes of Health to carry out subsection (a) with respect to tick-borne diseases.

(c) TICK-BORNE DISEASES WORKING GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish a working group, to be known as the Tick-Borne Disease Working Group (referred to in this section as the ''Working Group''), comprised of representatives of appropriate Federal agencies and other non-Federal entities, to provide expertise and to review all efforts within the Department of Health and Human Services related to all tick-borne diseases, to help ensure interagency coordination and minimize overlap, and to examine research priorities.

(2) RESPONSIBILITIES.—The working group shall—

(A) not later than 2 years after the date of enactment of this Act, develop or update a summary of—

(i) ongoing tick-borne disease research, including research related to causes, prevention, treatment, surveillance, diagnosis, diagnostics, duration of illness, and intervention for individuals with tick-borne diseases;

(ii) advances made pursuant to such research;

(iii) Federal activities related to tick-borne diseases, including—

(I) epidemiological activities related to tick-borne diseases; and

(II) basic, clinical, and translational tick-borne disease research related to the pathogenesis, prevention, diagnosis, and treatment of tick-borne diseases;

(iv) gaps in tick-borne disease research described in clause (iii)(II);

(v) the Working Group's meetings required under paragraph (4); and

(vi) the comments received by the Working Group;

(B) make recommendations to the Secretary regarding any appropriate changes or improvements to such activities and research; and

(C) solicit input from States, localities, and nongovernmental entities, including organizations representing patients, health care providers, researchers, and industry regarding scientific advances, research questions, surveillance activities, and emerging strains in species of pathogenic organisms.

(3) MEMBERSHIP.—The members of the working group shall represent a diversity of scientific disciplines and views and shall be composed of the following members:

(A) FEDERAL MEMBERS.—Seven Federal members, consisting of one of more representatives of each of the following:

(i) The Office of the Assistant Secretary for Health.

(ii) The Food and Drug Administration.

(iii) The Centers for Disease Control and Prevention.

(iv) The National Institutes of Health.

(v) Such other agencies and offices of the Department of Health and Human Services as the Secretary determines appropriate.

(B) NON–FEDERAL PUBLIC MEMBERS.—Seven non–Federal public members, consisting of representatives of the following categories:

(i) Physicians and other medical providers with experience in diagnosing and treating tick-borne diseases.

(ii) Scientists or researchers with expertise.

(iii) Patients and their family members.

(iv) Nonprofit organizations that advocate for patients with respect to tick-borne diseases.

(v) Other individuals whose expertise is determined by the Secretary to be beneficial to the functioning of the Working Group.

(4) MEETINGS.—The Working Group shall meet not less than twice each year.

(5) REPORTING.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter until termination of the Working Group pursuant to paragraph (7), the Working Group shall—

(A) submit a report on its activities under paragraph (2)(A) and any recommendations under paragraph (2)(B) to the Secretary, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, Labor, and Pensions of the Senate; and

(B) make such report publicly available on the Internet website of the Department of Health and Human Services.

(6) APPLICABILITY OF FACA.—The Working Group shall be treated as an advisory committee subject to the Federal Advisory Committee Act (5 U.S.C. App.).

(7) SUNSET.—The Working Group under this section shall terminate 6 years after the date of enactment of this Act.

SEC. 2063. ACCESSING, SHARING, AND USING HEALTH DATA FOR RESEARCH PURPOSES.

(a) GUIDANCE RELATED TO REMOTE ACCESS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall issue guidance clarifying that subparagraph (B) of section 164.512(i)(1)(ii) of part 164 of the Rule (prohibiting the removal of protected health information by a researcher) does not prohibit remote access to health information by a researcher for such purposes as described in section 164.512(i)(1)(ii) of part 164 of the Rule so long as—

(1) at a minimum, security and privacy safeguards, consistent with the requirements of the Rule, are maintained by the covered entity and the researcher; and

(2) the protected health information is not copied or otherwise retained by the researcher.

(b) GUIDANCE RELATED TO STREAMLINING AUTHORIZATION.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue guidance on the following:

(1) AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION.—Clarification of the circumstances under which the authorization for the use or disclosure of protected health information, with respect to an individual, for future research purposes contains a sufficient description of the purpose of the use or disclosure, such as if the authorization—

(A) sufficiently describes the purposes such that it would be reasonable for the individual to expect that the protected health information could be used or disclosed for such future research;

(B) either—

(i) states that the authorization will expire on a particular date or on the occurrence of a particular event; or

(ii) states that the authorization will remain valid unless and until it is revoked by the individual; and

(C) provides instruction to the individual on how to revoke such authorization at any time.

(2) REMINDER OF THE RIGHT TO REVOKE.—Clarification of the circumstances under which it is appropriate to provide an individual with an annual notice or reminder that the individual has the right to revoke such authorization.

(3) REVOCATION OF AUTHORIZATION.—Clarification of appropriate mechanisms by which an individual may revoke an authorization for future research purposes, such as described in paragraph (1)(C).

(c) WORKING GROUP ON PROTECTED HEALTH INFORMATION FOR RESEARCH.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall convene a working group to study and report on the uses and disclosures of protected health information for research purposes, under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(2) MEMBERS.—The working group shall include representatives of—

(A) relevant Federal agencies, including the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Office for Civil Rights;

(B) the research community;

(C) patients;

(D) experts in civil rights, such as privacy rights;

(E) developers of health information technology;

(F) experts in data privacy and security;

(G) health care providers;

(H) bioethicists; and

(I) other experts and entities, as the Secretary determines appropriate.

(3) REPORT.—Not later than 1 year after the date on which the working group is convened under paragraph (1), the working group shall conduct a review and submit a report to the Secretary containing recommendations on whether the uses and disclosures of protected health information for research purposes should be modified to allow protected health information to be available, as appropriate, for research purposes, including studies to obtain generalizable knowledge, while protecting individuals' privacy rights. In conducting the review and making recommendations, the working group shall—

(A) address, at a minimum—

(i) the appropriate manner and timing of authorization, including whether additional notification to the individual should be required when the individual's protected health information will be used or disclosed for such research;

(ii) opportunities for individuals to set preferences on the manner in which their protected health information is used in research;

(iii) opportunities for patients to revoke authorization;

(iv) notification to individuals of a breach in privacy;

(v) existing gaps in statute, regulation, or policy related to protecting the privacy of individuals, and

(vi) existing barriers to research related to the current restrictions on the uses and disclosures of protected health information; and

(B) consider, at a minimum—

(i) expectations and preferences on how an individual's protected health information is shared and used;

(ii) issues related to specific subgroups of people, such as children, incarcerated individuals, and individuals with a cognitive or intellectual disability impacting capacity to consent;

(iii) relevant Federal and State laws;

(iv) models of facilitating data access and levels of data access, including data segmentation, where applicable;

(v) potential impacts of disclosure and non-disclosure of protected health information on access to health care services; and

(vi) the potential uses of such data.

(4) REPORT SUBMISSION.—The Secretary shall submit the report under paragraph (3) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and shall post such report on the appropriate Internet website of the Department of Health and Human Services.

(5) TERMINATION.—The working group convened under paragraph (1) shall terminate the day after the report under paragraph (3) is submitted to Congress and made public in accordance with paragraph (4).

(d) DEFINITIONS.—In this section:

(1) THE RULE.—References to ''the Rule'' refer to part 160 or part 164, as appropriate, of title 45, Code of Federal Regulations (or any successor regulation).

(2) PART 164.—References to a specified section of ''part 164'', refer to such specified section of part 164 of title 45, Code of Federal Regulations (or any successor section).

Subtitle G—Promoting Pediatric Research

SEC. 2071. NATIONAL PEDIATRIC RESEARCH NETWORK.

Section 409D(d) of the Public Health Service Act (42 U.S.C. 284h(d)) is amended—

(1) in paragraph (1), by striking ''in consultation with the Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development and in collaboration with other appropriate national research institutes and national centers that carry out activities involving pediatric research, may provide for the establishment of'' and inserting ''in collaboration with the national research institutes and national centers that carry out activities involving pediatric research, shall support''; and

(2) in paragraph (2)(A) and the first sentence of paragraph (2)(E), by striking ''may'' each place such term appears and inserting ''shall''.

SEC. 2072. GLOBAL PEDIATRIC CLINICAL STUDY NETWORK.

It is the sense of Congress that—

(1) the National Institutes of Health should encourage a global pediatric clinical study network by providing grants, contracts, or cooperative agreements to support new and early stage

investigators who participate in the global pediatric clinical study network;

(2) the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') should engage with clinical investigators and appropriate authorities outside of the United States, including authorities in the European Union, during the formation of the global pediatric clinical study network to encourage the participation of such investigator and authorities; and

(3) once a global pediatric clinical study network is established and becomes operational, the Secretary should continue to encourage and facilitate the participation of clinical investigators and appropriate authorities outside of the United States, including in the European Union, to participate in the network with the goal of enhancing the global reach of the network.

TITLE III—DEVELOPMENT

Subtitle A—Patient-Focused Drug Development

SEC. 3001. PATIENT EXPERIENCE DATA.

Section 569C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''IN GENERAL'' and inserting ''PATIENT ENGAGEMENT IN DRUGS AND DEVICES'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs 2 ems to the right; and

(C) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary'';

(2) by redesignating subsections (b) through (e) as paragraphs (2) through (5), respectively, and moving such paragraphs 2 ems to the right; and

(3) by adding at the end the following:

''(b) STATEMENT OF PATIENT EXPERIENCE.—

''(1) IN GENERAL.—Following the approval of an application that was submitted under section 505(b) of this Act or section 351(a) of the Public Health Service Act at least 180 days after the date of enactment of the 21st Century Cures Act, the Secretary shall make public a brief statement regarding the patient experience data and related information, if any, submitted and reviewed as part of such application.

''(2) DATA AND INFORMATION.—The data and information referred to in paragraph (1) are—

''(A) patient experience data;

''(B) information on patient-focused drug development tools; and

''(C) other relevant information, as determined by the Secretary.

''(c) PATIENT EXPERIENCE DATA.—For purposes of this section, the term 'patient experience data' includes data that—

''(1) are collected by any persons (including patients, family members and caregivers of patients, patient advocacy organizations, disease research foundations, researchers, and drug manufacturers); and

''(2) are intended to provide information about patients' experiences with a disease or condition, including—

''(A) the impact of such disease or condition, or a related therapy, on patients' lives; and

''(B) patient preferences with respect to treatment of such disease or condition.''.

SEC. 3002. PATIENT-FOCUSED DRUG DEVELOPMENT GUIDANCE.

(a) PUBLICATION OF GUIDANCE DOCUMENTS.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall develop a plan to issue draft and final versions of one or more guidance documents, over a period of 5 years, regarding the collection of patient experience data, and the use of such data and related information in drug development. Not later than 18 months after the date of enactment of this Act, the Secretary shall issue a draft version of at least one such guidance document. Not later than 18 months after the public comment period on the draft guidance ends, the Secretary shall issue a revised draft guidance or final guidance.

(b) PATIENT EXPERIENCE DATA.—For purposes of this section, the term ''patient experience data'' has the meaning given such term in section 569C of the Federal Food, Drug, and Cosmetic Act (as added by section 3001).

(c) CONTENTS.—The guidance documents described in subsection (a) shall address—

(1) methodological approaches that a person seeking to collect patient experience data for submission to, and proposed use by, the Secretary in regulatory decisionmaking may use, that are relevant and objective and ensure that such data are accurate and representative of the intended population, including methods to collect meaningful patient input throughout the drug development process and methodological considerations for data collection, reporting, management, and analysis;

(2) methodological approaches that may be used to develop and identify what is most important to patients with respect to burden of disease, burden of treatment, and the benefits and risks in the management of the patient's disease;

(3) approaches to identifying and developing methods to measure impacts to patients that will help facilitate collection of patient experience data in clinical trials;

(4) methodologies, standards, and technologies to collect and analyze clinical outcome assessments for purposes of regulatory decisionmaking;

(5) how a person seeking to develop and submit proposed draft guidance relating to patient experience data for consideration by the Secretary may submit such proposed draft guidance to the Secretary;

(6) the format and content required for submissions under this section to the Secretary, including with respect to the information described in paragraph (1);

(7) how the Secretary intends to respond to submissions of information described in paragraph (1), if applicable, including any timeframe for response when such submission is not part of a regulatory application or other submission that has an associated timeframe for response; and

(8) how the Secretary, if appropriate, anticipates using relevant patient experience data and related information, including with respect to the structured risk-benefit assessment framework described in section 505(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(d)), to inform regulatory decisionmaking.

SEC. 3003. STREAMLINING PATIENT INPUT.

Chapter 35 of title 44, United States Code, shall not apply to the collection of information to which a response is voluntary, that is initiated by the Secretary under section 569C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c) (as amended by section 3001) or section 3002.

SEC. 3004. REPORT ON PATIENT EXPERIENCE DRUG DEVELOPMENT.

Not later than June 1 of 2021, 2026, and 2031, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall prepare and publish on the Internet website of the Food and Drug Administration a report assessing the use of patient experience data in regulatory decisionmaking, in particular with respect to the review of patient experience data and information on patient-focused drug development tools as part of applications approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)) or section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

Subtitle B—Advancing New Drug Therapies

SEC. 3011. QUALIFICATION OF DRUG DEVELOPMENT TOOLS.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 506F the following new section:

''SEC. 507. QUALIFICATION OF DRUG DEVELOPMENT TOOLS.

''(a) PROCESS FOR QUALIFICATION.—

''(1) IN GENERAL.—The Secretary shall establish a process for the qualification of drug development tools for a proposed context of use under which—

''(A)(i) a requestor initiates such process by submitting a letter of intent to the Secretary; and

''(ii) the Secretary accepts or declines to accept such letter of intent;

''(B)(i) if the Secretary accepts the letter of intent, a requestor submits a qualification plan to the Secretary; and

''(ii) the Secretary accepts or declines to accept the qualification plan; and

''(C)(i) if the Secretary accepts the qualification plan, the requestor submits to the Secretary a full qualification package;

''(ii) the Secretary determines whether to accept such qualification package for review; and

''(iii) if the Secretary accepts such qualification package for review, the Secretary conducts such review in accordance with this section.

''(2) ACCEPTANCE AND REVIEW OF SUBMISSIONS.—

''(A) IN GENERAL.—Subparagraphs (B), (C), and (D) shall apply with respect to the treatment of a letter of intent, a qualification plan, or a full qualification package submitted under paragraph (1) (referred to in this paragraph as 'qualification submissions').

''(B) ACCEPTANCE FACTORS; NONACCEPTANCE.—The Secretary shall determine whether to accept a qualification submission based on factors which may include the scientific merit of the qualification submission. A determination not to accept a submission under paragraph (1) shall not be construed as a final determination by the Secretary under this section regarding the qualification of a drug development tool for its proposed context of use.

''(C) PRIORITIZATION OF QUALIFICATION REVIEW.—The Secretary may prioritize the review of a full qualification package submitted under paragraph (1) with respect to a drug development tool, based on factors determined appropriate by the Secretary, including—

''(i) as applicable, the severity, rarity, or prevalence of the disease or condition targeted by the drug development tool and the availability or lack of alternative treatments for such disease or condition; and

''(ii) the identification, by the Secretary or by biomedical research consortia and other expert stakeholders, of such a drug development tool and its proposed context of use as a public health priority.

''(D) ENGAGEMENT OF EXTERNAL EXPERTS.—The Secretary may, for purposes of the review of qualification submissions, through the use of cooperative agreements, grants, or other appropriate mechanisms, consult with biomedical research consortia and may consider the recommendations of such consortia with respect to the review of any qualification plan submitted under paragraph (1) or the review of any full qualification package under paragraph (3).

''(3) REVIEW OF FULL QUALIFICATION PACKAGE.—The Secretary shall—

''(A) conduct a comprehensive review of a full qualification package accepted under paragraph (1)(C); and

''(B) determine whether the drug development tool at issue is qualified for its proposed context of use.

''(4) QUALIFICATION.—The Secretary shall determine whether a drug development tool is qualified for a proposed context of use based on

the scientific merit of a full qualification package reviewed under paragraph (3).

''(b) EFFECT OF QUALIFICATION.—

''(1) IN GENERAL.—A drug development tool determined to be qualified under subsection (a)(4) for a proposed context of use specified by the requestor may be used by any person in such context of use for the purposes described in paragraph (2).

''(2) USE OF A DRUG DEVELOPMENT TOOL.—Subject to paragraph (3), a drug development tool qualified under this section may be used for—

''(A) supporting or obtaining approval or licensure (as applicable) of a drug or biological product (including in accordance with section 506(c)) under section 505 of this Act or section 351 of the Public Health Service Act; or

''(B) supporting the investigational use of a drug or biological product under section 505(i) of this Act or section 351(a)(3) of the Public Health Service Act.

''(3) RESCISSION OR MODIFICATION.—

''(A) IN GENERAL.—The Secretary may rescind or modify a determination under this section to qualify a drug development tool if the Secretary determines that the drug development tool is not appropriate for the proposed context of use specified by the requestor. Such a determination may be based on new information that calls into question the basis for such qualification.

''(B) MEETING FOR REVIEW.—If the Secretary rescinds or modifies under subparagraph (A) a determination to qualify a drug development tool, the requestor involved shall, on request, be granted a meeting with the Secretary to discuss the basis of the Secretary's decision to rescind or modify the determination before the effective date of the rescission or modification.

''(c) TRANSPARENCY.—

''(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall make publicly available, and update on at least a biannual basis, on the Internet website of the Food and Drug Administration the following:

''(A) Information with respect to each qualification submission under the qualification process under subsection (a), including—

''(i) the stage of the review process applicable to the submission;

''(ii) the date of the most recent change in stage status;

''(iii) whether external scientific experts were utilized in the development of a qualification plan or the review of a full qualification package; and

''(iv) submissions from requestors under the qualification process under subsection (a), including any data and evidence contained in such submissions, and any updates to such submissions.

''(B) The Secretary's formal written determinations in response to such qualification submissions.

''(C) Any rescissions or modifications under subsection (b)(3) of a determination to qualify a drug development tool.

''(D) Summary reviews that document conclusions and recommendations for determinations to qualify drug development tools under subsection (a).

''(E) A comprehensive list of—

''(i) all drug development tools qualified under subsection (a); and

''(ii) all surrogate endpoints which were the basis of approval or licensure (as applicable) of a drug or biological product (including in accordance with section 506(c)) under section 505 of this Act or section 351 of the Public Health Service Act.

''(2) RELATION TO TRADE SECRETS ACT.—Information made publicly available by the Secretary under paragraph (1) shall be considered a disclosure authorized by law for purposes of section 1905 of title 18, United States Code.

''(3) APPLICABILITY.—Nothing in this section shall be construed as authorizing the Secretary to disclose any information contained in an application submitted under section 505 of this Act or section 351 of the Public Health Service Act that is confidential commercial or trade secret information subject to section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to alter the standards of evidence under subsection (c) or (d) of section 505, including the substantial evidence standard in such subsection (d), or under section 351 of the Public Health Service Act (as applicable); or

''(2) to limit the authority of the Secretary to approve or license products under this Act or the Public Health Service Act, as applicable (as in effect before the date of the enactment of the 21st Century Cures Act).

''(e) DEFINITIONS.—In this section:

''(1) BIOMARKER.—The term 'biomarker'—

''(A) means a characteristic (such as a physiologic, pathologic, or anatomic characteristic or measurement) that is objectively measured and evaluated as an indicator of normal biologic processes, pathologic processes, or biological responses to a therapeutic intervention; and

''(B) includes a surrogate endpoint.

''(2) BIOMEDICAL RESEARCH CONSORTIA.—The term 'biomedical research consortia' means collaborative groups that may take the form of public-private partnerships and may include government agencies, institutions of higher education (as defined in section 101(a) of the Higher Education Act of 1965), patient advocacy groups, industry representatives, clinical and scientific experts, and other relevant entities and individuals.

''(3) CLINICAL OUTCOME ASSESSMENT.—The term 'clinical outcome assessment' means—

''(A) a measurement of a patient's symptoms, overall mental state, or the effects of a disease or condition on how the patient functions; and

''(B) includes a patient-reported outcome.

''(4) CONTEXT OF USE.—The term 'context of use' means, with respect to a drug development tool, the circumstances under which the drug development tool is to be used in drug development and regulatory review.

''(5) DRUG DEVELOPMENT TOOL.—The term 'drug development tool' includes—

''(A) a biomarker;

''(B) a clinical outcome assessment; and

''(C) any other method, material, or measure that the Secretary determines aids drug development and regulatory review for purposes of this section.

''(6) PATIENT-REPORTED OUTCOME.—The term 'patient-reported outcome' means a measurement based on a report from a patient regarding the status of the patient's health condition without amendment or interpretation of the patient's report by a clinician or any other person.

''(7) QUALIFICATION.—The terms 'qualification' and 'qualified' mean a determination by the Secretary that a drug development tool and its proposed context of use can be relied upon to have a specific interpretation and application in drug development and regulatory review under this Act.

''(8) REQUESTOR.—The term 'requestor' means an entity or entities, including a drug sponsor or a biomedical research consortia, seeking to qualify a drug development tool for a proposed context of use under this section.

''(9) SURROGATE ENDPOINT.—The term 'surrogate endpoint' means a marker, such as a laboratory measurement, radiographic image, physical sign, or other measure, that is not itself a direct measurement of clinical benefit, and—

''(A) is known to predict clinical benefit and could be used to support traditional approval of a drug or biological product; or

''(B) is reasonably likely to predict clinical benefit and could be used to support the accelerated approval of a drug or biological product in accordance with section 506(c).''.

(b) GUIDANCE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, in consultation with biomedical research consortia (as defined in subsection (e) of section 507 of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a)) and other interested parties through a collaborative public process, issue guidance to implement such section 507 that—

(A) provides a conceptual framework describing appropriate standards and scientific approaches to support the development of biomarkers delineated under the taxonomy established under paragraph (3);

(B) with respect to the qualification process under such section 507—

(i) describes the requirements that entities seeking to qualify a drug development tool under such section shall observe when engaging in such process;

(ii) outlines reasonable timeframes for the Secretary's review of letters, qualification plans, or full qualification packages submitted under such process; and

(iii) establishes a process by which such entities or the Secretary may consult with biomedical research consortia and other individuals and entities with expert knowledge and insights that may assist the Secretary in the review of qualification plans and full qualification submissions under such section; and

(C) includes such other information as the Secretary determines appropriate.

(2) TIMING.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall issue draft guidance under paragraph (1) on the implementation of section 507 of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a)). The Secretary shall issue final guidance on the implementation of such section not later than 6 months after the date on which the comment period for the draft guidance closes.

(3) TAXONOMY.—

(A) IN GENERAL.—For purposes of informing guidance under this subsection, the Secretary shall, in consultation with biomedical research consortia and other interested parties through a collaborative public process, establish a taxonomy for the classification of biomarkers (and related scientific concepts) for use in drug development.

(B) PUBLIC AVAILABILITY.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall make such taxonomy publicly available in draft form for public comment. The Secretary shall finalize the taxonomy not later than 1 year after the close of the public comment period.

(c) MEETING AND REPORT.—

(1) MEETING.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall convene a public meeting to describe and solicit public input regarding the qualification process under section 507 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a).

(2) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall make publicly available on the Internet website of the Food and Drug Administration a report. Such report shall include, with respect to the qualification process under section 507 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), information on—

(A) the number of requests submitted, as a letter of intent, for qualification of a drug development tool (as defined in subsection (e) of such section 507);

(B) the number of such requests accepted and determined to be eligible for submission of a qualification plan or full qualification package (as such terms are defined in subsection (e) of such section 507), respectively;

(C) the number of such requests for which external scientific experts were utilized in the development of a qualification plan or review of a full qualification package;

(D) the number of qualification plans and full qualification packages, respectively, submitted to the Secretary; and

(E) the drug development tools qualified through such qualification process, specified by type of tool, such as a biomarker or clinical outcome assessment (as such terms are defined in subsection (e) of such section 507).

SEC. 3012. TARGETED DRUGS FOR RARE DISEASES.

Subchapter B of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360aa et seq.) is amended by inserting after section 529 the following:

''SEC. 529A. TARGETED DRUGS FOR RARE DISEASES.

''(a) PURPOSE.—The purpose of this section, through the approach provided for in subsection (b), is to—

''(1) facilitate the development, review, and approval of genetically targeted drugs and variant protein targeted drugs to address an unmet medical need in one or more patient subgroups, including subgroups of patients with different mutations of a gene, with respect to rare diseases or conditions that are serious or life-threatening; and

''(2) maximize the use of scientific tools or methods, including surrogate endpoints and other biomarkers, for such purposes.

''(b) LEVERAGING OF DATA FROM PREVIOUSLY APPROVED DRUG APPLICATION OR APPLICATIONS.—The Secretary may, consistent with applicable standards for approval under this Act or section 351(a) of the Public Health Service Act, allow the sponsor of an application under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act for a genetically targeted drug or a variant protein targeted drug to rely upon data and information—

''(1) previously developed by the same sponsor (or another sponsor that has provided the sponsor with a contractual right of reference to such data and information); and

''(2) submitted by a sponsor described in paragraph (1) in support of one or more previously approved applications that were submitted under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act,

for a drug that incorporates or utilizes the same or similar genetically targeted technology as the drug or drugs that are the subject of an application or applications described in paragraph (2) or for a variant protein targeted drug that is the same or incorporates or utilizes the same variant protein targeted drug, as the drug or drugs that are the subject of an application or applications described in paragraph (2).

''(c) DEFINITIONS.—For purposes of this section—

''(1) the term 'genetically targeted drug' means a drug that—

''(A) is the subject of an application under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act for the treatment of a rare disease or condition (as such term is defined in section 526) that is serious or life-threatening;

''(B) may result in the modulation (including suppression, up-regulation, or activation) of the function of a gene or its associated gene product; and

''(C) incorporates or utilizes a genetically targeted technology;

''(2) the term 'genetically targeted technology' means a technology comprising non-replicating nucleic acid or analogous compounds with a common or similar chemistry that is intended to treat one or more patient subgroups, including subgroups of patients with different mutations of a gene, with the same disease or condition, including a disease or condition due to other variants in the same gene; and

''(3) the term 'variant protein targeted drug' means a drug that—

''(A) is the subject of an application under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act for the treatment of a rare disease or condition (as such term is defined in section 526) that is serious or life-threatening;

''(B) modulates the function of a product of a mutated gene where such mutation is responsible in whole or in part for a given disease or condition; and

''(C) is intended to treat one or more patient subgroups, including subgroups of patients with different mutations of a gene, with the same disease or condition.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to—

''(1) alter the authority of the Secretary to approve drugs pursuant to this Act or section 351 of the Public Health Service Act (as authorized prior to the date of enactment of the 21st Century Cures Act), including the standards of evidence, and applicable conditions, for approval under such applicable Act; or

''(2) confer any new rights, beyond those authorized under this Act or the Public Health Service Act prior to enactment of this section, with respect to the permissibility of a sponsor referencing information contained in another application submitted under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act.''.

SEC. 3013. REAUTHORIZATION OF PROGRAM TO ENCOURAGE TREATMENTS FOR RARE PEDIATRIC DISEASES.

(a) IN GENERAL.—Section 529(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(b)) is amended by striking paragraph (5) and inserting the following:

''(5) TERMINATION OF AUTHORITY.—The Secretary may not award any priority review vouchers under paragraph (1) after September 30, 2020, unless the rare pediatric disease product application—

''(A) is for a drug that, not later than September 30, 2020, is designated under subsection (d) as a drug for a rare pediatric disease; and

''(B) is, not later than September 30, 2022, approved under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act.''.

(b) REPORT.—The Advancing Hope Act of 2016 (Public Law 114–229) is amended by striking section 3.

SEC. 3014. GAO STUDY OF PRIORITY REVIEW VOUCHER PROGRAMS.

(a) STUDY.—The Comptroller General of the United States (referred to in this section as the ''Comptroller General'') shall conduct a study addressing the effectiveness and overall impact of the following priority review voucher programs, including any such programs amended or established by this Act:

(1) The neglected tropical disease priority review voucher program under section 524 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360n).

(2) The rare pediatric disease priority review voucher program under section 529 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff).

(3) The medical countermeasure priority review voucher program under section 565A of the Federal Food, Drug, and Cosmetic Act, as added by section 3086.

(b) ISSUANCE OF REPORT.—Not later than January 31, 2020, the Comptroller General shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report containing the results of the study under subsection (a).

(c) CONTENTS OF REPORTS.—The report submitted under subsection (b) shall address—

(1) for each drug for which a priority review voucher has been awarded as of initiation of the study—

(A) the indications for which the drug is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)), pursuant to an application under section 505(b)(1) of such Act, or licensed under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a));

(B) whether, and to what extent, the voucher impacted the sponsor's decision to develop the drug; and

(C) whether, and to what extent, the approval or licensure of the drug, as applicable and appropriate—

(i) addressed a global unmet need related to the treatment or prevention of a neglected tropical disease, including whether the sponsor of a drug coordinated with international development organizations;

(ii) addressed an unmet need related to the treatment of a rare pediatric disease; or

(iii) affected the Nation's preparedness against a chemical, biological, radiological, or nuclear threat, including naturally occurring threats;

(2) for each drug for which a priority review voucher has been used—

(A) the indications for which such drug is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)), pursuant to an application under section 505(b)(1) of such Act, or licensed under section 351(a) of the Public Health Service Act (42 U.S.C. 262);

(B) the value of the voucher, if transferred; and

(C) the length of time between the date on which the voucher was awarded and the date on which the voucher was used; and

(3) an analysis of the priority review voucher programs described in subsection (a), including—

(A) the resources used by the Food and Drug Administration in reviewing drugs for which vouchers were used, including the effect of the programs on the Food and Drug Administration's review of drugs for which priority review vouchers were not awarded or used;

(B) whether any improvements to such programs are necessary to appropriately target incentives for the development of drugs that would likely not otherwise be developed, or developed in as timely a manner, and, as applicable and appropriate—

(i) address global unmet needs related to the treatment or prevention of neglected tropical diseases, including in countries in which neglected tropical diseases are endemic; or

(ii) address unmet needs related to the treatment of rare pediatric diseases; and

(C) whether the sunset of the rare pediatric disease program and medical countermeasure program has had an impact on the program, including any potential unintended consequences.

(d) PROTECTION OF NATIONAL SECURITY.—The Comptroller General shall conduct the study and issue reports under this section in a manner that does not compromise national security.

SEC. 3015. AMENDMENTS TO THE ORPHAN DRUG GRANTS.

Section 5 of the Orphan Drug Act (21 U.S.C. 360ee) is amended—

(1) in subsection (a), by striking paragraph (1) and inserting the following: ''(1) defraying the costs of developing drugs for rare diseases or conditions, including qualified testing expenses,''; and

(2) in subsection (b)(1)—

(A) in subparagraph (A)(ii), by striking ''and'' after the semicolon;

(B) in subparagraph (B), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(C) prospectively planned and designed observational studies and other analyses conducted to assist in the understanding of the natural history of a rare disease or condition and in the development of a therapy, including studies and analyses to—

''(i) develop or validate a drug development tool related to a rare disease or condition; or

''(ii) understand the full spectrum of the disease manifestations, including describing genotypic and phenotypic variability and identifying and defining distinct subpopulations affected by a rare disease or condition.''.

SEC. 3016. GRANTS FOR STUDYING CONTINUOUS DRUG MANUFACTURING.

(a) IN GENERAL.—The Secretary of Health and Human Services may award grants to institutions of higher education and nonprofit organizations for the purpose of studying and recommending improvements to the process of continuous manufacturing of drugs and biological products and similar innovative monitoring and control techniques.

(b) DEFINITIONS.—In this section—

(1) the term ''drug'' has the meaning given such term in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321);

(2) the term ''biological product'' has the meaning given such term in section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)); and

(3) the term ''institution of higher education'' has the meaning given such term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

Subtitle C—Modern Trial Design and Evidence Development

SEC. 3021. NOVEL CLINICAL TRIAL DESIGNS.

(a) PROPOSALS FOR USE OF NOVEL CLINICAL TRIAL DESIGNS FOR DRUGS AND BIOLOGICAL PRODUCTS.—For purposes of assisting sponsors in incorporating complex adaptive and other novel trial designs into proposed clinical protocols and applications for new drugs under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and biological products under section 351 of the Public Health Service Act (42 U.S.C. 262), the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a public meeting and issue guidance in accordance with subsection (b).

(b) GUIDANCE ADDRESSING USE OF NOVEL CLINICAL TRIAL DESIGNS.—

(1) IN GENERAL.—The Secretary, acting through the Commissioner of Food and Drugs, shall update or issue guidance addressing the use of complex adaptive and other novel trial design in the development and regulatory review and approval or licensure for drugs and biological products.

(2) CONTENTS.—The guidance under paragraph (1) shall address—

(A) the use of complex adaptive and other novel trial designs, including how such clinical trials proposed or submitted help to satisfy the substantial evidence standard under section 505(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(d));

(B) how sponsors may obtain feedback from the Secretary on technical issues related to modeling and simulations prior to—

(i) completion of such modeling or simulations; or

(ii) the submission of resulting information to the Secretary;

(C) the types of quantitative and qualitative information that should be submitted for review; and

(D) recommended analysis methodologies.

(3) PUBLIC MEETING.—Prior to updating or issuing the guidance required by paragraph (1), the Secretary shall consult with stakeholders, including representatives of regulated industry, academia, patient advocacy organizations, consumer groups, and disease research foundations, through a public meeting to be held not later than 18 months after the date of enactment of this Act.

(4) TIMING.—The Secretary shall update or issue a draft version of the guidance required by paragraph (1) not later than 18 months after the date of the public meeting required by paragraph (3) and finalize such guidance not later than 1 year after the date on which the public comment period for the draft guidance closes.

SEC. 3022. REAL WORLD EVIDENCE.

Chapter V of the Federal Food, Drug, and Cosmetic Act is amended by inserting after section 505E (21 U.S.C. 355f) the following:

''SEC. 505F. UTILIZING REAL WORLD EVIDENCE.

''(a) IN GENERAL.—The Secretary shall establish a program to evaluate the potential use of real world evidence—

''(1) to help to support the approval of a new indication for a drug approved under section 505(c); and

''(2) to help to support or satisfy postapproval study requirements.

''(b) REAL WORLD EVIDENCE DEFINED.—In this section, the term 'real world evidence' means data regarding the usage, or the potential benefits or risks, of a drug derived from sources other than randomized clinical trials.

''(c) PROGRAM FRAMEWORK.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of the 21st Century Cures Act, the Secretary shall establish a draft framework for implementation of the program under this section.

''(2) CONTENTS OF FRAMEWORK.—The framework shall include information describing—

''(A) the sources of real world evidence, including ongoing safety surveillance, observational studies, registries, claims, and patient-centered outcomes research activities;

''(B) the gaps in data collection activities;

''(C) the standards and methodologies for collection and analysis of real world evidence; and

''(D) the priority areas, remaining challenges, and potential pilot opportunities that the program established under this section will address.

''(3) CONSULTATION.—

''(A) IN GENERAL.—In developing the program framework under this subsection, the Secretary shall consult with regulated industry, academia, medical professional organizations, representatives of patient advocacy organizations, consumer organizations, disease research foundations, and other interested parties.

''(B) PROCESS.—The consultation under subparagraph (A) may be carried out through approaches such as—

''(i) a public-private partnership with the entities described in such subparagraph in which the Secretary may participate;

''(ii) a contract, grant, or other arrangement, as the Secretary determines appropriate, with such a partnership or an independent research organization; or

''(iii) public workshops with the entities described in such subparagraph.

''(d) PROGRAM IMPLEMENTATION.—The Secretary shall, not later than 2 years after the date of enactment of the 21st Century Cures Act and in accordance with the framework established under subsection (c), implement the program to evaluate the potential use of real world evidence.

''(e) GUIDANCE FOR INDUSTRY.—The Secretary shall—

''(1) utilize the program established under subsection (a), its activities, and any subsequent pilots or written reports, to inform a guidance for industry on—

''(A) the circumstances under which sponsors of drugs and the Secretary may rely on real world evidence for the purposes described in paragraphs (1) and (2) of subsection (a); and

''(B) the appropriate standards and methodologies for collection and analysis of real world evidence submitted for such purposes;

''(2) not later than 5 years after the date of enactment of the 21st Century Cures Act, issue draft guidance for industry as described in paragraph (1); and

''(3) not later than 18 months after the close of the public comment period for the draft guidance described in paragraph (2), issue revised draft guidance or final guidance.

''(f) RULE OF CONSTRUCTION.—

''(1) IN GENERAL.—Subject to paragraph (2), nothing in this section prohibits the Secretary from using real world evidence for purposes not specified in this section, provided the Secretary determines that sufficient basis exists for any such nonspecified use.

''(2) STANDARDS OF EVIDENCE AND SECRETARY'S AUTHORITY.—This section shall not be construed to alter—

''(A) the standards of evidence under—

''(i) subsection (c) or (d) of section 505, including the substantial evidence standard in such subsection (d); or

''(ii) section 351(a) of the Public Health Service Act; or

''(B) the Secretary's authority to require postapproval studies or clinical trials, or the standards of evidence under which studies or trials are evaluated.''.

SEC. 3023. PROTECTION OF HUMAN RESEARCH SUBJECTS.

(a) IN GENERAL.—In order to simplify and facilitate compliance by researchers with applicable regulations for the protection of human subjects in research, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, to the extent practicable and consistent with other statutory provisions, harmonize differences between the HHS Human Subject Regulations and the FDA Human Subject Regulations in accordance with subsection (b).

(b) AVOIDING REGULATORY DUPLICATION AND UNNECESSARY DELAYS.—The Secretary shall, as appropriate—

(1) make such modifications to the provisions of the HHS Human Subject Regulations, the FDA Human Subject Regulations, and the vulnerable populations rules as may be necessary—

(A) to reduce regulatory duplication and unnecessary delays;

(B) to modernize such provisions in the context of multisite and cooperative research projects; and

(C) to protect vulnerable populations, incorporate local considerations, and support community engagement through mechanisms such as consultation with local researchers and human research protection programs, in a manner consistent with subparagraph (B); and

(2) ensure that human subject research that is subject to the HHS Human Subject Regulations and to the FDA Human Subject Regulations may—

(A) use joint or shared review;

(B) rely upon the review of—

(i) an independent institutional review board; or

(ii) an institutional review board of an entity other than the sponsor of the research; or

(C) use similar arrangements to avoid duplication of effort.

(c) CONSULTATION.—In harmonizing or modifying regulations or guidance under this section, the Secretary shall consult with stakeholders (including researchers, academic organizations, hospitals, institutional research boards, pharmaceutical, biotechnology, and medical device developers, clinical research organizations, patient groups, and others).

(d) TIMING.—The Secretary shall complete the harmonization described in subsection (a) not later than 3 years after the date of enactment of this Act.

(e) PROGRESS REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report on the progress made toward completing such harmonization.

(f) DEFINITIONS.—

(1) HUMAN SUBJECT REGULATIONS.—In this section:

(A) FDA HUMAN SUBJECT REGULATIONS.—The term ''FDA Human Subject Regulations'' means the provisions of parts 50, 56, 312, and 812 of title 21, Code of Federal Regulations (or any successor regulations).

(B) HHS HUMAN SUBJECT REGULATIONS.—The term ''HHS Human Subject Regulations'' means the provisions of subpart A of part 46 of title 45, Code of Federal Regulations (or any successor regulations).

(C) VULNERABLE POPULATION RULES.—The term ''vulnerable population rules'' means—

(i) except in the case of research described in clause (ii), the provisions of subparts B through D of part 46, Code of Federal Regulations (or any successor regulations); and

(ii) in the case of research that is subject to FDA Human Subject Regulations, the provisions applicable to vulnerable populations under part 56 of title 21, Code of Federal Regulations (or any successor regulations) and subpart D of part 50 of such title 21 (or any successor regulations).

(2) INSTITUTIONAL REVIEW BOARD DEFINED.—In this section, the term ''institutional review board'' has the meaning that applies to the term ''institutional review board'' under the HHS Human Subject Regulations.

(B) LEAD INSTITUTIONAL REVIEW BOARD.—The term ''lead institutional review board'' means an institutional review board that otherwise meets the requirements of the HHS Human Subject Regulations and enters into a written agreement with an institution, another institutional review board, a sponsor, or a principal investigator to approve and oversee human subject research that is conducted at multiple locations. References to an institutional review board include an institutional review board that serves a single institution and a lead institutional review board.

SEC. 3024. INFORMED CONSENT WAIVER OR ALTERATION FOR CLINICAL INVESTIGATIONS.

(a) DEVICES.—Section 520(g)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j(g)(3)) is amended—

(1) in subparagraph (D), by striking ''except where subject to such conditions as the Secretary may prescribe, the investigator'' and inserting the following: ''except where, subject to such conditions as the Secretary may prescribe—

''(i) the proposed clinical testing poses no more than minimal risk to the human subject and includes appropriate safeguards to protect the rights, safety, and welfare of the human subject; or

''(ii) the investigator''; and

(2) in the matter following subparagraph (D), by striking ''subparagraph (D)'' and inserting ''subparagraph (D)(ii)''.

(b) DRUGS.—Section 505(i)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i)(4)) is amended by striking ''except where it is not feasible or it is contrary to the best interests of such human beings'' and inserting ''except where it is not feasible, it is contrary to the best interests of such human beings, or the proposed clinical testing poses no more than minimal risk to such human beings and includes appropriate safeguards as prescribed to protect the rights, safety, and welfare of such human beings''.

Subtitle D—Patient Access to Therapies and Information

SEC. 3031. SUMMARY LEVEL REVIEW.

(a) FFDCA.—Section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)) is amended by adding at the end the following:

''(5)(A) The Secretary may rely upon qualified data summaries to support the approval of a supplemental application, with respect to a qualified indication for a drug, submitted under subsection (b), if such supplemental application complies with subparagraph (B).

''(B) A supplemental application is eligible for review as described in subparagraph (A) only if—

''(i) there is existing data available and acceptable to the Secretary demonstrating the safety of the drug; and

''(ii) all data used to develop the qualified data summaries are submitted to the Secretary as part of the supplemental application.

''(C) The Secretary shall post on the Internet website of the Food and Drug Administration and update annually—

''(i) the number of applications reviewed solely under subparagraph (A) or section 351(a)(2)(E) of the Public Health Service Act;

''(ii) the average time for completion of review under subparagraph (A) or section 351(a)(2)(E) of the Public Health Service Act;

''(iii) the average time for review of supplemental applications where the Secretary did not use review flexibility under subparagraph (A) or section 351(a)(2)(E) of the Public Health Service Act; and

''(iv) the number of applications reviewed under subparagraph (A) or section 351(a)(2)(E) of the Public Health Service Act for which the Secretary made use of full data sets in addition to the qualified data summary.

''(D) In this paragraph—

''(i) the term 'qualified indication' means an indication for a drug that the Secretary determines to be appropriate for summary level review under this paragraph; and

''(ii) the term 'qualified data summary' means a summary of clinical data that demonstrates the safety and effectiveness of a drug with respect to a qualified indication.''.

(b) PHSA.—Section 351(a)(2) of the Public Health Service Act (42 U.S.C. 262(a)(2)) is amended by adding at the end the following:

''(E)(i) The Secretary may rely upon qualified data summaries to support the approval of a supplemental application, with respect to a qualified indication for a drug, submitted under this subsection, if such supplemental application complies with the requirements of subparagraph (B) of section 505(c)(5) of the Federal Food, Drug, and Cosmetic Act.

''(ii) In this subparagraph, the terms 'qualified indication' and 'qualified data summary' have the meanings given such terms in section 505(c)(5) of the Federal Food, Drug, and Cosmetic Act.''.

SEC. 3032. EXPANDED ACCESS POLICY.

Chapter V of the Federal Food, Drug, and Cosmetic Act is amended by inserting after section 561 (21 U.S.C. 360bbb) the following:

''SEC. 561A. EXPANDED ACCESS POLICY REQUIRED FOR INVESTIGATIONAL DRUGS.

''(a) IN GENERAL.—The manufacturer or distributor of one or more investigational drugs for the diagnosis, monitoring, or treatment of one or more serious diseases or conditions shall make available the policy of the manufacturer or distributor on evaluating and responding to requests submitted under section 561(b) for provision of such a drug.

''(b) PUBLIC AVAILABILITY OF EXPANDED ACCESS POLICY.—The policies under subsection (a) shall be made public and readily available, such as by posting such policies on a publicly available Internet website. Such policies may be generally applicable to all investigational drugs of such manufacturer or distributor.

''(c) CONTENT OF POLICY.—A policy described in subsection (a) shall include—

''(1) contact information for the manufacturer or distributor to facilitate communication about requests described in subsection (a);

''(2) procedures for making such requests;

''(3) the general criteria the manufacturer or distributor will use to evaluate such requests for individual patients, and for responses to such requests;

''(4) the length of time the manufacturer or distributor anticipates will be necessary to acknowledge receipt of such requests; and

''(5) a hyperlink or other reference to the clinical trial record containing information about the expanded access for such drug that is required under section 402(j)(2)(A)(ii)(II)(gg) of the Public Health Service Act.

''(d) NO GUARANTEE OF ACCESS.—The posting of policies by manufacturers and distributors under subsection (a) shall not serve as a guarantee of access to any specific investigational drug by any individual patient.

''(e) REVISED POLICY.—Nothing in this section shall prevent a manufacturer or distributor from revising a policy required under this section at any time.

''(f) APPLICATION.—This section shall apply to a manufacturer or distributor with respect to an investigational drug beginning on the later of—

''(1) the date that is 60 calendar days after the date of enactment of the 21st Century Cures Act; or

''(2) the first initiation of a phase 2 or phase 3 study (as such terms are defined in section 312.21(b) and (c) of title 21, Code of Federal Regulations (or any successor regulations)) with respect to such investigational drug.''.

SEC. 3033. ACCELERATED APPROVAL FOR REGENERATIVE ADVANCED THERAPIES.

(a) IN GENERAL.—Section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) is amended—

(1) by transferring subsection (e) (relating to construction) so that it appears before subsection (f) (relating to awareness efforts); and

(2) by adding at the end the following:

''(g) REGENERATIVE ADVANCED THERAPY.—

''(1) IN GENERAL.—The Secretary, at the request of the sponsor of a drug, shall facilitate an efficient development program for, and expedite review of, such drug if the drug qualifies as a regenerative advanced therapy under the criteria described in paragraph (2).

''(2) CRITERIA.—A drug is eligible for designation as a regenerative advanced therapy under this subsection if—

''(A) the drug is a regenerative medicine therapy (as defined in paragraph (8));

''(B) the drug is intended to treat, modify, reverse, or cure a serious or life-threatening disease or condition; and

''(C) preliminary clinical evidence indicates that the drug has the potential to address unmet medical needs for such a disease or condition.

''(3) REQUEST FOR DESIGNATION.—The sponsor of a drug may request the Secretary to designate the drug as a regenerative advanced therapy concurrently with, or at any time after, submission of an application for the investigation of the drug under section 505(i) of this Act or section 351(a)(3) of the Public Health Service Act.

''(4) DESIGNATION.—Not later than 60 calendar days after the receipt of a request under paragraph (3), the Secretary shall determine whether the drug that is the subject of the request meets the criteria described in paragraph (2). If the Secretary determines that the drug meets the criteria, the Secretary shall designate the drug as a regenerative advanced therapy and shall take such actions as are appropriate under paragraph (1). If the Secretary determines that a drug does not meet the criteria for such designation, the Secretary shall include with the determination a written description of the rationale for such determination.

''(5) ACTIONS.—The sponsor of a regenerative advanced therapy shall be eligible for the actions to expedite development and review of such therapy under subsection (a)(3)(B), including early interactions to discuss any potential surrogate or intermediate endpoint to be used to support the accelerated approval of an application for the product under subsection (c).

''(6) ACCESS TO EXPEDITED APPROVAL PATHWAYS.—An application for a regenerative advanced therapy under section 505(b)(1) of this Act or section 351(a) of the Public Health Service Act may be—

''(A) eligible for priority review, as described in the Manual of Policies and Procedures of the Food and Drug Administration and goals identified in the letters described in section 101(b) of the Prescription Drug User Fee Amendments of 2012; and

''(B) eligible for accelerated approval under subsection (c), as agreed upon pursuant to subsection (a)(3)(B), through, as appropriate—

''(i) surrogate or intermediate endpoints reasonably likely to predict long-term clinical benefit; or

''(ii) reliance upon data obtained from a meaningful number of sites, including through expansion to additional sites, as appropriate.

''(7) POSTAPPROVAL REQUIREMENTS.—The sponsor of a regenerative advanced therapy that is granted accelerated approval and is subject to the postapproval requirements under subsection

(c) may, as appropriate, fulfill such requirements, as the Secretary may require, through—

''(A) the submission of clinical evidence, clinical studies, patient registries, or other sources of real world evidence, such as electronic health records;

''(B) the collection of larger confirmatory data sets, as agreed upon pursuant to subsection (a)(3)(B); or

''(C) postapproval monitoring of all patients treated with such therapy prior to approval of the therapy.

''(8) DEFINITION.—For purposes of this section, the term 'regenerative medicine therapy' includes cell therapy, therapeutic tissue engineering products, human cell and tissue products, and combination products using any such therapies or products, except for those regulated solely under section 361 of the Public Health Service Act and part 1271 of title 21, Code of Federal Regulations.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section and the amendments made by this section shall be construed to alter the authority of the Secretary of Health and Human Services—

(1) to approve drugs pursuant to the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) and section 351 of the Public Health Service Act (42 U.S.C. 262) as authorized prior to the date of enactment of the 21st Century Cures Act, including the standards of evidence, and applicable conditions, for approval under such Acts; or

(2) to alter the authority of the Secretary to require postapproval studies pursuant to such Acts, as authorized prior to the date of enactment of the 21st Century Cures Act.

(c) CONFORMING AMENDMENT.—Section 506(e)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356(e)(1)) is amended by inserting ''and the 21st Century Cures Act'' after ''Food and Drug Administration Safety and Innovation Act''.

SEC. 3034. GUIDANCE REGARDING DEVICES USED IN THE RECOVERY, ISOLATION, OR DELIVERY OF REGENERATIVE ADVANCED THERAPIES.

(a) DRAFT GUIDANCE.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall issue draft guidance clarifying how, in the context of regenerative advanced therapies, the Secretary will evaluate devices used in the recovery, isolation, or delivery of regenerative advanced therapies. In doing so, the Secretary shall specifically address—

(1) how the Food and Drug Administration intends to simplify and streamline regulatory requirements for combination device and cell or tissue products;

(2) what, if any, intended uses or specific attributes would result in a device used with a regenerative therapy product to be classified as a class III device;

(3) when the Food and Drug Administration considers it is necessary, if ever, for the intended use of a device to be limited to a specific intended use with only one particular type of cell; and

(4) application of the least burdensome approach to demonstrate how a device may be used with more than one cell type.

(b) FINAL GUIDANCE.—Not later than 12 months after the close of the period for public comment on the draft guidance under subsection (a), the Secretary of Health and Human Services shall finalize such guidance.

SEC. 3035. REPORT ON REGENERATIVE ADVANCED THERAPIES.

(a) REPORT TO CONGRESS.—Before March 1 of each calendar year, the Secretary of Health and Human Services shall, with respect to the previous calendar year, submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives on—

(1) the number and type of applications for approval of regenerative advanced therapies filed, approved or licensed as applicable, withdrawn, or denied; and

(2) how many of such applications or therapies, as applicable, were granted accelerated approval or priority review.

(b) REGENERATIVE ADVANCED THERAPY.—In this section, the term ''regenerative advanced therapy'' has the meaning given such term in section 506(g) of the Federal Food, Drug, and Cosmetic Act, as added by section 3033 of this Act.

SEC. 3036. STANDARDS FOR REGENERATIVE MEDICINE AND REGENERATIVE ADVANCED THERAPIES.

Subchapter A of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 506F the following:

''SEC. 506G. STANDARDS FOR REGENERATIVE MEDICINE AND REGENERATIVE ADVANCED THERAPIES.

''(a) IN GENERAL.—Not later than 2 years after the date of enactment of the 21st Century Cures Act, the Secretary, in consultation with the National Institute of Standards and Technology and stakeholders (including regenerative medicine and advanced therapies manufacturers and clinical trial sponsors, contract manufacturers, academic institutions, practicing clinicians, regenerative medicine and advanced therapies industry organizations, and standard setting organizations), shall facilitate an effort to coordinate and prioritize the development of standards and consensus definition of terms, through a public process, to support, through regulatory predictability, the development, evaluation, and review of regenerative medicine therapies and regenerative advanced therapies, including with respect to the manufacturing processes and controls of such products.

''(b) ACTIVITIES.—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall continue to—

''(A) identity opportunities to help advance the development of regenerative medicine therapies and regenerative advanced therapies;

''(B) identify opportunities for the development of laboratory regulatory science research and documentary standards that the Secretary determines would help support the development, evaluation, and review of regenerative medicine therapies and regenerative advanced therapies through regulatory predictability; and

''(C) work with stakeholders, such as those described in subsection (a), as appropriate, in the development of such standards.

''(2) REGULATIONS AND GUIDANCE.—Not later than 1 year after the development of standards as described in subsection (a), the Secretary shall review relevant regulations and guidance and, through a public process, update such regulations and guidance as the Secretary determines appropriate.

''(c) DEFINITIONS.—For purposes of this section, the terms 'regenerative medicine therapy' and 'regenerative advanced therapy' have the meanings given such terms in section 506(g).''.

SEC. 3037. HEALTH CARE ECONOMIC INFORMATION.

Section 502(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(a)) is amended—

(1) by striking ''(a) If its'' and inserting ''(a)(1) If its'';

(2) by striking ''a formulary committee, or other similar entity, in the course of the committee or the entity carrying out its responsibilities for the selection of drugs for managed care or other similar organizations'' and inserting ''a payor, formulary committee, or other similar entity with knowledge and expertise in the area of health care economic analysis, carrying out its responsibilities for the selection of drugs for coverage or reimbursement'';

(3) by striking ''directly relates'' and inserting ''relates'';

(4) by striking ''and is based on competent and reliable scientific evidence. The requirements set forth in section 505(a) or in section 351(a) of the Public Health Service Act shall not apply to health care economic information provided to such a committee or entity in accordance with this paragraph'' and inserting '', is based on competent and reliable scientific evidence, and includes, where applicable, a conspicuous and prominent statement describing any material differences between the health care economic information and the labeling approved for the drug under section 505 or under section 351 of the Public Health Service Act. The requirements set forth in section 505(a) or in subsections (a) and (k) of section 351 of the Public Health Service Act shall not apply to health care economic information provided to such a payor, committee, or entity in accordance with this paragraph''; and

(5) by striking ''In this paragraph, the term'' and all that follows and inserting the following:

''(2)(A) For purposes of this paragraph, the term 'health care economic information' means any analysis (including the clinical data, inputs, clinical or other assumptions, methods, results, and other components underlying or comprising the analysis) that identifies, measures, or describes the economic consequences, which may be based on the separate or aggregated clinical consequences of the represented health outcomes, of the use of a drug. Such analysis may be comparative to the use of another drug, to another health care intervention, or to no intervention.

''(B) Such term does not include any analysis that relates only to an indication that is not approved under section 505 or under section 351 of the Public Health Service Act for such drug.''.

SEC. 3038. COMBINATION PRODUCT INNOVATION.

(a) IN GENERAL.—Section 503(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(g)) is amended—

(1) by striking paragraph (3);

(2) by redesignating paragraph (2) as paragraph (7);

(3) by redesignating paragraphs (4) and (5) as paragraphs (8) and (9), respectively;

(4) by striking ''(g)(1)'' and all that follows through the end of paragraph (1) and inserting the following:

''(g)(1)(A) The Secretary shall, in accordance with this subsection, assign a primary agency center to regulate products that constitute a combination of a drug, device, or biological product.

''(B) The Secretary shall conduct the premarket review of any combination product under a single application, whenever appropriate.

''(C) For purposes of this subsection, the term 'primary mode of action' means the single mode of action of a combination product expected to make the greatest contribution to the overall intended therapeutic effects of the combination product.

''(D) The Secretary shall determine the primary mode of action of the combination product. If the Secretary determines that the primary mode of action is that of—

''(i) a drug (other than a biological product), the agency center charged with premarket review of drugs shall have primary jurisdiction;

''(ii) a device, the agency center charged with premarket review of devices shall have primary jurisdiction; or

''(iii) a biological product, the agency center charged with premarket review of biological products shall have primary jurisdiction.

''(E) In determining the primary mode of action of a combination product, the Secretary shall not determine that the primary mode of action is that of a drug or biological product solely because the combination product has any chemical action within or on the human body.

''(F) If a sponsor of a combination product disagrees with the determination under subparagraph (D)—

''(i) such sponsor may request, and the Secretary shall provide, a substantive rationale to

such sponsor that references scientific evidence provided by the sponsor and any other scientific evidence relied upon by the Secretary to support such determination; and

''(ii)(I) the sponsor of the combination product may propose one or more studies (which may be nonclinical, clinical, or both) to establish the relevance, if any, of the chemical action in achieving the primary mode of action of such product;

''(II) if the sponsor proposes any such studies, the Secretary and the sponsor of such product shall collaborate and seek to reach agreement, within a reasonable time of such proposal, not to exceed 90 calendar days, on the design of such studies; and

''(III) if an agreement is reached under subclause (II) and the sponsor conducts one or more of such studies, the Secretary shall consider the data resulting from any such study when reevaluating the determination of the primary mode of action of such product, and unless and until such reevaluation has occurred and the Secretary issues a new determination, the determination of the Secretary under subparagraph (D) shall remain in effect.

''(2)(A)(i) To establish clarity and certainty for the sponsor, the sponsor of a combination product may request a meeting on such combination product. If the Secretary concludes that a determination of the primary mode of action pursuant to paragraph (1)(D) is necessary, the sponsor may request such meeting only after the Secretary makes such determination. If the sponsor submits a written meeting request, the Secretary shall, not later than 75 calendar days after receiving such request, meet with the sponsor of such combination product.

''(ii) A meeting under clause (i) may—

''(I) address the standards and requirements for market approval or clearance of the combination product;

''(II) address other issues relevant to such combination product, such as requirements related to postmarket modification of such combination product and good manufacturing practices applicable to such combination product; and

''(III) identify elements under subclauses (I) and (II) that may be more appropriate for discussion and agreement with the Secretary at a later date given that scientific or other information is not available, or agreement is otherwise not feasible regarding such elements, at the time a request for such meeting is made.

''(iii) Any agreement under this subparagraph shall be in writing and made part of the administrative record by the Secretary.

''(iv) Any such agreement shall remain in effect, except—

''(I) upon the written agreement of the Secretary and the sponsor or applicant; or

''(II) pursuant to a decision by the director of the reviewing division of the primary agency center, or a person more senior than such director, in consultation with consulting centers and the Office, as appropriate, that an issue essential to determining whether the standard for market clearance or other applicable standard under this Act or the Public Health Service Act applicable to the combination product has been identified since the agreement was reached, or that deviating from the agreement is otherwise justifiable based on scientific evidence, for public health reasons.

''(3) For purposes of conducting the premarket review of a combination product that contains an approved constituent part described in paragraph (4), the Secretary may require that the sponsor of such combination product submit to the Secretary only data or information that the Secretary determines is necessary to meet the standard for clearance or approval, as applicable, under this Act or the Public Health Service Act, including any incremental risks and benefits posed by such combination product, using a risk-based approach and taking into account any prior finding of safety and effectiveness or substantial equivalence for the approved constituent part relied upon by the applicant in accordance with paragraph (5).

''(4) For purposes of paragraph (3), an approved constituent part is—

''(A) a drug constituent part of a combination product being reviewed in a single application or request under section 515, 510(k), or 513(f)(2) (submitted in accordance with paragraph (5)), that is an approved drug, provided such application or request complies with paragraph (5);

''(B) a device constituent part approved under section 515 that is referenced by the sponsor and that is available for use by the Secretary under section 520(h)(4); or

''(C) any constituent part that was previously approved, cleared, or classified under section 505, 510(k), 513(f)(2), or 515 of this Act for which the sponsor has a right of reference or any constituent part that is a nonprescription drug, as defined in section 760(a)(2).

''(5)(A) If an application is submitted under section 515 or 510(k) or a request is submitted under section 513(f)(2), consistent with any determination made under paragraph (1)(D), for a combination product containing as a constituent part an approved drug—

''(i) the application or request shall include the certification or statement described in section 505(b)(2); and

''(ii) the applicant or requester shall provide notice as described in section 505(b)(3).

''(B) For purposes of this paragraph and paragraph (4), the term 'approved drug' means an active ingredient—

''(i) that was in an application previously approved under section 505(c);

''(ii) where such application is relied upon by the applicant submitting the application or request described in subparagraph (A);

''(iii) for which full reports of investigations that have been made to show whether such drug is safe for use and whether such drug is effective in use were not conducted by or for the applicant submitting the application or request described in subparagraph (A); and

''(iv) for which the applicant submitting the application or request described in subparagraph (A) has not obtained a right of reference or use from the person by or for whom the investigations described in clause (iii) were conducted.

''(C) The following provisions shall apply with respect to an application or request described in subparagraph (A) to the same extent and in the same manner as if such application or request were an application described in section 505(b)(2) that referenced the approved drug:

''(i) Subparagraphs (A), (B), (C), and (D) of section 505(c)(3).

''(ii) Clauses (ii), (iii), and (iv) of section 505(c)(3)(E).

''(iii) Subsections (b) and (c) of section 505A.

''(iv) Section 505E(a).

''(v) Section 527(a).

''(D) Notwithstanding any other provision of this subsection, an application or request for classification for a combination product described in subparagraph (A) shall be considered an application submitted under section 505(b)(2) for purposes of section 271(e)(2)(A) of title 35, United States Code.

''(6) Nothing in this subsection shall be construed as prohibiting a sponsor from submitting separate applications for the constituent parts of a combination product, unless the Secretary determines that a single application is necessary.'';

(5) in paragraph (8) (as redesignated by paragraph (3))—

(A) in subparagraph (C)—

(i) by amending clause (i) to read as follows:

''(i) In carrying out this subsection, the Office shall help to ensure timely and effective premarket review that involves more than one agency center by coordinating such reviews, overseeing the timeliness of such reviews, and overseeing the alignment of feedback regarding such reviews.'';

(ii) in clause (ii), by inserting ''and alignment'' after ''the timeliness'' each place it appears; and

(iii) by adding at the end the following new clauses:

''(iii) The Office shall ensure that, with respect to a combination product, a designated person or persons in the primary agency center is the primary point or points of contact for the sponsor of such combination product. The Office shall also coordinate communications to and from any consulting center involved in such premarket review, if requested by such primary agency center or any such consulting center. Agency communications and commitments, to the extent consistent with other provisions of law and the requirements of all affected agency centers, from the primary agency center shall be considered as communication from the Secretary on behalf of all agency centers involved in the review.

''(iv) The Office shall, with respect to the premarket review of a combination product—

''(I) ensure that any meeting between the Secretary and the sponsor of such product is attended by each agency center involved in the review, as appropriate;

''(II) ensure that each consulting agency center has completed its premarket review and provided the results of such review to the primary agency center in a timely manner; and

''(III) ensure that each consulting center follows the guidance described in clause (vi) and advises, as appropriate, on other relevant regulations, guidances, and policies.

''(v) In seeking agency action with respect to a combination product, the sponsor of such product—

''(I) shall identify the product as a combination product; and

''(II) may request in writing the participation of representatives of the Office in meetings related to such combination product, or to have the Office otherwise engage on such regulatory matters concerning the combination product.

''(vi) Not later than 4 years after the date of enactment of the 21st Century Cures Act, and after a public comment period of not less than 60 calendar days, the Secretary shall issue a final guidance that describes—

''(I) the structured process for managing presubmission interactions with sponsors developing combination products;

''(II) the best practices for ensuring that the feedback in such pre-submission interactions represents the Agency's best advice based on the information provided during such pre-submission interactions;

''(III) the information that is required to be submitted with a meeting request under paragraph (2), how such meetings relate to other types of meetings in the Food and Drug Administration, and the form and content of any agreement reached through a meeting under such paragraph (2);''; and

(B) in subparagraph (G)—

(i) in the matter preceding clause (i), by inserting ''(except with respect to clause (iv), beginning not later than one year after the date of the enactment of the 21st Century Cures Act)'' after ''enactment of this paragraph'';

(ii) in clause (ii), by striking ''and'' at the end;

(iii) in clause (iii), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following new clause:

''(iv) identifying the percentage of combination products for which a dispute resolution, with respect to premarket review, was requested by the combination product's sponsor.''; and

(6) in paragraph (9) (as redesignated by paragraph (3))—

(A) in subparagraph (C)—

(i) in clause (i), by striking the comma at the end and inserting a semicolon;

(ii) in clause (ii), by striking '', and'' at the end and inserting a semicolon;

(iii) in clause (iii), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following:

''(iv) de novo classification under section 513(a)(1).''; and

(B) by adding at the end the following:

''(D) The terms 'premarket review' and 'reviews' include all activities of the Food and Drug Administration conducted prior to approval or clearance of an application, notification, or request for classification submitted under section 505, 510(k), 513(f)(2), 515, or 520 of this Act or under section 351 of the Public Health Service Act, including with respect to investigational use of the product.''.

(b) INFORMATION FOR APPROVAL OF COMBINATION PRODUCTS.—Section 520(h)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j(h)(4)) is amended—

(1) in subparagraph (A), by striking ''Any information'' and inserting ''Subject to subparagraph (C), any information''; and

(2) by adding at the end the following new subparagraph:

''(C) No information contained in an application for premarket approval filed with the Secretary pursuant to section 515(c) may be used to approve or clear any application submitted under section 515 or 510(k) or to classify a product under section 513(f)(2) for a combination product containing as a constituent part an approved drug (as defined in section 503(g)(5)(B)) unless—

''(i) the application includes the certification or statement referenced in section 503(g)(5)(A);

''(ii) the applicant provides notice as described in section 503(g)(5)(A); and

''(iii) the Secretary's approval of such application is subject to the provisions in section 503(g)(5)(C).''.

(c) VARIATIONS FROM CGMP STREAMLINED APPROACH.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall identify types of combination products and manufacturing processes with respect to which the Secretary proposes that good manufacturing processes may be adopted that vary from the requirements set forth in section 4.4 of title 21, Code of Federal Regulations (or any successor regulations) or that the Secretary proposes can satisfy the requirements in section 4.4 through alternative or streamlined mechanisms. The Secretary shall identify such types, variations from such requirements, and such mechanisms, in a proposed list published in the Federal Register. After a public comment period regarding the appropriate good manufacturing practices for such types, the Secretary shall publish a final list in the Federal Register, notwithstanding section 553 of title 5, United States Code. The Secretary shall evaluate such types, variations, and mechanisms using a risk-based approach. The Secretary shall periodically review such final list.

Subtitle E—Antimicrobial Innovation and Stewardship

SEC. 3041. ANTIMICROBIAL RESISTANCE MONITORING.

(a) IN GENERAL.—Section 319E of the Public Health Service Act (42 U.S.C. 247d–5) is amended—

(1) by redesignating subsections (f) and (g) as subsections (l) and (m), respectively; and

(2) by inserting after subsection (e), the following:

''(f) MONITORING AT FEDERAL HEALTH CARE FACILITIES.—The Secretary shall encourage reporting on aggregate antimicrobial drug use and antimicrobial resistance to antimicrobial drugs and the implementation of antimicrobial stewardship programs by health care facilities of the Department of Defense, the Department of Veterans Affairs, and the Indian Health Service and shall provide technical assistance to the Secretary of Defense and the Secretary of Veterans Affairs, as appropriate and upon request.

''(g) REPORT ON ANTIMICROBIAL RESISTANCE IN HUMANS AND USE OF ANTIMICROBIAL DRUGS.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, and annually thereafter, the Secretary shall prepare and make publicly available data and information concerning—

''(1) aggregate national and regional trends of antimicrobial resistance in humans to antimicrobial drugs, including such drugs approved under section 506(h) of the Federal Food, Drug, and Cosmetic Act;

''(2) antimicrobial stewardship, which may include summaries of State efforts to address antimicrobial resistance in humans to antimicrobial drugs and antimicrobial stewardship; and

''(3) coordination between the Director of the Centers for Disease Control and Prevention and the Commissioner of Food and Drugs with respect to the monitoring of—

''(A) any applicable resistance under paragraph (1); and

''(B) drugs approved under section 506(h) of the Federal Food, Drug, and Cosmetic Act.

''(h) INFORMATION RELATED TO ANTIMICROBIAL STEWARDSHIP PROGRAMS.—The Secretary shall, as appropriate, disseminate guidance, educational materials, or other appropriate materials related to the development and implementation of evidence-based antimicrobial stewardship programs or practices at health care facilities, such as nursing homes and other long-term care facilities, ambulatory surgical centers, dialysis centers, outpatient clinics, and hospitals, including community and rural hospitals.

''(i) SUPPORTING STATE-BASED ACTIVITIES TO COMBAT ANTIMICROBIAL RESISTANCE.—The Secretary shall continue to work with State and local public health departments on statewide or regional programs related to antimicrobial resistance. Such efforts may include activities to related to—

''(1) identifying patterns of bacterial and fungal resistance in humans to antimicrobial drugs;

''(2) preventing the spread of bacterial and fungal infections that are resistant to antimicrobial drugs; and

''(3) promoting antimicrobial stewardship.

''(j) ANTIMICROBIAL RESISTANCE AND STEWARDSHIP ACTIVITIES.—

''(1) IN GENERAL.—For the purposes of supporting stewardship activities, examining changes in antimicrobial resistance, and evaluating the effectiveness of section 506(h) of the Federal Food, Drug, and Cosmetic Act, the Secretary shall—

''(A) provide a mechanism for facilities to report data related to their antimicrobial stewardship activities (including analyzing the outcomes of such activities); and

''(B) evaluate—

''(i) antimicrobial resistance data using a standardized approach; and

''(ii) trends in the utilization of drugs approved under such section 506(h) with respect to patient populations.

''(2) USE OF SYSTEMS.—The Secretary shall use available systems, including the National Healthcare Safety Network or other systems identified by the Secretary, to fulfill the requirements or conduct activities under this section.

''(k) ANTIMICROBIAL.—For purposes of subsections (f) through (j), the term 'antimicrobial' includes any antibacterial or antifungal drugs, and may include drugs that eliminate or inhibit the growth of other microorganisms, as appropriate.''.

(b) AVAILABILITY OF DATA.—The Secretary shall make the data collected pursuant to this subsection public. Nothing in this subsection shall be construed as authorizing the Secretary to disclose any information that is a trade secret or confidential information subject to section 552(b)(4) of title 5, United States Code, or section 1905 of title 18, United States Code.

SEC. 3042. LIMITED POPULATION PATHWAY.

Section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356), as amended by section 3033, is further amended by adding at the end the following:

''(h) LIMITED POPULATION PATHWAY FOR ANTIBACTERIAL AND ANTIFUNGAL DRUGS.—

''(1) IN GENERAL.—The Secretary may approve an antibacterial or antifungal drug, alone or in combination with one or more other drugs, as a limited population drug pursuant to this subsection only if—

''(A) the drug is intended to treat a serious or life-threatening infection in a limited population of patients with unmet needs;

''(B) the standards for approval under section 505(c) and (d), or the standards for licensure under section 351 of the Public Health Service Act, as applicable, are met; and

''(C) the Secretary receives a written request from the sponsor to approve the drug as a limited population drug pursuant to this subsection.

''(2) BENEFIT-RISK CONSIDERATION.—The Secretary's determination of safety and effectiveness of an antibacterial or antifungal drug shall reflect the benefit-risk profile of such drug in the intended limited population, taking into account the severity, rarity, or prevalence of the infection the drug is intended to treat and the availability or lack of alternative treatment in such limited population. Such drug may be approved under this subsection notwithstanding a lack of evidence to fully establish a favorable benefit-risk profile in a population that is broader than the intended limited population.

''(3) ADDITIONAL REQUIREMENTS.—A drug approved under this subsection shall be subject to the following requirements, in addition to any other applicable requirements of this Act:

''(A) LABELING.—To indicate that the safety and effectiveness of a drug approved under this subsection has been demonstrated only with respect to a limited population—

''(i) all labeling and advertising of an antibacterial or antifungal drug approved under this subsection shall contain the statement 'Limited Population' in a prominent manner and adjacent to, and not more prominent than—

''(I) the proprietary name of such drug, if any; or

''(II) if there is no proprietary name, the established name of the drug, if any, as defined in section 503(e)(3), or, in the case of a drug that is a biological product, the proper name, as defined by regulation; and

''(ii) the prescribing information for the drug required by section 201.57 of title 21, Code of Federal Regulations (or any successor regulation) shall also include the following statement: 'This drug is indicated for use in a limited and specific population of patients.'.

''(B) PROMOTIONAL MATERIAL.—The sponsor of an antibacterial or antifungal drug subject to this subsection shall submit to the Secretary copies of all promotional materials related to such drug at least 30 calendar days prior to dissemination of the materials.

''(4) OTHER PROGRAMS.—A sponsor of a drug that seeks approval of a drug under this subsection may also seek designation or approval, as applicable, of such drug under other applicable sections or subsections of this Act or the Public Health Service Act.

''(5) GUIDANCE.—Not later than 18 months after the date of enactment of the 21st Century Cures Act, the Secretary shall issue draft guidance describing criteria, processes, and other general considerations for demonstrating the safety and effectiveness of limited population antibacterial and antifungal drugs. The Secretary shall publish final guidance within 18 months of the close of the public comment period on such draft guidance. The Secretary may approve antibacterial and antifungal drugs under this subsection prior to issuing guidance under this paragraph.

''(6) ADVICE.—The Secretary shall provide prompt advice to the sponsor of a drug for

which the sponsor seeks approval under this subsection to enable the sponsor to plan a development program to obtain the necessary data for such approval, and to conduct any additional studies that would be required to gain approval of such drug for use in a broader population.

''(7) TERMINATION OF LIMITATIONS.—If, after approval of a drug under this subsection, the Secretary approves a broader indication for such drug under section 505(b) or section 351(a) of the Public Health Service Act, the Secretary may remove any postmarketing conditions, including requirements with respect to labeling and review of promotional materials under paragraph (3), applicable to the approval of the drug under this subsection.

''(8) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to alter the authority of the Secretary to approve drugs pursuant to this Act or section 351 of the Public Health Service Act, including the standards of evidence and applicable conditions for approval under such Acts, the standards of approval of a drug under such Acts, or to alter the authority of the Secretary to monitor drugs pursuant to such Acts.

''(9) REPORTING AND ACCOUNTABILITY.—

''(A) BIENNIAL REPORTING.—The Secretary shall report to Congress not less often than once every 2 years on the number of requests for approval, and the number of approvals, of an antibacterial or antifungal drug under this subsection.

''(B) GAO REPORT.—Not later than December 2021, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor and Pensions of the Senate a report on the coordination of activities required under section 319E of the Public Health Service Act. Such report shall include a review of such activities, and the extent to which the use of the pathway established under this subsection has streamlined premarket approval for antibacterial or antifungal drugs for limited populations, if such pathway has functioned as intended, if such pathway has helped provide for safe and effective treatment for patients, if such premarket approval would be appropriate for other categories of drugs, and if the authorities under this subsection have affected antibacterial or antifungal resistance.''.

SEC. 3043. PRESCRIBING AUTHORITY.

Nothing in this subtitle, or an amendment made by this subtitle, shall be construed to restrict the prescribing of antimicrobial drugs or other products, including drugs approved under subsection (h) of section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) (as added by section 3042), by health care professionals, or to limit the practice of health care.

SEC. 3044. SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA FOR MICROORGANISMS; ANTIMICROBIAL SUSCEPTIBILITY TESTING DEVICES.

(a) IN GENERAL.—Subchapter A of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 511 the following:

''SEC. 511A. SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA FOR MICROORGANISMS.

''(a) PURPOSE; IDENTIFICATION OF CRITERIA.—

''(1) PURPOSE.—The purpose of this section is to clarify the Secretary's authority to—

''(A) efficiently update susceptibility test interpretive criteria for antimicrobial drugs when necessary for public health, due to, among other things, the constant evolution of microorganisms that leads to the development of resistance to drugs that have been effective in decreasing morbidity and mortality for patients, which warrants unique management of antimicrobial drugs that is inappropriate for most other drugs in order to delay or prevent the development of further resistance to existing therapies;

''(B) provide for public notice of the availability of recognized interpretive criteria and interpretive criteria standards; and

''(C) clear under section 510(k), classify under section 513(f)(2), or approve under section 515, antimicrobial susceptibility testing devices utilizing updated, recognized susceptibility test interpretive criteria to characterize the in vitro susceptibility of particular bacteria, fungi, or other microorganisms, as applicable, to antimicrobial drugs.

''(2) IDENTIFICATION OF CRITERIA.—The Secretary shall identify appropriate susceptibility test interpretive criteria with respect to antimicrobial drugs—

''(A) if such criteria are available on the date of approval of the drug under section 505 of this Act or licensure of the drug under section 351 of the Public Health Service Act (as applicable), upon such approval or licensure; or

''(B) if such criteria are unavailable on such date, on the date on which such criteria are available for such drug.

''(3) BASES FOR INITIAL IDENTIFICATION.—The Secretary shall identify appropriate susceptibility test interpretive criteria under paragraph (2), based on the Secretary's review of, to the extent available and relevant—

''(A) preclinical and clinical data, including pharmacokinetic, pharmacodynamic, and epidemiological data;

''(B) the relationship of susceptibility test interpretive criteria to morbidity and mortality associated with the disease or condition for which such drug is used; and

''(C) such other evidence and information as the Secretary considers appropriate.

''(b) SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA WEBSITE.—

''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the 21st Century Cures Act, the Secretary shall establish, and maintain thereafter, on the website of the Food and Drug Administration, a dedicated website that contains a list of any appropriate new or updated susceptibility test interpretive criteria standards and interpretive criteria in accordance with paragraph (2) (referred to in this section as the 'Interpretive Criteria Website').

''(2) LISTING OF SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA STANDARDS AND INTERPRETIVE CRITERIA.—

''(A) IN GENERAL.—The list described in paragraph (1) shall consist of any new or updated susceptibility test interpretive criteria standards that are—

''(i) established by a nationally or internationally recognized standard development organization that—

''(I) establishes and maintains procedures to address potential conflicts of interest and ensure transparent decisionmaking;

''(II) holds open meetings to ensure that there is an opportunity for public input by interested parties, and establishes and maintains processes to ensure that such input is considered in decisionmaking; and

''(III) permits its standards to be made publicly available, through the National Library of Medicine or another similar source acceptable to the Secretary; and

''(ii) recognized in whole, or in part, by the Secretary under subsection (c).

''(B) OTHER LIST.—The Interpretive Criteria Website shall, in addition to the list described in subparagraph (A), include a list of interpretive criteria, if any, that the Secretary has determined to be appropriate with respect to legally marketed antimicrobial drugs, where—

''(i) the Secretary does not recognize, in whole or in part, an interpretive criteria standard described under subparagraph (A) otherwise applicable to such a drug;

''(ii) the Secretary withdraws under subsection (c)(1)(A) recognition of a standard, in whole or in part, otherwise applicable to such a drug;

''(iii) the Secretary approves an application under section 505 of this Act or section 351 of the Public Health Service Act, as applicable, with respect to marketing of such a drug for which there are no relevant interpretive criteria included in a standard recognized by the Secretary under subsection (c); or

''(iv) because the characteristics of such a drug differ from other drugs with the same active ingredient, the interpretive criteria with respect to such drug—

''(I) differ from otherwise applicable interpretive criteria included in a standard listed under subparagraph (A) or interpretive criteria otherwise listed under this subparagraph; and

''(II) are determined by the Secretary to be appropriate for the drug.

''(C) REQUIRED STATEMENTS.—The Interpretive Criteria Website shall include statements conveying—

''(i) that the website provides information about the in vitro susceptibility of bacteria, fungi, or other microorganisms, as applicable to a certain drug (or drugs);

''(ii) that—

''(I) the safety and efficacy of such drugs in treating clinical infections due to such bacteria, fungi, or other microorganisms, as applicable, may or may not have been established in adequate and well-controlled clinical trials in order for the susceptibility information described in clause (i) to be included on the website; and

''(II) the clinical significance of such susceptibility information in such instances is unknown;

''(iii) that the approved product labeling for specific drugs provides the uses for which the Secretary has approved the product; and

''(iv) any other information that the Secretary determines appropriate to adequately convey the meaning of the data supporting the recognition or listing of susceptibility test interpretive criteria standards or susceptibility test interpretive criteria included on the website.

''(3) NOTICE.—Not later than the date on which the Interpretive Criteria Website is established, the Secretary shall publish a notice of that establishment in the Federal Register.

''(4) INAPPLICABILITY OF MISBRANDING PROVISION.—The inclusion in the approved labeling of an antimicrobial drug of a reference or hyperlink to the Interpretive Criteria Website, in and of itself, shall not cause the drug to be misbranded in violation of section 502.

''(5) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—Nothing in this section shall be construed as authorizing the Secretary to disclose any information that is a trade secret or confidential information subject to section 552(b)(4) of title 5, United States Code.

''(c) RECOGNITION OF SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA.—

''(1) EVALUATION AND PUBLICATION.—

''(A) IN GENERAL.—Beginning on the date of the establishment of the Interpretive Criteria Website, and at least every 6 months thereafter, the Secretary shall—

''(i) evaluate any appropriate new or updated susceptibility test interpretive criteria standards established by a nationally or internationally recognized standard development organization described in subsection (b)(2)(A)(i); and

''(ii) publish on the public website of the Food and Drug Administration a notice—

''(I) withdrawing recognition of any different susceptibility test interpretive criteria standard, in whole or in part;

''(II) recognizing the new or updated standards;

''(III) recognizing one or more parts of the new or updated interpretive criteria specified in such a standard and declining to recognize the remainder of such standard; and

''(IV) making any necessary updates to the lists under subsection (b)(2).

''(B) UPON APPROVAL OF A DRUG.—Upon the approval of an initial or supplemental application for an antimicrobial drug under section 505 of this Act or section 351 of the Public Health Service Act, as applicable, where such approval is based on susceptibility test interpretive criteria which differ from those contained in a standard recognized, or from those otherwise

listed, by the Secretary pursuant to this subsection, or for which there are no relevant interpretive criteria standards recognized, or interpretive criteria otherwise listed, by the Secretary pursuant to this subsection, the Secretary shall update the lists under subparagraphs (A) and (B) of subsection (b)(2) to include the susceptibility test interpretive criteria upon which such approval was based.

''(2) BASES FOR UPDATING INTERPRETIVE CRITERIA STANDARDS.—In evaluating new or updated susceptibility test interpretive criteria standards under paragraph (1)(A), the Secretary may consider—

''(A) the Secretary's determination that such a standard is not applicable to a particular drug because the characteristics of the drug differ from other drugs with the same active ingredient;

''(B) information provided by interested third parties, including public comment on the annual compilation of notices published under paragraph (3);

''(C) any bases used to identify susceptibility test interpretive criteria under subsection (a)(2); and

''(D) such other information or factors as the Secretary determines appropriate.

''(3) ANNUAL COMPILATION OF NOTICES.—Each year, the Secretary shall compile the notices published under paragraph (1)(A) and publish such compilation in the Federal Register and provide for public comment. If the Secretary receives comments, the Secretary shall review such comments and, if the Secretary determines appropriate, update pursuant to this subsection susceptibility test interpretive criteria standards or criteria—

''(A) recognized by the Secretary under this subsection; or

''(B) otherwise listed on the Interpretive Criteria Website under subsection (b)(2).

''(4) RELATION TO SECTION 514(C).—Any susceptibility test interpretive standard recognized under this subsection or any criteria otherwise listed under subsection (b)(2)(B) shall be deemed to be recognized as a standard by the Secretary under section 514(c)(1).

''(5) VOLUNTARY USE OF INTERPRETIVE CRITERIA.—Nothing in this section prohibits a person from seeking approval or clearance of a drug or device, or changes to the drug or the device, on the basis of susceptibility test interpretive criteria which differ from those contained in a standard recognized, or from those otherwise listed, by the Secretary pursuant to subsection (b)(2).

''(d) ANTIMICROBIAL DRUG LABELING.—

''(1) DRUGS MARKETED PRIOR TO ESTABLISHMENT OF INTERPRETIVE CRITERIA WEBSITE.—

''(A) IN GENERAL.—With respect to an antimicrobial drug lawfully introduced or delivered for introduction into interstate commerce for commercial distribution before the establishment of the Interpretive Criteria Website, a holder of an approved application under section 505 of this Act or section 351 of the Public Health Service Act, as applicable, for each such drug, not later than 1 year after establishment of the Interpretive Criteria Website described in subsection (b)(1), shall remove susceptibility test interpretive criteria, if any, and related information from the approved drug labeling and replace it with a reference to the Interpretive Criteria Website.

''(B) LABELING CHANGES.—The labeling changes required by this section shall be considered a minor change under section 314.70 of title 21, Code of Federal Regulations (or any successor regulations) that may be implemented through documentation in the next applicable annual report.

''(2) DRUGS MARKETED SUBSEQUENT TO ESTABLISHMENT OF INTERPRETIVE CRITERIA WEBSITE.—With respect to antimicrobial drugs approved on or after the date of the establishment of the Interpretive Criteria Website described in subsection (b)(1), the labeling for such a drug shall include, in lieu of susceptibility test interpretive criteria and related information, a reference to such Website.

''(e) SPECIAL CONDITION FOR MARKETING OF ANTIMICROBIAL SUSCEPTIBILITY TESTING DEVICES.—

''(1) IN GENERAL.—Notwithstanding sections 501, 502, 505, 510, 513, and 515, if the conditions specified in paragraph (2) are met (in addition to other applicable provisions under this chapter) with respect to an antimicrobial susceptibility testing device described in subsection (f)(1), the Secretary may authorize the marketing of such device for a use described in such subsection.

''(2) CONDITIONS APPLICABLE TO ANTIMICROBIAL SUSCEPTIBILITY TESTING DEVICES.—The conditions specified in this paragraph are the following:

''(A) The device is used to make a determination of susceptibility using susceptibility test interpretive criteria that are—

''(i) included in a standard recognized by the Secretary under subsection (c); or

''(ii) otherwise listed on the Interpretive Criteria Website under subsection (b)(2).

''(B) The labeling of such device includes statements conveying—

''(i) that the device provides information about the in vitro susceptibility of bacteria, fungi, or other microorganisms, as applicable to antimicrobial drugs;

''(ii) that—

''(I) the safety and efficacy of such drugs in treating clinical infections due to such bacteria, fungi, or other microorganisms, as applicable, may or may not have been established in adequate and well-controlled clinical trials in order for the device to report the susceptibility of such bacteria, fungi, or other microorganisms, as applicable, to such drugs; and

''(II) the clinical significance of such susceptibility information in those instances is unknown;

''(iii) that the approved labeling for drugs tested using such a device provides the uses for which the Secretary has approved such drugs; and

''(iv) any other information the Secretary determines appropriate to adequately convey the meaning of the data supporting the recognition or listing of susceptibility test interpretive criteria standards or susceptibility test interpretive criteria described in subparagraph (A).

''(C) The antimicrobial susceptibility testing device meets all other requirements to be cleared under section 510(k), classified under section 513(f)(2), or approved under section 515.

''(f) DEFINITIONS.—In this section:

''(1) The term 'antimicrobial susceptibility testing device' means a device that utilizes susceptibility test interpretive criteria to determine and report the in vitro susceptibility of certain microorganisms to a drug (or drugs).

''(2) The term 'qualified infectious disease product' means a qualified infectious disease product designated under section 505E(d).

''(3) The term 'susceptibility test interpretive criteria' means—

''(A) one or more specific numerical values which characterize the susceptibility of bacteria or other microorganisms to the drug tested; and

''(B) related categorizations of such susceptibility, including categorization of the drug as susceptible, intermediate, resistant, or such other term as the Secretary determines appropriate.

''(4)(A) The term 'antimicrobial drug' means, subject to subparagraph (B), a systemic antibacterial or antifungal drug that—

''(i) is intended for human use in the treatment of a disease or condition caused by a bacterium or fungus;

''(ii) may include a qualified infectious disease product designated under section 505E(d); and

''(iii) is subject to section 503(b)(1).

''(B) If provided by the Secretary through regulations, such term may include—

''(i) drugs other than systemic antibacterial and antifungal drugs; and

''(ii) biological products (as such term is defined in section 351 of the Public Health Service Act) to the extent such products exhibit antimicrobial activity.

''(5) The term 'interpretive criteria standard' means a compilation of susceptibility test interpretive criteria developed by a standard development organization that meets the criteria set forth in subsection (b)(2)(A)(i).

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to—

''(1) alter the standards of evidence under subsection (c) or (d) of section 505 (including the substantial evidence standard under section 505(d)) or under section 351 of the Public Health Service Act (as applicable); or

''(2) with respect to clearing devices under section 510(k), classifying devices under section 513(f)(2), or approving devices under section 515—

''(A) apply with respect to any drug, device, or biological product, in any context other than an antimicrobial drug and an antimicrobial susceptibility testing device that uses susceptibility test interpretive criteria to characterize and report the susceptibility of certain bacteria, fungi, or other microorganisms, as applicable, to such drug to reflect patient morbidity and mortality in accordance with this section; or

''(B) unless specifically stated, have any effect on authorities provided under other sections of this Act, including any regulations issued under such sections.''.

(b) CONFORMING AMENDMENTS.—

(1) REPEAL OF PRIOR RELATED AUTHORITY.—Section 1111 of the Food and Drug Administration Amendments Act of 2007 (42 U.S.C. 247d–5a), relating to identification of clinically susceptible concentrations of antimicrobials, is repealed.

(2) ADDITION TO CATEGORIES OF MISBRANDED DRUGS.—Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amended by adding at the end the following:

''(dd) If it is an antimicrobial drug, as defined in section 511A(f), and its labeling fails to conform with the requirements under section 511A(d).''.

(3) RECOGNITION OF INTERPRETIVE CRITERIA STANDARD AS DEVICE STANDARD.—Section 514(c)(1)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360d(c)(1)(A)) is amended by inserting after ''the Secretary shall, by publication in the Federal Register'' the following: ''(or, with respect to a susceptibility test interpretive criteria standard under section 511A, by posting on the Interpretive Criteria Website in accordance with such section)''.

(c) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the progress made in implementing section 511A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360a), as added by subsection (a).

(d) REQUESTS FOR UPDATES TO INTERPRETIVE CRITERIA WEBSITE.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information from interested parties regarding updating the lists established under section 511A(b) of the Federal Food, Drug, and Cosmetic Act and posted on the Interpretive Criteria Website established under section 511A(c) of such Act.

Subtitle F—Medical Device Innovations

SEC. 3051. BREAKTHROUGH DEVICES.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 515B, as added by section 3034(b), the following:

"SEC. 515C. BREAKTHROUGH DEVICES.

''(a) PURPOSE.—The purpose of this section is to encourage the Secretary, and provide the Secretary with sufficient authority, to apply efficient and flexible approaches to expedite the development of, and prioritize the Food and Drug Administration's review of, devices that represent breakthrough technologies.

''(b) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program to expedite the development of, and provide for the priority review for, devices, as determined by the Secretary—

''(1) that provide for more effective treatment or diagnosis of life-threatening or irreversibly debilitating human disease or conditions; and

''(2)(A) that represent breakthrough technologies;

''(B) for which no approved or cleared alternatives exist;

''(C) that offer significant advantages over existing approved or cleared alternatives, including the potential, compared to existing approved alternatives, to reduce or eliminate the need for hospitalization, improve patient quality of life, facilitate patients' ability to manage their own care (such as through self-directed personal assistance), or establish long-term clinical efficiencies; or

''(D) the availability of which is in the best interest of patients.

''(c) REQUEST FOR DESIGNATION.—A sponsor of a device may request that the Secretary designate such device for expedited development and priority review under this section. Any such request for designation may be made at any time prior to the submission of an application under section 515(c), a notification under section 510(k), or a petition for classification under section 513(f)(2).

''(d) DESIGNATION PROCESS.—

''(1) IN GENERAL.—Not later than 60 calendar days after the receipt of a request under subsection (c), the Secretary shall determine whether the device that is the subject of the request meets the criteria described in subsection (b). If the Secretary determines that the device meets the criteria, the Secretary shall designate the device for expedited development and priority review.

''(2) REVIEW.—Review of a request under subsection (c) shall be undertaken by a team that is composed of experienced staff and senior managers of the Food and Drug Administration.

''(3) WITHDRAWAL.—The Secretary may not withdraw a designation granted under this section on the basis of the criteria under subsection (b) no longer applying because of the subsequent clearance or approval of another device that—

''(A) was designated under this section; or

''(B) was given priority review under section 515(d)(5), as in effect prior to the date of enactment of the 21st Century Cures Act.

''(e) EXPEDITED DEVELOPMENT AND PRIORITY REVIEW.—

''(1) ACTIONS.—For purposes of expediting the development and review of devices designated under subsection (d) the Secretary shall—

''(A) assign a team of staff, including a team leader with appropriate subject matter expertise and experience, for each device for which a request is submitted under subsection (c);

''(B) provide for oversight of the team by senior agency personnel to facilitate the efficient development of the device and the efficient review of any submission described in subsection (c) for the device;

''(C) adopt an efficient process for timely dispute resolution;

''(D) provide for interactive and timely communication with the sponsor of the device during the development program and review process;

''(E) expedite the Secretary's review of manufacturing and quality systems compliance, as applicable;

''(F) disclose to the sponsor, not less than 5 business days in advance, the topics of any consultation the Secretary intends to undertake with external experts or an advisory committee concerning the sponsor's device and provide the sponsor the opportunity to recommend such external experts;

''(G) provide for advisory committee input, as the Secretary determines appropriate (including in response to the request of the sponsor) for applications submitted under section 515(c); and

''(H) assign staff to be available within a reasonable time to address questions by institutional review committees concerning the conditions and clinical testing requirements applicable to the investigational use of the device pursuant to an exemption under section 520(g).

''(2) ADDITIONAL ACTIONS.—In addition to the actions described in paragraph (1), for purposes of expediting the development and review of devices designated under subsection (d), the Secretary, in collaboration with the device sponsor, may, as appropriate—

''(A) coordinate with the sponsor regarding early agreement on a data development plan;

''(B) take steps to ensure that the design of clinical trials is as efficient and flexible as practicable, when scientifically appropriate;

''(C) facilitate, when scientifically appropriate, expedited and efficient development and review of the device through utilization of timely postmarket data collection with regard to application for approval under section 515(c); and

''(D) agree in writing to clinical protocols that the Secretary will consider binding on the Secretary and the sponsor, subject to—

''(i) changes to such protocols agreed to in writing by the sponsor and the Secretary; or

''(ii) a decision, made by the director of the office responsible for reviewing the device submission, that a substantial scientific issue essential to determining the safety or effectiveness of such device exists, provided that such decision is in writing, and is made only after the Secretary provides to the device sponsor or applicant an opportunity for a meeting at which the director and the sponsor or applicant are present and at which the director documents the substantial scientific issue.

''(f) PRIORITY REVIEW GUIDANCE.—

''(1) CONTENT.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary shall issue guidance on the implementation of this section. Such guidance shall—

''(A) set forth the process by which a person may seek a designation under subsection (d);

''(B) provide a template for requests under subsection (c);

''(C) identify the criteria the Secretary will use in evaluating a request for designation under this section; and

''(D) identify the criteria and processes the Secretary will use to assign a team of staff, including team leaders, to review devices designated for expedited development and priority review, including any training required for such personnel to ensure effective and efficient review.

''(2) PROCESS.—Prior to finalizing the guidance under paragraph (1), the Secretary shall seek public comment on a proposed guidance.

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect—

''(1) the criteria and standards for evaluating an application pursuant to section 515(c), a report and request for classification under section 513(f)(2), or a report under section 510(k), including the recognition of valid scientific evidence as described in section 513(a)(3)(B) and consideration and application of the least burdensome means of evaluating device effectiveness or demonstrating substantial equivalence between devices with differing technological characteristics, as applicable;

''(2) the authority of the Secretary with respect to clinical holds under section 520(g)(8)(A);

''(3) the authority of the Secretary to act on an application pursuant to section 515(d) before completion of an establishment inspection, as the Secretary determines appropriate; or

''(4) the authority of the Secretary with respect to postmarket surveillance under sections 519(h) and 522.''.

(b) DOCUMENTATION AND REVIEW OF SIGNIFICANT DECISIONS.—Section 517A(a)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360g–1(a)(1)) is amended by inserting ''a request for designation under section 515C,'' after ''application under section 515,''.

(c) TERMINATION OF PREVIOUS PROGRAM.—

(1) IN GENERAL.—Section 515(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360e(d)) is amended—

(A) by striking paragraph (5); and

(B) by redesignating paragraph (6) as paragraph (5).

(2) CONFORMING AMENDMENT.—Section 737(5) of the Federal Food, Drug, and Cosmetics Act (21 U.S.C. 379i(5)) is amended by striking ''515(d)(6)'' and inserting ''515(d)(5)''.

(d) REPORT.—On January 1, 2019, the Secretary of Health and Human Services shall issue a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives—

(1) on the program under section 515C of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), in bringing safe and effective devices included in such program to patients as soon as possible; and

(2) that includes recommendations, if any, to strengthen the program to better meet patient device needs in a manner as timely as possible.

SEC. 3052. HUMANITARIAN DEVICE EXEMPTION.

(a) IN GENERAL.—Section 520(m) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) is amended—

(1) in paragraph (1) by striking ''fewer than 4,000'' and inserting ''not more than 8,000'';

(2) in paragraph (2)(A) by striking ''fewer than 4,000'' and inserting ''not more than 8,000''; and

(3) in paragraph (6)(A)(ii), by striking ''4,000'' and inserting ''8,000''.

(b) GUIDANCE DOCUMENT ON PROBABLE BENEFIT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall publish a draft guidance that defines the criteria for establishing ''probable benefit'' as that term is used in section 520(m)(2)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j(m)(2)(C)).

SEC. 3053. RECOGNITION OF STANDARDS.

(a) IN GENERAL.—Section 514(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360d(c)) is amended—

(1) in paragraph (1), by inserting after subparagraph (B) the following new subparagraphs:

''(C)(i) Any person may submit a request for recognition under subparagraph (A) of all or part of an appropriate standard established by a nationally or internationally recognized standard organization.

''(ii) Not later than 60 calendar days after the Secretary receives such a request, the Secretary shall—

''(I) make a determination to recognize all, part, or none of the standard that is the subject of the request; and

''(II) issue to the person who submitted such request a response in writing that states the Secretary's rationale for that determination, including the scientific, technical, regulatory, or other basis for such determination.

''(iii) The Secretary shall make a response issued under clause (ii)(II) publicly available, in such a manner as the Secretary determines appropriate.

''(iv) The Secretary shall take such actions as may be necessary to implement all or part of a standard recognized under clause (ii)(I), in accordance with subparagraph (A).

''(D) The Secretary shall make publicly available, in such manner as the Secretary determines appropriate, the rationale for recognition

under subparagraph (A) of all, part, or none of a standard, including the scientific, technical, regulatory, or other basis for the decision regarding such recognition.''; and

(2) by adding at the end the following:

''(4) The Secretary shall provide to all employees of the Food and Drug Administration who review premarket submissions for devices periodic training on the concept and use of recognized standards for purposes of meeting a premarket submission requirement or other applicable requirement under this Act, including standards relevant to an employee's area of device review.''.

(b) GUIDANCE.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall review and update, if necessary, previously published guidance and standard operating procedures identifying the principles for recognizing standards, and for withdrawing the recognition of standards, under section 514(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360d(c)), taking into account the experience with and reliance on a standard by foreign regulatory authorities and the device industry, and whether recognition of a standard will promote harmonization among regulatory authorities in the regulation of devices.

SEC. 3054. CERTAIN CLASS I AND CLASS II DEVICES.

(a) CLASS I DEVICES.—Section 510(l) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(l)) is amended—

(1) by striking ''A report under subsection (k)'' and inserting ''(1) A report under subsection (k)''; and

(2) by adding at the end the following new paragraph:

''(2) Not later than 120 calendar days after the date of enactment of the 21st Century Cures Act and at least once every 5 years thereafter, as the Secretary determines appropriate, the Secretary shall identify, through publication in the Federal Register, any type of class I device that the Secretary determines no longer requires a report under subsection (k) to provide reasonable assurance of safety and effectiveness. Upon such publication—

''(A) each type of class I device so identified shall be exempt from the requirement for a report under subsection (k); and

''(B) the classification regulation applicable to each such type of device shall be deemed amended to incorporate such exemption.''.

(b) CLASS II DEVICES.—Section 510(m) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(m)) is amended—

(1) by striking ''(m)(1)'' and all that follows through ''by the Secretary.'' and inserting the following:

''(m)(1) The Secretary shall—

''(A) not later than 90 days after the date of enactment of the 21st Century Cures Act and at least once every 5 years thereafter, as the Secretary determines appropriate—

''(i) publish in the Federal Register a notice that contains a list of each type of class II device that the Secretary determines no longer requires a report under subsection (k) to provide reasonable assurance of safety and effectiveness; and

''(ii) provide for a period of not less than 60 calendar days for public comment beginning on the date of the publication of such notice; and

''(B) not later than 210 calendar days after the date of enactment of the 21st Century Cures Act, publish in the Federal Register a list representing the Secretary's final determination with respect to the devices contained in the list published under subparagraph (A).''; and

(2) in paragraph (2)—

(A) by striking ''1 day after the date of publication of a list under this subsection,'' and inserting ''1 calendar day after the date of publication of the final list under paragraph (1)(B),''; and

(B) by striking ''30-day period'' and inserting ''60-calendar-day period''; and

(C) by adding at the end the following new paragraph:

''(3) Upon the publication of the final list under paragraph (1)(B)—

''(A) each type of class II device so listed shall be exempt from the requirement for a report under subsection (k); and

''(B) the classification regulation applicable to each such type of device shall be deemed amended to incorporate such exemption.''.

SEC. 3055. CLASSIFICATION PANELS.

(a) CLASSIFICATION PANELS.—Paragraph (5) of section 513(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c(b)) is amended—

(1) by striking ''(5)'' and inserting ''(5)(A)''; and

(2) by adding at the end the following:

''(B) When a device is specifically the subject of review by a classification panel, the Secretary shall—

''(i) ensure that adequate expertise is represented on the classification panel to assess—

''(I) the disease or condition which the device is intended to cure, treat, mitigate, prevent, or diagnose; and

''(II) the technology of the device; and

''(ii) provide an opportunity for the person whose device is specifically the subject of panel review to provide recommendations on the expertise needed among the voting members of the panel.

''(C) For purposes of subparagraph (B)(i), the term 'adequate expertise' means that the membership of the classification panel includes—

''(i) two or more voting members, with a specialty or other expertise clinically relevant to the device under review; and

''(ii) at least one voting member who is knowledgeable about the technology of the device.

''(D) The Secretary shall provide an annual opportunity for patients, representatives of patients, and sponsors of medical device submissions to provide recommendations for individuals with appropriate expertise to fill voting member positions on classification panels.''.

(b) PANEL REVIEW PROCESS.—Section 513(b)(6) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c(b)(6)) is amended—

(1) in subparagraph (A)(iii), by inserting before the period at the end '', including, subject to the discretion of the panel chairperson, by designating a representative who will be provided a time during the panel meeting to address the panel for the purpose of correcting misstatements of fact or providing clarifying information, and permitting the person or representative to call on experts within the person's organization to address such specific issues in the time provided''; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

''(B)(i) Any meeting of a classification panel with respect to the review of a device shall—

''(I) provide adequate time for initial presentations by the person whose device is specifically the subject of such review and by the Secretary; and

''(II) encourage free and open participation by all interested persons.

''(ii) Following the initial presentations described in clause (i), the panel may—

''(I) pose questions to a designated representative described in subparagraph (A)(iii); and

''(II) consider the responses to such questions in the panel's review of the device.''.

SEC. 3056. INSTITUTIONAL REVIEW BOARD FLEXIBILITY.

Section 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) is amended—

(1) in subsection (g)(3)—

(A) in subparagraph (A)(i)—

(i) by striking ''local''; and

(ii) by striking ''which has been''; and

(B) in subparagraph (B), by striking ''a local institutional'' and inserting ''an institutional''; and

(2) in subsection (m)(4)—

(A) by striking subparagraph (A) and inserting the following:

''(A) in facilities in which clinical testing of devices is supervised by an institutional review committee established in accordance with the regulations of the Secretary; and'';

(B) in subparagraph (B), by striking ''a local institutional'' and inserting ''an institutional''; and

(C) in the matter following subparagraph (B), by striking ''local''.

SEC. 3057. CLIA WAIVER IMPROVEMENTS.

(a) DRAFT REVISED GUIDANCE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall publish a draft guidance that—

(1) revises ''Section V. Demonstrating Insignificant Risk of an Erroneous Result – Accuracy'' of the guidance entitled ''Recommendations for Clinical Laboratory Improvement Amendments of 1988 (CLIA) Waiver Applications for Manufacturers of In Vitro Diagnostic Devices'' and dated January 30, 2008; and

(2) includes the appropriate use of comparable performance between a waived user and a moderately complex laboratory user to demonstrate accuracy.

(b) FINAL REVISED GUIDANCE.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall finalize the draft guidance published under subsection (a) not later than 1 year after the comment period for such draft guidance closes.

SEC. 3058. LEAST BURDENSOME DEVICE REVIEW.

(a) IN GENERAL.—Section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) is amended by adding at the end the following:

''(j) TRAINING AND OVERSIGHT OF LEAST BURDENSOME REQUIREMENTS.—

''(1) The Secretary shall—

''(A) ensure that each employee of the Food and Drug Administration who is involved in the review of premarket submissions, including supervisors, receives training regarding the meaning and implementation of the least burdensome requirements under subsections (a)(3)(D) and (i)(1)(D) of this section and section 515(c)(5); and

''(B) periodically assess the implementation of the least burdensome requirements, including the employee training under subparagraph (A), to ensure that the least burdensome requirements are fully and consistently applied.

''(2) Not later than 18 months after the date of enactment of the 21st Century Cures Act, the ombudsman for any organizational unit of the Food and Drug Administration responsible for the premarket review of devices shall—

''(A) conduct an audit of the training described in paragraph (1)(A), including the effectiveness of such training in implementing the least burdensome requirements;

''(B) include in such audit interviews of persons who are representatives of the device industry regarding their experiences in the device premarket review process, including with respect to the application of least burdensome concepts to premarket review and decisionmaking;

''(C) include in such audit a list of the measurement tools the Secretary uses to assess the implementation of the least burdensome requirements, including under paragraph (1)(B) and section 517A(a)(3), and may also provide feedback on the effectiveness of such tools in the implementation of the least burdensome requirements;

''(D) summarize the findings of such audit in a final audit report; and

''(E) within 30 calendar days of completion of such final audit report, make such final audit report available—

''(i) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives; and

''(ii) on the Internet website of the Food and Drug Administration.''.

(b) PREMARKET APPLICATIONS.—Section 515(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360e(c)) is amended by adding at the end the following:

''(5)(A) In requesting additional information with respect to an application under this section, the Secretary shall consider the least burdensome appropriate means necessary to demonstrate a reasonable assurance of device safety and effectiveness.

''(B) For purposes of subparagraph (A), the term 'necessary' means the minimum required information that would support a determination by the Secretary that an application provides a reasonable assurance of the safety and effectiveness of the device.

''(C) For purposes of this paragraph, the Secretary shall consider the role of postmarket information in determining the least burdensome means of demonstrating a reasonable assurance of device safety and effectiveness.

''(D) Nothing in this paragraph alters the standards for premarket approval of a device.''.

(c) RATIONALE FOR SIGNIFICANT DECISIONS REGARDING DEVICES.—Section 517A(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360g–1(a)) is amended by adding at the end the following:

''(3) APPLICATION OF LEAST BURDENSOME REQUIREMENTS.—The substantive summary required under this subsection shall include a brief statement regarding how the least burdensome requirements were considered and applied consistent with section 513(i)(1)(D), section 513(a)(3)(D), and section 515(c)(5), as applicable.''.

SEC. 3059. CLEANING INSTRUCTIONS AND VALIDATION DATA REQUIREMENT.

(a) IN GENERAL.—Section 510 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360) is amended by adding at the end the following:

''(q) REUSABLE MEDICAL DEVICES.—

''(1) IN GENERAL.—Not later than 180 days after the date of enactment of the 21st Century Cures Act, the Secretary shall identify and publish a list of reusable device types for which reports under subsection (k) are required to include—

''(A) instructions for use, which have been validated in a manner specified by the Secretary; and

''(B) validation data, the types of which shall be specified by the Secretary;

regarding cleaning, disinfection, and sterilization, and for which a substantial equivalence determination may be based.

''(2) REVISION OF LIST.—The Secretary shall revise the list under paragraph (2), as the Secretary determines appropriate, with notice in the Federal Register.

''(3) CONTENT OF REPORTS.—Reports under subsection (k) that are submitted after the publication of the list described in paragraph (1), for devices or types of devices included on such list, shall include such instructions for use and validation data.''.

(b) DEVICE MODIFICATIONS.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall issue final guidance regarding when a premarket notification under section 510(k) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k)) is required to be submitted for a modification or change to a legally marketed device. Such final guidance shall be issued not later than 1 year after the date on which the comment period closes for the draft guidance on such subject.

SEC. 3060. CLARIFYING MEDICAL SOFTWARE REGULATION.

(a) IN GENERAL.—Section 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) is amended by adding at the end the following:

''(o) REGULATION OF MEDICAL AND CERTAIN DECISIONS SUPPORT SOFTWARE.—

''(1) The term device, as defined in section 201(h), shall not include a software function that is intended—

''(A) for administrative support of a health care facility, including the processing and maintenance of financial records, claims or billing information, appointment schedules, business analytics, information about patient populations, admissions, practice and inventory management, analysis of historical claims data to predict future utilization or cost-effectiveness, determination of health benefit eligibility, population health management, and laboratory workflow;

''(B) for maintaining or encouraging a healthy lifestyle and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition;

''(C) to serve as electronic patient records, including patient-provided information, to the extent that such records are intended to transfer, store, convert formats, or display the equivalent of a paper medical chart, so long as—

''(i) such records were created, stored, transferred, or reviewed by health care professionals, or by individuals working under supervision of such professionals;

''(ii) such records are part of health information technology that is certified under section 3001(c)(5) of the Public Health Service Act; and

''(iii) such function is not intended to interpret or analyze patient records, including medical image data, for the purpose of the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition;

''(D) for transferring, storing, converting formats, or displaying clinical laboratory test or other device data and results, findings by a health care professional with respect to such data and results, general information about such findings, and general background information about such laboratory test or other device, unless such function is intended to interpret or analyze clinical laboratory test or other device data, results, and findings; or

''(E) unless the function is intended to acquire, process, or analyze a medical image or a signal from an in vitro diagnostic device or a pattern or signal from a signal acquisition system, for the purpose of—

''(i) displaying, analyzing, or printing medical information about a patient or other medical information (such as peer-reviewed clinical studies and clinical practice guidelines);

''(ii) supporting or providing recommendations to a health care professional about prevention, diagnosis, or treatment of a disease or condition; and

''(iii) enabling such health care professional to independently review the basis for such recommendations that such software presents so that it is not the intent that such health care professional rely primarily on any of such recommendations to make a clinical diagnosis or treatment decision regarding an individual patient.

''(2) In the case of a product with multiple functions that contains—

''(A) at least one software function that meets the criteria under paragraph (1) or that otherwise does not meet the definition of device under section 201(h); and

''(B) at least one function that does not meet the criteria under paragraph (1) and that otherwise meets the definition of a device under section 201(h),

the Secretary shall not regulate the software function of such product described in subparagraph (A) as a device. Notwithstanding the preceding sentence, when assessing the safety and effectiveness of the device function or functions of such product described in subparagraph (B), the Secretary may assess the impact that the software function or functions described in subparagraph (A) have on such device function or functions.

''(3)(A) Notwithstanding paragraph (1), a software function described in subparagraph (C), (D), or (E) of paragraph (1) shall not be excluded from the definition of device under section 201(h) if—

''(i) the Secretary makes a finding that use of such software function would be reasonably likely to have serious adverse health consequences; and

''(ii) the software function has been identified in a final order issued by the Secretary under subparagraph (B).

''(B) Subparagraph (A) shall apply only if the Secretary—

''(i) publishes a notification and proposed order in the Federal Register;

''(ii) includes in such notification the Secretary's finding, including the rationale and identification of the evidence on which such finding was based, as described in subparagraph (A)(i); and

''(iii) provides for a period of not less than 30 calendar days for public comment before issuing a final order or withdrawing such proposed order.

''(C) In making a finding under subparagraph (A)(i) with respect to a software function, the Secretary shall consider—

''(i) the likelihood and severity of patient harm if the software function were to not perform as intended;

''(ii) the extent to which the software function is intended to support the clinical judgment of a health care professional;

''(iii) whether there is a reasonable opportunity for a health care professional to review the basis of the information or treatment recommendation provided by the software function; and

''(iv) the intended user and user environment, such as whether a health care professional will use a software function of a type described in subparagraph (E) of paragraph (1).

''(4) Nothing in this subsection shall be construed as limiting the authority of the Secretary to—

''(A) exercise enforcement discretion as to any device subject to regulation under this Act;

''(B) regulate software used in the manufacture and transfusion of blood and blood components to assist in the prevention of disease in humans; or

''(C) regulate software as a device under this Act if such software meets the criteria under section 513(a)(1)(C).''.

(b) REPORTS.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), after consultation with agencies and offices of the Department of Health and Human Services involved in health information technology, shall publish a report, not later than 2 years after the date of enactment of this Act and every 2 years thereafter, that—

(1) includes input from outside experts, such as representatives of patients, consumers, health care providers, startup companies, health plans or other third-party payers, venture capital investors, information technology vendors, health information technology vendors, small businesses, purchasers, employers, and other stakeholders with relevant expertise, as determined by the Secretary;

(2) examines information available to the Secretary on any risks and benefits to health associated with software functions described in section 520(o)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360j) (as amended by subsection (a)); and

(3) summarizes findings regarding the impact of such software functions on patient safety, including best practices to promote safety, education, and competency related to such functions.

(c) CLASSIFICATION OF ACCESSORIES.—Section 513(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c(b)) is amended by adding at the end the following:

''(9) The Secretary shall classify an accessory under this section based on the intended use of the accessory, notwithstanding the classification of any other device with which such accessory is intended to be used.''.

(d) CONFORMING AMENDMENT.—Section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) is amended by adding at the end the following: ''The term 'device' does not include software functions excluded pursuant to section 520(o).''.

Subtitle G—Improving Scientific Expertise and Outreach at FDA

SEC. 3071. SILVIO O. CONTE SENIOR BIOMEDICAL RESEARCH AND BIOMEDICAL PRODUCT ASSESSMENT SERVICE.

(a) HIRING AND RETENTION AUTHORITY.—Section 228 of the Public Health Service Act (42 U.S.C. 237) is amended—

*(1) in the section heading, by inserting ''**AND BIOMEDICAL PRODUCT ASSESSMENT**'' after ''**RESEARCH**'';*

(2) in subsection (a)—

(A) in paragraph (1), by striking ''Silvio O. Conte Senior Biomedical Research Service, not to exceed 500 members'' and inserting ''Silvio O. Conte Senior Biomedical Research and Biomedical Product Assessment Service (in this section referred to as the 'Service'), not to exceed 2,000 members, the purpose of which is to recruit and retain outstanding and qualified scientific and technical experts in the fields of biomedical research, clinical research evaluation, and biomedical product assessment'';

(B) by amending paragraph (2) to read as follows:

''(2) The authority established in paragraph (1) may not be construed to require the Secretary to reduce the number of employees serving under any other employment system in order to offset the number of members serving in the Service.''; and

(C) by adding at the end the following:

''(3) The Secretary shall assign experts under this section to agencies within the Department of Health and Human Services taking into account the need for the expertise of such expert.'';

(3) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking ''or clinical research evaluation'' and inserting '', clinical research evaluation, or biomedical product assessment''; and

(B) in paragraph (1), by inserting ''or a doctoral or master's level degree in engineering, bioinformatics, or a related or emerging field,'' after the comma;

(4) in subsection (d)(2), by striking ''and shall not exceed the rate payable for level I of the Executive Schedule unless approved by the President under section 5377(d)(2) of title 5, United States Code'' and inserting ''and shall not exceed the amount of annual compensation (excluding expenses) specified in section 102 of title 3, United States Code'';

(5) by striking subsection (e); and

(6) by redesignating subsections (f) and (g) as subsections (e) and (f), respectively.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the effectiveness of the amendments to section 228 of the Public Health Service Act (42 U.S.C. 237) made by subsection (a) and the impact of such amendments, if any, on all agencies or departments of the Department of Health and Human Services, and, not later than 4 years after the date of enactment of this Act, shall submit a report based on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

(2) CONTENT OF STUDY AND REPORT.—The study and report under paragraph (1) shall include an examination of the extent to which recruitment and retention of outstanding and qualified scientific, medical, or technical experts in the fields of biomedical research, clinical research evaluation, and biomedical product assessment have improved or otherwise have been affected by the amendments to section 228 of the Public Health Service Act (42 U.S.C. 237) made by subsection (a), including by determining, during the period between the date of enactment of this Act and the completion of the study—

(A) the total number of members recruited and retained under the Senior Biomedical Research and Biomedical Product Assessment Service under such section 228, and the effect of increasing the number of members eligible for such Service;

(B) the number of members of such Senior Biomedical Research and Biomedical Product Assessment Service hired with a doctoral level degree in biomedicine or a related field, and the number of such members hired with a doctoral or master's level degree in engineering, bioinformatics, or a related or emerging field; and

(C) the number of Senior Biomedical Research and Biomedical Product Assessment Service members that have been hired by each agency or department of the Department of Health and Human Services, and how such Department assigns such members to each agency or department.

SEC. 3072. HIRING AUTHORITY FOR SCIENTIFIC, TECHNICAL, AND PROFESSIONAL PERSONNEL.

(a) IN GENERAL.—The Federal Food, Drug, and Cosmetic Act is amended by inserting after section 714 (21 U.S.C. 379d–3) the following:

''SEC. 714A. HIRING AUTHORITY FOR SCIENTIFIC, TECHNICAL, AND PROFESSIONAL PERSONNEL.

''(a) IN GENERAL.—The Secretary may, notwithstanding title 5, United States Code, governing appointments in the competitive service, appoint outstanding and qualified candidates to scientific, technical, or professional positions that support the development, review, and regulation of medical products. Such positions shall be within the competitive service.

''(b) COMPENSATION.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, including any requirement with respect to General Schedule pay rates under subchapter III of chapter 53 of title 5, United States Code, and consistent with the requirements of paragraph (2), the Commissioner of Food and Drugs may determine and set—

''(A) the annual rate of pay of any individual appointed under subsection (a); and

''(B) for purposes of retaining qualified employees, the annual rate of pay for any qualified scientific, technical, or professional personnel appointed to a position described in subsection (a) before the date of enactment of the 21st Century Cures Act.

''(2) LIMITATION.—The annual rate of pay established pursuant to paragraph (1) may not exceed the amount of annual compensation (excluding expenses) specified in section 102 of title 3, United States Code.

''(3) PUBLIC AVAILABILITY.—The annual rate of pay provided to an individual in accordance with this section shall be publicly available information.

''(c) RULE OF CONSTRUCTION.—The authorities under this section shall not be construed to affect the authority provided under section 714.

''(d) REPORT ON WORKFORCE PLANNING.—

''(1) IN GENERAL.—Not later than 18 months after the date of enactment of the 21st Century Cures Act, the Secretary shall submit a report on workforce planning to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that examines the extent to which the Food and Drug Administration has a critical need for qualified individuals for scientific, technical, or professional positions, including—

''(A) an analysis of the workforce needs at the Food and Drug Administration and the Secretary's strategic plan for addressing such needs, including through use of the authority under this section; and

''(B) a recruitment and retention plan for hiring qualified scientific, technical, and professional candidates, which may include the use of—

''(i) recruitment through nongovernmental recruitment or placement agencies;

''(ii) recruitment through academic institutions;

''(iii) recruitment or hiring bonuses, if applicable;

''(iv) recruitment using targeted direct hiring authorities; and

''(v) retention of qualified scientific, technical, and professional employees using the authority under this section, or other applicable authorities of the Secretary.

''(2) RECOMMENDATIONS.—The report under paragraph (1) may include the recommendations of the Commissioner of Food and Drugs that would help the Food and Drug Administration to better recruit and retain qualified individuals for scientific, technical, or professional positions at the agency.''.

(b) GAO STUDY AND REPORT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the ability of the Food and Drug Administration to hire, train, and retain qualified scientific, technical, and professional staff, not including contractors, necessary to fulfill the mission of the Food and Drug Administration to protect and promote public health. Not later than January 1, 2022, the Comptroller General shall submit a report on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

(2) CONTENTS OF STUDY.—The Comptroller General shall include in the study and report under paragraph (1)—

(A) information about the progress of the Food and Drug Administration in recruiting and retaining qualified scientific, technical, and professional staff outstanding in the field of biomedical research, clinical research evaluation, and biomedical product assessment;

(B) the extent to which critical staffing needs exist at the Food and Drug Administration, and barriers to hiring, training, and retaining qualified staff, if any;

(C) an examination of the recruitment and retention strategies of the Food and Drug Administration, including examining any strategic workforce plan, focused on improving scientific, technical, and professional staff recruitment and retention; and

(D) recommendations for potential improvements that would address staffing needs of the Food and Drug Administration.

SEC. 3073. ESTABLISHMENT OF FOOD AND DRUG ADMINISTRATION INTERCENTER INSTITUTES.

(a) IN GENERAL.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 1014. FOOD AND DRUG ADMINISTRATION INTERCENTER INSTITUTES.

''(a) IN GENERAL.—The Secretary shall establish one or more Intercenter Institutes within the Food and Drug Administration (referred to in this section as an 'Institute') for a major disease area or areas. With respect to the major disease area of focus of an Institute, such Institute shall develop and implement processes for coordination of activities, as applicable to such major disease area or areas, among the Center for Drug Evaluation and Research, the Center for Biologics Evaluation and Research, and the Center for Devices and Radiological Health (for the purposes of this section, referred to as the 'Centers'). Such activities may include—

''(1) coordination of staff from the Centers with diverse product expertise in the diagnosis, cure, mitigation, treatment, or prevention of the specific diseases relevant to the major disease area of focus of the Institute;

''(2) streamlining, where appropriate, the review of medical products to diagnose, cure, mitigate, treat, or prevent the specific diseases relevant to the major disease area of focus of the

Institute, applying relevant standards under sections 505, 510(k), 513(f)(2), and 515 of this Act and section 351 of the Public Health Service Act, and other applicable authorities;

''(3) promotion of scientific programs within the Centers related to the major disease area of focus of the Institute;

''(4) development of programs and enhancement of strategies to recruit, train, and provide continuing education opportunities for the personnel of the Centers with expertise related to the major disease area of focus of the Institute;

''(5) enhancement of the interactions of the Centers with patients, sponsors, and the external biomedical community regarding the major disease area of focus of the Institute; and

''(6) facilitation of the collaborative relationships of the Centers with other agencies within the Department of Health and Human Services regarding the major disease area of focus of the Institute.

''(b) PUBLIC PROCESS.—The Secretary shall provide a period for public comment during the time that each Institute is being implemented.

''(c) TIMING.—The Secretary shall establish at least one Institute under subsection (a) before the date that is 1 year after the date of enactment of the 21st Century Cures Act.

''(d) TERMINATION OF INSTITUTES.—The Secretary may terminate any Institute established pursuant to this section if the Secretary determines such Institute is no longer benefitting the public health. Not less than 60 days prior to so terminating an Institute, the Secretary shall provide public notice, including the rationale for such termination.''.

(b) TECHNICAL AMENDMENTS.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended—

(1) by redesignating section 1012 as section 1013; and

(2) by redesignating the second section 1011 (with respect to improving the training of State, local, territorial, and tribal food safety officials), as added by section 209(a) of the FDA Food Safety Modernization Act (Public Law 111–353), as section 1012.

SEC. 3074. SCIENTIFIC ENGAGEMENT.

(a) IN GENERAL.—Scientific meetings that are attended by scientific or medical personnel, or other professionals, of the Department of Health and Human Services for whom attendance at such meeting is directly related to their professional duties and the mission of the Department—

(1) shall not be considered conferences for the purposes of complying with Federal reporting requirements contained in annual appropriations Acts or in this section; and

(2) shall not be considered conferences for purposes of a restriction contained in an annual appropriations Act, based on Office of Management and Budget Memorandum M-12-12 or any other regulation restricting travel to such meeting.

(b) LIMITATION.—Nothing in this section shall be construed to exempt travel for scientific meetings from Federal regulations relating to travel.

(c) REPORTS.—Not later than 90 days after the end of the fiscal year, each operating division of the Department of Health and Human Services shall prepare, and post on an Internet website of the operating division, an annual report on scientific meeting attendance and related travel spending for each fiscal year. Such report shall include—

(1) general information concerning the scientific meeting activities involved;

(2) information concerning the total amount expended for such meetings;

(3) a description of all such meetings that were attended by scientific or medical personnel, or other professionals, of each such operating division where the total amount expended by the operating division associated with each such meeting were in excess of $30,000, including—

(A) the total amount of meeting expenses incurred by the operating division for such meeting;

(B) the location of such meeting;

(C) the date of such meeting;

(D) a brief explanation on how such meeting advanced the mission of the operating division; and

(E) the total number of individuals whose travel expenses or other scientific meeting expenses were paid by the operating division; and

(4) with respect to any such meeting where the total expenses to the operating division exceeded $150,000, a description of the exceptional circumstances that necessitated the expenditure of such amounts.

SEC. 3075. DRUG SURVEILLANCE.

(a) NEW DRUGS.—Section 505(k)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(k)(5)), as amended by section 2074, is further amended—

(1) in subparagraph (A), by striking '', biweekly screening'' and inserting ''screenings'';

(2) in subparagraph (B), as redesignated by section 2074(1)(C), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(C) make available on the Internet website of the Food and Drug Administration—

''(i) guidelines, developed with input from experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, that detail best practices for drug safety surveillance using the Adverse Event Reporting System; and

''(ii) criteria for public posting of adverse event signals.''.

(b) FAERS REVISION.—Section 505(r)(2)(D) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(r)(2)(D)) is amended by striking '', by 18 months'' and all that follows through the semicolon at the end of the subparagraph and inserting ''and making publicly available on the Internet website established under paragraph (1) best practices for drug safety surveillance activities for drugs approved under this section or section 351 of the Public Health Service Act;''.

(c) RISK EVALUATION AND MITIGATION STRATEGIES.—Section 505–1(f)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(f)(5)) is amended—

(1) in the matter preceding subparagraph (A), by inserting ''or other advisory committee'' after ''(or successor committee)''; and

(2) in subparagraph (B), by striking ''at least annually,'' and inserting ''periodically''.

SEC. 3076. REAGAN-UDALL FOUNDATION FOR THE FOOD AND DRUG ADMINISTRATION.

(a) BOARD OF DIRECTORS.—

(1) COMPOSITION AND SIZE.—Section 770(d)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379dd(d)(1)(C)) is amended—

(A) by redesignating clause (ii) as clause (iii);

(B) by inserting after clause (i) the following:

''(ii) ADDITIONAL MEMBERS.—The Board, through amendments to the bylaws of the Foundation, may provide that the number of voting members of the Board shall be a number (to be specified in such amendment) greater than 14. Any Board positions that are established by any such amendment shall be appointed (by majority vote) by the individuals who, as of the date of such amendment, are voting members of the Board and persons so appointed may represent any of the categories specified in subclauses (I) through (V) of clause (i), so long as no more than 30 percent of the total voting members of the Board (including members whose positions are established by such amendment) are representatives of the general pharmaceutical, device, food, cosmetic, and biotechnology industries.''; and

(C) in clause (iii)(I), as redesignated by subparagraph (A), by striking ''The ex officio members shall ensure'' and inserting ''The ex officio members, acting pursuant to clause (i), and the Board, acting pursuant to clause (ii), shall ensure''.

(2) FEDERAL EMPLOYEES ALLOWED TO SERVE ON BOARD.—Clause (iii)(II) of section 770(d)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379dd(d)(1)(C)), as redesignated by paragraph (1)(A), is amended by adding at the end the following: ''For purposes of this section, the term 'employee of the Federal Government' does not include a special Government employee, as that term is defined in section 202(a) of title 18, United States Code.''.

(3) STAGGERED TERMS.—Subparagraph (A) of section 770(d)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379dd(d)(3)) is amended to read as follows:

''(A) TERM.—The term of office of each member of the Board appointed under paragraph (1)(C)(i), and the term of office of any member of the Board whose position is established pursuant to paragraph (1)(C)(ii), shall be 4 years, except that—

''(i) the terms of offices for the members of the Board initially appointed under paragraph (1)(C)(i) shall expire on a staggered basis as determined by the ex officio members; and

''(ii) the terms of office for the persons initially appointed to positions established pursuant to paragraph (1)(C)(ii) may be made to expire on a staggered basis, as determined by the individuals who, as of the date of the amendment establishing such positions, are members of the Board.''.

(b) EXECUTIVE DIRECTOR COMPENSATION.—Section 770(g)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379dd(g)(2)) is amended by striking ''but shall not be greater than the compensation of the Commissioner''.

(c) SEPARATION OF FUNDS.—Section 770(m) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379dd(m)) is amended by striking ''are held in separate accounts from funds received from entities under subsection (i)'' and inserting ''are managed as individual programmatic funds under subsection (i), according to best accounting practices''.

Subtitle H—Medical Countermeasures Innovation

SEC. 3081. MEDICAL COUNTERMEASURE GUIDELINES.

Section 319F–2 of the Public Health Service Act (42 U.S.C. 247d–6b) is amended—

(1) in subsection (a), by adding at the end the following:

''(3) UTILIZATION GUIDELINES.—The Secretary shall ensure timely and accurate recommended utilization guidelines for qualified countermeasures (as defined in section 319F–1), qualified pandemic and epidemic products (as defined in section 319F–3), and security countermeasures (as defined in subsection (c)), including for such products in the stockpile.''; and

(2) in subsection (g)—

(A) by amending paragraph (4) to read as follows:

''(4) REPORT ON SECURITY COUNTERMEASURE PROCUREMENT.—Not later than March 1 of each year in which the Secretary determines that the amount of funds available for procurement of security countermeasures is less than $1,500,000,000, the Secretary shall submit to the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations and the Committee on Energy and Commerce of the House of Representatives a report detailing the amount of such funds available for procurement and the impact such amount of funding will have—

''(A) in meeting the security countermeasure needs identified under this section; and

''(B) on the annual Public Health Emergency Medical Countermeasures Enterprise and Strategy Implementation Plan (pursuant to section 2811(d)).''.

SEC. 3082. CLARIFYING BARDA CONTRACTING AUTHORITY.

(a) IN GENERAL.—Section 319F–2(g) of the Public Health Service Act (42 U.S.C. 247d–6b(g)) is amended by adding at the end the following:

''(5) CLARIFICATION ON CONTRACTING AUTHORITY.—The Secretary, acting through the Director of the Biomedical Advanced Research and

Development Authority, shall carry out the programs funded by the special reserve fund (for the procurement of security countermeasures under subsection (c) and for carrying out section 319L), including the execution of procurement contracts, grants, and cooperative agreements pursuant to this section and section 319L.''.

(b) BARDA CONTRACTING AUTHORITY.—Section 319L(c)(3) of the Public Health Service Act (42 U.S.C. 247d–7c) is amended by inserting '', including the execution of procurement contracts, grants, and cooperative agreements pursuant to this section'' before the period.

SEC. 3083. COUNTERMEASURE BUDGET PLAN.

Section 2811(b)(7) of the Public Health Service Act (42 U.S.C. 300hh–10(b)(7)) is amended—

(1) in the matter preceding subparagraph (A), by striking the first sentence and inserting ''Develop, and update not later than March 1 of each year, a coordinated 5-year budget plan based on the medical countermeasure priorities described in subsection (d), including with respect to chemical, biological, radiological, and nuclear agent or agents that may present a threat to the Nation, including such agents that are novel or emerging infectious diseases, and the corresponding efforts to develop qualified countermeasures (as defined in section 319F–1), security countermeasures (as defined in section 319F–2), and qualified pandemic or epidemic products (as defined in section 319F–3) for each such threat.'';

(2) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(3) in subparagraph (D), by striking ''to the appropriate committees of Congress upon request.'' and inserting '', not later than March 15 of each year, to the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations and the Committee on Energy and Commerce of the House of Representatives; and''; and

(4) by adding at the end the following:

''(E) not later than March 15 of each year, be made publicly available in a manner that does not compromise national security.''.

SEC. 3084. MEDICAL COUNTERMEASURES INNOVATION.

Section 319L(c)(4) of the Public Health Service Act (42 U.S.C. 247d–7e(c)(4)) is amended by adding at the end the following:

''(E) MEDICAL COUNTERMEASURES INNOVATION PARTNER.—

''(i) IN GENERAL.—To support the purposes described in paragraph (2), the Secretary, acting through the Director of BARDA, may enter into an agreement (including through the use of grants, contracts, cooperative agreements, or other transactions as described in paragraph (5)) with an independent, nonprofit entity to—

''(I) foster and accelerate the development and innovation of medical countermeasures and technologies that may assist advanced research and the development of qualified countermeasures and qualified pandemic or epidemic products, including through the use of strategic venture capital practices and methods;

''(II) promote the development of new and promising technologies that address urgent medical countermeasure needs, as identified by the Secretary;

''(III) address unmet public health needs that are directly related to medical countermeasure requirements, such as novel antimicrobials for multidrug resistant organisms and multiuse platform technologies for diagnostics, prophylaxis, vaccines, and therapeutics; and

''(IV) provide expert consultation and advice to foster viable medical countermeasure innovators, including helping qualified countermeasure innovators navigate unique industry challenges with respect to developing chemical, biological, radiological, and nuclear countermeasure products.

''(ii) ELIGIBILITY.—

''(I) IN GENERAL.—To be eligible to enter into an agreement under clause (i) an entity shall—

''(aa) be an independent, nonprofit entity;

''(bb) have a demonstrated record of being able to create linkages between innovators and investors and leverage such partnerships and resources for the purpose of addressing identified strategic needs of the Federal Government;

''(cc) have experience in promoting novel technology innovation;

''(dd) be problem-driven and solution-focused based on the needs, requirements, and problems identified by the Secretary under clause (iv);

''(ee) demonstrate the ability, or the potential ability, to promote the development of medical countermeasure products;

''(ff) demonstrate expertise, or the capacity to develop or acquire expertise, related to technical and regulatory considerations with respect to medical countermeasures; and

''(gg) not be within the Department of Health and Human Services.

''(II) PARTNERING EXPERIENCE.—In selecting an entity with which to enter into an agreement under clause (i), the Secretary shall place a high value on the demonstrated experience of the entity in partnering with the Federal Government to meet identified strategic needs.

''(iii) NOT AGENCY.—An entity that enters into an agreement under clause (i) shall not be deemed to be a Federal agency for any purpose, including for any purpose under title 5, United States Code.

''(iv) DIRECTION.—Pursuant to an agreement entered into under this subparagraph, the Secretary, acting through the Director of BARDA, shall provide direction to the entity that enters into an agreement under clause (i). As part of this agreement the Director of BARDA shall—

''(I) communicate the medical countermeasure needs, requirements, and problems to be addressed by the entity under the agreement;

''(II) develop a description of work to be performed by the entity under the agreement;

''(III) provide technical feedback and appropriate oversight over work carried out by the entity under the agreement, including subsequent development and partnerships consistent with the needs and requirements set forth in this subparagraph;

''(IV) ensure fair consideration of products developed under the agreement in order to maintain competition to the maximum practical extent, as applicable and appropriate under applicable provisions of this section; and

''(V) ensure, as a condition of the agreement that the entity—

''(aa) has in place a comprehensive set of policies that demonstrate a commitment to transparency and accountability;

''(bb) protects against conflicts of interest through a comprehensive set of policies that address potential conflicts of interest, ethics, disclosure, and reporting requirements;

''(cc) provides monthly accounting on the use of funds provided under such agreement; and

''(dd) provides on a quarterly basis, reports regarding the progress made toward meeting the identified needs set forth in the agreement.

''(v) SUPPLEMENT NOT SUPPLANT.—Activities carried out under this subparagraph shall supplement, and not supplant, other activities carried out under this section.

''(vi) NO ESTABLISHMENT OF ENTITY.—To prevent unnecessary duplication and target resources effectively, nothing in this subparagraph shall be construed to authorize the Secretary to establish within the Department of Health and Human Services an entity for the purposes of carrying out this subparagraph.

''(vii) TRANSPARENCY AND OVERSIGHT.—Upon request, the Secretary shall provide to Congress the information provided to the Secretary under clause (iv)(V)(dd).

''(viii) INDEPENDENT EVALUATION.—Not later than 4 years after the date of enactment of the 21st Century Cures Act, the Comptroller General of the United States shall conduct an independent evaluation, and submit to the Secretary and the appropriate committees of Congress a report, concerning the activities conducted under this subparagraph. Such report shall include recommendations with respect to any agreement or activities carried out pursuant to this subparagraph.

''(ix) SUNSET.—This subparagraph shall have no force or effect after September 30, 2022.''.

SEC. 3085. STREAMLINING PROJECT BIOSHIELD PROCUREMENT.

Section 319F–2(c) of the Public Health Service Act (42 U.S.C. 247d–6b(c)) is amended—

(1) in paragraph (4)(A)(ii), by striking ''make a recommendation under paragraph (6) that the special reserve fund as defined in subsection (h) be made available for the procurement of such countermeasure'' and inserting ''and subject to the availability of appropriations, make available the special reserve fund as defined in subsection (h) for procurement of such countermeasure, as applicable'';

(2) in paragraph (6)—

(A) by striking subparagraphs (A), (B), and (E);

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (A) and (B), respectively;

(C) by amending subparagraph (A), as so redesignated, to read as follows:

''(A) NOTICE TO APPROPRIATE CONGRESSIONAL COMMITTEES.—The Secretary shall notify the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations and the Committee on Energy and Commerce of the House of Representatives of each decision to make available the special reserve fund as defined in subsection (h) for procurement of a security countermeasure, including, where available, the number of, the nature of, and other information concerning potential suppliers of such countermeasure, and whether other potential suppliers of the same or similar countermeasures were considered and rejected for procurement under this section and the reasons for each such rejection.''; and

(D) in the heading, by striking ''RECOMMENDATION FOR PRESIDENT'S APPROVAL'' and inserting ''RECOMMENDATIONS FOR PROCUREMENT''; and

(3) in paragraph (7)—

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

''(A) PAYMENTS FROM SPECIAL RESERVE FUND.—The special reserve fund as defined in subsection (h) shall be available for payments made by the Secretary to a vendor for procurement of a security countermeasure in accordance with the provisions of this paragraph.''; and

(B) by redesignating subparagraph (C) as subparagraph (B).

SEC. 3086. ENCOURAGING TREATMENTS FOR AGENTS THAT PRESENT A NATIONAL SECURITY THREAT.

Subchapter E of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb et seq.) is amended by inserting after section 565 the following:

''SEC. 565A. PRIORITY REVIEW TO ENCOURAGE TREATMENTS FOR AGENTS THAT PRESENT NATIONAL SECURITY THREATS.

''(a) DEFINITIONS.—In this section:

''(1) HUMAN DRUG APPLICATION.—The term 'human drug application' has the meaning given such term in section 735(1).

''(2) PRIORITY REVIEW.—The term 'priority review', with respect to a human drug application, means review and action by the Secretary on such application not later than 6 months after receipt by the Secretary of such application, as described in the Manual of Policies and Procedures in the Food and Drug Administration and goals identified in the letters described in section 101(b) of the Food and Drug Administration Safety and Innovation Act.

''(3) PRIORITY REVIEW VOUCHER.—The term 'priority review voucher' means a voucher

issued by the Secretary to the sponsor of a material threat medical countermeasure application that entitles the holder of such voucher to priority review of a single human drug application submitted under section 505(b)(1) or section 351(a) of the Public Health Service Act after the date of approval of the material threat medical countermeasure application.

''(4) MATERIAL THREAT MEDICAL COUNTERMEASURE APPLICATION.—The term 'material threat medical countermeasure application' means an application that—

''(A) is a human drug application for a drug intended for use—

''(i) to prevent, or treat harm from a biological, chemical, radiological, or nuclear agent identified as a material threat under section 319F–2(c)(2)(A)(ii) of the Public Health Service Act; or

''(ii) to mitigate, prevent, or treat harm from a condition that may result in adverse health consequences or death and may be caused by administering a drug, or biological product against such agent; and

''(B) the Secretary determines eligible for priority review;

''(C) is approved after the date of enactment of the 21st Century Cures Act; and

''(D) is for a human drug, no active ingredient (including any ester or salt of the active ingredient) of which has been approved in any other application under section 505(b)(1) or section 351(a) of the Public Health Service Act.

''(b) PRIORITY REVIEW VOUCHER.—

''(1) IN GENERAL.—The Secretary shall award a priority review voucher to the sponsor of a material threat medical countermeasure application upon approval by the Secretary of such material threat medical countermeasure application.

''(2) TRANSFERABILITY.—The sponsor of a material threat medical countermeasure application that receives a priority review voucher under this section may transfer (including by sale) the entitlement to such voucher to a sponsor of a human drug for which an application under section 505(b)(1) or section 351(a) of the Public Health Service Act will be submitted after the date of the approval of the material threat medical countermeasure application. There is no limit on the number of times a priority review voucher may be transferred before such voucher is used.

''(3) NOTIFICATION.—

''(A) IN GENERAL.—The sponsor of a human drug application shall notify the Secretary not later than 90 calendar days prior to submission of the human drug application that is the subject of a priority review voucher of an intent to submit the human drug application, including the date on which the sponsor intends to submit the application. Such notification shall be a legally binding commitment to pay for the user fee to be assessed in accordance with this section.

''(B) TRANSFER AFTER NOTICE.—The sponsor of a human drug application that provides notification of the intent of such sponsor to use the voucher for the human drug application under subparagraph (A) may transfer the voucher after such notification is provided, if such sponsor has not yet submitted the human drug application described in the notification.

''(c) PRIORITY REVIEW USER FEE.—

''(1) IN GENERAL.—The Secretary shall establish a user fee program under which a sponsor of a human drug application that is the subject of a priority review voucher shall pay to the Secretary a fee determined under paragraph (2). Such fee shall be in addition to any fee required to be submitted by the sponsor under chapter VII.

''(2) FEE AMOUNT.—The amount of the priority review user fee shall be determined each fiscal year by the Secretary and based on the average cost incurred by the agency in the review of a human drug application subject to priority review in the previous fiscal year.

''(3) ANNUAL FEE SETTING.—The Secretary shall establish, before the beginning of each fiscal year beginning after September 30, 2016, for that fiscal year, the amount of the priority review user fee.

''(4) PAYMENT.—

''(A) IN GENERAL.—The priority review user fee required by this subsection shall be due upon the submission of a human drug application under section 505(b)(1) or section 351(a) of the Public Health Service Act for which the priority review voucher is used.

''(B) COMPLETE APPLICATION.—An application described under subparagraph (A) for which the sponsor requests the use of a priority review voucher shall be considered incomplete if the fee required by this subsection and all other applicable user fees are not paid in accordance with the Secretary's procedures for paying such fees.

''(C) NO WAIVERS, EXEMPTIONS, REDUCTIONS, OR REFUNDS.—The Secretary may not grant a waiver, exemption, reduction, or refund of any fees due and payable under this section.

''(5) OFFSETTING COLLECTIONS.—Fees collected pursuant to this subsection for any fiscal year—

''(A) shall be deposited and credited as offsetting collections to the account providing appropriations to the Food and Drug Administration; and

''(6) shall not be collected for any fiscal year except to the extent provided in advance in appropriation Acts.

''(d) NOTICE OF ISSUANCE OF VOUCHER AND APPROVAL OF PRODUCTS UNDER VOUCHER.—The Secretary shall publish a notice in the Federal Register and on the Internet website of the Food and Drug Administration not later than 30 calendar days after the occurrence of each of the following:

''(1) The Secretary issues a priority review voucher under this section.

''(2) The Secretary approves a drug pursuant to an application submitted under section 505(b) of this Act or section 351(a) of the Public Health Service Act for which the sponsor of the application used a priority review voucher issued under this section.

''(e) ELIGIBILITY FOR OTHER PROGRAMS.—Nothing in this section precludes a sponsor who seeks a priority review voucher under this section from participating in any other incentive program, including under this Act, except that no sponsor of a material threat medical countermeasure application may receive more than one priority review voucher issued under any section of this Act with respect to such drug.

''(f) RELATION TO OTHER PROVISIONS.—The provisions of this section shall supplement, not supplant, any other provisions of this Act or the Public Health Service Act that encourage the development of medical countermeasures.

''(g) SUNSET.—The Secretary may not award any priority review vouchers under subsection (b) after October 1, 2023.''.

SEC. 3087. PAPERWORK REDUCTION ACT WAIVER DURING A PUBLIC HEALTH EMERGENCY.

Section 319 of the Public Health Service Act (42 U.S.C. 247d) is amended by adding at the end the following:

''(f) DETERMINATION WITH RESPECT TO PAPERWORK REDUCTION ACT WAIVER DURING A PUBLIC HEALTH EMERGENCY.—

''(1) DETERMINATION.—If the Secretary determines, after consultation with such public health officials as may be necessary, that—

''(A)(i) the criteria set forth for a public health emergency under paragraph (1) or (2) of subsection (a) has been met; or

''(ii) a disease or disorder, including a novel and emerging public health threat, is significantly likely to become a public health emergency; and

''(B) the circumstances of such public health emergency, or potential for such significantly likely public health emergency, including the specific preparation for and response to such public health emergency or threat, necessitate a waiver from the requirements of subchapter I of chapter 35 of title 44, United States Code (commonly referred to as the Paperwork Reduction Act),

then the requirements of such subchapter I with respect to voluntary collection of information shall not be applicable during the immediate investigation of, and response to, such public health emergency during the period of such public health emergency or the period of time necessary to determine if a disease or disorder, including a novel and emerging public health threat, will become a public health emergency as provided for in this paragraph. The requirements of such subchapter I with respect to voluntary collection of information shall not be applicable during the immediate postresponse review regarding such public health emergency if such immediate postresponse review does not exceed a reasonable length of time.

''(2) TRANSPARENCY.—If the Secretary determines that a waiver is necessary under paragraph (1), the Secretary shall promptly post on the Internet website of the Department of Health and Human Services a brief justification for such waiver, the anticipated period of time such waiver will be in effect, and the agencies and offices within the Department of Health and Human Services to which such waiver shall apply, and update such information posted on the Internet website of the Department of Health and Human Services, as applicable.

''(3) EFFECTIVENESS OF WAIVER.—Any waiver under this subsection shall take effect on the date on which the Secretary posts information on the Internet website as provided for in this subsection.

''(4) TERMINATION OF WAIVER.—Upon determining that the circumstances necessitating a waiver under paragraph (1) no longer exist, the Secretary shall promptly update the Internet website of the Department of Health and Human Services to reflect the termination of such waiver.

''(5) LIMITATIONS.—

''(A) PERIOD OF WAIVER.—The period of a waiver under paragraph (1) shall not exceed the period of time for the related public health emergency, including a public health emergency declared pursuant to subsection (a), and any immediate postresponse review regarding the public health emergency consistent with the requirements of this subsection.

''(B) SUBSEQUENT COMPLIANCE.—An initiative subject to a waiver under paragraph (1) that is ongoing after the date on which the waiver expires, shall be subject to the requirements of subchapter I of chapter 35 of title 44, United States Code, and the Secretary shall ensure that compliance with such requirements occurs in as timely a manner as possible based on the applicable circumstances, but not to exceed 30 calendar days after the expiration of the applicable waiver.''.

SEC. 3088. CLARIFYING FOOD AND DRUG ADMINISTRATION EMERGENCY USE AUTHORIZATION.

(a) AUTHORIZATION FOR MEDICAL PRODUCTS FOR USE IN EMERGENCIES.—Section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3) is amended—

(1) in subsection (a)(2)—

(A) in subparagraph (A)—

(i) by striking ''or 515'' and inserting ''512, or 515''; and

(ii) by inserting ''or conditionally approved under section 571 of this Act'' after ''Public Health Service Act''; and

(B) in subparagraph (B), by inserting ''conditionally approved under section 571,'' after ''approved,'' each place the term appears;

(2) in subsection (b)(4), by striking the second comma after ''determination'';

(3) in subsection (e)(3)(B), by striking ''section 503(b)'' and inserting ''subsection (b) or (f) of section 503 or under section 504'';

(4) in subsection (f)(2)—

(A) by inserting '', or an animal to which,'' after ''to a patient to whom''; and

(B) by inserting ''or by the veterinarian caring for such animal, as applicable'' after ''attending physician'';

(5) in subsection (g)(1), by inserting ''conditional approval under section 571,'' after ''approval,'';

(6) in subsection (h)(1), by striking ''or section 520(g)''and inserting ''512(j), or 520(g)''; and

(7) in subsection (k), by striking ''section 520(g),''and inserting ''512(j), or 520(g)''.

(b) NEW ANIMAL DRUGS.—Section 512(a)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b(a)(1)) is amended—

(1) in subparagraph (B), by striking ''or'' at the end;

(2) in subparagraph (C), by striking the period and inserting ''; or''; and

(3) by inserting after subparagraph (C) the following:

''(D) there is in effect an authorization pursuant to section 564 with respect to such use or intended use of such drug, and such drug, its labeling, and such use conform to any conditions of such authorization.''.

(c) EMERGENCY USE OF MEDICAL PRODUCTS.—Section 564A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3a) is amended—

(1) in subsection (a)(1)(A), by inserting '', conditionally approved under section 571,'' after ''chapter''; and

(2) in subsection (d), by striking ''sections 503(b) and 520(e)'' and inserting ''subsections (b) and (f) of section 503, section 504, and section 520(e)''.

(d) PRODUCTS HELD FOR EMERGENCY USE.—Section 564B(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3b(2)) is amended—

(1) in subparagraph (A)—

(A) by inserting ''or conditionally approved under section 571 of this Act'' after ''Public Health Service Act''; and

(B) by striking ''or 515'' and inserting ''512, or 515''; and

(2) in subparagraph (B), by striking ''or 520'' and inserting ''512, or 520''.

Subtitle I—Vaccine Access, Certainty, and Innovation

SEC. 3091. PREDICTABLE REVIEW TIMELINES OF VACCINES BY THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES.

(a) CONSIDERATION OF NEW VACCINES.—Upon the licensure of any vaccine or any new indication for a vaccine, the Advisory Committee on Immunization Practices (in this section referred to as the ''Advisory Committee'') shall, as appropriate, consider the use of the vaccine at its next regularly scheduled meeting.

(b) ADDITIONAL INFORMATION.—If the Advisory Committee does not make a recommendation with respect to the use of a vaccine at the Advisory Committee's first regularly scheduled meeting after the licensure of the vaccine or any new indication for the vaccine, the Advisory Committee shall provide an update on the status of such committee's review.

(c) CONSIDERATION FOR BREAKTHROUGH THERAPIES AND FOR POTENTIAL USE DURING PUBLIC HEALTH EMERGENCY.—The Advisory Committee shall make recommendations with respect to the use of certain vaccines in a timely manner, as appropriate, including vaccines that—

(1) are designated as a breakthrough therapy under section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356) and licensed under section 351 of the Public Health Service Act (42 U.S.C. 262); or

(2) could be used in a public health emergency.

(d) DEFINITION.—In this section, the terms ''Advisory Committee on Immunization Practices'' and ''Advisory Committee'' mean the Advisory Committee on Immunization Practices established by the Secretary pursuant to section 222 of the Public Health Service Act (42 U.S.C. 217a), acting through the Director of the Centers for Disease Control and Prevention.''.

SEC. 3092. REVIEW OF PROCESSES AND CONSISTENCY OF ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES RECOMMENDATIONS.

(a) REVIEW.—The Director of the Centers for Disease Control and Prevention shall conduct a review of the processes used by the Advisory Committee on Immunization Practices in formulating and issuing recommendations pertaining to vaccines, including with respect to consistency.

(b) CONSIDERATIONS.—The review under subsection (a) shall include an assessment of—

(1) the criteria used to evaluate new and existing vaccines, including the identification of any areas for which flexibility in evaluating such criteria is necessary and the reason for such flexibility;

(2) the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach to the review and analysis of scientific and economic data, including the scientific basis for such approach; and

(3) the extent to which the processes used by the work groups of the Advisory Committee on Immunization Practices are consistent among such groups, including the identification of reasons for any variation.

(c) STAKEHOLDERS.—In carrying out the review under subsection (a), the Director of the Centers for Disease Control and Prevention shall solicit input from vaccine stakeholders.

(d) REPORT.—Not later than 18 months after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention shall submit to the appropriate committees of the Congress, and make publicly available, a report on the results of the review under subsection (a), including any recommendations on improving the consistency of the processes described in such subsection.

(e) DEFINITION.—In this section, the term ''Advisory Committee on Immunization Practices'' means the Advisory Committee on Immunization Practices established by the Secretary of Health and Human Services pursuant to section 222 of the Public Health Service Act (42 U.S.C. 217a), acting through the Director of the Centers for Disease Control and Prevention.

SEC. 3093. ENCOURAGING VACCINE INNOVATION.

(a) VACCINE MEETINGS.—The Director of the Centers for Disease Control and Prevention shall ensure that appropriate staff within the relevant centers and divisions of the Office of Infectious Diseases, and others, as appropriate, coordinate with respect to the public health needs, epidemiology, and program planning and implementation considerations related to immunization, including with regard to meetings with stakeholders related to such topics.

(b) REPORT ON VACCINE INNOVATION.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in collaboration with appropriate agencies or offices within the Department of Health and Human Services, including the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Biomedical Advanced Research and Development Authority, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and post publicly on the Internet website of the Department of Health and Human Services, a report on ways to promote innovation in the development of vaccines that minimize the burden of infectious disease.

(2) CONTENTS.—The report described in paragraph (1) shall review the current status of vaccine development and, as appropriate—

(A) consider the optimal process to determine which vaccines would be beneficial to public health and how information on such vaccines is disseminated to key stakeholders;

(B) examine and identify whether obstacles exist that inhibit the development of beneficial vaccines; and

(C) make recommendations about how best to remove any obstacles identified under subparagraph (B) in order to promote and incentivize vaccine innovation and development.

(3) CONSULTATION.—In preparing the report under this subsection, the Secretary may consult with—

(A) representatives of relevant Federal agencies and departments, including the Department of Defense and the Department of Veterans Affairs;

(B) academic researchers;

(C) developers and manufacturers of vaccines;

(D) medical and public health practitioners;

(E) representatives of patient, policy, and advocacy organizations; and

(F) representatives of other entities, as the Secretary determines appropriate.

(c) UPDATES RELATED TO MATERNAL IMMUNIZATION.—

(1) ADDITIONAL VACCINES.—Section 2114(e) of the Public Health Service Act (42 U.S.C. 300aa–14(e)) is amended by adding at the end the following:

''(3) VACCINES RECOMMENDED FOR USE IN PREGNANT WOMEN.—The Secretary shall revise the Vaccine Injury Table included in subsection (a), through the process described in subsection (c), to include vaccines recommended by the Centers for Disease Control and Prevention for routine administration in pregnant women and the information described in subparagraphs (B) and (C) of paragraph (2) with respect to such vaccines.''.

(2) PETITION CONTENT.—Section 2111 of the Public Health Service Act (42 U.S.C. 300aa–11) is amended by adding at the end the following:

''(f) MATERNAL IMMUNIZATION.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, for purposes of this subtitle, both a woman who received a covered vaccine while pregnant and any child who was in utero at the time such woman received the vaccine shall be considered persons to whom the covered vaccine was administered and persons who received the covered vaccine.

''(2) DEFINITION.—As used in this subsection, the term 'child' shall have the meaning given that term by subsections (a) and (b) of section 8 of title 1, United States Code, except that, for purposes of this subsection, such section 8 shall be applied as if the term 'include' in subsection (a) of such section were replaced with the term 'mean'.''.

(3) PETITIONERS.—Section 2111(b)(2) of the Public Health Service Act (42 U.S.C. 300aa–11(b)(2)) is amended by adding ''A covered vaccine administered to a pregnant woman shall constitute more than one administration, one to the mother and one to each child (as such term is defined in subsection (f)(2)) who was in utero at the time such woman was administered the vaccine.'' at the end.

Subtitle J—Technical Corrections

SEC. 3101. TECHNICAL CORRECTIONS.

(a) FFDCA.—

(1) REFERENCES.—Except as otherwise expressly provided, whenever in this subsection an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to that section or other provision of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.).

(2) AMENDMENTS.—

(A) PROHIBITED ACTS.—Section 301(r) (21 U.S.C. 331(r)) is amended by inserting '', drug,'' after ''device'' each place the term appears.

(B) NEW DRUGS.—Section 505 (21 U.S.C. 355) is amended—

(i) in subsection (d), in the last sentence, by striking ''premarket approval'' and inserting ''marketing approval''; and

(ii) in subsection (q)(5)(A), by striking ''subsection (b)(2) or (j) of the Act or 351(k)'' and inserting ''subsection (b)(2) or (j) of this section or section 351(k)''.

(C) RISK EVALUATION AND MITIGATION STRATEGIES.—Section 505–1(h)(21 U.S.C. 355–1(h)) is amended—

(i) in paragraph (2)(A)(iii)—

(I) in the clause heading, by striking ''LABEL'' and inserting ''LABELING'';

(II) by striking ''label'' each place the term appears and inserting ''labeling''; and

(III) by striking ''sponsor'' and inserting ''responsible person''; and

(ii) in paragraph (8), by striking ''and (7).'' and inserting ''and (7)''.

(D) PEDIATRIC STUDY PLANS.—Section 505B (21 U.S.C. 355c) is amended—

(i) in subsection (e)—

(I) in paragraph (2)—

(aa) in subparagraph (A), by inserting ''study'' after ''initial pediatric'' each place the term appears; and

(bb) in subparagraph (B), in the subparagraph heading, by striking ''INITIAL PLAN'' and inserting ''INITIAL PEDIATRIC STUDY PLAN'';

(II) in paragraph (5), in the paragraph heading, by inserting ''AGREED INITIAL PEDIATRIC STUDY'' before ''PLAN''; and

(III) in paragraph (6), by striking ''agreed initial pediatric plan'' and inserting ''agreed initial pediatric study plan''; and

(ii) in subsection (f)(1), by inserting ''and any significant amendments to such plans,'' after ''agreed initial pediatric study plans,''.

(E) DISCONTINUANCE OR INTERRUPTION IN THE PRODUCTION OF LIVE-SAVING DRUGS.—Section 506C (21 U.S.C. 356c) is amended—

(i) in subsection (c), by striking ''discontinuation'' and inserting ''discontinuance''; and

(ii) in subsection (g)(1), by striking ''section 505(j) that could help'' and inserting ''section 505(j), that could help''.

(F) ANNUAL REPORTING ON DRUG SHORTAGES.—Section 506C–1(a) (21 U.S.C. 331(a)) is amended, in the matter before paragraph (1)—

(i) by striking ''Not later than the end of calendar year 2013, and not later than the end of each calendar year thereafter,'' and inserting ''Not later than March 31 of each calendar year,''; and

(ii) by inserting '', with respect to the preceding calendar year,'' after ''a report''.

(G) DRUG SHORTAGE LIST.—Section 506E(b)(3)(E) (21 U.S.C. 356e(b)(3)(E)) is amended by striking ''discontinuation'' and inserting ''discontinuance''.

(H) INSPECTIONS OF ESTABLISHMENTS.—Section 510(h) (21 U.S.C. 360(h)) is amended—

(i) in paragraph (4), in the matter preceding subparagraph (A), by striking ''establishing the risk-based scheduled'' and inserting ''establishing a risk-based schedule''; and

(ii) in paragraph (6)—

(I) in subparagraph (A), by striking ''fiscal'' and inserting ''calendar'' each place the term appears; and

(II) in subparagraph (B), by striking ''an active ingredient of a drug, a finished drug product, or an excipient of a drug'' and inserting ''an active ingredient of a drug or a finished drug product''.

(I) CLASSIFICATION OF DEVICES INTENDED FOR HUMAN USE.—Section 513(f)(2)(A) (21 U.S.C. 360c(f)(2)(A)) is amended—

(i) in clause (i), by striking ''within 30 days''; and

(ii) in clause (iv), by striking ''low-moderate'' and inserting ''low to moderate''.

(J) PREMARKET APPROVAL.—Section 515(a)(1) (21 U.S.C. 360e(a)(1)) is amended by striking ''subject to a an order'' and inserting ''subject to an order''.

(K) PROGRAM TO IMPROVE THE DEVICE RECALL SYSTEM.—Section 518A (21 U.S.C. 360h–1) is amended—

(i) by striking subsection (c); and

(ii) by redesignating subsection (d) as subsection (c).

(L) UNIQUE DEVICE IDENTIFIER.—Section 519(f) (21 U.S.C. 360i(f)) is amended by striking ''and life sustaining'' and inserting ''or life sustaining''.

(M) PRIORITY REVIEW TO ENCOURAGE TREATMENTS FOR TROPICAL DISEASES.—Section 524(c)(4)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360n(c)(4)(A)) is amended by striking ''Services Act'' and inserting ''Service Act''.

(N) PRIORITY REVIEW FOR QUALIFIED INFECTIOUS DISEASE PRODUCTS.—Section 524A (21 U.S.C. 360n–1) is amended—

(i) by striking ''If the Secretary'' and inserting the following:

''(a) IN GENERAL.—If the Secretary'';

(ii) by striking ''any'' and inserting ''the first''; and

(iii) by adding at the end the following:

''(b) CONSTRUCTION.—Nothing in this section shall prohibit the Secretary from giving priority review to a human drug application or efficacy supplement submitted for approval under section 505(b) that otherwise meets the criteria for the Secretary to grant priority review.''.

(O) CONSULTATION WITH EXTERNAL EXPERTS ON RARE DISEASES, TARGETED THERAPIES, AND GENETIC TARGETING OF TREATMENTS.—Section 569(a)(2)(A) (21 U.S.C. 360bbb–8(a)(2)(A)) is amended, in the first sentence, by striking ''subsection (c)'' and inserting ''subsection (b)''.

(P) OPTIMIZING GLOBAL CLINICAL TRIALS.—Section 569A(c) (21 U.S.C. 360bbb–8a(c)) is amended by inserting ''or under the Public Health Service Act'' after ''this Act''.

(Q) USE OF CLINICAL INVESTIGATION DATA FROM OUTSIDE THE UNITED STATES.—Section 569B (21 U.S.C. 360bbb–8b) is amended by striking ''drug or device'' and inserting ''drug, biological product, or device'' each place the term appears.

(R) MEDICAL GASES DEFINITIONS.—Section 575(1)(H) (21 U.S.C. 360ddd(1)(H)) is amended—

(i) by inserting ''for a new drug'' after ''any period of exclusivity''; and

(ii) by inserting ''or any period of exclusivity for a new animal drug under section 512(c)(2)(F),'' after ''section 505A,''.

(S) REGULATION OF MEDICAL GASES.—Section 576(a) (21 U.S.C. 360ddd–1(a)) is amended—

(i) in the matter preceding subparagraph (A) of paragraph (1), by inserting ''who seeks to initially introduce or deliver for introduction a designated medical gas into interstate commerce'' after ''any person''; and

(ii) in paragraph (3)—

(I) in subparagraph (A)—

(aa) in clause (i)(VIII), by inserting ''for a new drug'' after ''any period of exclusivity''; and

(bb) in clause (ii), in the matter preceding subclause (I), by inserting ''the'' before ''final use''; and

(II) in subparagraph (B)—

(aa) in clause (i), by inserting ''for a new drug'' after ''any period of exclusivity''; and

(bb) in clause (ii), by inserting a comma after ''drug product''.

(T) INAPPLICABILITY OF DRUG FEES TO DESIGNATED MEDICAL GASES.—Section 577 (21 U.S.C. 360ddd–2) is amended by inserting ''or 740(a)'' after ''section 736(a)''.

(U) CONFLICTS OF INTEREST.—Section 712(e)(1)(B) (21 U.S.C. 379d–1(e)(1)(B)) is amended by striking ''services'' and inserting ''service''.

(V) AUTHORITY TO ASSESS AND USE BIOSIMILAR BIOLOGICAL PRODUCT FEES.—Section 744H(a) (21 U.S.C. 379j–52(a)) is amended—

(i) in paragraph (1)(A)(v), by striking ''Biosimilars User Fee Act of 2012'' and inserting ''Biosimilar User Fee Act of 2012''; and

(ii) in paragraph (2)(B), by striking ''Biosimilars User Fee Act of 2012'' and inserting ''Biosimilar User Fee Act of 2012''.

(W) REGISTRATION OF COMMERCIAL IMPORTERS.—

(i) AMENDMENT.—Section 801(s)(2) (21 U.S.C. 381(s)(2)) is amended by adding at the end the following:

''(D) EFFECTIVE DATE.—In establishing the effective date of the regulations under subparagraph (A), the Secretary shall, in consultation with the Secretary of Homeland Security acting through U.S. Customs and Border Protection, as determined appropriate by the Secretary of Health and Human Services, provide a reasonable period of time for an importer of a drug to comply with good importer practices, taking into account differences among importers and types of imports, including based on the level of risk posed by the imported product.''.

(ii) CONFORMING AMENDMENT.—Section 714 of the Food and Drug Administration Safety and Innovation Act (Public Law 112–144; 126 Stat. 1074) is amended by striking subsection (d).

(X) RECOGNITION OF FOREIGN GOVERNMENT INSPECTIONS.—Section 809(a)(2) (21 U.S.C. 384e(a)(2)) is amended by striking ''conduction'' and inserting ''conducting''.

(b) FDASIA.—

(1) FINDINGS RELATING TO DRUG APPROVAL.—Section 901(a)(1)(A) of the Food and Drug Administration Safety and Innovation Act (Public Law 112–144; 21 U.S.C. 356 note) is amended by striking ''serious and life-threatening diseases'' and inserting ''serious or life-threatening diseases''.

(2) REPORTING OF INCLUSION OF DEMOGRAPHIC SUBGROUPS.—Section 907 of the Food and Drug Administration Safety and Innovation Act (Public Law 112–144; 126 Stat. 1092, 1093) is amended—

*(A) in the section heading, by striking ''**BIOLOGICS**'' in the heading and inserting ''**BIOLOGICAL PRODUCTS**''; and*

(B) in subsection (a)(2)(B), by striking ''applications for new drug applications'' and inserting ''new drug applications''.

(3) COMBATING PRESCRIPTION DRUG ABUSE.—Section 1122 of the Food and Drug Administration Safety and Innovation Act (Public Law 112–144; 126 Stat. 1112, 1113) is amended—

(A) in subsection (a)(2), by striking ''dependance'' and inserting ''dependence''; and

(B) in subsection (c), by striking ''promulgate'' and inserting ''issue''.

SEC. 3102. COMPLETED STUDIES.

The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 505(k)(5) (21 U.S.C. 355(k)(5))—

(A) in subparagraph (A), by inserting ''and'' after the semicolon;

(B) by striking subparagraph (B); and

(C) by redesignating subparagraph (C) as subparagraph (B);

(2) in section 505A (21 U.S.C. 355a), by striking subsection (p);

(3) in section 505B (21 U.S.C. 355c)—

(A) by striking subsection (l); and

(B) by redesignating subsection (m) as subsection (l); and

(4) in section 523 (21 U.S.C. 360m), by striking subsection (d).

TITLE IV—DELIVERY

SEC. 4001. ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

(a) IN GENERAL.—The Health Information Technology for Economic and Clinical Health Act (title XIII of division A of Public Law 111–5) is amended—

(1) by adding at the end of part 1 of subtitle A the following:

''SEC. 13103. ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

''(a) REDUCTION IN BURDENS GOAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary'), in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health information technology developers, health care quality organizations, health care accreditation organizations, public health entities, States, and other appropriate entities, shall, in accordance with subsection (b)—

''(1) establish a goal with respect to the reduction of regulatory or administrative burdens

(such as documentation requirements) relating to the use of electronic health records;

''(2) develop a strategy for meeting the goal established under paragraph (1); and

''(3) develop recommendations for meeting the goal established under paragraph (1).

''(b) STRATEGY AND RECOMMENDATIONS.—

''(1) IN GENERAL.—To achieve the goal established under subsection (a)(1), the Secretary, in consultation with the entities described in such subsection, shall, not later than 1 year after the date of enactment of the 21st Century Cures Act, develop a strategy and recommendations to meet the goal in accordance with this subsection.

''(2) STRATEGY.—The strategy developed under paragraph (1) shall address the regulatory and administrative burdens (such as documentation requirements) relating to the use of electronic health records. Such strategy shall include broad public comment and shall prioritize—

''(A)(i) incentives for meaningful use of certified EHR technology for eligible professionals and hospitals under sections 1848(a)(7) and 1886(b)(3)(B)(ix), respectively, of the Social Security Act (42 U.S.C. 1395w–4(a)(7), 1395ww(b)(3)(B)(ix));

''(ii) the program for making payments under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) to encourage the adoption and use of certified EHR technology by Medicaid providers;

''(iii) the Merit-based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q));

''(iv) alternative payment models (as defined in section 1833(z)(3)(C) of the Social Security Act (42 U.S.C. 1395l(z)(3)(C));

''(v) the Hospital Value-Based Purchasing Program under section 1886(o) of the Social Security Act (42 U.S.C. 1395ww(o)); and

''(vi) other value-based payment programs, as the Secretary determines appropriate;

''(B) health information technology certification;

''(C) standards and implementation specifications, as appropriate;

''(D) activities that provide individuals access to their electronic health information;

''(E) activities related to protecting the privacy of electronic health information;

''(F) activities related to protecting the security of electronic health information;

''(G) activities related to facilitating health and clinical research;

''(H) activities related to public health;

''(I) activities related to aligning and simplifying quality measures across Federal programs and other payers;

''(J) activities related to reporting clinical data for administrative purposes; and

''(K) other areas, as the Secretary determines appropriate.

''(3) RECOMMENDATIONS.—The recommendations developed under paragraph (1) shall address—

''(A) actions that improve the clinical documentation experience;

''(B) actions that improve patient care;

''(C) actions to be taken by the Secretary and by other entities; and

''(D) other areas, as the Secretary determines appropriate, to reduce the reporting burden required of health care providers.

''(4) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the development of the goal, strategies, or recommendations described in this section.

''(c) APPLICATION OF CERTAIN REGULATORY REQUIREMENTS.—A physician (as defined in section 1861(r)(1) of the Social Security Act), to the extent consistent with applicable State law, may delegate electronic medical record documentation requirements specified in regulations promulgated by the Centers for Medicare & Medicaid Services to a person performing a scribe function who is not such physician if such physician has signed and verified the documentation.''; and

(2) in the table of contents in section 13001(b), by inserting after the item relating to section 13102 the following:

''13103. Assisting doctors and hospitals in improving the quality and care for patients.''.

(b) CERTIFICATION OF HEALTH INFORMATION TECHNOLOGY FOR MEDICAL SPECIALTIES AND SITES OF SERVICE.—Section 3001(c)(5) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(5)) is amended by adding at the end the following:

''(C) HEALTH INFORMATION TECHNOLOGY FOR MEDICAL SPECIALTIES AND SITES OF SERVICE.—

''(i) IN GENERAL.—The National Coordinator shall encourage, keep, or recognize, through existing authorities, the voluntary certification of health information technology under the program developed under subparagraph (A) for use in medical specialties and sites of service for which no such technology is available or where more technological advancement or integration is needed.

''(ii) SPECIFIC MEDICAL SPECIALTIES.—The Secretary shall accept public comment on specific medical specialties and sites of service, in addition to those described in clause (i), for the purpose of selecting additional specialties and sites of service as necessary.

''(iii) HEALTH INFORMATION TECHNOLOGY FOR PEDIATRICS.—Not later than 18 months after the date of enactment of the 21st Century Cures Act, the Secretary, in consultation with relevant stakeholders, shall make recommendations for the voluntary certification of health information technology for use by pediatric health providers to support the health care of children. Not later than 2 years after the date of enactment of the 21st Century Cures Act, the Secretary shall adopt certification criteria under section 3004 to support the voluntary certification of health information technology for use by pediatric health providers to support the health care of children.''.

(c) MEANINGFUL USE STATISTICS.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the HIT Advisory Committee of the Office of the National Coordinator for Health Information Technology, a report concerning attestation statistics for the Medicare and Medicaid EHR Meaningful Use Incentive programs to assist in informing standards adoption and related practices. Such statistics shall include attestation information delineated by State, including, to the extent practicable, the number of providers who did not meet the minimum criteria necessary to attest for the Medicare and Medicaid EHR Meaningful Use Incentive programs for a calendar year, and shall be made publicly available on the Internet website of the Secretary on at least a quarterly basis.

(2) AUTHORITY TO ALTER FORMAT.—The Secretary of Health and Human Services may alter the format of the reports on the attestation of eligible health care professionals following the first performance year of the Merit-based Incentive Payment System to account for changes arising from the implementation of such payment system.

SEC. 4002. TRANSPARENT REPORTING ON USABILITY, SECURITY, AND FUNCTIONALITY.

(a) ENHANCEMENTS TO CERTIFICATION.—Section 3001(c)(5) of the Public Health Service Act (42 U.S.C. 300jj–11), as amended by section 4001(b), is further amended by adding at the end the following:

''(D) CONDITIONS OF CERTIFICATION.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary, through notice and comment rulemaking, shall require, as a condition of certification and maintenance of certification for programs maintained or recognized under this paragraph, consistent with other conditions and requirements under this title, that the health information technology developer or entity—

''(i) does not take any action that constitutes information blocking as defined in section 3022(a);

''(ii) provides assurances satisfactory to the Secretary that such developer or entity, unless for legitimate purposes specified by the Secretary, will not take any action described in clause (i) or any other action that may inhibit the appropriate exchange, access, and use of electronic health information;

''(iii) does not prohibit or restrict communication regarding—

''(I) the usability of the health information technology;

''(II) the interoperability of the health information technology;

''(III) the security of the health information technology;

''(IV) relevant information regarding users' experiences when using the health information technology;

''(V) the business practices of developers of health information technology related to exchanging electronic health information; and

''(VI) the manner in which a user of the health information technology has used such technology;

''(iv) has published application programming interfaces and allows health information from such technology to be accessed, exchanged, and used without special effort through the use of application programming interfaces or successor technology or standards, as provided for under applicable law, including providing access to all data elements of a patient's electronic health record to the extent permissible under applicable privacy laws;

''(v) has successfully tested the real world use of the technology for interoperability (as defined in section 3000) in the type of setting in which such technology would be marketed;

''(vi) provides to the Secretary an attestation that the developer or entity—

''(I) has not engaged in any of the conduct described in clause (i);

''(II) has provided assurances satisfactory to the Secretary in accordance with clause (ii);

''(III) does not prohibit or restrict communication as described in clause (iii);

''(IV) has published information in accordance with clause (iv);

''(V) ensures that its technology allows for health information to be exchanged, accessed, and used, in the manner described in clause (iv); and

''(VI) has undertaken real world testing as described in clause (v); and

''(vii) submits reporting criteria in accordance with section 3009A(b).''.

''(E) COMPLIANCE WITH CONDITIONS OF CERTIFICATION.—The Secretary may encourage compliance with the conditions of certification described in subparagraph (D) and take action to discourage noncompliance, as appropriate.''.

(b) EHR SIGNIFICANT HARDSHIP EXCEPTION.—

(1) APPLICATION TO ELIGIBLE PROFESSIONALS.—

(A) IN CASE OF DECERTIFICATION.—Section 1848(a)(7)(B) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(B)) is amended by inserting after the first sentence the following new sentence: ''The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 3001(c)(5) of the Public Health Service Act.''.

(B) CONTINUED APPLICATION UNDER MIPS.—Section 1848(o)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(D)) is amended by adding at the end the following new sentence: ''The

provisions of subparagraphs (B) and (D) of subsection (a)(7), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).''.

(2) APPLICATION TO ELIGIBLE HOSPITALS.—Section 1886(b)(3)(B)(ix)(II) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(ix)(II)) is amended by inserting after the first sentence the following new sentence: ''The Secretary shall exempt an eligible hospital from the application of the payment adjustment under subclause (I) with respect to a fiscal year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such hospital is decertified under a program kept or recognized pursuant to section 3001(c)(5) of the Public Health Service Act.''.

(c) ELECTRONIC HEALTH RECORD REPORTING PROGRAM.—Subtitle A of title XXX of the Public Health Service Act (42 U.S.C. 300jj–11 et seq.) is amended by adding at the end the following:

''SEC. 3009A. ELECTRONIC HEALTH RECORD REPORTING PROGRAM.

''(a) REPORTING CRITERIA.—

''(1) CONVENING OF STAKEHOLDERS.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary shall convene stakeholders, as described in paragraph (2), for the purpose of developing the reporting criteria in accordance with paragraph (3).

''(2) DEVELOPMENT OF REPORTING CRITERIA.—The reporting criteria under this subsection shall be developed through a public, transparent process that reflects input from relevant stakeholders, including—

''(A) health care providers, including primary care and specialty care health care professionals;

''(B) hospitals and hospital systems;

''(C) health information technology developers;

''(D) patients, consumers, and their advocates;

''(E) data sharing networks, such as health information exchanges;

''(F) authorized certification bodies and testing laboratories;

''(G) security experts;

''(H) relevant manufacturers of medical devices;

''(I) experts in health information technology market economics;

''(J) public and private entities engaged in the evaluation of health information technology performance;

''(K) quality organizations, including the consensus based entity described in section 1890 of the Social Security Act;

''(L) experts in human factors engineering and the measurement of user-centered design; and

''(M) other entities or individuals, as the Secretary determines appropriate.

''(3) CONSIDERATIONS FOR REPORTING CRITERIA.—The reporting criteria developed under this subsection—

''(A) shall include measures that reflect categories including—

''(i) security;

''(ii) usability and user-centered design;

''(iii) interoperability;

''(iv) conformance to certification testing; and

''(v) other categories, as appropriate to measure the performance of electronic health record technology;

''(B) may include categories such as—

''(i) enabling the user to order and view the results of laboratory tests, imaging tests, and other diagnostic tests;

''(ii) submitting, editing, and retrieving data from registries such as clinician-led clinical data registries;

''(iii) accessing and exchanging information and data from and through health information exchanges;

''(iv) accessing and exchanging information and data from medical devices;

''(v) accessing and exchanging information and data held by Federal, State, and local agencies and other applicable entities useful to a health care provider or other applicable user in the furtherance of patient care;

''(vi) accessing and exchanging information from other health care providers or applicable users;

''(vii) accessing and exchanging patient generated information;

''(viii) providing the patient or an authorized designee with a complete copy of their health information from an electronic record in a computable format;

''(ix) providing accurate patient information for the correct patient, including exchanging such information, and avoiding the duplication of patients records; and

''(x) other categories regarding performance, accessibility, as the Secretary determines appropriate; and

''(C) shall be designed to ensure that small and startup health information technology developers are not unduly disadvantaged by the reporting criteria.

''(4) MODIFICATIONS.—After the reporting criteria have been developed under paragraph (3), the Secretary may convene stakeholders and conduct a public comment period for the purpose of modifying the reporting criteria developed under such paragraph.

''(b) PARTICIPATION.—As a condition of maintaining certification under section 3001(c)(5)(D), a developer of certified electronic health records shall submit to an appropriate recipient of a grant, contract, or agreement under subsection (c)(1) responses to the criteria developed under subsection (a), with respect to all certified technology offered by such developer.

''(c) REPORTING PROGRAM.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the 21st Century Cures Act, the Secretary shall award grants, contracts, or agreements to independent entities on a competitive basis to support the convening of stakeholders as described in subsection (a)(2), collect the information required to be reported in accordance with the criteria established as described subsection (a)(3), and develop and implement a process in accordance with paragraph (5) and report such information to the Secretary.

''(2) APPLICATIONS.—An independent entity that seeks a grant, contract, or agreement under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including a description of—

''(A) the proposed method for reviewing and summarizing information gathered based on reporting criteria established under subsection (a);

''(B) if applicable, the intended focus on a specific subset of certified electronic health record technology users, such as health care providers, including primary care, specialty care, and care provided in rural settings; hospitals and hospital systems; and patients, consumers, and patients and consumer advocates;

''(C) the plan for widely distributing reports described in paragraph (6);

''(D) the period for which the grant, contract, or agreement is requested, which may be up to 2 years; and

''(E) the budget for reporting program participation, and whether the eligible independent entity intends to continue participation after the period of the grant, contract, or agreement.

''(3) CONSIDERATIONS FOR INDEPENDENT ENTITIES.—In awarding grants, contracts, and agreements under paragraph (1), the Secretary shall give priority to independent entities with appropriate expertise in health information technology usability, interoperability, and security (especially entities with such expertise in electronic health records) with respect to—

''(A) health care providers, including primary care, specialty care, and care provided in rural settings;

''(B) hospitals and hospital systems; and

''(C) patients, consumers, and patient and consumer advocates.

''(4) LIMITATIONS.—

''(A) ASSESSMENT AND REDETERMINATION.—Not later than 4 years after the date of enactment of the 21st Century Cures Act and every 2 years thereafter, the Secretary, in consultation with stakeholders, shall—

''(i) assess performance of the recipients of the grants, contracts, and agreements under paragraph (1) based on quality and usability of reports described in paragraph (6); and

''(ii) re-determine grants, contracts, and agreements as necessary.

''(B) PROHIBITIONS ON PARTICIPATION.—The Secretary may not award a grant, contract, or cooperative agreement under paragraph (1) to—

''(i) a proprietor of certified health information technology or a business affiliate of such a proprietor;

''(ii) a developer of certified health information technology; or

''(iii) a State or local government agency.

''(5) FEEDBACK.—Based on reporting criteria established under subsection (a), the recipients of grants, contracts, and agreements under paragraph (1) shall develop and implement a process to collect and verify confidential feedback on such criteria from—

''(A) health care providers, patients, and other users of certified electronic health record technology; and

''(B) developers of certified electronic health record technology.

''(6) REPORTS.—

''(A) DEVELOPMENT OF REPORTS.—Each recipient of a grant, contract, or agreement under paragraph (1) shall report on the information reported to such recipient pursuant to subsection (a) and the user feedback collected under paragraph (5) by preparing summary reports and detailed reports of such information.

''(B) DISTRIBUTION OF REPORTS.—Each recipient of a grant, contract, or agreement under paragraph (1) shall submit the reports prepared under subparagraph (A) to the Secretary for public distribution in accordance with subsection (d).

''(d) PUBLICATION.—The Secretary shall distribute widely, as appropriate, and publish, on the Internet website of the Office of the National Coordinator—

''(1) the reporting criteria developed under subsection (a); and

''(2) the summary and detailed reports under subsection (c)(6).

''(e) REVIEW.—Each recipient of a grant, contract, or agreement under paragraph (1) shall develop and implement a process through which participating electronic health record technology developers may review and recommend changes to the reports created under subsection (c)(6) for products developed by such developer prior to the publication of such report under subsection (d).

''(f) ADDITIONAL RESOURCES.—The Secretary may provide additional resources on the Internet website of the Office of the National Coordinator to better inform consumers of health information technology. Such reports may be carried out through partnerships with private organizations with appropriate expertise.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $15,000,000 for purposes of carrying out subparagraph (D) of section 3001(c)(5) of the Public Health Service Act (42 U.S.C. 300jj–11) (as added by subsection (a)) and section 3009A of the Public Health Service Act (as added by subsection (b)), including for purposes of administering any contracts, grants, or agreements, to remain available until expended.

SEC. 4003. INTEROPERABILITY.

(a) DEFINITION.—Section 3000 of the Public Health Service Act (42 U.S.C. 300jj) is amended—

(1) by redesignating paragraphs (10) through (14), as paragraphs (11) through (15), respectively; and

(2) by inserting after paragraph (9) the following:

''(10) INTEROPERABILITY.—The term 'interoperability', with respect to health information technology, means such health information technology that—

''(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

''(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and

''(C) does not constitute information blocking as defined in section 3022(a).''.

(b) SUPPORT FOR INTEROPERABLE NETWORK EXCHANGE.—Section 3001(c) of the Public Health Service Act (42 U.S.C. 300jj–11(c)) is amended by adding at the end the following:

''(9) SUPPORT FOR INTEROPERABLE NETWORKS EXCHANGE.—

''(A) IN GENERAL.—The National Coordinator shall, in collaboration with the National Institute of Standards and Technology and other relevant agencies within the Department of Health and Human Services, for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally. Such convention may occur at a frequency determined appropriate by the Secretary.

''(B) ESTABLISHING A TRUSTED EXCHANGE FRAMEWORK.—

''(i) IN GENERAL.—Not later than 6 months after the date of enactment of the 21st Century Cures Act, the National Coordinator shall convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks. The common agreement may include—

''(I) a common method for authenticating trusted health information network participants;

''(II) a common set of rules for trusted exchange;

''(III) organizational and operational policies to enable the exchange of health information among networks, including minimum conditions for such exchange to occur; and

''(IV) a process for filing and adjudicating noncompliance with the terms of the common agreement.

''(ii) TECHNICAL ASSISTANCE.—The National Coordinator, in collaboration with the National Institute of Standards and Technology, shall provide technical assistance on how to implement the trusted exchange framework and common agreement under this paragraph.

''(iii) PILOT TESTING.—The National Coordinator, in consultation with the National Institute of Standards and Technology, shall provide for the pilot testing of the trusted exchange framework and common agreement established or supported under this subsection (as authorized under section 13201 of the Health Information Technology for Economic and Clinical Health Act). The National Coordinator, in consultation with the National Institute of Standards and Technology, may delegate pilot testing activities under this clause to independent entities with appropriate expertise.

''(C) PUBLICATION OF A TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT.—Not later than 1 year after convening stakeholders under subparagraph (A), the National Coordinator shall publish on its public Internet website, and in the Federal register, the trusted exchange framework and common agreement developed or supported under subparagraph (B). Such trusted exchange framework and common agreement shall be published in a manner that protects proprietary and security information, including trade secrets and any other protected intellectual property.

''(D) DIRECTORY OF PARTICIPATING HEALTH INFORMATION NETWORKS.—

''(i) IN GENERAL.—Not later than 2 years after convening stakeholders under subparagraph (A), and annually thereafter, the National Coordinator shall publish on its public Internet website a list of the health information networks that have adopted the common agreement and are capable of trusted exchange pursuant to the common agreement developed or supported under paragraph (B).

''(ii) PROCESS.—The Secretary shall, through notice and comment rulemaking, establish a process for health information networks that voluntarily elect to adopt the trusted exchange framework and common agreement to attest to such adoption of the framework and agreement.

''(E) APPLICATION OF THE TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT.—As appropriate, Federal agencies contracting or entering into agreements with health information exchange networks may require that as each such network upgrades health information technology or trust and operational practices, such network may adopt, where available, the trusted exchange framework and common agreement published under subparagraph (C).

''(F) RULE OF CONSTRUCTION.—

''(i) GENERAL ADOPTION.—Nothing in this paragraph shall be construed to require a health information network to adopt the trusted exchange framework or common agreement.

''(ii) ADOPTION WHEN EXCHANGE OF INFORMATION IS WITHIN NETWORK.—Nothing in this paragraph shall be construed to require a health information network to adopt the trusted exchange framework or common agreement for the exchange of electronic health information between participants of the same network.

''(iii) EXISTING FRAMEWORKS AND AGREEMENTS.—The trusted exchange framework and common agreement published under subparagraph (C) shall take into account existing trusted exchange frameworks and agreements used by health information networks to avoid the disruption of existing exchanges between participants of health information networks.

''(iv) APPLICATION BY FEDERAL AGENCIES.—Notwithstanding clauses (i), (ii), and (iii), Federal agencies may require the adoption of the trusted exchange framework and common agreement published under subparagraph (C) for health information exchanges contracting with or entering into agreements pursuant to subparagraph (E).

''(v) CONSIDERATION OF ONGOING WORK.—In carrying out this paragraph, the Secretary shall ensure the consideration of activities carried out by public and private organizations related to exchange between health information exchanges to avoid duplication of efforts.''.

(c) PROVIDER DIGITAL CONTACT INFORMATION INDEX.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, directly or through a partnership with a private entity, establish a provider digital contact information index to provide digital contact information for health professionals and health facilities.

(2) USE OF EXISTING INDEX.—In establishing the initial index under paragraph (1), the Secretary may utilize an existing provider directory to make such digital contact information available.

(3) CONTACT INFORMATION.—An index established under this subsection shall ensure that contact information is available at the individual health care provider level and at the health facility or practice level.

(4) RULE OF CONSTRUCTION.—

(A) IN GENERAL.—The purpose of this subsection is to encourage the exchange of electronic health information by providing the most useful, reliable, and comprehensive index of providers possible. In furthering such purpose, the Secretary shall include all health professionals and health facilities applicable to provide a useful, reliable, and comprehensive index for use in the exchange of health information.

(B) LIMITATION.—In no case shall exclusion from the index of providers be used as a measure to achieve objectives other the objectives described in subparagraph (A).

(d) STANDARDS DEVELOPMENT ORGANIZATIONS.—Section 3004 of the Public Health Service Act (42 U.S.C. 300jj–14) is amended by adding at the end the following:

''(c) DEFERENCE TO STANDARDS DEVELOPMENT ORGANIZATIONS.—In adopting and implementing standards under this section, the Secretary shall give deference to standards published by standards development organizations and voluntary consensus-based standards bodies.''.

(e) HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE.—

(1) IN GENERAL.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by striking sections 3002 (42 U.S.C. 300jj–12) and 3003 (42 U.S.C. 300jj–13) and inserting the following:

''SEC. 3002. HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE.

''(a) ESTABLISHMENT.—There is established a Health Information Technology Advisory Committee (referred to in this section as the 'HIT Advisory Committee') to recommend to the National Coordinator, consistent with the implementation of the strategic plan described in section 3001(c)(3), policies, and, for purposes of adoption under section 3004, standards, implementation specifications, and certification criteria, relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information. Such Committee shall serve to unify the roles of, and replace, the HIT Policy Committee and the HIT Standards Committee, as in existence before the date of the enactment of the 21st Century Cures Act.

''(b) DUTIES.—

''(1) RECOMMENDATIONS ON POLICY FRAMEWORK TO ADVANCE AN INTEROPERABLE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.—

''(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator a policy framework for adoption by the Secretary consistent with the strategic plan under section 3001(c)(3) for advancing the target areas described in this subsection. Such policy framework shall seek to prioritize achieving advancements in the target areas specified in subparagraph (B) of paragraph (2) and may, to the extent consistent with this section, incorporate policy recommendations made by the HIT Policy Committee, as in existence before the date of the enactment of the 21st Century Cures Act.

''(B) UPDATES.—The HIT Advisory Committee shall propose updates to such recommendations to the policy framework and make new recommendations, as appropriate.

''(2) GENERAL DUTIES AND TARGET AREAS.—

''(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator for purposes of adoption under section 3004, standards, implementation specifications, and certification criteria and an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria. Such recommendations shall include recommended standards, architectures, and software schemes for access to electronic individually identifiable health information across disparate systems including user

vetting, authentication, privilege management, and access control.

''(B) PRIORITY TARGET AREAS.—For purposes of this section, the HIT Advisory Committee shall make recommendations under subparagraph (A) with respect to at least each of the following target areas:

''(i) Achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchange, and use of health information, including through technology that provides accurate patient information for the correct patient, including exchanging such information, and avoids the duplication of patient records.

''(ii) The promotion and protection of privacy and security of health information in health information technology, including technologies that allow for an accounting of disclosures and protections against disclosures of individually identifiable health information made by a covered entity for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of the regulation promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996), including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care.

''(iii) The facilitation of secure access by an individual to such individual's protected health information and access to such information by a family member, caregiver, or guardian acting on behalf of a patient, including due to age-related and other disability, cognitive impairment, or dementia.

''(iv) Subject to subparagraph (D), any other target area that the HIT Advisory Committee identifies as an appropriate target area to be considered under this subparagraph.

''(C) ADDITIONAL TARGET AREAS.—For purposes of this section, the HIT Advisory Committee may make recommendations under subparagraph (A), in addition to areas described in subparagraph (B), with respect to any of the following areas:

''(i) The use of health information technology to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, reducing medical errors, improving population health, reducing chronic disease, and advancing research and education.

''(ii) The use of technologies that address the needs of children and other vulnerable populations.

''(iii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including at a minimum, race, ethnicity, primary language, and gender information.

''(iv) The use of self-service, telemedicine, home health care, and remote monitoring technologies.

''(v) The use of technologies that meet the needs of diverse populations.

''(vi) The use of technologies that support—

''(I) data for use in quality and public reporting programs;

''(II) public health; or

''(III) drug safety.

''(vii) The use of technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in a health information network or transported outside of the secure facilities or systems where the disclosing covered entity is responsible for security conditions.

''(viii) The use of a certified health information technology for each individual in the United States.

''(D) AUTHORITY FOR TEMPORARY ADDITIONAL PRIORITY TARGET AREAS.—For purposes of subparagraph (B)(iv), the HIT Advisory Committee may identify an area to be considered for purposes of recommendations under this subsection as a target area described in subparagraph (B) if—

''(i) the area is so identified for purposes of responding to new circumstances that have arisen in the health information technology community that affect the interoperability, privacy, or security of health information, or affect patient safety; and

''(ii) at least 30 days prior to treating such area as if it were a target area described in subparagraph (B), the National Coordinator provides adequate notice to Congress of the intent to treat such area as so described.

''(E) FOCUS OF COMMITTEE WORK.—It is the sense of Congress that the HIT Advisory Committee shall focus its work on the priority areas described in subparagraph (B) before proceeding to other work under subparagraph (C).

''(3) RULES RELATING TO RECOMMENDATIONS FOR STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—

''(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a), which may include standards, implementation specifications, and certification criteria that have been developed, harmonized, or recognized by the HIT Advisory Committee or predecessor committee. The HIT Advisory Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 3004(a)(2)(B). Such recommendations shall be consistent with the latest recommendations made by the Committee.

''(B) HARMONIZATION.—The HIT Advisory Committee may recognize harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specification.

''(C) PILOT TESTING OF STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—In the development, harmonization, or recognition of standards and implementation specifications, the HIT Advisory Committee for purposes of recommendations under paragraph (2)(B), shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 13201(a) of the Health Information Technology for Economic and Clinical Health Act.

''(D) CONSISTENCY.—The standards, implementation specifications, and certification criteria recommended under paragraph (2)(B) shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1173 of the Social Security Act.

''(E) SPECIAL RULE RELATED TO INTEROPERABILITY.—Any recommendation made by the HIT Advisory Committee after the date of the enactment of this subparagraph with respect to interoperability of health information technology shall be consistent with interoperability as described in section 3000.

''(4) FORUM.—The HIT Advisory Committee shall serve as a forum for the participation of a broad range of stakeholders with specific expertise in policies, including technical expertise, relating to the matters described in paragraphs (1), (2), and (3) to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of health information technology infrastructure nationally and locally that allows for the electronic access, exchange, and use of health information.

''(5) SCHEDULE.—Not later than 30 days after the date on which the HIT Advisory Committee first meets, such HIT Advisory Committee shall develop a schedule for the assessment of policy recommendations developed under paragraph (1). The HIT Advisory Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.

''(6) PUBLIC INPUT.—The HIT Advisory Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (5) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

''(c) MEASURED PROGRESS IN ADVANCING PRIORITY AREAS.—

''(1) IN GENERAL.—For purposes of this section, the National Coordinator, in collaboration with the Secretary, shall establish, and update as appropriate, objectives and benchmarks for advancing and measuring the advancement of the priority target areas described in subsection (b)(2)(B).

''(2) ANNUAL PROGRESS REPORTS ON ADVANCING INTEROPERABILITY.—

''(A) IN GENERAL.—The HIT Advisory Committee, in consultation with the National Coordinator, shall annually submit to the Secretary and Congress a report on the progress made during the preceding fiscal year in—

''(i) achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchange, and use of health information; and

''(ii) meeting the objectives and benchmarks described in paragraph (1).

''(B) CONTENT.—Each such report shall include, for a fiscal year—

''(i) a description of the work conducted by the HIT Advisory Committee during the preceding fiscal year with respect to the areas described in subsection (b)(2)(B);

''(ii) an assessment of the status of the infrastructure described in subparagraph (A), including the extent to which electronic health information is appropriately and readily available to enhance the access, exchange, and the use of electronic health information between users and across technology offered by different developers;

''(iii) the extent to which advancements have been achieved with respect to areas described in subsection (b)(2)(B);

''(iv) an analysis identifying existing gaps in policies and resources for—

''(I) achieving the objectives and benchmarks established under paragraph (1); and

''(II) furthering interoperability throughout the health information technology infrastructure;

''(v) recommendations for addressing the gaps identified in clause (iii); and

''(vi) a description of additional initiatives as the HIT Advisory Committee and National Coordinator determine appropriate.

''(3) SIGNIFICANT ADVANCEMENT DETERMINATION.—The Secretary shall periodically, based on the reports submitted under this subsection, review the target areas described in subsection (b)(2)(B), and, based on the objectives and benchmarks established under paragraph (1), the Secretary shall determine if significant advancement has been achieved with respect to such an area. Such determination shall be taken into consideration by the HIT Advisory Committee when determining to what extent the Committee makes recommendations for an area other than an area described in subsection (b)(2)(B).

''(d) MEMBERSHIP AND OPERATIONS.—

''(1) IN GENERAL.—The National Coordinator shall take a leading position in the establishment and operations of the HIT Advisory Committee.

''(2) MEMBERSHIP.—The membership of the HIT Advisory Committee shall—

''(A) include at least 25 members, of which—

''(i) no fewer than 2 members are advocates for patients or consumers of health information technology;

''(ii) 3 members are appointed by the Secretary, 1 of whom shall be appointed to represent the Department of Health and Human

Services and 1 of whom shall be a public health official;

''(iii) 2 members are appointed by the majority leader of the Senate;

''(iv) 2 members are appointed by the minority leader of the Senate;

''(v) 2 members are appointed by the Speaker of the House of Representatives;

''(vi) 2 members are appointed by the minority leader of the House of Representatives; and

''(vii) such other members are appointed by the Comptroller General of the United States; and

''(B) at least reflect providers, ancillary health care workers, consumers, purchasers, health plans, health information technology developers, researchers, patients, relevant Federal agencies, and individuals with technical expertise on health care quality, system functions, privacy, security, and on the electronic exchange and use of health information, including the use standards for such activity.

''(3) PARTICIPATION.—The members of the HIT Advisory Committee shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Committee.

''(4) TERMS.—

''(A) IN GENERAL.—The terms of the members of the HIT Advisory Committee shall be for 3 years, except that the Secretary shall designate staggered terms of the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy in the membership of the HIT Advisory Committee that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the HIT Advisory Committee shall be filled in the manner in which the original appointment was made.

''(C) LIMITS.—Members of the HIT Advisory Committee shall be limited to two 3-year terms, for a total of not to exceed 6 years of service on the Committee.

''(5) OUTSIDE INVOLVEMENT.—The HIT Advisory Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of policies and standards for the electronic exchange and use of health information, including in the areas of health information privacy and security.

''(6) QUORUM.—A majority of the members of the HIT Advisory Committee shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

''(7) CONSIDERATION.—The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.

''(8) ASSISTANCE.—For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Advisory Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not-for-profit entities that work in the public interest as a party of their mission.

''(e) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Advisory Committee.

''(f) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Advisory Committee under this section.''.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended—

(A) by striking—

(i) ''HIT Policy Committee'' and ''HIT Standards Committee'' each place that such terms appear (other than within the term ''HIT Policy Committee and the HIT Standards Committee'' or within the term ''HIT Policy Committee or the HIT Standards Committee'') and inserting ''HIT Advisory Committee'';

(ii) ''HIT Policy Committee and the HIT Standards Committee'' each place that such term appears and inserting ''HIT Advisory Committee''; and

(iii) ''HIT Policy Committee or the HIT Standards Committee'' each place that such term appears and inserting ''HIT Advisory Committee'';

(B) in section 3000 (42 U.S.C. 300jj)—

(i) by striking paragraphs (7) and (8) and redesignating paragraphs (9) through (14) as paragraphs (8) through (13), respectively; and

(ii) by inserting after paragraph (6) the following paragraph:

''(7) HIT ADVISORY COMMITTEE.—The term 'HIT Advisory Committee' means such Committee established under section 3002(a).'';

(C) in section 3001(c) (42 U.S.C. 300jj–11(c))—

(i) in paragraph (1)(A), by striking ''under section 3003'' and inserting ''under section 3002'';

(ii) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) HIT ADVISORY COMMITTEE.—The National Coordinator shall be a leading member in the establishment and operations of the HIT Advisory Committee and shall serve as a liaison between that Committee and the Federal Government.'';

(D) in section 3004(b)(3) (42 U.S.C. 300jj–14(b)(3)), by striking ''3003(b)(2)'' and inserting ''3002(b)(4)'';

(E) in section 3007(b) (42 U.S.C. 300jj–17(b)), by striking ''3003(a)'' and inserting ''3002(a)(2)''; and

(F) in section 3008 (42 U.S.C. 300jj–18)—

(i) in subsection (b), by striking ''or 3003''; and

(ii) in subsection (c), by striking ''3003(b)(1)(A)'' and inserting ''3002(b)(2)''.

(3) TRANSITION TO THE HIT ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall provide for an orderly and timely transition to the HIT Advisory Committee established under amendments made by this section.

(f) PRIORITIES FOR ADOPTION OF STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.), as amended by subsection (e), is further amended by inserting after section 3002 the following:

''SEC. 3003. SETTING PRIORITIES FOR STANDARDS ADOPTION.

''(a) IDENTIFYING PRIORITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date on which the HIT Advisory Committee first meets, the National Coordinator shall periodically convene the HIT Advisory Committee to—

''(A) identify priority uses of health information technology, focusing on priorities—

''(i) arising from the implementation of the incentive programs for the meaningful use of certified EHR technology, the Merit-based Incentive Payment System, Alternative Payment Models, the Hospital Value-Based Purchasing Program, and any other value-based payment program determined appropriate by the Secretary;

''(ii) related to the quality of patient care;

''(iii) related to public health;

''(iv) related to clinical research;

''(v) related to the privacy and security of electronic health information;

''(vi) related to innovation in the field of health information technology;

''(vii) related to patient safety;

''(viii) related to the usability of health information technology;

''(ix) related to individuals' access to electronic health information; and

''(x) other priorities determined appropriate by the Secretary;

''(B) identify existing standards and implementation specifications that support the use and exchange of electronic health information needed to meet the priorities identified in subparagraph (A); and

''(C) publish a report summarizing the findings of the analysis conducted under subparagraphs (A) and (B) and make appropriate recommendations.

''(2) PRIORITIZATION.—In identifying such standards and implementation specifications under paragraph (1)(B), the HIT Advisory Committee shall prioritize standards and implementation specifications developed by consensus-based standards development organizations.

''(3) GUIDELINES FOR REVIEW OF EXISTING STANDARDS AND SPECIFICATIONS.—In consultation with the consensus-based entity described in section 1890 of the Social Security Act and other appropriate Federal agencies, the analysis of existing standards under paragraph (1)(B) shall include an evaluation of the need for a core set of common data elements and associated value sets to enhance the ability of certified health information technology to capture, use, and exchange structured electronic health information.

''(b) REVIEW OF ADOPTED STANDARDS.—

''(1) IN GENERAL.—Beginning 5 years after the date of enactment of the 21st Century Cures Act and every 3 years thereafter, the National Coordinator shall convene stakeholders to review the existing set of adopted standards and implementation specifications and make recommendations with respect to whether to—

''(A) maintain the use of such standards and implementation specifications; or

''(B) phase out such standards and implementation specifications.

''(2) PRIORITIES.—The HIT Advisory Committee, in collaboration with the National Institute for Standards and Technology, shall annually and through the use of public input, review and publish priorities for the use of health information technology, standards, and implementation specifications to support those priorities.

''(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent the use or adoption of novel standards that improve upon the existing health information technology infrastructure and facilitate the secure exchange of health information.''.

SEC. 4004. INFORMATION BLOCKING.

Subtitle C of title XXX of the Public Health Service Act (42 U.S.C. 300jj–51 et seq.) is amended by adding at the end the following:

''SEC. 3022. INFORMATION BLOCKING.

''(a) DEFINITION.—

''(1) IN GENERAL.—In this section, the term 'information blocking' means a practice that—

''(A) except as required by law or specified by the Secretary pursuant to rulemaking under paragraph (3), is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information; and

''(B)(i) if conducted by a health information technology developer, exchange, or network, such developer, exchange, or network knows, or should know, that such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information; or

''(ii) if conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.

''(2) PRACTICES DESCRIBED.—The information blocking practices described in paragraph (1) may include—

''(A) practices that restrict authorized access, exchange, or use under applicable State or Federal law of such information for treatment and other permitted purposes under such applicable law, including transitions between certified health information technologies;

''(B) implementing health information technology in nonstandard ways that are likely to

substantially increase the complexity or burden of accessing, exchanging, or using electronic health information; and

''(C) implementing health information technology in ways that are likely to—

''(i) restrict the access, exchange, or use of electronic health information with respect to exporting complete information sets or in transitioning between health information technology systems; or

''(ii) lead to fraud, waste, or abuse, or impede innovations and advancements in health information access, exchange, and use, including care delivery enabled by health information technology.

''(3) RULEMAKING.—The Secretary, through rulemaking, shall identify reasonable and necessary activities that do not constitute information blocking for purposes of paragraph (1).

''(4) NO ENFORCEMENT BEFORE EXCEPTION IDENTIFIED.—The term 'information blocking' does not include any practice or conduct occurring prior to the date that is 30 days after the date of enactment of the 21st Century Cures Act.

''(5) CONSULTATION.—The Secretary may consult with the Federal Trade Commission in promulgating regulations under this subsection, to the extent that such regulations define practices that are necessary to promote competition and consumer welfare.

''(6) APPLICATION.—The term 'information blocking', with respect to an individual or entity, shall not include an act or practice other than an act or practice committed by such individual or entity.

''(7) CLARIFICATION.—In carrying out this section, the Secretary shall ensure that health care providers are not penalized for the failure of developers of health information technology or other entities offering health information technology to such providers to ensure that such technology meets the requirements to be certified under this title.

''(b) INSPECTOR GENERAL AUTHORITY.—

''(1) IN GENERAL.—The inspector general of the Department of Health and Human Services (referred to in this section as the 'Inspector General') may investigate any claim that—

''(A) a health information technology developer of certified health information technology or other entity offering certified health information technology—

''(i) submitted a false attestation under section 3001(c)(5)(D)(vii); or

''(ii) engaged in information blocking;

''(B) a health care provider engaged in information blocking; or

''(C) a health information exchange or network engaged in information blocking.

''(2) PENALTIES.—

''(A) DEVELOPERS, NETWORKS, AND EXCHANGES.—Any individual or entity described in subparagraph (A) or (C) of paragraph (1) that the Inspector General, following an investigation conducted under this subsection, determines to have committed information blocking shall be subject to a civil monetary penalty determined by the Secretary for all such violations identified through such investigation, which may not exceed $1,000,000 per violation. Such determination shall take into account factors such as the nature and extent of the information blocking and harm resulting from such information blocking, including, where applicable, the number of patients affected, the number of providers affected, and the number of days the information blocking persisted.

''(B) PROVIDERS.—Any individual or entity described in subparagraph (B) of paragraph (1) determined by the Inspector General to have committed information blocking shall be referred to the appropriate agency to be subject to appropriate disincentives using authorities under applicable Federal law, as the Secretary sets forth through notice and comment rulemaking.

''(C) PROCEDURE.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) of such section) shall apply to a civil money penalty applied under this paragraph in the same manner as such provisions apply to a civil money penalty or proceeding under such section 1128A(a).

''(D) RECOVERED PENALTY FUNDS.—The amounts recovered under this paragraph shall be allocated as follows:

''(i) ANNUAL OPERATING EXPENSES.—Each year following the establishment of the authority under this subsection, the Office of the Inspector General shall provide to the Secretary an estimate of the costs to carry out investigations under this section. Such estimate may include reasonable reserves to account for variance in annual amounts recovered under this paragraph. There is authorized to be appropriated for purposes of carrying out this section an amount equal to the amount specified in such estimate for the fiscal year.

''(ii) APPLICATION TO OTHER PROGRAMS.—The amounts recovered under this paragraph and remaining after amounts are made available under clause (i) shall be transferred to the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act, in such proportion as the Secretary determines appropriate.

''(E) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Office of the Inspector General to carry out this section $10,000,000, to remain available until expended.

''(3) RESOLUTION OF CLAIMS.—

''(A) IN GENERAL.—The Office of the Inspector General, if such Office determines that a consultation regarding the health privacy and security rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) will resolve an information blocking claim, may refer such instances of information blocking to the Office for Civil Rights of the Department of Health and Human Services for resolution.

''(B) LIMITATION ON LIABILITY.—If a health care provider or health information technology developer makes information available based on a good faith reliance on consultations with the Office for Civil Rights of the Department of Health and Human Services pursuant to a referral under subparagraph (A), with respect to such information, the health care provider or developer shall not be liable for such disclosure or disclosures made pursuant to subparagraph (A).

''(c) IDENTIFYING BARRIERS TO EXCHANGE OF CERTIFIED HEALTH INFORMATION TECHNOLOGY.—

''(1) TRUSTED EXCHANGE DEFINED.—In this section, the term 'trusted exchange' with respect to certified electronic health records means that the certified electronic health record technology has the technical capability to enable secure health information exchange between users and multiple certified electronic health record technology systems.

''(2) GUIDANCE.—The National Coordinator, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall issue guidance on common legal, governance, and security barriers that prevent the trusted exchange of electronic health information.

''(3) REFERRAL.—The National Coordinator and the Office for Civil Rights of the Department of Health and Human Services may refer to the Inspector General instances or patterns of refusal to exchange health information with an individual or entity using certified electronic health record technology that is technically capable of trusted exchange and under conditions when exchange is legally permissible.

''(d) ADDITIONAL PROVISIONS.—

''(1) INFORMATION SHARING PROVISIONS.—The National Coordinator may serve as a technical consultant to the Inspector General and the Federal Trade Commission for purposes of carrying out this section. The National Coordinator may, notwithstanding any other provision of law, share information related to claims or investigations under subsection (b) with the Federal Trade Commission for purposes of such investigations and shall share information with the Inspector General, as required by law.

''(2) PROTECTION FROM DISCLOSURE OF INFORMATION.—Any information that is received by the National Coordinator in connection with a claim or suggestion of possible information blocking and that could reasonably be expected to facilitate identification of the source of the information—

''(A) shall not be disclosed by the National Coordinator except as may be necessary to carry out the purpose of this section;

''(B) shall be exempt from mandatory disclosure under section 552 of title 5, United States Code, as provided by subsection (b)(3) of such section; and

''(C) may be used by the Inspector General or Federal Trade Commission for reporting purposes to the extent that such information could not reasonably be expected to facilitate identification of the source of such information.

''(3) STANDARDIZED PROCESS.—

''(A) IN GENERAL.—The National Coordinator shall implement a standardized process for the public to submit reports on claims of—

''(i) health information technology products or developers of such products (or other entities offering such products to health care providers) not being interoperable or resulting in information blocking;

''(ii) actions described in subsection (b)(1) that result in information blocking as described in subsection (a); and

''(iii) any other act described in subsection (a).

''(B) COLLECTION OF INFORMATION.—The standardized process implemented under subparagraph (A) shall provide for the collection of such information as the originating institution, location, type of transaction, system and version, timestamp, terminating institution, locations, system and version, failure notice, and other related information.

''(4) NONDUPLICATION OF PENALTY STRUCTURES.—In carrying out this subsection, the Secretary shall, to the extent possible, ensure that penalties do not duplicate penalty structures that would otherwise apply with respect to information blocking and the type of individual or entity involved as of the day before the date of the enactment of this section.''.

SEC. 4005. LEVERAGING ELECTRONIC HEALTH RECORDS TO IMPROVE PATIENT CARE.

(a) REQUIREMENT RELATING TO REGISTRIES.—

(1) IN GENERAL.—To be certified in accordance with title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.), electronic health records shall be capable of transmitting to, and where applicable, receiving and accepting data from, registries in accordance with standards recognized by the Office of the National Coordinator for Health Information Technology, including clinician-led clinical data registries, that are also certified to be technically capable of receiving and accepting from, and where applicable, transmitting data to certified electronic health record technology in accordance with such standards.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the certification of registries beyond the technical capability to exchange data in accordance with applicable recognized standards.

(b) DEFINITION.—For purposes of this Act, the term ''clinician-led clinical data registry'' means a clinical data repository—

(1) that is established and operated by a clinician-led or controlled, tax-exempt (pursuant to section 501(c) of the Internal Revenue Code of 1986), professional society or other similar clinician-led or -controlled organization, or such organization's controlled affiliate, devoted to the

care of a population defined by a particular disease, condition, exposure or therapy;

(2) that is designed to collect detailed, standardized data on an ongoing basis for medical procedures, services, or therapies for particular diseases, conditions, or exposures;

(3) that provides feedback to participants who submit reports to the repository;

(4) that meets standards for data quality including—

(A) systematically collecting clinical and other health care data, using standardized data elements and having procedures in place to verify the completeness and validity of those data; and

(B) being subject to regular data checks or audits to verify completeness and validity; and

(5) that provides ongoing participant training and support.

(c) TREATMENT OF HEALTH INFORMATION TECHNOLOGY DEVELOPERS WITH RESPECT TO PATIENT SAFETY ORGANIZATIONS.—

(1) IN GENERAL.—In applying part C of title IX of the Public Health Service Act (42 U.S.C. 299b–21 et seq.), a health information technology developer shall be treated as a provider (as defined in section 921 of such Act) for purposes of reporting and conducting patient safety activities concerning improving clinical care through the use of health information technology that could result in improved patient safety, health care quality, or health care outcomes.

(2) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report concerning best practices and current trends voluntarily provided, without identifying individual providers or disclosing or using protected health information or individually identifiable information, by patient safety organizations to improve the integration of health information technology into clinical practice.

SEC. 4006. EMPOWERING PATIENTS AND IMPROVING PATIENT ACCESS TO THEIR ELECTRONIC HEALTH INFORMATION.

(a) USE OF HEALTH INFORMATION EXCHANGES FOR PATIENT ACCESS.—Section 3009 of the Public Health Service Act (42 U.S.C. 300jj–19) is amended by adding at the end the following:

''(c) PROMOTING PATIENT ACCESS TO ELECTRONIC HEALTH INFORMATION THROUGH HEALTH INFORMATION EXCHANGES .—

''(1) IN GENERAL.—The Secretary shall use existing authorities to encourage partnerships between health information exchange organizations and networks and health care providers, health plans, and other appropriate entities with the goal of offering patients access to their electronic health information in a single, longitudinal format that is easy to understand, secure, and may be updated automatically.

''(2) EDUCATION OF PROVIDERS.—The Secretary, in coordination with the Office for Civil Rights of the Department of Health and Human Services, shall—

''(A) educate health care providers on ways of leveraging the capabilities of health information exchanges (or other relevant platforms) to provide patients with access to their electronic health information;

''(B) clarify misunderstandings by health care providers about using health information exchanges (or other relevant platforms) for patient access to electronic health information; and

''(C) to the extent practicable, educate providers about health information exchanges (or other relevant platforms) that employ some or all of the capabilities described in paragraph (1).

''(3) REQUIREMENTS.—In carrying out paragraph (1), the Secretary, in coordination with the Office for Civil Rights, shall issue guidance to health information exchanges related to best practices to ensure that the electronic health information provided to patients is—

''(A) private and secure;

''(B) accurate;

''(C) verifiable; and

''(D) where a patient's authorization to exchange information is required by law, easily exchanged pursuant to such authorization.

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State laws applicable to patient consent for the access of information through a health information exchange (or other relevant platform) that provide protections to patients that are greater than the protections otherwise provided for under applicable Federal law.

''(d) EFFORTS TO PROMOTE ACCESS TO HEALTH INFORMATION.—The National Coordinator and the Office for Civil Rights of the Department of Health and Human Services shall jointly promote patient access to health information in a manner that would ensure that such information is available in a form convenient for the patient, in a reasonable manner, without burdening the health care provider involved.

''(e) ACCESSIBILITY OF PATIENT RECORDS.—

''(1) ACCESSIBILITY AND UPDATING OF INFORMATION.—

''(A) IN GENERAL.—The Secretary, in consultation with the National Coordinator, shall promote policies that ensure that a patient's electronic health information is accessible to that patient and the patient's designees, in a manner that facilitates communication with the patient's health care providers and other individuals, including researchers, consistent with such patient's consent.

''(B) UPDATING EDUCATION ON ACCESSING AND EXCHANGING PERSONAL HEALTH INFORMATION.—To promote awareness that an individual has a right of access to inspect, obtain a copy of, and transmit to a third party a copy of such individual's protected health information pursuant to the Health Information Portability and Accountability Act, Privacy Rule (subpart E of part 164 of title 45, Code of Federal Regulations), the Director of the Office for Civil Rights, in consultation with the National Coordinator, shall assist individuals and health care providers in understanding a patient's rights to access and protect personal health information under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191), including providing best practices for requesting personal health information in a computable format, including using patient portals or third-party applications and common cases when a provider is permitted to exchange and provide access to health information.''.

''(2) CERTIFYING USABILITY FOR PATIENTS.—In carrying out certification programs under section 3001(c)(5), the National Coordinator may require that—

''(A) the certification criteria support—

''(i) patient access to their electronic health information, including in a single longitudinal format that is easy to understand, secure, and may be updated automatically;

''(ii) the patient's ability to electronically communicate patient-reported information (such as family history and medical history); and

''(iii) patient access to their personal electronic health information for research at the option of the patient; and

''(B) the HIT Advisory Committee develop and prioritize standards, implementation specifications, and certification criteria required to help support patient access to electronic health information, patient usability, and support for technologies that offer patients access to their electronic health information in a single, longitudinal format that is easy to understand, secure, and may be updated automatically.''.

(b) ACCESS TO INFORMATION IN AN ELECTRONIC FORMAT.—Section 13405(e) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17935) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1), the following:

''(2) if the individual makes a request to a business associate for access to, or a copy of, protected health information about the individual, or if an individual makes a request to a business associate to grant such access to, or transmit such copy directly to, a person or entity designated by the individual, a business associate may provide the individual with such access or copy, which may be in an electronic form, or grant or transmit such access or copy to such person or entity designated by the individual; and''.

SEC. 4007. GAO STUDY ON PATIENT MATCHING.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study to—

(1) review the policies and activities of the Office of the National Coordinator for Health Information Technology and other relevant stakeholders, which may include standards development organizations, experts in the technical aspects of health information technology, health information technology developers, providers of health services, health care suppliers, health care payers, health care quality organizations, States, health information technology policy experts, and other appropriate entities, to ensure appropriate patient matching to protect patient privacy and security with respect to electronic health records and the exchange of electronic health information; and

(2) survey ongoing efforts related to the policies and activities described in paragraph (1) and the effectiveness of such efforts occurring in the private sector.

(b) AREAS OF CONCENTRATION.—In conducting the study under subsection (a), the Comptroller General shall—

(1) evaluate current methods used in certified electronic health records for patient matching based on performance related to factors such as—

(A) the privacy of patient information;

(B) the security of patient information;

(C) improving matching rates;

(D) reducing matching errors; and

(E) reducing duplicate records; and

(2) determine whether the Office of the National Coordinator for Health Information Technology could improve patient matching by taking steps including—

(A) defining additional data elements to assist in patient data matching;

(B) agreeing on a required minimum set of elements that need to be collected and exchanged;

(C) requiring electronic health records to have the ability to make certain fields required and use specific standards; and

(D) other options recommended by the relevant stakeholders consulted pursuant to subsection (a).

(c) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to the appropriate committees of Congress a report concerning the findings of the study conducted under subsection (a).

SEC. 4008. GAO STUDY ON PATIENT ACCESS TO HEALTH INFORMATION.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the ''Comptroller General'') shall build on prior Government Accountability Office studies and other literature review and conduct a study to review patient access to their own protected health information, including barriers to such patient access and complications or difficulties providers experience in providing access to patients. In conducting such study, the Comptroller General shall consider the increase in adoption of health information technology and the increasing prevalence of protected health information that is maintained electronically.

(2) AREAS OF CONCENTRATION.—In conducting the review under paragraph (1), the Comptroller General shall consider—

(A) instances when covered entities charge individuals, including patients, third parties, and health care providers, for record requests, including records that are requested in an electronic format;

(B) examples of the amounts and types of fees charged to individuals for record requests, including instances when the record is requested to be transmitted to a third party;

(C) the extent to which covered entities are unable to provide the access requested by individuals in the form and format requested by the individual, including examples of such instances;

(D) instances in which third parties may request protected health information through patients' individual right of access, including instances where such requests may be used to circumvent appropriate fees that may be charged to third parties;

(E) opportunities that permit covered entities to charge appropriate fees to third parties for patient records while providing patients with access to their protected health information at low or no cost;

(F) the ability of providers to distinguish between requests originating from an individual that require limitation to a cost-based fee and requests originating from third parties that may not be limited to cost-based fees; and

(G) other circumstances that may inhibit the ability of providers to provide patients with access to their records, and the ability of patients to gain access to their records.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit a report to Congress on the findings of the study conducted under subsection (a).

SEC. 4009. IMPROVING MEDICARE LOCAL COVERAGE DETERMINATIONS.

(a) IN GENERAL.—Section 1862(l)(5) of the Social Security Act (42 U.S.C. 1395y(l)(5)) is amended by adding at the end the following new subparagraph:

''(D) LOCAL COVERAGE DETERMINATIONS.—The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

''(i) Such determination in its entirety.

''(ii) Where and when the proposed determination was first made public.

''(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

''(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

''(v) An explanation of the rationale that supports such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to local coverage determinations that are proposed or revised on or after the date that is 180 days after the date of enactment of this Act.

SEC. 4010. MEDICARE PHARMACEUTICAL AND TECHNOLOGY OMBUDSMAN.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

''(d) PHARMACEUTICAL AND TECHNOLOGY OMBUDSMAN.—

''(1) IN GENERAL.—Not later than 12 months after the date of enactment of this paragraph, the Secretary shall provide for a pharmaceutical and technology ombudsman within the Centers for Medicare & Medicaid Services who shall receive and respond to complaints, grievances, and requests that—

''(A) are from entities that manufacture pharmaceutical, biotechnology, medical device, or diagnostic products that are covered or for which coverage is being sought under this title; and

''(B) are with respect to coverage, coding, or payment under this title for such products.

''(2) APPLICATION.—The second sentence of subsection (c)(2) shall apply to the ombudsman under subparagraph (A) in the same manner as such sentence applies to the Medicare Beneficiary Ombudsman under subsection (c).''.

SEC. 4011. MEDICARE SITE-OF-SERVICE PRICE TRANSPARENCY.

Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(t) SITE-OF-SERVICE PRICE TRANSPARENCY.—

''(1) IN GENERAL.—In order to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center under this title, the Secretary shall, for 2018 and each year thereafter, make available to the public via a searchable Internet website, with respect to an appropriate number of such items and services—

''(A) the estimated payment amount for the item or service under the outpatient department fee schedule under subsection (t) of section 1833 and the ambulatory surgical center payment system under subsection (i) of such section; and

''(B) the estimated amount of beneficiary liability applicable to the item or service.

''(2) CALCULATION OF ESTIMATED BENEFICIARY LIABILITY.—For purposes of paragraph (1)(B), the estimated amount of beneficiary liability, with respect to an item or service, is the amount for such item or service for which an individual who does not have coverage under a Medicare supplemental policy certified under section 1882 or any other supplemental insurance coverage is responsible.

''(3) IMPLEMENTATION.—In carrying out this subsection, the Secretary—

''(A) shall include in the notice described in section 1804(a) a notification of the availability of the estimated amounts made available under paragraph (1); and

''(B) may utilize mechanisms in existence on the date of enactment of this subsection, such as the portion of the Internet website of the Centers for Medicare & Medicaid Services on which information comparing physician performance is posted (commonly referred to as the Physician Compare Internet website), to make available such estimated amounts under such paragraph.

''(4) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account, of $6,000,000 for fiscal year 2017, to remain available until expended.''.

SEC. 4012. TELEHEALTH SERVICES IN MEDICARE.

(a) PROVISION OF INFORMATION BY CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than 1 year after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall provide to the committees of jurisdiction of the House of Representatives and the Senate information on the following:

(1) The populations of Medicare beneficiaries, such as those who are dually eligible for the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) and those with chronic conditions, whose care may be improved most in terms of quality and efficiency by the expansion, in a manner that meets or exceeds the existing in-person standard of care under the Medicare program under such title XVIII, of telehealth services under section 1834(m)(4) of such Act (42 U.S.C. 1395m(m)(4)).

(2) Activities by the Center for Medicare and Medicaid Innovation which examine the use of telehealth services in models, projects, or initiatives funded through section 1115A of such Act (42 U.S.C. 1315a).

(3) The types of high-volume services (and related diagnoses) under such title XVIII which might be suitable to be furnished using telehealth.

(4) Barriers that might prevent the expansion of telehealth services under section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)) beyond such services that are in effect as of the date of enactment of this Act.

(b) PROVISION OF INFORMATION BY MEDPAC.—Not later than March 15, 2018, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall, using quantitative and qualitative research methods, provide information to the committees of jurisdiction of the House of Representatives and the Senate that identifies—

(1) the telehealth services for which payment can be made, as of the date of enactment of this Act, under the fee-for-service program under parts A and B of title XVIII of such Act;

(2) the telehealth services for which payment can be made, as of such date, under private health insurance plans; and

(3) with respect to services identified under paragraph (2) but not under paragraph (1), ways in which payment for such services might be incorporated into such fee-for-service program (including any recommendations for ways to accomplish this incorporation).

(c) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) eligible originating sites should be expanded beyond those originating sites described in section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)); and

(2) any expansion of telehealth services under the Medicare program under title XVIII of such Act should—

(A) recognize that telemedicine is the delivery of safe, effective, quality health care services, by a health care provider, using technology as the mode of care delivery;

(B) meet or exceed the conditions of coverage and payment with respect to the Medicare program if the service was furnished in person, including standards of care, unless specifically addressed in subsequent legislation; and

(C) involve clinically appropriate means to furnish such services.

TITLE V—SAVINGS

SEC. 5001. SAVINGS IN THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)), as amended by section 704(h) of the Comprehensive Addiction and Recovery Act of 2016, is amended by striking ''$140,000,000'' and inserting ''$270,000,000''.

SEC. 5002. MEDICAID REIMBURSEMENT TO STATES FOR DURABLE MEDICAL EQUIPMENT.

Section 1903(i)(27) of the Social Security Act (42 U.S.C. 1396b(i)(27)) is amended by striking ''January 1, 2019'' and inserting ''January 1, 2018''.

SEC. 5003. PENALTIES FOR VIOLATIONS OF GRANTS, CONTRACTS, AND OTHER AGREEMENTS.

(a) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsections:

''(o) Any person (including an organization, agency, or other entity, but excluding a program beneficiary, as defined in subsection (q)(4)) that, with respect to a grant, contract, or other agreement for which the Secretary provides funding—

''(1) knowingly presents or causes to be presented a specified claim (as defined in subsection (r)) under such grant, contract, or other agreement that the person knows or should know is false or fraudulent;

''(2) knowingly makes, uses, or causes to be made or used any false statement, omission, or

misrepresentation of a material fact in any application, proposal, bid, progress report, or other document that is required to be submitted in order to directly or indirectly receive or retain funds provided in whole or in part by such Secretary pursuant to such grant, contract, or other agreement;

''(3) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent specified claim under such grant, contract, or other agreement;

''(4) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation (as defined in subsection (s)) to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit funds or property to such Secretary with respect to such grant, contract, or other agreement; or

''(5) fails to grant timely access, upon reasonable request (as defined by such Secretary in regulations), to the Inspector General of the Department, for the purpose of audits, investigations, evaluations, or other statutory functions of such Inspector General in matters involving such grants, contracts, or other agreements;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty in cases under paragraph (1), of not more than $10,000 for each specified claim; in cases under paragraph (2), not more than $50,000 for each false statement, omission, or misrepresentation of a material fact; in cases under paragraph (3), not more than $50,000 for each false record or statement; in cases under paragraph (4), not more than $50,000 for each false record or statement or $10,000 for each day that the person knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay; or in cases under paragraph (5), not more than $15,000 for each day of the failure described in such paragraph. In addition, in cases under paragraphs (1) and (3), such a person shall be subject to an assessment of not more than 3 times the amount claimed in the specified claim described in such paragraph in lieu of damages sustained by the United States or a specified State agency because of such specified claim, and in cases under paragraphs (2) and (4), such a person shall be subject to an assessment of not more than 3 times the total amount of the funds described in paragraph (2) or (4), respectively (or, in the case of an obligation to transmit property to the Secretary described in paragraph (4), of the value of the property described in such paragraph) in lieu of damages sustained by the United States or a specified State agency because of such case. In addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

''(p) The provisions of subsections (c), (d), (g), and (h) shall apply to a civil money penalty or assessment under subsection (o) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a). In applying subsection (d), each reference to a claim under such subsection shall be treated as including a reference to a specified claim (as defined in subsection (r)).

''(q) For purposes of this subsection and subsections (o) and (p):

''(1) The term 'Department' means the Department of Health and Human Services.

''(2) The term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

''(3) The term 'other agreement' includes a cooperative agreement, scholarship, fellowship, loan, subsidy, payment for a specified use, donation agreement, award, or subaward (regardless of whether one or more of the persons entering into the agreement is a contractor or subcontractor).

''(4) The term 'program beneficiary' means, in the case of a grant, contract, or other agreement designed to accomplish the objective of awarding or otherwise furnishing benefits or assistance to individuals and for which the Secretary provides funding, an individual who applies for, or who receives, such benefits or assistance from such grant, contract, or other agreement. Such term does not include, with respect to such grant, contract, or other agreement, an officer, employee, or agent of a person or entity that receives such grant or that enters into such contract or other agreement.

''(5) The term 'recipient' includes a subrecipient or subcontractor.

''(6) The term 'specified State agency' means an agency of a State government established or designated to administer or supervise the administration of a grant, contract, or other agreement funded in whole or in part by the Secretary.

''(r) For purposes of this section, the term 'specified claim' means any application, request, or demand under a grant, contract, or other agreement for money or property, whether or not the United States or a specified State agency has title to the money or property, that is not a claim (as defined in subsection (i)(2)) and that—

''(1) is presented or caused to be presented to an officer, employee, or agent of the Department or agency thereof, or of any specified State agency; or

''(2) is made to a contractor, grantee, or any other recipient if the money or property is to be spent or used on the Department's behalf or to advance a Department program or interest, and if the Department—

''(A) provides or has provided any portion of the money or property requested or demanded; or

''(B) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

''(s) For purposes of subsection (o), the term 'obligation' means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, for a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.''.

(b) CONFORMING AMENDMENTS.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (e), by inserting ''or specified claim'' after ''claim'' in the first sentence; and

(2) in subsection (f)—

(A) in the matter preceding paragraph (1)—

(i) by inserting ''or specified claim (as defined in subsection (r))'' after ''district where the claim''; and

(ii) by inserting ''(or, with respect to a person described in subsection (o), the person)'' after ''claimant''; and

(B) in the matter following paragraph (4), by inserting ''(or, in the case of a penalty or assessment under subsection (o), by a specified State agency (as defined in subsection (q)(6)),'' after ''or a State agency''.

SEC. 5004. REDUCING OVERPAYMENTS OF INFUSION DRUGS.

(a) TREATMENT OF INFUSION DRUGS FURNISHED THROUGH DURABLE MEDICAL EQUIPMENT.—Section 1842(o)(1) of the Social Security Act (42 U.S.C. 1395u(o)(1)) is amended—

(1) in subparagraph (C), by inserting ''(and including a drug or biological described in subparagraph (D)(i) furnished on or after January 1, 2017)'' after ''2005''; and

(2) in subparagraph (D)—

(A) by striking ''infusion drugs'' and inserting ''infusion drugs or biologicals'' each place it appears; and

(B) in clause (i)—

(i) by striking ''2004'' and inserting ''2004, and before January 1, 2017''; and

(ii) by striking ''for such drug''.

(b) NONINCLUSION OF DME INFUSION DRUGS UNDER DME COMPETITIVE ACQUISITION PROGRAMS.—

(1) IN GENERAL.—Section 1847(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)(A)) is amended—

(A) by striking ''and excluding'' and inserting '', excluding''; and

(B) by inserting before the period at the end the following: '', and excluding drugs and biologicals described in section 1842(o)(1)(D)''.

(2) CONFORMING AMENDMENT.—Section 1842(o)(1)(D)(ii) of the Social Security Act (42 U.S.C. 1395u(o)(1)(D)(ii)) is amended by striking ''2007'' and inserting ''2007, and before the date of the enactment of the 21st Century Cures Act.''.

SEC. 5005. INCREASING OVERSIGHT OF TERMINATION OF MEDICAID PROVIDERS.

(a) INCREASED OVERSIGHT AND REPORTING.—

(1) STATE REPORTING REQUIREMENTS.—Section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)) is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) PROVIDER TERMINATIONS.—

''(A) IN GENERAL.—Beginning on July 1, 2018, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan (or under a waiver of the plan), the State, not later than 30 days after the effective date of such termination submits to the Secretary with respect to any such provider or person, as appropriate—

''(i) the name of such provider or person;

''(ii) the provider type of such provider or person;

''(iii) the specialty of such provider's or person's practice;

''(iv) the date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);

''(v) the reason for the termination;

''(vi) a copy of the notice of termination sent to the provider or person;

''(vii) the date on which such termination is effective, as specified in the notice; and

''(viii) any other information required by the Secretary.

''(B) EFFECTIVE DATE DEFINED.—For purposes of this paragraph, the term 'effective date' means, with respect to a termination described in subparagraph (A), the later of—

''(i) the date on which such termination is effective, as specified in the notice of such termination; or

''(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.''.

(2) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)) is amended by adding at the end the following new paragraph:

''(5) CONTRACT REQUIREMENT FOR MANAGED CARE ENTITIES.—With respect to any contract with a managed care entity under section 1903(m) or 1905(t)(3) (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1902(kk)(8)) from participation under this title, title XVIII, or title XXI shall be terminated from participating under this title as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this title.''.

(3) TERMINATION NOTIFICATION DATABASE.—Section 1902 of the Social Security Act (42 U.S.C.

1396a) is amended by adding at the end the following new subsection:

''(ll) TERMINATION NOTIFICATION DATABASE.—In the case of a provider of services or any other person whose participation under this title or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).''.

(4) NO FEDERAL FUNDS FOR ITEMS AND SERVICES FURNISHED BY TERMINATED PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(2)—

(i) in subparagraph (A), by striking the comma at the end and inserting a semicolon;

(ii) in subparagraph (B), by striking ''or'' at the end; and

(iii) by adding at the end the following new subparagraph:

''(D) beginning on July 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(ll); or''; and

(B) in subsection (m), by inserting after paragraph (2) the following new paragraph:

''(3) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—

''(A) beginning on July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1932(d)(5); and

''(B) beginning on January 1, 2018, complies with the requirement specified in section 1932(d)(6)(A).''.

(5) DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.—Not later than July 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as added by paragraph (1), for the termination (as described in such paragraph (8)) of the participation of certain providers in the Medicaid program under title XIX of such Act or the Children's Health Insurance Program under title XXI of such Act.

(6) CONFORMING AMENDMENT.—Section 1902(a)(41) of the Social Security Act (42 U.S.C. 1396a(a)(41)) is amended by striking ''provide that whenever'' and inserting ''provide, in accordance with subsection (kk)(8) (as applicable), that whenever''.

(b) INCREASING AVAILABILITY OF MEDICAID PROVIDER INFORMATION.—

(1) FFS PROVIDER ENROLLMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide that, not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);''.

(2) MANAGED CARE PROVIDER ENROLLMENT.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6) ENROLLMENT OF PARTICIPATING PROVIDERS.—

''(A) IN GENERAL.—Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

''(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this title.''.

(c) COORDINATION WITH CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), (M), (N), and (O) as subparagraphs (D), (E), (F), (G), (H), (I), (J), (K), (M), (N), (O), (P), (Q), and (R), respectively;

(B) by inserting after subparagraph (A) the following new subparagraphs:

''(B) Section 1902(a)(39) (relating to termination of participation of certain providers).

''(C) Section 1902(a)(78) (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).'';

(C) by inserting after subparagraph (K) (as redesignated by subparagraph (A)) the following new subparagraph:

''(L) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).''; and

(D) in subparagraph (P) (as redesignated by subparagraph (A)), by striking ''(a)(2)(C) and (h)'' and inserting ''(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)''.

(2) EXCLUDING FROM MEDICAID PROVIDERS EXCLUDED FROM CHIP.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended by striking ''title XVIII or any other State plan under this title'' and inserting ''title XVIII, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act''.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act.

(e) OIG REPORT.—Not later than March 31, 2020, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the implementation of the amendments made by this section. Such report shall include the following:

(1) An assessment of the extent to which providers who are included under subsection (ll) of section 1902 of the Social Security Act (42 U.S.C. 1396a) (as added by subsection (a)(3)) in the database or similar system referred to in such subsection are terminated (as described in paragraph (8) of subsection (kk) of such section, as added by subsection (a)(1)) from participation in all State plans under title XIX of such Act (or waivers of such plans).

(2) Information on the amount of Federal financial participation paid to States under section 1903 of such Act in violation of the limitation on such payment specified in subparagraph (D) of subsection (i)(2) of such section and paragraph (3) of subsection (m) of such section, as added by subsection (a)(4).

(3) An assessment of the extent to which contracts with managed care entities under title XIX of such Act comply with the requirement specified in paragraph (5) of section 1932(d) of such Act, as added by subsection (a)(2).

(4) An assessment of the extent to which providers have been enrolled under section 1902(a)(78) or 1932(d)(6)(A) of such Act (42 U.S.C. 1396a(a)(78), 1396u–2(d)(6)(A)) with State agencies administering State plans under title XIX of such Act (or waivers of such plans).

SEC. 5006. REQUIRING PUBLICATION OF FEE-FOR-SERVICE PROVIDER DIRECTORY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82) the following new paragraph:

''(83) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

''(A) includes—

''(i) with respect to each such physician or provider—

''(I) the name of the physician or provider;

''(II) the specialty of the physician or provider;

''(III) the address at which the physician or provider provides services; and

''(IV) the telephone number of the physician or provider; and

''(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

''(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title; and

''(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office; and

''(B) may include, at State option, with respect to each such physician or provider—

''(i) the Internet website of such physician or provider; or

''(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.''.

(b) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section

5005(a)(3), is further amended by adding at the end the following new subsection:

''(mm) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—A physician or provider described in this subsection is—

''(1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or provider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

''(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

''(B) received payment under the State plan in the 12-month period preceding such date; and

''(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).''.

(c) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—The amendment made by subsection (a) shall not be construed to apply in the case of a State (as defined for purposes of title XIX of the Social Security Act) in which all the individuals enrolled in the State plan under such title (or under a waiver of such plan), other than individuals described in paragraph (2), are enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A))), including prepaid inpatient health plans and prepaid ambulatory health plans (as defined by the Secretary of Health and Human Services).

(2) INDIVIDUALS DESCRIBED.—An individual described in this paragraph is an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or an Alaska Native.

(d) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 5007. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS TRUSTS.

(a) IN GENERAL.—Section 1917(d)(4)(A) of the Social Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended by inserting ''the individual,'' after ''for the benefit of such individual by''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to trusts established on or after the date of the enactment of this Act.

SEC. 5008. ELIMINATING FEDERAL FINANCIAL PARTICIPATION WITH RESPECT TO EXPENDITURES UNDER MEDICAID FOR AGENTS USED FOR COSMETIC PURPOSES OR HAIR GROWTH.

(a) IN GENERAL.—Section 1903(i)(21) of the Social Security Act (42 U.S.C. 1396b(i)(21)) is amended by inserting ''section 1927(d)(2)(C) (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and'' after ''drugs described in''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to calendar quarters beginning on or after the date of the enactment of this Act.

SEC. 5009. AMENDMENT TO THE PREVENTION AND PUBLIC HEALTH FUND.

Section 4002(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11(b)) is amended—

(1) in paragraph (3), by striking ''$1,250,000,000'' and inserting ''$900,000,000'';

(2) in paragraph (4), by striking ''$1,500,000,000'' and inserting ''$1,000,000,000''; and

(3) by striking paragraph (5) and inserting the following:

''(5) for fiscal year 2022, $1,500,000,000;

''(6) for fiscal year 2023, $1,000,000,000;

''(7) for fiscal year 2024, $1,700,000,000; and

''(8) for fiscal year 2025 and each fiscal year thereafter, $2,000,000,000.''.

SEC. 5010. STRATEGIC PETROLEUM RESERVE DRAWDOWN.

(a) DRAWDOWN AND SALE.—

(1) IN GENERAL.—Notwithstanding section 161 of the Energy Policy and Conservation Act (42 U.S.C. 6241), except as provided in subsections (b) and (c), the Secretary of Energy shall drawdown and sell from the Strategic Petroleum Reserve—

(A) 10,000,000 barrels of crude oil during fiscal year 2017;

(B) 9,000,000 barrels of crude oil during fiscal year 2018; and

(C) 6,000,000 barrels of crude oil during fiscal year 2019.

(2) DEPOSIT OF AMOUNTS RECEIVED FROM SALE.—Amounts received from a sale under paragraph (1) shall be deposited in the general fund of the Treasury during the fiscal year in which the sale occurs.

(b) EMERGENCY PROTECTION.—The Secretary shall not draw down and sell crude oil under this section in quantities that would limit the authority to sell petroleum products under section 161(h) of the Energy Policy and Conservation Act (42 U.S.C. 6241(h)) in the full quantity authorized by that subsection.

(c) STRATEGIC PETROLEUM DRAWDOWN LIMITATIONS.—Subparagraphs (C) and (D) of section 161(h)(2) of the Energy Policy and Conservation Act (42 U.S.C. 6241(h)(2)(C) and (D)) are both amended by striking ''500,000,000'' and inserting ''450,000,000''.

SEC. 5011. RESCISSION OF PORTION OF ACA TERRITORY FUNDING.

Of the unobligated amounts available under section 1323(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18043(c)(1)), $464,000,000 is rescinded immediately upon the date of the enactment of this Act.

SEC. 5012. MEDICARE COVERAGE OF HOME INFUSION THERAPY.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraph (EE);

(B) by inserting ''and'' at the end of subparagraph (FF); and

(C) by inserting at the end the following new subparagraph:

''(GG) home infusion therapy (as defined in subsection (iii)(1));''; and

(2) by adding at the end the following new subsection:

''(iii) HOME INFUSION THERAPY.—(1) The term 'home infusion therapy' means the items and services described in paragraph (2) furnished by a qualified home infusion therapy supplier (as defined in paragraph (3)(D)) which are furnished in the individual's home (as defined in paragraph (3)(B)) to an individual—

''(A) who is under the care of an applicable provider (as defined in paragraph (3)(A)); and

''(B) with respect to whom a plan prescribing the type, amount, and duration of infusion therapy services that are to be furnished such individual has been established by a physician (as defined in subsection (r)(1)) and is periodically reviewed by a physician (as so defined) in coordination with the furnishing of home infusion drugs (as defined in paragraph (3)(C)) under part B.

''(2) The items and services described in this paragraph are the following:

''(A) Professional services, including nursing services, furnished in accordance with the plan.

''(B) Training and education (not otherwise paid for as durable medical equipment (as defined in subsection (n)), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

''(3) For purposes of this subsection:

''(A) The term 'applicable provider' means—

''(i) a physician;

''(ii) a nurse practitioner; and

''(iii) a physician assistant.

''(B) The term 'home' means a place of residence used as the home of an individual (as defined for purposes of subsection (n)).

''(C) The term 'home infusion drug' means a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in subsection (n)). Such term does not include the following:

''(i) Insulin pump systems.

''(ii) A self-administered drug or biological on a self-administered drug exclusion list.

''(D)(i) The term 'qualified home infusion therapy supplier' means a pharmacy, physician, or other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider or services or supplier furnishes items or services and that—

''(I) furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;

''(II) ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;

''(III) is accredited by an organization designated by the Secretary pursuant to section 1834(u)(5); and

''(IV) meets such other requirements as the Secretary determines appropriate, taking into account the standards of care for home infusion therapy established by Medicare Advantage plans under part C and in the private sector.

''(ii) A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet the requirements of this subparagraph.''.

(b) PAYMENT AND RELATED REQUIREMENTS FOR HOME INFUSION THERAPY.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4011, is further amended by adding at the end the following new subsection:

''(u) PAYMENT AND RELATED REQUIREMENTS FOR HOME INFUSION THERAPY.—

''(1) PAYMENT.—

''(A) SINGLE PAYMENT.—

''(i) IN GENERAL.—Subject to clause (iii) and subparagraphs (B) and (C), the Secretary shall implement a payment system under which a single payment is made under this title to a qualified home infusion therapy supplier for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2)) furnished by a qualified home infusion therapy supplier (as defined in section 1861(iii)(3)(D)) in coordination with the furnishing of home infusion drugs (as defined in section 1861(iii)(3)(C)) under this part.

''(ii) UNIT OF SINGLE PAYMENT.—A unit of single payment under the payment system implemented under this subparagraph is for each infusion drug administration calendar day in the individual's home. The Secretary shall, as appropriate, establish single payment amounts for types of infusion therapy, including to take into account variation in utilization of nursing services by therapy type.

''(iii) LIMITATION.—The single payment amount determined under this subparagraph

after application of subparagraph (B) and paragraph (3) shall not exceed the amount determined under the fee schedule under section 1848 for infusion therapy services furnished in a calendar day if furnished in a physician office setting, except such single payment shall not reflect more than 5 hours of infusion for a particular therapy in a calendar day.

''(B) REQUIRED ADJUSTMENTS.—The Secretary shall adjust the single payment amount determined under subparagraph (A) for home infusion therapy services under section 1861(iii)(1) to reflect other factors such as—

''(i) a geographic wage index and other costs that may vary by region; and

''(ii) patient acuity and complexity of drug administration.

''(C) DISCRETIONARY ADJUSTMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may adjust the single payment amount determined under subparagraph (A) (after application of subparagraph (B)) to reflect outlier situations and other factors as the Secretary determines appropriate.

''(ii) REQUIREMENT OF BUDGET NEUTRALITY.—Any adjustment under this subparagraph shall be made in a budget neutral manner.

''(2) CONSIDERATIONS.—In developing the payment system under this subsection, the Secretary may consider the costs of furnishing infusion therapy in the home, consult with home infusion therapy suppliers, consider payment amounts for similar items and services under this part and part A, and consider payment amounts established by Medicare Advantage plans under part C and in the private insurance market for home infusion therapy (including average per treatment day payment amounts by type of home infusion therapy).

''(3) ANNUAL UPDATES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall update the single payment amount under this subsection from year to year beginning in 2022 by increasing the single payment amount from the prior year by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

''(B) ADJUSTMENT.—For each year, the Secretary shall reduce the percentage increase described in subparagraph (A) by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year.

''(4) AUTHORITY TO APPLY PRIOR AUTHORIZATION.—The Secretary may, as determined appropriate by the Secretary, apply prior authorization for home infusion therapy services under section 1861(iii)(1).

''(5) ACCREDITATION OF QUALIFIED HOME INFUSION THERAPY SUPPLIERS.—

''(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

''(i) The ability of the organization to conduct timely reviews of accreditation applications.

''(ii) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

''(iii) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

''(iv) Such other factors as the Secretary determines appropriate.

''(B) DESIGNATION.—Not later than January 1, 2021, the Secretary shall designate organizations to accredit suppliers furnishing home infusion therapy. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

''(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

''(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

''(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

''(D) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2021, by an accreditation organization designated by the Secretary under subparagraph (B) as of January 1, 2019, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2023, for the remaining period such accreditation is in effect.

''(6) NOTIFICATION OF INFUSION THERAPY OPTIONS AVAILABLE PRIOR TO FURNISHING HOME INFUSION THERAPY.—Prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan described in section 1861(iii)(1) for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy under this part.''.

(c) CONFORMING AMENDMENTS.—

(1) PAYMENT REFERENCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and'' before ''(AA)''; and

(B) by inserting before the semicolon at the end the following: '', and (BB) with respect to home infusion therapy, the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under section 1834(u)''.

(2) DIRECT PAYMENT.—The first sentence of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and'' before ''(H)''; and

(B) by inserting before the period at the end the following: '', and (I) in the case of home infusion therapy, payment shall be made to the qualified home infusion therapy supplier''.

(3) EXCLUSION FROM HOME HEALTH SERVICES.—Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) is amended, in the first sentence, by inserting the following before the period at the end: ''and home infusion therapy (as defined in subsection (iii)(i))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2021.

DIVISION B—HELPING FAMILIES IN MENTAL HEALTH CRISIS

SEC. 6000. SHORT TITLE.

This division may be cited as the ''Helping Families in Mental Health Crisis Reform Act of 2016''.

TITLE VI—STRENGTHENING LEADERSHIP AND ACCOUNTABILITY

Subtitle A—Leadership

SEC. 6001. ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE.

(a) ASSISTANT SECRETARY.—Section 501(c) of the Public Health Service Act (42 U.S.C. 290aa(c)) is amended to read as follows:

''(c) ASSISTANT SECRETARY AND DEPUTY ASSISTANT SECRETARY.—

''(1) ASSISTANT SECRETARY.—The Administration shall be headed by an official to be known as the Assistant Secretary for Mental Health and Substance Use (hereinafter in this title referred to as the 'Assistant Secretary') who shall be appointed by the President, by and with the advice and consent of the Senate.

''(2) DEPUTY ASSISTANT SECRETARY.—The Assistant Secretary, with the approval of the Secretary, may appoint a Deputy Assistant Secretary and may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the activities to be carried out through the Administration.''.

(b) TRANSFER OF AUTHORITIES.—The Secretary of Health and Human Services shall delegate to the Assistant Secretary for Mental Health and Substance Use all duties and authorities that—

(1) as of the day before the date of enactment of this Act, were vested in the Administrator of the Substance Abuse and Mental Health Services Administration; and

(2) are not terminated by this Act.

(c) CONFORMING AMENDMENTS.—Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.), as amended by the previous provisions of this section, is further amended—

(1) by striking ''Administrator of the Substance Abuse and Mental Health Services Administration'' each place it appears and inserting ''Assistant Secretary for Mental Health and Substance Use''; and

(2) by striking ''Administrator'' or ''ADMINISTRATOR'' each place it appears (including in any headings) and inserting ''Assistant Secretary'' or ''ASSISTANT SECRETARY'', respectively, except where the term ''Administrator'' appears—

(A) in each of subsections (e) and (f) of section 501 of such Act (42 U.S.C. 290aa), including the headings of such subsections, within the term ''Associate Administrator'';

(B) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term ''Administrator of the Health Resources and Services Administration'';

(C) in section 507(b)(6) of such Act (42 U.S.C. 290bb(b)(6)), within the term ''Administrator of the Centers for Medicare & Medicaid Services'';

(D) in section 519B(c)(1)(B) of such Act (42 U.S.C. 290bb–25b(c)(1)(B)), within the term ''Administrator of the National Highway Traffic Safety Administration''; or

(E) in each of sections 519B(c)(1)(B), 520C(a), and 520D(a) of such Act (42 U.S.C. 290bb–25b(c)(1)(B), 290bb–34(a), 290bb–35(a)), within the term ''Administrator of the Office of Juvenile Justice and Delinquency Prevention''.

(d) REFERENCES.—After executing subsections (a), (b), and (c), any reference in statute, regulation, or guidance to the Administrator of the Substance Abuse and Mental Health Services Administration shall be construed to be a reference to the Assistant Secretary for Mental Health and Substance Use.

SEC. 6002. STRENGTHENING THE LEADERSHIP OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.

Section 501 of the Public Health Service Act (42 U.S.C. 290aa), as amended by section 6001, is further amended—

(1) in subsection (b)—

(A) in the subsection heading, by striking ''AGENCIES'' and inserting ''CENTERS''; and

(B) in the matter preceding paragraph (1), by striking ''entities'' and inserting ''Centers'';

(2) in subsection (d)—

(A) in paragraph (1)—

(i) by striking ''agencies'' each place the term appears and inserting ''Centers''; and

(ii) by striking ''such agency'' and inserting ''such Center'';

(B) in paragraph (2)—

(i) by striking ''agencies'' and inserting ''Centers'';

(ii) by striking ''with respect to substance abuse'' and inserting ''with respect to substance use disorders''; and

(iii) by striking ''and individuals who are substance abusers'' and inserting ''and individuals with substance use disorders'';

(C) in paragraph (5), by striking ''substance abuse'' and inserting ''substance use disorder'';

(D) in paragraph (6)—

(i) by striking ''the Centers for Disease Control'' and inserting ''the Centers for Disease Control and Prevention,'';

(ii) by striking ''Administration develop'' and inserting ''Administration, develop'';

(iii) by striking ''HIV or tuberculosis among substance abusers and individuals with mental illness'' and inserting ''HIV, hepatitis, tuberculosis, and other communicable diseases among individuals with mental or substance use disorders,''; and

(iv) by striking ''illnesses'' at the end and inserting ''diseases or disorders'';

(E) in paragraph (7), by striking ''abuse utilizing anti-addiction medications, including methadone'' and inserting ''use disorders, including services that utilize drugs or devices approved or cleared by the Food and Drug Administration for the treatment of substance use disorders'';

(F) in paragraph (8)—

(i) by striking ''Agency for Health Care Policy Research'' and inserting ''Agency for Healthcare Research and Quality''; and

(ii) by striking ''treatment and prevention'' and inserting ''prevention and treatment'';

(G) in paragraph (9)—

(i) by inserting ''and maintenance'' after ''development'';

(ii) by striking ''Agency for Health Care Policy Research'' and inserting ''Agency for Healthcare Research and Quality''; and

(iii) by striking ''treatment and prevention services'' and inserting ''prevention, treatment, and recovery support services and are appropriately incorporated into programs carried out by the Administration'';

(H) in paragraph (10), by striking ''abuse'' and inserting ''use disorder'';

(I) by striking paragraph (11) and inserting the following:

''(11) work with relevant agencies of the Department of Health and Human Services on integrating mental health promotion and substance use disorder prevention with general health promotion and disease prevention and integrating mental and substance use disorders treatment services with physical health treatment services;'';

(J) in paragraph (13)—

(i) in the matter preceding subparagraph (A), by striking ''this title, assure that'' and inserting ''this title or part B of title XIX, or grant programs otherwise funded by the Administration'';

(ii) in subparagraph (A)—

(I) by inserting ''require that'' before ''all grants''; and

(II) by striking ''and'' at the end;

(iii) by redesignating subparagraph (B) as subparagraph (C);

(iv) by inserting after subparagraph (A) the following:

''(B) ensure that the director of each Center of the Administration consistently documents the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded;'';

(v) in subparagraph (C), as so redesignated—

(I) by inserting ''require that'' before ''all grants''; and

(II) in clause (ii), by inserting ''and'' after the semicolon at the end; and

(vi) by adding at the end the following:

''(D) inform a State when any funds are awarded through such a grant to any entity within such State;'';

(K) in paragraph (16), by striking ''abuse and mental health information'' and inserting ''use disorder information, including evidence-based and promising best practices for prevention, treatment, and recovery support services for individuals with mental and substance use disorders,'';

(L) in paragraph (17)—

(i) by striking ''substance abuse'' and inserting ''substance use disorder''; and

(ii) by striking ''and'' at the end;

(M) in paragraph (18), by striking the period and inserting a semicolon; and

(N) by adding at the end the following:

''(19) consult with State, local, and tribal governments, nongovernmental entities, and individuals with mental illness, particularly adults with a serious mental illness, children with a serious emotional disturbance, and the family members of such adults and children, with respect to improving community-based and other mental health services;

''(20) collaborate with the Secretary of Defense and the Secretary of Veterans Affairs to improve the provision of mental and substance use disorder services provided by the Department of Defense and the Department of Veterans Affairs to members of the Armed Forces, veterans, and the family members of such members and veterans, including through the provision of services using the telehealth capabilities of the Department of Defense and the Department of Veterans Affairs;

''(21) collaborate with the heads of relevant Federal agencies and departments, States, communities, and nongovernmental experts to improve mental and substance use disorders services for chronically homeless individuals, including by designing strategies to provide such services in supportive housing;

''(22) work with States and other stakeholders to develop and support activities to recruit and retain a workforce addressing mental and substance use disorders;

''(23) collaborate with the Attorney General and representatives of the criminal justice system to improve mental and substance use disorders services for individuals who have been arrested or incarcerated;

''(24) after providing an opportunity for public input, set standards for grant programs under this title for mental and substance use disorders services and prevention programs, which standards may address—

''(A) the capacity of the grantee to implement the award;

''(B) requirements for the description of the program implementation approach;

''(C) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will reach the population of focus and provide a statement of need, which may include information on how the grantee will increase access to services and a description of measurable objectives for improving outcomes;

''(D) the extent to which the grantee must collect and report on required performance measures; and

''(E) the extent to which the grantee is proposing to use evidence-based practices; and

''(25) advance, through existing programs, the use of performance metrics, including those based on the recommendations on performance metrics from the Assistant Secretary for Planning and Evaluation under section 6021(d) of the Helping Families in Mental Health Crisis Reform Act of 2016.''; and

(3) in subsection (m), by adding at the end the following:

''(4) EMERGENCY RESPONSE.—Amounts made available for carrying out this subsection shall remain available through the end of the fiscal year following the fiscal year for which such amounts are appropriated.''.

SEC. 6003. CHIEF MEDICAL OFFICER.

Section 501 of the Public Health Service Act (42 U.S.C. 290aa), as amended by sections 6001 and 6002, is further amended—

(1) by redesignating subsections (g) through (j) and subsections (k) through (o) as subsections (h) through (k) and subsections (m) through (q), respectively;

(2) in subsection (e)(3)(C), by striking ''subsection (k)'' and inserting ''subsection (m)'';

(3) in subsection (f)(2)(C)(iii), by striking ''subsection (k)'' and inserting ''subsection (m)''; and

(4) by inserting after subsection (f) the following:

''(g) CHIEF MEDICAL OFFICER.—

''(1) IN GENERAL.—The Assistant Secretary, with the approval of the Secretary, shall appoint a Chief Medical Officer to serve within the Administration.

''(2) ELIGIBLE CANDIDATES.—The Assistant Secretary shall select the Chief Medical Officer from among individuals who—

''(A) have a doctoral degree in medicine or osteopathic medicine;

''(B) have experience in the provision of mental or substance use disorder services;

''(C) have experience working with mental or substance use disorder programs;

''(D) have an understanding of biological, psychosocial, and pharmaceutical treatments of mental or substance use disorders; and

''(E) are licensed to practice medicine in one or more States.

''(3) DUTIES.—The Chief Medical Officer shall—

''(A) serve as a liaison between the Administration and providers of mental and substance use disorders prevention, treatment, and recovery services;

''(B) assist the Assistant Secretary in the evaluation, organization, integration, and coordination of programs operated by the Administration;

''(C) promote evidence-based and promising best practices, including culturally and linguistically appropriate practices, as appropriate, for the prevention and treatment of, and recovery from, mental and substance use disorders, including serious mental illness and serious emotional disturbances;

''(D) participate in regular strategic planning with the Administration;

''(E) coordinate with the Assistant Secretary for Planning and Evaluation to assess the use of performance metrics to evaluate activities within the Administration related to mental and substance use disorders; and

''(F) coordinate with the Assistant Secretary to ensure mental and substance use disorders grant programs within the Administration consistently utilize appropriate performance metrics and evaluation designs.''.

SEC. 6004. IMPROVING THE QUALITY OF BEHAVIORAL HEALTH PROGRAMS.

Section 505 of the Public Health Service Act (42 U.S.C. 290aa–4), as amended by section 6001(c), is amended—

(1) by striking the section designation and heading and inserting the following:

''SEC. 505. CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY.'';

(2) by redesignating subsections (a) through (d) as subsections (b) through (e), respectively;

(3) before subsection (b), as redesignated by paragraph (2), by inserting the following:

''(a) IN GENERAL.—The Assistant Secretary shall maintain within the Administration a Center for Behavioral Health Statistics and Quality (in this section referred to as the 'Center'). The Center shall be headed by a Director (in this section referred to as the 'Director') appointed

by the Secretary from among individuals with extensive experience and academic qualifications in research and analysis in behavioral health care or related fields.'';

(4) in subsection (b), as redesignated by paragraph (2)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(B) by striking ''The Secretary, acting'' and all that follows through ''year on—'' and inserting ''The Director shall—

''(1) coordinate the Administration's integrated data strategy, including by collecting data each year on—'';

(C) in the subparagraph (B), as redesignated by subparagraph (A), by striking ''Assistant Secretary'' and inserting ''Director''; and

(D) by adding at the end the following new paragraphs:

''(2) provide statistical and analytical support for activities of the Administration;

''(3) recommend a core set of performance metrics to evaluate activities supported by the Administration; and

''(4) coordinate with the Assistant Secretary, the Assistant Secretary for Planning and Evaluation, and the Chief Medical Officer appointed under section 501(g), as appropriate, to improve the quality of services provided by programs of the Administration and the evaluation of activities carried out by the Administration.'';

(5) in subsection (c), as so redesignated—

(A) by striking ''With respect to the activities'' and inserting ''MENTAL HEALTH.—With respect to the activities'';

(B) by striking ''Assistant Secretary'' each place it appears and inserting ''Director''; and

(C) by striking ''subsection (a)'' and inserting ''subsection (b)(1)'';

(6) in subsection (d), as so redesignated—

(A) by striking the subsection designation and all that follows through ''With respect to the activities'' and inserting the following:

''(d) SUBSTANCE ABUSE.—

''(1) IN GENERAL.—With respect to the activities'';

(B) in paragraph (1)—

(i) in the matter before subparagraph (A)—

(I) by striking ''subsection (a)'' and inserting ''subsection (b)(1)''; and

(II) by striking ''Assistant Secretary'' each place it appears and inserting ''Director''; and

(ii) in subparagraph (B), by inserting ''in coordination with the Centers for Disease Control and Prevention'' before the semicolon at the end; and

(C) in paragraph (2), by striking ''ANNUAL SURVEYS'' and inserting ''ANNUAL SURVEYS; PUBLIC AVAILABILITY OF DATA.—Annual surveys''; and

(7) in subsection (e), as so redesignated—

(A) by striking ''After consultation'' and inserting ''CONSULTATION.—After consultation''; and

(B) by striking ''Assistant Secretary shall develop'' and inserting ''Assistant Secretary shall use existing standards and best practices to develop''.

SEC. 6005. STRATEGIC PLAN.

Section 501 of the Public Health Service Act (42 U.S.C. 290aa), as amended by sections 6001 through 6003, is further amended by inserting after subsection (k), as redesignated by section 6003, the following:

''(l) STRATEGIC PLAN.—

''(1) IN GENERAL.—Not later than September 30, 2018, and every 4 years thereafter, the Assistant Secretary shall develop and carry out a strategic plan in accordance with this subsection for the planning and operation of activities carried out by the Administration, including evidence-based programs.

''(2) COORDINATION.—In developing and carrying out the strategic plan under this subsection, the Assistant Secretary shall take into consideration the findings and recommendations of the Assistant Secretary for Planning and Evaluation under section 6021(d) of the Helping Families in Mental Health Crisis Reform Act of 2016 and the report of the Interdepartmental Serious Mental Illness Coordinating Committee under section 6031 of such Act.

''(3) PUBLICATION OF PLAN.—Not later than September 30, 2018, and every 4 years thereafter, the Assistant Secretary shall—

''(A) submit the strategic plan developed under paragraph (1) to the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate; and

''(B) post such plan on the Internet website of the Administration.

''(4) CONTENTS.—The strategic plan developed under paragraph (1) shall—

''(A) identify strategic priorities, goals, and measurable objectives for mental and substance use disorders activities and programs operated and supported by the Administration, including priorities to prevent or eliminate the burden of mental and substance use disorders;

''(B) identify ways to improve the quality of services for individuals with mental and substance use disorders, and to reduce homelessness, arrest, incarceration, violence, including self-directed violence, and unnecessary hospitalization of individuals with a mental or substance use disorder, including adults with a serious mental illness or children with a serious emotional disturbance;

''(C) ensure that programs provide, as appropriate, access to effective and evidence-based prevention, diagnosis, intervention, treatment, and recovery services, including culturally and linguistically appropriate services, as appropriate, for individuals with a mental or substance use disorder;

''(D) identify opportunities to collaborate with the Health Resources and Services Administration to develop or improve—

''(i) initiatives to encourage individuals to pursue careers (especially in rural and underserved areas and with rural and underserved populations) as psychiatrists, including child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, physician assistants, clinical social workers, certified peer support specialists, licensed professional counselors, or other licensed or certified mental health or substance use disorder professionals, including such professionals specializing in the diagnosis, evaluation, or treatment of adults with a serious mental illness or children with a serious emotional disturbance; and

''(ii) a strategy to improve the recruitment, training, and retention of a workforce for the treatment of individuals with mental or substance use disorders, or co-occurring disorders;

''(E) identify opportunities to improve collaboration with States, local governments, communities, and Indian tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act); and

''(F) specify a strategy to disseminate evidence-based and promising best practices related to prevention, diagnosis, early intervention, treatment, and recovery services related to mental illness, particularly for adults with a serious mental illness and children with a serious emotional disturbance, and for individuals with a substance use disorder.'';

SEC. 6006. BIENNIAL REPORT CONCERNING ACTIVITIES AND PROGRESS.

(a) IN GENERAL.—Section 501 of the Public Health Service Act (42 U.S.C. 290aa), as so amended, is further amended by amending subsection (m), as redesignated by section 6003, to read as follows:

''(m) BIENNIAL REPORT CONCERNING ACTIVITIES AND PROGRESS.—Not later than September 30, 2020, and every 2 years thereafter, the Assistant Secretary shall prepare and submit to the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate, and post on the Internet website of the Administration, a report containing at a minimum—

''(1) a review of activities conducted or supported by the Administration, including progress toward strategic priorities, goals, and objectives identified in the strategic plan developed under subsection (l);

''(2) an assessment of programs and activities carried out by the Assistant Secretary, including the extent to which programs and activities under this title and part B of title XIX meet identified goals and performance measures developed for the respective programs and activities;

''(3) a description of the progress made in addressing gaps in mental and substance use disorders prevention, treatment, and recovery services and improving outcomes by the Administration, including with respect to serious mental illnesses, serious emotional disturbances, and co-occurring disorders;

''(4) a description of the manner in which the Administration coordinates and partners with other Federal agencies and departments related to mental and substance use disorders, including activities related to—

''(A) the implementation and dissemination of research findings into improved programs, including with respect to how advances in serious mental illness and serious emotional disturbance research have been incorporated into programs;

''(B) the recruitment, training, and retention of a mental and substance use disorders workforce;

''(C) the integration of mental disorder services, substance use disorder services, and physical health services;

''(D) homelessness; and

''(E) veterans;

''(5) a description of the manner in which the Administration promotes coordination by grantees under this title, and part B of title XIX, with State or local agencies; and

''(6) a description of the activities carried out under section 501A(e), with respect to mental and substance use disorders, including—

''(A) the number and a description of grants awarded;

''(B) the total amount of funding for grants awarded;

''(C) a description of the activities supported through such grants, including outcomes of programs supported; and

''(D) information on how the National Mental Health and Substance Use Policy Laboratory is consulting with the Assistant Secretary for Planning and Evaluation and collaborating with the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, the Center for Behavioral Health Statistics and Quality, and the Center for Mental Health Services to carry out such activities; and

''(7) recommendations made by the Assistant Secretary for Planning and Evaluation under section 6021 of the Helping Families in Mental Health Crisis Reform Act of 2016 to improve programs within the Administration, and actions taken in response to such recommendations to improve programs within the Administration.

The Assistant Secretary may meet reporting requirements established under this title by providing the contents of such reports as an addendum to the biennial report established under this subsection, notwithstanding the timeline of other reporting requirements in this title. Nothing in this subsection shall be construed to alter the content requirements of such reports or authorize the Assistant Secretary to alter the timeline of any such reports to be less frequent than biennially, unless as specified in this title.'';

(b) CONFORMING AMENDMENT.—Section 508(p) of the Public Health Service Act (42 U.S.C. 290bb–1(p)) is amended by striking ''section 501(k)'' and inserting ''section 501(m)''.

SEC. 6007. AUTHORITIES OF CENTERS FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE PREVENTION, AND SUBSTANCE ABUSE TREATMENT.

(a) CENTER FOR MENTAL HEALTH SERVICES.—Section 520(b) of the Public Health Service Act (42 U.S.C. 290bb–31(b)) is amended—

(1) by redesignating paragraphs (3) through (15) as paragraphs (4) through (16), respectively;

(2) by inserting after paragraph (2) the following:

''(3) collaborate with the Director of the National Institute of Mental Health and the Chief Medical Officer, appointed under section 501(g), to ensure that, as appropriate, programs related to the prevention and treatment of mental illness and the promotion of mental health and recovery support are carried out in a manner that reflects the best available science and evidence-based practices, including culturally and linguistically appropriate services, as appropriate;'';

(3) in paragraph (5), as so redesignated, by inserting '', including through programs that reduce risk and promote resiliency'' before the semicolon;

(4) in paragraph (6), as so redesignated, by inserting ''in collaboration with the Director of the National Institute of Mental Health,'' before ''develop'';

(5) in paragraph (8), as so redesignated, by inserting '', increase meaningful participation of individuals with mental illness in programs and activities of the Administration,'' before ''and protect the legal'';

(6) in paragraph (10), as so redesignated, by striking ''professional and paraprofessional personnel pursuant to section 303'' and inserting ''health paraprofessional personnel and health professionals'';

(7) in paragraph (11), as so redesignated, by inserting ''and tele-mental health'' after ''rural mental health'';

(8) in paragraph (12), as so redesignated, by striking ''establish a clearinghouse for mental health information to assure the widespread dissemination of such information'' and inserting ''disseminate mental health information, including evidence-based practices,'';

(9) in paragraph (15), as so redesignated, by striking ''and'' at the end;

(10) in paragraph (16), as so redesignated, by striking the period and inserting ''; and''; and

(11) by adding at the end the following:

''(17) ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded.''.

(b) DIRECTOR OF THE CENTER FOR SUBSTANCE ABUSE PREVENTION.—Section 515 of the Public Health Service Act (42 U.S.C. 290bb–21) is amended—

(1) in the section heading, by striking ''OFFICE'' and inserting ''CENTER'';

(2) in subsection (a)—

(A) by striking ''an Office'' and inserting ''a Center''; and

(B) by striking ''The Office'' and inserting ''The Prevention Center''; and

(3) in subsection (b)—

(A) in paragraph (1), by inserting ''through the reduction of risk and the promotion of resiliency'' before the semicolon;

(B) by redesignating paragraphs (3) through (11) as paragraphs (4) through (12), respectively;

(C) by inserting after paragraph (2) the following:

''(3) collaborate with the Director of the National Institute on Drug Abuse, the Director of the National Institute on Alcohol Abuse and Alcoholism, and States to promote the study of substance abuse prevention and the dissemination and implementation of research findings that will improve the delivery and effectiveness of substance abuse prevention activities;'';

(D) in paragraph (4), as so redesignated, by striking ''literature on the adverse effects of cocaine free base (known as crack)'' and inserting ''educational information on the effects of drugs abused by individuals, including drugs that are emerging as abused drugs'';

(E) in paragraph (6), as so redesignated—

(i) by striking ''substance abuse counselors'' and inserting ''health professionals who provide substance use and misuse prevention and treatment services''; and

(ii) by striking ''drug abuse education, prevention,'' and inserting ''illicit drug use education and prevention'';

(F) by amending paragraph (7), as so redesignated, to read as follows:

''(7) in cooperation with the Director of the Centers for Disease Control and Prevention, develop and disseminate educational materials to increase awareness for individuals at greatest risk for substance use disorders to prevent the transmission of communicable diseases, such as HIV, hepatitis, tuberculosis, and other communicable diseases;'';

(G) in paragraph (9), as so redesignated—

(i) by striking ''to discourage'' and inserting ''that reduce the risk of''; and

(ii) by inserting before the semicolon ''and promote resiliency'';

(H) in paragraph (11), as so redesignated, by striking ''and'' after the semicolon;

(I) in paragraph (12), as so redesignated, by striking the period and inserting a semicolon; and

(J) by adding at the end the following:

''(13) ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded; and

''(14) assist and support States in preventing illicit drug use, including emerging illicit drug use issues.''.

(c) DIRECTOR OF THE CENTER FOR SUBSTANCE ABUSE TREATMENT.—Section 507 of the Public Health Service Act (42 U.S.C. 290bb) is amended—

(1) in subsection (a)—

(A) by striking ''treatment of substance abuse'' and inserting ''treatment of substance use disorders''; and

(B) by striking ''abuse treatment systems'' and inserting ''use disorder treatment systems''; and

(2) in subsection (b)—

(A) in paragraph (1), by striking ''abuse'' and inserting ''use disorder'';

(B) in paragraph (3), by striking ''abuse'' and inserting ''use disorder'';

(C) in paragraph (4), by striking ''individuals who abuse drugs'' and inserting ''individuals who illicitly use drugs'';

(D) in paragraph (9), by striking ''carried out by the Director'';

(E) by striking paragraph (10);

(F) by redesignating paragraphs (11) through (14) as paragraphs (10) through (13), respectively;

(G) in paragraph (12), as so redesignated, by striking ''; and'' and inserting a semicolon; and

(H) by striking paragraph (13), as so redesignated, and inserting the following:

''(13) ensure the consistent documentation of the application of criteria when awarding grants and the ongoing oversight of grantees after such grants are awarded; and

''(14) work with States, providers, and individuals in recovery, and their families, to promote the expansion of recovery support services and systems of care oriented toward recovery.''.

SEC. 6008. ADVISORY COUNCILS.

Section 502(b) of the Public Health Service Act (42 U.S.C. 290aa–1(b)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (E), by striking ''and'' after the semicolon;

(B) by redesignating subparagraph (F) as subparagraph (J); and

(C) by inserting after subparagraph (E), the following:

''(F) the Chief Medical Officer, appointed under section 501(g);

''(G) the Director of the National Institute of Mental Health for the advisory councils appointed under subsections (a)(1)(A) and (a)(1)(D);

''(H) the Director of the National Institute on Drug Abuse for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C);

''(I) the Director of the National Institute on Alcohol Abuse and Alcoholism for the advisory councils appointed under subsections (a)(1)(A), (a)(1)(B), and (a)(1)(C); and''; and

(2) in paragraph (3), by adding at the end the following:

''(C) Not less than half of the members of the advisory council appointed under subsection (a)(1)(D)—

''(i) shall—

''(I) have a medical degree;

''(II) have a doctoral degree in psychology; or

''(III) have an advanced degree in nursing or social work from an accredited graduate school or be a certified physician assistant; and

''(ii) shall specialize in the mental health field.

''(D) Not less than half of the members of the advisory councils appointed under subsections (a)(1)(B) and (a)(1)(C)—

''(i) shall—

''(I) have a medical degree;

''(II) have a doctoral degree; or

''(III) have an advanced degree in nursing, public health, behavioral or social sciences, or social work from an accredited graduate school or be a certified physician assistant; and

''(ii) shall have experience in the provision of substance use disorder services or the development and implementation of programs to prevent substance misuse.''.

SEC. 6009. PEER REVIEW.

Section 504(b) of the Public Health Service Act (42 U.S.C. 290aa–3(b)) is amended by adding at the end the following: ''In the case of any such peer review group that is reviewing a grant, cooperative agreement, or contract related to mental illness treatment, not less than half of the members of such peer review group shall be licensed and experienced professionals in the prevention, diagnosis, or treatment of, or recovery from, mental illness or co-occurring mental illness and substance use disorders and have a medical degree, a doctoral degree in psychology, or an advanced degree in nursing or social work from an accredited program, and the Secretary, in consultation with the Assistant Secretary, shall, to the extent possible, ensure such peer review groups include broad geographic representation, including both urban and rural representatives.''.

Subtitle B—Oversight and Accountability

SEC. 6021. IMPROVING OVERSIGHT OF MENTAL AND SUBSTANCE USE DISORDERS PROGRAMS THROUGH THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation, shall ensure efficient and effective planning and evaluation of mental and substance use disorders prevention and treatment programs and related activities.

(b) EVALUATION STRATEGY.—In carrying out subsection (a), the Assistant Secretary for Planning and Evaluation shall, not later than 180 days after the date of enactment of this Act, develop a strategy for conducting ongoing evaluations that identifies priority programs to be evaluated by the Assistant Secretary for Planning and Evaluation and priority programs to be evaluated by other relevant offices and agencies within the Department of Health and Human Services. The strategy shall—

(1) include a plan for evaluating programs related to mental and substance use disorders, including co-occurring disorders, across agencies, as appropriate, including programs related to—

(A) prevention, intervention, treatment, and recovery support services, including such services for adults with a serious mental illness or children with a serious emotional disturbance;

(B) the reduction of homelessness and incarceration among individuals with a mental or substance use disorder; and

(C) public health and health services; and

(2) include a plan for assessing the use of performance metrics to evaluate activities carried out by entities receiving grants, contracts, or cooperative agreements related to mental and substance use disorders prevention and treatment services under title V or title XIX of the Public Health Service Act (42 U.S.C. 290aa et seq.; 42 U.S.C. 300w et seq.).

(c) CONSULTATION.—In carrying out this section, the Assistant Secretary for Planning and Evaluation shall consult, as appropriate, with the Assistant Secretary for Mental Health and Substance Use, the Chief Medical Officer of the Substance Abuse and Mental Health Services Administration appointed under section 501(g) of the Public Health Service Act (42 U.S.C. 290aa(g)), as amended by section 6003, the Behavioral Health Coordinating Council of the Department of Health and Human Services, other agencies within the Department of Health and Human Services, and other relevant Federal departments and agencies.

(d) RECOMMENDATIONS.—In carrying out this section, the Assistant Secretary for Planning and Evaluation shall provide recommendations to the Secretary of Health and Human Services, the Assistant Secretary for Mental Health and Substance Use, and the Congress on improving the quality of prevention and treatment programs and activities related to mental and substance use disorders, including recommendations for the use of performance metrics. The Assistant Secretary for Mental Health and Substance Use shall include such recommendations in the biennial report required by subsection 501(m) of the Public Health Service Act, as redesignated by section 6003 of this Act.

SEC. 6022. REPORTING FOR PROTECTION AND ADVOCACY ORGANIZATIONS.

(a) PUBLIC AVAILABILITY OF REPORTS.—Section 105(a)(7) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)(7)) is amended by striking ''is located a report'' and inserting ''is located, and make publicly available, a report''.

(b) DETAILED ACCOUNTING.—Section 114(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10824(a)) is amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) in paragraph (4), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(5) using data from the existing required annual program progress reports submitted by each system funded under this title, a detailed accounting for each such system of how funds are spent, disaggregated according to whether the funds were received from the Federal Government, the State government, a local government, or a private entity.''.

SEC. 6023. GAO STUDY.

(a) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States, in consultation with the Secretary of Health and Human Services and the Assistant Secretary for Mental Health and Substance Use, shall conduct an independent evaluation, and submit a report, to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, on programs funded by allotments made under title I of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10801 et seq.).

(b) CONTENTS.—The report and evaluation required under subsection (a) shall include—

(1) a review of the programs described in such subsection that are carried out by State agencies and such programs that are carried out by private, nonprofit organizations; and

(2) a review of the compliance of the programs described in subsection (a) with statutory and regulatory responsibilities, such as—

(A) responsibilities relating to family engagement;

(B) responsibilities relating to the grievance procedure for clients or prospective clients of the system to assure that individuals with mental illness have full access to the services of the system, for individuals who have received or are receiving mental health services, and for family members of such individuals with mental illness, or representatives of such individuals or family members, to assure that the eligible system is operating in compliance with the provisions of the Protection and Advocacy for Individuals with Mental Illness Act, as required to be established by section 105(a)(9) of such Act (42 U.S.C. 10805(a)(9));

(C) investigation of alleged abuse and neglect of persons with mental illness;

(D) availability of adequate medical and behavioral health treatment;

(E) denial of rights for persons with mental illness; and

(F) compliance with the Federal prohibition on lobbying.

Subtitle C—Interdepartmental Serious Mental Illness Coordinating Committee

SEC. 6031. INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 3 months after the date of enactment of this Act, the Secretary of Health and Human Services, or the designee of the Secretary, shall establish a committee to be known as the Interdepartmental Serious Mental Illness Coordinating Committee (in this section referred to as the ''Committee'').

(2) FEDERAL ADVISORY COMMITTEE ACT.—Except as provided in this section, the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee.

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

(c) RESPONSIBILITIES.—Not later than 1 year after the date of enactment of this Act, and 5 years after such date of enactment, the Committee shall submit to Congress and any other relevant Federal department or agency a report including—

(1) a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of serious mental illnesses, serious emotional disturbances, and advances in access to services and support for adults with a serious mental illness or children with a serious emotional disturbance;

(2) an evaluation of the effect Federal programs related to serious mental illness have on public health, including public health outcomes such as—

(A) rates of suicide, suicide attempts, incidence and prevalence of serious mental illnesses, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, interaction with the criminal justice system, homelessness, and unemployment;

(B) increased rates of employment and enrollment in educational and vocational programs;

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

(D) any other criteria as may be determined by the Secretary; and

(3) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance.

(d) COMMITTEE EXTENSION.—Upon the submission of the second report under subsection (c), the Secretary shall submit a recommendation to Congress on whether to extend the operation of the Committee.

(e) MEMBERSHIP.—

(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or the designees of such representatives—

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

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

(C) the Attorney General;

(D) the Secretary of Veterans Affairs;

(E) the Secretary of Defense;

(F) the Secretary of Housing and Urban Development;

(G) the Secretary of Education;

(H) the Secretary of Labor;

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

(J) the Commissioner of Social Security.

(2) NON-FEDERAL MEMBERS.—The Committee shall also include not less than 14 non-Federal public members appointed by the Secretary of Health and Human Services, of which—

(A) at least 2 members shall be an individual who has received treatment for a diagnosis of a serious mental illness;

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

(C) at least 1 member shall be a representative of a leading research, advocacy, or service organization for adults with a serious mental illness;

(D) at least 2 members shall be—

(i) a licensed psychiatrist with experience in treating serious mental illnesses;

(ii) a licensed psychologist with experience in treating serious mental illnesses or serious emotional disturbances;

(iii) a licensed clinical social worker with experience treating serious mental illnesses or serious emotional disturbances; or

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

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

(F) at least 1 member shall be a mental health professional who has research or clinical mental health experience in working with minorities;

(G) at least 1 member shall be a mental health professional who has research or clinical mental health experience in working with medically underserved populations;

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

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

(J) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with adults with a serious mental illness, children with a serious emotional disturbance, or individuals in a mental health crisis; and

(K) at least 1 member shall have experience providing services for homeless individuals and working with adults with a serious mental illness, children with a serious emotional disturbance, or individuals in a mental health crisis.

(3) TERMS.—A member of the Committee appointed under subsection (e)(2) shall serve for a term of 3 years, and may be reappointed for 1 or more additional 3-year terms. Any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve after the expiration of the member's term until a successor has been appointed.

(f) WORKING GROUPS.—In carrying out its functions, the Committee may establish working

groups. Such working groups shall be composed of Committee members, or their designees, and may hold such meetings as are necessary.

(g) SUNSET.—The Committee shall terminate on the date that is 6 years after the date on which the Committee is established under subsection (a)(1).

TITLE VII—ENSURING MENTAL AND SUBSTANCE USE DISORDERS PREVENTION, TREATMENT, AND RECOVERY PROGRAMS KEEP PACE WITH SCIENCE AND TECHNOLOGY

SEC. 7001. ENCOURAGING INNOVATION AND EVIDENCE-BASED PROGRAMS.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by inserting after section 501 (42 U.S.C. 290aa) the following:

"SEC. 501A. NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY.

''(a) IN GENERAL.—There shall be established within the Administration a National Mental Health and Substance Use Policy Laboratory (referred to in this section as the 'Laboratory').

''(b) RESPONSIBILITIES.—The Laboratory shall—

''(1) continue to carry out the authorities and activities that were in effect for the Office of Policy, Planning, and Innovation as such Office existed prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016;

''(2) identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health, mental illness, recovery supports, and the prevention and treatment of substance use disorder services;

''(3) work with the Center for Behavioral Health Statistics and Quality to collect, as appropriate, information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

''(4) provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental and substance use disorders;

''(5) periodically review programs and activities operated by the Administration relating to the diagnosis or prevention of, treatment for, and recovery from, mental and substance use disorders to—

''(A) identify any such programs or activities that are duplicative;

''(B) identify any such programs or activities that are not evidence-based, effective, or efficient; and

''(C) formulate recommendations for coordinating, eliminating, or improving programs or activities identified under subparagraph (A) or (B) and merging such programs or activities into other successful programs or activities; and

''(6) carry out other activities as deemed necessary to continue to encourage innovation and disseminate evidence-based programs and practices.

''(c) EVIDENCE-BASED PRACTICES AND SERVICE DELIVERY MODELS.—

''(1) IN GENERAL.—In carrying out subsection (b)(3), the Laboratory—

''(A) may give preference to models that improve—

''(i) the coordination between mental health and physical health providers;

''(ii) the coordination among such providers and the justice and corrections system; and

''(iii) the cost effectiveness, quality, effectiveness, and efficiency of health care services furnished to adults with a serious mental illness, children with a serious emotional disturbance, or individuals in a mental health crisis; and

''(B) may include clinical protocols and practices that address the needs of individuals with early serious mental illness.

''(2) CONSULTATION.—In carrying out this section, the Laboratory shall consult with—

''(A) the Chief Medical Officer appointed under section 501(g);

''(B) representatives of the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, on an ongoing basis;

''(C) other appropriate Federal agencies;

''(D) clinical and analytical experts with expertise in psychiatric medical care and clinical psychological care, health care management, education, corrections health care, and mental health court systems, as appropriate; and

''(E) other individuals and agencies as determined appropriate by the Assistant Secretary.

''(d) DEADLINE FOR BEGINNING IMPLEMENTATION.—The Laboratory shall begin implementation of this section not later than January 1, 2018.

''(e) PROMOTING INNOVATION.—

''(1) IN GENERAL.—The Assistant Secretary, in coordination with the Laboratory, may award grants to States, local governments, Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), educational institutions, and nonprofit organizations to develop evidence-based interventions, including culturally and linguistically appropriate services, as appropriate, for—

''(A) evaluating a model that has been scientifically demonstrated to show promise, but would benefit from further applied development, for—

''(i) enhancing the prevention, diagnosis, intervention, and treatment of, and recovery from, mental illness, serious emotional disturbances, substance use disorders, and co-occurring illness or disorders; or

''(ii) integrating or coordinating physical health services and mental and substance use disorders services; and

''(B) expanding, replicating, or scaling evidence-based programs across a wider area to enhance effective screening, early diagnosis, intervention, and treatment with respect to mental illness, serious mental illness, serious emotional disturbances, and substance use disorders, primarily by—

''(i) applying such evidence-based programs to the delivery of care, including by training staff in effective evidence-based treatments; or

''(ii) integrating such evidence-based programs into models of care across specialties and jurisdictions.

''(2) CONSULTATION.—In awarding grants under this subsection, the Assistant Secretary shall, as appropriate, consult with the Chief Medical Officer, appointed under section 501(g), the advisory councils described in section 502, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

''(A) to carry out paragraph (1)(A), $7,000,000 for the period of fiscal years 2018 through 2020; and

''(B) to carry out paragraph (1)(B), $7,000,000 for the period of fiscal years 2018 through 2020.''.

SEC. 7002. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by inserting after section 543 of such Act (42 U.S.C. 290dd–2) the following:

"SEC. 543A. PROMOTING ACCESS TO INFORMATION ON EVIDENCE-BASED PROGRAMS AND PRACTICES.

''(a) IN GENERAL.—The Assistant Secretary shall, as appropriate, improve access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders for States, local communities, nonprofit entities, and other stakeholders, by posting on the Internet website of the Administration information on evidence-based programs and practices that have been reviewed by the Assistant Secretary in accordance with the requirements of this section.

''(b) APPLICATIONS.—

''(1) APPLICATION PERIOD.—In carrying out subsection (a), the Assistant Secretary may establish a period for the submission of applications for evidence-based programs and practices to be posted publicly in accordance with subsection (a).

''(2) NOTICE.—In establishing the application period under paragraph (1), the Assistant Secretary shall provide for the public notice of such application period in the Federal Register. Such notice may solicit applications for evidence-based programs and practices to address gaps in information identified by the Assistant Secretary, the National Mental Health and Substance Use Policy Laboratory established under section 501A, or the Assistant Secretary for Planning and Evaluation, including pursuant to the evaluation and recommendations under section 6021 of the Helping Families in Mental Health Crisis Reform Act of 2016 or priorities identified in the strategic plan under section 501(l).

''(c) REQUIREMENTS.—The Assistant Secretary may establish minimum requirements for the applications submitted under subsection (b), including applications related to the submission of research and evaluation.

''(d) REVIEW AND RATING.—

''(1) IN GENERAL.—The Assistant Secretary shall review applications prior to public posting in accordance with subsection (a), and may prioritize the review of applications for evidence-based programs and practices that are related to topics included in the notice provided under subsection (b)(2).

''(2) SYSTEM.—In carrying out paragraph (1), the Assistant Secretary may utilize a rating and review system, which may include information on the strength of evidence associated with the evidence-based programs and practices and a rating of the methodological rigor of the research supporting the applications.

''(3) PUBLIC ACCESS TO METRICS AND RATING.—The Assistant Secretary shall make the metrics used to evaluate applications under this section, and any resulting ratings of such applications, publicly available.''.

SEC. 7003. PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

Section 520A of the Public Health Service Act (42 U.S.C. 290bb–32) is amended—

(1) in subsection (a)—

(A) in paragraph (4), by inserting before the period '', which may include technical assistance centers''; and

(B) in the flush sentence following paragraph (4)—

(i) by inserting '', contracts,'' before ''or cooperative agreements''; and

(ii) by striking ''Indian tribes and tribal organizations'' and inserting ''Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), health facilities, or programs operated by or in accordance with a contract or grant with the Indian Health Service, or''; and

(2) by amending subsection (f) to read as follows:

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $394,550,000 for each of fiscal years 2018 through 2022.''.

SEC. 7004. PRIORITY SUBSTANCE USE DISORDER TREATMENT NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

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

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking ''abuse'' and inserting ''use disorder'';

(B) in paragraph (3), by inserting before the period ''that permit States, local governments, communities, and Indian tribes and tribal organizations (as the terms 'Indian tribes' and 'tribal organizations' are defined in section 4 of the Indian Self-Determination and Education Assistance Act) to focus on emerging trends in substance abuse and co-occurrence of substance use disorders with mental illness or other conditions''; and

(C) in the flush sentence following paragraph (3)—

(i) by inserting '', contracts,'' before ''or cooperative agreements''; and

(ii) by striking ''Indian tribes and tribal organizations,'' and inserting ''Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), health facilities, or programs operated by or in accordance with a contract or grant with the Indian Health Service, or'';

(2) in subsection (b)—

(A) in paragraph (1), by striking ''abuse'' and inserting ''use disorder''; and

(B) in paragraph (2), by striking ''abuse'' and inserting ''use disorder'';

(3) in subsection (e), by striking ''abuse'' and inserting ''use disorder''; and

(4) in subsection (f), by striking ''$300,000,000'' and all that follows through the period and inserting ''$333,806,000 for each of fiscal years 2018 through 2022.''.

SEC. 7005. PRIORITY SUBSTANCE USE DISORDER PREVENTION NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

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

*(1) in the section heading, by striking ''**ABUSE**'' and inserting ''**USE DISORDER**'';*

(2) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking ''abuse'' and inserting ''use disorder'';

(B) in paragraph (3), by inserting before the period '', including such programs that focus on emerging drug abuse issues''; and

(C) in the flush sentence following paragraph (3)—

(i) by inserting '', contracts,'' before ''or cooperative agreements''; and

(ii) by striking ''Indian tribes and tribal organizations,'' and inserting ''Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), health facilities, or programs operated by or in accordance with a contract or grant with the Indian Health Service,'';

(3) in subsection (b)—

(A) in paragraph (1), by striking ''abuse'' and inserting ''use disorder''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''; and'' at the end and inserting '';'';

(ii) in subparagraph (B)—

(I) by striking ''abuse'' and inserting ''use disorder''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(C) substance use disorder prevention among high-risk groups.'';

(4) in subsection (e), by striking ''abuse'' and inserting ''use disorder''; and

(5) in subsection (f), by striking ''$300,000,000'' and all that follows through the period and inserting ''$211,148,000 for each of fiscal years 2018 through 2022.''.

TITLE VIII—SUPPORTING STATE PREVENTION ACTIVITIES AND RESPONSES TO MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS

SEC. 8001. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT.

(a) FORMULA GRANTS.—Section 1911(b) of the Public Health Service Act (42 U.S.C. 300x(b)) is amended—

(1) by redesignating paragraphs (1) through (3) as paragraphs (2) through (4), respectively; and

(2) by inserting before paragraph (2) (as so redesignated) the following:

''(1) providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance as defined in accordance with section 1912(c);''.

(b) STATE PLAN.—Section 1912(b) of the Public Health Service Act (42 U.S.C. 300x–1(b)) is amended—

(1) in paragraph (3), by redesignating subparagraphs (A) through (C) as clauses (i) through (iii), respectively, and realigning the margins accordingly;

(2) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (E), respectively, and realigning the margins accordingly;

(3) in the matter preceding subparagraph (A) (as so redesignated), by striking ''With respect to'' and all that follows through ''are as follows:'' and inserting ''In accordance with subsection (a), a State shall submit to the Secretary a plan every two years that, at a minimum, includes each of the following:'';

(4) by inserting before subparagraph (A) (as so redesignated) the following:

''(1) SYSTEM OF CARE.—A description of the State's system of care that contains the following:'';

(5) by striking subparagraph (A) (as so redesignated) and inserting the following:

''(A) COMPREHENSIVE COMMUNITY-BASED HEALTH SYSTEMS.—The plan shall—

''(i) identify the single State agency to be responsible for the administration of the program under the grant, including any third party who administers mental health services and is responsible for complying with the requirements of this part with respect to the grant;

''(ii) provide for an organized community-based system of care for individuals with mental illness, and describe available services and resources in a comprehensive system of care, including services for individuals with co-occurring disorders;

''(iii) include a description of the manner in which the State and local entities will coordinate services to maximize the efficiency, effectiveness, quality, and cost-effectiveness of services and programs to produce the best possible outcomes (including health services, rehabilitation services, employment services, housing services, educational services, substance use disorder services, legal services, law enforcement services, social services, child welfare services, medical and dental care services, and other support services to be provided with Federal, State, and local public and private resources) with other agencies to enable individuals receiving services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act;

''(iv) include a description of how the State promotes evidence-based practices, including those evidence-based programs that address the needs of individuals with early serious mental illness regardless of the age of the individual at onset, provide comprehensive individualized treatment, or integrate mental and physical health services;

''(v) include a description of case management services;

''(vi) include a description of activities that seek to engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers; and

''(vii) as appropriate to, and reflective of, the uses the State proposes for the block grant funds, include—

''(I) a description of the activities intended to reduce hospitalizations and hospital stays using the block grant funds;

''(II) a description of the activities intended to reduce incidents of suicide using the block grant funds;

''(III) a description of how the State integrates mental health and primary care using the block grant funds, which may include providing, in the case of individuals with co-occurring mental and substance use disorders, both mental and substance use disorders services in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings; and

''(IV) a description of recovery and recovery support services for adults with a serious mental illness and children with a serious emotional disturbance.'';

(6) in subparagraph (B) (as so redesignated)—

(A) by striking ''The plan contains'' and inserting ''The plan shall contain''; and

(B) by striking ''presents quantitative targets to be achieved in the implementation of the system described in paragraph (1)'' and inserting ''present quantitative targets and outcome measures for programs and services provided under this subpart'';

(7) in subparagraph (C) (as so redesignated)—

(A) by striking ''serious emotional disturbance'' in the matter preceding clause (i) (as so redesignated) and all that follows through ''substance abuse services'' in clause (i) (as so redesignated) and inserting the following: ''a serious emotional disturbance (as defined pursuant to subsection (c)), the plan shall provide for a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services'';

(B) by striking ''Education Act);'' and inserting ''Education Act).''; and

(C) by striking clauses (ii) and (iii) (as so redesignated);

(8) in subparagraph (D) (as so redesignated), by striking ''plan describes'' and inserting ''plan shall describe'';

(9) in subparagraph (E) (as so redesignated)—

(A) in the subparagraph heading by striking ''SYSTEMS'' and inserting ''SERVICES'';

(B) in the first sentence, by striking ''plan describes'' and all that follows through ''and provides for'' and inserting ''plan shall describe the financial resources available, the existing mental health workforce, and the workforce trained in treating individuals with co-occurring mental and substance use disorders, and shall provide for''; and

(C) in the second sentence—

(i) by striking ''further describes'' and inserting ''shall further describe''; and

(ii) by striking ''involved.'' and inserting ''involved, and the manner in which the State intends to comply with each of the funding agreements in this subpart and subpart III.'';

(10) by striking the flush matter at the end; and

(11) by adding at the end the following:

''(2) GOALS AND OBJECTIVES.—The establishment of goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those targets.''.

(c) EARLY SERIOUS MENTAL ILLNESS.—Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9) is amended by adding at the end the following:

''(c) EARLY SERIOUS MENTAL ILLNESS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.

''(2) STATE FLEXIBILITY.—In lieu of expending 10 percent of the amount the State receives

under this section for a fiscal year as required under paragraph (1), a State may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.''.

(d) ADDITIONAL PROVISIONS.—Section 1915(b) of the Public Health Service Act (42 U.S.C. 300x–4(b)) is amended—

(1) in paragraph (3)—

(A) by striking ''The Secretary'' and inserting the following:

''(A) IN GENERAL.—The Secretary'';

(B) by striking ''paragraph (1) if'' and inserting ''paragraph (1) in whole or in part if'';

(C) by striking ''State justify the waiver.'' and inserting ''State in the fiscal year involved or in the previous fiscal year justify the waiver''; and

(D) by adding at the end the following:

''(B) DATE CERTAIN FOR ACTION UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under this paragraph not later than 120 days after the date on which the request is made.

''(C) APPLICABILITY OF WAIVER.—A waiver provided by the Secretary under this paragraph shall be applicable only to the fiscal year involved.''; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) by inserting after the subparagraph designation the following: ''IN GENERAL.—'';

(ii) by striking ''In making a grant'' and inserting the following:

''(i) DETERMINATION.—In making a grant''; and

(iii) by inserting at the end the following:

''(ii) ALTERNATIVE.—A State that has failed to comply with paragraph (1) and would otherwise be subject to a reduction in the State's allotment under section 1911 may, upon request by the State, in lieu of having the amount of the allotment under section 1911 for the State reduced for the fiscal year of the grant, agree to comply with a negotiated agreement that is approved by the Secretary and carried out in accordance with guidelines issued by the Secretary. If a State fails to enter into or comply with a negotiated agreement, the Secretary may take action under this paragraph or the terms of the negotiated agreement.''; and

(B) in subparagraph (B)—

(i) by inserting after the subparagraph designation the following: ''SUBMISSION OF INFORMATION TO THE SECRETARY.—''; and

(ii) by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(i)''.

(e) APPLICATION FOR GRANT.—Section 1917(a) of the Public Health Service Act (42 U.S.C. 300x–6(a)) is amended—

(1) in paragraph (1), by striking ''1941'' and inserting ''1942(a)''; and

(2) in paragraph (5), by striking ''1915(b)(3)(B)'' and inserting ''1915(b)''.

(f) FUNDING.—Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9) is amended—

(1) in subsection (a)—

(A) by striking ''section 505'' and inserting ''section 505(c)''; and

(B) by striking ''$450,000,000'' and all that follows through the period and inserting ''$532,571,000 for each of fiscal years 2018 through 2022.''; and

(2) in subsection (b)(2) by striking ''sections 505 and'' and inserting ''sections 505(c) and''.

SEC. 8002. SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT.

(a) FORMULA GRANTS.—Section 1921(b) of the Public Health Service Act (42 U.S.C. 300x–21(b)) is amended—

(1) by inserting ''carrying out the plan developed in accordance with section 1932(b) and for'' after ''for the purpose of''; and

(2) by striking ''abuse'' and inserting ''use disorders''.

(b) OUTREACH TO PERSONS WHO INJECT DRUGS.—Section 1923(b) of the Public Health Service Act (42 U.S.C. 300x–23(b)) is amended—

(1) in the subsection heading, by striking ''REGARDING INTRAVENOUS SUBSTANCE ABUSE'' and inserting ''TO PERSONS WHO INJECT DRUGS''; and

(2) by striking ''for intravenous drug abuse'' and inserting ''for persons who inject drugs''.

(c) REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS.—Section 1924 of the Public Health Service Act (42 U.S.C. 300x–24) is amended—

(1) in subsection (a)(1)—

(A) in the matter preceding subparagraph (A), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(B) in subparagraph (A), by striking ''such abuse'' and inserting ''such disorders'';

(2) in subsection (b)—

(A) in paragraph (1)(A), by striking ''substance abuse'' and inserting ''substance use disorders'';

(B) in paragraph (2), by inserting ''and Prevention'' after ''Disease Control'';

(C) in paragraph (3)—

(i) in the paragraph heading, by striking ''ABUSE'' and inserting ''USE DISORDERS''; and

(ii) by striking ''substance abuse'' and inserting ''substance use disorders''; and

(D) in paragraph (6)(B), by striking ''substance abuse'' and inserting ''substance use disorders'';

(3) by striking subsection (d); and

(4) by redesignating subsection (e) as subsection (d).

(d) GROUP HOMES.—Section 1925 of the Public Health Service Act (42 U.S.C. 300x–25) is amended—

(1) in the section heading, by striking ''**RECOVERING SUBSTANCE ABUSERS**'' and inserting ''**PERSONS IN RECOVERY FROM SUBSTANCE USE DISORDERS**''; and

(2) in subsection (a), in the matter preceding paragraph (1), by striking ''recovering substance abusers'' and inserting ''persons in recovery from substance use disorders''.

(e) ADDITIONAL AGREEMENTS.—Section 1928 of the Public Health Service Act (42 U.S.C. 300x–28) is amended—

(1) in subsection (a), by striking ''(relative to fiscal year 1992)'';

(2) by striking subsection (b) and inserting the following:

''(b) PROFESSIONAL DEVELOPMENT.—A funding agreement for a grant under section 1921 is that the State involved will ensure that prevention, treatment, and recovery personnel operating in the State's substance use disorder prevention, treatment, and recovery systems have an opportunity to receive training, on an ongoing basis, concerning—

''(1) recent trends in substance use disorders in the State;

''(2) improved methods and evidence-based practices for providing substance use disorder prevention and treatment services;

''(3) performance-based accountability;

''(4) data collection and reporting requirements; and

''(5) any other matters that would serve to further improve the delivery of substance use disorder prevention and treatment services within the State.''; and

(3) in subsection (d)(1), by striking ''substance abuse'' and inserting ''substance use disorders''.

(f) REPEAL.—Section 1929 of the Public Health Service Act (42 U.S.C. 300x–29) is repealed.

(g) MAINTENANCE OF EFFORT.—Section 1930 of the Public Health Service Act (42 U.S.C. 300x–30) is amended—

(1) in subsection (c)(1), by striking ''in the State justify the waiver'' and inserting ''exist in the State, or any part of the State, to justify the waiver''; and

(2) in subsection (d), by inserting at the end the following:

''(3) ALTERNATIVE.—A State that has failed to comply with this section and would otherwise be subject to a reduction in the State's allotment under section 1921, may, upon request by the State, in lieu of having the State's allotment under section 1921 reduced, agree to comply with a negotiated agreement that is approved by the Secretary and carried out in accordance with guidelines issued by the Secretary. If a State fails to enter into or comply with a negotiated agreement, the Secretary may take action under this paragraph or the terms of the negotiated agreement.''.

(h) RESTRICTIONS ON EXPENDITURES.—Section 1931(b)(1) of the Public Health Service Act (42 U.S.C. 300x–31(b)(1)) is amended by striking ''substance abuse'' and inserting ''substance use disorders''.

(i) APPLICATION.—Section 1932 of the Public Health Service Act (42 U.S.C. 300x–32) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking ''subsections (c) and (d)(2)'' and inserting ''subsection (c)''; and

(B) in paragraph (5), by striking ''the information required in section 1929, the information required in section 1930(c)(2), and'';

(2) in subsection (b)—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—In order for a State to be in compliance with subsection (a)(6), the State shall submit to the Secretary a plan that, at a minimum, includes the following:

''(A) A description of the State's system of care that—

''(i) identifies the single State agency responsible for the administration of the program, including any third party who administers substance use disorder services and is responsible for complying with the requirements of the grant;

''(ii) provides information on the need for substance use disorder prevention and treatment services in the State, including estimates on the number of individuals who need treatment, who are pregnant women, women with dependent children, individuals with a co-occurring mental health and substance use disorder, persons who inject drugs, and persons who are experiencing homelessness;

''(iii) provides aggregate information on the number of individuals in treatment within the State, including the number of such individuals who are pregnant women, women with dependent children, individuals with a co-occurring mental health and substance use disorder, persons who inject drugs, and persons who are experiencing homelessness;

''(iv) provides a description of the system that is available to provide services by modality, including the provision of recovery support services;

''(v) provides a description of the State's comprehensive statewide prevention efforts, including the number of individuals being served in the system, target populations, and priority needs, and provides a description of the amount of funds from the prevention set-aside expended on primary prevention;

''(vi) provides a description of the financial resources available;

''(vii) describes the existing substance use disorders workforce and workforce trained in treating co-occurring substance use and mental disorders;

''(viii) includes a description of how the State promotes evidence-based practices; and

''(ix) describes how the State integrates substance use disorder services and primary health care, which in the case of those individuals with co-occurring mental health and substance use disorders may include providing both mental health and substance use disorder services in primary care settings or providing primary and specialty care services in community-based mental health and substance use disorder service settings.

''(B) The establishment of goals and objectives for the period of the plan, including targets and milestones that are intended to be met, and the activities that will be undertaken to achieve those targets.

''(C) A description of how the State will comply with each funding agreement for a grant under section 1921 that is applicable to the State, including a description of the manner in which the State intends to expend grant funds.''; and

(B) in paragraph (2)—

(i) in the paragraph heading, by striking ''AUTHORITY OF SECRETARY REGARDING MODIFICATIONS'' and inserting ''MODIFICATIONS'';

(ii) by striking ''As a condition'' and inserting the following:

''(A) AUTHORITY OF SECRETARY.—As a condition;''; and

(iii) by adding at the end the following:

''(B) STATE REQUEST FOR MODIFICATION.—If the State determines that a modification to such plan is necessary, the State may request the Secretary to approve the modification. Any such modification shall be in accordance with paragraph (1) and section 1941.''; and

(C) in paragraph (3), by inserting, '', including any modification under paragraph (2)'' after ''subsection (a)(6)''; and

(3) in subsection (e)(2), by striking ''section 1922(c)'' and inserting ''section 1922(b)''.

(j) DEFINITIONS.—Section 1934 of the Public Health Service Act (42 U.S.C. 300x–34) is amended—

(1) in paragraph (3), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(2) in paragraph (7), by striking ''substance abuse'' and inserting ''substance use disorders''.

(k) FUNDING.—Section 1935 of the Public Health Service Act (42 U.S.C. 300x–35) is amended—

(1) in subsection (a)—

(A) by striking ''section 505'' and inserting ''section 505(d)''; and

(B) by striking ''$2,000,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003'' and inserting ''$1,858,079,000 for each of fiscal years 2018 through 2022.''; and

(2) in subsection (b)(1)(B) by striking ''sections 505 and'' and inserting ''sections 505(d) and''.

SEC. 8003. ADDITIONAL PROVISIONS RELATED TO THE BLOCK GRANTS.

Subpart III of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–51 et seq.) is amended—

(1) in section 1943(a)(3) (42 U.S.C. 300x–53(a)(3)), by striking ''section 505'' and inserting ''subsections (c) and (d) of section 505'';

(2) in section 1953(b) (42 U.S.C. 300x–63(b)), by striking ''substance abuse'' and inserting ''substance use disorder''; and

(3) by adding at the end the following:

''SEC. 1957. PUBLIC HEALTH EMERGENCIES.

''In the case of a public health emergency (as determined under section 319), the Secretary, on a State by State basis, may, as the circumstances of the emergency reasonably require and for the period of the emergency, grant an extension, or waive application deadlines or compliance with any other requirement, of a grant authorized under section 521, 1911, or 1921 or an allotment authorized under Public Law 99–319 (42 U.S.C. 10801 et seq.).

''SEC. 1958. JOINT APPLICATIONS.

''The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall permit a joint application to be submitted for grants under subpart I and subpart II upon the request of a State. Such application may be jointly reviewed and approved by the Secretary with respect to such subparts, consistent with the purposes and authorized activities of each such grant program. A State submitting such a joint application shall otherwise meet the requirements with respect to each such subpart.''.

SEC. 8004. STUDY OF DISTRIBUTION OF FUNDS UNDER THE SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT AND THE COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall through a grant or contract, or through an agreement with a third party, conduct a study on the formulas for distribution of funds under the substance abuse prevention and treatment block grant, and the community mental health services block grant, under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) and recommend changes if necessary. Such study shall include—

(1) an analysis of whether the distributions under such block grants accurately reflect the need for the services under the grants in the States;

(2) an examination of whether the indices used under the formulas for distribution of funds under such block grants are appropriate, and if not, alternatives recommended by the Secretary;

(3) where recommendations are included under paragraph (2) for the use of different indices, a description of the variables and data sources that should be used to determine the indices;

(4) an evaluation of the variables and data sources that are being used for each of the indices involved, and whether such variables and data sources accurately represent the need for services, the cost of providing services, and the ability of the States to pay for such services;

(5) the effect that the minimum allotment requirements for each such block grant have on each State's final allotment and the effect of such requirements, if any, on each State's formula-based allotment;

(6) recommendations for modifications to the minimum allotment provisions to ensure an appropriate distribution of funds; and

(7) any other information that the Secretary determines appropriate.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report containing the findings and recommendations of the study conducted under subsection (a) and the study conducted under section 9004(g).

TITLE IX—PROMOTING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE

Subtitle A—Helping Individuals and Families

SEC. 9001. GRANTS FOR TREATMENT AND RECOVERY FOR HOMELESS INDIVIDUALS.

Section 506 of the Public Health Service Act (42 U.S.C. 290aa–5) is amended—

(1) in subsection (a), by striking ''substance abuse'' and inserting ''substance use disorder'';

(2) in subsection (b)—

(A) in paragraphs (1) and (3), by striking ''substance abuse'' each place the term appears and inserting ''substance use disorder''; and

(B) in paragraph (4), by striking ''substance abuse'' and inserting ''a substance use disorder'';

(3) in subsection (c)—

(A) in paragraph (1), by striking ''substance abuse disorder'' and inserting ''substance use disorder''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''substance abuse'' and inserting ''a substance use disorder''; and

(ii) in subparagraph (B), by striking ''substance abuse'' and inserting ''substance use disorder''; and

(4) in subsection (e), by striking '', $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003'' and inserting ''$41,304,000 for each of fiscal years 2018 through 2022''.

SEC. 9002. GRANTS FOR JAIL DIVERSION PROGRAMS.

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

(1) by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder'';

(2) in subsection (a)—

(A) by striking ''Indian tribes, and tribal organizations'' and inserting ''and Indian tribes and tribal organizations (as the terms 'Indian tribes' and 'tribal organizations' are defined in section 4 of the Indian Self-Determination and Education Assistance Act)''; and

(B) by inserting ''or a health facility or program operated by or in accordance with a contract or grant with the Indian Health Service,'' after ''entities,'';

(3) in subsection (c)(2)(A)(i), by striking ''the best known'' and inserting ''evidence-based'';

(4) by redesignating subsections (d) through (i) as subsections (e) through (j), respectively;

(5) by inserting after subsection (c) the following:

''(d) SPECIAL CONSIDERATION REGARDING VETERANS.—In awarding grants under subsection (a), the Secretary shall, as appropriate, give special consideration to entities proposing to use grant funding to support jail diversion services for veterans.'';

(6) in subsection (e), as so redesignated—

(A) in paragraph (3), by striking ''; and'' and inserting a semicolon;

(B) in paragraph (4), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(5) develop programs to divert individuals prior to booking or arrest.''; and

(7) in subsection (j), as so redesignated, by striking ''$10,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 through 2003'' and inserting ''$4,269,000 for each of fiscal years 2018 through 2022''.

SEC. 9003. PROMOTING INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE.

Section 520K of the Public Health Service Act (42 U.S.C. 290bb–42) is amended to read as follows:

''SEC. 520K. INTEGRATION INCENTIVE GRANTS AND COOPERATIVE AGREEMENTS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, or other appropriate State agency, in collaboration with 1 or more qualified community programs as described in section 1913(b)(1) or 1 or more community health centers as described in section 330.

''(2) INTEGRATED CARE.—The term 'integrated care' means collaborative models or practices offering mental and physical health services, which may include practices that share the same space in the same facility.

''(3) SPECIAL POPULATION.—The term 'special population' means—

''(A) adults with a mental illness who have co-occurring physical health conditions or chronic diseases;

''(B) adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases;

''(C) children and adolescents with a serious emotional disturbance with co-occurring physical health conditions or chronic diseases; or

''(D) individuals with a substance use disorder.

''(b) GRANTS AND COOPERATIVE AGREEMENTS.—

''(1) IN GENERAL.—The Secretary may award grants and cooperative agreements to eligible entities to support the improvement of integrated care for primary care and behavioral health care in accordance with paragraph (2).

''(2) PURPOSES.—A grant or cooperative agreement awarded under this section shall be designed to—

''(A) promote full integration and collaboration in clinical practices between primary and behavioral health care;

''(B) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness or children with a serious emotional disturbance; and

''(C) promote integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

''(c) APPLICATIONS.—

''(1) IN GENERAL.—An eligible entity seeking a grant or cooperative agreement under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require, including the contents described in paragraph (2).

''(2) CONTENTS.—The contents described in this paragraph are—

''(A) a description of a plan to achieve fully collaborative agreements to provide services to special populations;

''(B) a document that summarizes the policies, if any, that serve as barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers;

''(C) a description of partnerships or other arrangements with local health care providers to provide services to special populations;

''(D) an agreement and plan to report to the Secretary performance measures necessary to evaluate patient outcomes and facilitate evaluations across participating projects; and

''(E) a plan for sustainability beyond the grant or cooperative agreement period under subsection (e).

''(d) GRANT AND COOPERATIVE AGREEMENT AMOUNTS.—

''(1) TARGET AMOUNT.—The target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section shall be $2,000,000.

''(2) ADJUSTMENT PERMITTED.—The Secretary, taking into consideration the quality of the application and the number of eligible entities that received grants under this section prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, may adjust the target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section.

''(3) LIMITATION.—An eligible entity receiving funding under this section may not allocate more than 10 percent of funds awarded under this section to administrative functions, and the remaining amounts shall be allocated to health facilities that provide integrated care.

''(e) DURATION.—A grant or cooperative agreement under this section shall be for a period not to exceed 5 years.

''(f) REPORT ON PROGRAM OUTCOMES.—An eligible entity receiving a grant or cooperative agreement under this section shall submit an annual report to the Secretary that includes—

''(1) the progress made to reduce barriers to integrated care as described in the entity's application under subsection (c); and

''(2) a description of functional outcomes of special populations, including—

''(A) with respect to adults with a serious mental illness, participation in supportive housing or independent living programs, attendance in social and rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and mental health appointments, and compliance with prescribed medication regimes;

''(B) with respect to individuals with co-occurring mental illness and physical health conditions and chronic diseases, attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes, and participation in learning opportunities related to improved health and lifestyle practices; and

''(C) with respect to children and adolescents with a serious emotional disturbance who have co-occurring physical health conditions and chronic diseases, attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes, and participation in learning opportunities at school and extracurricular activities.

''(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAVIORAL HEALTH CARE INTEGRATION.—

''(1) IN GENERAL.—The Secretary may provide appropriate information, training, and technical assistance to eligible entities that receive a grant or cooperative agreement under this section, in order to help such entities meet the requirements of this section, including assistance with—

''(A) development and selection of integrated care models;

''(B) dissemination of evidence-based interventions in integrated care;

''(C) establishment of organizational practices to support operational and administrative success; and

''(D) other activities, as the Secretary determines appropriate.

''(2) ADDITIONAL DISSEMINATION OF TECHNICAL INFORMATION.—The information and resources provided by the Secretary under paragraph (1) shall, as appropriate, be made available to States, political subdivisions of States, Indian tribes or tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act), outpatient mental health and addiction treatment centers, community mental health centers that meet the criteria under section 1913(c), certified community behavioral health clinics described in section 223 of the Protecting Access to Medicare Act of 2014, primary care organizations such as Federally qualified health centers or rural health clinics as defined in section 1861(aa) of the Social Security Act, other community-based organizations, or other entities engaging in integrated care activities, as the Secretary determines appropriate.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $51,878,000 for each of fiscal years 2018 through 2022.''.

SEC. 9004. PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS.

(a) FORMULA GRANTS TO STATES.—Section 521 of the Public Health Service Act (42 U.S.C. 290cc–21) is amended by striking ''1991 through 1994'' and inserting ''2018 through 2022''.

(b) PURPOSE OF GRANTS.—Section 522 of the Public Health Service Act (42 U.S.C. 290cc–22) is amended—

(1) in subsection (a)(1)(B), by striking ''substance abuse'' and inserting ''a substance use disorder'';

(2) in subsection (b)(6), by striking ''substance abuse'' and inserting ''substance use disorder'';

(3) in subsection (c), by striking ''substance abuse'' and inserting ''a substance use disorder'';

(4) in subsection (e)—

(A) in paragraph (1), by striking ''substance abuse'' and inserting ''a substance use disorder''; and

(B) in paragraph (2), by striking ''substance abuse'' and inserting ''substance use disorder'';

(5) by striking subsection (g) and redesignating subsections (h) and (i) as (g) and (h), accordingly; and

(6) in subsection (g), as redesignated by paragraph (5), by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder''.

(c) DESCRIPTION OF INTENDED EXPENDITURES OF GRANT.—Section 527 of the Public Health Service Act (42 U.S.C. 290cc–27) is amended by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder''.

(d) TECHNICAL ASSISTANCE.—Section 530 of the Public Health Service Act (42 U.S.C. 290cc–30) is amended by striking ''through the National Institute of Mental Health, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse'' and inserting ''acting through the Assistant Secretary''.

(e) DEFINITIONS.—Section 534(4) of the Public Health Service Act (42 U.S.C. 290cc–34(4)) is amended to read as follows:

''(4) SUBSTANCE USE DISORDER SERVICES.—The term 'substance use disorder services' has the meaning given the term 'substance abuse services' in section 330(h)(5)(C).''.

(f) FUNDING.—Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc–35(a)) is amended by striking ''$75,000,000 for each of the fiscal years 2001 through 2003'' and inserting ''$64,635,000 for each of fiscal years 2018 through 2022''.

(g) STUDY CONCERNING FORMULA.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Assistant Secretary for Mental Health and Substance Use (referred to in this section as the ''Assistant Secretary'') shall conduct a study concerning the formula used under section 524 of the Public Health Service Act (42 U.S.C. 290cc–24) for making allotments to States under section 521 of such Act (42 U.S.C. 290cc–21). Such study shall include an evaluation of quality indicators of need for purposes of revising the formula for determining the amount of each allotment for the fiscal years following the submission of the study.

(2) REPORT.—In accordance with section 8004(b), the Assistant Secretary shall submit to the committees of Congress described in such section a report concerning the results of the study conducted under paragraph (1).

SEC. 9005. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by inserting after section 520E–2 (42 U.S.C. 290bb–36b) the following:

''SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline program (referred to in this section as the 'program'), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016.

''(b) ACTIVITIES.—In maintaining the program, the activities of the Secretary shall include—

''(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night;

''(2) maintaining a suicide prevention hotline to link callers to local emergency, mental health, and social services resources; and

''(3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans' suicide prevention hotline.

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $7,198,000 for each of fiscal years 2018 through 2022.''.

SEC. 9006. CONNECTING INDIVIDUALS AND FAMILIES WITH CARE.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 9005, is further amended by inserting after section 520E–3 the following:

''SEC. 520E–4. TREATMENT REFERRAL ROUTING SERVICE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain the National Treatment Referral Routing Service (referred to in this section as the 'Routing Service') to assist individuals and families in locating mental and substance use disorders treatment providers.

''(b) ACTIVITIES OF THE SECRETARY.—To maintain the Routing Service, the activities of the Assistant Secretary shall include administering—

''(1) a nationwide, telephone number providing year-round access to information that is updated on a regular basis regarding local behavioral health providers and community-based organizations in a manner that is confidential, without requiring individuals to identify themselves, is in languages that include at least English and Spanish, and is at no cost to the individual using the Routing Service; and

''(2) an Internet website to provide a searchable, online treatment services locator of behavioral health treatment providers and community-based organizations, which shall include information on the name, location, contact information, and basic services provided by such providers and organizations.

''(c) REMOVING PRACTITIONER CONTACT INFORMATION.—In the event that the Internet website described in subsection (b)(2) contains information on any qualified practitioner that is certified to prescribe medication for opioid dependency under section 303(g)(2)(B) of the Controlled Substances Act, the Assistant Secretary—

''(1) shall provide an opportunity to such practitioner to have the contact information of the practitioner removed from the website at the request of the practitioner; and

''(2) may evaluate other methods to periodically update the information displayed on such website.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent the Assistant Secretary from using any unobligated amounts otherwise made available to the Administration to maintain the Routing Service.''.

SEC. 9007. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

Section 520F of the Public Health Service Act (42 U.S.C. 290bb–37) is amended to read as follows:

''SEC. 520F. STRENGTHENING COMMUNITY CRISIS RESPONSE SYSTEMS.

''(a) IN GENERAL.—The Secretary shall award competitive grants to—

''(1) State and local governments and Indian tribes and tribal organizations, to enhance community-based crisis response systems; or

''(2) States to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for adults with a serious mental illness, children with a serious emotional disturbance, or individuals with a substance use disorder.

''(b) APPLICATIONS.—

''(1) IN GENERAL.—To receive a grant under subsection (a), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(2) COMMUNITY-BASED CRISIS RESPONSE PLAN.—An application for a grant under subsection (a)(1) shall include a plan for—

''(A) promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers;

''(B) developing memoranda of understanding with public and private entities to implement crisis response services;

''(C) addressing gaps in community resources for crisis intervention and prevention; and

''(D) developing models for minimizing hospital readmissions, including through appropriate discharge planning.

''(3) BEDS DATABASE PLAN.—An application for a grant under subsection (a)(2) shall include a plan for developing, maintaining, or enhancing a real-time, Internet-based bed database to collect, aggregate, and display information about beds in inpatient psychiatric facilities and crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental or substance use disorder crisis.

''(c) DATABASE REQUIREMENTS.—A bed database described in this section is a database that—

''(1) includes information on inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder facilities in the State involved, including contact information for the facility or unit;

''(2) provides real-time information about the number of beds available at each facility or unit and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow for the proper identification of appropriate facilities for treatment of individuals in mental or substance use disorder crisis; and

''(3) enables searches of the database to identify available beds that are appropriate for the treatment of individuals in mental or substance use disorder crisis.

''(d) EVALUATION.—An entity receiving a grant under subsection (a)(1) shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may reasonably require, a report, including an evaluation of the effect of such grant on—

''(1) local crisis response services and measures for individuals receiving crisis planning and early intervention supports;

''(2) individuals reporting improved functional outcomes; and

''(3) individuals receiving regular followup care following a crisis.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $12,500,000 for the period of fiscal years 2018 through 2022.''.

SEC. 9008. GARRETT LEE SMITH MEMORIAL ACT REAUTHORIZATION.

(a) SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.—Section 520C of the Public Health Service Act (42 U.S.C. 290bb–34), as amended by section 6001, is further amended—

(1) in the section heading, by striking ''**YOUTH INTERAGENCY RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE CENTERS**'' and inserting ''**SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER**'';

(2) in subsection (a), by striking ''acting through the Assistant Secretary for Mental Health and Substance Use'' and all that follows through the period at the end of paragraph (2) and inserting ''acting through the Assistant Secretary, shall establish a research, training, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations regarding the prevention of suicide among all ages, particularly among groups that are at a high risk for suicide.'';

(3) by striking subsections (b) and (c);

(4) by redesignating subsection (d) as subsection (b);

(5) in subsection (b), as so redesignated—

(A) in the subsection heading, by striking ''ADDITIONAL CENTER'' and inserting ''RESPONSIBILITIES OF THE CENTER'';

(B) in the matter preceding paragraph (1), by striking ''The additional research'' and all that follows through ''nonprofit organizations for'' and inserting ''The center established under subsection (a) shall conduct activities for the purpose of'';

(C) by striking ''youth suicide'' each place such term appears and inserting ''suicide'';

(D) in paragraph (1)—

(i) by striking ''the development or continuation of'' and inserting ''developing and continuing''; and

(ii) by inserting ''for all ages, particularly among groups that are at a high risk for suicide'' before the semicolon at the end;

(E) in paragraph (2), by inserting ''for all ages, particularly among groups that are at a high risk for suicide'' before the semicolon at the end;

(F) in paragraph (3), by inserting ''and tribal'' after ''statewide'';

(G) in paragraph (5), by inserting ''and prevention'' after ''intervention'';

(H) in paragraph (8), by striking ''in youth'';

(I) in paragraph (9), by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(J) in paragraph (10), by inserting ''conducting'' before ''other''; and

(6) by striking subsection (e) and inserting the following:

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $5,988,000 for each of fiscal years 2018 through 2022.

''(d) ANNUAL REPORT.—Not later than 2 years after the date of enactment of this subsection, the Secretary shall submit to Congress a report on the activities carried out by the center established under subsection (a) during the year involved, including the potential effects of such activities, and the States, organizations, and institutions that have worked with the center.''.

(b) YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.—Section 520E of the Public Health Service Act (42 U.S.C. 290bb–36) is amended—

(1) in paragraph (1) of subsection (a) and in subsection (c), by striking ''substance abuse'' each place such term appears and inserting ''substance use disorder'';

(2) in subsection (b)—

(A) in paragraph (2)—

(i) by striking ''ensure that each State is awarded only 1 grant or cooperative agreement under this section'' and inserting ''ensure that a State does not receive more than 1 grant or cooperative agreement under this section at any 1 time''; and

(ii) by striking ''been awarded'' and inserting ''received''; and

(B) by adding after paragraph (2) the following:

''(3) CONSIDERATION.—In awarding grants under this section, the Secretary shall take into consideration the extent of the need of the applicant, including the incidence and prevalence of suicide in the State and among the populations of focus, including rates of suicide determined by the Centers for Disease Control and Prevention for the State or population of focus.'';

(3) in subsection (g)(2), by striking ''2 years after the date of enactment of this section,'' and insert ''2 years after the date of enactment of Helping Families in Mental Health Crisis Reform Act of 2016,''; and

(4) by striking subsection (m) and inserting the following:

''(m) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $30,000,000 for each of fiscal years 2018 through 2022.''.

SEC. 9009. ADULT SUICIDE PREVENTION.

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

''SEC. 520L. ADULT SUICIDE PREVENTION.

''(a) GRANTS.—

''(1) IN GENERAL.—The Assistant Secretary shall award grants to eligible entities described in paragraph (2) to implement suicide prevention and intervention programs, for individuals

who are 25 years of age or older, that are designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk of suicide.

''(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a community-based primary care or behavioral health care setting, an emergency department, a State mental health agency (or State health agency with mental or behavioral health functions), public health agency, a territory of the United States, or an Indian tribe or tribal organization (as the terms 'Indian tribe' and 'tribal organization' are defined in section 4 of the Indian Self-Determination and Education Assistance Act).

''(3) USE OF FUNDS.—The grants awarded under paragraph (1) shall be used to implement programs, in accordance with such paragraph, that include one or more of the following components:

''(A) Screening for suicide risk, suicide intervention services, and services for referral for treatment for individuals at risk for suicide.

''(B) Implementing evidence-based practices to provide treatment for individuals at risk for suicide, including appropriate followup services.

''(C) Raising awareness and reducing stigma of suicide.

''(b) EVALUATIONS AND TECHNICAL ASSISTANCE.—The Assistant Secretary shall—

''(1) evaluate the activities supported by grants awarded under subsection (a), and disseminate, as appropriate, the findings from the evaluation; and

''(2) provide appropriate information, training, and technical assistance, as appropriate, to eligible entities that receive a grant under this section, in order to help such entities to meet the requirements of this section, including assistance with selection and implementation of evidence-based interventions and frameworks to prevent suicide.

''(c) DURATION.—A grant under this section shall be for a period of not more than 5 years.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $30,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 9010. MENTAL HEALTH AWARENESS TRAINING GRANTS.

Section 520J of the Public Health Service Act (42 U.S.C. 290bb–41) is amended—

*(1) in the section heading, by inserting ''**MENTAL HEALTH AWARENESS**'' before ''**TRAINING**''; and*

(2) in subsection (b)—

(A) in the subsection heading, by striking ''ILLNESS'' and inserting ''HEALTH'';

(B) in paragraph (1), by inserting ''veterans, law enforcement, and other categories of individuals, as determined by the Secretary,'' after ''emergency services personnel'';

(C) in paragraph (5)—

(i) in the matter preceding subparagraph (A), by striking ''to'' and inserting ''for evidence-based programs that provide training and education in accordance with paragraph (1) on matters including''; and

(ii) by striking subparagraphs (A) through (C) and inserting the following:

''(A) recognizing the signs and symptoms of mental illness; and

''(B)(i) resources available in the community for individuals with a mental illness and other relevant resources; or

''(ii) safely de-escalating crisis situations involving individuals with a mental illness.''; and

(D) in paragraph (7), by striking '', $25,000,000'' and all that follows through the period at the end and inserting ''$14,693,000 for each of fiscal years 2018 through 2022.''.

SEC. 9011. SENSE OF CONGRESS ON PRIORITIZING AMERICAN INDIANS AND ALASKA NATIVE YOUTH WITHIN SUICIDE PREVENTION PROGRAMS.

(a) FINDINGS.—The Congress finds as follows:

(1) Suicide is the eighth leading cause of death among American Indians and Alaska Natives across all ages.

(2) Among American Indians and Alaska Natives who are 10 to 34 years of age, suicide is the second leading cause of death.

(3) The suicide rate among American Indian and Alaska Native adolescents and young adults ages 15 to 34 (17.9 per 100,000) is approximately 1.3 times higher than the national average for that age group (13.3 per 100,000).

(b) SENSE OF CONGRESS.—It is the sense of Congress that the Secretary of Health and Human Services, in carrying out suicide prevention and intervention programs, should prioritize programs and activities for populations with disproportionately high rates of suicide, such as American Indians and Alaska Natives.

SEC. 9012. EVIDENCE-BASED PRACTICES FOR OLDER ADULTS.

Section 520A(e) of the Public Health Service Act (42 U.S.C. 290bb–32(e)) is amended by adding at the end the following:

''(3) GERIATRIC MENTAL DISORDERS.—The Secretary shall, as appropriate, provide technical assistance to grantees regarding evidence-based practices for the prevention and treatment of geriatric mental disorders and co-occurring mental health and substance use disorders among geriatric populations, as well as disseminate information about such evidence-based practices to States and nongrantees throughout the United States.''.

SEC. 9013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, is encouraged to improve, particularly through the inclusion of additional States, the National Violent Death Reporting System as authorized by title III of the Public Health Service Act (42 U.S.C. 241 et seq.). Participation in the system by the States shall be voluntary.

SEC. 9014. ASSISTED OUTPATIENT TREATMENT.

Section 224 of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 290aa note) is amended—

(1) in subsection (e), by striking ''and 2018,'' and inserting ''2018, 2019, 2020, 2021, and 2022,''; and

(2) in subsection (g)—

(A) in paragraph (1), by striking ''2018'' and inserting ''2022''; and

(B) in paragraph (2), by striking ''is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2018'' and inserting ''are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2017, $20,000,000 for fiscal year 2018, $19,000,000 for each of fiscal years 2019 and 2020, and $18,000,000 for each of fiscal years 2021 and 2022''.

SEC. 9015. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM.

Part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.), as amended by section 9009, is further amended by adding at the end the following:

''SEC. 520M. ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM.

''(a) IN GENERAL.—The Assistant Secretary shall award grants to eligible entities—

''(1) to establish assertive community treatment programs for adults with a serious mental illness; or

''(2) to maintain or expand such programs.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a State, political subdivision of a State, Indian tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), mental health system, health care facility, or any other entity the Assistant Secretary deems appropriate.

''(c) SPECIAL CONSIDERATION.—In selecting among applicants for a grant under this section, the Assistant Secretary may give special consideration to the potential of the applicant's program to reduce hospitalization, homelessness, and involvement with the criminal justice system while improving the health and social outcomes of the patient.

''(d) ADDITIONAL ACTIVITIES.—The Assistant Secretary shall—

''(1) not later than the end of fiscal year 2021, submit a report to the appropriate congressional committees on the grant program under this section, including an evaluation of—

''(A) any cost savings and public health outcomes such as mortality, suicide, substance use disorders, hospitalization, and use of services;

''(B) rates of involvement with the criminal justice system of patients;

''(C) rates of homelessness among patients; and

''(D) patient and family satisfaction with program participation; and

''(2) provide appropriate information, training, and technical assistance to grant recipients under this section to help such recipients to establish, maintain, or expand their assertive community treatment programs.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $5,000,000 for the period of fiscal years 2018 through 2022.

''(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, not more than 5 percent shall be available to the Assistant Secretary for carrying out subsection (d).''.

SEC. 9016. SOBER TRUTH ON PREVENTING UNDERAGE DRINKING REAUTHORIZATION.

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

(1) in subsection (c)(3), by striking ''fiscal year 2007'' and all that follows through the period at the end and inserting ''each of the fiscal years 2018 through 2022.'';

(2) in subsection (d)(4), by striking ''fiscal year 2007'' and all that follows through the period at the end and inserting ''each of the fiscal years 2018 through 2022.'';

(3) in subsection (e)(1)(I), by striking ''fiscal year 2007'' and all that follows through the period at the end and inserting ''each of the fiscal years 2018 through 2022.'';

(4) in subsection (f)(2), by striking ''$6,000,000 for fiscal year 2007'' and all that follows through the period at the end and inserting ''$3,000,000 for each of the fiscal years 2018 through 2022''; and

(5) by adding at the end the following new subsection:

''(g) REDUCING UNDERAGE DRINKING THROUGH SCREENING AND BRIEF INTERVENTION.—

''(1) GRANTS TO PEDIATRIC HEALTH CARE PROVIDERS TO REDUCE UNDERAGE DRINKING.—The Assistant Secretary may make grants to eligible entities to increase implementation of practices for reducing the prevalence of alcohol use among individuals under the age of 21, including college students.

''(2) PURPOSES.—Grants under this subsection shall be made to improve—

''(A) screening children and adolescents for alcohol use;

''(B) offering brief interventions to children and adolescents to discourage such use;

''(C) educating parents about the dangers of, and methods of discouraging, such use;

''(D) diagnosing and treating alcohol use disorders; and

''(E) referring patients, when necessary, to other appropriate care.

''(3) USE OF FUNDS.—An entity receiving a grant under this subsection may use such funding for the purposes identified in paragraph (2) by—

''(A) providing training to health care providers;

''(B) disseminating best practices, including culturally and linguistically appropriate best practices, as appropriate, and developing and distributing materials; and

''(C) supporting other activities, as determined appropriate by the Assistant Secretary.

''(4) APPLICATION.—To be eligible to receive a grant under this subsection, an entity shall submit an application to the Assistant Secretary at such time, and in such manner, and accompanied by such information as the Assistant Secretary may require. Each application shall include—

''(A) a description of the entity;

''(B) a description of activities to be completed;

''(C) a description of how the services specified in paragraphs (2) and (3) will be carried out and the qualifications for providing such services; and

''(D) a timeline for the completion of such activities.

''(5) DEFINITIONS.—For the purpose of this subsection:

''(A) BRIEF INTERVENTION.—The term 'brief intervention' means, after screening a patient, providing the patient with brief advice and other brief motivational enhancement techniques designed to increase the insight of the patient regarding the patient's alcohol use, and any realized or potential consequences of such use, to effect the desired related behavioral change.

''(B) CHILDREN AND ADOLESCENTS.—The term 'children and adolescents' means any person under 21 years of age.

''(C) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity consisting of pediatric health care providers and that is qualified to support or provide the activities identified in paragraph (2).

''(D) PEDIATRIC HEALTH CARE PROVIDER.—The term 'pediatric health care provider' means a provider of primary health care to individuals under the age of 21 years.

''(E) SCREENING.—The term 'screening' means using validated patient interview techniques to identify and assess the existence and extent of alcohol use in a patient.''.

SEC. 9017. CENTER AND PROGRAM REPEALS.

Part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by striking section 506B (42 U.S.C. 290aa–5b), the second section 514 (42 U.S.C. 290bb–9) relating to methamphetamine and amphetamine treatment initiatives, and each of sections 514A, 517, 519A, 519C, 519E, 520B, 520D, and 520H (42 U.S.C. 290bb–8, 290bb–23, 290bb–25a, 290bb–25c, 290bb–25e, 290bb–33, 290bb–35, and 290bb–39).

Subtitle B—Strengthening the Health Care Workforce

SEC. 9021. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

Section 756 of the Public Health Service Act (42 U.S.C. 294e–1) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking ''of higher education''; and

(B) by striking paragraphs (1) through (4) and inserting the following:

''(1) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing (which may include master's and doctoral level programs), social work, school social work, substance use disorder prevention and treatment, marriage and family therapy, occupational therapy, school counseling, or professional counseling, including such programs with a focus on child and adolescent mental health and transitional-age youth;

''(2) accredited doctoral, internship, and postdoctoral residency programs of health service psychology (including clinical psychology, counseling, and school psychology) for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral health services, including substance use disorder prevention and treatment services, as well as the development of faculty in health service psychology;

''(3) accredited master's and doctoral degree programs of social work for the development and implementation of interdisciplinary training of social work graduate students for providing behavioral health services, including substance use disorder prevention and treatment services, and the development of faculty in social work; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training in a behavioral health-related paraprofessional field with preference for preservice or in-service training of paraprofessional child and adolescent mental health workers.'';

(2) in subsection (b)—

(A) by striking paragraph (5);

(B) by redesignating paragraphs (1) through (4) as paragraphs (2) through (5), respectively;

(C) by inserting before paragraph (2), as so redesignated, the following:

''(1) an ability to recruit and place the students described in subsection (a) in areas with a high need and high demand population;'';

(D) in paragraph (3), as so redesignated, by striking ''subsection (a)'' and inserting ''paragraph (2), especially individuals with mental disorder symptoms or diagnoses, particularly children and adolescents, and transitional-age youth'';

(E) in paragraph (4), as so redesignated, by striking '';'' and inserting ''; and''; and

(F) in paragraph (5), as so redesignated, by striking ''; and'' and inserting a period;

(3) in subsection (c), by striking ''authorized under subsection (a)(1)'' and inserting ''awarded under paragraphs (2) and (3) of subsection (a)'';

(4) by amending subsection (d) to read as follows:

''(d) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to—

''(1) programs that have demonstrated the ability to train psychology, psychiatry, and social work professionals to work in integrated care settings for purposes of recipients under paragraphs (1), (2), and (3) of subsection (a); and

''(2) programs for paraprofessionals that emphasize the role of the family and the lived experience of the consumer and family-paraprofessional partnerships for purposes of recipients under subsection (a)(4).''; and

(5) by striking subsection (e) and inserting the following:

''(e) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary shall include in the biennial report submitted to Congress under section 501(m) an assessment on the effectiveness of the grants under this section in—

''(1) providing graduate students support for experiential training (internship or field placement);

''(2) recruiting students interested in behavioral health practice;

''(3) recruiting students in accordance with subsection (b)(1);

''(4) developing and implementing interprofessional training and integration within primary care;

''(5) developing and implementing accredited field placements and internships; and

''(6) collecting data on the number of students trained in behavioral health care and the number of available accredited internships and field placements.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For each of fiscal years 2018 through 2022, there are authorized to be appropriated to carry out this section $50,000,000, to be allocated as follows:

''(1) For grants described in subsection (a)(1), $15,000,000.

''(2) For grants described in subsection (a)(2), $15,000,000.

''(3) For grants described in subsection (a)(3), $10,000,000.

''(4) For grants described in subsection (a)(4), $10,000,000.''.

SEC. 9022. STRENGTHENING THE MENTAL AND SUBSTANCE USE DISORDERS WORKFORCE.

Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

''SEC. 760. TRAINING DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish a training demonstration program to award grants to eligible entities to support—

''(1) training for medical residents and fellows to practice psychiatry and addiction medicine in underserved, community-based settings that integrate primary care with mental and substance use disorders prevention and treatment services;

''(2) training for nurse practitioners, physician assistants, health service psychologists, and social workers to provide mental and substance use disorders services in underserved community-based settings that integrate primary care and mental and substance use disorders services; and

''(3) establishing, maintaining, or improving academic units or programs that—

''(A) provide training for students or faculty, including through clinical experiences and research, to improve the ability to be able to recognize, diagnose, and treat mental and substance use disorders, with a special focus on addiction; or

''(B) develop evidence-based practices or recommendations for the design of the units or programs described in subparagraph (A), including curriculum content standards.

''(b) ACTIVITIES.—

''(1) TRAINING FOR RESIDENTS AND FELLOWS.—A recipient of a grant under subsection (a)(1)—

''(A) shall use the grant funds—

''(i)(I) to plan, develop, and operate a training program for medical psychiatry residents and fellows in addiction medicine practicing in eligible entities described in subsection (c)(1); or

''(II) to train new psychiatric residents and fellows in addiction medicine to provide and expand access to integrated mental and substance use disorders services; and

''(ii) to provide at least 1 training track that is—

''(I) a virtual training track that includes an in-person rotation at a teaching health center or in a community-based setting, followed by a virtual rotation in which the resident or fellow continues to support the care of patients at the teaching health center or in the community-based setting through the use of health information technology and, as appropriate, telehealth services;

''(II) an in-person training track that includes a rotation, during which the resident or fellow practices at a teaching health center or in a community-based setting; or

''(III) an in-person training track that includes a rotation during which the resident practices in a community-based setting that specializes in the treatment of infants, children, adolescents, or pregnant or postpartum women; and

''(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such training.

''(2) TRAINING FOR OTHER PROVIDERS.—A recipient of a grant under subsection (a)(2)—

''(A) shall use the grant funds to plan, develop, or operate a training program to provide

mental and substance use disorders services in underserved, community-based settings, as appropriate, that integrate primary care and mental and substance use disorders prevention and treatment services; and

''(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such program.

''(3) ACADEMIC UNITS OR PROGRAMS.—A recipient of a grant under subsection (a)(3) shall enter into a partnership with organizations such as an education accrediting organization (such as the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Commission on Osteopathic College Accreditation, the Accreditation Commission for Education in Nursing, the Commission on Collegiate Nursing Education, the Accreditation Council for Pharmacy Education, the Council on Social Work Education, American Psychological Association Commission on Accreditation, or the Accreditation Review Commission on Education for the Physician Assistant) to carry out activities under subsection (a)(3).

''(c) ELIGIBLE ENTITIES.—

''(1) TRAINING FOR RESIDENTS AND FELLOWS.—To be eligible to receive a grant under subsection (a)(1), an entity shall—

''(A) be a consortium consisting of—

''(i) at least one teaching health center; and

''(ii) the sponsoring institution (or parent institution of the sponsoring institution) of—

''(I) a psychiatry residency program that is accredited by the Accreditation Council of Graduate Medical Education (or the parent institution of such a program); or

''(II) a fellowship in addiction medicine, as determined appropriate by the Secretary; or

''(B) be an entity described in subparagraph (A)(ii) that provides opportunities for residents or fellows to train in community-based settings that integrate primary care with mental and substance use disorders prevention and treatment services.

''(2) TRAINING FOR OTHER PROVIDERS.—To be eligible to receive a grant under subsection (a)(2), an entity shall be—

''(A) a teaching health center (as defined in section 749A(f));

''(B) a Federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act);

''(C) a community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act);

''(D) a rural health clinic (as defined in section 1861(aa) of the Social Security Act);

''(E) a health center operated by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(F) an entity with a demonstrated record of success in providing training for nurse practitioners, physician assistants, health service psychologists, and social workers.

''(3) ACADEMIC UNITS OR PROGRAMS.—To be eligible to receive a grant under subsection (a)(3), an entity shall be a school of medicine or osteopathic medicine, a nursing school, a physician assistant training program, a school of pharmacy, a school of social work, an accredited public or nonprofit private hospital, an accredited medical residency program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant.

''(d) PRIORITY.—

''(1) IN GENERAL.—In awarding grants under subsection (a)(1) or (a)(2), the Secretary shall give priority to eligible entities that—

''(A) demonstrate sufficient size, scope, and capacity to undertake the requisite training of an appropriate number of psychiatric residents, fellows, nurse practitioners, physician assistants, or social workers in addiction medicine per year to meet the needs of the area served;

''(B) demonstrate experience in training providers to practice team-based care that integrates mental and substance use disorder prevention and treatment services with primary care in community-based settings;

''(C) demonstrate experience in using health information technology and, as appropriate, telehealth to support—

''(i) the delivery of mental and substance use disorders services at the eligible entities described in subsections (c)(1) and (c)(2); and

''(ii) community health centers in integrating primary care and mental and substance use disorders treatment; or

''(D) have the capacity to expand access to mental and substance use disorders services in areas with demonstrated need, as determined by the Secretary, such as tribal, rural, or other underserved communities.

''(2) ACADEMIC UNITS OR PROGRAMS.—In awarding grants under subsection (a)(3), the Secretary shall give priority to eligible entities that—

''(A) have a record of training the greatest percentage of mental and substance use disorders providers who enter and remain in these fields or who enter and remain in settings with integrated primary care and mental and substance use disorder prevention and treatment services;

''(B) have a record of training individuals who are from underrepresented minority groups, including native populations, or from a rural or disadvantaged background;

''(C) provide training in the care of vulnerable populations such as infants, children, adolescents, pregnant and postpartum women, older adults, homeless individuals, victims of abuse or trauma, individuals with disabilities, and other groups as defined by the Secretary;

''(D) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals; or

''(E) provide training in cultural competency and health literacy.

''(e) DURATION.—Grants awarded under this section shall be for a minimum of 5 years.

''(f) STUDY AND REPORT.—

''(1) STUDY.—

''(A) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct a study on the results of the demonstration program under this section.

''(B) DATA SUBMISSION.—Not later than 90 days after the completion of the first year of the training program and each subsequent year that the program is in effect, each recipient of a grant under subsection (a) shall submit to the Secretary such data as the Secretary may require for analysis for the report described in paragraph (2).

''(2) REPORT TO CONGRESS.—Not later than 1 year after receipt of the data described in paragraph (1)(B), the Secretary shall submit to Congress a report that includes—

''(A) an analysis of the effect of the demonstration program under this section on the quality, quantity, and distribution of mental and substance use disorders services;

''(B) an analysis of the effect of the demonstration program on the prevalence of untreated mental and substance use disorders in the surrounding communities of health centers participating in the demonstration; and

''(C) recommendations on whether the demonstration program should be expanded.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2018 through 2022.''.

SEC. 9023. CLARIFICATION ON CURRENT ELIGIBILITY FOR LOAN REPAYMENT PROGRAMS.

The Administrator of the Health Resources and Services Administration shall clarify the eligibility pursuant to section 338B(b)(1)(B) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) of child and adolescent psychiatrists for the National Health Service Corps Loan Repayment Program under subpart III of part D of title III of such Act (42 U.S.C. 254l et seq.).

SEC. 9024. MINORITY FELLOWSHIP PROGRAM.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''PART K—MINORITY FELLOWSHIP PROGRAM

''SEC. 597. FELLOWSHIPS.

''(a) IN GENERAL.—The Secretary shall maintain a program, to be known as the Minority Fellowship Program, under which the Secretary shall award fellowships, which may include stipends, for the purposes of—

''(1) increasing the knowledge of mental and substance use disorders practitioners on issues related to prevention, treatment, and recovery support for individuals who are from racial and ethnic minority populations and who have a mental or substance use disorder;

''(2) improving the quality of mental and substance use disorder prevention and treatment services delivered to racial and ethnic minority populations; and

''(3) increasing the number of culturally competent mental and substance use disorders professionals who teach, administer services, conduct research, and provide direct mental or substance use disorder services to racial and ethnic minority populations.

''(b) TRAINING COVERED.—The fellowships awarded under subsection (a) shall be for postbaccalaureate training (including for master's and doctoral degrees) for mental and substance use disorder treatment professionals, including in the fields of psychiatry, nursing, social work, psychology, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling.

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $12,669,000 for each of fiscal years 2018 through 2022.''.

SEC. 9025. LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following:

''(q)(1) For purposes of this section, a health professional volunteer at a deemed entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

''(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) if the following conditions are met:

''(A) The service is provided to the individual at the facilities of an entity described in subsection (g)(4), or through offsite programs or events carried out by the entity.

''(B) The entity is sponsoring the health care practitioner pursuant to paragraph (3)(B).

''(C) The health care practitioner does not receive any compensation for the service from the individual, the entity described in subsection (g)(4), or any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual, which may include travel expenses to or from the site of services.

''(D) Before the service is provided, the health care practitioner or the entity described in subsection (g)(4) posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection.

''(E) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable Federal and State laws regarding the provision of the service.

''(F) At the time the service is provided, the entity described in subsection (g)(4) maintains relevant documentation certifying that the health care practitioner meets the requirements of this subsection.

''(3) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4), and subject to the following:

''(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

''(B) With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—

''(i) with respect to the health care practitioner, the entity submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

''(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

''(C) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

''(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

''(4)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

''(B)(i) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of health professional volunteers, will be paid pursuant to this section during the calendar year that begins in the following fiscal year.

''(ii) Subsection (k)(1)(B) applies to the estimate under clause (i) regarding health professional volunteers to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

''(iii) The report shall include a summary of the data relied upon for the estimate in clause (i), including the number of claims filed and paid from the previous calendar year.

''(C) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

''(5)(A) This subsection shall take effect on October 1, 2017, except as provided in subparagraph (B) and paragraph (6).

''(B) Effective on the date of the enactment of this subsection—

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (3)(B); and

''(ii) reports under paragraph (4)(B) may be submitted to Congress.

''(6) Beginning on October 1, 2022, this subsection shall cease to have any force or effect.''.

SEC. 9026. REPORTS.

(a) WORKFORCE DEVELOPMENT REPORT.—

*(1) IN GENERAL.—*Not later than 2 years after the date of enactment of this Act, the Administrator of the Health Resources and Services Administration, in consultation with the Assistant Secretary for Mental Health and Substance Use, shall conduct a study and publicly post on the appropriate Internet website of the Department of Health and Human Services a report on the adult and pediatric mental health and substance use disorder workforce in order to inform Federal, State, and local efforts related to workforce enhancement.

*(2) CONTENTS.—*The report under this subsection shall contain—

(A) national and State-level projections of the supply and demand of the mental health and substance use disorder health workforce, disaggregated by profession;

(B) an assessment of the mental health and substance use disorder workforce capacity, strengths, and weaknesses as of the date of the report, including the extent to which primary care providers are preventing, screening, or referring for mental and substance use disorder services;

(C) information on trends within the mental health and substance use disorder provider workforce, including the number of individuals expected to enter the mental health workforce over the next 5 years; and

(D) any additional information determined by the Administrator of the Health Resources and Services Administration, in consultation with the Assistant Secretary for Mental Health and Substance Use, to be relevant to the mental health and substance use disorder provider workforce.

(b) PEER-SUPPORT SPECIALIST PROGRAMS.—

*(1) IN GENERAL.—*The Comptroller General of the United States shall conduct a study on peer-support specialist programs in up to 10 States that receive funding from the Substance Abuse and Mental Health Services Administration.

*(2) CONTENTS OF STUDY.—*In conducting the study under paragraph (1), the Comptroller General of the United States shall examine and identify best practices, in the States selected pursuant to such paragraph, related to training and credential requirements for peer-support specialist programs, such as—

(A) hours of formal work or volunteer experience related to mental and substance use disorders conducted through such programs;

(B) types of peer-support specialist exams required for such programs in the selected States;

(C) codes of ethics used by such programs in the selected States;

(D) required or recommended skill sets for such programs in the selected States; and

(E) requirements for continuing education.

*(3) REPORT.—*Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the study conducted under paragraph (1).

Subtitle C—Mental Health on Campus Improvement

SEC. 9031. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ON CAMPUS.

Section 520E–2 of the Public Health Service Act (42 U.S.C. 290bb–36b) is amended—

(1) in the section heading, by striking ''**AND BEHAVIORAL HEALTH**'' *and inserting* ''**HEALTH AND SUBSTANCE USE DISORDER**'';

(2) in subsection (a)—

(A) by striking ''Services,'' and inserting ''Services and'';

(B) by striking ''and behavioral health problems'' and inserting ''health or substance use disorders'';

(C) by striking ''substance abuse'' and inserting ''substance use disorders''; and

(D) by adding after, ''suicide attempts,'' the following: ''prevent mental and substance use disorders, reduce stigma, and improve the identification and treatment for students at risk,'';

(3) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking ''for—'' and inserting ''for one or more of the following:''; and

(B) by striking paragraphs (1) through (6) and inserting the following:

''(1) Educating students, families, faculty, and staff to increase awareness of mental and substance use disorders.

''(2) The operation of hotlines.

''(3) Preparing informational material.

''(4) Providing outreach services to notify students about available mental and substance use disorder services.

''(5) Administering voluntary mental and substance use disorder screenings and assessments.

''(6) Supporting the training of students, faculty, and staff to respond effectively to students with mental and substance use disorders.

''(7) Creating a network infrastructure to link institutions of higher education with health care providers who treat mental and substance use disorders.

''(8) Providing mental and substance use disorders prevention and treatment services to students, which may include recovery support services and programming and early intervention, treatment, and management, including through the use of telehealth services.

''(9) Conducting research through a counseling or health center at the institution of higher education involved regarding improving the behavioral health of students through clinical services, outreach, prevention, or academic success, in a manner that is in compliance with all applicable personal privacy laws.

''(10) Supporting student groups on campus, including athletic teams, that engage in activities to educate students, including activities to reduce stigma surrounding mental and behavioral disorders, and promote mental health.

''(11) Employing appropriately trained staff.

''(12) Developing and supporting evidence-based and emerging best practices, including a focus on culturally and linguistically appropriate best practices.'';

(4) in subsection (c)(5), by striking ''substance abuse'' and inserting ''substance use disorder'';

(5) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''An institution of higher education desiring a grant under this section'' and inserting ''To be eligible to receive a grant under this section, an institution of higher education'';

(B) by striking paragraph (1) and inserting—

''(1) A description of the population to be targeted by the program carried out under the grant, including veterans whenever possible and appropriate, and of identified mental and substance use disorder needs of students at the institution of higher education.'';

(C) in paragraph (2), by inserting '', which may include, as appropriate and in accordance with subsection (b)(7), a plan to seek input from relevant stakeholders in the community, including appropriate public and private entities, in

order to carry out the program under the grant'' before the period at the end; and

(D) by adding after paragraph (5) the following new paragraphs:

''(6) An outline of the objectives of the program carried out under the grant.

''(7) For an institution of higher education proposing to use the grant for an activity described in paragraph (8) or (9) of subsection (b), a description of the policies and procedures of the institution of higher education that are related to applicable laws regarding access to, and sharing of, treatment records of students at any campus-based mental health center or partner organization, including the policies and State laws governing when such records can be accessed and shared for non-treatment purposes and a description of the process used by the institution of higher education to notify students of these policies and procedures, including the extent to which written consent is required.

''(8) An assurance that grant funds will be used to supplement and not supplant any other Federal, State, or local funds available to carry out activities of the type carried out under the grant.'';

(6) in subsection (e)(1), by striking ''and behavioral health problems'' and inserting ''health and substance use disorders'';

(7) in subsection (f)(2)—

(A) by striking ''and behavioral health'' and inserting ''health and substance use disorder''; and

(B) by striking ''suicide and substance abuse'' and inserting ''suicide and substance use disorders'';

(8) by redesignating subsection (h) as subsection (i);

(9) by inserting after subsection (g) the following new subsection:

''(h) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to grantees in carrying out this section.''; and

(10) in subsection (i), as redesignated by paragraph (8), by striking ''$5,000,000 for fiscal year 2005'' and all that follows through the period at the end and inserting ''$7,000,000 for each of fiscal years 2018 through 2022.''.

SEC. 9032. INTERAGENCY WORKING GROUP ON COLLEGE MENTAL HEALTH.

(a) PURPOSE.—It is the purpose of this section to provide for the establishment of a College Campus Task Force to discuss mental and behavioral health concerns on campuses of institutions of higher education.

(b) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a College Campus Task Force (referred to in this section as the ''Task Force'') to discuss mental and behavioral health concerns on campuses of institutions of higher education.

(c) MEMBERSHIP.—The Task Force shall be composed of a representative from each Federal agency (as appointed by the head of the agency) that has jurisdiction over, or is affected by, mental health and education policies and projects, including—

(1) the Department of Education;

(2) the Department of Health and Human Services;

(3) the Department of Veterans Affairs; and

(4) such other Federal agencies as the Assistant Secretary for Mental Health and Substance Use, in consultation with the Secretary, determines to be appropriate.

(d) DUTIES.—The Task Force shall—

(1) serve as a centralized mechanism to coordinate a national effort to—

(A) discuss and evaluate evidence and knowledge on mental and behavioral health services available to, and the prevalence of mental illness among, the age population of students attending institutions of higher education in the United States;

(B) determine the range of effective, feasible, and comprehensive actions to improve mental and behavioral health on campuses of institutions of higher education;

(C) examine and better address the needs of the age population of students attending institutions of higher education dealing with mental illness;

(D) survey Federal agencies to determine which policies are effective in encouraging, and how best to facilitate outreach without duplicating, efforts relating to mental and behavioral health promotion;

(E) establish specific goals within and across Federal agencies for mental health promotion, including determinations of accountability for reaching those goals;

(F) develop a strategy for allocating responsibilities and ensuring participation in mental and behavioral health promotion, particularly in the case of competing agency priorities;

(G) coordinate plans to communicate research results relating to mental and behavioral health amongst the age population of students attending institutions of higher education to enable reporting and outreach activities to produce more useful and timely information;

(H) provide a description of evidence-based practices, model programs, effective guidelines, and other strategies for promoting mental and behavioral health on campuses of institutions of higher education;

(I) make recommendations to improve Federal efforts relating to mental and behavioral health promotion on campuses of institutions of higher education and to ensure Federal efforts are consistent with available standards, evidence, and other programs in existence as of the date of enactment of this Act;

(J) monitor Federal progress in meeting specific mental and behavioral health promotion goals as they relate to settings of institutions of higher education; and

(K) examine and disseminate best practices related to intracampus sharing of treatment records;

(2) consult with national organizations with expertise in mental and behavioral health, especially those organizations working with the age population of students attending institutions of higher education; and

(3) consult with and seek input from mental health professionals working on campuses of institutions of higher education as appropriate.

(e) MEETINGS.—

(1) IN GENERAL.—The Task Force shall meet not fewer than three times each year.

(2) ANNUAL CONFERENCE.—The Secretary shall sponsor an annual conference on mental and behavioral health in settings of institutions of higher education to enhance coordination, build partnerships, and share best practices in mental and behavioral health promotion, data collection, analysis, and services.

(f) DEFINITION.—In this section, the term ''institution of higher education'' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $1,000,000 for the period of fiscal years 2018 through 2022.

SEC. 9033. IMPROVING MENTAL HEALTH ON COLLEGE CAMPUSES.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

''SEC. 549. MENTAL AND BEHAVIORAL HEALTH OUTREACH AND EDUCATION ON COLLEGE CAMPUSES.

''(a) PURPOSE.—It is the purpose of this section to increase access to, and reduce the stigma associated with, mental health services to ensure that students at institutions of higher education have the support necessary to successfully complete their studies.

''(b) NATIONAL PUBLIC EDUCATION CAMPAIGN.—The Secretary, acting through the Assistant Secretary and in collaboration with the Director of the Centers for Disease Control and Prevention, shall convene an interagency, public-private sector working group to plan, establish, and begin coordinating and evaluating a targeted public education campaign that is designed to focus on mental and behavioral health on the campuses of institutions of higher education. Such campaign shall be designed to—

''(1) improve the general understanding of mental health and mental disorders;

''(2) encourage help-seeking behaviors relating to the promotion of mental health, prevention of mental disorders, and treatment of such disorders;

''(3) make the connection between mental and behavioral health and academic success; and

''(4) assist the general public in identifying the early warning signs and reducing the stigma of mental illness.

''(c) COMPOSITION.—The working group convened under subsection (b) shall include—

''(1) mental health consumers, including students and family members;

''(2) representatives of institutions of higher education;

''(3) representatives of national mental and behavioral health associations and associations of institutions of higher education;

''(4) representatives of health promotion and prevention organizations at institutions of higher education;

''(5) representatives of mental health providers, including community mental health centers; and

''(6) representatives of private-sector and public-sector groups with experience in the development of effective public health education campaigns.

''(d) PLAN.—The working group under subsection (b) shall develop a plan that—

''(1) targets promotional and educational efforts to the age population of students at institutions of higher education and individuals who are employed in settings of institutions of higher education, including through the use of roundtables;

''(2) develops and proposes the implementation of research-based public health messages and activities;

''(3) provides support for local efforts to reduce stigma by using the National Health Information Center as a primary point of contact for information, publications, and service program referrals; and

''(4) develops and proposes the implementation of a social marketing campaign that is targeted at the population of students attending institutions of higher education and individuals who are employed in settings of institutions of higher education.

''(e) DEFINITION.—In this section, the term 'institution of higher education' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $1,000,000 for the period of fiscal years 2018 through 2022.''.

TITLE X—STRENGTHENING MENTAL AND SUBSTANCE USE DISORDER CARE FOR CHILDREN AND ADOLESCENTS

SEC. 10001. PROGRAMS FOR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE.

(a) COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE.—Section 561(a)(1) of the Public Health Service Act (42 U.S.C. 290ff(a)(1)) is amended by inserting '', which may include efforts to identify and serve children at risk'' before the period.

(b) REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF GRANTS.—Section 562(b) of the Public Health Service Act (42 U.S.C. 290ff–1(b)) is amended by striking ''will not provide an individual with access to the system if the individual is more than 21 years of age'' and inserting ''will provide an individual with access to the system through the age of 21 years''.

(c) ADDITIONAL PROVISIONS.—Section 564(f) of the Public Health Service Act (42 U.S.C. 290ff–

3(f)) is amended by inserting ''(and provide a copy to the State involved)'' after ''to the Secretary''.

(d) GENERAL PROVISIONS.—Section 565 of the Public Health Service Act (42 U.S.C. 290ff–4) is amended—

(1) in subsection (b)(1)—

(A) in the matter preceding subparagraph (A), by striking ''receiving a grant under section 561(a)'' and inserting '', regardless of whether such public entity is receiving a grant under section 561(a)''; and

(B) in subparagraph (B), by striking ''pursuant to'' and inserting ''described in'';

(2) in subsection (d)(1), by striking ''not more than 21 years of age'' and inserting ''through the age of 21 years''; and

(3) in subsection (f)(1), by striking ''$100,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003'' and inserting ''$119,026,000 for each of fiscal years 2018 through 2022''.

SEC. 10002. INCREASING ACCESS TO PEDIATRIC MENTAL HEALTH CARE.

Title III of the Public Health Service Act is amended by inserting after section 330L of such Act (42 U.S.C. 254c–18) the following new section:

''SEC. 330M PEDIATRIC MENTAL HEALTH CARE ACCESS GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in coordination with other relevant Federal agencies, shall award grants to States, political subdivisions of States, and Indian tribes and tribal organizations (for purposes of this section, as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) to promote behavioral health integration in pediatric primary care by—

''(1) supporting the development of statewide or regional pediatric mental health care telehealth access programs; and

''(2) supporting the improvement of existing statewide or regional pediatric mental health care telehealth access programs.

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—A pediatric mental health care telehealth access program referred to in subsection (a), with respect to which a grant under such subsection may be used, shall—

''(A) be a statewide or regional network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;

''(B) support and further develop organized State or regional networks of pediatric mental health teams to provide consultative support to pediatric primary care sites;

''(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers' preferred mechanisms for receiving consultation, training, and technical assistance;

''(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;

''(E) provide rapid statewide or regional clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

''(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;

''(G) provide information to pediatric providers about, and assist pediatric providers in accessing, pediatric mental health care providers, including child and adolescent psychiatrists, and licensed mental health professionals, such as psychologists, social workers, or mental health counselors and in scheduling and conducting technical assistance;

''(H) assist with referrals to specialty care and community or behavioral health resources; and

''(I) establish mechanisms for measuring and monitoring increased access to pediatric mental health care services by pediatric primary care providers and expanded capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

''(2) PEDIATRIC MENTAL HEALTH TEAMS.—In this subsection, the term 'pediatric mental health team' means a team consisting of at least one case coordinator, at least one child and adolescent psychiatrist, and at least one licensed clinical mental health professional, such as a psychologist, social worker, or mental health counselor. Such a team may be regionally based.

''(c) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the comprehensive evaluation of activities that are carried out with funds received under such grant.

''(d) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under this section shall prepare and submit an evaluation of activities that are carried out with funds received under such grant to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including a process and outcome evaluation.

''(e) ACCESS TO BROADBAND.—In administering grants under this section, the Secretary may coordinate with other agencies to ensure that funding opportunities are available to support access to reliable, high-speed Internet for providers.

''(f) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section unless the State, political subdivision of a State, Indian tribe, or tribal organization involved agrees, with respect to the costs to be incurred by the State, political subdivision of a State, Indian tribe, or tribal organization in carrying out the purpose described in this section, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 20 percent of Federal funds provided in the grant.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated, $9,000,000 for the period of fiscal years 2018 through 2022.''.

SEC. 10003. SUBSTANCE USE DISORDER TREATMENT AND EARLY INTERVENTION SERVICES FOR CHILDREN AND ADOLESCENTS.

The first section 514 of the Public Health Service Act (42 U.S.C. 290bb–7), relating to substance abuse treatment services for children and adolescents, is amended—

*(1) in the section heading, by striking ''**ABUSE TREATMENT**'' and inserting ''**USE DISORDER TREATMENT AND EARLY INTERVENTION**'';*

(2) by striking subsection (a) and inserting the following:

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to public and private nonprofit entities, including Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), or health facilities or programs operated by or in accordance with a contract or grant with the Indian Health Service, for the purpose of—

''(1) providing early identification and services to meet the needs of children and adolescents who are at risk of substance use disorders;

''(2) providing substance use disorder treatment services for children, including children and adolescents with co-occurring mental illness and substance use disorders; and

''(3) providing assistance to pregnant women, and parenting women, with substance use disorders, in obtaining treatment services, linking mothers to community resources to support independent family lives, and staying in recovery so that children are in safe, stable home environments and receive appropriate health care services.'';

(3) in subsection (b)—

(A) by striking paragraph (1) and inserting the following:

''(1) apply evidence-based and cost-effective methods;'';

(B) in paragraph (2)—

(i) by striking ''treatment''; and

(ii) by inserting ''substance abuse,'' after ''child welfare,'';

(C) in paragraph (3), by striking ''substance abuse disorders'' and inserting ''substance use disorders, including children and adolescents with co-occurring mental illness and substance use disorders,'';

(D) in paragraph (5), by striking ''treatment;'' and inserting ''services; and'';

(E) in paragraph (6), by striking ''substance abuse treatment; and'' and inserting ''treatment.''; and

(F) by striking paragraph (7); and

(4) in subsection (f), by striking ''$40,000,000'' and all that follows through the period and inserting ''$29,605,000 for each of fiscal years 2018 through 2022.''.

SEC. 10004. CHILDREN'S RECOVERY FROM TRAUMA.

The first section 582 of the Public Health Service Act (42 U.S.C. 290hh–1; relating to grants to address the problems of persons who experience violence related stress) is amended—

(1) in subsection (a), by striking ''developing programs'' and all that follows through the period at the end and inserting the following: ''developing and maintaining programs that provide for—

''(1) the continued operation of the National Child Traumatic Stress Initiative (referred to in this section as the 'NCTSI'), which includes a cooperative agreement with a coordinating center, that focuses on the mental, behavioral, and biological aspects of psychological trauma response, prevention of the long-term consequences of child trauma, and early intervention services and treatment to address the long-term consequences of child trauma; and

''(2) the development of knowledge with regard to evidence-based practices for identifying and treating mental, behavioral, and biological disorders of children and youth resulting from witnessing or experiencing a traumatic event.'';

(2) in subsection (b)—

(A) by striking ''subsection (a) related'' and inserting ''subsection (a)(2) (related'';

(B) by striking ''treating disorders associated with psychological trauma'' and inserting ''treating mental, behavioral, and biological disorders associated with psychological trauma)''; and

(C) by striking ''mental health agencies and programs that have established clinical and basic research'' and inserting ''universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research'';

(3) by redesignating subsections (c) through (g) as subsections (g) through (k), respectively;

(4) by inserting after subsection (b), the following:

''(c) CHILD OUTCOME DATA.—The NCTSI coordinating center described in subsection (a)(1) shall collect, analyze, report, and make publicly available, as appropriate, NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based treatment and services for children and families served by the NCTSI grantees.

''(d) TRAINING.—The NCTSI coordinating center shall facilitate the coordination of training initiatives in evidence-based and trauma-informed treatments, interventions, and practices offered to NCTSI grantees, providers, and partners.

''(e) DISSEMINATION AND COLLABORATION.—The NCTSI coordinating center shall, as appropriate, collaborate with—

''(1) the Secretary, in the dissemination of evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders; and

''(2) appropriate agencies that conduct or fund research within the Department of Health and Human Services, for purposes of sharing NCTSI expertise, evaluation data, and other activities, as appropriate.

''(f) REVIEW.—The Secretary shall, consistent with the peer-review process, ensure that NCTSI applications are reviewed by appropriate experts in the field as part of a consensus-review process. The Secretary shall include review criteria related to expertise and experience in child trauma and evidence-based practices.'';

(5) in subsection (g) (as so redesignated), by striking ''with respect to centers of excellence are distributed equitably among the regions of the country'' and inserting ''are distributed equitably among the regions of the United States'';

(6) in subsection (i) (as so redesignated), by striking ''recipient may not exceed 5 years'' and inserting ''recipient shall not be less than 4 years, but shall not exceed 5 years''; and

(7) in subsection (j) (as so redesignated), by striking ''$50,000,000'' and all that follows through ''2006'' and inserting ''$46,887,000 for each of fiscal years 2018 through 2022''.

SEC. 10005. SCREENING AND TREATMENT FOR MATERNAL DEPRESSION.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317L (42 U.S.C. 247b–13) the following:

''SEC. 317L–1. SCREENING AND TREATMENT FOR MATERNAL DEPRESSION.

''(a) GRANTS.—The Secretary shall make grants to States to establish, improve, or maintain programs for screening, assessment, and treatment services, including culturally and linguistically appropriate services, as appropriate, for women who are pregnant, or who have given birth within the preceding 12 months, for maternal depression.

''(b) APPLICATION.—To seek a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require. At a minimum, any such application shall include explanations of—

''(1) how a program, or programs, will increase the percentage of women screened and treated, as appropriate, for maternal depression in 1 or more communities; and

''(2) how a program, or programs, if expanded, would increase access to screening and treatment services for maternal depression.

''(c) PRIORITY.—In awarding grants under this section, the Secretary may give priority to States proposing to improve or enhance access to screening services for maternal depression in primary care settings.

''(d) USE OF FUNDS.—The activities eligible for funding through a grant under subsection (a)—

''(1) shall include—

''(A) providing appropriate training to health care providers; and

''(B) providing information to health care providers, including information on maternal depression screening, treatment, and followup support services, and linkages to community-based resources; and

''(2) may include—

''(A) enabling health care providers (including obstetrician-gynecologists, pediatricians, psychiatrists, mental health care providers, and adult primary care clinicians) to provide or receive real-time psychiatric consultation (in-person or remotely) to aid in the treatment of pregnant and parenting women;

''(B) establishing linkages with and among community-based resources, including mental health resources, primary care resources, and support groups; and

''(C) utilizing telehealth services for rural areas and medically underserved areas (as defined in section 330I(a)).

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2018 through 2022.''.

SEC. 10006. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

''SEC. 399Z–2. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

''(a) GRANTS.—The Secretary shall—

''(1) award grants to eligible entities to develop, maintain, or enhance infant and early childhood mental health promotion, intervention, and treatment programs, including—

''(A) programs for infants and children at significant risk of developing, showing early signs of, or having been diagnosed with mental illness, including a serious emotional disturbance; and

''(B) multigenerational therapy and other services that support the caregiving relationship; and

''(2) ensure that programs funded through grants under this section are evidence-informed or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

''(b) ELIGIBLE CHILDREN AND ENTITIES.—In this section:

''(1) ELIGIBLE CHILD.—The term 'eligible child' means a child from birth to not more than 12 years of age who—

''(A) is at risk for, shows early signs of, or has been diagnosed with a mental illness, including a serious emotional disturbance; and

''(B) may benefit from infant and early childhood intervention or treatment programs or specialized preschool or elementary school programs that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' means a human services agency or nonprofit institution that—

''(A) employs licensed mental health professionals who have specialized training and experience in infant and early childhood mental health assessment, diagnosis, and treatment, or is accredited or approved by the appropriate State agency, as applicable, to provide for children from infancy to 12 years of age mental health promotion, intervention, or treatment services; and

''(B) provides services or programs described in subsection (a) that are evidence-based or that have been scientifically demonstrated to show promise but would benefit from further applied development.

''(c) APPLICATION.—An eligible entity seeking a grant under subsection (a) shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS FOR EARLY INTERVENTION AND TREATMENT PROGRAMS.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) to carry out the following:

''(1) Provide age-appropriate mental health promotion and early intervention services or mental illness treatment services, which may include specialized programs, for eligible children at significant risk of developing, showing early signs of, or having been diagnosed with a mental illness, including a serious emotional disturbance. Such services may include social and behavioral services as well as multigenerational therapy and other services that support the caregiving relationship.

''(2) Provide training for health care professionals with expertise in infant and early childhood mental health care with respect to appropriate and relevant integration with other disciplines such as primary care clinicians, early intervention specialists, child welfare staff, home visitors, early care and education providers, and others who work with young children and families.

''(3) Provide mental health consultation to personnel of early care and education programs (including licensed or regulated center-based and home-based child care, home visiting, preschool special education, and early intervention programs) who work with children and families.

''(4) Provide training for mental health clinicians in infant and early childhood in promising and evidence-based practices and models for infant and early childhood mental health treatment and early intervention, including with regard to practices for identifying and treating mental illness and behavioral disorders of infants and children resulting from exposure or repeated exposure to adverse childhood experiences or childhood trauma.

''(5) Provide age-appropriate assessment, diagnostic, and intervention services for eligible children, including early mental health promotion, intervention, and treatment services.

''(e) MATCHING FUNDS.—The Secretary may not award a grant under this section to an eligible entity unless the eligible entity agrees, with respect to the costs to be incurred by the eligible entity in carrying out the activities described in subsection (d), to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $20,000,000 for the period of fiscal years 2018 through 2022.''.

TITLE XI—COMPASSIONATE COMMUNICATION ON HIPAA

SEC. 11001. SENSE OF CONGRESS.

(a) FINDINGS.—Congress finds the following:

(1) According to the National Survey on Drug Use and Health, in 2015, there were approximately 9,800,000 adults in the United States with serious mental illness.

(2) The Substance Abuse and Mental Health Services Administration defines the term ''serious mental illness'' as an illness affecting individuals 18 years of age or older as having, at any time in the past year, a diagnosable mental, behavioral, or emotional disorder that results in serious functional impairment and substantially interferes with or limits one or more major life activities.

(3) In reporting on the incidence of serious mental illness, the Substance Abuse and Mental Health Services Administration includes major depression, schizophrenia, bipolar disorder, and other mental disorders that cause serious impairment.

(4) Adults with a serious mental illness are at a higher risk for chronic physical illnesses and premature death.

(5) According to the World Health Organization, adults with a serious mental illness have lifespans that are 10 to 25 years shorter than those without serious mental illness. The vast majority of these deaths are due to chronic physical medical conditions, such as cardiovascular, respiratory, and infectious diseases, as well as diabetes and hypertension.

(6) According to the World Health Organization, the majority of deaths of adults with a serious mental illness that are due to physical medical conditions are preventable.

(7) Supported decision making can facilitate care decisions in areas where serious mental illness may impact the capacity of an individual to determine a course of treatment while still allowing the individual to make decisions independently.

(8) Help should be provided to adults with a serious mental illness to address their acute or chronic physical illnesses, make informed choices about treatment, and understand and follow through with appropriate treatment.

(9) There is confusion in the health care community regarding permissible practices under the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (commonly known as ''HIPAA''). This confusion may hinder appropriate communication of health care information or treatment preferences with appropriate caregivers.

(b) SENSE OF CONGRESS.—It is the sense of Congress that clarification is needed regarding the privacy rule promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) regarding existing permitted uses and disclosures of health information by health care professionals to communicate with caregivers of adults with a serious mental illness to facilitate treatment.

SEC. 11002. CONFIDENTIALITY OF RECORDS.

Not later than 1 year after the date on which the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') first finalizes regulations updating part 2 of title 42, Code of Federal Regulations, relating to confidentiality of alcohol and drug abuse patient records, after the date of enactment of this Act, the Secretary shall convene relevant stakeholders to determine the effect of such regulations on patient care, health outcomes, and patient privacy.

SEC. 11003. CLARIFICATION ON PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary, acting through the Director of the Office for Civil Rights, shall ensure that health care providers, professionals, patients and their families, and others involved in mental or substance use disorder treatment have adequate, accessible, and easily comprehensible resources relating to appropriate uses and disclosures of protected health information under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(b) GUIDANCE.—

(1) ISSUANCE.—In carrying out subsection (a), not later than 1 year after the date of enactment of this section, the Secretary shall issue guidance clarifying the circumstances under which, consistent with regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, a health care provider or covered entity may use or disclose protected health information.

(2) CIRCUMSTANCES ADDRESSED.—The guidance issued under this section shall address circumstances including those that—

(A) require the consent of the patient;

(B) require providing the patient with an opportunity to object;

(C) are based on the exercise of professional judgment regarding whether the patient would object when the opportunity to object cannot practicably be provided because of the incapacity of the patient or an emergency treatment circumstance; and

(D) are determined, based on the exercise of professional judgment, to be in the best interest of the patient when the patient is not present or otherwise incapacitated.

(3) COMMUNICATION WITH FAMILY MEMBERS AND CAREGIVERS.—In addressing the circumstances described in paragraph (2), the guidance issued under this section shall clarify permitted uses or disclosures of protected health information for purposes of—

(A) communicating with a family member of the patient, caregiver of the patient, or other individual, to the extent that such family member, caregiver, or individual is involved in the care of the patient;

(B) in the case that the patient is an adult, communicating with a family member of the patient, caregiver of the patient, or other individual involved in the care of the patient;

(C) in the case that the patient is a minor, communicating with the parent or caregiver of the patient;

(D) involving the family members or caregivers of the patient, or others involved in the patient's care or care plan, including facilitating treatment and medication adherence;

(E) listening to the patient, or receiving information with respect to the patient from the family or caregiver of the patient;

(F) communicating with family members of the patient, caregivers of the patient, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and

(G) communicating to law enforcement and family members or caregivers of the patient about the admission of the patient to receive care at, or the release of a patient from, a facility for an emergency psychiatric hold or involuntary treatment.

SEC. 11004. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS.

(a) INITIAL PROGRAMS AND MATERIALS.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with appropriate experts, shall identify the following model programs and materials, or (in the case that no such programs or materials exist) recognize private or public entities to develop and disseminate each of the following:

(1) Model programs and materials for training health care providers (including physicians, emergency medical personnel, psychiatrists, including child and adolescent psychiatrists, psychologists, counselors, therapists, nurse practitioners, physician assistants, behavioral health facilities and clinics, care managers, and hospitals, including individuals such as general counsels or regulatory compliance staff who are responsible for establishing provider privacy policies) regarding the permitted uses and disclosures, consistent with the standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) and regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and such part C, of the protected health information of patients seeking or undergoing mental or substance use disorder treatment.

(2) A model program and materials for training patients and their families regarding their rights to protect and obtain information under the standards and regulations specified in paragraph (1).

(b) PERIODIC UPDATES.—The Secretary shall—

(1) periodically review and update the model programs and materials identified or developed under subsection (a); and

(2) disseminate the updated model programs and materials to the individuals described in subsection (a).

(c) COORDINATION.—The Secretary shall carry out this section in coordination with the Director of the Office for Civil Rights within the Department of Health and Human Services, the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the heads of other relevant agencies within the Department of Health and Human Services.

(d) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials under subsections (a) and (b), the Secretary shall solicit the input of relevant national, State, and local associations; medical societies; licensing boards; providers of mental and substance use disorder treatment; organizations with expertise on domestic violence, sexual assault, elder abuse, and child abuse; and organizations representing patients and consumers and the families of patients and consumers.

(e) FUNDING.—There are authorized to be appropriated to carry out this section—

(1) $4,000,000 for fiscal year 2018;

(2) $2,000,000 for each of fiscal years 2019 and 2020; and

(3) $1,000,000 for each of fiscal years 2021 and 2022.

TITLE XII—MEDICAID MENTAL HEALTH COVERAGE

SEC. 12001. RULE OF CONSTRUCTION RELATED TO MEDICAID COVERAGE OF MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES FURNISHED ON THE SAME DAY.

Nothing in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall be construed as prohibiting separate payment under the State plan under such title (or under a waiver of the plan) for the provision of a mental health service or primary care service under such plan, with respect to an individual, because such service is—

(1) a primary care service furnished to the individual by a provider at a facility on the same day a mental health service is furnished to such individual by such provider (or another provider) at the facility; or

(2) a mental health service furnished to the individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility.

SEC. 12002. STUDY AND REPORT RELATED TO MEDICAID MANAGED CARE REGULATION.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a study on coverage under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of services provided through a medicaid managed care organization (as defined in section 1903(m) of such Act (42 U.S.C. 1396b(m)) or a prepaid inpatient health plan (as defined in section 438.2 of title 42, Code of Federal Regulations (or any successor regulation)) with respect to individuals over the age of 21 and under the age of 65 for the treatment of a mental health disorder in institutions for mental diseases (as defined in section 1905(i) of such Act (42 U.S.C. 1396d(i))). Such study shall include information on the following:

(1) The extent to which States, including the District of Columbia and each territory or possession of the United States, are providing capitated payments to such organizations or plans for enrollees who are receiving services in institutions for mental diseases.

(2) The number of individuals receiving medical assistance under a State plan under such title XIX, or a waiver of such plan, who receive services in institutions for mental diseases through such organizations and plans.

(3) The range of and average number of months, and the length of stay during such months, that such individuals are receiving such services in such institutions.

(4) How such organizations or plans determine when to provide for the furnishing of such services through an institution for mental diseases in lieu of other benefits (including the full range of community-based services) under their contract with the State agency administering the State plan under such title XIX, or a waiver of such plan, to address psychiatric or substance use disorder treatment.

(5) The extent to which the provision of services within such institutions has affected the capitated payments for such organizations or plans.

(b) REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 12003. GUIDANCE ON OPPORTUNITIES FOR INNOVATION.

Not later than 1 year after the date of the enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a State Medicaid Director letter regarding opportunities to design innovative service delivery systems, including systems for providing

community-based services, for adults with a serious mental illness or children with a serious emotional disturbance who are receiving medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The letter shall include opportunities for demonstration projects under section 1115 of such Act (42 U.S.C. 1315) to improve care for such adults and children.

SEC. 12004. STUDY AND REPORT ON MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) COLLECTION OF INFORMATION.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall, to the extent practical and data is available, with respect to each State that has participated in the demonstration project established under section 2707 of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note), collect from each such State information on the following:

(1) The number of institutions for mental diseases (as defined in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i))) and beds in such institutions that received payment for the provision of services to individuals who receive medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) through the demonstration project in each such State as compared to the total number of institutions for mental diseases and beds in the State.

(2) The extent to which there is a reduction in expenditures under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or other spending on the full continuum of physical or mental health care for individuals who receive treatment in an institution for mental diseases under the demonstration project, including outpatient, inpatient, emergency, and ambulatory care, that is attributable to such individuals receiving treatment in institutions for mental diseases under the demonstration project.

(3) The number of forensic psychiatric hospitals, the number of beds in such hospitals, and the number of forensic psychiatric beds in other hospitals in such State, based on the most recent data available, to the extent practical, as determined by such Administrator.

(4) The amount of any disproportionate share hospital payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) that institutions for mental diseases in the State received during the period beginning on July 1, 2012, and ending on June 30, 2015, and the extent to which the demonstration project reduced the amount of such payments.

(5) The most recent data regarding all facilities or sites in the State in which any adults with a serious mental illness who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan) are treated during the period referred to in paragraph (4), to the extent practical, as determined by the Administrator, including—

(A) the types of such facilities or sites (such as an institution for mental diseases, a hospital emergency department, or other inpatient hospital);

(B) the average length of stay in such a facility or site by such an individual, disaggregated by facility type; and

(C) the payment rate under the State plan (or a waivers of such plan) for services furnished to such an individual for that treatment, disaggregated by facility type, during the period in which the demonstration project is in operation.

(6) The extent to which the utilization of hospital emergency departments during the period in which the demonstration project was is in operation differed, with respect to individuals who are receiving medical assistance under a State plan under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or under a waiver of such plan), between—

(A) those individuals who received treatment in an institution for mental diseases under the demonstration project;

(B) those individuals who met the eligibility requirements for the demonstration project but who did not receive treatment in an institution for mental diseases under the demonstration project; and

(C) those adults with a serious mental illness who did not meet such eligibility requirements and did not receive treatment for such illness in an institution for mental diseases.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that summarizes and analyzes the information collected under subsection (a). Such report may be submitted as part of the report required under section 2707(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note) or separately.

SEC. 12005. PROVIDING EPSDT SERVICES TO CHILDREN IN IMDS.

(a) IN GENERAL.—Section 1905(a)(16) of the Social Security Act (42 U.S.C. 1396d(a)(16)) is amended—

(1) by striking ''effective January 1, 1973'' and inserting ''(A) effective January 1, 1973''; and

(2) by inserting before the semicolon at the end the following: '', and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to items and services furnished in calendar quarters beginning on or after January 1, 2019.

SEC. 12006. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES AND HOME HEALTH CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:

''(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

''(A) in the case of personal care services—

''(i) for calendar quarters in 2019 and 2020, by .25 percentage points;

''(ii) for calendar quarters in 2021, by .5 percentage points;

''(iii) for calendar quarters in 2022, by .75 percentage points; and

''(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

''(B) in the case of home health care services—

''(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

''(ii) for calendar quarters in 2025, by .5 percentage points;

''(iii) for calendar quarters in 2026, by .75 percentage points; and

''(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

''(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

''(A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—

''(i) is minimally burdensome;

''(ii) takes into account existing best practices and electronic visit verification systems in use in the State; and

''(iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

''(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

''(C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

''(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

''(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

''(i) in the case of personal care services, for calendar quarters in 2019; and

''(ii) in the case of home health care services, for calendar quarters in 2023.

''(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

''(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

''(ii) in implementing such a system, has encountered unavoidable system delays.

''(5) In this subsection:

''(A) The term 'electronic visit verification system' means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

''(i) the type of service performed;

''(ii) the individual receiving the service;

''(iii) the date of the service;

''(iv) the location of service delivery;

''(v) the individual providing the service; and

''(vi) the time the service begins and ends.

''(B) The term 'home health care services' means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

''(C) The term 'personal care services' means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

''(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

''(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers

to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.''.

(b) COLLECTION AND DISSEMINATION OF BEST PRACTICES.—Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (l)(5)); and

(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

(c) RULES OF CONSTRUCTION.—

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

(3) NO LIMITS ON PROVISION OF CARE.—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

(4) NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

TITLE XIII—MENTAL HEALTH PARITY

SEC. 13001. ENHANCED COMPLIANCE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE REQUIREMENTS.

(a) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

''(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled 'Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance'.

''(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

''(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, based on investigations of violations of such sections, including—

''(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

''(II) descriptions of the violations uncovered during the course of such investigations.

''(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

''(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

''(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable; and

''(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

''(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.''.

(b) ADDITIONAL GUIDANCE.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)), as amended by subsection (a), is further amended by adding at the end the following:

''(7) ADDITIONAL GUIDANCE.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(B) DISCLOSURE.—

''(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

''(ii) DOCUMENTS FOR PARTICIPANTS, BENEFICIARIES, CONTRACTING PROVIDERS, OR AUTHORIZED REPRESENTATIVES.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

''(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

''(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

''(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

''(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812

of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

''(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

''(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

''(II) limitations with respect to prescription drug formulary design; and

''(III) use of fail-first or step therapy protocols;

''(ii) examples of methods of determining—

''(I) network admission standards (such as credentialing); and

''(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

''(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

''(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

''(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

''(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

''(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

''(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

''(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

''(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.''.

(c) AVAILABILITY OF PLAN INFORMATION.—

(1) SOLICITATION OF PUBLIC FEEDBACK.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall solicit feedback from the public on how the disclosure request process for documents containing information that health plans or health insurance issuers are required under Federal or State law to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with existing mental health parity and addiction equity requirements can be improved while continuing to ensure consumers' rights to access all information required by Federal or State law to be disclosed.

(2) PUBLIC AVAILABILITY.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall make such feedback publicly available.

(3) NAIC.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall share feedback obtained pursuant to paragraph (1) directly with the National Association of Insurance Commissioners to the extent such feedback includes recommendations for the development of simplified information disclosure tools to provide consistent information for consumers. Such feedback may be taken into consideration by the National Association of Insurance Commissioners and other appropriate entities for the voluntary development and voluntary use of common templates and other sample standardized forms to improve consumer access to plan information.

(d) IMPROVING COMPLIANCE.—

(1) IN GENERAL.—In the case that the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury determines that a group health plan or health insurance issuer offering group or individual health insurance coverage has violated, at least 5 times, section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), or section 9812 of the Internal Revenue Code of 1986, respectively, the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary's determination in order to help improve compliance with such section.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority, as in effect on the day before the date of enactment of this Act, of the Secretary of Health and Human Services, the Secretary of Labor, or the Secretary of the Treasury to audit documents of health plans or health insurance issuers.

SEC. 13002. ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE.

(a) PUBLIC MEETING.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall convene a public meeting of stakeholders described in paragraph (2) to produce an action plan for improved Federal and State coordination related to the enforcement of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, and any comparable provisions of State law (in this section such sections and provisions are collectively referred to as ''mental health parity and addiction equity requirements'').

(2) STAKEHOLDERS.—The stakeholders described in this paragraph shall include each of the following:

(A) The Federal Government, including representatives from—

(i) the Department of Health and Human Services;

(ii) the Department of the Treasury;

(iii) the Department of Labor; and

(iv) the Department of Justice.

(B) State governments, including—

(i) State health insurance commissioners;

(ii) appropriate State agencies, including agencies on public health or mental health; and

(iii) State attorneys general or other representatives of State entities involved in the enforcement of mental health parity and addiction equity requirements.

(C) Representatives from key stakeholder groups, including—

(i) the National Association of Insurance Commissioners;

(ii) health insurance issuers;

(iii) providers of mental health and substance use disorder treatment;

(iv) employers; and

(v) patients or their advocates.

(b) ACTION PLAN.—Not later than 6 months after the conclusion of the public meeting under subsection (a), the Secretary of Health and Human Services shall finalize the action plan described in such subsection and make it plainly available on the Internet website of the Department of Health and Human Services.

(c) CONTENT.—The action plan under this section shall—

(1) take into consideration the recommendations of the Mental Health and Substance Use Disorder Parity Task Force in its final report issued in October of 2016, and any subsequent Federal and State actions in relation to such recommendations;

(2) reflect the input of the stakeholders participating in the public meeting under subsection (a);

(3) identify specific strategic objectives regarding how the various Federal and State agencies charged with enforcement of mental health parity and addiction equity requirements will collaborate to improve enforcement of such requirements;

(4) provide a timeline for implementing the action plan; and

(5) provide specific examples of how such objectives may be met, which may include—

(A) providing common educational information and documents, such as the Consumer Guide to Disclosure Rights, to patients about their rights under mental health parity and addiction equity requirements;

(B) facilitating the centralized collection of, monitoring of, and response to patient complaints or inquiries relating to mental health parity and addiction equity requirements, which may be through the development and administration of—

(i) a single, toll-free telephone number; and

(ii) a new parity website—

(I) to help consumers find the appropriate Federal or State agency to assist with their parity complaints, appeals, and other actions; and

(II) that takes into consideration, but is not duplicative of, the parity beta site being tested, and released for public comment, by the Department of Health and Human Services as of the date of the enactment of this Act;

(C) Federal and State law enforcement agencies entering into memoranda of understanding to better coordinate enforcement responsibilities and information sharing—

(i) including whether such agencies should make the results of enforcement actions related to mental health parity and addiction equity requirements publicly available; and

(ii) which may include State Policy Academies on Parity Implementation for State Officials and other forums to bring together national experts to provide technical assistance to teams of State officials on strategies to advance compliance with mental health parity and addiction equity requirements in both the commercial market, and in the Medicaid program under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act; and

(D) recommendations to the Congress regarding the need for additional legal authority to improve enforcement of mental health parity and addiction equity requirements, including the need for additional legal authority to ensure that nonquantitative treatment limitations are applied, and the extent and frequency of the applications of such limitations, both to medical and surgical benefits and to mental health and substance use disorder benefits in a comparable manner.

SEC. 13003. REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and annually

thereafter for the subsequent 5 years, the Assistant Secretary of Labor of the Employee Benefits Security Administration, in collaboration with the Administrator of the Centers for Medicare & Medicaid Services and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report summarizing the results of all closed Federal investigations completed during the preceding 12-month period with findings of any serious violation regarding compliance with mental health and substance use disorder coverage requirements under section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

(b) CONTENTS.—Subject to subsection (c), a report under subsection (a) shall, with respect to investigations described in such subsection, include each of the following:

(1) The number of closed Federal investigations conducted during the covered reporting period.

(2) Each benefit classification examined by any such investigation conducted during the covered reporting period.

(3) Each subject matter, including compliance with requirements for quantitative and nonquantitative treatment limitations, of any such investigation conducted during the covered reporting period.

(4) A summary of the basis of the final decision rendered for each closed investigation conducted during the covered reporting period that resulted in a finding of a serious violation.

(c) LIMITATION.—Any individually identifiable information shall be excluded from reports under subsection (a) consistent with protections under the health privacy and security rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

SEC. 13004. GAO STUDY ON PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States, in consultation with the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report detailing the extent to which group health plans or health insurance issuers offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, medicaid managed care organizations with a contract under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)), and health plans provided under the State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) comply with section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, including—

(1) how nonquantitative treatment limitations, including medical necessity criteria, of such plans or issuers comply with such sections;

(2) how the responsible Federal departments and agencies ensure that such plans or issuers comply with such sections, including an assessment of how the Secretary of Health and Human Services has used its authority to conduct audits of such plans to ensure compliance;

(3) a review of how the various Federal and State agencies responsible for enforcing mental health parity requirements have improved enforcement of such requirements in accordance with the objectives and timeline described in the action plan under section 13002; and

(4) recommendations for how additional enforcement, education, and coordination activities by responsible Federal and State departments and agencies could better ensure compliance with such sections, including recommendations regarding the need for additional legal authority.

SEC. 13005. INFORMATION AND AWARENESS ON EATING DISORDERS.

(a) INFORMATION.—The Secretary of Health and Human Services, acting through the Director of the Office on Women's Health, may—

(1) update information, related fact sheets, and resource lists related to eating disorders that are available on the public Internet website of the National Women's Health Information Center sponsored by the Office on Women's Health, to include—

(A) updated findings and current research related to eating disorders, as appropriate; and

(B) information about eating disorders, including information related to males and females;

(2) incorporate, as appropriate, and in coordination with the Secretary of Education, information from publicly available resources into appropriate obesity prevention programs developed by the Office on Women's Health; and

(3) make publicly available (through a public Internet website or other method) information, related fact sheets, and resource lists, as updated under paragraph (1), and the information incorporated into appropriate obesity prevention programs under paragraph (2).

(b) AWARENESS.—The Secretary of Health and Human Services may advance public awareness on—

(1) the types of eating disorders;

(2) the seriousness of eating disorders, including prevalence, comorbidities, and physical and mental health consequences;

(3) methods to identify, intervene, refer for treatment, and prevent behaviors that may lead to the development of eating disorders;

(4) discrimination and bullying based on body size;

(5) the effects of media on self-esteem and body image; and

(6) the signs and symptoms of eating disorders.

SEC. 13006. EDUCATION AND TRAINING ON EATING DISORDERS.

The Secretary of Health and Human Services may facilitate the identification of model programs and materials for educating and training health professionals in effective strategies to—

(1) identify individuals with eating disorders;

(2) provide early intervention services for individuals with eating disorders;

(3) refer patients with eating disorders for appropriate treatment;

(4) prevent the development of eating disorders; and

(5) provide appropriate treatment services for individuals with eating disorders.

SEC. 13007. CLARIFICATION OF EXISTING PARITY RULES.

If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986.

TITLE XIV—MENTAL HEALTH AND SAFE COMMUNITIES

Subtitle A—Mental Health and Safe Communities

SEC. 14001. LAW ENFORCEMENT GRANTS FOR CRISIS INTERVENTION TEAMS, MENTAL HEALTH PURPOSES.

(a) EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT PROGRAM.—Section 501(a)(1) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(a)(1)) is amended by adding at the end the following:

''(H) Mental health programs and related law enforcement and corrections programs, including behavioral programs and crisis intervention teams.''.

(b) COMMUNITY ORIENTED POLICING SERVICES PROGRAM.—Section 1701(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd(b)) is amended—

(1) in paragraph (17), by striking ''and'' at the end;

(2) by redesignating paragraph (18) as paragraph (22);

(3) by inserting after paragraph (17) the following:

''(18) to provide specialized training to law enforcement officers to—

''(A) recognize individuals who have a mental illness; and

''(B) properly interact with individuals who have a mental illness, including strategies for verbal de-escalation of crises;

''(19) to establish collaborative programs that enhance the ability of law enforcement agencies to address the mental health, behavioral, and substance abuse problems of individuals encountered by law enforcement officers in the line of duty;

''(20) to provide specialized training to corrections officers to recognize individuals who have a mental illness;

''(21) to enhance the ability of corrections officers to address the mental health of individuals under the care and custody of jails and prisons, including specialized training and strategies for verbal de-escalation of crises; and''; and

(4) in paragraph (22), as redesignated, by striking ''through (17)'' and inserting ''through (21)''.

(c) MODIFICATIONS TO THE STAFFING FOR ADEQUATE FIRE AND EMERGENCY RESPONSE GRANTS.—Section 34(a)(1)(B) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229a(a)(1)(B)) is amended by inserting before the period at the end the following: ''and to provide specialized training to paramedics, emergency medical services workers, and other first responders to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness, including strategies for verbal de-escalation of crises''.

SEC. 14002. ASSISTED OUTPATIENT TREATMENT PROGRAMS.

(a) IN GENERAL.—Section 2201 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ii) is amended in paragraph (2)(B), by inserting before the semicolon the following: '', or court-ordered assisted outpatient treatment when the court has determined such treatment to be necessary''.

(b) DEFINITIONS.—Section 2202 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ii—1) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(3) the term 'court-ordered assisted outpatient treatment' means a program through which a court may order a treatment plan for an eligible patient that—

''(A) requires such patient to obtain outpatient mental health treatment while the patient is not currently residing in a correctional facility or inpatient treatment facility; and

''(B) is designed to improve access and adherence by such patient to intensive behavioral health services in order to—

''(i) avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior; and

''(ii) provide such patient with the opportunity to live in a less restrictive alternative to incarceration or involuntary hospitalization; and

''(4) the term 'eligible patient' means an adult, mentally ill person who, as determined by a court—

''(A) has a history of violence, incarceration, or medically unnecessary hospitalizations;

''(B) without supervision and treatment, may be a danger to self or others in the community;

''(C) is substantially unlikely to voluntarily participate in treatment;

''(D) may be unable, for reasons other than indigence, to provide for any of his or her basic needs, such as food, clothing, shelter, health, or safety;

''(E) has a history of mental illness or a condition that is likely to substantially deteriorate if the person is not provided with timely treatment; or

''(F) due to mental illness, lacks capacity to fully understand or lacks judgment to make informed decisions regarding his or her need for treatment, care, or supervision.''.

SEC. 14003. FEDERAL DRUG AND MENTAL HEALTH COURTS.

(a) DEFINITIONS.—In this section—

(1) the term ''eligible offender'' means a person who—

(A)(i) previously or currently has been diagnosed by a qualified mental health professional as having a mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders; or

(ii) manifests obvious signs of mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders during arrest or confinement or before any court;

(B) comes into contact with the criminal justice system or is arrested or charged with an offense that is not—

(i) a crime of violence, as defined under applicable State law or in section 3156 of title 18, United States Code; or

(ii) a serious drug offense, as defined in section 924(e)(2)(A) of title 18, United States Code; and

(C) is determined by a judge to be eligible; and

(2) the term ''mental illness'' means a diagnosable mental, behavioral, or emotional disorder—

(A) of sufficient duration to meet diagnostic criteria within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; and

(B) that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities.

(b) ESTABLISHMENT OF PROGRAM.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall establish a pilot program to determine the effectiveness of diverting eligible offenders from Federal prosecution, Federal probation, or a Bureau of Prisons facility, and placing such eligible offenders in drug or mental health courts.

(c) PROGRAM SPECIFICATIONS.—The pilot program established under subsection (b) shall involve—

(1) continuing judicial supervision, including periodic review, of program participants who have a substance abuse problem or mental illness; and

(2) the integrated administration of services and sanctions, which shall include—

(A) mandatory periodic testing, as appropriate, for the use of controlled substances or other addictive substances during any period of supervised release or probation for each program participant;

(B) substance abuse treatment for each program participant who requires such services;

(C) diversion, probation, or other supervised release with the possibility of prosecution, confinement, or incarceration based on noncompliance with program requirements or failure to show satisfactory progress toward completing program requirements;

(D) programmatic offender management, including case management, and aftercare services, such as relapse prevention, health care, education, vocational training, job placement, housing placement, and child care or other family support services for each program participant who requires such services;

(E) outpatient or inpatient mental health treatment, as ordered by the court, that carries with it the possibility of dismissal of charges or reduced sentencing upon successful completion of such treatment;

(F) centralized case management, including—

(i) the consolidation of all cases, including violations of probations, of the program participant; and

(ii) coordination of all mental health treatment plans and social services, including life skills and vocational training, housing and job placement, education, health care, and relapse prevention for each program participant who requires such services; and

(G) continuing supervision of treatment plan compliance by the program participant for a term not to exceed the maximum allowable sentence or probation period for the charged or relevant offense and, to the extent practicable, continuity of psychiatric care at the end of the supervised period.

(d) IMPLEMENTATION; DURATION.—The pilot program established under subsection (b) shall be conducted—

(1) in not less than 1 United States judicial district, designated by the Attorney General in consultation with the Director of the Administrative Office of the United States Courts, as appropriate for the pilot program; and

(2) during fiscal year 2017 through fiscal year 2021.

(e) CRITERIA FOR DESIGNATION.—Before making a designation under subsection (d)(1), the Attorney General shall—

(1) obtain the approval, in writing, of the United States Attorney for the United States judicial district being designated;

(2) obtain the approval, in writing, of the chief judge for the United States judicial district being designated; and

(3) determine that the United States judicial district being designated has adequate behavioral health systems for treatment, including substance abuse and mental health treatment.

(f) ASSISTANCE FROM OTHER FEDERAL ENTITIES.—The Administrative Office of the United States Courts and the United States Probation Offices shall provide such assistance and carry out such functions as the Attorney General may request in monitoring, supervising, providing services to, and evaluating eligible offenders placed in a drug or mental health court under this section.

(g) REPORTS.—The Attorney General, in consultation with the Director of the Administrative Office of the United States Courts, shall monitor the drug and mental health courts under this section, and shall submit a report to Congress on the outcomes of the program at the end of the period described in subsection (d)(2).

SEC. 14004. MENTAL HEALTH IN THE JUDICIAL SYSTEM.

Part V of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ii et seq.) is amended by inserting at the end the following:

''SEC. 2209. MENTAL HEALTH RESPONSES IN THE JUDICIAL SYSTEM.

''(a) PRETRIAL SCREENING AND SUPERVISION.—

''(1) IN GENERAL.—The Attorney General may award grants to States, units of local government, territories, Indian Tribes, nonprofit agencies, or any combination thereof, to develop, implement, or expand pretrial services programs to improve the identification and outcomes of individuals with mental illness.

''(2) ALLOWABLE USES.—Grants awarded under this subsection may be may be used for—

''(A) behavioral health needs and risk screening of defendants, including verification of interview information, mental health evaluation, and criminal history screening;

''(B) assessment of risk of pretrial misconduct through objective, statistically validated means, and presentation to the court of recommendations based on such assessment, including services that will reduce the risk of pre-trial misconduct;

''(C) followup review of defendants unable to meet the conditions of pretrial release;

''(D) evaluation of process and results of pretrial service programs;

''(E) supervision of defendants who are on pretrial release, including reminders to defendants of scheduled court dates;

''(F) reporting on process and results of pretrial services programs to relevant public and private mental health stakeholders; and

''(G) data collection and analysis necessary to make available information required for assessment of risk.

''(b) BEHAVIORAL HEALTH ASSESSMENTS AND INTERVENTION.—

''(1) IN GENERAL.—The Attorney General may award grants to States, units of local government, territories, Indian Tribes, nonprofit agencies, or any combination thereof, to develop, implement, or expand a behavioral health screening and assessment program framework for State or local criminal justice systems.

''(2) ALLOWABLE USES.—Grants awarded under this subsection may be used for—

''(A) promotion of the use of validated assessment tools to gauge the criminogenic risk, substance abuse needs, and mental health needs of individuals;

''(B) initiatives to match the risk factors and needs of individuals to programs and practices associated with research-based, positive outcomes;

''(C) implementing methods for identifying and treating individuals who are most likely to benefit from coordinated supervision and treatment strategies, and identifying individuals who can do well with fewer interventions; and

''(D) collaborative decision-making among the heads of criminal justice agencies, mental health systems, judicial systems, substance abuse systems, and other relevant systems or agencies for determining how treatment and intensive supervision services should be allocated in order to maximize benefits, and developing and utilizing capacity accordingly.

''(c) USE OF GRANT FUNDS.—A State, unit of local government, territory, Indian Tribe, or nonprofit agency that receives a grant under this section shall, in accordance with subsection (b)(2), use grant funds for the expenses of a treatment program, including—

''(1) salaries, personnel costs, equipment costs, and other costs directly related to the operation of the program, including costs relating to enforcement;

''(2) payments for treatment providers that are approved by the State or Indian Tribe and licensed, if necessary, to provide needed treatment to program participants, including aftercare supervision, vocational training, education, and job placement; and

''(3) payments to public and nonprofit private entities that are approved by the State or Indian Tribe and licensed, if necessary, to provide alcohol and drug addiction treatment to offenders participating in the program.

''(d) SUPPLEMENT OF NON-FEDERAL FUNDS.—

''(1) IN GENERAL.—Grants awarded under this section shall be used to supplement, and not supplant, non-Federal funds that would otherwise be available for programs described in this section.

''(2) FEDERAL SHARE.—The Federal share of a grant made under this section may not exceed 50 percent of the total costs of the program described in an application under subsection (e).

''(e) APPLICATIONS.—To request a grant under this section, a State, unit of local government, territory, Indian Tribe, or nonprofit agency shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.

''(f) GEOGRAPHIC DISTRIBUTION.—The Attorney General shall ensure that, to the extent practicable, the distribution of grants under this section is equitable and includes—

''(1) each State; and

''(2) a unit of local government, territory, Indian Tribe, or nonprofit agency—

''(A) in each State; and

''(B) in rural, suburban, Tribal, and urban jurisdictions.

''(g) REPORTS AND EVALUATIONS.—For each fiscal year, each grantee under this section during that fiscal year shall submit to the Attorney General a report on the effectiveness of activities carried out using such grant. Each report shall include an evaluation in such form and containing such information as the Attorney General may reasonably require. The Attorney General shall specify the dates on which such reports shall be submitted.

''(h) ACCOUNTABILITY.—Grants awarded under this section shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of the Department of Justice under subparagraph (C) that the audited grantee has used grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 1 year after the date on which final audit report is issued.

''(B) AUDITS.—Beginning in the first fiscal year beginning after the date of enactment of this section, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of grantees under this section to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) FINAL AUDIT REPORT.—The Inspector General of the Department of Justice shall submit to the Attorney General a final report on each audit conducted under subparagraph (B).

''(D) MANDATORY EXCLUSION.—Grantees under this section about which there is an unresolved audit finding shall not be eligible to receive a grant under this section during the 2 fiscal years beginning after the end of the 1-year period described in subparagraph (A).

''(E) PRIORITY.—In making grants under this section, the Attorney General shall give priority to applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this section.

''(F) REIMBURSEMENT.—If an entity receives a grant under this section during the 2-fiscal-year period during which the entity is prohibited from receiving grants under subparagraph (D), the Attorney General shall—

''(i) deposit an amount equal to the amount of the grant that was improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment under clause (i) from the grantee that was erroneously awarded grant funds.

''(2) NONPROFIT AGENCY REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant program under this section, the term 'nonprofit agency' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. 501(c)(3)) and is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986 (26 U.S.C. 501(a)).

''(B) PROHIBITION.—The Attorney General may not award a grant under this section to a nonprofit agency that holds money in an offshore account for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986 (26 U.S.C. 511(a)).

''(C) DISCLOSURE.—Each nonprofit agency that is awarded a grant under this section and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the Attorney General, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—Not more than $20,000 of the amounts made available to the Department of Justice to carry out this section may be used by the Attorney General, or by any individual or entity awarded a grant under this section to host, or make any expenditures relating to, a conference unless the Deputy Attorney General provides prior written authorization that the funds may be expended to host the conference or make such expenditure.

''(B) WRITTEN APPROVAL.—Written approval under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—The Deputy Attorney General shall submit an annual report to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives on all conference expenditures approved under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, the Attorney General shall submit to the Committee on the Judiciary and the Committee on Appropriations of the Senate and the Committee on the Judiciary and the Committee on Appropriations of the House of Representatives an annual certification—

''(A) indicating whether—

''(i) all final audit reports issued by the Office of the Inspector General under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

''(ii) all mandatory exclusions required under paragraph (1)(D) have been issued; and

''(iii) any reimbursements required under paragraph (1)(F) have been made; and

''(B) that includes a list of any grantees excluded under paragraph (1)(D) from the previous year.

''(i) PREVENTING DUPLICATIVE GRANTS.—

''(1) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this section, the Attorney General shall compare the possible grant with any other grants awarded to the applicant under this Act to determine whether the grants are for the same purpose.

''(2) REPORT.—If the Attorney General awards multiple grants to the same applicant for the same purpose, the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that includes—

''(A) a list of all duplicate grants awarded, including the total dollar amount of any such grants awarded; and

''(B) the reason the Attorney General awarded the duplicate grants.''.

SEC. 14005. FORENSIC ASSERTIVE COMMUNITY TREATMENT INITIATIVES.

Section 2991 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is amended by—

(1) redesignating subsection (j) as subsection (o); and

(2) inserting after subsection (i) the following:

''(j) FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) INITIATIVE PROGRAM.—

''(1) IN GENERAL.—The Attorney General may make grants to States, units of local government, territories, Indian Tribes, nonprofit agencies, or any combination thereof, to develop, implement, or expand Assertive Community Treatment initiatives to develop forensic assertive community treatment (referred to in this subsection as 'FACT') programs that provide high intensity services in the community for individuals with mental illness with involvement in the criminal justice system to prevent future incarcerations.

''(2) ALLOWABLE USES.—Grant funds awarded under this subsection may be used for—

''(A) multidisciplinary team initiatives for individuals with mental illnesses with criminal justice involvement that address criminal justice involvement as part of treatment protocols;

''(B) FACT programs that involve mental health professionals, criminal justice agencies, chemical dependency specialists, nurses, psychiatrists, vocational specialists, forensic peer specialists, forensic specialists, and dedicated administrative support staff who work together to provide recovery oriented, 24/7 wraparound services;

''(C) services such as integrated evidence-based practices for the treatment of co-occurring mental health and substance-related disorders, assertive outreach and engagement, community-based service provision at participants' residence or in the community, psychiatric rehabilitation, recovery oriented services, services to address criminogenic risk factors, and community tenure;

''(D) payments for treatment providers that are approved by the State or Indian Tribe and licensed, if necessary, to provide needed treatment to eligible offenders participating in the program, including behavioral health services and aftercare supervision; and

''(E) training for all FACT teams to promote high-fidelity practice principles and technical assistance to support effective and continuing integration with criminal justice agency partners.

''(3) SUPPLEMENT AND NOT SUPPLANT.—Grants made under this subsection shall be used to supplement, and not supplant, non-Federal funds that would otherwise be available for programs described in this subsection.

''(4) APPLICATIONS.—To request a grant under this subsection, a State, unit of local government, territory, Indian Tribe, or nonprofit agency shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.''.

SEC. 14006. ASSISTANCE FOR INDIVIDUALS TRANSITIONING OUT OF SYSTEMS.

Section 2976(f) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797w(f)) is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(7) provide mental health treatment and transitional services for those with mental illnesses or with co-occurring disorders, including housing placement or assistance; and''.

SEC. 14007. CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH CHALLENGES IN DRUG COURTS.

Part EE of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797u et seq.) is amended—

(1) in section 2951(a)(1) (42 U.S.C. 3797u(a)(1)), by inserting '', including co-occurring substance abuse and mental health problems,'' after ''problems''; and

(2) in section 2959(a) (42 U.S.C. 3797u–8(a)), by inserting '', including training for drug court personnel and officials on identifying and addressing co-occurring substance abuse and mental health problems'' after ''part''.

SEC. 14008. MENTAL HEALTH TRAINING FOR FEDERAL UNIFORMED SERVICES.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Defense, the Secretary of Homeland

Security, the Secretary of Health and Human Services, and the Secretary of Commerce shall provide the following to each of the uniformed services (as that term is defined in section 101 of title 10, United States Code) under their direction:

(1) TRAINING PROGRAMS.—Programs that offer specialized and comprehensive training in procedures to identify and respond appropriately to incidents in which the unique needs of individuals with mental illnesses are involved.

(2) IMPROVED TECHNOLOGY.—Computerized information systems or technological improvements to provide timely information to Federal law enforcement personnel, other branches of the uniformed services, and criminal justice system personnel to improve the Federal response to mentally ill individuals.

(3) COOPERATIVE PROGRAMS.—The establishment and expansion of cooperative efforts to promote public safety through the use of effective intervention with respect to mentally ill individuals encountered by members of the uniformed services.

SEC. 14009. ADVANCING MENTAL HEALTH AS PART OF OFFENDER REENTRY.

(a) REENTRY DEMONSTRATION PROJECTS.—Section 2976(f) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797w(f)), as amended by section 14006, is amended—

(1) in paragraph (3)(C), by inserting ''mental health services,'' before ''drug treatment''; and

(2) by adding at the end the following:

''(8) target offenders with histories of homelessness, substance abuse, or mental illness, including a prerelease assessment of the housing status of the offender and behavioral health needs of the offender with clear coordination with mental health, substance abuse, and homelessness services systems to achieve stable and permanent housing outcomes with appropriate support service.''.

(b) MENTORING GRANTS.—Section 211(b)(2) of the Second Chance Act of 2007 (42 U.S.C. 17531(b)(2)) is amended by inserting '', including mental health care'' after ''community''.

SEC. 14010. SCHOOL MENTAL HEALTH CRISIS INTERVENTION TEAMS.

Section 2701(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797a(b)) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively; and

(2) by inserting after paragraph (3) the following:

''(4) The development and operation of crisis intervention teams that may include coordination with law enforcement agencies and specialized training for school officials in responding to mental health crises.''.

SEC. 14011. ACTIVE-SHOOTER TRAINING FOR LAW ENFORCEMENT.

The Attorney General, as part of the Preventing Violence Against Law Enforcement and Ensuring Officer Resilience and Survivability Initiative (VALOR) of the Department of Justice, may provide safety training and technical assistance to local law enforcement agencies, including active-shooter response training.

SEC. 14012. CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH CHALLENGES IN RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS.

Section 1901(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff(a)) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(3) developing and implementing specialized residential substance abuse treatment programs that identify and provide appropriate treatment to inmates with co-occurring mental health and substance abuse disorders or challenges.''.

SEC. 14013. MENTAL HEALTH AND DRUG TREATMENT ALTERNATIVES TO INCARCERATION PROGRAMS.

Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended by striking part CC and inserting the following:

''PART CC—MENTAL HEALTH AND DRUG TREATMENT ALTERNATIVES TO INCARCERATION PROGRAMS

''SEC. 2901. MENTAL HEALTH AND DRUG TREATMENT ALTERNATIVES TO INCARCERATION PROGRAMS.

''(a) DEFINITIONS.—In this section—

''(1) the term 'eligible entity' means a State, unit of local government, Indian tribe, or nonprofit organization; and

''(2) the term 'eligible participant' means an individual who—

''(A) comes into contact with the criminal justice system or is arrested or charged with an offense that is not—

''(i) a crime of violence, as defined under applicable State law or in section 3156 of title 18, United States Code; or

''(ii) a serious drug offense, as defined in section 924(e)(2)(A) of title 18, United States Code;

''(B) has a history of, or a current—

''(i) substance use disorder;

''(ii) mental illness; or

''(iii) co-occurring mental illness and substance use disorder; and

''(C) has been approved for participation in a program funded under this section by the relevant law enforcement agency, prosecuting attorney, defense attorney, probation official, corrections official, judge, representative of a mental health agency, or representative of a substance abuse agency, as required by law.

''(b) PROGRAM AUTHORIZED.—The Attorney General may make grants to eligible entities to develop, implement, or expand a treatment alternative to incarceration program for eligible participants, including—

''(1) pre-booking treatment alternative to incarceration programs, including—

''(A) law enforcement training on substance use disorders, mental illness, and co-occurring mental illness and substance use disorders;

''(B) receiving centers as alternatives to incarceration of eligible participants;

''(C) specialized response units for calls related to substance use disorders, mental illness, or co-occurring mental illness and substance use disorders; and

''(D) other arrest and pre-booking treatment alternatives to incarceration models; or

''(2) post-booking treatment alternative to incarceration programs, including—

''(A) specialized clinical case management;

''(B) pre-trial services related to substances use disorders, mental illness, and co-occurring mental illness and substance use disorders;

''(C) prosecutor and defender based programs;

''(D) specialized probation;

''(E) treatment and rehabilitation programs; and

''(F) problem-solving courts, including mental health courts, drug courts, co-occurring mental health and substance abuse courts, DWI courts, and veterans treatment courts.

''(c) APPLICATION.—

''(1) IN GENERAL.—An eligible entity desiring a grant under this section shall submit an application to the Attorney General—

''(A) that meets the criteria under paragraph (2); and

''(B) at such time, in such manner, and accompanied by such information as the Attorney General may require.

''(2) CRITERIA.—An eligible entity, in submitting an application under paragraph (1), shall—

''(A) provide extensive evidence of collaboration with State and local government agencies overseeing health, community corrections, courts, prosecution, substance abuse, mental health, victims services, and employment services, and with local law enforcement agencies;

''(B) demonstrate consultation with the Single State Authority for Substance Abuse of the State (as that term is defined in section 201(e) of the Second Chance Act of 2007);

''(C) demonstrate that evidence-based treatment practices will be utilized; and

''(D) demonstrate that evidence-based screening and assessment tools will be used to place participants in the treatment alternative to incarceration program.

''(d) REQUIREMENTS.—Each eligible entity awarded a grant for a treatment alternative to incarceration program under this section shall—

''(1) determine the terms and conditions of participation in the program by eligible participants, taking into consideration the collateral consequences of an arrest, prosecution or criminal conviction;

''(2) ensure that each substance abuse and mental health treatment component is licensed and qualified by the relevant jurisdiction;

''(3) for programs described in subsection (b)(2), organize an enforcement unit comprised of appropriately trained law enforcement professionals under the supervision of the State, Tribal, or local criminal justice agency involved, the duties of which shall include—

''(A) the verification of addresses and other contact information of each eligible participant who participates or desires to participate in the program; and

''(B) if necessary, the location, apprehension, arrest, and return to custody of an eligible participant in the program who has absconded from the facility of a treatment provider or has otherwise significantly violated the terms and conditions of the program, consistent with Federal and State confidentiality requirements;

''(4) notify the relevant criminal justice entity if any eligible participant in the program absconds from the facility of the treatment provider or otherwise violates the terms and conditions of the program, consistent with Federal and State confidentiality requirements;

''(5) submit periodic reports on the progress of treatment or other measured outcomes from participation in the program of each eligible participant in the program to the relevant State, Tribal, or local criminal justice agency, including mental health courts, drug courts, co-occurring mental health and substance abuse courts, DWI courts, and veterans treatment courts;

''(6) describe the evidence-based methodology and outcome measurements that will be used to evaluate the program, and specifically explain how such measurements will provide valid measures of the impact of the program; and

''(7) describe how the program could be broadly replicated if demonstrated to be effective.

''(e) USE OF FUNDS.—An eligible entity shall use a grant received under this section for expenses of a treatment alternative to incarceration program, including—

''(1) salaries, personnel costs, equipment costs, and other costs directly related to the operation of the program, including the enforcement unit;

''(2) payments for treatment providers that are approved by the relevant State or Tribal jurisdiction and licensed, if necessary, to provide needed treatment to eligible offenders participating in the program, including aftercare supervision, vocational training, education, and job placement; and

''(3) payments to public and nonprofit private entities that are approved by the State or Tribal jurisdiction and licensed, if necessary, to provide alcohol and drug addiction treatment to eligible offenders participating in the program.

''(f) SUPPLEMENT NOT SUPPLANT.—An eligible entity shall use Federal funds received under this section only to supplement the funds that would, in the absence of those Federal funds, be made available from other Federal and non-Federal sources for the activities described in this section, and not to supplant those funds. The Federal share of a grant made under this section may not exceed 50 percent of the total costs of the program described in an application under subsection (d).

''(g) GEOGRAPHIC DISTRIBUTION.—The Attorney General shall ensure that, to the extent practicable, the geographical distribution of grants under this section is equitable and includes a grant to an eligible entity in—

''(1) each State;

''(2) rural, suburban, and urban areas; and

''(3) Tribal jurisdictions.

''(h) REPORTS AND EVALUATIONS.—Each fiscal year, each recipient of a grant under this section during that fiscal year shall submit to the Attorney General a report on the outcomes of activities carried out using that grant in such form, containing such information, and on such dates as the Attorney General shall specify.

''(i) ACCOUNTABILITY.—All grants awarded by the Attorney General under this section shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of the Department of Justice that the audited grantee has utilized grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months from the date on which the final audit report is issued.

''(B) AUDITS.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of recipients of grants under this section to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) MANDATORY EXCLUSION.—A recipient of grant funds under this section that is found to have an unresolved audit finding shall not be eligible to receive grant funds under this section during the first 2 fiscal years beginning after the end of the 12-month period described in subparagraph (A).

''(D) PRIORITY.—In awarding grants under this section, the Attorney General shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this section.

''(E) REIMBURSEMENT.—If an entity is awarded grant funds under this section during the 2-fiscal-year period during which the entity is barred from receiving grants under subparagraph (C), the Attorney General shall—

''(i) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

''(2) NONPROFIT ORGANIZATION REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant programs under this part, the term 'nonprofit organization' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

''(B) PROHIBITION.—The Attorney General may not award a grant under this part to a nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986.

''(C) DISCLOSURE.—Each nonprofit organization that is awarded a grant under this section and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the Attorney General, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—No amounts made available to the Department of Justice under this section may be used by the Attorney General, or by any individual or entity awarded discretionary funds through a cooperative agreement under this section, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the Department of Justice, unless the head of the relevant agency or department, provides prior written authorization that the funds may be expended to host the conference.

''(B) WRITTEN APPROVAL.—Written approval under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—The Deputy Attorney General shall submit an annual report to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives on all conference expenditures approved under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, the Attorney General shall submit, to the Committee on the Judiciary and the Committee on Appropriations of the Senate and the Committee on the Judiciary and the Committee on Appropriations of the House of Representatives, an annual certification—

''(A) indicating whether—

''(i) all audits issued by the Office of the Inspector General under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

''(ii) all mandatory exclusions required under paragraph (1)(C) have been issued; and

''(iii) all reimbursements required under paragraph (1)(E) have been made; and

''(B) that includes a list of any grant recipients excluded under paragraph (1) from the previous year.

''(5) PREVENTING DUPLICATIVE GRANTS.—

''(A) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this section, the Attorney General shall compare potential grant awards with other grants awarded under this Act to determine if duplicate grant awards are awarded for the same purpose.

''(B) REPORT.—If the Attorney General awards duplicate grants to the same applicant for the same purpose the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that includes—

''(i) a list of all duplicate grants awarded, including the total dollar amount of any duplicate grants awarded; and

''(ii) the reason the Attorney General awarded the duplicate grants.''.

SEC. 14014. NATIONAL CRIMINAL JUSTICE AND MENTAL HEALTH TRAINING AND TECHNICAL ASSISTANCE.

Part HH of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa et seq.) is amended by adding at the end the following:

''SEC. 2992. NATIONAL CRIMINAL JUSTICE AND MENTAL HEALTH TRAINING AND TECHNICAL ASSISTANCE.

''(a) AUTHORITY.—The Attorney General may make grants to eligible organizations to provide for the establishment of a National Criminal Justice and Mental Health Training and Technical Assistance Center.

''(b) ELIGIBLE ORGANIZATION.—For purposes of subsection (a), the term 'eligible organization' means a national nonprofit organization that provides technical assistance and training to, and has special expertise and broad, national-level experience in, mental health, crisis intervention, criminal justice systems, law enforcement, translating evidence into practice, training, and research, and education and support of people with mental illness and the families of such individuals.

''(c) USE OF FUNDS.—Any organization that receives a grant under subsection (a) shall collaborate with other grant recipients to establish and operate a National Criminal Justice and Mental Health Training and Technical Assistance Center to—

''(1) provide law enforcement officer training regarding mental health and working with individuals with mental illnesses, with an emphasis on de-escalation of encounters between law enforcement officers and those with mental disorders or in crisis, which shall include support the development of in-person and technical information exchanges between systems and the individuals working in those systems in support of the concepts identified in the training;

''(2) provide education, training, and technical assistance for States, Indian tribes, territories, units of local government, service providers, nonprofit organizations, probation or parole officers, prosecutors, defense attorneys, emergency response providers, and corrections institutions to advance practice and knowledge relating to mental health crisis and approaches to mental health and criminal justice across systems;

''(3) provide training and best practices to mental health providers and criminal justice agencies relating to diversion initiatives, jail and prison strategies, reentry of individuals with mental illnesses into the community, and dispatch protocols and triage capabilities, including the establishment of learning sites;

''(4) develop suicide prevention and crisis intervention training and technical assistance for criminal justice agencies;

''(5) develop a receiving center system and pilot strategy that provides, for a jurisdiction, a single point of entry into the mental health and substance abuse system for assessments and appropriate placement of individuals experiencing a crisis;

''(6) collect data and best practices in mental health and criminal health and criminal justice initiatives and policies from grantees under this part, other recipients of grants under this section, Federal, State, and local agencies involved in the provision of mental health services, and nongovernmental organizations involved in the provision of mental health services;

''(7) develop and disseminate to mental health providers and criminal justice agencies evaluation tools, mechanisms, and measures to better assess and document performance measures and outcomes relating to the provision of mental health services;

''(8) disseminate information to States, units of local government, criminal justice agencies, law enforcement agencies, and other relevant entities about best practices, policy standards, and research findings relating to the provision of mental health services; and

''(9) provide education and support to individuals with mental illness involved with, or at risk of involvement with, the criminal justice system, including the families of such individuals.

''(d) ACCOUNTABILITY.—Grants awarded under this section shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of the Department of Justice under subparagraph (C) that the audited grantee has used grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 1 year after the date on which the final audit report is issued.

''(B) AUDITS.—Beginning in the first fiscal year beginning after the date of enactment of this section, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of grantees under this section to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) FINAL AUDIT REPORT.—The Inspector General of the Department of Justice shall submit to the Attorney General a final report on each audit conducted under subparagraph (B).

''(D) MANDATORY EXCLUSION.—Grantees under this section about which there is an unresolved audit finding shall not be eligible to receive a grant under this section during the 2 fiscal years beginning after the end of the 1-year period described in subparagraph (A).

''(E) PRIORITY.—In making grants under this section, the Attorney General shall give priority to applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this section.

''(F) REIMBURSEMENT.—If an entity receives a grant under this section during the 2-fiscal-year period during which the entity is prohibited from receiving grants under subparagraph (D), the Attorney General shall—

''(i) deposit an amount equal to the amount of the grant that was improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment under clause (i) from the grantee that was erroneously awarded grant funds.

''(2) NONPROFIT AGENCY REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant program under this section, the term 'nonprofit agency' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. 501(c)(3)) and is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986 (26 U.S.C. 501(a)).

''(B) PROHIBITION.—The Attorney General may not award a grant under this section to a nonprofit agency that holds money in an offshore account for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986 (26 U.S.C. 511(a)).

''(C) DISCLOSURE.—Each nonprofit agency that is awarded a grant under this section and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the Attorney General, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—No amounts made available to the Department of Justice under this section may be used by the Attorney General, or by any individual or entity awarded discretionary funds through a cooperative agreement under this section, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the Department of Justice, unless the head of the relevant agency or department, provides prior written authorization that the funds may be expended to host the conference.

''(B) WRITTEN APPROVAL.—Written approval under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—The Deputy Attorney General shall submit an annual report to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives on all conference expenditures approved under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, the Attorney General shall submit to the Committee on the Judiciary and the Committee on Appropriations of the Senate and the Committee on the Judiciary and the Committee on Appropriations of the House of Representatives an annual certification—

''(A) indicating whether—

''(i) all final audit reports issued by the Office of the Inspector General under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

''(ii) all mandatory exclusions required under paragraph (1)(D) have been issued; and

''(iii) any reimbursements required under paragraph (1)(F) have been made; and

''(B) that includes a list of any grantees excluded under paragraph (1)(D) from the previous year.

''(5) PREVENTING DUPLICATIVE GRANTS.—

''(A) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this section, the Attorney General shall compare potential grant awards with other grants awarded under this Act to determine if duplicate grant awards are awarded for the same purpose.

''(B) REPORT.—If the Attorney General awards duplicate grants to the same applicant for the same purpose the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that includes—

''(i) a list of all duplicate grants awarded, including the total dollar amount of any duplicate grants awarded; and

''(ii) the reason the Attorney General awarded the duplicate grants.''.

SEC. 14015. IMPROVING DEPARTMENT OF JUSTICE DATA COLLECTION ON MENTAL ILLNESS INVOLVED IN CRIME.

(a) IN GENERAL.—Notwithstanding any other provision of law, on or after the date that is 90 days after the date on which the Attorney General promulgates regulations under subsection (b), any data prepared by, or submitted to, the Attorney General or the Director of the Federal Bureau of Investigation with respect to the incidences of homicides, law enforcement officers killed, seriously injured, and assaulted, or individuals killed or seriously injured by law enforcement officers shall include data with respect to the involvement of mental illness in such incidences, if any.

(b) REGULATIONS.—Not later than 90 days after the date of the enactment of this Act, the Attorney General shall promulgate or revise regulations as necessary to carry out subsection (a).

SEC. 14016. REPORTS ON THE NUMBER OF MENTALLY ILL OFFENDERS IN PRISON.

(a) REPORT ON THE COST OF TREATING THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYSTEM.—Not later than 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report detailing the cost of imprisonment for individuals who have serious mental illness by the Federal Government or a State or unit of local government, which shall include—

(1) the number and type of crimes committed by individuals with serious mental illness each year; and

(2) detail strategies or ideas for preventing crimes by those individuals with serious mental illness from occurring.

(b) DEFINITION.—For purposes of this section, the Attorney General, in consultation with the Assistant Secretary of Mental Health and Substance Use Disorders, shall define ''serious mental illness'' based on the ''Health Care Reform for Americans with Severe Mental Illnesses: Report'' of the National Advisory Mental Health Council, American Journal of Psychiatry 1993; 150:1447–1465.

SEC. 14017. CODIFICATION OF DUE PROCESS FOR DETERMINATIONS BY SECRETARY OF VETERANS AFFAIRS OF MENTAL CAPACITY OF BENEFICIARIES.

(a) IN GENERAL.—Chapter 55 of title 38, United States Code, is amended by inserting after section 5501 the following new section:

''§ 5501A. Beneficiaries' rights in mental competence determinations

''The Secretary may not make an adverse determination concerning the mental capacity of a beneficiary to manage monetary benefits paid to or for the beneficiary by the Secretary under this title unless such beneficiary has been provided all of the following, subject to the procedures and timelines prescribed by the Secretary for determinations of incompetency:

''(1) Notice of the proposed adverse determination and the supporting evidence.

''(2) An opportunity to request a hearing.

''(3) An opportunity to present evidence, including an opinion from a medical professional or other person, on the capacity of the beneficiary to manage monetary benefits paid to or for the beneficiary by the Secretary under this title.

''(4) An opportunity to be represented at no expense to the Government (including by counsel) at any such hearing and to bring a medical professional or other person to provide relevant testimony at any such hearing.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter 55 is amended by inserting after the item relating to section 5501 the following new item:

''5501A. Beneficiaries' rights in mental competence determinations''.

(c) EFFECTIVE DATE.—Section 5501A of title 38, United States Code, as added by subsection (a), shall apply to determinations made by the Secretary of Veterans Affairs on or after the date of the enactment of this Act.

SEC. 14018. REAUTHORIZATION OF APPROPRIATIONS.

Subsection (o) of section 2991 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa), as redesignated by section 14006, is amended—

(1) in paragraph (1)(C), by striking ''2009 through 2014'' and inserting ''2017 through 2021''; and

(2) by adding at the end the following:

''(3) LIMITATION.—Not more than 20 percent of the funds authorized to be appropriated under this section may be used for purposes described in subsection (i) (relating to veterans).''.

Subtitle B—Comprehensive Justice and Mental Health

SEC. 14021. SEQUENTIAL INTERCEPT MODEL.

Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa), as amended by section 14005, is amended by inserting after subsection (j), the following:

''(k) SEQUENTIAL INTERCEPT GRANTS.—

''(1) DEFINITION.—In this subsection, the term 'eligible entity' means a State, unit of local government, Indian tribe, or tribal organization.

''(2) AUTHORIZATION.—The Attorney General may make grants under this subsection to an eligible entity for sequential intercept mapping and implementation in accordance with paragraph (3).

''(3) SEQUENTIAL INTERCEPT MAPPING; IMPLEMENTATION.—An eligible entity that receives a grant under this subsection may use funds for—

''(A) sequential intercept mapping, which—

''(i) shall consist of—

''(I) convening mental health and criminal justice stakeholders to—

''(aa) develop a shared understanding of the flow of justice-involved individuals with mental illnesses through the criminal justice system; and

''(bb) identify opportunities for improved collaborative responses to the risks and needs of individuals described in item (aa); and

''(II) developing strategies to address gaps in services and bring innovative and effective programs to scale along multiple intercepts, including—

''(aa) emergency and crisis services;

''(bb) specialized police-based responses;

''(cc) court hearings and disposition alternatives;

''(dd) reentry from jails and prisons; and

''(ee) community supervision, treatment and support services; and

''(ii) may serve as a starting point for the development of strategic plans to achieve positive public health and safety outcomes; and

''(B) implementation, which shall—

''(i) be derived from the strategic plans described in subparagraph (A)(ii); and

''(ii) consist of—

''(I) hiring and training personnel;

''(II) identifying the eligible entity's target population;

''(III) providing services and supports to reduce unnecessary penetration into the criminal justice system;

''(IV) reducing recidivism;

''(V) evaluating the impact of the eligible entity's approach; and

''(VI) planning for the sustainability of effective interventions.''.

SEC. 14022. PRISON AND JAILS.

Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is amended by inserting after subsection (k), as added by section 14021, the following:

''(l) CORRECTIONAL FACILITIES.—

''(1) DEFINITIONS.—

''(A) CORRECTIONAL FACILITY.—The term 'correctional facility' means a jail, prison, or other detention facility used to house people who have been arrested, detained, held, or convicted by a criminal justice agency or a court.

''(B) ELIGIBLE INMATE.—The term 'eligible inmate' means an individual who—

''(i) is being held, detained, or incarcerated in a correctional facility; and

''(ii) manifests obvious signs of a mental illness or has been diagnosed by a qualified mental health professional as having a mental illness.

''(2) CORRECTIONAL FACILITY GRANTS.—The Attorney General may award grants to applicants to enhance the capabilities of a correctional facility—

''(A) to identify and screen for eligible inmates;

''(B) to plan and provide—

''(i) initial and periodic assessments of the clinical, medical, and social needs of inmates; and

''(ii) appropriate treatment and services that address the mental health and substance abuse needs of inmates;

''(C) to develop, implement, and enhance—

''(i) post-release transition plans for eligible inmates that, in a comprehensive manner, coordinate health, housing, medical, employment, and other appropriate services and public benefits;

''(ii) the availability of mental health care services and substance abuse treatment services; and

''(iii) alternatives to solitary confinement and segregated housing and mental health screening and treatment for inmates placed in solitary confinement or segregated housing; and

''(D) to train each employee of the correctional facility to identify and appropriately respond to incidents involving inmates with mental health or co-occurring mental health and substance abuse disorders.''.

SEC. 14023. ALLOWABLE USES.

Section 2991(b)(5)(I) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(b)(5)(I)) is amended by adding at the end the following:

''(v) TEAMS ADDRESSING FREQUENT USERS OF CRISIS SERVICES.—Multidisciplinary teams that—

''(I) coordinate, implement, and administer community-based crisis responses and long-term plans for frequent users of crisis services;

''(II) provide training on how to respond appropriately to the unique issues involving frequent users of crisis services for public service personnel, including criminal justice, mental health, substance abuse, emergency room, healthcare, law enforcement, corrections, and housing personnel;

''(III) develop or support alternatives to hospital and jail admissions for frequent users of crisis services that provide treatment, stabilization, and other appropriate supports in the least restrictive, yet appropriate, environment; and

''(IV) develop protocols and systems among law enforcement, mental health, substance abuse, housing, corrections, and emergency medical service operations to provide coordinated assistance to frequent users of crisis services.''.

SEC. 14024. LAW ENFORCEMENT TRAINING.

Section 2991(h) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(h)) is amended—

(1) in paragraph (1), by adding at the end the following:

''(F) ACADEMY TRAINING.—To provide support for academy curricula, law enforcement officer orientation programs, continuing education training, and other programs that teach law enforcement personnel how to identify and respond to incidents involving persons with mental health disorders or co-occurring mental health and substance abuse disorders.''; and

(2) by adding at the end the following:

''(4) PRIORITY CONSIDERATION.—The Attorney General, in awarding grants under this subsection, shall give priority to programs that law enforcement personnel and members of the mental health and substance abuse professions develop and administer cooperatively.''.

SEC. 14025. FEDERAL LAW ENFORCEMENT TRAINING.

Not later than 1 year after the date of enactment of this Act, the Attorney General shall provide direction and guidance for the following:

(1) TRAINING PROGRAMS.—Programs that offer specialized and comprehensive training, in procedures to identify and appropriately respond to incidents in which the unique needs of individuals who have a mental illness are involved, to first responders and tactical units of—

(A) Federal law enforcement agencies; and

(B) other Federal criminal justice agencies such as the Bureau of Prisons, the Administrative Office of the United States Courts, and other agencies that the Attorney General determines appropriate.

(2) IMPROVED TECHNOLOGY.—The establishment of, or improvement of existing, computerized information systems to provide timely information to employees of Federal law enforcement agencies, and Federal criminal justice agencies to improve the response of such employees to situations involving individuals who have a mental illness.

SEC. 14026. GAO REPORT.

No later than 1 year after the date of enactment of this Act, the Comptroller General of the United States, in coordination with the Attorney General, shall submit to Congress a report on—

(1) the practices that Federal first responders, tactical units, and corrections officers are trained to use in responding to individuals with mental illness;

(2) procedures to identify and appropriately respond to incidents in which the unique needs of individuals who have a mental illness are involved, to Federal first responders and tactical units;

(3) the application of evidence-based practices in criminal justice settings to better address individuals with mental illnesses; and

(4) recommendations on how the Department of Justice can expand and improve information sharing and dissemination of best practices.

SEC. 14027. EVIDENCE BASED PRACTICES.

Section 2991(c) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(c)) is amended—

(1) in paragraph (3), by striking ''or'' at the end;

(2) by redesignating paragraph (4) as paragraph (6); and

(3) by inserting after paragraph (3), the following:

''(4) propose interventions that have been shown by empirical evidence to reduce recidivism;

''(5) when appropriate, use validated assessment tools to target preliminarily qualified offenders with a moderate or high risk of recidivism and a need for treatment and services; or''.

SEC. 14028. TRANSPARENCY, PROGRAM ACCOUNTABILITY, AND ENHANCEMENT OF LOCAL AUTHORITY.

(a) IN GENERAL.—Section 2991(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa(a)) is amended—

(1) in paragraph (7)—

(A) in the heading, by striking ''MENTAL ILLNESS'' and inserting ''MENTAL ILLNESS; MENTAL HEALTH DISORDER''; and

(B) by striking ''term 'mental illness' means'' and inserting ''terms 'mental illness' and 'mental health disorder' mean''; and

(2) by striking paragraph (9) and inserting the following:

''(9) PRELIMINARILY QUALIFIED OFFENDER.—

''(A) IN GENERAL.—The term 'preliminarily qualified offender' means an adult or juvenile accused of an offense who—

''(i)(I) previously or currently has been diagnosed by a qualified mental health professional as having a mental illness or co-occurring mental illness and substance abuse disorders;

''(II) manifests obvious signs of mental illness or co-occurring mental illness and substance abuse disorders during arrest or confinement or before any court; or

''(III) in the case of a veterans treatment court provided under subsection (i), has been diagnosed with, or manifests obvious signs of, mental illness or a substance abuse disorder or co-occurring mental illness and substance abuse disorder;

''(ii) has been unanimously approved for participation in a program funded under this section by, when appropriate—

''(I) the relevant—

''(aa) prosecuting attorney;

''(bb) defense attorney;

''(cc) probation or corrections official; and

''(dd) judge; and

''(II) a representative from the relevant mental health agency described in subsection (b)(5)(B)(i);

''(iii) has been determined, by each person described in clause (ii) who is involved in approving the adult or juvenile for participation in a program funded under this section, to not pose a risk of violence to any person in the program, or the public, if selected to participate in the program; and

''(iv) has not been charged with or convicted of—

''(I) any sex offense (as defined in section 111 of the Sex Offender Registration and Notification Act (42 U.S.C. 16911)) or any offense relating to the sexual exploitation of children; or

''(II) murder or assault with intent to commit murder.

''(B) DETERMINATION.—In determining whether to designate a defendant as a preliminarily qualified offender, the relevant prosecuting attorney, defense attorney, probation or corrections official, judge, and mental health or substance abuse agency representative shall take into account—

''(i) whether the participation of the defendant in the program would pose a substantial risk of violence to the community;

''(ii) the criminal history of the defendant and the nature and severity of the offense for which the defendant is charged;

''(iii) the views of any relevant victims to the offense;

''(iv) the extent to which the defendant would benefit from participation in the program;

''(v) the extent to which the community would realize cost savings because of the defendant's participation in the program; and

''(vi) whether the defendant satisfies the eligibility criteria for program participation unanimously established by the relevant prosecuting attorney, defense attorney, probation or corrections official, judge and mental health or substance abuse agency representative.''.

(b) TECHNICAL AND CONFORMING AMENDMENT.—Section 2927(2) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797s–6(2)) is amended by striking ''has the meaning given that term in section 2991(a).'' and inserting ''means an offense that—

''(A) does not have as an element the use, attempted use, or threatened use of physical force against the person or property of another; or

''(B) is not a felony that by its nature involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense.''.

SEC. 14029. GRANT ACCOUNTABILITY.

Section 2991 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is amended by inserting after subsection (l), as added by section 14022, the following:

''(m) ACCOUNTABILITY.—All grants awarded by the Attorney General under this section shall be subject to the following accountability provisions:

''(1) AUDIT REQUIREMENT.—

''(A) DEFINITION.—In this paragraph, the term 'unresolved audit finding' means a finding in the final audit report of the Inspector General of the Department of Justice that the audited grantee has utilized grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months from the date when the final audit report is issued.

''(B) AUDITS.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of recipients of grants under this section to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

''(C) MANDATORY EXCLUSION.—A recipient of grant funds under this section that is found to have an unresolved audit finding shall not be eligible to receive grant funds under this section during the first 2 fiscal years beginning after the end of the 12-month period described in subparagraph (A).

''(D) PRIORITY.—In awarding grants under this section, the Attorney General shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this section.

''(E) REIMBURSEMENT.—If an entity is awarded grant funds under this section during the 2-fiscal-year period during which the entity is barred from receiving grants under subparagraph (C), the Attorney General shall—

''(i) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

''(ii) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

''(2) NONPROFIT ORGANIZATION REQUIREMENTS.—

''(A) DEFINITION.—For purposes of this paragraph and the grant programs under this part, the term 'nonprofit organization' means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

''(B) PROHIBITION.—The Attorney General may not award a grant under this part to a nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986.

''(C) DISCLOSURE.—Each nonprofit organization that is awarded a grant under this section and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose to the Attorney General, in the application for the grant, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed under this subparagraph available for public inspection.

''(3) CONFERENCE EXPENDITURES.—

''(A) LIMITATION.—No amounts made available to the Department of Justice under this section may be used by the Attorney General, or by any individual or entity awarded discretionary funds through a cooperative agreement under this section, to host or support any expenditure for conferences that uses more than $20,000 in funds made available by the Department of Justice, unless the head of the relevant agency or department, provides prior written authorization that the funds may be expended to host the conference.

''(B) WRITTEN APPROVAL.—Written approval under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

''(C) REPORT.—The Deputy Attorney General shall submit an annual report to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives on all conference expenditures approved under this paragraph.

''(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this subsection, the Attorney General shall submit, to the Committee on the Judiciary and the Committee on Appropriations of the Senate and the Committee on the Judiciary and the Committee on Appropriations of the House of Representatives, an annual certification—

''(A) indicating whether—

''(i) all audits issued by the Office of the Inspector General under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

''(ii) all mandatory exclusions required under paragraph (1)(C) have been issued; and

''(iii) all reimbursements required under paragraph (1)(E) have been made; and

''(B) that includes a list of any grant recipients excluded under paragraph (1) from the previous year.

''(n) PREVENTING DUPLICATIVE GRANTS.—

''(1) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this section, the Attorney General shall compare potential grant awards with other grants awarded under this Act to determine if duplicate grant awards are awarded for the same purpose.

''(2) REPORT.—If the Attorney General awards duplicate grants to the same applicant for the same purpose the Attorney General shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that includes—

''(A) a list of all duplicate grants awarded, including the total dollar amount of any duplicate grants awarded; and

''(B) the reason the Attorney General awarded the duplicate grants.''.

DIVISION C—INCREASING CHOICE, ACCESS, AND QUALITY IN HEALTH CARE FOR AMERICANS

SEC. 15000. SHORT TITLE.

This division may be cited as the ''Increasing Choice, Access, and Quality in Health Care for Americans Act''.

TITLE XV—PROVISIONS RELATING TO MEDICARE PART A

SEC. 15001. DEVELOPMENT OF MEDICARE HCPCS VERSION OF MS–DRG CODES FOR SIMILAR HOSPITAL SERVICES.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(t) RELATING SIMILAR INPATIENT AND OUTPATIENT HOSPITAL SERVICES.—

''(1) DEVELOPMENT OF HCPCS VERSION OF MS–DRG CODES.—Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that are similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with a ICD–10–PCS code.

''(2) COVERAGE OF SURGICAL MS–DRGS.—In carrying out paragraph (1), the Secretary shall develop HCPCS versions of MS–DRG codes for not fewer than 10 surgical MS–DRGs.

''(3) PUBLICATION AND DISSEMINATION OF THE HCPCS VERSIONS OF MS–DRGS.—

''(A) IN GENERAL.—The Secretary shall develop a HCPCS MS–DRG definitions manual and software that is similar to the definitions manual and software for ICD–10–PCS codes for such MS–DRGs. The Secretary shall post the HCPCS MS–DRG definitions manual and software on the Internet website of the Centers for Medicare & Medicaid Services. The HCPCS MS–DRG definitions manual and software shall be in the public domain and available for use and redistribution without charge.

''(B) USE OF PREVIOUS ANALYSIS DONE BY MEDPAC.—In developing the HCPCS MS–DRG definitions manual and software under subparagraph (A), the Secretary shall consult with the Medicare Payment Advisory Commission and shall consider the analysis done by such Commission in translating outpatient surgical claims into inpatient surgical MS–DRGs in preparing chapter 7 (relating to hospital short-stay policy issues) of its 'Medicare and the Health Care Delivery System' report submitted to Congress in June 2015.

''(4) DEFINITION AND REFERENCE.—In this subsection:

''(A) HCPCS.—The term 'HCPCS' means, with respect to hospital items and services, the code under the Healthcare Common Procedure Coding System (HCPCS) (or a successor code) for such items and services.

''(B) ICD–10–PCS.—The term 'ICD–10–PCS' means the International Classification of Diseases, 10th Revision, Procedure Coding System, and includes any subsequent revision of such International Classification of Diseases, Procedure Coding System.''.

SEC. 15002. ESTABLISHING BENEFICIARY EQUITY IN THE MEDICARE HOSPITAL READMISSION PROGRAM.

(a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLE POPULATION.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)) is amended—

(1) in subparagraph (A), by inserting ''subject to subparagraph (D),'' after ''purposes of paragraph (1),''; and

(2) by adding at the end the following new subparagraph:

''(D) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGIBLES.—

''(i) IN GENERAL.—In determining a hospital's adjustment factor under this paragraph for purposes of making payments for discharges occurring during and after fiscal year 2019, and before the application of clause (i) of subparagraph (E), the Secretary shall assign hospitals

to groups (as defined by the Secretary under clause (ii)) and apply the applicable provisions of this subsection using a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary.

''(ii) DEFINING GROUPS.—For purposes of this subparagraph, the Secretary shall define groups of hospitals, based on their overall proportion, of the inpatients who are entitled to, or enrolled for, benefits under part A, and who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)). In defining groups, the Secretary shall consult the Medicare Payment Advisory Commission and may consider the analysis done by such Commission in preparing the portion of its report submitted to Congress in June 2013 relating to readmissions.

''(iii) MINIMIZING REPORTING BURDEN ON HOSPITALS.—In carrying out this subparagraph, the Secretary shall not impose any additional reporting requirements on hospitals.

''(iv) BUDGET NEUTRAL DESIGN METHODOLOGY.—The Secretary shall design the methodology to implement this subparagraph so that the estimated total amount of reductions in payments under this subsection equals the estimated total amount of reductions in payments that would otherwise occur under this subsection if this subparagraph did not apply.''.

(b) CHANGES IN RISK ADJUSTMENT.—Section 1886(q)(3) of the Social Security Act (42 U.S.C. 1395ww(q)(3)), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

''(E) CHANGES IN RISK ADJUSTMENT.—

''(i) CONSIDERATION OF RECOMMENDATIONS IN IMPACT REPORTS.—The Secretary may take into account the studies conducted and the recommendations made by the Secretary under section 2(d)(1) of the IMPACT Act of 2014 (Public Law 113–185; 42 U.S.C. 1395lll note) with respect to the application under this subsection of risk adjustment methodologies. Nothing in this clause shall be construed as precluding consideration of the use of groupings of hospitals.

''(ii) CONSIDERATION OF EXCLUSION OF PATIENT CASES BASED ON V OR OTHER APPROPRIATE CODES.—In promulgating regulations to carry out this subsection with respect to discharges occurring after fiscal year 2018, the Secretary may consider the use of V or other ICD-related codes for removal of a readmission. The Secretary may consider modifying measures under this subsection to incorporate V or other ICD-related codes at the same time as other changes are being made under this subparagraph.

''(iii) REMOVAL OF CERTAIN READMISSIONS.—In promulgating regulations to carry out this subsection, with respect to discharges occurring after fiscal year 2018, the Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse. The Secretary may consider modifying measures under this subsection to remove readmissions at the same time as other changes are being made under this subparagraph.''.

(c) MEDPAC STUDY ON READMISSIONS PROGRAM.—The Medicare Payment Advisory Commission shall conduct a study to review overall hospital readmissions described in section 1886(q)(5)(E) of the Social Security Act (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmissions are related to any changes in outpatient and emergency services furnished. The Commission shall submit to Congress a report on such study in its report to Congress in June 2018.

SEC. 15003. FIVE-YEAR EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 42 U.S.C. 1395ww note) is amended—

(1) in subsection (a)(5), by striking ''5-year extension period'' and inserting ''10-year extension period''; and

(2) in subsection (g)—

(A) in the subsection heading, by striking ''FIVE-YEAR'' and inserting ''TEN-YEAR'';

(B) in paragraph (1), by striking ''additional 5-year'' and inserting ''additional 10-year'';

(C) by striking ''5-year extension period'' and inserting ''10-year extension period'' each place it appears;

(D) in paragraph (4)(B)—

(i) in the matter preceding clause (i), by inserting ''each 5-year period in'' after ''hospital during''; and

(ii) in clause (i), by inserting ''each applicable 5-year period in'' after ''the first day of''; and

(E) by adding at the end the following new paragraphs:

''(5) OTHER HOSPITALS IN DEMONSTRATION PROGRAM.—During the second 5 years of the 10-year extension period, the Secretary shall apply the provisions of paragraph (4) to rural community hospitals that are not described in paragraph (4) but are participating in the demonstration program under this section as of December 30, 2014, in a similar manner as such provisions apply to rural community hospitals described in paragraph (4).

''(6) EXPANSION OF DEMONSTRATION PROGRAM TO RURAL AREAS IN ANY STATE.—

''(A) IN GENERAL.—The Secretary shall, notwithstanding subsection (a)(2) or paragraph (2) of this subsection, not later than 120 days after the date of the enactment of this paragraph, issue a solicitation for applications to select up to the maximum number of additional rural community hospitals located in any State to participate in the demonstration program under this section for the second 5 years of the 10-year extension period without exceeding the limitation under paragraph (3) of this subsection.

''(B) PRIORITY.—In determining which rural community hospitals that submitted an application pursuant to the solicitation under subparagraph (A) to select for participation in the demonstration program, the Secretary—

''(i) shall give priority to rural community hospitals located in one of the 20 States with the lowest population densities (as determined by the Secretary using the 2015 Statistical Abstract of the United States); and

''(ii) may consider—

''(I) closures of hospitals located in rural areas in the State in which the rural community hospital is located during the 5-year period immediately preceding the date of the enactment of this paragraph; and

''(II) the population density of the State in which the rural community hospital is located.''.

(b) CHANGE IN TIMING FOR REPORT.—Subsection (e) of such section 410A is amended—

(1) by striking ''Not later than 6 months after the completion of the demonstration program under this section'' and inserting ''Not later than August 1, 2018''; and

(2) by striking ''such program'' and inserting ''the demonstration program under this section''.

SEC. 15004. REGULATORY RELIEF FOR LTCHS.

(a) TECHNICAL CHANGE TO THE MEDICARE LONG-TERM CARE HOSPITAL MORATORIUM EXCEPTION.—

(1) IN GENERAL.—Section 114(d)(7) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111–148, section 1206(b)(2) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67), and section 112 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), is amended by striking ''The moratorium under paragraph (1)(A)'' and inserting ''Any moratorium under paragraph (1)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 112 of the Protecting Access to Medicare Act of 2014.

(b) MODIFICATION TO MEDICARE LONG-TERM CARE HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraph:

''(7) TREATMENT OF HIGH COST OUTLIER PAYMENTS.—

''(A) ADJUSTMENT TO THE STANDARD FEDERAL PAYMENT RATE FOR ESTIMATED HIGH COST OUTLIER PAYMENTS.—Under the system described in paragraph (1), for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of high cost outlier payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

''(B) LIMITATION ON HIGH COST OUTLIER PAYMENT AMOUNTS.—Notwithstanding subparagraph (A), the Secretary shall set the fixed loss amount for high cost outlier payments such that the estimated aggregate amount of high cost outlier payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year.

''(C) WAIVER OF BUDGET NEUTRALITY.—Any reduction in payments resulting from the application of subparagraph (B) shall not be taken into account in applying any budget neutrality provision under such system.

''(D) NO EFFECT ON SITE NEUTRAL HIGH COST OUTLIER PAYMENT RATE.—This paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under paragraph (6).''.

SEC. 15005. SAVINGS FROM IPPS MACRA PAY-FOR THROUGH NOT APPLYING DOCUMENTATION AND CODING ADJUSTMENTS.

Section 7(b)(1)(B) of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110–90), as amended by section 631(b) of the American Taxpayer Relief Act of 2012 (Public Law 112–240) and section 414(1)(B)(iii) of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), is amended in clause (iii) by striking ''an increase of 0.5 percentage points for discharges occurring during each of fiscal years 2018 through 2023'' and inserting ''an increase of 0.4588 percentage points for discharges occurring during fiscal year 2018 and 0.5 percentage points for discharges occurring during each of fiscal years 2019 through 2023''.

SEC. 15006. EXTENSION OF CERTAIN LTCH MEDICARE PAYMENT RULES.

(a) 25–PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT.—Section 114(c)(1)(A) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of division B of the American Recovery and Reinvestment Act (Public Law 111–5), sections 3106(a) and 10312(a) of Public Law 111–148, and section 1206(b)(1)(B) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67), is amended by striking ''for a 9-year period'' and inserting ''through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before October 1, 2017''.

(b) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—Section 114(c)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of division B of the American Recovery and Reinvestment Act (Public Law 111–5), sections 3106(a) and 10312(a) of Public Law 111–148, and section 1206(b)(1)(A) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67), is amended—

(1) in subparagraph (A), by inserting ''or any similar provision,'' after ''Regulations,'';

(2) in subparagraph (B)—

(A) in clause (i), by inserting ''or any similar provision,'' after ''Regulations,''; and

(B) in clause (ii), by inserting '', or any similar provision,'' after ''Regulations''; and

(3) in subparagraph (C), by striking ''for a 9-year period'' and inserting ''through June 30, 2016, and for discharges occurring on or after October 1, 2016, and before October 1, 2017''.

SEC. 15007. APPLICATION OF RULES ON THE CALCULATION OF HOSPITAL LENGTH OF STAY TO ALL LTCHS.

(a) IN GENERAL.—Section 1206(a)(3) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67; 42 U.S.C. 1395ww note) is amended—

(1) by striking subparagraph (B);

(2) by striking ''SITE NEUTRAL BASIS.—'' and all that follows through ''For discharges occurring'' and inserting ''SITE NEUTRAL BASIS.—For discharges occurring'';

(3) by striking ''subject to subparagraph (B),''; and

(4) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively, and moving each of such subparagraphs (as so redesignated) 2 ems to the left.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 1206(a)(3) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113–67; 42 U.S.C. 1395ww note).

SEC. 15008. CHANGE IN MEDICARE CLASSIFICATION FOR CERTAIN HOSPITALS.

(a) IN GENERAL.—Subsection (d)(1)(B)(iv) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(1) in subclause (I), by striking ''or'' at the end;

(2) in subclause (II)—

(A) by striking '', or'' at the end and inserting a semicolon;

(B) by redesignating such subclause as clause (vi) and by moving it to immediately follow clause (v); and

(C) in clause (v), by striking the semicolon at the end and inserting '', or''; and

(3) by striking ''(iv)(I) a hospital'' and inserting ''(iv) a hospital''.

(b) CONFORMING PAYMENT REFERENCES.—The second sentence of subsection (d)(1)(B) of such section is amended—

(1) by inserting ''(as in effect as of such date)'' after ''clause (iv)''; and

(2) by inserting ''(or, in the case of a hospital described in clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause (vi) and for cost reporting periods beginning on or after January 1, 2015, shall not be subject to subsection (m) as of the date of such classification)'' after ''so classified''.

(c) APPLICATION.—

(1) IN GENERAL.—For cost reporting periods beginning on or after January 1, 2015, in the case of an applicable hospital (as defined in paragraph (3)), the following shall apply:

(A) Payment for inpatient operating costs shall be made on a reasonable cost basis in the manner provided in section 412.526(c)(3) of title 42, Code of Federal Regulations (as in effect on January 1, 2015) and in any subsequent modifications.

(B) Payment for capital costs shall be made in the manner provided by section 412.526(c)(4) of title 42, Code of Federal Regulations (as in effect on such date).

(C) Claims for payment for Medicare beneficiaries who are discharged on or after January 1, 2017, shall be processed as claims which are paid on a reasonable cost basis as described in section 412.526(c) of title 42, Code of Federal Regulations (as in effect on such date).

(2) APPLICABLE HOSPITAL DEFINED.—In this subsection, the term ''applicable hospital'' means a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) on the day before the date of the enactment of this Act and which is classified under clause (vi) of such section, as redesignated and moved by subsection (a), on or after such date of enactment.

(d) CONFORMING TECHNICAL AMENDMENTS.—

(1) Section 1899B(a)(2)(A)(iv) of the Social Security Act (42 U.S.C. 1395lll(a)(2)(A)(iv)) is amended by striking ''1886(d)(1)(B)(iv)(II)'' and inserting ''1886(d)(1)(B)(vi)''.

(2) Section 1886(m)(5)(F) of such Act (42 U.S.C. 1395ww(m)(5)(F)) is amended in each of clauses (i) and (ii) by striking ''(d)(1)(B)(iv)(II)'' and inserting ''(d)(1)(B)(vi)''.

SEC. 15009. TEMPORARY EXCEPTION TO THE APPLICATION OF THE MEDICARE LTCH SITE NEUTRAL PROVISIONS FOR CERTAIN SPINAL CORD SPECIALTY HOSPITALS.

(a) EXCEPTION.—Section 1886(m)(6) of the Social Security Act (42 U.S.C. 1395ww(m)(6)) is amended—

(1) in subparagraph (A)(i), by striking ''and (E)'' and inserting '', (E), and (F)''; and

(2) by adding at the end the following new subparagraph:

''(F) TEMPORARY EXCEPTION FOR CERTAIN SPINAL CORD SPECIALTY HOSPITALS.—For discharges in cost reporting periods beginning during fiscal years 2018 and 2019, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge is from a long-term care hospital that meets each of the following requirements:

''(i) NOT-FOR-PROFIT.—The long-term care hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data.

''(ii) PRIMARILY PROVIDING TREATMENT FOR CATASTROPHIC SPINAL CORD OR ACQUIRED BRAIN INJURIES OR OTHER PARALYZING NEUROMUSCULAR CONDITIONS.—Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under this section, at least 50 percent were classified under MS–LTCH–DRGs 28, 29, 52, 57, 551, 573, and 963.

''(iii) SIGNIFICANT OUT-OF-STATE ADMISSIONS.—

''(I) IN GENERAL.—The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under this title and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States, determined by the States of residency of such inpatients and based on such data submitted by the hospital to the Secretary as the Secretary may require.

''(II) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement subclause (I) by program instruction or otherwise.

''(III) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to data collected under this clause.''.

(b) STUDY AND REPORT ON THE STATUS AND VIABILITY OF CERTAIN SPINAL CORD SPECIALTY LONG-TERM CARE HOSPITALS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on long-term care hospitals described in section 1886(m)(6)(F) of the Social Security Act, as added by subsection (a). Such report shall include an analysis of the following:

(A) The impact on such hospitals of the classification and facility licensure by State agencies of such hospitals.

(B) The Medicare payment rates for such hospitals.

(C) Data on the number and health care needs of Medicare beneficiaries who have been diagnosed with catastrophic spinal cord or acquired brain injuries or other paralyzing neuromuscular conditions (as described within the discharge classifications specified in clause (ii) of such section) who are receiving services from such hospitals.

(2) REPORT.—Not later than October 1, 2018, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 15010. TEMPORARY EXTENSION TO THE APPLICATION OF THE MEDICARE LTCH SITE NEUTRAL PROVISIONS FOR CERTAIN DISCHARGES WITH SEVERE WOUNDS.

(a) IN GENERAL.—Section 1886(m)(6) of the Social Security Act (42 U.S.C. 1395ww(m)(6)), as amended by section 15009, is further amended—

(1) in subparagraph (A)(i) by striking ''and (F)'' and inserting ''(F), and (G)'';

(2) in subparagraph (E)(i)(I)(aa), by striking ''the amendment made'' and all that follows before the semicolon and inserting ''the last sentence of subsection (d)(1)(B)''; and

(3) by adding at the end the following new subparagraph:

''(G) ADDITIONAL TEMPORARY EXCEPTION FOR CERTAIN SEVERE WOUND DISCHARGES FROM CERTAIN LONG-TERM CARE HOSPITALS.—

''(i) IN GENERAL.—For a discharge occurring in a cost reporting period beginning during fiscal year 2018, subparagraph (A)(i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) if such discharge—

''(I) is from a long-term care hospital identified by the last sentence of subsection (d)(1)(B);

''(II) is classified under MS–LTCH–DRG 602, 603, 539, or 540; and

''(III) is with respect to an individual treated by a long-term care hospital for a severe wound.

''(ii) SEVERE WOUND DEFINED.—In this subparagraph, the term 'severe wound' means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the long-term care hospital.

''(iii) WOUND DEFINED.—In this subparagraph, the term 'wound' means an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.''.

(c) STUDY AND REPORT TO CONGRESS.—

(1) STUDY.—The Comptroller General of the United States shall, in consultation with relevant stakeholders, conduct a study on the treatment needs of individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title who require specialized wound care, and the cost, for such individuals and the Medicare program under such title, of treating severe wounds in rural and urban areas. Such study shall include an assessment of—

(A) access of such individuals to appropriate levels of care for such cases;

(B) the potential impact that section 1886(m)(6)(A)(i) of such Act (42 U.S.C. 1395ww(m)(6)(A)(i)) will have on the access, quality, and cost of care for such individuals; and

(C) how to appropriately pay for such care under the Medicare program under such title.

(2) REPORT.—Not later than October 1, 2020, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

TITLE XVI—PROVISIONS RELATING TO MEDICARE PART B

SEC. 16001. CONTINUING MEDICARE PAYMENT UNDER HOPD PROSPECTIVE PAYMENT SYSTEM FOR SERVICES FURNISHED BY MID-BUILD OFF-CAMPUS OUTPATIENT DEPARTMENTS OF PROVIDERS.

(a) IN GENERAL.—Section 1833(t)(21) of the Social Security Act (42 U.S.C. 1395l(t)(21)) is amended—

(1) in subparagraph (B)—

(A) in clause (i), by striking ''clause (ii)'' and inserting ''the subsequent provisions of this subparagraph''; and

(B) by adding at the end the following new clauses:

''(iii) DEEMED TREATMENT FOR 2017.—For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

''(iv) ALTERNATIVE EXCEPTION BEGINNING WITH 2018.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term 'off-campus outpatient department of a provider' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

''(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after the date of the enactment of this clause), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

''(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(j); and

''(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after the date of the enactment of this clause, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

''(v) MID-BUILD REQUIREMENT DESCRIBED.—The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department.

''(vii) AUDIT.—Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term 'off-campus outpatient department of a provider' under such clause.

''(viii) IMPLEMENTATION.—For purposes of implementing clauses (iii) through (vii):

''(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

''(II) Subchapter I of chapter 35 of title 44, United States Code, shall not apply.

''(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until December 31, 2018.''; and

(2) in subparagraph (E), by adding at the end the following new clause:

''(iv) The determination of an audit under subparagraph (B)(vii).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).

SEC. 16002. TREATMENT OF CANCER HOSPITALS IN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER POLICY.

(a) IN GENERAL.—Section 1833(t)(21)(B) of the Social Security Act (42 U.S.C. 1395l(t)(21)(B)), as amended by section 16001(a), is amended—

(1) by inserting after clause (v) the following new clause:

''(vi) EXCLUSION FOR CERTAIN CANCER HOSPITALS.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term 'off-campus outpatient department of a provider' also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1886(d)(1)(B)(v) and—

''(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before the date of the enactment of this clause, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date of enactment; or

''(II) in the case of a department that meets such requirements after such date of enactment, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.'';

(2) in clause (vii), by inserting after the first sentence the following: ''Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department.''; and

(3) in clause (viii)(III), by adding at the end the following: ''For purposes of carrying out this subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until expended.''.

(b) OFFSETTING SAVINGS.—Section 1833(t)(18) of the Social Security Act (42 U.S.C. 1395l(t)(18)) is amended—

(1) in subparagraph (B), by inserting '', subject to subparagraph (C),'' after ''shall''; and

(2) by adding at the end the following new subparagraph:

''(C) TARGET PCR ADJUSTMENT.—In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this paragraph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1886(d)(1)(B)(v). In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of section 603 of the Bipartisan Budget Act of 2015 (Public Law 114–74).

SEC. 16003. TREATMENT OF ELIGIBLE PROFESSIONALS IN AMBULATORY SURGICAL CENTERS FOR MEANINGFUL USE AND MIPS.

Section 1848(a)(7)(D) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(D)) is amended—

(1) by striking ''HOSPITAL-BASED ELIGIBLE PROFESSIONALS'' and all that follows through ''No payment'' and inserting the following: ''HOSPITAL-BASED AND AMBULATORY SURGICAL CENTER-BASED ELIGIBLE PROFESSIONALS.—

''(i) HOSPITAL-BASED.—No payment''; and

(2) by adding at the end the following new clauses:

''(ii) AMBULATORY SURGICAL CENTER-BASED.—Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

''(iii) DETERMINATION.—The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

''(I) the site of service (as defined by the Secretary); or

''(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

''(iv) SUNSET.—Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.''.

SEC. 16004. CONTINUING ACCESS TO HOSPITALS ACT OF 2016.

(a) EXTENSION OF ENFORCEMENT INSTRUCTION ON SUPERVISION REQUIREMENTS FOR OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2016.—Section 1 of Public Law 113–198, as amended by section 1 of Public Law 114–112, is amended—

*(1) in the heading, by striking ''**2014 AND 2015**'' and inserting ''**2016**''; and*

(2) by striking ''and 2015'' and inserting '', 2015, and 2016''.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6)) shall submit to Congress a report analyzing the effect of the extension of the enforcement instruction under section 1 of Public Law 113–198, as amended by section 1 of Public Law 114–112 and subsection (a) of this section, on the access to health care by Medicare beneficiaries, on the economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries.

SEC. 16005. DELAY OF IMPLEMENTATION OF MEDICARE FEE SCHEDULE ADJUSTMENTS FOR WHEELCHAIR ACCESSORIES AND SEATING SYSTEMS WHEN USED IN CONJUNCTION WITH COMPLEX REHABILITATION TECHNOLOGY (CRT) WHEELCHAIRS.

Section 2(a) of the Patient Access and Medicare Protection Act (42 U.S.C. 1305 note) is amended by striking ''January 1, 2017'' and inserting ''July 1, 2017''.

SEC. 16006. ALLOWING PHYSICAL THERAPISTS TO UTILIZE LOCUM TENENS ARRANGEMENTS UNDER MEDICARE.

(a) IN GENERAL.—The first sentence of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)), as amended by section 5012, is further amended—

(1) by striking ''and'' before ''(I)''; and

(2) by inserting before the period at the end the following: '', and (J) in the case of outpatient physical therapy services furnished by physical therapists in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), a medically underserved area (as designated pursuant to section 330(b)(3)(A) of such Act), or a rural area (as defined in section 1886(d)(2)(D)), subparagraph (D) of this sentence shall apply to such services and therapists in the same manner as such subparagraph applies to physicians' services furnished by physicians''.

(b) EFFECTIVE DATE; IMPLEMENTATION.—

(1) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished beginning not later than six months after the date of the enactment of this Act.

(2) IMPLEMENTATION.—The Secretary of Health and Human Services may implement subparagraph (J) of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)), as added by subsection (a)(2), by program instruction or otherwise.

SEC. 16007. EXTENSION OF THE TRANSITION TO NEW PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall extend the transition period described in clause (i) of section 414.210(g)(9) of title 42, Code of Federal Regulations, from June 30, 2016, to December 31, 2016 (with the full implementation described in clause (ii) of such section applying to items and services furnished with dates of service on or after January 1, 2017).

(b) STUDY AND REPORT.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study that examines the impact of applicable payment adjustments upon—

(i) the number of suppliers of durable medical equipment that, on a date that is not before January 1, 2016, and not later than December 31, 2016, ceased to conduct business as such suppliers; and

(ii) the availability of durable medical equipment, during the period beginning on January 1, 2016, and ending on December 31, 2016, to individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or enrolled under part B of such title.

(B) DEFINITIONS.—For purposes of this subsection, the following definitions apply:

(i) SUPPLIER; DURABLE MEDICAL EQUIPMENT.—The terms ''supplier'' and ''durable medical equipment'' have the meanings given such terms by section 1861 of the Social Security Act (42 U.S.C. 1395x).

(ii) APPLICABLE PAYMENT ADJUSTMENT.—The term ''applicable payment adjustment'' means a payment adjustment described in section 414.210(g) of title 42, Code of Federal Regulations, that is phased in by paragraph (9)(i) of such section. For purposes of the preceding sentence, a payment adjustment that is phased in pursuant to the extension under subsection (a) shall be considered a payment adjustment that is phased in by such paragraph (9)(i).

(2) REPORT.—The Secretary of Health and Human Services shall, not later than January 12, 2017, submit to the Committees on Ways and Means and on Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a report on the findings of the study conducted under paragraph (1).

SEC. 16008. REQUIREMENTS IN DETERMINING ADJUSTMENTS USING INFORMATION FROM COMPETITIVE BIDDING PROGRAMS.

(a) IN GENERAL.—Section 1834(a)(1)(G) of the Social Security Act (42 U.S.C. 1395m(a)(1)(G)) is amended by adding at the end the following new sentence: ''In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1842(s)(3)(B), the Secretary shall—

''(i) solicit and take into account stakeholder input; and

''(ii) take into account the highest amount bid by a winning supplier in a competitive acquisition area and a comparison of each of the following with respect to non-competitive acquisition areas and competitive acquisition areas:

''(I) The average travel distance and cost associated with furnishing items and services in the area.

''(II) The average volume of items and services furnished by suppliers in the area.

''(III) The number of suppliers in the area.''.

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(1)(H)(ii) of the Social Security Act (42 U.S.C. 1395m(h)(1)(H)(ii)) is amended by striking ''the Secretary'' and inserting ''subject to subsection (a)(1)(G), the Secretary''.

(2) Section 1842(s)(3)(B) of the Social Security Act (42 U.S.C. 1395m(s)(3)(B)) is amended by striking ''the Secretary'' and inserting ''subject to section 1834(a)(1)(G), the Secretary''.

TITLE XVII—OTHER MEDICARE PROVISIONS

SEC. 17001. DELAY IN AUTHORITY TO TERMINATE CONTRACTS FOR MEDICARE ADVANTAGE PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.

(a) FINDINGS.—Consistent with the studies provided under the IMPACT Act of 2014 (Public Law 113–185), it is the intent of Congress—

(1) to continue to study and request input on the effects of socioeconomic status and dual-eligible populations on the Medicare Advantage STARS rating system before reforming such system with the input of stakeholders; and

(2) pending the results of such studies and input, to provide for a temporary delay in authority of the Centers for Medicare & Medicaid Services (CMS) to terminate Medicare Advantage plan contracts solely on the basis of performance of plans under the STARS rating system.

(b) DELAY IN MA CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATINGS.—Section 1857(h) of the Social Security Act (42 U.S.C. 1395w–27(h)) is amended by adding at the end the following new paragraph:

''(3) DELAY IN CONTRACT TERMINATION AUTHORITY FOR PLANS FAILING TO ACHIEVE MINIMUM QUALITY RATING.—During the period beginning on the date of the enactment of this paragraph and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1853(o)(4).''.

SEC. 17002. REQUIREMENT FOR ENROLLMENT DATA REPORTING FOR MEDICARE.

Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(g) REQUIREMENT FOR ENROLLMENT DATA REPORTING.—

''(1) IN GENERAL.—Each year (beginning with 2016), the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on Medicare enrollment data (and, in the case of part A, on data on individuals receiving benefits under such part) as of a date in such year specified by the Secretary. Such data shall be presented—

''(A) by Congressional district and State; and

''(B) in a manner that provides for such data based on—

''(i) fee-for-service enrollment (as defined in paragraph (2));

''(ii) enrollment under part C (including separate for aggregate enrollment in MA–PD plans and aggregate enrollment in MA plans that are not MA–PD plans); and

''(iii) enrollment under part D.

''(2) FEE-FOR-SERVICE ENROLLMENT DEFINED.—For purpose of paragraph (1)(B)(i), the term 'fee-for-service enrollment' means aggregate enrollment (including receipt of benefits other than through enrollment) under—

''(A) part A only;

''(B) part B only; and

''(C) both part A and part B.''.

SEC. 17003. UPDATING THE WELCOME TO MEDICARE PACKAGE.

(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w–21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w–101 et seq.)). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

(b) REQUEST FOR INFORMATION.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.

SEC. 17004. NO PAYMENT FOR ITEMS AND SERVICES FURNISHED BY NEWLY ENROLLED PROVIDERS OR SUPPLIERS WITHIN A TEMPORARY MORATORIUM AREA.

(a) MEDICARE.—Section 1866(j)(7) of the Social Security Act (42 U.S.C. 1395cc(j)(7)) is amended—

(1) in the paragraph heading, by inserting ''; NONPAYMENT'' before the period; and

(2) by adding at the end the following new subparagraph:

''(C) NONPAYMENT.—

''(i) IN GENERAL.—No payment may be made under this title or under a program described in subparagraph (A) with respect to an item or service described in clause (ii) furnished on or after October 1, 2017.

''(ii) ITEM OR SERVICE DESCRIBED.—An item or service described in this clause is an item or service furnished—

''(I) within a geographic area with respect to which a temporary moratorium imposed under subparagraph (A) is in effect; and

''(II) by a provider of services or supplier that meets the requirements of clause (iii).

''(iii) REQUIREMENTS.—For purposes of clause (ii), the requirements of this clause are that a provider of services or supplier—

''(I) enrolls under this title on or after the effective date of such temporary moratorium; and

''(II) is within a category of providers of services and suppliers (as described in subparagraph (A)) subject to such temporary moratorium.

''(iv) PROHIBITION ON CHARGES FOR SPECIFIED ITEMS OR SERVICES.—In no case shall a provider of services or supplier described in clause (ii)(II) charge an individual or other person for an item or service described in clause (ii) furnished on or after October 1, 2017, to an individual entitled to benefits under part A or enrolled under part B or an individual under a program specified in subparagraph (A).''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—

(A) IN GENERAL.—Section 1903(i)(2) of the Social Security Act (42 U.S.C. 1396b(i)(2)), as amended by section 5005(a)(4), is further amended—

(i) in subparagraph (C), by striking ''or'' at the end; and

(ii) by adding at the end the following new subparagraph:

''(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1902(kk)(4)(A)(ii)(II), within a geographic area that is subject to a moratorium imposed under section 1866(j)(7) by a provider or supplier that meets the requirements specified in subparagraph (C)(iii) of such section, during the period of such moratorium; or''.

(B) EXCEPTION WITH RESPECT TO ACCESS.—Section 1902(kk)(4)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(kk)(4)(A)(ii)) is amended to read as follows:

''(ii) EXCEPTIONS.—

''(I) COMPLIANCE WITH MORATORIUM.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

''(II) FFP AVAILABLE.—Notwithstanding section 1903(i)(2)(E), payment may be made to a State under this title with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this title (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.''.

(C) STATE PLAN REQUIREMENT WITH RESPECT TO LIMITATION ON CHARGES TO BENEFICIARIES.—Section 1902(kk)(4)(A) of the Social Security Act (42 U.S.C. 1396a(kk)(4)(A)) is amended by adding at the end the following new clause:

''(iii) LIMITATION ON CHARGES TO BENEFICIARIES.—With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1866(j)(7) from charging an individual or other person eligible to receive medical assistance under the State plan under this title (or a waiver of the plan) for an item or service described in section 1903(i)(2)(E) furnished to such an individual.''.

(2) CORRECTING AMENDMENTS TO RELATED PROVISIONS.—

(A) SECTION 1866(J).—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(i) in paragraph (1)(A)—

(I) by striking ''paragraph (4)'' and inserting ''paragraph (5)'';

(II) by striking ''moratoria in accordance with paragraph (5)'' and inserting ''moratoria in accordance with paragraph (7)''; and

(III) by striking ''paragraph (6)'' and inserting ''paragraph (9)''; and

(ii) by redesignating the second paragraph (8) (redesignated by section 1304(1) of Public Law 111–152) as paragraph (9).

(B) SECTION 1902(KK).—Section 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is amended—

(i) in paragraph (1), by striking ''section 1886(j)(2)'' and inserting ''section 1866(j)(2)'';

(ii) in paragraph (2), by striking ''section 1886(j)(3)'' and inserting ''section 1866(j)(3)'';

(iii) in paragraph (3), by striking ''section 1886(j)(4)'' and inserting ''section 1866(j)(5)''; and

(iv) in paragraph (4)(A), by striking ''section 1886(j)(6)'' and inserting ''section 1866(j)(7)''.

SEC. 17005. PRESERVATION OF MEDICARE BENEFICIARY CHOICE UNDER MEDICARE ADVANTAGE.

Section 1851(e)(2) of the Social Security Act (42 U.S.C. 1395w–21(e)(2)) is amended—

(1) in subparagraph (C)—

(A) in the heading, by inserting ''FROM 2011 THROUGH 2018'' after ''45-DAY PERIOD''; and

(B) by inserting ''and ending with 2018'' after ''beginning with 2011''; and

(2) by adding at the end the following new subparagraph:

''(G) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN 2016 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D)—

''(I) in the case of an MA eligible individual who is enrolled in an MA plan, at any time during the first 3 months of a year (beginning with 2019); or

''(II) in the case of an individual who first becomes an MA eligible individual during a year (beginning with 2019) and enrolls in an MA plan, during the first 3 months during such year in which the individual is an MA eligible individual;

such MA eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF ONE CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may change the election pursuant to clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

''(iii) LIMITED APPLICATION TO PART D.—Clauses (i) and (ii) of this subparagraph shall only apply with respect to changes in enrollment in a prescription drug plan under part D in the case of an individual who, previous to such change in enrollment, is enrolled in a Medicare Advantage plan.

''(iv) LIMITATIONS ON MARKETING.—Pursuant to subsection (j), no unsolicited marketing or marketing materials may be sent to an individual described in clause (i) during the continuous open enrollment and disenrollment period established for the individual under such clause, notwithstanding marketing guidelines established by the Centers for Medicare & Medicaid Services.''.

SEC. 17006. ALLOWING END-STAGE RENAL DISEASE BENEFICIARIES TO CHOOSE A MEDICARE ADVANTAGE PLAN.

(a) REMOVING PROHIBITION.—

(1) IN GENERAL.—Section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)) is amended—

(A) by striking subparagraph (B); and

(B) by striking ''ELIGIBLE INDIVIDUAL'' and all that follows through ''In this title, subject to subparagraph (B),'' and inserting ''ELIGIBLE INDIVIDUAL.—In this title,''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1852(b)(1) of the Social Security Act (42 U.S.C. 1395w–22(b)(1)) is amended—

(i) by striking subparagraph (B); and

(ii) by striking ''BENEFICIARIES'' and all that follows through ''A Medicare+Choice organization'' and inserting ''BENEFICIARIES.—A Medicare Advantage organization''.

(B) Section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) is amended, in the last sentence, by striking ''may waive'' and all that follows through ''subparagraph and''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(b) EXCLUDING COSTS FOR KIDNEY ACQUISITIONS FROM MA BENCHMARK.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (k)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''paragraphs (2) and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

(ii) in subparagraph (B)(i), by striking ''paragraphs (2) and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

(B) by adding at the end the following new paragraph:

''(5) EXCLUSION OF COSTS FOR KIDNEY ACQUISITIONS FROM CAPITATION RATES.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d)) in the area for the year.''; and

(2) in subsection (n)(2)—

(A) in subparagraph (A)(i), by inserting ''and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)'' before the semicolon at the end;

(B) in subparagraph (E), in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (G)''; and

(C) by adding at the end the following new subparagraph:

''(G) APPLICATION OF KIDNEY ACQUISITIONS ADJUSTMENT.—The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.''.

(c) FFS COVERAGE OF KIDNEY ACQUISITIONS.—

(1) IN GENERAL.—Section 1852(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)(i)) is amended by inserting ''or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)'' after ''hospice care''.

(2) CONFORMING AMENDMENT.—Section 1851(i) of the Social Security Act (42 U.S.C. 1395w–21(i)) is amended by adding at the end the following new paragraph:

''(3) FFS PAYMENT FOR EXPENSES FOR KIDNEY ACQUISITIONS.—Paragraphs (1) and (2) shall not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(d) EVALUATION OF QUALITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an evaluation of whether the 5-star rating system based on the data collected under section 1852(e) of the Social Security Act (42 U.S.C. 1395w–22(e)) should include a quality measure specifically related to care for enrollees in Medicare Advantage plans under part C of title XVIII of such Act determined to have end-stage renal disease.

(2) PUBLIC AVAILABILITY.—Not later than April 1, 2020, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services the results of the evaluation under paragraph (1).

(e) REPORT.—Not later than December 31, 2023, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall submit to Congress a report on the impact of the provisions of, and amendments made by, this section with respect to the following:

(1) Spending under—

(A) the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act; and

(B) the Medicare Advantage program under part C of such title.

(2) The number of enrollees determined to have end-stage renal disease—

(A) in the original Medicare fee-for-service program; and

(B) in the Medicare Advantage program.

(3) The sufficiency of the amount of data under the original Medicare fee-for-service program for individuals determined to have end-stage renal disease for purposes of determining payment rates for end-stage renal disease under the Medicare Advantage program.

(f) IMPROVEMENTS TO RISK ADJUSTMENT UNDER MEDICARE ADVANTAGE.—

(1) IN GENERAL.—Section 1853(a)(1) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)) is amended—

(A) in subparagraph (C)(i), by striking ''The Secretary'' and inserting ''Subject to subparagraph (I), the Secretary''; and

(B) by adding at the end the following new subparagraph:

''(I) IMPROVEMENTS TO RISK ADJUSTMENT FOR 2019 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

''(I) TAKING INTO ACCOUNT TOTAL NUMBER OF DISEASES OR CONDITIONS.—The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

''(II) USING AT LEAST 2 YEARS OF DIAGNOSTIC DATA.—The Secretary may use at least 2 years of diagnosis data.

''(III) PROVIDING SEPARATE ADJUSTMENTS FOR DUAL ELIGIBLE INDIVIDUALS.—With respect to individuals who are dually eligible for benefits under this title and title XIX, the Secretary shall make separate adjustments for each of the following:

''(aa) Full-benefit dual eligible individuals (as defined in section 1935(c)(6)).

''(bb) Such individuals not described in item (aa).

''(IV) EVALUATION OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS.—The Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.

''(V) EVALUATION OF CHRONIC KIDNEY DISEASE.—The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model.

''(VI) EVALUATION OF PAYMENT RATES FOR END-STAGE RENAL DISEASE.—The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

''(ii) PHASED-IN IMPLEMENTATION.—The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

''(iii) OPPORTUNITY FOR REVIEW AND PUBLIC COMMENT.—The Secretary shall provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.''.

(2) STUDIES AND REPORTS.—

(A) REPORTS ON THE RISK ADJUSTMENT SYSTEM.—

(i) MEDPAC EVALUATION AND REPORT.—

(I) EVALUATION.—The Medicare Payment Advisory Commission shall conduct an evaluation of the impact of the provisions of, and amendments made by, this section on risk scores for enrollees in Medicare Advantage plans under part C of title XVIII of the Social Security Act and payments to Medicare Advantage plans under such part, including the impact of such provisions and amendments on the overall accuracy of risk scores under the Medicare Advantage program.

(II) REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory Commission shall submit to Congress a report on the evaluation under subclause (I), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(ii) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than December 31, 2018, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the risk adjustment model and the ESRD risk adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act, including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees.

(B) STUDY AND REPORT ON FUNCTIONAL STATUS.—

(i) STUDY.—The Comptroller General of the United States (in this subparagraph referred to as the ''Comptroller General'') shall conduct a study on how to most accurately measure the functional status of enrollees in Medicare Advantage plans and whether the use of such functional status would improve the accuracy of risk adjustment payments under the Medicare Advantage program under part C of title XVIII of the Social Security Act. Such study shall include an analysis of the challenges in collecting and reporting functional status information for Medicare Advantage plans under such part, providers of services and suppliers under the Medicare program, and the Centers for Medicare & Medicaid Services.

(ii) REPORT.—Not later than June 30, 2018, the Comptroller General shall submit to Congress a report containing the results of the study under clause (i), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 17007. IMPROVEMENTS TO THE ASSIGNMENT OF BENEFICIARIES UNDER THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899(c) of the Social Security Act (42 U.S.C. 1395jjj(c)) is amended—

(1) by striking ''utilization of primary'' and inserting ''utilization of—

''(1) in the case of performance years beginning on or after April 1, 2012, primary'';

(2) in paragraph (1), as added by paragraph (1) of this section, by striking the period at the end and inserting ''; and'';

(3) by adding at the end the following new paragraph:

''(2) in the case of performance years beginning on or after January 1, 2019, services provided under this title by a Federally qualified health center or rural health clinic (as those terms are defined in section 1861(aa)), as may be determined by the Secretary.''.

TITLE XVIII—OTHER PROVISIONS

SEC. 18001. EXCEPTION FROM GROUP HEALTH PLAN REQUIREMENTS FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.

(a) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986 AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.—

(1) IN GENERAL.—Section 9831 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) EXCEPTION FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this title (except as provided in section 4980I(f)(4) and notwithstanding any other provision of this title), the term 'group health plan' shall not include any qualified small employer health reimbursement arrangement.

''(2) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified small employer health reimbursement arrangement' means an arrangement which—

''(i) is described in subparagraph (B), and

''(ii) is provided on the same terms to all eligible employees of the eligible employer.

''(B) ARRANGEMENT DESCRIBED.—An arrangement is described in this subparagraph if—

''(i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,

''(ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement), and

''(iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed $4,950 ($10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

''(C) CERTAIN VARIATION PERMITTED.—For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee's permitted benefit under such arrangement varies in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

''(i) the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee's family members, the age of such family members), or

''(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

''(D) RULES RELATING TO MAXIMUM DOLLAR LIMITATION.—

''(i) AMOUNT PRORATED IN CERTAIN CASES.—In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (B)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (B)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

''(ii) INFLATION ADJUSTMENT.—In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (B)(iii) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of $50, such dollar amount shall be rounded to the next lowest multiple of $50.

''(3) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting '90 days' for '3 years' in clause (i) thereof).

''(B) ELIGIBLE EMPLOYER.—The term 'eligible employer' means an employer that—

''(i) is not an applicable large employer as defined in section 4980H(c)(2), and

''(ii) does not offer a group health plan to any of its employees.

''(C) PERMITTED BENEFIT.—The term 'permitted benefit' means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health reimbursement arrangement for the year with respect to such employee.

''(4) NOTICE.—

''(A) IN GENERAL.—An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible), provide a written notice to each eligible employee which includes the information described in subparagraph (B).

''(B) CONTENTS OF NOTICE.—The notice required under subparagraph (A) shall include each of the following:

''(i) A statement of the amount which would be such eligible employee's permitted benefit under the arrangement for the year.

''(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

''(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.''.

(2) LIMITATION ON EXCLUSION FROM GROSS INCOME.—Section 106 of such Code is amended by adding at the end the following:

''(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).''.

(3) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—Section 36B(c) of such Code is amended by adding at the end the following new paragraph:

''(4) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

''(A) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

''(B) DENIAL OF DOUBLE BENEFIT.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

''(C) AFFORDABLE COVERAGE.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

''(i) the excess of—

''(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

''(II) 1/12 of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

''(ii) 1/12 of 9.5 percent of the employee's household income.

''(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term 'qualified small employer health reimbursement arrangement' has the meaning given such term by section 9831(d)(2).

''(E) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting 'the number of months during the year for which such arrangement was provided' for '12'.

''(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).''.

(4) APPLICATION OF EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.—

(A) IN GENERAL.—Section 4980I(f)(4) of such Code is amended by adding at the end the following: ''Section 9831(d)(1) shall not apply for purposes of this section.''.

(B) DETERMINATION OF COST OF COVERAGE.—Section 4980I(d)(2) of such Code is amended by redesignating subparagraph (D) as subparagraph (E) and by inserting after subparagraph (C) the following new subparagraph:

''(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of applicable employer-sponsored coverage consisting of coverage under any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)), the cost of coverage shall be equal to the amount described in section 6051(a)(15).''.

(5) ENFORCEMENT OF NOTICE REQUIREMENT.—Section 6652 of such Code is amended by adding at the end the following new subsection:

''(o) FAILURE TO PROVIDE NOTICES WITH RESPECT TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of each failure to provide a written notice as required by section 9831(d)(4), unless it is shown that such failure is due to reasonable cause and not willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written notice, an amount equal to $50 per employee per incident of failure to provide such notice, but the total amount imposed on such person for all such failures during any calendar year shall not exceed $2,500.''.

(6) REPORTING.—

(A) W–2 REPORTING.—Section 6051(a) of such Code is amended by striking ''and'' at the end of paragraph (13), by striking the period at the end of paragraph (14) and inserting '', and'', and by inserting after paragraph (14) the following new paragraph:

''(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee.''.

(B) INFORMATION REQUIRED TO BE PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—Section 1411(b)(3) of the Patient Protection and Affordable Care Act is amended by redesignating subparagraph (B) as subparagraph (C) and by inserting after subparagraph (A) the following new subparagraph:

''(B) CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES OBTAINED THROUGH SMALL EMPLOYERS.—The amount of the enrollee's permitted benefit (as defined in section 9831(d)(3)(C) of the Internal Revenue Code of 1986) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such Code).''.

(7) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amendments made by this subsection shall apply to years beginning after December 31, 2016.

(B) TRANSITION RELIEF.—The relief under Treasury Notice 2015–17 shall be treated as applying to any plan year beginning on or before December 31, 2016.

(C) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—The amendments made by paragraph (3) shall apply to taxable years beginning after December 31, 2016.

(D) EMPLOYEE NOTICE.—

(i) IN GENERAL.—The amendments made by paragraph (5) shall apply to notices with respect to years beginning after December 31, 2016.

(ii) TRANSITION RELIEF.—For purposes of section 6652(o) of the Internal Revenue Code of 1986 (as added by this Act), a person shall not be treated as failing to provide a written notice as required by section 9831(d)(4) of such Code if such notice is so provided not later than 90 days after the date of the enactment of this Act.

(E) W–2 REPORTING.—The amendments made by paragraph (6)(A) shall apply to calendar years beginning after December 31, 2016.

(F) INFORMATION PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—

(i) IN GENERAL.—The amendments made by paragraph (6)(B) shall apply to applications for enrollment made after December 31, 2016.

(ii) VERIFICATION.—Verification under section 1411 of the Patient Protection and Affordable Care Act of information provided under section 1411(b)(3)(B) of such Act shall apply with respect to months beginning after October 2016.

(iii) TRANSITIONAL RELIEF.—In the case of an application for enrollment under section 1411(b) of the Patient Protection and Affordable Care Act made before April 1, 2017, the requirement of section 1411(b)(3)(B) of such Act shall be treated as met if the information described therein is provided not later than 30 days after the date on which the applicant receives the notice described in section 9831(d)(4) of the Internal Revenue Code of 1986.

(8) SUBSTANTIATION REQUIREMENTS.—The Secretary of the Treasury (or his designee) may issue substantiation requirements as necessary to carry out this subsection.

(b) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following: ''Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).''.

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS, ETC.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended by adding at the end the following: ''Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2016.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by adding at the end the following: ''Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).''.

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS.—Section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1)) is amended by adding at the end the following: ''Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2016.

TITLE XIX—INVESTING IN PREVENTION AND FAMILY SERVICES

SEC. 19001. PURPOSE.

The purpose of this title is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services.

Subtitle A—Prevention Activities Under Title IV–E

SEC. 19011. FOSTER CARE PREVENTION SERVICES AND PROGRAMS.

(a) STATE OPTION.—Section 471 of the Social Security Act (42 U.S.C. 671) is amended—

(1) in subsection (a)(1), by striking ''and'' and all that follows through the semicolon and inserting '', adoption assistance in accordance with section 473, and, at the option of the State, services or programs specified in subsection (e)(1) of this section for children who are candidates for foster care or who are pregnant or parenting foster youth and the parents or kin caregivers of the children, in accordance with the requirements of that subsection;''; and

(2) by adding at the end the following:

''(e) PREVENTION AND FAMILY SERVICES AND PROGRAMS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary may make a payment to a State for providing the following services or programs for a child described in paragraph (2) and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:

''(A) MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child.

''(B) IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.

''(2) CHILD DESCRIBED.—For purposes of paragraph (1), a child described in this paragraph is the following:

''(A) A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1).

''(B) A child in foster care who is a pregnant or parenting foster youth.

''(3) DATE DESCRIBED.—For purposes of paragraph (1), the dates described in this paragraph are the following:

''(A) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a child who is a candidate for foster care (as defined in section 475(13)).

''(B) The date on which a child is identified in a prevention plan maintained under paragraph (4) as a pregnant or parenting foster youth in need of services or programs specified in paragraph (1).

''(4) REQUIREMENTS RELATED TO PROVIDING SERVICES AND PROGRAMS.—Services and programs specified in paragraph (1) may be provided under this subsection only if specified in advance in the child's prevention plan described in subparagraph (A) and the requirements in subparagraphs (B) through (E) are met:

''(A) PREVENTION PLAN.—The State maintains a written prevention plan for the child that meets the following requirements (as applicable):

''(i) CANDIDATES.—In the case of a child who is a candidate for foster care described in paragraph (2)(A), the prevention plan shall—

''(I) identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;

''(II) list the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and

''(III) comply with such other requirements as the Secretary shall establish.

''(ii) PREGNANT OR PARENTING FOSTER YOUTH.—In the case of a child who is a pregnant or parenting foster youth described in paragraph (2)(B), the prevention plan shall—

''(I) be included in the child's case plan required under section 475(1);

''(II) list the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent;

''(III) describe the foster care prevention strategy for any child born to the youth; and

''(IV) comply with such other requirements as the Secretary shall establish.

''(B) TRAUMA-INFORMED.—The services or programs to be provided to or on behalf of a child are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

''(C) ONLY SERVICES AND PROGRAMS PROVIDED IN ACCORDANCE WITH PROMISING, SUPPORTED, OR WELL-SUPPORTED PRACTICES PERMITTED.—

''(i) IN GENERAL.—Only State expenditures for services or programs specified in subparagraph (A) or (B) of paragraph (1) that are provided in accordance with practices that meet the requirements specified in clause (ii) of this subparagraph and that meet the requirements specified in clause (iii), (iv), or (v), respectively, for being a promising, supported, or well-supported practice, shall be eligible for a Federal matching payment under section 474(a)(6)(A).

''(ii) GENERAL PRACTICE REQUIREMENTS.—The general practice requirements specified in this clause are the following:

''(I) The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.

''(II) There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

''(III) If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice.

''(IV) Outcome measures are reliable and valid, and are administrated consistently and accurately across all those receiving the practice.

''(V) There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

''(iii) PROMISING PRACTICE.—A practice shall be considered to be a 'promising practice' if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

''(I) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; and

''(II) utilized some form of control (such as an untreated group, a placebo group, or a wait list study).

''(iv) SUPPORTED PRACTICE.—A practice shall be considered to be a 'supported practice' if—

''(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that—

''(aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

''(bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and

''(cc) was carried out in a usual care or practice setting; and

''(II) the study described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

''(v) WELL-SUPPORTED PRACTICE.—A practice shall be considered to be a 'well-supported practice' if—

''(I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that—

''(aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;

''(bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and

''(cc) were carried out in a usual care or practice setting; and

''(II) at least one of the studies described in subclause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment.

''(D) GUIDANCE ON PRACTICES CRITERIA AND PRE-APPROVED SERVICES AND PROGRAMS.—

''(i) IN GENERAL.—Not later than October 1, 2018, the Secretary shall issue guidance to States regarding the practices criteria required for services or programs to satisfy the requirements of subparagraph (C). The guidance shall include a pre-approved list of services and programs that satisfy the requirements.

''(ii) UPDATES.—The Secretary shall issue updates to the guidance required by clause (i) as often as the Secretary determines necessary.

''(E) OUTCOME ASSESSMENT AND REPORTING.—The State shall collect and report to the Secretary the following information with respect to each child for whom, or on whose behalf mental health and substance abuse prevention and treatment services or in-home parent skill-based programs are provided during a 12-month period beginning on the date the child is determined by the State to be a child described in paragraph (2):

''(i) The specific services or programs provided and the total expenditures for each of the services or programs.

''(ii) The duration of the services or programs provided.

''(iii) In the case of a child described in paragraph (2)(A), the child's placement status at the beginning, and at the end, of the 1-year period, respectively, and whether the child entered foster care within 2 years after being determined a candidate for foster care.

''(5) STATE PLAN COMPONENT.—

''(A) IN GENERAL.—A State electing to provide services or programs specified in paragraph (1) shall submit as part of the State plan required by subsection (a) a prevention services and programs plan component that meets the requirements of subparagraph (B).

''(B) PREVENTION SERVICES AND PROGRAMS PLAN COMPONENT.—In order to meet the requirements of this subparagraph, a prevention services and programs plan component, with respect to each 5-year period for which the plan component is in operation in the State, shall include the following:

''(i) How providing services and programs specified in paragraph (1) is expected to improve specific outcomes for children and families.

''(ii) How the State will monitor and oversee the safety of children who receive services and

programs specified in paragraph (1), including through periodic risk assessments throughout the period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph (4) for the provision of the services or programs if the State determines the risk of the child entering foster care remains high despite the provision of the services or programs.

''(iii) With respect to the services and programs specified in subparagraphs (A) and (B) of paragraph (1), information on the specific promising, supported, or well-supported practices the State plans to use to provide the services or programs, including a description of—

''(I) the services or programs and whether the practices used are promising, supported, or well-supported;

''(II) how the State plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;

''(III) how the State selected the services or programs;

''(IV) the target population for the services or programs; and

''(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary.

''(iv) A description of the consultation that the State agencies responsible for administering the State plans under this part and part B engage in with other State agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph (2) and their parents or kin caregivers.

''(v) A description of how the State shall assess children and their parents or kin caregivers to determine eligibility for services or programs specified in paragraph (1).

''(vi) A description of how the services or programs specified in paragraph (1) that are provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the State plan under part B.

''(vii) Descriptions of steps the State is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—

''(I) ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and

''(II) developing appropriate prevention plans, and conducting the risk assessments required under clause (iii).

''(viii) A description of how the State will provide training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.

''(ix) A description of how caseload size and type for prevention caseworkers will be determined, managed, and overseen.

''(x) An assurance that the State will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph (1), including information and data necessary to determine the performance measures for the State under paragraph (6) and compliance with paragraph (7).

''(C) REIMBURSEMENT FOR SERVICES UNDER THE PREVENTION PLAN COMPONENT.—

''(i) LIMITATION.—Except as provided in subclause (ii), a State may not receive a Federal payment under this part for a given promising, supported, or well-supported practice unless (in accordance with subparagraph (B)(iii)(V)) the plan includes a well-designed and rigorous evaluation strategy for that practice.

''(ii) WAIVER OF LIMITATION.—The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice.

''(6) PREVENTION SERVICES MEASURES.—

''(A) ESTABLISHMENT; ANNUAL UPDATES.—Beginning with fiscal year 2021, and annually thereafter, the Secretary shall establish the following prevention services measures based on information and data reported by States that elect to provide services and programs specified in paragraph (1):

''(i) PERCENTAGE OF CANDIDATES FOR FOSTER CARE WHO DO NOT ENTER FOSTER CARE.—The percentage of candidates for foster care for whom, or on whose behalf, the services or programs are provided who do not enter foster care, including those placed with a kin caregiver outside of foster care, during the 12-month period in which the services or programs are provided and through the end of the succeeding 12-month-period.

''(ii) PER-CHILD SPENDING.—The total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skill-based programs, respectively, for, or on behalf of, each child described in paragraph (2).

''(B) DATA.—The Secretary shall establish and annually update the prevention services measures—

''(i) based on the median State values of the information reported under each clause of subparagraph (A) for the 3 then most recent years; and

''(ii) taking into account State differences in the price levels of consumption goods and services using the most recent regional price parities published by the Bureau of Economic Analysis of the Department of Commerce or such other data as the Secretary determines appropriate.

''(C) PUBLICATION OF STATE PREVENTION SERVICES MEASURES.—The Secretary shall annually make available to the public the prevention services measures of each State.

''(7) MAINTENANCE OF EFFORT FOR STATE FOSTER CARE PREVENTION EXPENDITURES.—

''(A) IN GENERAL.—If a State elects to provide services and programs specified in paragraph (1) for a fiscal year, the State foster care prevention expenditures for the fiscal year shall not be less than the amount of the expenditures for fiscal year 2014 (or, at the option of a State described in subparagraph (E), fiscal year 2015 or fiscal year 2016 (whichever the State elects)).

''(B) STATE FOSTER CARE PREVENTION EXPENDITURES.—The term 'State foster care prevention expenditures' means the following:

''(i) TANF; IV–B; SSBG.—State expenditures for foster care prevention services and activities under the State program funded under part A (including from amounts made available by the Federal Government), under the State plan developed under part B (including any such amounts), or under the Social Services Block Grant Programs under subtitle A of title XX (including any such amounts).

''(ii) OTHER STATE PROGRAMS.—State expenditures for foster care prevention services and activities under any State program that is not described in clause (i) (other than any State expenditures for foster care prevention services and activities under the State program under this part (including under a waiver of the program)).

''(C) STATE EXPENDITURES.—The term 'State expenditures' means all State or local funds that are expended by the State or a local agency including State or local funds that are matched or reimbursed by the Federal Government and State or local funds that are not matched or reimbursed by the Federal Government.

''(D) DETERMINATION OF PREVENTION SERVICES AND ACTIVITIES.—The Secretary shall require each State that elects to provide services and programs specified in paragraph (1) to report the expenditures specified in subparagraph (B) for fiscal year 2014 and for such fiscal years thereafter as are necessary to determine whether the State is complying with the maintenance of effort requirement in subparagraph (A). The Secretary shall specify the specific services and activities under each program referred to in subparagraph (B) that are 'prevention services and activities' for purposes of the reports.

''(E) STATE DESCRIBED.—For purposes of subparagraph (A), a State is described in this subparagraph if the population of children in the State in 2014 was less than 200,000 (as determined by the Bureau of the Census).

''(8) PROHIBITION AGAINST USE OF STATE FOSTER CARE PREVENTION EXPENDITURES AND FEDERAL IV–E PREVENTION FUNDS FOR MATCHING OR EXPENDITURE REQUIREMENT.—A State that elects to provide services and programs specified in paragraph (1) shall not use any State foster care prevention expenditures for a fiscal year for the State share of expenditures under section 474(a)(6) for a fiscal year.

''(9) ADMINISTRATIVE COSTS.—Expenditures described in section 474(a)(6)(B)—

''(A) shall not be eligible for payment under subparagraph (A), (B), or (E) of section 474(a)(3); and

''(B) shall be eligible for payment under section 474(a)(6)(B) without regard to whether the expenditures are incurred on behalf of a child who is, or is potentially, eligible for foster care maintenance payments under this part.

''(10) APPLICATION.—

''(A) IN GENERAL.—The provision of services or programs under this subsection to or on behalf of a child described in paragraph (2) shall not be considered to be receipt of aid or assistance under the State plan under this part for purposes of eligibility for any other program established under this Act.

''(B) CANDIDATES IN KINSHIP CARE.—A child described in paragraph (2) for whom such services or programs under this subsection are provided for more than 6 months while in the home of a kin caregiver, and who would satisfy the AFDC eligibility requirement of section 472(a)(3)(A)(ii)(II) but for residing in the home of the caregiver for more than 6 months, is deemed to satisfy that requirement for purposes of determining whether the child is eligible for foster care maintenance payments under section 472.''.

(b) DEFINITION.—Section 475 of such Act (42 U.S.C. 675) is amended by adding at the end the following:

''(13) The term 'child who is a candidate for foster care' means, a child who is identified in a prevention plan under section 471(e)(4)(A) as being at imminent risk of entering foster care (without regard to whether the child would be eligible for foster care maintenance payments under section 472 or is or would be eligible for adoption assistance or kinship guardianship assistance payments under section 473) but who can remain safely in the child's home or in a kinship placement as long as services or programs specified in section 471(e)(1) that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.''.

(c) PAYMENTS UNDER TITLE IV–E.—Section 474(a) of such Act (42 U.S.C. 674(a)) is amended—

(1) in paragraph (5), by striking the period at the end and inserting ''; plus''; and

(2) by adding at the end the following:

''(6) subject to section 471(e)—

''(A) for each quarter—

''(i) subject to clause (ii)—

''(I) beginning after September 30, 2019, and before October 1, 2025, an amount equal to 50 percent of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C); and

''(II) beginning after September 30, 2025, an amount equal to the Federal medical assistance percentage (which shall be as defined in section 1905(b), in the case of a State other than the District of Columbia, or 70 percent, in the case of the District of Columbia) of the total amount expended during the quarter for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C) (or, with respect to the payments made during the quarter under a cooperative agreement or contract entered into by the State and an Indian tribe, tribal organization, or tribal consortium for the administration or payment of funds under this part, an amount equal to the Federal medical assistance percentage that would apply under section 479B(d) (in this paragraph referred to as the 'tribal FMAP') if the Indian tribe, tribal organization, or tribal consortium made the payments under a program operated under that section, unless the tribal FMAP is less than the Federal medical assistance percentage that applies to the State); except that

''(ii) not less than 50 percent of the total amount payable to a State under clause (i) for a fiscal year shall be for the provision of services or programs specified in subparagraph (A) or (B) of section 471(e)(1) that are provided in accordance with well-supported practices; plus

''(B) for each quarter specified in subparagraph (A), an amount equal to the sum of the following proportions of the total amount expended during the quarter:

''(i) 50 percent of so much of the expenditures as are found necessary by the Secretary for the proper and efficient administration of the State plan for the provision of services or programs specified in section 471(e)(1), including expenditures for activities approved by the Secretary that promote the development of necessary processes and procedures to establish and implement the provision of the services and programs for individuals who are eligible for the services and programs and expenditures attributable to data collection and reporting; and

''(ii) 50 percent of so much of the expenditures with respect to the provision of services and programs specified in section 471(e)(1) as are for training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision and of the members of the staff of State-licensed or State-approved child welfare agencies providing services to children described in section 471(e)(2) and their parents or kin caregivers, including on how to determine who are individuals eligible for the services or programs, how to identify and provide appropriate services and programs, and how to oversee and evaluate the ongoing appropriateness of the services and programs.''.

(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, AND DATA COLLECTION AND EVALUATIONS.—Section 476 of such Act (42 U.S.C. 676) is amended by adding at the end the following:

''(d) TECHNICAL ASSISTANCE AND BEST PRACTICES, CLEARINGHOUSE, DATA COLLECTION, AND EVALUATIONS RELATING TO PREVENTION SERVICES AND PROGRAMS.—

''(1) TECHNICAL ASSISTANCE AND BEST PRACTICES.—The Secretary shall provide to States and, as applicable, to Indian tribes, tribal organizations, and tribal consortia, technical assistance regarding the provision of services and programs described in section 471(e)(1) and shall disseminate best practices with respect to the provision of the services and programs, including how to plan and implement a well-designed and rigorous evaluation of a promising, supported, or well-supported practice.

''(2) CLEARINGHOUSE OF PROMISING, SUPPORTED, AND WELL-SUPPORTED PRACTICES.—The Secretary shall, directly or through grants, contracts, or interagency agreements, evaluate research on the practices specified in clauses (iii), (iv), and (v), respectively, of section 471(e)(4)(C), and programs that meet the requirements described in section 427(a)(1), including culturally specific, or location- or population-based adaptations of the practices, to identify and establish a public clearinghouse of the practices that satisfy each category described by such clauses. In addition, the clearinghouse shall include information on the specific outcomes associated with each practice, including whether the practice has been shown to prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.

''(3) DATA COLLECTION AND EVALUATIONS.—The Secretary, directly or through grants, contracts, or interagency agreements, may collect data and conduct evaluations with respect to the provision of services and programs described in section 471(e)(1) for purposes of assessing the extent to which the provision of the services and programs—

''(A) reduces the likelihood of foster care placement;

''(B) increases use of kinship care arrangements; or

''(C) improves child well-being.

''(4) REPORTS TO CONGRESS.—

''(A) IN GENERAL.—The Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives periodic reports based on the provision of services and programs described in section 471(e)(1) and the activities carried out under this subsection.

''(B) PUBLIC AVAILABILITY.—The Secretary shall make the reports to Congress submitted under this paragraph publicly available.

''(5) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary $1,000,000 for fiscal year 2017 and each fiscal year thereafter to carry out this subsection.''.

(e) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—

(1) IN GENERAL.—Section 479B of such Act (42 U.S.C. 679c) is amended—

(A) in subsection (c)(1)—

(i) in subparagraph (C)(i)—

(I) in subclause (II), by striking ''and'' after the semicolon;

(II) in subclause (III), by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following:

''(IV) at the option of the tribe, organization, or consortium, services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers, in accordance with section 471(e) and subparagraph (E).''; and

(ii) by adding at the end the following:

''(E) PREVENTION SERVICES AND PROGRAMS FOR CHILDREN AND THEIR PARENTS AND KIN CAREGIVERS.—

''(i) IN GENERAL.—In the case of a tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1) to children described in section 471(e)(2) and their parents or kin caregivers under the plan, the Secretary shall specify the requirements applicable to the provision of the services and programs. The requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to States under section 471(e) and shall permit the provision of the services and programs in the form of services and programs that are adapted to the culture and context of the tribal communities served.

''(ii) PERFORMANCE MEASURES.—The Secretary shall establish specific performance measures for each tribe, organization, or consortium that elects to provide services and programs specified in section 471(e)(1). The performance measures shall, to the greatest extent practicable, be consistent with the prevention services measures required for States under section 471(e)(6) but shall allow for consideration of factors unique to the provision of the services by tribes, organizations, or consortia.''; and

(B) in subsection (d)(1), by striking ''and (5)'' and inserting ''(5), and (6)(A)''.

(2) CONFORMING AMENDMENT.—The heading for subsection (d) of section 479B of such Act (42 U.S.C. 679c) is amended by striking ''FOR FOSTER CARE MAINTENANCE AND ADOPTION ASSISTANCE PAYMENTS''.

(f) APPLICATION TO PROGRAMS OPERATED BY TERRITORIES.—Section 1108(a)(2) of the Social Security Act (42 U.S.C. 1308(a)(2)) is amended by striking ''or 413(f)'' and inserting ''413(f), or 474(a)(6)''.

SEC. 19012. FOSTER CARE MAINTENANCE PAYMENTS FOR CHILDREN WITH PARENTS IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.

(a) IN GENERAL.—Section 472 of the Social Security Act (42 U.S.C. 672) is amended—

(1) in subsection (a)(2)(C), by striking ''or'' and inserting '', with a parent residing in a licensed residential family-based treatment facility, but only to the extent permitted under subsection (j), or in a''; and

(2) by adding at the end the following:

''(j) CHILDREN PLACED WITH A PARENT RESIDING IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, a child who is eligible for foster care maintenance payments under this section, or who would be eligible for the payments if the eligibility were determined without regard to paragraphs (1)(B) and (3) of subsection (a), shall be eligible for the payments for a period of not more than 12 months during which the child is placed with a parent who is in a licensed residential family-based treatment facility for substance abuse, but only if—

''(A) the recommendation for the placement is specified in the child's case plan before the placement;

''(B) the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and

''(C) the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

''(2) APPLICATION.—With respect to children for whom foster care maintenance payments are made under paragraph (1), only the children who satisfy the requirements of paragraphs (1)(B) and (3) of subsection (a) shall be considered to be children with respect to whom foster care maintenance payments are made under this section for purposes of subsection (h) or section 473(b)(3)(B).''.

(b) CONFORMING AMENDMENT.—Section 474(a)(1) of such Act (42 U.S.C. 674(a)(1)) is amended by inserting ''subject to section 472(j),'' before ''an amount equal to the Federal'' the first place it appears.

SEC. 19013. TITLE IV–E PAYMENTS FOR EVIDENCE-BASED KINSHIP NAVIGATOR PROGRAMS.

Section 474(a) of the Social Security Act (42 U.S.C. 674(a)), as amended by section 19011(c), is amended—

(1) in paragraph (6), by striking the period at the end and inserting ''; plus''; and

(2) by adding at the end the following:

''(7) an amount equal to 50 percent of the amounts expended by the State during the quarter as the Secretary determines are for kinship navigator programs that meet the requirements described in section 427(a)(1) and that the Secretary determines are operated in accordance with promising, supported, or well-supported practices that meet the applicable criteria specified for the practices in section 471(e)(4)(C), without regard to whether the expenditures are incurred on behalf of children who are, or are potentially, eligible for foster care maintenance payments under this part.''.

Subtitle B—Enhanced Support Under Title IV–B

SEC. 19021. ELIMINATION OF TIME LIMIT FOR FAMILY REUNIFICATION SERVICES WHILE IN FOSTER CARE AND PERMITTING TIME-LIMITED FAMILY REUNIFICATION SERVICES WHEN A CHILD RETURNS HOME FROM FOSTER CARE.

(a) IN GENERAL.—Section 431(a)(7) of the Social Security Act (42 U.S.C. 629a(a)(7)) is amended—

(1) in the paragraph heading, by striking ''TIME-LIMITED FAMILY'' and inserting ''FAMILY''; and

(2) in subparagraph (A)—

(A) by striking ''time-limited family'' and inserting ''family'';

(B) by inserting ''or a child who has been returned home'' after ''child care institution''; and

(C) by striking '', but only during the 15-month period that begins on the date that the child, pursuant to section 475(5)(F), is considered to have entered foster care'' and inserting ''and to ensure the strength and stability of the reunification. In the case of a child who has been returned home, the services and activities shall only be provided during the 15-month period that begins on the date that the child returns home''.

(b) CONFORMING AMENDMENTS.—

(1) Section 430 of such Act (42 U.S.C. 629) is amended in the matter preceding paragraph (1), by striking ''time-limited''.

(2) Subsections (a)(4), (a)(5)(A), and (b)(1) of section 432 of such Act (42 U.S.C. 629b) are amended by striking ''time-limited'' each place it appears.

SEC. 19022. REDUCING BUREAUCRACY AND UNNECESSARY DELAYS WHEN PLACING CHILDREN IN HOMES ACROSS STATE LINES.

(a) STATE PLAN REQUIREMENT.—Section 471(a)(25) of the Social Security Act (42 U.S.C. 671(a)(25)) is amended—

(1) by striking ''provide'' and insert ''provides''; and

(2) by inserting '', which, not later than October 1, 2026, shall include the use of an electronic interstate case-processing system'' before the first semicolon.

(b) GRANTS FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—Section 437 of such Act (42 U.S.C. 629g) is amended by adding at the end the following:

''(g) GRANTS FOR THE DEVELOPMENT OF AN ELECTRONIC INTERSTATE CASE-PROCESSING SYSTEM TO EXPEDITE THE INTERSTATE PLACEMENT OF CHILDREN IN FOSTER CARE OR GUARDIANSHIP, OR FOR ADOPTION.—

''(1) PURPOSE.—The purpose of this subsection is to facilitate the development of an electronic interstate case-processing system for the exchange of data and documents to expedite the placements of children in foster, guardianship, or adoptive homes across State lines.

''(2) APPLICATION REQUIREMENTS.—A State that desires a grant under this subsection shall submit to the Secretary an application containing the following:

''(A) A description of the goals and outcomes to be achieved during the period for which grant funds are sought, which goals and outcomes must result in—

''(i) reducing the time it takes for a child to be provided with a safe and appropriate permanent living arrangement across State lines;

''(ii) improving administrative processes and reducing costs in the foster care system; and

''(iii) the secure exchange of relevant case files and other necessary materials in real time, and timely communications and placement decisions regarding interstate placements of children.

''(B) A description of the activities to be funded in whole or in part with the grant funds, including the sequencing of the activities.

''(C) A description of the strategies for integrating programs and services for children who are placed across State lines.

''(D) Such other information as the Secretary may require.

''(3) GRANT AUTHORITY.—The Secretary may make a grant to a State that complies with paragraph (2).

''(4) USE OF FUNDS.—A State to which a grant is made under this subsection shall use the grant to support the State in connecting with the electronic interstate case-processing system described in paragraph (1).

''(5) EVALUATIONS.—Not later than 1 year after the final year in which grants are awarded under this subsection, the Secretary shall submit to the Congress, and make available to the general public by posting on a website, a report that contains the following information:

''(A) How using the electronic interstate case-processing system developed pursuant to paragraph (4) has changed the time it takes for children to be placed across State lines.

''(B) The number of cases subject to the Interstate Compact on the Placement of Children that were processed through the electronic interstate case-processing system, and the number of interstate child placement cases that were processed outside the electronic interstate case-processing system, by each State in each year.

''(C) The progress made by States in implementing the electronic interstate case-processing system.

''(D) How using the electronic interstate case-processing system has affected various metrics related to child safety and well-being, including the time it takes for children to be placed across State lines.

''(E) How using the electronic interstate case-processing system has affected administrative costs and caseworker time spent on placing children across State lines.

''(6) DATA INTEGRATION.—The Secretary, in consultation with the Secretariat for the Interstate Compact on the Placement of Children and the States, shall assess how the electronic interstate case-processing system developed pursuant to paragraph (4) could be used to better serve and protect children that come to the attention of the child welfare system, by—

''(A) connecting the system with other data systems (such as systems operated by State law enforcement and judicial agencies, systems operated by the Federal Bureau of Investigation for the purposes of the Innocence Lost National Initiative, and other systems);

''(B) simplifying and improving reporting related to paragraphs (34) and (35) of section 471(a) regarding children or youth who have been identified as being a sex trafficking victim or children missing from foster care; and

''(C) improving the ability of States to quickly comply with background check requirements of section 471(a)(20), including checks of child abuse and neglect registries as required by section 471(a)(20)(B).''.

(c) RESERVATION OF FUNDS TO IMPROVE THE INTERSTATE PLACEMENT OF CHILDREN.—Section 437(b) of such Act (42 U.S.C. 629g(b)) is amended by adding at the end the following:

''(4) IMPROVING THE INTERSTATE PLACEMENT OF CHILDREN.—The Secretary shall reserve $5,000,000 of the amount made available for fiscal year 2017 for grants under subsection (g), and the amount so reserved shall remain available through fiscal year 2021.''.

SEC. 19023. ENHANCEMENTS TO GRANTS TO IMPROVE WELL-BEING OF FAMILIES AFFECTED BY SUBSTANCE ABUSE.

Section 437(f) of the Social Security Act (42 U.S.C. 629g(f)) is amended—

(1) in the subsection heading, by striking ''INCREASE THE WELL-BEING OF, AND TO IMPROVE THE PERMANENCY OUTCOMES FOR, CHILDREN AFFECTED BY'' and inserting ''IMPLEMENT IV–E PREVENTION SERVICES, AND IMPROVE THE WELL-BEING OF, AND IMPROVE PERMANENCY OUTCOMES FOR, CHILDREN AND FAMILIES AFFECTED BY HEROIN, OPIOIDS, AND OTHER'';

(2) by striking paragraph (2) and inserting the following:

''(2) REGIONAL PARTNERSHIP DEFINED.—In this subsection, the term 'regional partnership' means a collaborative agreement (which may be established on an interstate, State, or intrastate basis) entered into by the following:

''(A) MANDATORY PARTNERS FOR ALL PARTNERSHIP GRANTS.—

''(i) The State child welfare agency that is responsible for the administration of the State plan under this part and part E.

''(ii) The State agency responsible for administering the substance abuse prevention and treatment block grant provided under subpart II of part B of title XIX of the Public Health Service Act.

''(B) MANDATORY PARTNERS FOR PARTNERSHIP GRANTS PROPOSING TO SERVE CHILDREN IN OUT-OF-HOME PLACEMENTS.—If the partnership proposes to serve children in out-of-home placements, the Juvenile Court or Administrative Office of the Court that is most appropriate to oversee the administration of court programs in the region to address the population of families who come to the attention of the court due to child abuse or neglect.

''(C) OPTIONAL PARTNERS.—At the option of the partnership, any of the following:

''(i) An Indian tribe or tribal consortium.

''(ii) Nonprofit child welfare service providers.

''(iii) For-profit child welfare service providers.

''(iv) Community health service providers, including substance abuse treatment providers.

''(v) Community mental health providers.

''(vi) Local law enforcement agencies.

''(vii) School personnel.

''(viii) Tribal child welfare agencies (or a consortia of the agencies).

''(ix) Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under a State plan approved under this subpart.

''(D) EXCEPTION FOR REGIONAL PARTNERSHIPS WHERE THE LEAD APPLICANT IS AN INDIAN TRIBE OR TRIBAL CONSORTIA.—If an Indian tribe or tribal consortium enters into a regional partnership for purposes of this subsection, the Indian tribe or tribal consortium—

''(i) may (but is not required to) include the State child welfare agency as a partner in the collaborative agreement;

''(ii) may not enter into a collaborative agreement only with tribal child welfare agencies (or a consortium of the agencies); and

''(iii) if the condition described in paragraph (2)(B) applies, may include tribal court organizations in lieu of other judicial partners.'';

(3) in paragraph (3)—

(A) in subparagraph (A)—

(i) by striking ''2012 through 2016'' and inserting ''2017 through 2021''; and

(ii) by striking ''$500,000 and not more than $1,000,000'' and inserting ''$250,000 and not more than $1,000,000'';

(B) in subparagraph (B)—

(i) in the subparagraph heading, by inserting ''; PLANNING'' after ''APPROVAL'';

(ii) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) and (iii)''; and

(iii) by adding at the end the following:

''(iii) SUFFICIENT PLANNING.—A grant awarded under this subsection shall be disbursed in two phases: a planning phase (not to exceed 2 years); and an implementation phase. The total disbursement to a grantee for the planning phase may not exceed $250,000, and may not exceed the total anticipated funding for the implementation phase.''; and

(C) by adding at the end the following:

''(D) LIMITATION ON PAYMENT FOR A FISCAL YEAR.—No payment shall be made under subparagraph (A) or (C) for a fiscal year until the Secretary determines that the eligible partnership has made sufficient progress in meeting the goals of the grant and that the members of the eligible partnership are coordinating to a reasonable degree with the other members of the eligible partnership.'';

(4) in paragraph (4)—

(A) in subparagraph (B)—

(i) in clause (i), by inserting '', parents, and families'' after ''children'';

(ii) in clause (ii), by striking ''safety and permanence for such children; and'' and inserting ''safe, permanent caregiving relationships for the children;'';

(iii) in clause (iii), by striking ''or'' and inserting ''increase reunification rates for children who have been placed in out of home care, or decrease''; and

(iv) by redesignating clause (iii) as clause (v) and inserting after clause (ii) the following:

''(iii) improve the substance abuse treatment outcomes for parents including retention in treatment and successful completion of treatment;

''(iv) facilitate the implementation, delivery, and effectiveness of prevention services and programs under section 471(e); and'';

(B) in subparagraph (D), by striking ''where appropriate,''; and

(C) by striking subparagraphs (E) and (F) and inserting the following:

''(E) A description of a plan for sustaining the services provided by or activities funded under the grant after the conclusion of the grant period, including through the use of prevention services and programs under section 471(e) and other funds provided to the State for child welfare and substance abuse prevention and treatment services.

''(F) Additional information needed by the Secretary to determine that the proposed activities and implementation will be consistent with research or evaluations showing which practices and approaches are most effective.'';

(5) in paragraph (5)(A), by striking ''abuse treatment'' and inserting ''use disorder treatment including medication assisted treatment and in-home substance abuse disorder treatment and recovery'';

(6) in paragraph (7)—

(A) by striking ''and'' at the end of subparagraph (C); and

(B) by redesignating subparagraph (D) as subparagraph (E) and inserting after subparagraph (C) the following:

''(D) demonstrate a track record of successful collaboration among child welfare, substance abuse disorder treatment and mental health agencies; and'';

(7) in paragraph (8)—

(A) in subparagraph (A)—

(i) by striking ''establish indicators that will be'' and inserting ''review indicators that are''; and

(ii) by striking ''in using funds made available under such grants to achieve the purpose of this subsection'' and inserting ''and establish a set of core indicators related to child safety, parental recovery, parenting capacity, and family well-being. In developing the core indicators, to the extent possible, indicators shall be made consistent with the outcome measures described in section 471(e)(6)''; and

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting ''base the performance measures on lessons learned from prior rounds of regional partnership grants under this subsection, and'' before ''consult''; and

(ii) by striking clauses (iii) and (iv) and inserting the following:

''(iii) Other stakeholders or constituencies as determined by the Secretary.'';

(8) in paragraph (9)(A), by striking clause (i) and inserting the following:

''(i) SEMIANNUAL REPORTS.—Not later than September 30 of each fiscal year in which a recipient of a grant under this subsection is paid funds under the grant, and every 6 months thereafter, the grant recipient shall submit to the Secretary a report on the services provided and activities carried out during the reporting period, progress made in achieving the goals of the program, the number of children, adults, and families receiving services, and such additional information as the Secretary determines is necessary. The report due not later than September 30 of the last such fiscal year shall include, at a minimum, data on each of the performance indicators included in the evaluation of the regional partnership.''; and

(9) in paragraph (10), by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

Subtitle C—Miscellaneous

SEC. 19031. REVIEWING AND IMPROVING LICENSING STANDARDS FOR PLACEMENT IN A RELATIVE FOSTER FAMILY HOME.

(a) IDENTIFICATION OF REPUTABLE MODEL LICENSING STANDARDS.—Not later than October 1, 2017, the Secretary of Health and Human Services shall identify reputable model licensing standards with respect to the licensing of foster family homes (as defined in section 472(c)(1) of the Social Security Act).

(b) STATE PLAN REQUIREMENT.—Section 471(a) of the Social Security Act (42 U.S.C. 671(a)) is amended—

(1) in paragraph (34)(B), by striking ''and'' after the semicolon;

(2) in paragraph (35)(B), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(36) provides that, not later than April 1, 2018, the State shall submit to the Secretary information addressing—

''(A) whether the State licensing standards are in accord with model standards identified by the Secretary, and if not, the reason for the specific deviation and a description as to why having a standard that is reasonably in accord with the corresponding national model standards is not appropriate for the State;

''(B) whether the State has elected to waive standards established in 471(a)(10)(A) for relative foster family homes (pursuant to waiver authority provided by 471(a)(10)(D)), a description of which standards the State most commonly waives, and if the State has not elected to waive the standards, the reason for not waiving these standards;

''(C) if the State has elected to waive standards specified in subparagraph (B), how caseworkers are trained to use the waiver authority and whether the State has developed a process or provided tools to assist caseworkers in waiving nonsafety standards per the authority provided in 471(a)(10)(D) to quickly place children with relatives; and

''(D) a description of the steps the State is taking to improve caseworker training or the process, if any; and''.

SEC. 19032. DEVELOPMENT OF A STATEWIDE PLAN TO PREVENT CHILD ABUSE AND NEGLECT FATALITIES.

Section 422(b)(19) of the Social Security Act (42 U.S.C. 622(b)(19)) is amended to read as follows:

''(19) document steps taken to track and prevent child maltreatment deaths by including—

''(A) a description of the steps the State is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the State agency referred to in paragraph (1), including gathering relevant information on the deaths from the relevant organizations in the State including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners or coroners; and

''(B) a description of the steps the state is taking to develop and implement of a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.''.

SEC. 19033. MODERNIZING THE TITLE AND PURPOSE OF TITLE IV–E.

(a) PART HEADING.—The heading for part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) is amended to read as follows:

''PART E—FEDERAL PAYMENTS FOR FOSTER CARE, PREVENTION, AND PERMANENCY''.

(b) PURPOSE.—The first sentence of section 470 of such Act (42 U.S.C. 670) is amended—

(1) by striking ''1995) and'' and inserting ''1995),'';

(2) by inserting ''kinship guardianship assistance, and prevention services or programs specified in section 471(e)(1),'' after ''needs,''; and

(3) by striking ''(commencing with the fiscal year which begins October 1, 1980)''.

SEC. 19034. EFFECTIVE DATES.

(a) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), subject to subsection (b), the amendments made by this title shall take effect on January 1, 2017.

(2) EXCEPTIONS.—The amendments made by sections 19031 and 19033 shall take effect on the date of enactment of this Act.

(b) TRANSITION RULE.—

(1) IN GENERAL.—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this title, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(2) APPLICATION TO PROGRAMS OPERATED BY INDIAN TRIBAL ORGANIZATIONS.—In the case of an Indian tribe, tribal organization, or tribal consortium which the Secretary of Health and Human Services determines requires time to take action necessary to comply with the additional requirements imposed by the amendments made by this title (whether the tribe, organization, or tribal consortium has a plan under section 479B of the Social Security Act or a cooperative agreement or contract entered into with a State), the Secretary shall provide the tribe, organization, or tribal consortium with such additional time as the Secretary determines is necessary for the tribe, organization, or tribal consortium to take the action to comply with the

additional requirements before being regarded as failing to comply with the requirements.

TITLE XX—ENSURING THE NECESSITY OF A PLACEMENT THAT IS NOT IN A FOSTER FAMILY HOME

SEC. 20001. LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES.

(a) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

(1) IN GENERAL.—Section 472 of the Social Security Act (42 U.S.C. 672), as amended by section 19012, is amended—

(A) in subsection (a)(2)(C), by inserting '', but only to the extent permitted under subsection (k)'' after ''institution''; and

(B) by adding at the end the following:

''(k) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

''(1) IN GENERAL.—Beginning with the third week for which foster care maintenance payments are made under this section on behalf of a child placed in a child-care institution, no Federal payment shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child unless—

''(A) the child is placed in a child-care institution that is a setting specified in paragraph (2) (or is placed in a licensed residential family-based treatment facility consistent with subsection (j)); and

''(B) in the case of a child placed in a qualified residential treatment program (as defined in paragraph (4)), the requirements specified in paragraph (3) and section 475A(c) are met.

''(2) SPECIFIED SETTINGS FOR PLACEMENT.—The settings for placement specified in this paragraph are the following:

''(A) A qualified residential treatment program (as defined in paragraph (4)).

''(B) A setting specializing in providing prenatal, post-partum, or parenting supports for youth.

''(C) In the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently.

''(D) A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims, in accordance with section 471(a)(9)(C).

''(3) ASSESSMENT TO DETERMINE APPROPRIATENESS OF PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—

''(A) DEADLINE FOR ASSESSMENT.—In the case of a child who is placed in a qualified residential treatment program, if the assessment required under section 475A(c)(1) is not completed within 30 days after the placement is made, no Federal payment shall be made to the State under section 474(a)(1) for any amounts expended for foster care maintenance payments on behalf of the child during the placement.

''(B) DEADLINE FOR TRANSITION OUT OF PLACEMENT.—If the assessment required under section 475A(c)(1) determines that the placement of a child in a qualified residential treatment program is not appropriate, a court disapproves such a placement under section 475A(c)(2), or a child who has been in an approved placement in a qualified residential treatment program is going to return home or be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home, Federal payments shall be made to the State under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of the child while the child remains in the qualified residential treatment program only during the period necessary for the child to transition home or to such a placement. In no event shall a State receive Federal payments under section 474(a)(1) for amounts expended for foster care maintenance payments on behalf of a child who remains placed in a qualified residential treatment program after the end of the 30-day period that begins on the date a determination is made that the placement is no longer the recommended or approved placement for the child.

''(4) QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—For purposes of this part, the term 'qualified residential treatment program' means a program that—

''(A) has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 475A(c);

''(B) subject to paragraph (5), has registered or licensed nursing staff and other licensed clinical staff who—

''(i) provide care within the scope of their practice as defined by State law;

''(ii) are on-site during business hours; and

''(iii) are available 24 hours a day and 7 days a week;

''(C) to extent appropriate, and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program;

''(D) facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;

''(E) documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;

''(F) provides discharge planning and family-based aftercare support for at least 6 months post-discharge; and

''(G) is licensed in accordance with section 471(a)(10) and is accredited by any of the following independent, not-for-profit organizations:

''(i) The Commission on Accreditation of Rehabilitation Facilities (CARF).

''(ii) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

''(iii) The Council on Accreditation (COA).

''(iv) Any other independent, not-for-profit accrediting organization approved by the Secretary.

''(5) FLEXIBILITY IN STAFFING REQUIREMENTS FOR QUALIFIED RESIDENTIAL TREATMENT PROGRAMS.—

''(A) IN GENERAL.—In the case of any State that the Secretary determines is described in subparagraph (B) and satisfies the requirements of subparagraphs (C) and (D), respectively, the State may elect to satisfy the requirement of paragraph (4)(B) that a qualified residential treatment program have registered or licensed nursing staff and other licensed clinical staff with clinical staff which include staff licensed to monitor medications and physical and behavioral health staff with demonstrated training in child development and trauma, in lieu of with registered or licensed nursing staff and other licensed clinical staff.

''(B) STATE DESCRIBED.—Subject to subparagraph (E), a State is described in this subparagraph if for the most recent fiscal year for which data are available—

''(i) the percentage of children in foster care under the responsibility of the State who have been placed in congregate care settings—

''(I) is at or below 5 percent for the fiscal year; or

''(II) has been reduced by at least 20 percent from the preceding fiscal year; and

''(ii) the average length of stay for children in foster care under the responsibility of the State in congregate care settings is at or below 9 months.

''(C) DEMONSTRATION OF CAPACITY AND NEED.—A State described in subparagraph (B) shall be eligible to use the alternative staffing model permitted under subparagraph (A) if the State can demonstrate to the satisfaction of the Secretary that the qualified residential treatment programs utilizing the alternative staffing models permitted under subparagraph (A) have the capacity to serve children and youth whose treatment plans—

''(i) indicate a need for increased supervision based on behavioral history, history of juvenile delinquency, or history of sexual offenses; and

''(ii) require a placement that conforms to the alternative staffing model permitted under subparagraph (A).

''(D) EQUITABLE DISTRIBUTION OF CONGREGATE CARE POPULATION.—A State described in subparagraph (B) shall be eligible to use the alternative staffing model permitted under subparagraph (A) if the State annually demonstrates to the satisfaction of the Secretary that the State is reducing the number of children in foster care under the responsibility of the State who are in congregate care placements on a general statewide basis and without wide disparities between rural, suburban, and urban areas in the rates of such children in congregate care placements.

''(E) ANNUAL DETERMINATION OF STATE ELIGIBILITY BASED ON AFCARS AND OTHER DATA.—The Secretary annually shall make the determinations required under subparagraph (B) with respect to a State and a fiscal year, on the basis of data meeting the requirements of the system established pursuant to section 479, as reported by the State and approved by the Secretary, and, to the extent the Secretary determines necessary, on the basis of such other information reported to the Secretary as the Secretary may require to determine that a State is, or continues to be, a State described in subparagraph (B).

''(F) CONGREGATE CARE SETTINGS.—In this paragraph, the term 'congregate care settings' includes any settings described as 'group homes' or 'institutions' for purposes of data reported in accordance with the requirements of the system established pursuant to section 479 or any similar placement settings reported in accordance with such requirements.

''(6) ADMINISTRATIVE COSTS.—The prohibition in paragraph (1) on Federal payments under section 474(a)(1) shall not be construed as prohibiting Federal payments for administrative expenditures incurred on behalf of a child placed in a child-care institution and for which payment is available under section 474(a)(3).''.

(2) CONFORMING AMENDMENT.—Section 474(a)(1) of the Social Security Act (42 U.S.C. 674(a)(1)), as amended by section 19012(b), is amended by striking ''section 472(j)'' and inserting ''subsections (j) and (k) of section 472''.

(b) DEFINITION OF FOSTER FAMILY HOME, CHILD-CARE INSTITUTION.—Section 472(c) of such Act (42 U.S.C. 672(c)(1)) is amended to read as follows:

''(c) DEFINITIONS.—For purposes of this part:

''(1) FOSTER FAMILY HOME.—

''(A) IN GENERAL.—The term 'foster family home' means the home of an individual or family—

''(i) that is licensed or approved by the State in which it is situated as a foster family home that meets the standards established for the licensing or approval; and

''(ii) in which a child in foster care has been placed in the care of an individual, who resides with the child and who has been licensed or approved by the State to be a foster parent—

''(I) that the State deems capable of adhering to the reasonable and prudent parent standard;

''(II) that provides 24-hour substitute care for children placed away from their parents or other caretakers; and

''(III) that provides the care for not more than six children in foster care.

''(B) STATE FLEXIBILITY.—The number of foster children that may be cared for in a home under subparagraph (A) may exceed the numerical limitation in subparagraph (A)(ii)(III), at the option of the State, for any of the following reasons:

''(i) To allow a parenting youth in foster care to remain with the child of the parenting youth.

''(ii) To allow siblings to remain together.

''(iii) To allow a child with an established meaningful relationship with the family to remain with the family.

''(iv) To allow a family with special training or skills to provide care to a child who has a severe disability.

''(C) RULE OF CONSTRUCTION.—Subparagraph (A) shall not be construed as prohibiting a foster parent from renting the home in which the parent cares for a foster child placed in the parent's care.

''(2) CHILD-CARE INSTITUTION.—

''(A) IN GENERAL.—The term 'child-care institution' means a private child-care institution, or a public child-care institution which accommodates no more than 25 children, which is licensed by the State in which it is situated or has been approved by the agency of the State responsible for licensing or approval of institutions of this type as meeting the standards established for the licensing.

''(B) SUPERVISED SETTINGS.—In the case of a child who has attained 18 years of age, the term shall include a supervised setting in which the individual is living independently, in accordance with such conditions as the Secretary shall establish in regulations.

''(C) EXCLUSIONS.—The term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.''.

(c) TRAINING FOR STATE JUDGES, ATTORNEYS, AND OTHER LEGAL PERSONNEL IN CHILD WELFARE CASES.—Section 438(b)(1) of such Act (42 U.S.C. 629h(b)(1)) is amended in the matter preceding subparagraph (A) by inserting ''shall provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are placed in settings that are not a foster family home,'' after ''with respect to the child,''.

(d) ASSURANCE OF NONIMPACT ON JUVENILE JUSTICE SYSTEM.—

(1) STATE PLAN REQUIREMENT.—Section 471(a) of such Act (42 U.S.C. 671(a)), as amended by section 19031, is further amended by adding at the end the following:

''(37) includes a certification that, in response to the limitation imposed under section 472(k) with respect to foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, the State will not enact or advance policies or practices that would result in a significant increase in the population of youth in the State's juvenile justice system.''.

(2) GAO STUDY AND REPORT.—The Comptroller General of the United States shall evaluate the impact, if any, on State juvenile justice systems of the limitation imposed under section 472(k) of the Social Security Act (as added by section 19001(a)(1)) on foster care maintenance payments made on behalf of any child who is placed in a setting that is not a foster family home, in accordance with the amendments made by subsections (a) and (b) of this section. In particular, the Comptroller General shall evaluate the extent to which children in foster care who also are subject to the juvenile justice system of the State are placed in a facility under the jurisdiction of the juvenile justice system and whether the lack of available congregate care placements under the jurisdiction of the child welfare systems is a contributing factor to that result. Not later than December 31, 2023, the Comptroller General shall submit to Congress a report on the results of the evaluation.

SEC. 20002. ASSESSMENT AND DOCUMENTATION OF THE NEED FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.

Section 475A of the Social Security Act (42 U.S.C. 675a) is amended by adding at the end the following:

''(c) ASSESSMENT, DOCUMENTATION, AND JUDICIAL DETERMINATION REQUIREMENTS FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.—In the case of any child who is placed in a qualified residential treatment program (as defined in section 472(k)(4)), the following requirements shall apply for purposes of approving the case plan for the child and the case system review procedure for the child:

''(1)(A) Within 30 days of the start of each placement in such a setting, a qualified individual (as defined in subparagraph (D)) shall—

''(i) assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by the Secretary;

''(ii) determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting from among the settings specified in section 472(k)(2) would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

''(iii) develop a list of child-specific short- and long-term mental and behavioral health goals.

''(B)(i) The State shall assemble a family and permanency team for the child in accordance with the requirements of clauses (ii) and (iii). The qualified individual conducting the assessment required under subparagraph (A) shall work in conjunction with the family of, and permanency team for, the child while conducting and making the assessment.

''(ii) The family and permanency team shall consist of all appropriate biological family members, relative, and fictive kin of the child, as well as, as appropriate, professionals who are a resource to the family of the child, such as teachers, medical or mental health providers who have treated the child, or clergy. In the case of a child who has attained age 14, the family and permanency team shall include the members of the permanency planning team for the child that are selected by the child in accordance with section 475(5)(C)(iv).

''(iii) The State shall document in the child's case plan—

''(I) the reasonable and good faith effort of the State to identify and include all such individuals on the family of, and permanency team for, the child;

''(II) all contact information for members of the family and permanency team, as well as contact information for other family members and fictive kin who are not part of the family and permanency team;

''(III) evidence that meetings of the family and permanency team, including meetings relating to the assessment required under subparagraph (A), are held at a time and place convenient for family;

''(IV) if reunification is the goal, evidence demonstrating that the parent from whom the child was removed provided input on the members of the family and permanency team;

''(V) evidence that the assessment required under subparagraph (A) is determined in conjunction with the family and permanency team; and

''(VI) the placement preferences of the family and permanency team relative to the assessment and, if the placement preferences of the family and permanency team and child are not the placement setting recommended by the qualified individual conducting the assessment under subparagraph (A), the reasons why the preferences of the team and of the child were not recommended.

''(C) In the case of a child who the qualified individual conducting the assessment under subparagraph (A) determines should not be placed in a foster family home, the qualified individual shall specify in writing the reasons why the needs of the child cannot be met by the family of the child or in a foster family home. A shortage or lack of foster family homes shall not be an acceptable reason for determining that a needs of the child cannot be met in a foster family home. The qualified individual also shall specify in writing why the recommended placement in a qualified residential treatment program is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child.

''(D)(i) Subject to clause (ii), in this subsection, the term 'qualified individual' means a trained professional or licensed clinician who is not an employee of the State agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State.

''(ii) The Secretary may approve a request of a State to waive any requirement in clause (i) upon a submission by the State, in accordance with criteria established by the Secretary, that certifies that the trained professionals or licensed clinicians with responsibility for performing the assessments described in subparagraph (A) shall maintain objectivity with respect to determining the most effective and appropriate placement for a child.

''(2) Within 60 days of the start of each placement in a qualified residential treatment program, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, shall—

''(A) consider the assessment, determination, and documentation made by the qualified individual conducting the assessment under paragraph (1);

''(B) determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and

''(C) approve or disapprove the placement.

''(3) The written documentation made under paragraph (1)(C) and documentation of the determination and approval or disapproval of the placement in a qualified residential treatment program by a court or administrative body under paragraph (2) shall be included in and made part of the case plan for the child.

''(4) As long as a child remains placed in a qualified residential treatment program, the State agency shall submit evidence at each status review and each permanency hearing held with respect to the child—

''(A) demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;

''(B) documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and

''(C) documenting the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home.

''(5) In the case of any child who is placed in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or nonconsecutive months), the State agency shall submit to the Secretary—

''(A) the most recent versions of the evidence and documentation specified in paragraph (4); and

''(B) the signed approval of the head of the State agency for the continued placement of the child in that setting.''.

SEC. 20003. PROTOCOLS TO PREVENT INAPPROPRIATE DIAGNOSES.

(a) STATE PLAN REQUIREMENT.—Section 422(b)(15)(A) of the Social Security Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (vi), by striking ''and'' after the semicolon;

(2) by redesignating clause (vii) as clause (viii); and

(3) by inserting after clause (vi) the following:

''(vii) the procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and''.

(b) EVALUATION.—Section 476 of such Act (42 U.S.C. 676), as previously amended, is further amended by adding at the end the following:

''(e) EVALUATION OF STATE PROCEDURES AND PROTOCOLS TO PREVENT INAPPROPRIATE DIAGNOSES OF MENTAL ILLNESS OR OTHER CONDITIONS.—The Secretary shall conduct an evaluation of the procedures and protocols established by States in accordance with the requirements of section 422(b)(15)(A)(vii). The evaluation shall analyze the extent to which States comply with and enforce the procedures and protocols and the effectiveness of various State procedures and protocols and shall identify best practices. Not later than January 1, 2019, the Secretary shall submit a report on the results of the evaluation to Congress.''.

SEC. 20004. ADDITIONAL DATA AND REPORTS REGARDING CHILDREN PLACED IN A SETTING THAT IS NOT A FOSTER FAMILY HOME.

Section 479A(a)(7)(A) of the Social Security Act (42 U.S.C. 679b(a)(7)(A)) is amended by striking clauses (i) through (vi) and inserting the following:

''(i) with respect to each such placement—

''(I) the type of the placement setting, including whether the placement is shelter care, a group home and if so, the range of the child population in the home, a residential treatment facility, a hospital or institution providing medical, rehabilitative, or psychiatric care, a setting specializing in providing prenatal, post-partum or parenting supports, or some other kind of child-care institution and if so, what kind;

''(II) the number of children in the placement setting and the age, race, ethnicity, and gender of each of the children;

''(III) for each child in the placement setting, the length of the placement of the child in the setting, whether the placement of the child in the setting is the first placement of the child and if not, the number and type of previous placements of the child, and whether the child has special needs or another diagnosed mental or physical illness or condition; and

''(IV) the extent of any specialized education, treatment, counseling, or other services provided in the setting; and

''(ii) separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement; and''.

SEC. 20005. EFFECTIVE DATES; APPLICATION TO WAIVERS.

(a) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2) and subsections (b) and (c), the amendments made by this title shall take effect on January 1, 2017.

(2) TRANSITION RULE.—In the case of a State plan under part B or E of title IV of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this title, the State plan shall not be regarded as failing to comply with the requirements of such part solely on the basis of the failure of the plan to meet the additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be deemed to be a separate regular session of the State legislature.

(b) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR PLACEMENTS THAT ARE NOT IN FOSTER FAMILY HOMES AND RELATED PROVISIONS.—

(1) IN GENERAL.—The amendments made by sections 20001(a), 20001(b), 20001(d), and 20002 shall take effect on October 1, 2019.

(2) STATE OPTION TO DELAY EFFECTIVE DATE FOR NOT MORE THAN 2 YEARS.—At the sole discretion of a State and for not more than 2 years, the Secretary of Health and Human Services shall delay the effective date provided for in paragraph (1) with respect to the State. If the effective date is so delayed for a period with respect to a State under the preceding sentence, then—

(A) notwithstanding section 1904, the date that the amendments made by section 19011(c) take effect with respect to the State shall be delayed for the period; and

(B) in applying section 474(a)(6) of the Social Security Act with respect to the State, ''on or after the date this paragraph takes effect with respect to the State'' is deemed to be substituted for ''after September 30, 2019'' in subparagraph (A)(i)(I) of such section.

(c) APPLICATION TO STATES WITH WAIVERS.—In the case of a State that, on the date of enactment of this Act, has in effect a waiver approved under section 1130 of the Social Security Act (42 U.S.C. 1320a–9), the amendments made by this title shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent the amendments are inconsistent with the terms of the waiver.

TITLE XXI—CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES

SEC. 21001. SUPPORTING AND RETAINING FOSTER FAMILIES FOR CHILDREN.

(a) SUPPORTING AND RETAINING FOSTER PARENTS AS A FAMILY SUPPORT SERVICE.—Section 431(a)(2)(B) of the Social Security Act (42 U.S.C. 631(a)(2)(B)) is amended by redesignating clauses (iii) through (vi) as clauses (iv) through (vii), respectively, and inserting after clause (ii) the following:

''(iii) To support and retain foster families so they can provide quality family-based settings for children in foster care.''.

(b) SUPPORT FOR FOSTER FAMILY HOMES.—Section 436 of such Act (42 U.S.C. 629f) is amended by adding at the end the following:

''(c) SUPPORT FOR FOSTER FAMILY HOMES.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2018, $8,000,000 for the Secretary to make competitive grants to States, Indian tribes, or tribal consortia to support the recruitment and retention of high-quality foster families to increase their capacity to place more children in family settings, focused on States, Indian tribes, or tribal consortia with the highest percentage of children in non-family settings. The amount appropriated under this subparagraph shall remain available through fiscal year 2022.''.

SEC. 21002. EXTENSION OF CHILD AND FAMILY SERVICES PROGRAMS.

(a) EXTENSION OF STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM.—Section 425 of the Social Security Act (42 U.S.C. 625) is amended by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

(b) EXTENSION OF PROMOTING SAFE AND STABLE FAMILIES PROGRAM AUTHORIZATIONS.—

(1) IN GENERAL.—Section 436(a) of such Act (42 U.S.C. 629f(a)) is amended by striking all that follows ''$345,000,000'' and inserting ''for each of fiscal years 2017 through 2021.''.

(2) DISCRETIONARY GRANTS.—Section 437(a) of such Act (42 U.S.C. 629g(a)) is amended by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

(c) EXTENSION OF FUNDING RESERVATIONS FOR MONTHLY CASEWORKER VISITS AND REGIONAL PARTNERSHIP GRANTS.—Section 436(b) of such Act (42 U.S.C. 629f(b)) is amended—

(1) in paragraph (4)(A), by striking ''2012 through 2016'' and inserting ''2017 through 2021''; and

(2) in paragraph (5), by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

(d) REAUTHORIZATION OF FUNDING FOR STATE COURTS.—

(1) EXTENSION OF PROGRAM.—Section 438(c)(1) of such Act (42 U.S.C. 629h(c)(1)) is amended by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

(2) EXTENSION OF FEDERAL SHARE.—Section 438(d) of such Act (42 U.S.C. 629h(d)) is amended by striking ''2012 through 2016'' and inserting ''2017 through 2021''.

(e) REPEAL OF EXPIRED PROVISIONS.—Section 438(e) of such Act (42 U.S.C. 629h(e)) is repealed.

SEC. 21003. IMPROVEMENTS TO THE JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM AND RELATED PROVISIONS.

(a) AUTHORITY TO SERVE FORMER FOSTER YOUTH UP TO AGE 23.—Section 477 of the Social Security Act (42 U.S.C. 677) is amended—

(1) in subsection (a)(5), by inserting ''(or 23 years of age, in the case of a State with a certification under subsection (b)(3)(A)(ii) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with such subsection)'' after ''21 years of age'';

(2) in subsection (b)(3)(A)—

(A) by inserting ''(i)'' before ''A certification'';

(B) by striking ''children who have left foster care'' and all that follows through the period and inserting ''youths who have aged out of foster care and have not attained 21 years of age.''; and

(C) by adding at the end the following:

''(ii) If the State has elected under section 475(8)(B) to extend eligibility for foster care to all children who have not attained 21 years of age, or if the Secretary determines that the State agency responsible for administering the State plans under this part and part B uses State funds or any other funds not provided under this part to provide services and assistance for youths who have aged out of foster care that are comparable to the services and assistance the youths would receive if the State had made such an election, the certification required under clause (i) may provide that the State will provide assistance and services to youths who have aged out of foster care and have not attained 23 years of age.''; and

(3) in subsection (b)(3)(B), by striking ''children who have left foster care'' and all that follows through the period and inserting ''youths who have aged out of foster care and have not attained 21 years of age (or 23 years of age, in the case of a State with a certification under subparagraph (A)(i) to provide assistance and services to youths who have aged out of foster care and have not attained such age, in accordance with subparagraph (A)(ii)).''.

(b) AUTHORITY TO REDISTRIBUTE UNSPENT FUNDS.—Section 477(d) of such Act (42 U.S.C. 677(d)) is amended—

(1) in paragraph (4), by inserting ''or does not expend allocated funds within the time period specified under section 477(d)(3)'' after ''provided by the Secretary''; and

(2) by adding at the end the following:

''(5) REDISTRIBUTION OF UNEXPENDED AMOUNTS.—

''(A) AVAILABILITY OF AMOUNTS.—To the extent that amounts paid to States under this section in a fiscal year remain unexpended by the States at the end of the succeeding fiscal year, the Secretary may make the amounts available for redistribution in the second succeeding fiscal year among the States that apply for additional funds under this section for that second succeeding fiscal year.

''(B) REDISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall redistribute the amounts made available under subparagraph (A) for a fiscal year among eligible applicant States. In this subparagraph, the term 'eligible applicant State' means a State that has applied for additional funds for the fiscal year under subparagraph (A) if the Secretary determines that the State will use the funds for the purpose for which originally allotted under this section.

''(ii) AMOUNT TO BE REDISTRIBUTED.—The amount to be redistributed to each eligible applicant State shall be the amount so made available multiplied by the State foster care ratio, (as defined in subsection (c)(4), except that, in such subsection, 'all eligible applicant States (as defined in subsection (d)(5)(B)(i))' shall be substituted for 'all States').

''(iii) TREATMENT OF REDISTRIBUTED AMOUNT.—Any amount made available to a State under this paragraph shall be regarded as part of the allotment of the State under this section for the fiscal year in which the redistribution is made.

''(C) TRIBES.—For purposes of this paragraph, the term 'State' includes an Indian tribe, tribal organization, or tribal consortium that receives an allotment under this section.''.

(c) EXPANDING AND CLARIFYING THE USE OF EDUCATION AND TRAINING VOUCHERS.—

(1) IN GENERAL.—Section 477(i)(3) of such Act (42 U.S.C. 677(i)(3)) is amended—

(A) by striking ''on the date'' and all that follows through ''23'' and inserting ''to remain eligible until they attain 26''; and

(B) by inserting '', but in no event may a youth participate in the program for more than 5 years (whether or not consecutive)'' before the period.

(2) CONFORMING AMENDMENT.—Section 477(i)(1) of such Act (42 U.S.C. 677(i)(1)) is amended by inserting ''who have attained 14 years of age'' before the period.

(d) OTHER IMPROVEMENTS.—Section 477 of such Act (42 U.S.C. 677), as amended by subsections (a), (b), and (c), is amended—

*(1) in the section heading, by striking ''**INDEPENDENCE PROGRAM**'' and inserting ''**PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD**'';*

(2) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services'' and inserting ''support all youth who have experienced foster care at age 14 or older in their transition to adulthood through transitional services'';

(ii) by inserting ''and post-secondary education'' after ''high school diploma''; and

(iii) by striking ''training in daily living skills, training in budgeting and financial management skills'' and inserting ''training and opportunities to practice daily living skills (such as financial literacy training and driving instruction)'';

(B) in paragraph (2), by striking ''who are likely to remain in foster care until 18 years of age receive the education, training, and services necessary to obtain employment'' and inserting ''who have experienced foster care at age 14 or older achieve meaningful, permanent connections with a caring adult'';

(C) in paragraph (3), by striking ''who are likely to remain in foster care until 18 years of age prepare for and enter postsecondary training and education institutions'' and inserting ''who have experienced foster care at age 14 or older engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience''; and

(D) by striking paragraph (4) and redesignating paragraphs (5) through (8) as paragraphs (4) through (7);

(3) in subsection (b)—

(A) in paragraph (2)(D), by striking ''adolescents'' and inserting ''youth''; and

(B) in paragraph (3)—

(i) in subparagraph (D)—

(I) by inserting ''including training on youth development'' after ''to provide training''; and

(II) by striking ''adolescents preparing for independent living'' and all that follows through the period and inserting ''youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult.'';

(ii) in subparagraph (H), by striking ''adolescents'' each place it appears and inserting ''youth''; and

(iii) in subparagraph (K)—

(I) by striking ''an adolescent'' and inserting ''a youth''; and

(II) by striking ''the adolescent'' each place it appears and inserting ''the youth''; and

(4) in subsection (f), by striking paragraph (2) and inserting the following:

''(2) REPORT TO CONGRESS.—Not later than October 1, 2017, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the National Youth in Transition Database and any other databases in which States report outcome measures relating to children in foster care and children who have aged out of foster care or left foster care for kinship guardianship or adoption. The report shall include the following:

''(A) A description of the reasons for entry into foster care and of the foster care experiences, such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the National Youth in Transition Database and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17.

''(B) A description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 to the National Youth in Transition Database.

''(C) Benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans the Executive branch will take to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care.

''(D) An analysis of the association between types of placement, number of overall placements, time spent in foster care, and other factors, and outcomes at ages 19 and 21.

''(E) An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among States.''.

(e) CLARIFYING DOCUMENTATION PROVIDED TO FOSTER YOUTH LEAVING FOSTER CARE.—Section 475(5)(I) of such Act (42 U.S.C. 675(5)(I)) is amended by inserting after ''REAL ID Act of 2005'' the following: '', and any official documentation necessary to prove that the child was previously in foster care''.

TITLE XXII—CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP

SEC. 22001. REAUTHORIZING ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PROGRAMS.

Section 473A of the Social Security Act (42 U.S.C. 673b) is amended—

(1) in subsection (b)(4), by striking ''2013 through 2015'' and inserting ''2016 through 2020'';

(2) in subsection (h)(1)(D), by striking ''2016'' and inserting ''2021''; and

(3) in subsection (h)(2), by striking ''2016'' and inserting ''2021''.

TITLE XXIII—TECHNICAL CORRECTIONS

SEC. 23001. TECHNICAL CORRECTIONS TO DATA EXCHANGE STANDARDS TO IMPROVE PROGRAM COORDINATION.

(a) IN GENERAL.—Section 440 of the Social Security Act (42 U.S.C. 629m) is amended to read as follows:

''SEC. 440. DATA EXCHANGE STANDARDS FOR IMPROVED INTEROPERABILITY.

''(a) DESIGNATION.—The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part and part E—

''(1) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

''(2) Federal reporting and data exchange required under applicable Federal law.

''(b) REQUIREMENTS.—The data exchange standards required by paragraph (1) shall, to the extent practicable—

''(1) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the eXtensible Markup Language;

''(2) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

''(3) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

''(4) be consistent with and implement applicable accounting principles;

''(5) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

''(6) be capable of being continually upgraded as necessary.

''(c) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a change to existing data exchange standards found to be effective and efficient.''.

(b) EFFECTIVE DATE.—Not later than the date that is 24 months after the date of the enactment of this section, the Secretary of Health and Human Services shall issue a proposed rule that—

(1) identifies federally required data exchanges, include specification and timing of exchanges to be standardized, and address the factors used in determining whether and when to standardize data exchanges; and

(2) specifies State implementation options and describes future milestones.

SEC. 23002. TECHNICAL CORRECTIONS TO STATE REQUIREMENT TO ADDRESS THE DEVELOPMENTAL NEEDS OF YOUNG CHILDREN.

Section 422(b)(18) of the Social Security Act (42 U.S.C. 622(b)(18)) is amended by striking ''such children'' and inserting ''all vulnerable children under 5 years of age''.

TITLE XXIV—ENSURING STATES REINVEST SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE

SEC. 24001. DELAY OF ADOPTION ASSISTANCE PHASE-IN.

(a) IN GENERAL.—The table in section 473(e)(1)(B) of the Social Security Act (42 U.S.C. 673(e)(1)(B)) is amended—

(1) by striking ''2016'' and inserting ''2016, 2017, 2018, or 2019'';

(2) by striking ''2017'' and inserting ''2020''; and

(3) by striking ''2018'' and inserting ''2021''.

(b) SPECIAL RULE.—Section 473(e) of the Social Security Act (42 U.S.C. 673(e)) is amended by adding at the end the following new paragraph:

''(3) ADDITIONAL EXCEPTION.—Notwithstanding paragraph (1) of this subsection, during the period that begins on October 1, 2016, and ends on December 31, 2016, such term shall include a child—

''(A) who satisfies the requirements for being considered an applicable child under paragraph (1) (as in effect during that period);

''(B) who meets the requirements of subsection (a)(2)(A)(ii); and

''(C) on whose behalf an adoption assistance agreement is entered into under this section during that period.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2017.

SEC. 24002. GAO STUDY AND REPORT ON STATE REINVESTMENT OF SAVINGS RESULTING FROM INCREASE IN ADOPTION ASSISTANCE.

(a) STUDY.—The Comptroller General of the United States shall study the extent to which States are complying with the requirements of section 473(a)(8) of the Social Security Act relating to the effects of phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of the Social Security Act, as enacted by section 402 of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351; 122 Stat. 3975) and amended by section 206 of the Preventing Sex Trafficking and Strengthening Families Act (Public Law 113–183; 128 Stat. 1919). In particular, the Comptroller General shall analyze the extent to which States are complying with the following requirements under section 473(a)(8)(D) of the Social Security Act:

(1) The requirement to spend an amount equal to the amount of the savings (if any) in State expenditures under part E of title IV of the Social Security resulting from phasing out the AFDC income eligibility requirements for adoption assistance payments under section 473 of such Act to provide to children of families any service that may be provided under part B or E of title IV of such Act.

(2) The requirement that a State shall spend not less than 30 percent of the amount of any savings described in subparagraph (A) on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least ⅔ of the spending by the State to comply with the 30 percent requirement being spent on post-adoption and post-guardianship services.

(b) REPORT.—The Comptroller General of the United States shall submit to the Committee on Finance of the Senate, the Committee on Ways and Means of the House of Representatives, and the Secretary of Health and Human Services a report that contains the results of the study required by subsection (a), including recommendations to ensure compliance with laws referred to in subsection (a).

TITLE XXV—SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS

SEC. 25001. SHORT TITLE.

This title may be cited as the ''Social Impact Partnership to Pay for Results Act''.

SEC. 25002. SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS.

Section 403 of the Social Security Act (42 U.S.C. 603) is amended by adding at the end the following:

''(c) SOCIAL IMPACT DEMONSTRATION PROJECTS.—

''(1) PURPOSES.—The purposes of this subsection are the following:

''(A) To improve the lives of families and individuals in need in the United States by funding social programs that achieve real results.

''(B) To redirect funds away from programs that, based on objective data, are ineffective, and into programs that achieve demonstrable, measurable results.

''(C) To ensure Federal funds are used effectively on social services to produce positive outcomes for both service recipients and taxpayers.

''(D) To establish the use of social impact partnerships to address some of our Nation's most pressing problems.

''(E) To facilitate the creation of public-private partnerships that bundle philanthropic or other private resources with existing public spending to scale up effective social interventions already being implemented by private organizations, nonprofits, charitable organizations, and State and local governments across the country.

''(F) To bring pay-for-performance to the social sector, allowing the United States to improve the impact and effectiveness of vital social services programs while redirecting inefficient or duplicative spending.

''(G) To incorporate outcomes measurement and randomized controlled trials or other rigorous methodologies for assessing program impact.

''(2) SOCIAL IMPACT PARTNERSHIP APPLICATION.—

''(A) NOTICE.—Not later than 1 year after the date of the enactment of this subsection, the Secretary of the Treasury, in consultation with the Federal Interagency Council on Social Impact Partnerships, shall publish in the Federal Register a request for proposals from States or local governments for social impact partnership projects in accordance with this paragraph.

''(B) REQUIRED OUTCOMES FOR SOCIAL IMPACT PARTNERSHIP PROJECT.—To qualify as a social impact partnership project under this subsection, a project must produce one or more measurable, clearly defined outcomes that result in social benefit and Federal, State, or local savings through any of the following:

''(i) Increasing work and earnings by individuals in the United States who are unemployed for more than 6 consecutive months.

''(ii) Increasing employment and earnings of individuals who have attained 16 years of age but not 25 years of age.

''(iii) Increasing employment among individuals receiving Federal disability benefits.

''(iv) Reducing the dependence of low-income families on Federal means-tested benefits.

''(v) Improving rates of high school graduation.

''(vi) Reducing teen and unplanned pregnancies.

''(vii) Improving birth outcomes and early childhood health and development among low-income families and individuals.

''(viii) Reducing rates of asthma, diabetes, or other preventable diseases among low-income families and individuals to reduce the utilization of emergency and other high-cost care.

''(ix) Increasing the proportion of children living in two-parent families.

''(x) Reducing incidences and adverse consequences of child abuse and neglect.

''(xi) Reducing the number of youth in foster care by increasing adoptions, permanent guardianship arrangements, reunifications, or placements with a fit and willing relative, or by avoiding placing children in foster care by ensuring they can be cared for safely in their own homes.

''(xii) Reducing the number of children and youth in foster care residing in group homes, child care institutions, agency-operated foster homes, or other non-family foster homes, unless it is determined that it is in the interest of the child's long-term health, safety, or psychological well-being to not be placed in a family foster home.

''(xiii) Reducing the number of children returning to foster care.

''(xiv) Reducing recidivism among juvenile offenders, individuals released from prison, or other high-risk populations.

''(xv) Reducing the rate of homelessness among our most vulnerable populations.

''(xvi) Improving the health and well-being of those with mental, emotional, and behavioral health needs.

''(xvii) Improving the educational outcomes of special-needs or low-income children.

''(xviii) Improving the employment and well-being of returning United States military members.

''(xix) Increasing the financial stability of low-income families.

''(xx) Increasing the independence and employability of individuals who are physically or mentally disabled.

''(xxi) Other measurable outcomes defined by the State or local government that result in positive social outcomes and Federal savings.

''(C) APPLICATION REQUIRED.—The notice described in subparagraph (A) shall require a State or local government to submit an application for the social impact partnership project that addresses the following:

''(i) The outcome goals of the project.

''(ii) A description of each intervention in the project and anticipated outcomes of the intervention.

''(iii) Rigorous evidence demonstrating that the intervention can be expected to produce the desired outcomes.

''(iv) The target population that will be served by the project.

''(v) The expected social benefits to participants who receive the intervention and others who may be impacted.

''(vi) Projected Federal, State, and local government costs and other costs to conduct the project.

''(vii) Projected Federal, State, and local government savings and other savings, including an estimate of the savings to the Federal Government, on a program-by-program basis and in the aggregate, if the project is implemented and the outcomes are achieved as a result of the intervention.

''(viii) If savings resulting from the successful completion of the project are estimated to accrue to the State or local government, the likelihood of the State or local government to realize those savings.

''(ix) A plan for delivering the intervention through a social impact partnership model.

''(x) A description of the expertise of each service provider that will administer the intervention, including a summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or demonstrating that the service provider has the expertise necessary to deliver the proposed intervention.

''(xi) An explanation of the experience of the State or local government, the intermediary, or the service provider in raising private and philanthropic capital to fund social service investments.

''(xii) The detailed roles and responsibilities of each entity involved in the project, including any State or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

''(xiii) A summary of the experience of the service provider in delivering the proposed intervention or a similar intervention, or a summary demonstrating the service provider has the expertise necessary to deliver the proposed intervention.

''(xiv) A summary of the unmet need in the area where the intervention will be delivered or among the target population who will receive the intervention.

''(xv) The proposed payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

''(xvi) The project budget.

''(xvii) The project timeline.

''(xviii) The criteria used to determine the eligibility of an individual for the project, including how selected populations will be identified, how they will be referred to the project, and how they will be enrolled in the project.

''(xix) The evaluation design.

''(xx) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of the intervention and how the metrics will be measured.

''(xxi) An explanation of how the metrics used in the evaluation to determine whether the outcomes achieved as a result of the intervention are independent, objective indicators of impact and are not subject to manipulation by the service provider, intermediary, or investor.

''(xxii) A summary explaining the independence of the evaluator from the other entities involved in the project and the evaluator's experience in conducting rigorous evaluations of program effectiveness including, where available, well-implemented randomized controlled trials on the intervention or similar interventions.

''(xxiii) The capacity of the service provider to deliver the intervention to the number of participants the State or local government proposes to serve in the project.

''(xxiv) A description of whether and how the State or local government and service providers plan to sustain the intervention, if it is timely and appropriate to do so, to ensure that successful interventions continue to operate after the period of the social impact partnership.

''(D) PROJECT INTERMEDIARY INFORMATION REQUIRED.—The application described in subparagraph (C) shall also contain the following information about any intermediary for the social impact partnership project (whether an intermediary is a service provider or other entity):

''(i) Experience and capacity for providing or facilitating the provision of the type of intervention proposed.

''(ii) The mission and goals.

''(iii) Information on whether the intermediary is already working with service providers that provide this intervention or an explanation of the capacity of the intermediary to begin working with service providers to provide the intervention.

''(iv) Experience working in a collaborative environment across government and nongovernmental entities.

''(v) Previous experience collaborating with public or private entities to implement evidence-based programs.

''(vi) Ability to raise or provide funding to cover operating costs (if applicable to the project).

''(vii) Capacity and infrastructure to track outcomes and measure results, including—

''(I) capacity to track and analyze program performance and assess program impact; and

''(II) experience with performance-based awards or performance-based contracting and achieving project milestones and targets.

''(viii) Role in delivering the intervention.

''(ix) How the intermediary would monitor program success, including a description of the interim benchmarks and outcome measures.

''(E) FEASIBILITY STUDIES FUNDED THROUGH OTHER SOURCES.—The notice described in subparagraph (A) shall permit a State or local government to submit an application for social impact partnership funding that contains information from a feasibility study developed for purposes other than applying for funding under this subsection.

''(3) AWARDING SOCIAL IMPACT PARTNERSHIP AGREEMENTS.—

''(A) TIMELINE IN AWARDING AGREEMENT.—Not later than 6 months after receiving an application in accordance with paragraph (2), the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, shall determine whether to enter into an agreement for a social impact partnership project with a State or local government.

''(B) CONSIDERATIONS IN AWARDING AGREEMENT.—In determining whether to enter into an agreement for a social impact partnership project (the application for which was submitted under paragraph (2)) the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships (established by paragraph (6)) and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall consider each of the following:

''(i) The recommendations made by the Commission on Social Impact Partnerships.

''(ii) The value to the Federal Government of the outcomes expected to be achieved if the outcomes specified in the agreement are achieved as a result of the intervention.

''(iii) The likelihood, based on evidence provided in the application and other evidence, that the State or local government in collaboration with the intermediary and the service providers will achieve the outcomes.

''(iv) The savings to the Federal Government if the outcomes specified in the agreement are achieved as a result of the intervention.

''(v) The savings to the State and local governments if the outcomes specified in the agreement are achieved as a result of the intervention.

''(vi) The expected quality of the evaluation that would be conducted with respect to the agreement.

''(vii) The capacity and commitment of the State or local government to sustain the intervention, if appropriate and timely and if the intervention is successful, beyond the period of the social impact partnership.

''(C) AGREEMENT AUTHORITY.—

''(i) AGREEMENT REQUIREMENTS.—In accordance with this paragraph, the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, may enter into an agreement for a social impact partnership project with a State or local government if the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, determines that each of the following requirements are met:

''(I) The State or local government agrees to achieve one or more outcomes as a result of the intervention, as specified in the agreement and validated by independent evaluation, in order to receive payment.

''(II) The Federal payment to the State or local government for each specified outcome achieved as a result of the intervention is less than or equal to the value of the outcome to the Federal Government over a period not to exceed 10 years, as determined by the Secretary, in consultation with the State or local government.

''(III) The duration of the project does not exceed 10 years.

''(IV) The State or local government has demonstrated, through the application submitted under paragraph (2), that, based on prior rigorous experimental evaluations or rigorous quasi-experimental studies, the intervention can be expected to achieve each outcome specified in the agreement.

''(V) The State, local government, intermediary, or service provider has experience raising private or philanthropic capital to fund social service investments (if applicable to the project).

''(VI) The State or local government has shown that each service provider has experience delivering the intervention, a similar intervention, or has otherwise demonstrated the expertise necessary to deliver the intervention.

''(ii) PAYMENT.—The Secretary shall pay the State or local government only if the independent evaluator described in paragraph (5) determines that the social impact partnership project has met the requirements specified in the agreement and achieved an outcome as a result of the intervention, as specified in the agreement and validated by independent evaluation.

''(D) NOTICE OF AGREEMENT AWARD.—Not later than 30 days after entering into an agreement under this paragraph, the Secretary shall publish a notice in the Federal Register that includes, with regard to the agreement, the following:

''(i) The outcome goals of the social impact partnership project.

''(ii) A description of each intervention in the project.

''(iii) The target population that will be served by the project.

''(iv) The expected social benefits to participants who receive the intervention and others who may be impacted.

''(v) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

''(vi) The payment terms, the methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

''(vii) The project budget.

''(viii) The project timeline.

''(ix) The project eligibility criteria.

''(x) The evaluation design.

''(xi) The metrics that will be used in the evaluation to determine whether the outcomes have been achieved as a result of each intervention and how these metrics will be measured.

''(xii) The estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, if the agreement is entered into and implemented and the outcomes are achieved as a result of each intervention.

''(E) AUTHORITY TO TRANSFER ADMINISTRATION OF AGREEMENT.—The Secretary may transfer to the head of another Federal agency the authority to administer (including making payments under) an agreement entered into under subparagraph (C), and any funds necessary to do so.

''(F) REQUIREMENT ON FUNDING USED TO BENEFIT CHILDREN.—Not less than 50 percent of all Federal payments made to carry out agreements under this paragraph shall be used for initiatives that directly benefit children.

''(4) FEASIBILITY STUDY FUNDING.—

''(A) REQUESTS FOR FUNDING FOR FEASIBILITY STUDIES.—The Secretary shall reserve a portion of the amount reserved to carry out this subsection to assist States or local governments in developing feasibility studies to apply for social impact partnership funding under paragraph (2). To be eligible to receive funding to assist with completing a feasibility study, a State or local government shall submit an application for feasibility study funding addressing the following:

''(i) A description of the outcome goals of the social impact partnership project.

''(ii) A description of the intervention, including anticipated program design, target population, an estimate regarding the number of individuals to be served, and setting for the intervention.

''(iii) Evidence to support the likelihood that the intervention will produce the desired outcomes.

''(iv) A description of the potential metrics to be used.

''(v) The expected social benefits to participants who receive the intervention and others who may be impacted.

''(vi) Estimated costs to conduct the project.

''(vii) Estimates of Federal, State, and local government savings and other savings if the

project is implemented and the outcomes are achieved as a result of each intervention.

''(viii) An estimated timeline for implementation and completion of the project, which shall not exceed 10 years.

''(ix) With respect to a project for which the State or local government selects an intermediary to operate the project, any partnerships needed to successfully execute the project and the ability of the intermediary to foster the partnerships.

''(x) The expected resources needed to complete the feasibility study for the State or local government to apply for social impact partnership funding under paragraph (2).

''(B) FEDERAL SELECTION OF APPLICATIONS FOR FEASIBILITY STUDY.—Not later than 6 months after receiving an application for feasibility study funding under subparagraph (A), the Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships and the head of any Federal agency administering a similar intervention or serving a population similar to that served by the project, shall select State or local government feasibility study proposals for funding based on the following:

''(i) The recommendations made by the Commission on Social Impact Partnerships.

''(ii) The likelihood that the proposal will achieve the desired outcomes.

''(iii) The value of the outcomes expected to be achieved as a result of each intervention.

''(iv) The potential savings to the Federal Government if the social impact partnership project is successful.

''(v) The potential savings to the State and local governments if the project is successful.

''(C) PUBLIC DISCLOSURE.—Not later than 30 days after selecting a State or local government for feasibility study funding under this paragraph, the Secretary shall cause to be published on the website of the Federal Interagency Council on Social Impact Partnerships information explaining why a State or local government was granted feasibility study funding.

''(D) FUNDING RESTRICTION.—

''(i) FEASIBILITY STUDY RESTRICTION.—The Secretary may not provide feasibility study funding under this paragraph for more than 50 percent of the estimated total cost of the feasibility study reported in the State or local government application submitted under subparagraph (A).

''(ii) AGGREGATE RESTRICTION.—Of the total amount reserved to carry out this subsection, the Secretary may not use more than $10,000,000 to provide feasibility study funding to States or local governments under this paragraph.

''(iii) NO GUARANTEE OF FUNDING.—The Secretary shall have the option to award no funding under this paragraph.

''(E) SUBMISSION OF FEASIBILITY STUDY REQUIRED.—Not later than 9 months after the receipt of feasibility study funding under this paragraph, a State or local government receiving the funding shall complete the feasibility study and submit the study to the Federal Interagency Council on Social Impact Partnerships.

''(F) DELEGATION OF AUTHORITY.—The Secretary may transfer to the head of another Federal agency the authorities provided in this paragraph and any funds necessary to exercise the authorities.

''(5) EVALUATIONS.—

''(A) AUTHORITY TO ENTER INTO AGREEMENTS.—For each State or local government awarded a social impact partnership project approved by the Secretary under this subsection, the head of the relevant agency, as recommended by the Federal Interagency Council on Social Impact Partnerships and determined by the Secretary, shall enter into an agreement with the State or local government to pay for all or part of the independent evaluation to determine whether the State or local government project has achieved a specific outcome as a result of the intervention in order for the State or local government to receive outcome payments under this subsection.

''(B) EVALUATOR QUALIFICATIONS.—The head of the relevant agency may not enter into an agreement with a State or local government unless the head determines that the evaluator is independent of the other parties to the agreement and has demonstrated substantial experience in conducting rigorous evaluations of program effectiveness including, where available and appropriate, well-implemented randomized controlled trials on the intervention or similar interventions.

''(C) METHODOLOGIES TO BE USED.—The evaluation used to determine whether a State or local government will receive outcome payments under this subsection shall use experimental designs using random assignment or other reliable, evidence-based research methodologies, as certified by the Federal Interagency Council on Social Impact Partnerships, that allow for the strongest possible causal inferences when random assignment is not feasible.

''(D) PROGRESS REPORT.—

''(i) SUBMISSION OF REPORT.—The independent evaluator shall—

''(I) not later than 2 years after a project has been approved by the Secretary and biannually thereafter until the project is concluded, submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report summarizing the progress that has been made in achieving each outcome specified in the agreement; and

''(II) before the scheduled time of the first outcome payment and before the scheduled time of each subsequent payment, submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report that includes the results of the evaluation conducted to determine whether an outcome payment should be made along with information on the unique factors that contributed to achieving or failing to achieve the outcome, the challenges faced in attempting to achieve the outcome, and information on the improved future delivery of this or similar interventions.

''(ii) SUBMISSION TO THE SECRETARY AND CONGRESS.—Not later than 30 days after receipt of the written report pursuant to clause (i)(II), the Federal Interagency Council on Social Impact Partnerships shall submit the report to the Secretary and each committee of jurisdiction in the House of Representatives and the Senate.

''(E) FINAL REPORT.—

''(i) SUBMISSION OF REPORT.—Within 6 months after the social impact partnership project is completed, the independent evaluator shall—

''(I) evaluate the effects of the activities undertaken pursuant to the agreement with regard to each outcome specified in the agreement; and

''(II) submit to the head of the relevant agency and the Federal Interagency Council on Social Impact Partnerships a written report that includes the results of the evaluation and the conclusion of the evaluator as to whether the State or local government has fulfilled each obligation of the agreement, along with information on the unique factors that contributed to the success or failure of the project, the challenges faced in attempting to achieve the outcome, and information on the improved future delivery of this or similar interventions.

''(ii) SUBMISSION TO THE SECRETARY AND CONGRESS.—Not later than 30 days after receipt of the written report pursuant to clause (i)(II), the Federal Interagency Council on Social Impact Partnerships shall submit the report to the Secretary and each committee of jurisdiction in the House of Representatives and the Senate.

''(F) LIMITATION ON COST OF EVALUATIONS.—Of the amount reserved under this subsection for social impact partnership projects, the Secretary may not obligate more than 15 percent to evaluate the implementation and outcomes of the projects.

''(G) DELEGATION OF AUTHORITY.—The Secretary may transfer to the head of another Federal agency the authorities provided in this paragraph and any funds necessary to exercise the authorities.

''(6) FEDERAL INTERAGENCY COUNCIL ON SOCIAL IMPACT PARTNERSHIPS.—

''(A) ESTABLISHMENT.—There is established the Federal Interagency Council on Social Impact Partnerships (in this paragraph referred to as the 'Council') to—

''(i) coordinate with the Secretary on the efforts of social impact partnership projects funded under this subsection;

''(ii) advise and assist the Secretary in the development and implementation of the projects;

''(iii) advise the Secretary on specific programmatic and policy matter related to the projects;

''(iv) provide subject-matter expertise to the Secretary with regard to the projects;

''(v) certify to the Secretary that each State or local government that has entered into an agreement with the Secretary for a social impact partnership project under this subsection and each evaluator selected by the head of the relevant agency under paragraph (5) has access to Federal administrative data to assist the State or local government and the evaluator in evaluating the performance and outcomes of the project;

''(vi) address issues that will influence the future of social impact partnership projects in the United States;

''(vii) provide guidance to the executive branch on the future of social impact partnership projects in the United States;

''(viii) prior to approval by the Secretary, certify that each State and local government application for a social impact partnership contains rigorous, independent data and reliable, evidence-based research methodologies to support the conclusion that the project will yield savings to the State or local government or the Federal Government if the project outcomes are achieved;

''(ix) certify to the Secretary, in the case of each approved social impact partnership that is expected to yield savings to the Federal Government, that the project will yield a projected savings to the Federal Government if the project outcomes are achieved, and coordinate with the relevant Federal agency to produce an after-action accounting once the project is complete to determine the actual Federal savings realized, and the extent to which actual savings aligned with projected savings; and

''(x) provide periodic reports to the Secretary and make available reports periodically to Congress and the public on the implementation of this subsection.

''(B) COMPOSITION OF COUNCIL.—The Council shall have 11 members, as follows:

''(i) CHAIR.—The Chair of the Council shall be the Director of the Office of Management and Budget.

''(ii) OTHER MEMBERS.—The head of each of the following entities shall designate one officer or employee of the entity to be a Council member:

''(I) The Department of Labor.

''(II) The Department of Health and Human Services.

''(III) The Social Security Administration.

''(IV) The Department of Agriculture.

''(V) The Department of Justice.

''(VI) The Department of Housing and Urban Development.

''(VII) The Department of Education.

''(VIII) The Department of Veterans Affairs.

''(IX) The Department of the Treasury.

''(X) The Corporation for National and Community Service.

''(7) COMMISSION ON SOCIAL IMPACT PARTNERSHIPS.—

''(A) ESTABLISHMENT.—There is established the Commission on Social Impact Partnerships (in this paragraph referred to as the 'Commission').

''(B) DUTIES.—The duties of the Commission shall be to—

''(i) assist the Secretary and the Federal Interagency Council on Social Impact Partnerships in reviewing applications for funding under this subsection;

''(ii) make recommendations to the Secretary and the Federal Interagency Council on Social Impact Partnerships regarding the funding of social impact partnership agreements and feasibility studies; and

''(iii) provide other assistance and information as requested by the Secretary or the Federal Interagency Council on Social Impact Partnerships.

''(C) COMPOSITION.—The Commission shall be composed of nine members, of whom—

''(i) one shall be appointed by the President, who will serve as the Chair of the Commission;

''(ii) one shall be appointed by the Majority Leader of the Senate;

''(iii) one shall be appointed by the Minority Leader of the Senate;

''(iv) one shall be appointed by the Speaker of the House of Representatives;

''(v) one shall be appointed by the Minority Leader of the House of Representatives;

''(vi) one shall be appointed by the Chairman of the Committee on Finance of the Senate;

''(vii) one shall be appointed by the ranking member of the Committee on Finance of the Senate;

''(viii) one member shall be appointed by the Chairman of the Committee on Ways and Means of the House of Representatives; and

''(ix) one shall be appointed by the ranking member of the Committee on Ways and Means of the House of Representatives.

''(D) QUALIFICATIONS OF COMMISSION MEMBERS.—The members of the Commission shall—

''(i) be experienced in finance, economics, pay for performance, or program evaluation;

''(ii) have relevant professional or personal experience in a field related to one or more of the outcomes listed in this subsection; or

''(iii) be qualified to review applications for social impact partnership projects to determine whether the proposed metrics and evaluation methodologies are appropriately rigorous and reliant upon independent data and evidence-based research.

''(E) TIMING OF APPOINTMENTS.—The appointments of the members of the Commission shall be made not later than 120 days after the date of the enactment of this subsection, or, in the event of a vacancy, not later than 90 days after the date the vacancy arises. If a member of Congress fails to appoint a member by that date, the President may select a member of the President's choice on behalf of the member of Congress. Notwithstanding the preceding sentence, if not all appointments have been made to the Commission as of that date, the Commission may operate with no fewer than five members until all appointments have been made.

''(F) TERM OF APPOINTMENTS.—

''(i) IN GENERAL.—The members appointed under subparagraph (C) shall serve as follows:

''(I) Three members shall serve for 2 years.

''(II) Three members shall serve for 3 years.

''(III) Three members (one of which shall be Chair of the Commission appointed by the President) shall serve for 4 years.

''(ii) ASSIGNMENT OF TERMS.—The Commission shall designate the term length that each member appointed under subparagraph (C) shall serve by unanimous agreement. In the event that unanimous agreement cannot be reached, term lengths shall be assigned to the members by a random process.

''(G) VACANCIES.—Subject to subparagraph (E), in the event of a vacancy in the Commission, whether due to the resignation of a member, the expiration of a member's term, or any other reason, the vacancy shall be filled in the manner in which the original appointment was made and shall not affect the powers of the Commission.

''(H) APPOINTMENT POWER.—Members of the Commission appointed under subparagraph (C) shall not be subject to confirmation by the Senate.

''(8) LIMITATION ON USE OF FUNDS.—Of the amounts reserved to carry out this subsection, the Secretary may not use more than $2,000,000 in any fiscal year to support the review, approval, and oversight of social impact partnership projects, including activities conducted by—

''(A) the Federal Interagency Council on Social Impact Partnerships; and

''(B) any other agency consulted by the Secretary before approving a social impact partnership project or a feasibility study under paragraph (4).

''(9) NO FEDERAL FUNDING FOR CREDIT ENHANCEMENTS.—No amount reserved to carry out this subsection may be used to provide any insurance, guarantee, or other credit enhancement to a State or local government under which a Federal payment would be made to a State or local government as the result of a State or local government failing to achieve an outcome specified in a contract.

''(10) AVAILABILITY OF FUNDS.—Amounts reserved to carry out this subsection shall remain available until 10 years after the date of the enactment of this subsection.

''(11) WEBSITE.—The Federal Interagency Council on Social Impact Partnerships shall establish and maintain a public website that shall display the following:

''(A) A copy of, or method of accessing, each notice published regarding a social impact partnership project pursuant to this subsection.

''(B) A copy of each feasibility study funded under this subsection.

''(C) For each State or local government that has entered into an agreement with the Secretary for a social impact partnership project, the website shall contain the following information:

''(i) The outcome goals of the project.

''(ii) A description of each intervention in the project.

''(iii) The target population that will be served by the project.

''(iv) The expected social benefits to participants who receive the intervention and others who may be impacted.

''(v) The detailed roles, responsibilities, and purposes of each Federal, State, or local government entity, intermediary, service provider, independent evaluator, investor, or other stakeholder.

''(vi) The payment terms, methodology used to calculate outcome payments, the payment schedule, and performance thresholds.

''(vii) The project budget.

''(viii) The project timeline.

''(ix) The project eligibility criteria.

''(x) The evaluation design.

''(xi) The metrics used to determine whether the proposed outcomes have been achieved and how these metrics are measured.

''(D) A copy of the progress reports and the final reports relating to each social impact partnership project.

''(E) An estimate of the savings to the Federal, State, and local government, on a program-by-program basis and in the aggregate, resulting from the successful completion of the social impact partnership project.

''(12) REGULATIONS.—The Secretary, in consultation with the Federal Interagency Council on Social Impact Partnerships, may issue regulations as necessary to carry out this subsection.

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

''(A) AGENCY.—The term 'agency' has the meaning given that term in section 551 of title 5, United States Code.

''(B) INTERVENTION.—The term 'intervention' means a specific service delivered to achieve an impact through a social impact partnership project.

''(C) SECRETARY.—The term 'Secretary' means the Secretary of the Treasury.

''(D) SOCIAL IMPACT PARTNERSHIP PROJECT.—The term 'social impact partnership project' means a project that finances social services using a social impact partnership model.

''(E) SOCIAL IMPACT PARTNERSHIP MODEL.—The term 'social impact partnership model' means a method of financing social services in which—

''(i) Federal funds are awarded to a State or local government only if a State or local government achieves certain outcomes agreed on by the State or local government and the Secretary; and

''(ii) the State or local government coordinates with service providers, investors (if applicable to the project), and (if necessary) an intermediary to identify—

''(I) an intervention expected to produce the outcome;

''(II) a service provider to deliver the intervention to the target population; and

''(III) investors to fund the delivery of the intervention.

''(F) STATE.—The term 'State' means each State of the United States, the District of Columbia, each commonwealth, territory or possession of the United States, and each federally recognized Indian tribe.

''(14) FUNDING.—Of the amounts made available to carry out subsection (b) for fiscal year 2017, the Secretary shall reserve $100,000,000 to carry out this subsection.''.

SEC. 25003. EXTENSION OF TANF PROGRAM.

(a) FAMILY ASSISTANCE GRANTS.—Section 403(a)(1) of the Social Security Act (42 U.S.C. 603(a)(1)) is amended in each of subparagraphs (A) and (C), by striking ''2012'' and inserting ''2017''.

(b) HEALTHY MARRIAGE PROMOTION AND RESPONSIBLE FATHERHOOD GRANTS.—Section 403(a)(2)(D) of such Act (42 U.S.C. 603(a)(2)(D)) is amended by striking ''2012'' each place it appears and inserting ''2017''.

(c) TRIBAL GRANTS.—Section 412(a) of such Act (42 U.S.C. 612(a)) is amended in each of paragraphs (1)(A) and (2)(A) by striking ''2012'' and inserting ''2017''.

(d) CHILD CARE ENTITLEMENT.—Section 418(a)(3) of such Act (42 U.S.C. 618(a)(3)) is amended by striking ''2012'' and inserting ''2017''.

(e) GRANTS TO THE TERRITORIES.—Section 1108(b)(2) of such Act (42 U.S.C. 1308(b)(2)) is amended by striking ''2012'' and inserting ''2017''.

SEC. 25004. STRENGTHENING WELFARE RESEARCH AND EVALUATION AND DEVELOPMENT OF A WHAT WORKS CLEARINGHOUSE.

(a) IN GENERAL.—Section 413 of the Social Security Act (42 U.S.C. 613) is amended to read as follows:

''SEC. 413. EVALUATION OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES AND RELATED PROGRAMS.

''(a) EVALUATION OF THE IMPACTS OF TANF.—The Secretary shall conduct research on the effect of State programs funded under this part and any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i)) on employment, self-sufficiency, child well-being, unmarried births, marriage, poverty, economic mobility, and other factors as determined by the Secretary.

''(b) EVALUATION OF GRANTS TO IMPROVE CHILD WELL-BEING BY PROMOTING HEALTHY MARRIAGE AND RESPONSIBLE FATHERHOOD.—The Secretary shall conduct research to determine the effects of the grants made under section 403(a)(2) on child well-being, marriage, family stability, economic mobility, poverty, and other factors as determined by the Secretary.

''(c) DISSEMINATION OF INFORMATION.—The Secretary shall, in consultation with States receiving funds provided under this part, develop methods of disseminating information on any research, evaluation, or study conducted under this section, including facilitating the sharing of information and best practices among States and localities.

''(d) STATE-INITIATED EVALUATIONS.—A State shall be eligible to receive funding to evaluate the State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i)) if—

''(1) the State submits to the Secretary a description of the proposed evaluation;

''(2) the Secretary determines that the design and approach of the proposed evaluation is rigorous and is likely to yield information that is credible and will be useful to other States; and

''(3) unless waived by the Secretary, the State contributes to the cost of the evaluation, from non-Federal sources, an amount equal to at least 25 percent of the cost of the proposed evaluation.

''(e) CENSUS BUREAU RESEARCH.—

''(1) The Bureau of the Census shall implement or enhance household surveys of program participation, in consultation with the Secretary and the Bureau of Labor Statistics and made available to interested parties, to allow for the assessment of the outcomes of continued welfare reform on the economic and child well-being of low-income families with children, including those who received assistance or services from a State program funded under this part or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i)). The content of the surveys should include such information as may be necessary to examine the issues of unmarried childbearing, marriage, welfare dependency and compliance with work requirements, the beginning and ending of spells of assistance, work, earnings and employment stability, and the well-being of children.

''(2) To carry out the activities specified in paragraph (1), the Bureau of the Census, the Secretary, and the Bureau of Labor Statistics shall consider ways to improve the surveys and data derived from the surveys to—

''(A) address under reporting of the receipt of means-tested benefits and tax benefits for low-income individuals and families;

''(B) increase understanding of poverty spells and long-term poverty, including by facilitating the matching of information to better understand intergenerational poverty;

''(C) generate a better geographical understanding of poverty such as through State-based estimates and measures of neighborhood poverty;

''(D) increase understanding of the effects of means-tested benefits and tax benefits on the earnings and incomes of low-income families; and

''(E) improve how poverty and economic well-being are measured, including through the use of consumption measures, material deprivation measures, social exclusion measures, and economic and social mobility measures.

''(f) RESEARCH AND EVALUATION CONDUCTED UNDER THIS SECTION.—Research and evaluation conducted under this section designed to determine the effects of a program or policy (other than research conducted under subsection (e)) shall use experimental designs using random assignment or other reliable, evidence-based research methodologies that allow for the strongest possible causal inferences when random assignment is not feasible.

''(g) DEVELOPMENT OF WHAT WORKS CLEARINGHOUSE OF PROVEN AND PROMISING APPROACHES TO MOVE WELFARE RECIPIENTS INTO WORK.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, shall develop a database (which shall be referred to as the 'What Works Clearinghouse of Proven and Promising Projects to Move Welfare Recipients into Work') of the projects that used a proven approach or a promising approach in moving welfare recipients into work, based on independent, rigorous evaluations of the projects. The database shall include a separate listing of projects that used a developmental approach in delivering services and a further separate listing of the projects with no or negative effects. The Secretary shall add to the What Works Clearinghouse of Proven and Promising Projects to Move Welfare Recipients into Work data about the projects that, based on an independent, well-conducted experimental evaluation of a program or project, using random assignment or other research methodologies that allow for the strongest possible causal inferences, have shown they are proven, promising, developmental, or ineffective approaches.

''(2) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF APPROACH.—The Secretary, in consultation with the Secretary of Labor and organizations with experience in evaluating research on the effectiveness of various approaches in delivering services to move welfare recipients into work, shall—

''(A) establish criteria for evidence of effectiveness; and

''(B) ensure that the process for establishing the criteria—

''(i) is transparent;

''(ii) is consistent across agencies;

''(iii) provides opportunity for public comment; and

''(iv) takes into account efforts of Federal agencies to identify and publicize effective interventions, including efforts at the Department of Health and Human Services, the Department of Education, and the Department of Justice.

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

''(A) APPROACH.—The term 'approach' means a process, product, strategy, or practice that is—

''(i) research-based, based on the results of one or more empirical studies, and linked to program-determined outcomes; and

''(ii) evaluated using rigorous research designs.

''(B) PROVEN APPROACH.—The term 'proven approach' means an approach that—

''(i) meets the requirements of a promising approach; and

''(ii) has demonstrated significant and substantively important positive outcomes at more than one site in terms of increasing work and earnings of participants, reducing poverty and dependence, improving child well-being, or strengthening families.

''(C) PROMISING APPROACH.—The term 'promising approach' means an approach—

''(i) that meets the requirements of subparagraph (D)(i);

''(ii) that has been evaluated using well-designed and rigorous randomized controlled trials (or, if not available, rigorous quasi-experimental research designs);

''(iii) that has demonstrated significant and substantively important positive outcomes at one site in terms of increasing work and earnings of participants, reducing poverty and dependence, improving child well-being, or strengthening families; and

''(iv) under which the benefits of the positive outcomes have exceeded the costs of achieving the outcomes.

''(D) DEVELOPMENTAL APPROACH.—The term 'developmental approach' means an approach that—

''(i) is research-based, grounded in relevant empirically-based knowledge, and linked to program-determined outcomes;

''(ii) is evaluated using rigorous research designs; and

''(iii) has yet to demonstrate a significant positive outcome in terms of increasing work and earnings of participants in a cost-effective way.

''(h) APPROPRIATION.—

''(1) IN GENERAL.—Of the amount appropriated by section 403(a)(1) for each fiscal year, 0.33 percent shall be available for research, technical assistance, and evaluation under this section.

''(2) ALLOCATION.—Of the amount made available under paragraph (1) for each fiscal year, the Secretary shall make available $10,000,000 plus such additional amount as the Secretary deems necessary and appropriate, to carry out subsection (e).''.

(b) CONFORMING AMENDMENT.—Section 403(a)(1)(B) of such Act (42 U.S.C. 603(a)(1)(B)) is amended by inserting '', reduced by the percentage specified in section 413(h) with respect to the fiscal year,'' before ''as the amount''.

SEC. 25005. TECHNICAL CORRECTIONS TO DATA EXCHANGE STANDARDS TO IMPROVE PROGRAM COORDINATION.

(a) IN GENERAL.—Section 411(d) of the Social Security Act (42 U.S.C. 611(d)) is amended to read as follows:

''(d) DATA EXCHANGE STANDARDS FOR IMPROVED INTEROPERABILITY.—

''(1) DESIGNATION.—The Secretary shall, in consultation with an interagency work group established by the Office of Management and Budget and considering State government perspectives, by rule, designate data exchange standards to govern, under this part—

''(A) necessary categories of information that State agencies operating programs under State plans approved under this part are required under applicable Federal law to electronically exchange with another State agency; and

''(B) Federal reporting and data exchange required under applicable Federal law.

''(2) REQUIREMENTS.—The data exchange standards required by paragraph (1) shall, to the extent practicable—

''(A) incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as the eXtensible Markup Language;

''(B) contain interoperable standards developed and maintained by intergovernmental partnerships, such as the National Information Exchange Model;

''(C) incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance;

''(D) be consistent with and implement applicable accounting principles;

''(E) be implemented in a manner that is cost-effective and improves program efficiency and effectiveness; and

''(F) be capable of being continually upgraded as necessary.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a change to existing data exchange standards found to be effective and efficient.''.

(b) EFFECTIVE DATE.—Not later than the date that is 24 months after the date of the enactment of this section, the Secretary of Health and Human Services shall issue a proposed rule that—

(1) identifies federally required data exchanges, include specification and timing of exchanges to be standardized, and address the factors used in determining whether and when to standardize data exchanges; and

(2) specifies State implementation options and describes future milestones.

The SPEAKER pro tempore. Pursuant to House Resolution 934, the motion shall be debatable for 80 minutes, with 60 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce and 20 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Ways and Means.

The gentleman from Michigan (Mr. UPTON) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes. The gentleman from Texas (Mr. BRADY) and the gentleman from Michigan (Mr. LEVIN) each will control 10 minutes.

The Chair recognizes the gentleman from Michigan (Mr. UPTON).

□ 1345

GENERAL LEAVE

Mr. UPTON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on H.R. 34.

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

There was no objection.

Mr. UPTON. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, there is not a single person in this Chamber or watching at home today who has not been touched by disease in some way. We have all said too many early good-byes to folks that we hold dear—families robbed of a parent who will never get to see their child's milestones, a child born without the gift of a future.

Every day, countless folks living vibrant lives are delivered unexpected diagnoses. It is a cycle that repeats itself over and over in every community. Life changes in an instant, and hope seems out of reach, whether it be Alzheimer's, lupus, MS, cancer, you name it.

No matter where you are from, one thing that binds us all together is that we all want more time with our loved ones. That is why we are here today, because the clock is ticking for patients and their families.

So, Mr. Speaker, this brings us to the 21st Century Cures Act. This bipartisan bill will ensure that our health system can keep pace with the incredible advances in science and technology. In Cures, we have got a medical innovation game-changer that will deliver hope to patients across the country.

We have been here before. In July of 2015, after a series of roundtables, hearings, white papers, and public feedback, the House overwhelmingly voted in support of 21st Century Cures.

Sure, we have encountered a number of detours and obstacles along the path to Cures, but we have taken great inspiration in those patients who have partnered in this effort to persevere, stay positive, and continue forward to get the job done, just like my two little Michigan girls, Brooke and Brielle, who are battling SMA, do every day. Each day, they muster incredible strength and courage, conquering challenges that most folks will never encounter in a lifetime.

So 3 years ago, we had an idea that, yes, we could do better. We needed to do something to transform our health research system to effectively fight disease in this century. Finding cures and boosting research and innovation was absent from any policy to-do list. People didn't seem to care that the gap between biomedical innovation and our regulatory process was widening, or that of the 10,000 known diseases—7,000 of which are rare—there are treatments for only about 500. We needed to change the conversation and restore urgency. And working together, we have.

First, we listened to more than just Brooke and Brielle, but to Barb, Becky, Lisa, Geno, the Dons, the Betsys, little Max, and our own little Steve LaTourette who always sat in the corner. Virtually everyone here had a story to tell and for folks here to listen to.

Science and biomedical innovation have made incredible strides over the last two decades: mapping the human genome, new biomarkers, and personal healthcare apps. Each have offered new opportunities to find new treatment and cures. But the way the FDA and the NIH apply these new innovations to our regulatory process, in fact, has lagged behind.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. UPTON. Mr. Speaker, I yield myself an additional 2 minutes.

These agencies and the rules and regs they produce, affecting the discovery, development, and delivery of lifesaving drugs and devices, also need modernization and innovation. They need a game-changer, and now we have it. This legislation breaks down regulatory barriers and expedites the approvals for drugs and devices, coupled with billions more for research.

The former head of the NCI and the FDA, Andy von Eschenbach, has called this the most transformational biomedical legislation in the past 3 years. He is right.

But this package is not just about Cures. No. It also achieves several additional top-line priorities for our Energy and Commerce Committee, including valuable resources to fight the opioid epidemic and delivering landmark mental health reforms spearheaded by Dr. TIM MURPHY to help families in crisis and treat mental illnesses rather than incarceration. This is, without a doubt, the most important and impactful bill that we will enact in this Congress.

Patients aren't interested in debating the timelines. The failure rates, the size and cost of conducting clinical trials, are at an all-time high. They just know that despite the promise of scientific breakthroughs, they can't get the therapy that might save their life. That is why we need this bill.

I want to give a special thanks to my many partners, including especially DIANA DEGETTE, not to mention JOE PITTS, FRANK PALLONE, TIM MURPHY, and LAMAR ALEXANDER, the leadership on both sides of the aisle in both Chambers. I thank my truly brilliant committee and personal staff led by Gary Andres and Joan Hillebrands, Health Counsel Paul Edattel, and, of course, my wife, Amey.

We are on the cusp of something special, a once-in-a-generation opportunity to transform how we treat disease. With this vote, we are taking a giant leap on the path to Cures. Working together, we will deliver Cures now.

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

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentlewoman from Colorado (Ms. DEGETTE), who is the Democratic sponsor of the bill and who has worked so hard to make this day a reality.

Ms. DEGETTE. Mr. Speaker, I rise today in strong support of the 21st Century Cures Act, knowing that I am far from alone in supporting this bill. More than 700 groups representing patients, healthcare providers, researchers, and others have voiced support for the bill, as has the White House, which provided its enthusiastic endorsement last night.

This is a watershed moment in this country for biomedical research. With this bill, we bring hope to millions of patients who suffer from cancer, Alzheimer's, diabetes, and a host of other ailments.

As my cosponsor and partner in crime, FRED UPTON, just said, we started working on this measure 3 years ago. We traveled the country together to gather information about much-needed reforms, and we had tremendous participation in the process from patient groups, medical professionals, academia, and Federal and State healthcare authorities, not to mention the entire Democratic and Republican membership of the Energy and Commerce Committee who worked so closely together to make this happen.

All of this led to a bill that was passed in July, 2015, by 344–77. We can barely pass the Journal every day by that amount, Mr. Speaker.

Now, this was in the summer of 2015, and we have worked tirelessly in a bipartisan way since then to improve and expand the bill and to make sure it can pass through the Senate and be signed by the White House.

The result will help to overcome obstacles to medical progress from discovery to development to delivery through investing in innovation, incorporating the patient perspective, and modernizing clinical trials.

Among the key provisions, this consensus version of the bill will provide $4.8 billion to the National Institutes of Health, including money for Vice President BIDEN's Cancer Moonshot initiative, including money for Precision Medicine and the BRAIN Initiative. It will provide almost $1 billion in grants to the States to address the urgent opioid crisis in this country.

It removes the silos at the Food and Drug Administration by transitioning it to a disease-centric approach, and it gives $500 million so the FDA can implement these reforms. It includes all-important mental health legislation that we have also worked on so hard for so long, and it will catalyze cutting-edge research by supporting potentially transformative efforts.

Mr. Speaker, at a time of heightened acrimony in Washington and in the wake of one of the most rancorous elections we have ever had, isn't it wonderful that we can come together to find cures that affect millions of Americans?

Disease doesn't discriminate according to political party. It knows nothing of claims and counterclaims. It responds only to carefully developed

treatments and cures. What we are doing today is we are voting to put vital innovations in biomedical research within reach, potentially saving countless lives. I urge all of our colleagues to think about the millions of Americans who will be heartened by this bill's progress, and I urge you to vote ''yes'' on the 21st Century Cures Act.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BARTON), who is the former chairman and now chairman emeritus of the Energy and Commerce Committee. My friend, the Honorable JOE BARTON, really helped us push this bill every step of the way.

(Mr. BARTON asked and was given permission to revise and extend his remarks.)

Mr. BARTON. Mr. Speaker, the Affordable Care Act failed because it was a one-sided, partisan, and close-looped system. This bill, the 21st Century Cures Act, will succeed because it has been done just the opposite.

Chairman UPTON, DIANA DEGETTE, FRANK PALLONE, and many other people have worked together, as they said, for the last 3 years to find the best pathway forward to get new drugs and new therapies to our citizenship more quickly and efficiently. I want to congratulate both of them plus Chairman BRADY, Dr. MURPHY, and the others that have worked on this.

This bill makes it possible for cures to actually be put into practice without all the red tape and regulatory overkill. Let me give you an example. This bill makes possible the use of what is called regenerative medicine which we call stem cell therapy.

My 11-year-old son, Jack, last week played football with Coach Sam Harrell of Ennis, Texas, who 3 years ago could not get out of bed because of his disease. He had to go out of the country twice to get stem cell therapy. He can now act normally.

This bill makes possible those kinds of cures. I rise in strong support and thank Chairman UPTON for his strong work on this.

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

Mr. Speaker, over the past 2 years, my colleagues and I on the Energy and Commerce Committee have worked to craft the 21st Century Cures Act with the goal of getting new treatments and cures to the people who need them the most. It has been a long journey, and I want to thank my colleagues, Chairman UPTON, Representatives DeGette and GENE GREEN of Texas for their commitment to this important legislation.

This is not a perfect bill, but, after much consideration, I believe the benefits outweigh my concerns, and I fully support its passage. This final bill includes many provisions that my Democratic colleagues and I, as well as the administration, fought hard to have included.

The bill provides new funding for the National Institutes of Health, the President's Precision Medicine Initiative, and the Vice President's Cancer Moonshot initiative. It also provides new resources for the Food and Drug Administration and grants for States currently battling the opioid abuse crisis.

This final legislation also includes important policy changes that break down the research silos that have existed for years. The bill includes data sharing among NIH-supported scientists and increases the number of racial and ethnic minorities and women that are included in NIH-funded clinical trials.

These important changes will allow the entire scientific community to learn lessons from this critical NIH-funded research and will strengthen research for diverse populations.

I am also pleased, Mr. Speaker, that the bill includes a new FDA grant program to study the process of continuous drug manufacturing. This innovative process will allow for more effective drug production without sacrificing quality. The bill also includes important hiring provisions to help the FDA recruit and retain the best and the brightest and policies to move us closer to ensuring we have interoperable electronic health records, which are critical to reducing costs and improving care.

As I said, this is not a perfect bill, and I have some concerns with the final product. I am disappointed that the bill does not contain guaranteed funding. Instead, we must ensure each year that the Appropriations Committee and the Republican majority lives up to the promises they make today, and we will hold them to these promises. The lack of immediate funding for the FDA is a particular concern given the fact that this bill asks the FDA to take on significantly more responsibilities that we know are extremely resource intensive.

I am also concerned that the bill removes certain categories of medical software from FDA oversight. This makes it difficult for FDA, in the future, to bring software that is used to support or sustain human life back under FDA's jurisdiction.

I am also troubled by the new priority review voucher program which will likely require the FDA to issue significantly more PRVs. This could pose a burden on FDA drug reviewers when redeemed and could prevent the FDA from being able to prioritize its review of drugs based on public health priorities.

The bill includes new language added without full consideration by the House or Senate regarding FDA oversight of regenerative medicine products.

□ 1400

While most of the harmful language was taken out, I do remain troubled that the bill creates a new designation process under FDA's accelerated approval pathway.

I am pleased, Mr. Speaker, that this package includes the Helping Families in Mental Health Crisis Act. This is a helpful step towards the more substantial reforms our broken mental health system needs.

I am specifically proud that the bill expands an important set of Medicaid benefits to kids receiving inpatient psychiatric treatment. However, let's be clear, the benefits of the mental health bill will be far outweighed by the catastrophic harm caused by individuals with mental illness if the Republicans move forward with their radical plans to repeal the Affordable Care Act or block grants for Medicaid or cut benefits for low-income individuals.

Again, on balance, this is a good bill. I fully support it. I want to thank all of my committee colleagues and their staff for their hard work on this legislation.

I reserve the balance of my time.

Mr. UPTON. Mr. Speaker, I yield 30 seconds to the gentleman from Illinois (Mr. SHIMKUS), one of the senior subcommittee chairmen on the Energy and Commerce Committee, one that helped lead the fight all across the Nation in support of this bill.

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, I thank Chairman UPTON, and I congratulate my friend DIANA DEGETTE. Also, I thank FRANK PALLONE for a good job. I thank him for being supportive, especially today, as we move this forward.

Thank you for including six of my bills that I had involved, one that deals with the lack of antibiotics in the market in the pipeline. So that is helpful. Four other bills help innovation to get lifesaving devices to the market.

I encourage all of my colleagues on both sides of the aisle to support this bill.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. GENE GREEN), the ranking member of the Health Subcommittee, who, again, has been critical, particularly in the last 3 months, in putting this bill together.

Mr. GENE GREEN of Texas. Mr. Speaker, I thank my colleague for providing the time.

I rise to express strong support for the 21st Century Cures Act.

Almost 3 years ago, we set out on a mission to do something positive to boost medical research and innovation and accelerate the discovery, development, and delivery of new cures and treatments.

After countless hours devoted to roundtables, white papers, hearings, and drafts, today, Cures has bipartisan support and endorsements from over 700 organizations representing a full spectrum of stakeholders and the strong support of the administration. My Houston area neighbors, Congressmen PETE OLSON and MIKE BURGESS, and I held a roundtable in the Houston area with the great institutions at our

Texas Media Center in the Houston area.

It dedicates $6.3 billion in new investments to support priorities like the Cancer Moonshot and Precision Medicine Initiative within the National Institutes of Health, and to combat prescription drug abuse. This also provides money for the Food and Drug Administration to advance the agency's mission and implement the policies in the underlying bill. This influx of investment will be put towards solving today's complex scientific problems, getting new treatments from the lab table to the bedside, and improving public health.

In addition to this much-needed funding, there are so many provisions in this package worthy of support. From facilitating the development of new antibiotics to fight against superbugs, to advancing the use of modern clinical trial designs, to fostering the next generation of medical researchers, the 21st Century Cures Act will develop hope and new treatments for Americans in need. While some of these provisions are technical in nature, the real-world impact they will have is not abstract. Patients and families deserve to have their elected officials respond to their needs, and this bill does that.

Eighteen months ago, 344 Members supported Cures when it passed the House of Representatives. Since then, we have responded to feedback and tailored the bill, and it now includes additional priorities like improvements to our mental health system and nonpartisan provisions to strengthen Medicare on behalf of beneficiaries.

I want to thank Chairman UPTON, Ranking Member PALLONE, Congresswoman DEGETTE, and Chairman PITTS for their leadership, vision, and determination. I also want to thank our staff, the House Legislative Counsel, and the countless stakeholders without whom we would not be here today.

It was a privilege to be part of this landmark effort. As an original sponsor and coauthor of the 21st Century Cures Act, I urge my colleagues to vote ''yes.''

Mr. Speaker, the following is my complete statement: I rise to express my strong support for the 21st Century Cures Act.

Almost three years ago, we set out on a mission: do something positive to boost medical research and innovation, and accelerate the discovery, development, and delivery of new cures and treatments.

After countless hours devoted to roundtables, whitepapers, hearings and drafts, today Cures has bipartisan support and endorsements from over 700 organizations representing the full spectrum of stakeholders, and the strong support of the Administration. My Houston area neighbors Congressmen PETE OLSON and MIKE BURGESS held a roundtable with the many great institutions at our Texas Media Center.

It dedicates $6.3 billion in new investments to support priorities like the Cancer Moonshot and Precision Medicine Initiative within the National Institutes of Health (NIH), and to combat prescription drug abuse.

It also provides money to the Food and Drug Administration (FDA) to advance the agency's mission and implement the policies in the underlying bill.

This influx of investment will be put towards solving today's complex scientific problems, getting new treatments from the lab table to the bedside, and improving public health.

In addition to this much needed funding, there are so many provisions in this package worthy of support.

From facilitating the development of new antibiotics to fight against superbugs to advancing the use of modern clinical trial designs to the fostering of the next generation of medical researchers, the 21st Century Cures Act will deliver hope and new treatments to Americans in need.

While some of the provisions are technical in nature, the real-world impact they will have is not abstract.

Patients and families deserve to have their elected officials respond to their needs.

This bill does that.

Eighteen months ago, 344 members supported Cures (H.R. 6) when it passed the House of Representatives.

Since then, we have responded to feedback and tailored the bill, and it now includes additional priorities like improvements to our mental health care system and non-partisan provisions to strengthen Medicare on behalf of beneficiaries.

I want to thank Chairman UPTON, Ranking Member PALLONE, Congresswoman DEGETTE, and Chairman PITTS for their leadership, vision, and determination.

I also want to thank our staff, House Legislative Council, and the countless stakeholders without whom we would not be here today.

I want to particularly thank Tiffany Guarascio, Arielle Woronoff, Rachel Pryor, Kimberlee Trzeciak, Megan Velez, Waverly Gordon, Polly Webster, Kristen O'Neill, Paul Edattel, John Stone, Carly McWilliams, Adriana Simonelli, JP Paluskiewicz, Tim Pataki, Josh Trent and others on the Energy and Commerce Committee staff for all their work.

It was a privilege to be a part of this landmark effort.

As an original sponsor and co-author of the 21st Century Cures Act, I urge my colleagues to vote yes.

Mr. UPTON. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. MURPHY), one of the subcommittee chairmen who helped craft the bipartisan Murphy mental health bill, which passed the House 422–2 earlier this year, and is a very valuable member of the committee.

Mr. MURPHY of Pennsylvania. Mr. Speaker, this is a moment of great joy out of a situation of tremendous tragedy.

After the last 4 years, since the time of the terrible tragedy at Sandy Hook Elementary School followed by repeated other ones, our Nation has awoken from a slumber of ignoring the problems of mental illness in America, one that when we closed down our institutions decades ago, we turned our eye to those who lay homeless on the street, who filled our prisons, who filled our cemeteries or lay on a gurney in an emergency room or were sent back home to a family who felt helpless and hopeless.

We have changed now to a situation where we are coming together on a bill that will save lives. This is a new era of health care and the next generation of hope for Americans that really transcends boundaries.

To all of the families who brought their stories out of the shadows, that dared to share their sorrows, their hopes, their shattered dreams, today is a day of joy. And today is only possible, I say to all of those families, because they dared to step forward. There is not time enough to thank all of those involved, but to those families who have helped, I say thank you.

I also want to make sure I thank Chairman UPTON, Speaker RYAN, EDDIE BERNICE JOHNSON, DIANA DEGETTE, FRANK PALLONE, Senators BILL CASSIDY and CHRIS MURPHY, Leader KEVIN MCCARTHY, Whip STEVE SCALISE, and so many others from our committee who have worked so hard to make this happen. And a special shout-out to some of the staff: Scott Dziengelski, Gary Andres, Karen Christian, Paul Edattel, Susan Mosychuk, and so many other staff who worked so hard on this.

We can look back on this moment in history and say today that, although we have much to do and although we didn't get everything we needed, we needed everything that we did get. But this is the moment from this day forward we can say today that we took action to save lives.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. CASTOR).

Ms. CASTOR of Florida. Mr. Speaker, I rise today in support of the 21st Century Cures Act legislation and the important investment that it will make in medical research across America.

This legislation supports an additional $4.8 billion for the National Institutes of Health, specifically for President Obama's Precision Medicine Initiative and the BRAIN Initiative so we can tackle the challenge of Alzheimer's. It supports Vice President BIDEN's Cancer Moonshot initiative. Hopefully, it will keep the young scientists on the job at institutions like the Moffitt Cancer Center and the University of South Florida's Alzheimer's Research Institute back home in Tampa.

While additional support for NIH is vital and this is a move in the right direction, I would have much preferred that we put this in the mandatory category as we voted on in H.R. 6 earlier in the year. I know many of you agree with that, that medical research in America today shouldn't be subject to the whims of congressional budget battles or political fights. I will continue to advocate for mandatory funding for NIH so that we can remain on the cutting edge of medical innovation and boost higher wage jobs back home. These initiatives save lives and provide investments that we need to make sure that we are developing the cures of tomorrow.

I am very pleased that legislation I introduced with my colleague Representative HERRERA BEUTLER was included in this package. The Safe Medications for Moms and Babies Act ensures that expectant mothers and doctors have accurate information about medications used during pregnancy and when nursing to facilitate the best health outcomes. Representative HERRERA BEUTLER has been a champion for families, and I am grateful to her for leading this effort to improve the quality of data and information on medication used during pregnancy and breastfeeding.

I also applaud the inclusion of language to improve our mental health system, the $1 billion to address the opioid epidemic. This is very positive. I would like to thank Chairman FRED UPTON for his devotion to the issue, to Congresswoman DEGETTE, and to all of my colleagues on the Energy and Commerce Committee.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. PALLONE. I yield the gentlewoman an additional 30 seconds.

Ms. CASTOR of Florida. This is the way legislation is supposed to be developed: in a bipartisan way, through studies, through asking, reaching out, and working with experts all across the country, because all of the answers do not emanate from a congressional committee in Washington. It is very important that we tap the expertise all across the country to get something done.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentlewoman from Tennessee (Mrs. BLACKBURN), the vice chairman of the Energy and Commerce Committee, who, again, helped so much with the medical community to rally around and provide us the input necessary to move this bill to where it is today.

Mrs. BLACKBURN. Mr. Speaker, I congratulate Chairman UPTON and all of our colleagues on the Energy and Commerce Committee for a job well done, and done in the appropriate manner. It really has, as Ms. DEGETTE said, been so interesting to work across the country and work with patients, with physicians, with researchers, with those who are innovating new concepts, who are delving into delivery systems that are necessary for precision medicine which underpins 21st century health care.

There are three components that I want to bring attention to. First of all, section 3060 is there addressing medical technology and software. This is so important that we get the FDA on the right track and move components of this away so that it does not face FDA approval processes that will slow down access to the marketplace for patients.

Also, section 2038, the Children's Count Act—Mrs. CAPPS and I worked on this—allowing children access to clinical trials, and section 3076, the reauthorization of the Reagan-Udall language.

I congratulate my colleagues.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. SCHRADER).

Mr. SCHRADER. Mr. Speaker, I rise today in strong support of the 21st Century Cures Act and to thank Chairman UPTON and my friends, Mr. PALLONE, Ms. DEGETTE, and Mr. GREEN, for their leadership and willingness to work across the aisle to produce this quality piece of legislation.

For too long, Congress has been shirking its responsibility when it comes to funding the critical research that will lead to cures and treatments at the NIH. Our scientists, physicians, and medical institutions are getting closer every day to medical breakthroughs that will help families and save lives. In my State alone, the NIH is funding research into new therapeutic avenues to combat cancer, heart disease, and illness born by pollution. It is time to streamline the path for critically needed medical devices and pharmaceuticals for vulnerable populations that can't afford to wait.

This bill takes a giant step forward to help fix the mental health infrastructure of our country. Currently, as a result of the mental health system's inadequacy, our emergency rooms, our prisons, and our homeless shelters are full of people who are having trouble getting the care they need. The status quo is not okay.

This bill moves us in the right direction through innovation and integration of mental health services for the overall healthcare system. The Cures Act enhances the capabilities of our law enforcement and first responders, strengthens our crisis intervention programs, and ensures that our Medicaid program does not deny access to beneficiaries seeking mental health care. It also includes a number of Medicare provisions to make sure seniors aren't left behind by bureaucratic red tape.

Getting to this point wasn't easy. Democrats and Republicans didn't always agree on every provision of this bill, but we were able to work together and find common ground and produce a bill that takes great strides toward producing better healthcare outcomes for Americans.

I hope the President-elect and Members of this body are taking note of this achievement today as we move forward instead of pushing through divisive harmful policies that will reduce access to quality health care. Let's work together and produce better results for all Americans.

□ 1415

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Kentucky (Mr. GUTHRIE), a member of the committee and a leader in pushing this bill forward.

Mr. GUTHRIE. I thank the chairman for yielding.

Mr. Speaker, all of us have families who come to our offices, and they are advocating for research or for cures for diseases to which they have lost a parent or a child, or they have their children with them who have the diseases, and they are just hoping for a move forward.

In being on the Health Subcommittee, at least weekly and sometimes daily, innovators and entrepreneurs come to my office, and they talk about a new procedure or a new product—something that is innovative, that will change the lives of these families—but they are having trouble getting them through the system and getting them approved.

It hurts families, though, like a family in Elizabethtown, who has someone with a degenerative disease. This family is trying to beat the clock because they think there is some kind of help out there. I have a friend of mine from Bowling Green whose son went through a diabetes trial. The first time they said they got any sleep through the night was when their kid was in this trial. Then they called me, crying, saying they were out of the trial and that it may be another year before they get in. So, in taking our entrepreneurs and our innovators and putting together these cures, it is not just about getting these products to market—it is about changing the dynamics of these families who are suffering.

Our chairman and Ms. DEGETTE from Colorado put together this effort to move forward, and I urge support for this bill because it will change families' lives.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. I thank the gentleman.

Mr. Speaker, I think everybody has been thanked who should be thanked, but I certainly want to thank Mr. UPTON for all of his work and Mr. PALLONE for his time and his work and Ms. DEGETTE. I also want to thank Senator ROGER WICKER, who worked on a bill that is incorporated into this bill that Congressman DUNCAN and I sponsored, called the EUREKA Act, which will incentivize and reward research on diseases for which there is not great public-private partnerships but for which there is a great handicap and problem for the American public because of the particular disease. It will reward successful treatments through a competition, which I think is a great way to go about encouraging research and then paying for it. ROGER WICKER, I think, came up with the idea, and I sponsored it with JOHN DUNCAN, and it is included in the bill. It was originally aimed at Alzheimer's. It is now for other diseases, but Alzheimer's is one of them.

Alzheimer's is a disease that is going to have a particularly crippling effect on our country economically in the future. Beyond that, it will affect many of us, and it will affect our pocketbooks; so it is important that this bill goes after Alzheimer's and that it deals with the opioid crisis, which is great in my State and across the country. It

works against all diseases and it encourages moneys in the National Institutes of Health.

I have long said, while we need to have a strong Defense Department, that my Secretary of Defense is Francis Collins, the head of the NIH, because the true enemy of each and every one of us isn't somebody in South Korea or somebody in Iran or ISIS or one of those folk—it is cancer; it is Alzheimer's; it is AIDS; it is diabetes; it is heart disease; it is Parkinson's. It is all of those diseases—the dreadful, awful, awful diseases for which the NIH is looking for cures. That is our Secretary of Defense, and that is what we need to invest our moneys in. I don't think there is enough money that we can put into the NIH, because it is important and it affects all Americans independent of political party, race, sexual orientation—you name it.

I thank the Members for their work on this, and I am proud to vote for it.

Mr. UPTON. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), a valuable member of the Health Subcommittee and whose father once chaired that subcommittee.

Mr. BILIRAKIS. I thank the chairman for all of his hard work on this great bill.

Mr. Speaker, I rise to talk about the incredible impact the 21st Century Cures Act would have on so many Americans.

Deadly diseases like cancer, Alzheimer's, ALS, and more affect each and every one of us. Within Cures, one will find the voices of patients, doctors, advocacy groups, and families I have met with from throughout Florida's 12th Congressional District. I am proud to say that a lot of their input is reflected in this final bill.

Samantha Lindsay, from Lutz, Florida, has Alpha-1, which is a rare genetic condition that results in serious lung problems. When we met, she talked about the need to use biomarkers for the faster approval of drugs for rare diseases. We did that. We have a framework for biomarker qualifications in this legislation.

Wayne Taylor, from Hudson, Florida, was a leukemia patient. He talked about the difficulty of participating in the clinical trials that eventually saved his life. This bill has reforms to make clinical trials more patient-focused and input-driven.

Dr. David Morgan, the CEO of the Health Byrd Alzheimer's Institute at the University of South Florida, talked about the need for stable funding for Alzheimer's and about reforming institutional review boards.

This bill invests in the NIH, and it reforms the IRB system. Cures also includes my provisions to reform the FDA's Office of Combination Products in order to streamline the approval of these products; to establish a new Medicare Web site to help seniors price shop; and to allow physical therapists to enter into locum tenens arrangements so they can take maternity leave or sick time without having to turn away patients.

For many families, including my own, the potential impact of 21st Century Cures could change their lives. Let's get this meaningful bill across the finish line.

Mr. PALLONE. Mr. Speaker, I have a few additional speakers on their way; so I reserve the balance of my time.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. JOHNSON), a valuable member of our committee who has worked so hard to get this bill to where it is today.

Mr. JOHNSON of Ohio. I thank the chairman.

Mr. Speaker, I rise in support of the 21st Century Cures Act and add my voice to the steady stream of acclaim this legislation has already received.

American families and communities are suffering from rare diseases, and this innovative legislation works to align Federal incentives and regulations with the science and technology that make treatments and cures possible and attainable. I am proud to have supported this bill all along the way.

This package includes mental health reform—work that I am grateful to have been a part of during my time on the Oversight and Investigations Subcommittee with Chairman MURPHY. His tireless efforts will benefit many individuals and families who struggle with mental illness and substance abuse. This bill also includes $1 billion for grants to States to fight opioid abuse. A recent report shows that my home State of Ohio leads the Nation in opioid overdose deaths. This funding is sorely needed to address the issue head on.

I ask my colleagues to support the Cures bill today.

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

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentlewoman from North Carolina (Mrs. ELLMERS), a member of the important Health Subcommittee and a real proponent of this legislation from day one.

Mrs. ELLMERS of North Carolina. I thank Chairman UPTON; Ranking Member PALLONE; Ms. DEGETTE, my good friend; TIM MURPHY from Pennsylvania, who worked so hard on the mental health reforms; and Chairman PITTS, the Health Subcommittee's chairman.

Mr. Speaker, there has been a great deal of effort put into this great piece of legislation, which basically has the goal of bringing our healthcare innovation infrastructure into the 21st Century Cures so that real hope for patients and loved ones can be achieved.

From removing barriers in the mental health system, to ensuring collaboration, to modernizing the clinical trial pathways, to boosting modern medical interventions, 21st Century Cures is a win for everyone. It will accelerate the discovery, development, and delivery of lifesaving therapies in a safe and effective way. It will also empower families to support their loved ones.

In closing, Cures will change lives. I, personally, as a nurse, would like to say that this is one of the most important pieces of legislation we will pass here in the House.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. KENNEDY), who has been such a strong advocate on mental health issues.

Mr. KENNEDY. I thank the ranking member for yielding. I also thank him, as well as Chairman UPTON and Congresswoman DEGETTE, for being tireless throughout the entire process in their advocacy of trying to get this bill as a bipartisan compromise and for creating an environment that allows for our committee's members to raise their voices and shape this legislation.

Mr. Speaker, when we first passed the version of this bill last year, it was as a result of strong, bipartisan compromise and sacrifice. It certainly was not easy, but the legislative process is not intended to be.

While I am disappointed that the funding levels for the NIH were cut even further and that the investment is no longer mandatory, I take my Republican colleagues at their word that it will be appropriated in the years ahead. I am also pleased that this legislation includes language to remove obstacles for children who are covered by Medicaid; but my real concerns with the legislation lie with the mental health reform proposals, which don't go nearly far enough. Mental health parity is already the law, thanks to the Mental Health Parity and Addiction Equity Act and the Affordable Care Act; but each study we read, Mr. Speaker, and each story we hear proves that insurance companies are skirting those rules.

Instead of further guidance or meetings or studies carried out years down the road, we need enforcement and transparency today. We need random audits before there have been violations, not after. We need insurers to publicly disclose the rates and reasons for denials in a way that patients and their families can understand, not in a way that mental health advocates can't even obtain. We need to increase Medicaid reimbursements in order to expand access to care, not to reduce them or roll back expansion; and we need to appreciate the difference the ACA has made for mental health patients, especially for the most vulnerable among us. Until we do, we cannot consider these proposals comprehensive, and we certainly can't pretend that they are nearly enough.

This is an important compromise forged from an awful lot of hard work. I am happy and pleased to support this proposal, and I thank my colleagues on both sides of the aisle for getting it here today.

Mr. UPTON. Mr. Speaker, I yield myself 15 seconds.

I appreciate the gentleman from Massachusetts' statement. He is a very valuable player as we move this legislation on all fronts forward. I look very forward to working with the gentleman and with every Member of this body to make sure that the funding is there as we have laid out in this bill and to work with our colleagues in the Senate to make sure that it happens.

Mr. Speaker, how much time remains on both sides?

The SPEAKER pro tempore. The gentleman from Michigan has 15¼ minutes remaining, and the gentleman from New Jersey has 12 minutes remaining.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. LANCE), another valuable member of the Health Subcommittee and someone who pursued this legislation from the very get-go.

Mr. LANCE. Mr. Speaker, I rise in strong support of the 21st Century Cures legislation.

This bill provides significant investments to accelerate the discovery, development, and delivery of new cures and treatments for millions of Americans. The passage of this legislation will protect and create American jobs and will ensure that the United States remains the global leader in biomedical innovation and discovery. The measure reforms and strengthens the country's mental health system and makes mental health a strong national priority. The legislation includes critical funding for States to prevent opioid abuse and provide the needed treatment for those suffering from this public health crisis.

Reducing bureaucratic redtape, advancing lifesaving research, reforming our broken mental health system, and tackling opioid abuse in our communities will reduce healthcare costs and give many Americans new opportunities to live long, healthy, and productive lives.

I thank Chairman UPTON for his unparalleled leadership on this issue. It is an honor to have worked with him and all of our colleagues on the Energy and Commerce Committee to have crafted this landmark legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. I thank Ranking Member PALLONE for yielding me the time.

Mr. Speaker, I rise in strong support of the bipartisan 21st Century Cures Act, which dedicates more than $6 billion to implement key health priorities, such as combating the heroin and prescription opioid epidemic across this country and the Vice President's Cancer Moonshot. It also takes steps to improve mental health, including provisions that build on the work of the President's Mental Health and Substance Use Disorder Parity Task Force and policies to further modernize the drug approval process. This will mean so much to the researchers across this country who are trying to unlock the mysteries of the human brain and heal.

□ 1430

The legislation includes $1 billion over 2 years, including $500 million in fiscal year 2017, to combat the prescription opioid and heroin epidemic as well. The legislation dedicates support for other key research initiatives with the goal of helping researchers find new ways to treat, cure, and prevent brain disorders, such as Alzheimer's disease, epilepsy, and traumatic brain injury.

This legislation includes a much-needed renewed emphasis on evidence-based strategies for treating serious mental illness, improved coordination between primary care and behavioral health services, reauthorization of important programs focused on suicide prevention and other prevention services, and mental health and substance use disorder parity provisions.

I would like to thank Dr. Joseph Calabrese at Case Western Reserve University in Cleveland and my good friend, Representative TIM MURPHY, who came to Ohio and hosted a roundtable on mental health that can be added to this major bill in order to move America forward.

I thank Chairman FRED UPTON, knowing the deep commitment that he has to so many Americans who desperately need the help that this bill will provide. Again, to Congressman FRANK PALLONE of New Jersey, I want to compliment both men for working together to do something great for this country for so many Americans who are desperate to find answers for those who are ill. I want to thank Congresswoman DIANA DEGETTE of Colorado who has shepherded this to this point.

Although not perfect or complete, this legislation offers advances in health that greatly outweigh any concerns we might have. I am proud to add my strong support for 21st Century Cures Act.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BUCSHON), who again hosted a number of roundtables and discussions throughout the country and a very valuable member of the committee.

Mr. BUCSHON. Mr. Speaker, I urge my colleagues to support the Senate amendment to H.R. 34, the 21st Century Cures Act.

Over our country's history, American innovators have proven among the best in the world, especially in the field of drug and device research.

21st Century Cures streamlines the process for American innovators to see their research and development reach patients faster than ever, while maintaining a safe and effective review process.

It also invests in the areas we need it the most, to advance research and testing on the most complex and devastating diseases in our country. It also gives young scientists the support they need to bring new ideas to the scientific community.

The mental health and opioid abuse provisions in this legislation are also critical. As a physician who has relied on medical innovation to care for patients, working to pass the 21st Century Cures Act and ensuring America remains on the forefront of cutting edge research has been one of the highlights of my time in Congress.

I thank Chairman UPTON and Representative DEGETTE for their leadership and commitment to this legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in opposition to this bill. The 21st Century Cures bill aims to promote biomedical innovation and mental health, noble goals that I share. Unfortunately, this bill sets a dangerous precedent and has the potential to do more harm than good for millions of Americans.

In its attempt to speed up the drug and device approval process, this legislation neglects the very people whom clinical trials are meant to help, that is, the patients. Rather than protect those who rely on the healthcare system, it reduces the already weak regulation on medical devices, allows drugs to be approved with only limited evidence of the drug's safety and efficacy, and rushes the use of new and unproven antibiotics.

An example, 13 models of the St. Jude's defibrillators are currently being recalled for sudden battery failure that has been linked to at least two deaths, 10 people fainting, and 37 people feeling dizzy.

When the cost of our prescription drugs is skyrocketing, this bill does nothing to combat excessive prices.

Finally, this bill strips away funding from the public health and prevention fund. While the bill authorizes $4.8 billion to the NIH over the next 10 years—on average, a mere $480 million a year—this is barely a quarter per year of what the House passed last year. Let us not forget that we would need to provide $7 billion a year to keep up where we were in 2003.

There is also no guarantee that the appropriators will follow through and provide funding each year, as we have seen with the public health prevention fund, which has been used to fill appropriations shortfalls.

Illness touches us all. We owe it to the patients who depend on the standards that we set. Unfortunately, I believe the standards in this bill are both weak and dangerous. This legislation is the wrong path forward, and I strongly oppose it.

Mr. UPTON. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. COLLINS), whose personal knowledge of the maze of the regulatory approval process made him a very valuable member of the Health Subcommittee in pushing this legislation forward.

Mr. COLLINS of New York. Mr. Speaker, I thank all the people who worked tirelessly to make this legislation a reality.

Simply stated, the goal of this legislation is to incentivize innovation to defeat disease. Today, the 21st Century Cures Act will do that and much more for patients suffering from currently incurable diseases.

This legislation provides substantial funding to the National Institutes of Health, including $1.8 billion to speed up cancer research, $1.5 billion to improve our understanding of debilitating diseases such as Alzheimer's, and another $1.5 billion to assist in genetic and other individual specific research efforts.

This bill provides funding to fight the opioid addiction crisis, which has been particularly devastating to western New York, and it includes mental health legislation to improve those services nationwide.

I am excited that this final bill contains a few provisions I authored and worked on over the past 2 years. Section 3021 encourages the broader application of innovative clinical trial designs to enhance and accelerate effective clinical trials.

Section 3071 will expedite and improve drug approval processes by increasing the allowable number of senior biomedical researchers the FDA is allowed to hire and making their salary more competitive with the private industry.

Section 9023, which I worked on with Representative JOE COURTNEY, incentivizes child and adolescent psychiatrists to begin their practices in underserved areas like those in rural western New York.

Lastly, Section 5006, which I worked on with Congressman PAUL TONKO, includes the House-passed Medicaid DOC Act, which requires States to publish an online directory of physicians who have billed Medicaid in the past year and indicate whether those physicians are accepting new patients.

None of this would have been possible without the tireless work of Chairman FRED UPTON and the entire staff on Energy and Commerce. I thank them for their tremendous effort and look forward to seeing innovation defeat disease because of this game-changing legislation.

Mr. PALLONE. Mr. Speaker, how much time remains on both sides?

The SPEAKER pro tempore. The gentleman from New Jersey has 8 minutes remaining, and the gentleman from Michigan has 11¼ minutes remaining.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from New Mexico (Mr. BEN RAY LUJÁN).

Mr. BEN RAY LUJÁN of New Mexico. Mr. Speaker, I begin by thanking Chairman UPTON and Ranking Member PALLONE of the Energy and Commerce Committee, as well as Congresswoman DEGETTE, for their bipartisan cooperation during this long legislative process.

This is a good, if imperfect, bill that will provide vital funding to the National Institutes of Health and the Vice President's Cancer Moonshot while taking steps to strengthen our mental health system. I want to focus my remarks on the critical investments this bill promises to combat the opioid epidemic.

In communities across our country, families are struggling with the pain of addiction to opioids. Earlier this year, Congress took an important step against substance abuse by passing the Comprehensive Addiction and Recovery Act, or CARA.

Unfortunately, congressional Republicans did not support including the necessary funding to CARA's success. This was a missed opportunity. In the months since Congress passed CARA, we have lost parents, siblings, children, and friends—129 people every day.

When I talk to New Mexicans on the front lines of this crisis, the most urgent need is for more resources. That is why I introduced the Opioid and Heroin Abuse Crisis Investment Act. This bill, cosponsored by nearly 100 of my colleagues, sought to advance the President's proposal to combat this epidemic.

This legislation we are considering today—like my bill—promises $1 billion for the opioid crisis. Though we cannot bring back those that we have lost, we owe it to them and their families to pass this bill. This funding will make a real difference in people's lives.

While I am relieved that we will soon be able to get the resources to our communities, I am fearful that some of my colleagues will see this as a mission accomplished instead of what it must be, which is only a first step toward healing our communities.

I can't help but ask my Republican colleagues, who support the advances we are making today for mental health: Why are they preparing to roll back the most important advances we made for mental health in the past 8 years by promising to repeal the Affordable Care Act?

The 21st Century Cures Act shows what we can do and what can happen when we work across the aisle, and I hope we will truly continue to work together to strengthen our Nation's health system.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. MIMI WALTERS), an original cosponsor of our bill and great proponent from day one.

Mrs. MIMI WALTERS of California. Mr. Speaker, over the last 2 years, I have worked with organizations in my district, including the Children's Hospital of Orange County, the Juvenile Diabetes Research Foundation, and Alzheimer's Orange County.

During my visits with these groups, I have met with constituents who are suffering from incurable diseases. I have met with parents of children suffering from prescription drug addiction and families struggling to find adequate mental health care for their loved ones.

All of these people have one thing in common. The 21st Century Cures Act would directly improve the care they receive. This innovative legislation will provide them with faster and better cures and treatment.

In passing this legislation, we have the opportunity to accelerate the discovery, development, and delivery of lifesaving and life-improving therapies.

I urge my colleagues to join me in supporting the 21st Century Cures Act. It is time for cures now.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, I thank Mr. PALLONE for yielding me the time and for being an unerring partner on this quest that we have had.

I just want to take a few minutes to talk about the extraordinary journey that we have had here. When Representative FRED UPTON came up to me on the floor about 3 years ago and asked if I would help him work on a bill to help modernize and update the way we do biomedical research in this country, little did I realize the road that lay ahead. There have been a lot of twists and turns in that road. There have been some very interesting sightings along that road, and it has been an extraordinary effort for all of us. It has really brought the Energy and Commerce Committee together in a bipartisan way, and I am hoping that we can continue those efforts in the next Congress.

So many of my colleagues are right. We still have a lot that we have to do in the area of mental health, in the area of biomedical research, and so much more.

I want to thank a number of people because they really all deserve to be thanked: Of course, Energy and Commerce Committee Chairman UPTON and Ranking Member PALLONE, and Subcommittee on Health Ranking Member GENE GREEN and Chairman JOE PITTS. I want to thank the entire committee, as I said.

I want to thank the patient advocacy community who have been with us unerringly throughout this process. I want to thank the researchers. I want to thank the entrepreneurs who came and talked to us about what they needed. I want to thank the agencies themselves, specifically the FDA and the NIH, for technical assistance, and the entire executive branch.

I want to thank a number of people. First of all, I want to thank Lisa Cohen, my chief of staff, who has been with me for 20 years through thick and thin. I want to thank Polly Webster, my health policy director, who took the bar exam, got married, and actually helped pass this bill all during this process. I want to thank Lynne Weil, my communications director, and Eleanor Bastian, my legislative director. I want to thank Rachel Stauffer, my former health policy director who started this, and Matt Inzeo, who is Lynne's predecessor.

From the Upton staff, I want to thank Gary Andres, Joan Hillebrand,

Paul Edattel, John Stone, Carly McWilliams, Adrianna Simonelli, and J.P. Paluskiewicz. All of you guys have worked together as a team with my team.

□ 1445

I want to thank Kristen O'Neill from Mr. GREEN's staff. I don't think I thanked Mr. GREEN. I want to thank Mr. GREEN, who has done such an extraordinary job and who has really been my wingman. I want to thank Wendell Primus, who is Leader PELOSI's senior adviser; and Charlene MacDonald, who is Mr. HOYER's adviser. Finally, I want to thank the entire Pallone team, who has worked as our committee staff tirelessly: Jeff Carroll, Tiffany, Kim, Arielle, Waverly, and Megan. They have been fabulous. We haven't always agreed on everything, but in the end we have all worked together. It really is a great team. I hope we can use this in the next Congress to get to even greater heights.

I urge the House to pass this bill on a strong bipartisan basis, and I urge the other body to take it up.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. CARTER), the only pharmacist in the Congress.

Mr. CARTER of Georgia. Mr. Speaker, I rise today in support of H.R. 34, the 21st Century Cures Act. This long-awaited legislation promotes medical innovation by streamlining the discovery, development, and delivery of critical medicines. This bill also helps reform our Nation's deteriorating mental health system to ensure that millions of Americans receive the care they need. Such reforms include the reduction of regulatory red tape that slows prescription drugs' entry to the market, the breaking down of barriers that restrict data sharing, and expediting the review of potentially breakthrough devices.

While some may believe that the resources needed to develop new cures or new devices are too costly and time consuming, the potential savings to the broader healthcare system will be significant. By modernizing the governance surrounding the development of new medicines and treatment, we ensure that the lives of millions—not only here in the U.S., but across the world—will improve.

I want to thank Chairman UPTON and Chairman MURPHY for their unrelenting determination to bring this negotiated piece of legislation to the floor for a vote. I urge my colleagues to support H.R. 34.

Mr. PALLONE. Mr. Speaker, I have no additional speakers other than myself to close, so I am going to continue to reserve the balance of my time.

Mr. UPTON. Mr. Speaker, we have a good number of speakers left, and we will use all of our time.

I yield 1 minute to the gentleman from Pennsylvania (Mr. ROTHFUS).

Mr. ROTHFUS. Mr. Speaker, I rise today in strong support of this important legislation that provides significant investments and reforms to accelerate the discovery of new treatments and cures for Americans. I also applaud the inclusion of a provision I authored that is crucial for our seniors. It would restore the open enrollment period for Medicare Advantage beneficiaries, who until 2011 had the ability to change Medicare Advantage plans during the first 3 months of the year.

Unfortunately, those 3 months of flexibility have been replaced with an annual Medicare Advantage disenrollment period during the first 45 days of the year. Given Medicare Advantage's popularity and history of success, seniors should be given the choice of changing to a plan that addresses their needs. Restoring this 90-day open enrollment window will allow seniors who find that their plan is not working for them to make the change that does work for them.

This bill also contains very important legislation authored by my colleague from Pennsylvania, Representative MURPHY, to help families dealing with a mental health crisis by significantly reforming our mental healthcare system. These reforms are crucial for families, veterans, and all individuals dealing with a mental health crisis and the drug addictions that can often accompany such illnesses.

I commend Chairman UPTON's work in bringing this critical legislation to the floor. I urge its passage.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. SMITH), my dear friend who I have served with all my years here in Congress.

Mr. SMITH of New Jersey. I thank the gentleman for yielding and for his extraordinary leadership on this legislation.

Mr. Speaker, in 1992, 24 years ago, I met—along with a great advocate, Pat Smith—with top officials of NIH and CDC on Federal guidelines that precluded the existence of chronic Lyme disease. Subsequently, every Congress, I would introduce legislation trying to get a diversity of viewpoints so that clinicians, patients, and other advocates could be heard.

Today, CDC estimates there are about 380,000 cases of Lyme disease; and a provision in this bill, an important, game-changing provision, insisted upon by Majority Leader KEVIN MCCARTHY and Chairman UPTON requires that a new working group on tickborne disease includes members with a diversity of viewpoints, including patients, clinicians, and researchers. This working group will make a difference. Those patients—and there are tens of thousands of them—have been told chronic Lyme disease doesn't exist, what you are feeling can be attributable to some other disease, and they don't get better.

I thank the chairman for doing this. Also, as cofounder and co-chairman of both the Alzheimer's Caucus 16 years ago and the Autism Caucus 16 years ago, I am thankful for the great work that this will do for those patients as well.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentlewoman from Washington (Ms. HERRERA BEUTLER).

Ms. HERRERA BEUTLER. Mr. Speaker, I am really excited about this bill, and I am excited about an inclusion in the 21st Century bill that we are voting today that is going to help moms and babies. Nearly all of the 400 million women who give birth each year in the U.S. and the 3 million women who breast-feed will take medications or receive a vaccine during their pregnancy or while they are nursing.

This bill that we are voting on, that we hope is going to pass and be signed into law, contains a provision that will reduce the health risks faced by these moms. Here is where the risk lies. Pregnant women are often not included in clinical trials on medications, so we really don't know what the effects are of drugs on a woman and on her pregnancy.

Without reliable information, women and doctors are really just playing a guessing game, trying to figure out the impacts of medication, and that could be on medication that is a prescription for a chronic disease: hypertension, diabetes, or severe depression.

The other undesirable choice for moms is whether or not to choose just not to treat their condition. If they don't know what the impact is, maybe they are just going to forgo their therapy altogether.

Moms should be able to safely manage ongoing conditions throughout their pregnancies and while breast-feeding without playing this guessing game. Fortunately, the Safe Medications for Moms and Babies Act is included in the bill that we are voting on. I urge its support.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. COSTELLO), a long-time supporter of this legislation.

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I rise today in support of the 21st Century Cures Act, and I want to thank the chairman and ranking member for their advocacy and leadership to bring this bill to the floor today.

I also congratulate my colleague and neighbor, Congressman JOE PITTS, for his leadership as chairman of the Health Subcommittee. Mr. PITTS and I represent adjoining and very similar districts in Pennsylvania, each including parts of Chester and Berks counties. He has done outstanding work for our constituencies by incorporating the concerns and issues important to southeastern Pennsylvania into the Cures Act.

This bill will make an immediate, long-lasting impact on the families and communities we represent. It supports medical research, helps fight the opioid epidemic, and would improve the delivery of mental health care by putting

patients at the center of the review process. In short, this bill includes major priorities that will make our communities healthier and safer.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. GIBSON). This may be his last speech on the House floor, as he announced his retirement some time ago. He is a good Member in support of this legislation. He hounded us from the get-go.

Mr. GIBSON. Mr. Speaker, I rise in strong support of 21st Century Cures. I want to thank the chairman, and I want to thank Majority Leader KEVIN MCCARTHY and my colleague CHRIS SMITH for insisting that we restore original language that deals with chronic Lyme and tickborne diseases. This was critically important to my district and to the Nation. I have so many friends and neighbors who are sick, chronically sick, and they are desperate for cures and solutions. Thanks to this bill, they now have a voice and a fighting chance. I am deeply grateful.

Mr. UPTON. Mr. Speaker, I yield 1 minute to the gentlewoman from Arizona (Ms. MCSALLY), my friend who is, again, a strong advocate of this legislation.

Ms. MCSALLY. Mr. Speaker, I rise in strong support of this important legislation. I want to thank Chairman UPTON for his tireless leadership on the 21st Century Cures Act. The bill is the result of years of hard work and brings hope to countless Americans suffering from incurable diseases in all of our districts around this country.

I also want to recognize the work of Congressman TIM MURPHY, who has served as a leader and a champion on the critical issue of mental health and is the author of legislation included in this bill that will overhaul our mental health system for the first time in 50 years.

Additionally, this legislation includes parts of a bill that I introduced with Senator JOHN CORNYN to improve mental health collaboration between Federal, State, and local justice systems to allow better responses to mental health crises. These provisions will also divert low-level offenders from incarceration to treatment programs, help reduce recidivism and provide support to mentally ill offenders reentering the community.

Many diverse groups came together in support of these bipartisan efforts, including mental health advocates and law enforcement organizations. I urge all of my colleagues to vote in favor of this very important bill. I thank the chairman for his leadership.

Mr. UPTON. Mr. Speaker, I have no further speakers. Therefore, I will let Mr. PALLONE use the balance of his time to close, and then I will use the balance of mine.

I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, may I inquire how much time remains on each side?

The SPEAKER pro tempore. The gentleman from New Jersey has 2½ minutes remaining. The gentleman from Michigan (Mr. UPTON) has 3½ minutes remaining.

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

Mr. Speaker, I would like to conclude by referencing the Statement of Administration Policy because I believe it reflects my position for the most part.

If I could just read some sections—I am not reading the whole thing—it says:

''The Administration strongly supports passage of the bipartisan House Amendment to the Senate Amendment to H.R. 34, the 21st Century Cures Act, which dedicates more than $6 billion to implement key priorities such as the President's proposal to combat the heroin and prescription opioid epidemic; the Vice President's Cancer Moonshot; and the President's signature biomedical research initiatives, the Precision Medicine and Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiatives. It also takes important steps to improve mental health . . .

''The Administration is committed to taking immediate action to lay the groundwork to ensure that the funds in the bill would be disbursed quickly and effectively so we can begin to address these important public health challenges . . .

''There are . . . provisions in the bill that raise concerns, but that have been modified from previous versions to help address those concerns, such as provisions that allow for the marketing of drugs to payers for off-label uses. In addition, a number of effective dates will be challenging to meet, especially without additional administrative funding . . .

''That said, this legislation offers advances in health that far outweigh these concerns. As such, the Administration strongly supports passage of the House Amendment to the Senate Amendment to H.R. 34, the 21st Century Cures Act.''

Let me just say also in conclusion, I believe that this is an important piece of legislation that we need to pass, and I would hope that the Senate would take it up and pass it, and, obviously, the administration or the President will sign it.

From the very beginning, when we passed the 21st Century Cures Act, I thought that it would make important strides in actually dealing with those diseases for which we have not made a lot of progress in terms of advancing and finding cures, but, at the same time, I am happy that this legislation has now become a little more of a catch-all or a lot more of a catch-all, if you will, because it is addressing funding for opioids. Many of us know we passed an opioid package that the President signed in July, but it is not funded. So there will be funding for that bill now.

As far as the mental health reforms, our committee spent a tremendous amount of time over the last 2 years trying to address that legislation. We passed a bill here in the House. Again, I am happy that this is included because the kinds of reforms that were in that bill are now in this bill, and I think they are important strides in terms of addressing some of the mental health concerns that we have in this country.

The same is true for Cancer Moonshot. The President spent a lot of time, the Vice President as well, and this will make at least a down payment on that. So, overall, this is a good bill. I support it. I urge my colleagues to support it as well.

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

Mr. UPTON. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I just want to thank all the people who have been involved in this Chamber, our staff, our Members, the Senate as well. I want to thank all the people outside the Chamber who brought their message to us because one of the things that we wanted to do from the very start was listen. You tell us what we need to do so we can find these cures for you—name the disease. I will confess that some of us had probably never heard of some of the diseases and some of the disease patient advocacy groups that actually came to us.

We are doing the right thing because, yes, we listened; yes, we knew we needed more research; and as fiscal conservatives—and we all care about the deficit, we all do—we want to make sure that we can actually have the resources and a timeline to spend it in a prudent manner, really outlining the priorities that both sides of the aisle share.

□ 1500

I commend the President. He was personally involved in this issue, not a Johnny-come-lately, coming up this aisle with his last couple of State of the Union Addresses on both Precision Medicine and the Cancer Moonshot. Vice President BIDEN spent weeks of his time and many hours with us helping us draft the legislation that we all care about and is included in this legislation. There are LAMAR ALEXANDER, MITCH MCCONNELL, PATTY MURRAY, CHUCK SCHUMER, and others in the Senate caring about this legislation, knowing its impact on so many millions of people—our researchers, who have devoted their lives, and, again, many of us here.

We traveled to MD Anderson, the Mayo Clinic, Ann Arbor, the Cleveland Clinic, and other great places to do research that actually can save people's lives. And we learned a lot. We learned a lot that, working together, we can get something done, and that is what this bill does.

But I will tell you why this vote is important when we take it at about 5 p.m. or so. We don't want to win by a narrow margin. We want to win by a

huge margin. We want to send a message to the Senate that what we did in countless hearings and roundtables has made a difference, that it is a strong bipartisan message, including the mental health legislation, again, which we debated for weeks and months here in the House, not only in the committee, but on the House floor. It is very important. It is important to people like JOE KENNEDY, who spoke on the floor earlier today. The Ways and Means provisions that passed on a voice vote here are included so we can get the job done.

Our leadership on both sides—John Boehner, PAUL RYAN, KEVIN MCCARTHY, STEVE SCALISE, CATHY MCMORRIS RODGERS, NANCY PELOSI, STENY HOYER—have really been outstanding. They knew from the get-go that we needed to get this thing done. Patients can't wait. They cannot wait. We are going to have the cure to get this thing done, and, yes, it will impact millions of lives.

So, in an hour or two, when we vote on this, I would urge all my colleagues on both sides of the aisle to vote ''yes'' for patients.

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

Mr. BRADY of Texas. Madam Speaker, I yield myself such time as I may consume.

America has always been a leader in developing cutting-edge medical treatments and technologies, breakthroughs that have saved countless lives; but due to outdated and burdensome Federal healthcare policies, medical innovation in our country is failing to keep pace with the 21st century challenges facing doctors and families.

Today, Americans nationwide are being forced to wait for the lifesaving treatments they need while important advancements are held up by unnecessary red tape. Chairman UPTON's 21st Century Cures Act provides an opportunity to put America back at the forefront of medical innovation and the delivery of cutting-edge care.

This legislation will empower America's researchers and doctors with the tools needed to solve the biggest healthcare challenges of our time. It includes many bipartisan solutions that will increase healthcare choice, access, and affordability for the American people.

Thanks to Chairman UPTON's leadership and the hard work of many Members of Congress from multiple committees, the 21st Century Cures Act brings together a variety of solutions that will help Americans throughout the country.

Ten of these patient-focused measures are from the Ways and Means Committee. All 10 are bipartisan. More than 20 of our members crafted and introduced these bills. Many more helped move them forward.

In particular, I would like to recognize the leadership of Congressman PAT TIBERI and JIM MCDERMOTT, the chairman and ranking member of our Health Subcommittee.

Ranking Member MCDERMOTT, by the way, is retiring at the end of this Congress. I want to take this moment to thank him for his years of service and friendship. I want to thank him and Chairman TIBERI for their efforts in support of the 21st Century Cures Act.

The Ways and Means healthcare provisions in the bill will remove harmful regulations on providers to impede the delivery of care. They will increase healthcare options for job creators and families. They will expand access to high-quality, affordable care for America's most vulnerable patients.

I am also excited that this legislation includes a policy by Representative ENGEL and Chairman TIBERI to ensure patients have access to new home infusion benefits. We look forward to working with the Energy and Commerce Committee next year to quickly implement this solution so that more patients have access to this vital service.

In closing, I want to thank all the Members on both sides of the aisle who helped develop the bill before us today. I again want to thank Chairman UPTON for his leadership. This historic legislation has been years in the making. We would not be here today without Chairman UPTON's dedication, vision, and commitment to bipartisan collaboration.

The 21st Century Cures Act is an incredible opportunity to help Americans from all walks of life for generations to come. I urge all my colleagues to join me in supporting its passage.

Madam Speaker, I reserve the balance of my time.

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

This bill is a typical lameduck bill. It has one provision in it that people really want, and that is a giveaway to the pharmaceutical industry.

Every provision that Mr. BRADY has talked about with respect to the Ways and Means Committee has already been passed out of here, and none of them are harmless, but the issue here is reducing the effect of the FDA in protecting the American public. My colleague, Ms. DELAURO from Connecticut, was absolutely right: the weakening of the FDA in protecting the American public is the central part of this bill.

Now, it is wrapped in $4 billion worth of inadequate money for NIH. It would take $7 billion to keep us where we are today. The money that went out of here a few months ago was mandatory, and now it is subject to appropriation. Everybody says: Oh, well, there are commitments made. There are commitments made.

Anybody who believes in the tooth fairy will believe that money is going to go to NIH. But the changes in law in how we push drugs, that is going to be in law.

Now, let me tell you what the problem with that is. If you push drugs out there quickly, there are some side effects and people die and people say, Well, it is too bad; the FDA approved it. We put the FDA in the position of protecting the American public, and then we cut them out at the knees.

Once we have done these cures, we come up with these great drugs, who can afford them? The other thing that is wrong with this bill and that this House has failed to do is to deal with the cost of pharmaceuticals in this country. There is not one single thing in this bill.

There is a specialty drug called Sovaldi. It is a treatment for hepatitis C. There are actually several million people in this country who need that drug. One pill costs $1,000. Full treatment costs $84,000. Who can afford it? Who is going to pay for that? Are you going to be willing to put the money into part D of Medicare to pay for it?

The question here is: What are we doing in giving away to the pharmaceutical companies an open door to push any drug out they want or that they can get through the screen, make the screen big so that it is easy to get them out, and then we pick up the pieces for the American people? That is the reason I oppose this bill. I think there are good things in it.

I come from a university that is the number one recipient of research money in this country. The University of Washington is the number one public university. We have so little money at NIH now that you have to be 40 years old until you get a grant from NIH for a research project. It used to be that 17 percent of all the grants were approved. Now we are down to 6 percent. That is because we have been squeezing the life out of NIH. And this $4 billion sounds like a lot of money, but it isn't even the $7 billion to keep us at the present level. That is what is wrong with this bill.

Madam Speaker, I reserve the balance of my time.

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentleman from Ohio (Mr. TIBERI), the chairman of the Health Subcommittee who shepherded these bills through the House earlier and leads the effort to correct issues so important to our hospitals and cancer hospitals, as well as some new reforms for infusion healthcare patients.

Mr. TIBERI. Madam Speaker, I thank Chairman BRADY for his leadership on this issue.

Madam Speaker, Chairman UPTON unveiled the 21st Century Cures Act back in 2014 to initiate quicker development and pathways to approve treatments and cure diseases. This bipartisan and bicameral bill is another example how the House is delivering on patient-focused solutions for Americans.

I am incredibly pleased that three of my initiatives are included in this final package, the first of which is a bill that provides necessary regulatory relief to providers and fixes a site-neutral policy to hospitals that were in the middle of construction when the policy went into effect.

Second, the 21st Century Cures Act gives relief to long-term care hospitals from the 25 percent rule and commonsense Medicare reforms.

Lastly, the bill includes a provision of a bill I sponsored that provides infusion therapy to Medicare beneficiaries in their home.

I look forward to continuing work on these issues with my colleagues in the next session of Congress. I want to congratulate Chairman UPTON for his incredible work on this. He solicited feedback from stakeholders, Members, patients, and has worked tirelessly to make this bill the best version possible. His accomplishments during his chairmanship are admirable, and I am grateful to call him a close friend.

Let's pass the 21st Century Cures Act on a bipartisan basis, Madam Speaker, and get America back in the driver's seat on medical innovation.

Mr. MCDERMOTT. Madam Speaker, I yield 3 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Madam Speaker, while certainly saluting the many Members who have worked so diligently on this measure, I cannot vote for it.

In a wide and endless desert of support for research funding, even getting a few drops of rain is understandably welcomed by the thirsty. Under Republican rule, we have seen a dreadful drought in research funding. This is a bill that attempts to address that shortfall. I voted for the bill when it was on the floor of the House at a previous time. At that point, it promised the hope, after this long drought of almost $10 billion in assured, certain funding, for research so that we might find cures for some of these diseases before we get them ourselves—the concern of so many people.

Now, under this new measure, we have only about a fourth of the funding previously approved in the House, and it is no longer certain money; it is maybe money for the future. So there may be bipartisan agreement, but there is not a bipartisan advancement.

At the same time that research dollars are dramatically cut—the very research dollars that were the reason for having this bill in the first place—Big Pharma got some of its wish list approved. And how very appropriate that this measure and so many other moving parts have been packed into what it calls the Tsunami Warning bill.

If there is one thing we can be sure of this past year, it is that those people who rely on lifesaving drugs and who want to be able to have a prescription that the doctor prescribes have been hit by a real tsunami. They have been buried in one wave after another wave after another giant wave of pharmaceutical price gouging. Whether it is the EpiPen for a child who is might have an allergic reaction, whether it is insulin for someone who is diabetic and relies on that insulin, whether it is an oncology drug that costs over $100,000, it is wave after wave of a tsunami of price gouging.

□ 1515

And what has this Congress done about that?

Absolutely nothing. I must say, the administration has done very little more. They have looked at it. There have been a few speeches about it, but there has not been effective action.

So what we get in this bill are a few things that Big Pharma wants that have been on its wish list for a long time, and consumers, they get nothing to look forward to other than more of those big waves of huge price increases.

I am also concerned that the policy arm that publishes Consumer Reports magazine has expressed deep concerns about additional patient risk as a result of some of the provisions that the pharmaceutical companies and the medical device manufacturers have insisted as the price for getting a little additional research funding.

So I am voting ''no,'' not because this provides some research dollars. It ought to be providing the level of certain research funding we approved already, but because it fails to address this critical health need.

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS), one of our key members of the Health Subcommittee who also focuses on rural hospitals and access to care for rural communities.

Ms. JENKINS of Kansas. Madam Speaker, I rise today to support this legislation. It improves access to health care for rural communities through measures I introduced, such as the Continuing Access to Hospitals Act, which stops unjustified regulations from interfering with rural healthcare providers offering quality services; and the Rural ACO Provider Equity Act, which will ensure the work of PAs and nurse practitioners is recognized so that rural hospitals can join ACOs and afford to remain open and serve our rural communities.

Finally, it will help the 40 million Americans who deal with a mental illness each year through inclusion of my Mental Health First Aid Act. This bipartisan legislation delivers $15 million every year to train police officers, teachers, veterans' advocates, and others to identify and aid those with a mental illness, building a stronger mental health safety net in America that addresses the needs of millions of Americans.

I urge my colleagues to pass this legislation.

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

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentleman from Minnesota (Mr. PAULSEN), one of our leaders in medical devices innovation and bringing lifesaving cures to the market sooner.

Mr. PAULSEN. Madam Speaker, I rise in strong support of the bipartisan 21st Century Cures Act.

There are more than 10,000 known diseases in the world, and many of them are rare diseases. Yet, there are only 500 of them that have an FDA-approved treatment. Millions of Americans today feel powerless because they have a deadly disease and they have no hope of a cure because there aren't enough resources for research or the regulatory barriers are discouraging innovation.

This bipartisan initiative today gives patients new hope. It supports more NIH research; it streamlines the regulatory approval process; and it gives patients more input in the treatment and delivery process.

I am also pleased today, Madam Speaker, that we are providing important reforms to our mental health system. For too long, patients and families, mental healthcare professionals, and law enforcement have been crying for help. This legislative effort represents the most significant improvement to the mental health system that we have seen in over a decade.

Madam Speaker, this is an innovation game-changer. It is a once-in-a-generation, transformational opportunity to change the way we treat disease. It expedites the discovery, the development, and the delivery of new treatments and cures; and it ensures that America will be a leader in the global fight for medical innovation.

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

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentleman from Ohio (Mr. RENACCI), who has, among many healthcare issues, led the charge to create much smarter measurements in hospital readmissions.

Mr. RENACCI. Madam Speaker, I rise in support of H.R. 34, the 21st Century Cures Act. At its core, this legislation, while not perfect, ensures our country will continue to be at the forefront of medical innovations and breakthroughs.

Also important is what the bill does for States like Ohio that are fighting the opioid epidemic. Just today it was reported that Ohio has seen more opioid overdose deaths than any other State in the Nation. This bill would especially help Ohio reverse this devastating trend.

I also applaud the inclusion of my bill, H.R. 1343, the Establishing Equity in the Hospital Readmission Program. The Hospital Readmission Program was created due to concerns that too few resources were being spent on reducing acute care hospital readmissions. While reducing acute care hospital readmissions is important, my bill ensures that we are not disproportionately penalizing those who see a large number of our most vulnerable patients.

This is one of the many commonsense, bipartisan reforms to improve our healthcare system included in the 21st Century Cures Act, and I urge all Members to support this bill.

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

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentleman

from Pennsylvania (Mr. MEEHAN), again, another key member of our committee who is focused on health care and, in this case, increasing information to seniors about their Medicare plans in advance, and also improving physical therapy, so critical to so many in health care.

Mr. MEEHAN. Madam Speaker, the 21st Century Cures Act is a historic, bipartisan legislation that will eliminate the barriers standing between us and cures for diseases like Alzheimer's and diabetes, and cancer.

The bill fosters coordination and research related to pediatric diseases and birth defects, and we encourage the NIH and FDA to establish a global pediatric clinical study network with the hope that more collaboration will lead to new treatments, and it will help build our understanding of how treatments geared for adults can help to lead to cures for children.

Just 3 years ago, after a fight with Washington bureaucrats, Sarah Murnaghan, a 10-year-old young woman from my district, received an adult lung transplant. She is now a thriving 14-year-old. And through ''Sarah's Heroes,'' we highlight the stories of other children who are courageously working to overcome challenges presented by cystic fibrosis and lung transplant.

Schizophrenia and mental illness are among other conditions without a cure. The bill improves access to mental health by increasing the number of healthcare professionals trained to treat patients. It also strengthens the requirement that mental health coverage be on par with coverage for physical ailments; many good reasons to continue to support. I urge my colleagues to do so.

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

Mr. BRADY of Texas. Madam Speaker, I yield 1 minute to the gentleman from Illinois (Mr. DOLD), one of our smartest members on the Ways and Means Committee who has really carved out a niche in support of medical innovation, really bringing these breakthroughs to the community and patients quickly.

Mr. DOLD. Madam Speaker, I certainly thank the chairman for his leadership.

I also stand here today in strong support of the 21st Century Cures Act. I want to thank Chairman UPTON for his leadership, and Ranking Member PALLONE, Congresswoman DEGETTE, and Congressman MURPHY for their great work on compiling things that are in this bill.

I have been a longtime advocate for both the 21st Century Cures Act and the Helping Families in Mental Health Crisis Act because I believe it is critically important that we modernize how we treat mental health and how we develop lifesaving cures. This package accomplishes both of these important goals and many more.

Over the next 10 years, we will provide an additional $4.8 billion to the National Institutes of Health in support of groundbreaking medical research and an additional $500 million to the FDA to help bring drugs and devices to patients more quickly.

We will also be providing States with $1 billion in grants over the next 2 years to help combat the opioid epidemic, which is impacting every single community across our Nation.

Finally, we will increase choice, access, and quality in health care by making serious improvements to Medicare.

The SPEAKER pro tempore (Mrs. LUMMIS). The time of the gentleman has expired.

Mr. BRADY of Texas. I yield the gentleman an additional 1½ minutes.

Mr. DOLD. This package is proof that when we are willing to work together, we can improve our healthcare system for all Americans through changes large and small. I encourage all of my colleagues to join me in supporting the 21st Century Cures Act.

I also want to thank, again, Chairman UPTON, Congressman MURPHY, Congresswoman DEGETTE, and all those that helped put this together, and the staff that were so instrumental in making this become a reality today.

Mr. BRADY of Texas. Madam Speaker, I have no further speakers and I am prepared to close if the gentleman would like to close.

I reserve the balance of my time.

Mr. MCDERMOTT. Madam Speaker, I yield myself such time as I may consume. I want to thank my colleagues for their interest in children. I hear some of the speakers stand up and say they are really interested in kids, yet they oppose the CHIP program. They talk about cutting back the help to children.

Now, the problem here is that if you are talking about cures, and you are going to create a magnificent cure that costs $80,000, if you don't provide Medicaid, the children who are poor in this country aren't going to get access to that cure. That is a cure for rich people who could pay it out of their clippings on their bonds and their stock.

The EPSDT program, which is the program that covers kids, the President-elect has put in the charge of that a woman from Indiana who testified against it. This is the benefit that ensures sick kids will get cures.

Now, you are setting in motion something here for pharmaceutical companies to find a way to take as much money out of the system as they can with every drug they can put out there, and you are, at the same time, moving in the direction of making it impossible for poor children to be taken care of in this country.

How many States have the Governors said: We don't believe in Medicaid; we don't believe that the government should give Medicaid; we believe the government should stay out of medicine?

So they deny their own people health care, simple, everyday, ordinary health care; and we are talking about cures for disease. As somebody said, there were 50 cases in the United States of it last year. One feels for those 50.

I am a physician. I have listened to those people. I know that it is awful, but you have to keep in balance and say to yourself: Are we going to spend all the money there or are we going to spend it dealing with all the Americans?

That is what is wrong with this bill. The pharmaceutical industry has no control on it whatsoever. When you put in that benefit, in part D, you tied the Secretary of Health and Human Services' hands, and he or she cannot negotiate lower prices. You said: Whatever the pharmaceutical company says the cost is, that is what we are going to pay.

Now, the Veterans Administration—veterans are different than ordinary people in this country. They have an administration that has the right to negotiate changes in prices, and their pharmaceutical prices are down 50, 60 percent from what people pay in Medicare.

Now, as long as you have that kind of giveaway going on to the pharmaceutical companies, this bill is just kind of frosting on the cake, and I guess Members will vote for it. In the short run it will seem like, you know, it didn't make any difference, but you are going to pay down the line.

This is going to be a Fram commercial. You either pay now or you are going to pay later, because if you do not screen those drugs carefully and make sure that they are really doing something, and let the pharmaceutical companies add a Chlorine ion or a Boron or whatever, they are simply putting drugs out on the table that cost too much for the Americans to buy.

I urge a ''no'' vote.

I yield back the balance of my time.

Mr. BRADY of Texas. Madam Speaker, I yield myself the balance of my time.

There are so many Americans who could be watching today who wonder when that lifesaving drug, that new treatment will be made available to them. They know it is in other countries. They read about it in other places, but they can't get it here in America. The Cures Act changes that. It streamlines it, moves things faster; and when you are in that tough situation, it provides options for health care, experimental drugs never before available to them. This is important to patients and it is important to doing it better in America. I urge its support.

I yield back the balance of my time.

Mr. THOMPSON of California. Madam Speaker, I rise in support of this bill.

H.R. 34, the 21st Century Cures Act, is the product of extensive bipartisan, bicameral collaboration between stakeholders and policy makers.

This bill stands to help us make significant progress when it comes to keeping Americans healthy, and keeping America on the forefront of medical innovation.

Included in the bill text are provisions based on legislation I authored, known as the Small Business Healthcare Relief Act.

These provisions would allow small businesses with fewer than 50 employees to offer tax preferred Health Reimbursement Arrangements, or HRAs, to their workforce.

The HRAs can be used to buy health insurance in the individual market, or pay for qualified health expenses if an individual already has coverage.

This targeted bill seeks not to override those long-standing responsibilities between employers and their employees, nor does it seek to override ERISA protections that existed before the Affordable Care Act was enacted, but to provide small employers an option for coverage in a robust individual market.

Given that this bill will be passed late in the year, it's my hope that the incoming Administration acts promptly to ensure a smooth transition for employers, employees, and the current exchange infrastructure.

Small businesses drive job creation and grow our economy. We should be going out of our way to help them support their employees so that they can focus on what they do best: running their business.

I urge my colleagues to support this bill.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise in support of H.R. 34, the 21st Century Cures Act which will encourage innovation in biomedical research and development of new treatments.

The bill contains $6.3 billion in spending over the next ten years. With $4.8 billion in funding over the next ten years delivered to Innovation Funds within the National Institutes of Health and $500 million for the Food and Drug Administration over the next five years, it is clear that Congress is committed to investing in health research. Developing a better system of funding towards high-risk high reward research and research by early stage investigators is crucial to finding better health outcomes. With a better focus on infectious disease, precision medicine, and biomarkers, I strongly believe that we will finally address these areas of unmet medical needs, which are often the most pervasive issues in our health system.

The legislation also includes elements of H.R. 2646, the Helping Families in Mental Health Crisis Act, in order to get mental health reforms across the Senate's finish line. I am proud that this legislation will include many of the provisions that Congressman TIM MURPHY (R–PA) and I worked on for several years. The bill establishes an Assistant Secretary for Mental Health and Substance Use within the Substance Abuse and Mental Health Services Administration; reauthorizes Assisted Outpatient Treatment grant programs; and requires the Secretary to clarify HIPAA rules regarding circumstances when a provider can share information. Among other provisions, these aforementioned are just a few that will benefit patients directly and immediately.

While H.R. 34 contains many provisions regarding the biomedical research workforce, clinical trials, FDA improvements, I strongly believe that the Congress has not placed enough importance on scientific research and this is a way to get us back on track. Investing in innovation will yield high rewards for the medical community, especially patients. I am proud to support H.R. 34, the 21st Century Cures Act and urge my Senate colleagues to pass this legislation swiftly.

Ms. JACKSON LEE. Madam Speaker, I rise in support of the House Amendment to the Senate Amendment to H.R. 34, the ''21st Century Cures Act,'' a bipartisan piece of legislation that is vital to the future and health of our Nation's citizens and ecosystem.

This thoughtful legislation is the culmination of the hard work of my dedicated colleagues who have sought out and engaged in public conversations with patients, innovators, providers, regulators and researchers about how to move advances in science and medicine into new therapies.

This outreach has garnered the critical input and support of more than 370 patient and physician groups, state and local organizations, cancer centers, and research and life sciences.

I am proud to be one of the cosponsors of 21st Century Cures Act, which represents a new national effort to find treatment and cures for thousands of unknown and rare diseases.

Looking to the various policies this legislation aims to address, it is important to highlight the commendable objectives and that will not only accelerate the discovery, development and delivery of new treatments and cures for thousands of serious and rare diseases, but it will also open the doors of innovation and the growth of health care system by enhancing and enriching the medical field for all Americans.

The most ambitious action calls for $6.3 billion in mandatory funding to be delivered over the next ten years to the National Institutes of Health (NIH).

NIH is part of our nation's top ranked educational research institutions in the world.

In order to maintain our global competitiveness in the biomedical field, we must invest in the industries that guarantee economic prosperity for our current and future economies.

It has been estimated that every $1 of NIH funding generates about $2.21 in local economic growth, and, in 2012, NIH-funded research supported an estimated 402,000 jobs all across the U.S.

The bill's funding for NIH would provide for an annual 3 percent increase in the NIH budget, which has been stagnant for the past few years and which desperately needs more funding to capitalize on emerging scientific insights.

This increased funding not only aims to continue the sustainability of our economy but it also supports our President's initiative to provide more resources to the biomedical field.

The 21st Century Cures Act supports the President's Precision Medicine Initiative, which would advance a new model of participant-centered research to accelerate biomedical discoveries and provide clinicians with new tools and therapies tailored to individual patients' needs.

The Obama Administration believes we can build on the progress in improving the drug development and approval process made to date by: Incorporating patients' voices into the Food and Drug Administration (FDA) decision-making; encouraging the development and qualification of reliable biomarkers to accelerate work on important new therapies; and reducing barriers to initiating medical device trials.

In furtherance of this initiative, the legislation before us allows, for the creation of an ''Innovation Fund'' through the National Institute of Health.

This ''Innovation Fund'' is a welcome effort because it promotes the maintenance of the best biomedical workforce in the world and help to increase the diversity of the biomedical workforce.

In particular, the $4.8 billion provided for the Innovation Fund, will not only increase the number of the research projects it supports but it also increases the cap for NIH's loan repayment programs.

This would include a repayment program for clinical scientists who do research in health disparities and for clinical scientist from disadvantaged backgrounds, from $35,000 per year to $50,000 per year plus a yearly inflation for adjustment.

With the support of H.R. 34, underrepresented communities and those with disadvantaged backgrounds from across the country can undoubtedly provide the future researchers and workers of the biomedical workforce.

The Journal on STEM Education reported in 2011 that only 8.34 percent of the STEM doctorates awarded in 2006 were given to underrepresented minorities, despite making up approximately 28 percent of the U.S. population.

Furthermore, GAO found noted that while the percentage of underrepresented minorities nationwide increased from 13 percent to 19 percent from 1994 to 2003, the total number of STEM doctorates awarded to the same group dropped during this period from 8,335 to 7,310.

In response, the National Institute of General Medical Sciences (NIGMS) created the Minority Opportunities in Research (MORE) Division and similar academic intervention programs.

The MORE programs are comprised of four primary components: research experience, mentoring and advisement, supplemental instruction and workshops, and financial support.

In 2007, NIGMS' annual budget was $1.9 billion, of which nearly $126 million was spent on its MORE programs.

This amount includes the Minority Biomedical Research Support-Research Initiative for Scientific Enhancement (MBRS-RISE) program, the Minority Access to Research Careers (MARC), Post-baccalaureate Research Education Program (PREP), and the Bridges to the Baccalaureate and Bridges to the PhD programs.

The amount of funds dedicated to these programs reflects the commitment by the science and research community to the goals of the MORE Division in addressing this problem.

Increased funding set forth in H.R. 34 will only strengthen NIH's focus on diversifying the biomedical workforce by requiring NIH to focus on ensuring participation from scientists from underrepresented communities.

In addition to addressing the needs of underrepresented communities, H.R. 34 also calls for specific action to increase representation of racial minorities.

The 21st Century Cures Act acknowledges that there are disturbing statistics on the low numbers of African Americans, Hispanics and Native Americans pursuing academic qualification and participating in scientific research.

Under H.R. 34, the National Institute on Minority Health and Health Disparities will necessarily include strategies for increasing representation of minority communities in its strategic plan.

I am proud that H.R. 34 incorporates the Jackson Lee Amendment which I offered during the initial consideration of the 21st Century Cures Act by the House which will help ensure that the national goals of finding and bringing more cures and treatments to patients and strengthening the biomedical innovation ecosystem in the United States is aided by an expanding pool of diverse and talented medical researchers.

Specifically, the Jackson Lee Amendment instructed the Secretary of Health and Human Services to conduct outreach to historically Black colleges and universities, Hispanic-serving institutions, Native American colleges, and rural colleges to ensure that health professionals from underrepresented populations are aware of research opportunities under this Act.

Many racial health disparities stem from lack of access to effective test, treatments and cures for illnesses that have devastating consequences for African American, Hispanic and Native American populations.

For example:

1. African-Americans (represent 12 percent of the U.S. population but only 5 percent of clinical trial participants.

2. Hispanics make up 16 percent of the population but only 1 percent of clinical trial participants.

3. Women are under-represented in cardiovascular device trials, which have 67 percent male participation.

The most significant barriers limiting clinical participation are race, age, and sex of participants:

1. Women and minority patients are more difficult to recruit.

2. Women and minority physicians have less experience and are relatively more costly to engage.

3. Minority patients with limited English proficiency can require costly translation services.

Physicians are the gateway to the patient. Increasing diversity of those conducting research will have implications on the types of conditions that are researched and the participants in clinical trials that are seeking answers to illnesses like lupus, triple negative breast cancer, and sickle cell disease that can be difficult to detect, treat and cure.

Certain medical illnesses have been known to have higher prevalence in certain demographic groups, including type II diabetes, lupus, sickle cell anemia, and Triple Negative Breast Cancer for which African Americans are more than twice as likely to be diagnosed on average.

Lupus, triple negative breast cancer and sickle cell disease are of particular concern because they are often difficult to diagnose and disproportionately impact persons of color and especially women.

In particular, Lupus is a chronic, complex and prevalent autoimmune disease that affects more than 1.5 million Americans. Yet, Lupus is one of America's least recognized major diseases.

More than 90 percent of lupus sufferers are women, mostly young women between the ages of 15 to 44, and women of color are two to three times more at risk for lupus than Caucasians.

Triple negative breast cancer also disproportionately impacts younger women, African American women, Hispanic/Latina women, and women with a "BRCA1" genetic mutation, which is prevalent in Jewish women.

More than 30 percent of all breast cancer diagnoses in African American are of the triple negative variety, and African American women are far more susceptible to this dangerous subtype than white or Hispanic women.

Additionally, there are about 2 million people who carry the sickle cell trait and with about 100,000 having the disease. According to the Centers for Disease Control and Prevention, sickle cell trait is common among African Americans and occurs in about 1 in 12, and sickle cell disease occurs in about 1 out of every 500 African-American births, compared to about 1 out of every 36,000 Hispanic-American births.

Treatments for Lupus, triple negative breast cancer and sickle cell disease are not progressing as quickly as desired by patients, researchers, and policy makers. We must support the advancement of legislation that will allow for the remediation and end of health care disparities and the promotion of research parity for diseases such as lupus, triple negative breast cancer, sickle cell disease, and countless other rare and serious diseases.

Race and ethnicity have also been shown to affect the effectiveness of and response to certain drugs, such as anti-hypertensive therapies in the treatment of hypertension in African Americans and anti-depressants in Hispanics.

Increased diversity in research trials could help researchers find better, more precise ways to fight diseases that disproportionately impact certain populations, and may be important for the safe and effective use of new therapies. As one of the most diverse cities in the country, Houston is the 4th largest city in the United States and the 5th most populated metropolitan area in the nation. Houston is home to the largest medical complex in the world—the Texas Medical Center, which provides clinical health care, research and education at its 54 institutions.

The University of Houston, ranked number three out of all other colleges and universities in Texas, is an example of a premier institution that can produce students with advanced STEM degrees who would be able to join a progressing biomedical field.

Another important requirement of H.R. 34 is that it would require National Institute of Health to publically report the number of children by race and gender who participate in NIH funded clinical trials.

This legislation would help ensure that children of all races are adequately represented in clinical trials and that we can determine the safety and effectiveness of drugs on children of all demographic backgrounds.

With 10,000 known diseases, 7,000 of which are rare, and treatments for only 500 of them—clear there is much work to do. Medical research saves lives and improves the quality of life for millions of Americans because the government provides a steady and reliable commitment to basic research into cures for debilitating and deadly diseases.

Given the array of commendable initiatives, H.R. 34 is a necessary piece of legislation that will accelerate the discovery, development, and delivery of promising new treatments and cures for all patients while investing in our nation's ability to maintain the best and most diverse biomedical workforce in the world.

Madam Speaker, I call for the support of all of my colleagues in ensuring the passage of the important legislation.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 934, the previous question is ordered on the motion to concur.

The question is on the motion to concur offered by the gentleman from Michigan (Mr. UPTON).

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

Mr. MCDERMOTT. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, and the order of the House of today, further proceedings on this question will be postponed.

□ 1530

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. DOLD). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

OVERTIME PAY FOR SECRET SERVICE AGENTS ACT OF 2016

Mr. CHAFFETZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6302) to provide an increase in premium pay for United States Secret Service agents performing protective services during 2016, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6302

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Overtime Pay for Secret Service Agents Act of 2016''.

SEC. 2. PREMIUM PAY EXCEPTION IN 2016 FOR WORK AUTHORIZED UNDER SECTION 3056 OF TITLE 18.

(a) IN GENERAL.—Notwithstanding any other provision of law, including section 5307 of title 5, United States Code, and subject to subsection (b), during calendar year 2016—

(1) section 5547(a) of such title shall not apply to an employee who performs work authorized by section 3056(a) of title 18, United States Code; and

(2) such an employee may be paid premium pay to the extent that the payment of such pay does not cause the total of basic pay and such premium pay for any pay period for such employee to exceed the annual rate of basic pay payable to level II of the Executive Schedule under section 5313 of title 5, United States Code.

(b) TREATMENT OF ADDITIONAL PAY.—To the extent that subsection (a) results in payment of additional premium pay of a type that is normally creditable as basic pay for retirement or any other purpose, such additional pay shall not be considered to be basic pay for any purpose and shall not be used in computing a lump-sum payment for accumulated and accrued annual leave under section 5551 of title 5, United States Code.