

117TH CONGRESS  
2D SESSION

# H. R. 7666

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## AN ACT

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

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

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

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

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

Sec. 1. Short title; table of contents.

**TITLE I—MENTAL HEALTH AND CRISIS CARE NEEDS**

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

Sec. 101. Behavioral Health Crisis Coordinating Office.

Sec. 102. Crisis response continuum of care.

Sec. 103. Suicide Prevention Lifeline Improvement.

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

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

Sec. 112. Maternal mental health hotline.

Sec. 113. Task force on maternal mental health.

**Subtitle C—Reaching Improved Mental Health Outcomes for Patients**

Sec. 121. Innovation for mental health.

Sec. 122. Crisis care coordination.

Sec. 123. Treatment of serious mental illness.

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

**Subtitle D—Anna Westin Legacy**

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

**Subtitle E—Community Mental Health Services Block Grant Reauthorization**

Sec. 141. Reauthorization of block grants for community mental health services.

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

Sec. 151. Peer-supported mental health services.

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

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

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

Subtitle A—Native Behavioral Health Access Improvement

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

Subtitle B—Summer Barrow Prevention, Treatment, and Recovery

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

Subtitle C—Excellence in Recovery Housing

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

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

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

Subtitle E—Timely Treatment for Opioid Use Disorder

Sec. 251. Study on exemptions for treatment of opioid use disorder through opioid treatment programs during the COVID–19 public health emergency.

Sec. 252. Changes to Federal opioid treatment standards.

#### Subtitle F—Additional Provisions Relating to Addiction Treatment

Sec. 261. Prohibition.

Sec. 262. Eliminating additional requirements for dispensing narcotic drugs in schedule III, IV, and V for maintenance or detoxification treatment.

Sec. 263. Requiring prescribers of controlled substances to complete training.

Sec. 264. Increase in number of days before which certain controlled substances must be administered.

Sec. 265. Block, report, and suspend suspicious shipments.

#### Subtitle G—Opioid Epidemic Response

Sec. 271. Opioid prescription verification.

Sec. 272. Synthetic Opioid Danger Awareness.

Sec. 273. Grant program for State and Tribal response to opioid and stimulant use and misuse.

### TITLE III—ACCESS TO MENTAL HEALTH CARE AND COVERAGE

#### Subtitle A—Collaborate in an Orderly and Cohesive Manner

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

#### Subtitle B—Helping Enable Access to Lifesaving Services

Sec. 311. Reauthorization and provision of certain programs to strengthen the health care workforce.

Sec. 312. Reauthorization of minority fellowship program.

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

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

#### Subtitle D—Mental Health and Substance Use Disorder Parity Implementation

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

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

Sec. 341. Helping emergency responders overcome.

#### Subtitle F—Other Provisions

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

### TITLE IV—CHILDREN AND YOUTH

#### Subtitle A—Supporting Children’s Mental Health Care Access

Sec. 401. Pediatric mental health care access grants.

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

#### Subtitle B—Continuing Systems of Care for Children

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

#### Subtitle C—Garrett Lee Smith Memorial Reauthorization

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

#### Subtitle D—Media and Mental Health

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

### TITLE V—MEDICAID AND CHIP

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

### TITLE VI—MISCELLANEOUS PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

20               “(B) the Veterans Crisis Line;

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

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

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

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

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

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

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

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

21           “(b) BEST PRACTICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17               “(B) appropriate timely response; and

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

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

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

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

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

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

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

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

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

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

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

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

14          (a) SUICIDE PREVENTION LIFELINE.—

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

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

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

22               “(c) PLAN.—

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

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

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

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

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

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

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

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

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

1 guidance determined by the Secretary to be  
2 appropriate.

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

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

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

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

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

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

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

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

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

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

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

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

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

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

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

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

10                   (A) a full description of the program;

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

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

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

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

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

24                   (1) complete a study on—

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

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

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

18 (d) GAO STUDY AND REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (2) in subsection (a)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19          (1) in paragraph (1)—

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

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

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

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

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

defined in section 330N), to aid in the treatment of pregnant and postpartum women; and”; and

(2) in paragraph (2)—

(A) by striking subparagraph (A) and redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively;

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

(C) in subparagraph (B), as redesignated—

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

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

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

“(C) providing assistance to pregnant and postpartum women to receive maternal mental health and substance use disorder treatment, including patient consultation, care coordination, and navigation for such treatment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(1) be a 24/7 real-time hotline;

16 “(2) provide voice and text support;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(b) MEMBERSHIP.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(C) include—

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

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

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

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

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

21 “(c) DUTIES.—The Task Force shall—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(3) Each year thereafter—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18       “(a) ESTABLISHMENT.—

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

1           “(2) FEDERAL ADVISORY COMMITTEE ACT.—

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

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

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

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

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

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

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

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

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

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

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

17 “(d) MEMBERSHIP.—

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

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

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

3           “(C) the Attorney General;

4           “(D) the Secretary of Veterans Affairs;

5           “(E) the Secretary of Defense;

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

8           “(G) the Secretary of Education;

9           “(H) the Secretary of Labor;

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

12          “(J) the Commissioner of Social Security.

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

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

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

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

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

3 “(D) at least 2 members shall be—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (2) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19          “(d) REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (C) in paragraph (5)—

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

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

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

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

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

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

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

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

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

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

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

4 (1) in subsection (a)—

5 (A) in paragraph (2)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23               “(2) Rates of incarceration of patients.

24               “(3) Rates of homelessness of patients.

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

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

7           “(f) DEFINITIONS.—In this section:

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

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

19          “(g) FUNDING.—

20               “(1) AMOUNT OF GRANTS.—

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

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

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

5 “(2) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

19 (1) nongovernmental entities; and

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

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

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

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

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

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

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

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

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

3 (B) criminal and judicial proceedings;

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

7 (D) incarceration.

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

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

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

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

19 (1) disaggregate data by—

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

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

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

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

10 (B) the percentage of such individuals in—

11 (i) homeless shelters;

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

15 (iii) nursing facilities.

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

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

22 (2) make such report publicly available.

## 1     **Subtitle D—Anna Westin Legacy**

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

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

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

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

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

22                 “(1) across geographical regions; and

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

24            “(c) ACTIVITIES.—The Center—

25                 “(1) shall—

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

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

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

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

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

1 support of individuals with eating disorders;  
2 and

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

9 “(2) may—

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

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

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

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

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

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

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

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

19 “(d) CRISIS CARE.—

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

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

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

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

15               “(A) Crisis call centers.

16               “(B) 24/7 mobile crisis services.

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

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

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

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

9 (c) EARLY INTERVENTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4                   “(A) the signs of mental illness;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(a) DEFINITIONS.—In this section:

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

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

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

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

3       “(b) FORMULA FUNDS.—

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

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

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

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

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

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

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

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

18          “(d) REGULATIONS.—

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

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

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

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

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

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

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

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

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

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

20 **SEC. 211. GRANTS FOR THE BENEFIT OF HOMELESS INDIV-**  
21 **IDUALS.**

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

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

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

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

7 (2) in subsection (a)—

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

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

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

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

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

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

1 (1) in subsection (a)(1)—

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

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

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

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

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

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

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

19 (1) in subsection (a)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(F) ANNUAL REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “(B) STATE PERFORMANCE MEASURES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9           “(3) AUTHORIZATION OF APPROPRIATIONS.—

10          There is authorized to be appropriated to carry out  
11          this subsection \$1,000,000 for each of fiscal years  
12          2023 through 2027.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           “(8) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(A) screening adolescents for alcohol use;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20          “(6) AUTHORIZATION OF APPROPRIATIONS.—

21          There is authorized to be appropriated to carry out  
22          this subsection \$3,000,000 for each of fiscal years  
23          2023 through 2027.

24          “(g) DATA COLLECTION AND RESEARCH.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6           (1) in subsection (a)—

7                 (A) by striking “up to 125”; and

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

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

14           (3) in subsection (c)—

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

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

23           (4) in subsection (e)—

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

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

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

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

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

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

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

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

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

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

2 (a) GRANTS.—

3 (1) REPEAL OF MAXIMUM GRANT AMOUNT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(1) INFORMATION ON BEST PRACTICES.—

12 “(A) HEALTH AND HUMAN SERVICES.—

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

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

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

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

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

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

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

4 (7) TECHNICAL AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 “(3) LIMITATIONS.—A State may—

“(A) use not more than 10 percent of a grant under this section for educating the public pursuant to subsection (a)(5); and

“(B) use not less than 20 percent of a grant under this section to offset cost-sharing for distribution and dispensing of drugs or devices approved, cleared, or otherwise authorized under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.”.

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

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

**SEC. 221. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.**

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

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

1 (2) in subsection (b)—

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

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

6 (C) in paragraph (2)—

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

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

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

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

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

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

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

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

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

17 (2) in subsection (a)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (2) in paragraph (2)—

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

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

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

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

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

11 “(A) made publicly available; and

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

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

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

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

1           (1) by redesignating subsections (e), (f), and  
2           (g) as subsections (g), (h), and (i), respectively; and  
3           (2) by inserting after subsection (d) the fol-  
4           lowing:

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(iv) The Office of Inspector General.

4 “(v) The Indian Health Service.

5 “(vi) The Department of Agriculture.

6 “(vii) The Department of Justice.

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

9 “(ix) The Bureau of Indian Affairs.

10 “(x) The Department of Labor.

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Section 550 of the Public Health Service Act (42  
8 U.S.C. 290ee–5) (relating to national recovery housing  
9 best practices), as amended by sections 232 and 233, is  
10 further amended by inserting after subsection (e) (as in-  
11 serted by section 233) the following:

12 “(f) GRANTS FOR IMPLEMENTING NATIONAL RECOV-  
13 ERY HOUSING BEST PRACTICES.—

14 “(1) IN GENERAL.—The Secretary shall award  
15 grants to States (and political subdivisions thereof),  
16 Tribes, and territories—

17 “(A) for the provision of technical assist-  
18 ance to implement the guidelines and rec-  
19 ommendations developed under subsection (a);  
20 and

21 “(B) to promote—

22 “(i) the availability of recovery hous-  
23 ing for individuals with a substance use  
24 disorder; and

1                   “(ii) the maintenance of recovery  
2                   housing in accordance with best practices  
3                   developed under this section.

4                   “(2) STATE PROMOTION PLANS.—Not later  
5                   than 90 days after receipt of a grant under para-  
6                   graph (1), and every 2 years thereafter, each State  
7                   (or political subdivisions thereof,) Tribe, or territory  
8                   receiving a grant under paragraph (1) shall submit  
9                   to the Secretary, and publish on a publicly accessible  
10                  internet website of the State (or political subdivi-  
11                  sions thereof), Tribe, or territory—

12                  “(A) the plan of the State (or political sub-  
13                  divisions thereof), Tribe, or territory, with re-  
14                  spect to the promotion of recovery housing for  
15                  individuals with a substance use disorder lo-  
16                  cated within the jurisdiction of such State (or  
17                  political subdivisions thereof), Tribe, or terri-  
18                  tory; and

19                  “(B) a description of how such plan is con-  
20                  sistent with the best practices developed under  
21                  this section.”.

22 **SEC. 236. FUNDING.**

23                  Subsection (i) of section 550 of the Public Health  
24                  Service Act (42 U.S.C. 290ee–5) (relating to national re-  
25                  covery housing best practices), as redesignated by section

1 233, is amended by striking “\$3,000,000 for the period  
2 of fiscal years 2019 through 2021” and inserting  
3 “\$5,000,000 for the period of fiscal years 2023 through  
4 2027”.

5 **SEC. 237. TECHNICAL CORRECTION.**

6 Title V of the Public Health Service Act (42 U.S.C.  
7 290aa et seq.) is amended—

8 (1) by redesignating section 550 (relating to  
9 Sobriety Treatment and Recovery Teams) (42  
10 U.S.C. 290ee–10), as added by section 8214 of Pub-  
11 lic Law 115–271, as section 550A; and

12 (2) by moving such section so it appears after  
13 section 550 (relating to national recovery housing  
14 best practices).

15 **Subtitle D—Substance Use Preven-**  
16 **tion, Treatment, and Recovery**  
17 **Services Block Grant**

18 **SEC. 241. ELIMINATING STIGMATIZING LANGUAGE RELAT-**  
19 **ING TO SUBSTANCE USE.**

20 (a) BLOCK GRANTS FOR PREVENTION AND TREAT-  
21 MENT OF SUBSTANCE USE.—Part B of title XIX of the  
22 Public Health Service Act (42 U.S.C. 300x et seq.) is  
23 amended—

1 (1) in the part heading, by striking “**SUB-**  
 2 **STANCE ABUSE**” and inserting “**SUBSTANCE**  
 3 **USE**”;

4 (2) in subpart II, by amending the subpart  
 5 heading to read as follows: “**Block Grants for**  
 6 **Substance Use Prevention, Treatment,**  
 7 **and Recovery Services**”;

8 (3) in section 1922(a) (42 U.S.C. 300x–  
 9 22(a))—

10 (A) in paragraph (1), in the matter pre-  
 11 ceding subparagraph (A), by striking “sub-  
 12 stance abuse” and inserting “substance use dis-  
 13 orders”; and

14 (B) by striking “such abuse” each place it  
 15 appears in paragraphs (1) and (2) and insert-  
 16 ing “such disorders”;

17 (4) in section 1923 (42 U.S.C. 300x–23)—

18 (A) in the section heading, by striking  
 19 “**SUBSTANCE ABUSE**” and inserting “**SUB-**  
 20 **STANCE USE**”; and

21 (B) in subsection (a), by striking “drug  
 22 abuse” and inserting “substance use disorders”;

23 (5) in section 1925(a)(1) (42 U.S.C. 300x–  
 24 25(a)(1)), by striking “alcohol or drug abuse” and  
 25 inserting “alcohol or other substance use disorders”;

1 (6) in section 1926(b)(2)(B) (42 U.S.C. 300x–  
2 26(b)(2)(B)), by striking “substance abuse”;

3 (7) in section 1931(b)(2) (42 U.S.C. 300x–  
4 31(b)(2)), by striking “substance abuse” and insert-  
5 ing “substance use disorders”;

6 (8) in section 1933(d)(1) (42 U.S.C. 300x–  
7 33(d)), in the matter following subparagraph (B), by  
8 striking “abuse of alcohol and other drugs” and in-  
9 serting “use of substances”;

10 (9) by amending paragraph (4) of section 1934  
11 (42 U.S.C. 300x–34) to read as follows:

12 “(4) The term ‘substance use disorder’ means  
13 the recurrent use of alcohol or other drugs that  
14 causes clinically significant impairment.”;

15 (10) in section 1935 (42 U.S.C. 300x–35)—

16 (A) in subsection (a), by striking “sub-  
17 stance abuse” and inserting “substance use dis-  
18 orders”; and

19 (B) in subsection (b)(1), by striking “sub-  
20 stance abuse” each place it appears and insert-  
21 ing “substance use disorders”;

22 (11) in section 1949 (42 U.S.C. 300x–59), by  
23 striking “substance abuse” each place it appears in  
24 subsections (a) and (d) and inserting “substance use  
25 disorders”;

1           (12) in section 1954(b)(4) (42 U.S.C. 300x–  
2       64(b)(4))—

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

5           (B) by striking “such abuse” and inserting  
6       “such disorders”;

7           (13) in section 1955 (42 U.S.C. 300x–65), by  
8       striking “substance abuse” each place it appears  
9       and inserting “substance use disorder”; and

10          (14) in section 1956 (42 U.S.C. 300x–66), by  
11       striking “substance abuse” and inserting “substance  
12       use disorders”.

13       (b) CERTAIN PROGRAMS REGARDING MENTAL  
14 HEALTH AND SUBSTANCE ABUSE.—Part C of title XIX  
15 of the Public Health Service Act (42 U.S.C. 300y et seq.)  
16 is amended—

17          (1) in the part heading, by striking “**SUB-**  
18       **STANCE ABUSE**” and inserting “**SUBSTANCE**  
19       **USE**”;

20          (2) in section 1971 (42 U.S.C. 300y), by strik-  
21       ing “substance abuse” each place it appears in sub-  
22       sections (a), (b), and (f) and inserting “substance  
23       use”; and

1 (3) in section 1976 (42 U.S.C. 300y–11), by  
 2 striking “intravenous abuse” each place it appears  
 3 and inserting “intravenous use”.

4 **SEC. 242. AUTHORIZED ACTIVITIES.**

5 Section 1921(b) of the Public Health Service Act (42  
 6 U.S.C. 300x–21(b)) is amended by striking “prevent and  
 7 treat substance use disorders” and inserting “prevent,  
 8 treat, and provide recovery support services for substance  
 9 use disorders”.

10 **SEC. 243. REQUIREMENTS RELATING TO CERTAIN INFEC-**  
 11 **TIOUS DISEASES AND HUMAN IMMUNO-**  
 12 **DEFICIENCY VIRUS.**

13 Section 1924 of the Public Health Service Act (42  
 14 U.S.C. 300x–24) is amended—

15 (1) in the section heading, by striking “**TUBER-**  
 16 **CULOSIS AND HUMAN IMMUNODEFICIENCY**  
 17 **VIRUS**” and inserting “**TUBERCULOSIS, VIRAL**  
 18 **HEPATITIS, AND HUMAN IMMUNODEFICIENCY**  
 19 **VIRUS**”;

20 (2) by amending subsection (a)(2) to read as  
 21 follows:

22 “(2) DESIGNATED STATES.—

23 “(A) FISCAL YEARS THROUGH FISCAL  
 24 YEAR 2024.—For purposes of this subsection,  
 25 through September 30, 2024, a State described

1 in this paragraph is any State whose rate of  
2 cases of acquired immune deficiency syndrome  
3 is 10 or more such cases per 100,000 individ-  
4 uals (as indicated by the number of such cases  
5 reported to and confirmed by the Director of  
6 the Centers for Disease Control and Prevention  
7 for the most recent calendar year for which  
8 such data are available).

9 “(B) FISCAL YEAR 2025 AND SUCCEEDING  
10 FISCAL YEARS.—

11 “(i) IN GENERAL.—Beginning with  
12 fiscal year 2025, for purposes of this sub-  
13 section, a State described in this para-  
14 graph is any State whose rate of cases of  
15 human immunodeficiency virus is 10 or  
16 more such cases per 100,000 individuals  
17 (as indicated by the number of such cases  
18 newly reported to and confirmed by the Di-  
19 rector of the Centers for Disease Control  
20 and Prevention for the most recent cal-  
21 endar year for which such data are avail-  
22 able).

23 “(ii) CONTINUATION OF DESIGNATED  
24 STATE STATUS.—In the case of a State  
25 whose rate of cases of human immuno-

1           deficiency virus falls below the threshold  
2           specified in clause (i) for a calendar year,  
3           such State shall, notwithstanding clause  
4           (i), continue to be described in this para-  
5           graph unless the rate of cases falls below  
6           such threshold for three consecutive cal-  
7           endar years.”.

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

10          (4) by inserting after subsection (b) the fol-  
11          lowing:

12          “(c) VIRAL HEPATITIS.—

13                 “(1) IN GENERAL.—A funding agreement for a  
14                 grant under section 1921 is that the State involved  
15                 will require that any entity receiving amounts from  
16                 the grant for operating a program of treatment for  
17                 substance use disorders—

18                         “(A) will, directly or through arrangements  
19                         with other public or nonprofit private entities,  
20                         routinely make available viral hepatitis services  
21                         to each individual receiving treatment for such  
22                         disorders; and

23                         “(B) in the case of an individual in need  
24                         of such treatment who is denied admission to  
25                         the program on the basis of the lack of the ca-

1           capacity of the program to admit the individual,  
 2           will refer the individual to another provider of  
 3           viral hepatitis services.

4           “(2) VIRAL HEPATITIS SERVICES.—For pur-  
 5           poses of paragraph (1), the term ‘viral hepatitis  
 6           services’, with respect to an individual, means—

7                   “(A) screening the individual for viral hep-  
 8                   atitis; and

9                   “(B) referring the individual to a provider  
 10           whose practice includes viral hepatitis vaccina-  
 11           tion and treatment.”.

12 **SEC. 244. STATE PLAN REQUIREMENTS.**

13           Section 1932(b)(1)(A) of the Public Health Service  
 14   Act (42 U.S.C. 300x–32(b)(1)(A)) is amended—

15           (1) by redesignating clauses (vi) through (ix) as  
 16           clauses (vii) through (x), respectively; and

17           (2) by inserting after clause (v) the following:

18                   “(vi) provides a description of—

19                           “(I) the State’s comprehensive  
 20                           statewide recovery support services ac-  
 21                           tivities, including the number of indi-  
 22                           viduals being served, target popu-  
 23                           lations, and priority needs; and

24                           “(II) the amount of funds re-  
 25                           ceived under this subpart expended on

1 recovery support services,  
 2 disaggregated by the amount ex-  
 3 pended for type of service activity;”.

4 **SEC. 245. UPDATING CERTAIN LANGUAGE RELATING TO**  
 5 **TRIBES.**

6 Section 1933(d) of the Public Health Service Act (42  
 7 U.S.C. 300x-33(d)) is amended—

8 (1) in paragraph (1)—

9 (A) in subparagraph (A)—

10 (i) by striking “of an Indian tribe or  
 11 tribal organization” and inserting “of an  
 12 Indian Tribe or Tribal organization”; and

13 (ii) by striking “such tribe” and in-  
 14 serting “such Tribe”;

15 (B) in subparagraph (B)—

16 (i) by striking “tribe or tribal organi-  
 17 zation” and inserting “Tribe or Tribal or-  
 18 ganization”; and

19 (ii) by striking “Secretary under this”  
 20 and inserting “Secretary under this sub-  
 21 part”; and

22 (C) in the matter following subparagraph  
 23 (B), by striking “tribe or tribal organization”  
 24 and inserting “Tribe or Tribal organization”;

1           (2) by amending paragraph (2) to read as fol-  
2       lows:

3           “(2) INDIAN TRIBE OR TRIBAL ORGANIZATION  
4       AS GRANTEE.—The amount reserved by the Sec-  
5       retary on the basis of a determination under this  
6       subsection shall be granted to the Indian Tribe or  
7       Tribal organization serving the individuals for whom  
8       such a determination has been made.”;

9           (3) in paragraph (3), by striking “tribe or trib-  
10      al organization” and inserting “Tribe or Tribal or-  
11      ganization”; and

12          (4) in paragraph (4)—

13               (A) in the paragraph heading, by striking  
14               “DEFINITION” and inserting “DEFINITIONS”;  
15               and

16               (B) by striking “The terms” and all that  
17               follows through “given such terms” and insert-  
18               ing the following: “The terms ‘Indian Tribe’  
19               and ‘Tribal organization’ have the meanings  
20               given the terms ‘Indian tribe’ and ‘tribal orga-  
21               nization’ ”.

1 **SEC. 246. BLOCK GRANTS FOR SUBSTANCE USE PREVEN-**  
2 **TION, TREATMENT, AND RECOVERY SERV-**  
3 **ICES.**

4 (a) IN GENERAL.—Section 1935(a) of the Public  
5 Health Service Act (42 U.S.C. 300x–35(a)), as amended  
6 by section 241, is further amended by striking “appro-  
7 priated” and all that follows through “2022.” and insert-  
8 ing the following: “appropriated \$1,908,079,000 for each  
9 of fiscal years 2023 through 2027.”.

10 (b) TECHNICAL CORRECTIONS.—Section  
11 1935(b)(1)(B) of the Public Health Service Act (42  
12 U.S.C. 300x–35(b)(1)(B)) is amended by striking “the  
13 collection of data in this paragraph is”.

14 **SEC. 247. REQUIREMENT OF REPORTS AND AUDITS BY**  
15 **STATES.**

16 Section 1942(a) of the Public Health Service Act (42  
17 U.S.C. 300x–52(a)) is amended—

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

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

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

23 “(3) the amount provided to each recipient in  
24 the previous fiscal year.”.

1 **SEC. 248. STUDY ON ASSESSMENT FOR USE IN DISTRIBU-**  
2 **TION OF LIMITED STATE RESOURCES.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services, acting through the Assistant Secretary  
5 for Mental Health and Substance Use (in this section re-  
6 ferred to as the “Secretary”), shall, in consultation with  
7 States and other local entities providing prevention, treat-  
8 ment, or recovery support services related to substance  
9 use, conduct a study to develop a model needs assessment  
10 process for States to consider to help determine how best  
11 to allocate block grant funding received under subpart II  
12 of part B of title XIX of the Public Health Service Act  
13 (42 U.S.C. 300x–21) to provide services to substance use  
14 disorder prevention, treatment, and recovery support. The  
15 study shall include cost estimates with each model needs  
16 assessment process.

17 (b) REPORT.—Not later than 2 years after the date  
18 of the enactment of this Act, the Secretary shall submit  
19 to the Committee on Energy and Commerce of the House  
20 of Representatives and the Committee on Health, Edu-  
21 cation, Labor, and Pensions of the Senate a report on the  
22 results of the study conducted under paragraph (1).

**Subtitle E—Timely Treatment for  
Opioid Use Disorder**

**SEC. 251. STUDY ON EXEMPTIONS FOR TREATMENT OF  
OPIOID USE DISORDER THROUGH OPIOID  
TREATMENT PROGRAMS DURING THE COVID-  
19 PUBLIC HEALTH EMERGENCY.**

(a) STUDY.—The Assistant Secretary for Mental Health and Substance Use shall conduct a study, in consultation with patients and other stakeholders, on activities carried out pursuant to exemptions granted—

(1) to a State (including the District of Columbia or any territory of the United States) or an opioid treatment program;

(2) pursuant to section 8.11(h) of title 42, Code of Federal Regulations; and

(3) during the period—

(A) beginning on the declaration of the public health emergency for the COVID-19 pandemic under section 319 of the Public Health Service Act (42 U.S.C. 247d); and

(B) ending on the earlier of—

(i) the termination of such public health emergency, including extensions thereof pursuant to such section 319; and

(ii) the end of calendar year 2022.

1 (b) PRIVACY.—The section does not authorize the  
 2 disclosure by the Department of Health and Human Serv-  
 3 ices of individually identifiable information about patients.

4 (c) FEEDBACK.—In conducting the study under sub-  
 5 section (a), the Assistant Secretary for Mental Health and  
 6 Substance Use shall gather feedback from the States and  
 7 opioid treatment programs on their experiences in imple-  
 8 menting exemptions described in subsection (a).

9 (d) REPORT.—Not later than 180 days after the end  
 10 of the period described in subsection (a)(3)(B), and sub-  
 11 ject to subsection (c), the Assistant Secretary for Mental  
 12 Health and Substance Use shall publish a report on the  
 13 results of the study under this section.

14 **SEC. 252. CHANGES TO FEDERAL OPIOID TREATMENT**  
 15 **STANDARDS.**

16 (a) MOBILE MEDICATION UNITS.—Section 302(e) of  
 17 the Controlled Substances Act (21 U.S.C. 822(e)) is  
 18 amended by adding at the end the following:

19 “(3) Notwithstanding paragraph (1), a registrant  
 20 that is dispensing pursuant to section 303(g) narcotic  
 21 drugs to individuals for maintenance treatment or detoxi-  
 22 fication treatment shall not be required to have a separate  
 23 registration to incorporate one or more mobile medication  
 24 units into the registrant’s practice to dispense such nar-  
 25 cotics at locations other than the registrant’s principal

1 place of business or professional practice described in  
 2 paragraph (1), so long as the registrant meets such stand-  
 3 ards for operation of a mobile medication unit as the At-  
 4 torney General may establish.”.

5 (b) REVISE OPIOID TREATMENT PROGRAM ADMIS-  
 6 SION CRITERIA TO ELIMINATE REQUIREMENT THAT PA-  
 7 TIENTS HAVE AN OPIOID USE DISORDER FOR AT LEAST  
 8 1 YEAR.—Not later than 18 months after the date of en-  
 9 actment of this Act, the Secretary of Health and Human  
 10 Services shall revise section 8.12(e)(1) of title 42, Code  
 11 of Federal Regulations (or successor regulations), to elimi-  
 12 nate the requirement that an opioid treatment program  
 13 only admit an individual for treatment under the program  
 14 if the individual has been addicted to opioids for at least  
 15 1 year before being so admitted for treatment.

16 (c) FINAL REGULATION ON PERIODS FOR TAKE-  
 17 HOME SUPPLY REQUIREMENTS.—

18 (1) IN GENERAL.—Not later than 18 months  
 19 after the date of enactment of this Act, the Sec-  
 20 retary of Health and Human Services shall promul-  
 21 gate a final regulation amending paragraphs (i)(3)(i)  
 22 through (i)(3)(vi) of section 8.12 of title 42, Code of  
 23 Federal Regulations, as appropriate based on the  
 24 findings of the study under section 251 of this Act.

1           (2) CRITERIA.—The regulation under para-  
2       graph (1) shall establish relevant criteria for the  
3       medical director or an appropriately licensed practi-  
4       tioner of an opioid treatment program, to determine  
5       whether a patient is stable and may qualify for un-  
6       supervised use, which criteria may allow for consid-  
7       eration of each of the following:

8           (A) Whether the benefits of providing un-  
9       supervised doses to a patient outweigh the  
10      risks.

11          (B) The patient's demonstrated adherence  
12      to their treatment plan.

13          (C) The patient's history of negative tox-  
14      icology tests.

15          (D) Whether there is an absence of serious  
16      behavioral problems.

17          (E) The patient's stability in living ar-  
18      rangements and social relationships.

19          (F) Whether there is an absence of sub-  
20      stance misuse-related behaviors.

21          (G) Whether there is an absence of recent  
22      diversion activity.

23          (H) Whether there is an assurance that  
24      the medication can be safely stored by the pa-  
25      tient.

1 (I) Any other criterion the Secretary of  
2 Health and Human Services determines appro-  
3 priate.

4 (3) PROHIBITED SOLE CONSIDERATION.—The  
5 regulation under paragraph (1) shall prohibit the  
6 medical director of an opioid treatment program  
7 from considering, as the sole consideration in deter-  
8 mining whether a patient is sufficiently responsible  
9 in handling opioid drugs for unsupervised use,  
10 whether the patient has an absence of recent misuse  
11 of drugs (whether narcotic or nonnarcotic), including  
12 alcohol.

13 **Subtitle F—Additional Provisions**  
14 **Relating to Addiction Treatment**

15 **SEC. 261. PROHIBITION.**

16 Notwithstanding any provision of this Act and the  
17 amendments made by this Act, no funds made available  
18 to carry out this Act or any amendment made by this Act  
19 shall be used to purchase, procure, or distribute pipes or  
20 cylindrical objects intended to be used to smoke or inhale  
21 illegal scheduled substances.

1 **SEC. 262. ELIMINATING ADDITIONAL REQUIREMENTS FOR**  
2 **DISPENSING NARCOTIC DRUGS IN SCHEDULE**  
3 **III, IV, AND V FOR MAINTENANCE OR DETOXI-**  
4 **FICATION TREATMENT.**

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

7 (1) by striking paragraph (2);

8 (2) by striking “(g)(1) Except as provided in  
9 paragraph (2), practitioners who dispense narcotic  
10 drugs to individuals for maintenance treatment or  
11 detoxification treatment” and inserting “(g) Practi-  
12 tioners who dispense narcotic drugs (other than nar-  
13 cotic drugs in schedule III, IV, or V) to individuals  
14 for maintenance treatment or detoxification treat-  
15 ment”;

16 (3) by redesignating subparagraphs (A), (B),  
17 and (C) as paragraphs (1), (2), and (3), respectively;  
18 and

19 (4) in paragraph (2), as so redesignated—

20 (A) by striking “(i) security of stocks” and  
21 inserting “(A) security of stocks”; and

22 (B) by striking “(ii) the maintenance of  
23 records” and inserting “(B) the maintenance of  
24 records”.

25 (b) CONFORMING CHANGES.—

1           (1) Subsections (a) and (d)(1) of section 304 of  
2           the Controlled Substances Act (21 U.S.C. 824) are  
3           each amended by striking “303(g)(1)” each place it  
4           appears and inserting “303(g)”.

5           (2) Section 309A(a)(2) of the Controlled Sub-  
6           stances Act (21 U.S.C. 829a) is amended—

7                   (A) in the matter preceding subparagraph  
8                   (A), by striking “the controlled substance is to  
9                   be administered for the purpose of maintenance  
10                  or detoxification treatment under section  
11                  303(g)(2)” and inserting “the controlled sub-  
12                  stance is a narcotic drug in schedule III, IV, or  
13                  V to be administered for the purpose of mainte-  
14                  nance or detoxification treatment”; and

15                  (B) by striking “and—” and all that fol-  
16                  lows through “is to be administered by injection  
17                  or implantation;” and inserting “and is to be  
18                  administered by injection or implantation;”.

19           (3) Section 520E–4(c) of the Public Health  
20           Service Act (42 U.S.C. 290bb–36d(c)) is amended  
21           by striking “information on any qualified practi-  
22           tioner that is certified to prescribe medication for  
23           opioid dependency under section 303(g)(2)(B) of the  
24           Controlled Substances Act” and inserting “informa-  
25           tion on any practitioner who prescribes narcotic

1 drugs in schedule III, IV, or V of section 202 of the  
2 Controlled Substances Act for the purpose of main-  
3 tenance or detoxification treatment”.

4 (4) Section 544(a)(3) of the Public Health  
5 Service Act (42 U.S.C. 290dd-3), as added by sec-  
6 tion 219(a)(2), is amended by striking “any practi-  
7 tioner dispensing narcotic drugs pursuant to section  
8 303(g) of the Controlled Substances Act” and in-  
9 serting “any practitioner dispensing narcotic drugs  
10 for the purpose of maintenance or detoxification  
11 treatment”.

12 (5) Section 1833(bb)(3)(B) of the Social Secu-  
13 rity Act (42 U.S.C. 1395l(bb)(3)(B)) is amended by  
14 striking “first receives a waiver under section 303(g)  
15 of the Controlled Substances Act on or after Janu-  
16 ary 1, 2019” and inserting “first begins prescribing  
17 narcotic drugs in schedule III, IV, or V of section  
18 202 of the Controlled Substances Act for the pur-  
19 pose of maintenance or detoxification treatment on  
20 or after January 1, 2021”.

21 (6) Section 1834(o)(3)(C)(ii) of the Social Se-  
22 curity Act (42 U.S.C. 1395m(o)(3)(C)(ii)) is amend-  
23 ed by striking “first receives a waiver under section  
24 303(g) of the Controlled Substances Act on or after  
25 January 1, 2019” and inserting “first begins pre-

7 (A) in subparagraph (A), by adding “and”  
8 at the end;

11 (C) by striking subparagraph (C).

14 (A) in clause (i), by adding “and” at the  
15 end;

(C) by redesignating clause (iii) as clause  
(ii).

Section 303 of the Controlled Substances Act (21 U.S.C. 823) is amended by adding at the end the following:

•HR 7666 EH

1           “(1) TRAINING REQUIRED.—As a condition on  
2 registration under this section to dispense controlled  
3 substances in schedule II, III, IV, or V, the Attorney  
4 General shall require any qualified practitioner, be-  
5 ginning with the first applicable registration for the  
6 practitioner, to meet the following:

7           “(A) If the practitioner is a physician (as  
8 defined under section 1861(r) of the Social Se-  
9 curity Act), the practitioner meets one or more  
10 of the following conditions:

11           “(i) The physician holds a board cer-  
12 tification in addiction psychiatry or addic-  
13 tion medicine from the American Board of  
14 Medical Specialties.

15           “(ii) The physician holds a board cer-  
16 tification from the American Board of Ad-  
17 diction Medicine.

18           “(iii) The physician holds a board cer-  
19 tification in addiction medicine from the  
20 American Osteopathic Association.

21           “(iv) The physician has, with respect  
22 to the treatment and management of pa-  
23 tients with opioid or other substance use  
24 disorders, or the safe pharmacological  
25 management of dental pain and screening,

1           brief intervention, and referral for appro-  
2           priate treatment of patients with or at risk  
3           of developing opioid or other substance use  
4           disorders, completed not less than 8 hours  
5           of training (through classroom situations,  
6           seminars at professional society meetings,  
7           electronic communications, or otherwise)  
8           that is provided by—

9                       “(I) the American Society of Ad-  
10                      diction Medicine, the American Acad-  
11                      emy of Addiction Psychiatry, the  
12                      American Medical Association, the  
13                      American Osteopathic Association, the  
14                      American Dental Association, the  
15                      American Association of Oral and  
16                      Maxillofacial Surgeons, the American  
17                      Psychiatric Association, or any other  
18                      organization accredited by the Accred-  
19                      itation Council for Continuing Medical  
20                      Education (commonly known as the  
21                      ‘ACCME’) or the Commission on  
22                      Dental Accreditation;

23                      “(II) any organization accredited  
24                      by a State medical society accreditor  
25                      that is recognized by the ACCME or

1 the Commission on Dental Accredita-  
2 tion;

3 “(III) any organization accred-  
4 ited by the American Osteopathic As-  
5 sociation to provide continuing med-  
6 ical education; or

7 “(IV) any organization approved  
8 by the Assistant Secretary for Mental  
9 Health and Substance Abuse, the  
10 ACCME, or the Commission on Den-  
11 tal Accreditation.

12 “(v) The physician graduated in good  
13 standing from an accredited school of  
14 allopathic medicine, osteopathic medicine,  
15 dental surgery, or dental medicine in the  
16 United States during the 5-year period im-  
17 mediately preceding the date on which the  
18 physician first registers or renews under  
19 this section and has successfully completed  
20 a comprehensive allopathic or osteopathic  
21 medicine curriculum or accredited medical  
22 residency or dental surgery or dental medi-  
23 cine curriculum that included not less than  
24 8 hours of training on—

1                   “(I) treating and managing pa-  
2                   tients with opioid and other substance  
3                   use disorders, including the appro-  
4                   priate clinical use of all drugs ap-  
5                   proved by the Food and Drug Admin-  
6                   istration for the treatment of a sub-  
7                   stance use disorder; or

8                   “(II) the safe pharmacological  
9                   management of dental pain and  
10                  screening, brief intervention, and re-  
11                  ferral for appropriate treatment of pa-  
12                  tients with or at risk of developing  
13                  opioid and other substance use dis-  
14                  orders.

15                  “(B) If the practitioner is not a physician  
16                  (as defined under section 1861(r) of the Social  
17                  Security Act), the practitioner meets one or  
18                  more of the following conditions:

19                  “(i) The practitioner has completed  
20                  not fewer than 8 hours of training with re-  
21                  spect to the treatment and management of  
22                  patients with opioid or other substance use  
23                  disorders (through classroom situations,  
24                  seminars at professional society meetings,  
25                  electronic communications, or otherwise)

1 provided by the American Society of Addic-  
2 tion Medicine, the American Academy of  
3 Addiction Psychiatry, the American Med-  
4 ical Association, the American Osteopathic  
5 Association, the American Nurses  
6 Credentialing Center, the American Psy-  
7 chiatric Association, the American Associa-  
8 tion of Nurse Practitioners, the American  
9 Academy of Physician Associates, or any  
10 other organization approved or accredited  
11 by the Assistant Secretary for Mental  
12 Health and Substance Abuse or the Ac-  
13 creditation Council for Continuing Medical  
14 Education.

15 “(ii) The practitioner has graduated  
16 in good standing from an accredited physi-  
17 cian assistant school or accredited school  
18 of advanced practice nursing in the United  
19 States during the 5-year period imme-  
20 diately preceding the date on which the  
21 practitioner first registers or renews under  
22 this section and has successfully completed  
23 a comprehensive physician assistant or ad-  
24 vanced practice nursing curriculum that  
25 included not fewer than 8 hours of training

1 on treating and managing patients with  
2 opioid and other substance use disorders,  
3 including the appropriate clinical use of all  
4 drugs approved by the Food and Drug Ad-  
5 ministration for the treatment of a sub-  
6 stance use disorder.

7 “(2) ONE-TIME TRAINING.—

8 “(A) IN GENERAL.—The Attorney General  
9 shall not require any qualified practitioner to  
10 complete the training described in clause (iv) or  
11 (v) of paragraph (1)(A) or clause (i) or (ii) of  
12 paragraph (1)(B) more than once.

13 “(B) NOTIFICATION.—Not later than 90  
14 days after the date of the enactment of the Re-  
15 storing Hope for Mental Health and Well-Being  
16 Act of 2022, the Attorney General shall provide  
17 to qualified practitioners a single written, elec-  
18 tronic notification of the training described in  
19 clauses (iv) and (v) of paragraph (1)(A) or  
20 clauses (i) and (ii) of paragraph (1)(B).

21 “(3) RULE OF CONSTRUCTION.—Nothing in  
22 this subsection shall be construed to preclude the  
23 use, by a qualified practitioner, of training received  
24 pursuant to this subsection to satisfy registration re-

1       quirements of a State or for some other lawful pur-  
2       pose.

3               “(4) DEFINITIONS.—In this section:

4                       “(A) FIRST APPLICABLE REGISTRATION.—

5               The term ‘first applicable registration’ means  
6               the first registration or renewal of registration  
7               by a qualified practitioner under this section  
8               that occurs on or after the date that is 180  
9               days after the date of enactment of the Restor-  
10              ing Hope for Mental Health and Well-Being  
11              Act of 2022.

12                      “(B) QUALIFIED PRACTITIONER.—In this  
13              subsection, the term ‘qualified practitioner’  
14              means a practitioner who—

15                              “(i) is licensed under State law to pre-  
16                              scribe controlled substances; and

17                              “(ii) is not solely a veterinarian.”.

18   **SEC. 264. INCREASE IN NUMBER OF DAYS BEFORE WHICH**  
19                              **CERTAIN CONTROLLED SUBSTANCES MUST**  
20                              **BE ADMINISTERED.**

21       Section 309A(a)(5) of the Controlled Substances Act  
22   (21 U.S.C. 829a(a)(5)) is amended by striking “14 days”  
23   and inserting “60 days”.

1 **SEC. 265. BLOCK, REPORT, AND SUSPEND SUSPICIOUS**  
2 **SHIPMENTS.**

3 (a) CLARIFICATION OF PROCESS FOR REGISTRANTS  
4 TO EXERCISE DUE DILIGENCE UPON DISCOVERING A  
5 SUSPICIOUS ORDER.—Paragraph (3) of section 312(a) of  
6 the Controlled Substances Act (21 U.S.C. 832(a)) is  
7 amended to read as follows:

8 “(3) upon discovering a suspicious order or se-  
9 ries of orders, and in a manner consistent with the  
10 other requirements of this section—

11 “(A) exercise due diligence as appropriate;

12 “(B) establish and maintain (for not less  
13 than a period to be determined by the Adminis-  
14 trator of the Drug Enforcement Administra-  
15 tion) a record of the due diligence that was per-  
16 formed;

17 “(C) decline to fill the order or series of  
18 orders if the due diligence fails to dispel all of  
19 the indicators that give rise to the suspicion  
20 that, if the order or series of orders is filled, the  
21 drugs that are the subject of the order or series  
22 of orders are likely to be diverted; and

23 “(D) notify the Administrator of the Drug  
24 Enforcement Administration and the Special  
25 Agent in Charge of the Division Office of the  
26 Drug Enforcement Administration for the area

1           in which the registrant is located or conducts  
2           business of—

3                   “(i) each suspicious order or series of  
4                   orders discovered by the registrant; and

5                   “(ii) the indicators giving rise to the  
6                   suspicion that, if the order or series of or-  
7                   ders is filled, the drugs that are the sub-  
8                   ject of the order or series of orders are  
9                   likely to be diverted.”.

10       (b) RESOLUTION OF SUSPICIOUS INDICATORS.—Sec-  
11       tion 312 of the Controlled Substances Act (21 U.S.C. 832)  
12       is amended—

13           (1) by redesignating subsection (b) and (c) as  
14           subsections (c) and (d), respectively; and

15           (2) by inserting after subsection (a) the fol-  
16           lowing:

17       “(b) RESOLUTION OF SUSPICIOUS INDICATORS.—If  
18       a registrant resolves all of the indicators giving rise to sus-  
19       picion about an order or series of orders under subsection  
20       (a)(3)—

21           “(1) notwithstanding subsection (a)(3)(C), the  
22           registrant may choose to fill the order or series of  
23           orders; and

1           “(2) notwithstanding subsection (a)(3)(D), the  
2           registrant may choose not to make the notification  
3           otherwise required by such subsection.”.

4           (c) REGULATIONS.—Not later than 1 year after the  
5           date of enactment of this Act, for purposes of subsections  
6           (a)(3) and (b) of section 312 of the Controlled Substances  
7           Act, as amended or inserted by subsection (a), the Attor-  
8           ney General of the United States shall promulgate a final  
9           regulation specifying the indicators that give rise to a sus-  
10          picion that, if an order or series of orders is filled, the  
11          drugs that are the subject of the order or series of orders  
12          are likely to be diverted.

13          (d) APPLICABILITY.—Subsections (a)(3) and (b) of  
14          section 312 of the Controlled Substances Act, as amended  
15          or inserted by subsection (a), shall apply beginning on the  
16          day that is 1 year after the date of enactment of this Act.  
17          Until such day, section 312(a)(3) of the Controlled Sub-  
18          stances Act shall apply as such section 312(a)(3) was in  
19          effect on the day before the date of enactment of this Act.

## 20           **Subtitle G—Opioid Epidemic** 21           **Response**

### 22   **SEC. 271. OPIOID PRESCRIPTION VERIFICATION.**

23          (a) MATERIALS FOR TRAINING PHARMACISTS ON  
24          CERTAIN CIRCUMSTANCES UNDER WHICH A PHARMACIST  
25          MAY DECLINE TO FILL A PRESCRIPTION.—

1           (1) UPDATES TO MATERIALS.—Section 3212(a)  
2       of the SUPPORT for Patients and Communities Act  
3       (21 U.S.C. 829 note) is amended by striking “Not  
4       later than 1 year after the date of enactment of this  
5       Act, the Secretary of Health and Human Services,  
6       in consultation with the Administrator of the Drug  
7       Enforcement Administration, Commissioner of Food  
8       and Drugs, Director of the Centers for Disease Con-  
9       trol and Prevention, and Assistant Secretary for  
10      Mental Health and Substance Use, shall develop and  
11      disseminate” and inserting “The Secretary of  
12      Health and Human Services, in consultation with  
13      the Administrator of the Drug Enforcement Admin-  
14      istration, Commissioner of Food and Drugs, Direc-  
15      tor of the Centers for Disease Control and Preven-  
16      tion, and Assistant Secretary for Mental Health and  
17      Substance Use, shall develop and disseminate not  
18      later than 1 year after the date of enactment of this  
19      Act, and update periodically thereafter”.

20           (2) MATERIALS INCLUDED.—Section 3212(b) of  
21      the SUPPORT for Patients and Communities Act  
22      (21 U.S.C. 829 note) is amended—

23                   (A) by redesignating paragraphs (1) and  
24                   (2) as paragraphs (2) and (3), respectively; and

1 (B) by inserting before paragraph (2), as  
2 so redesignated, the following new paragraph:

3 “(1) pharmacists on how to verify the identity  
4 of the patient;”.

5 (3) MATERIALS FOR TRAINING ON PATIENT  
6 VERIFICATION .—Section 3212 of the SUPPORT  
7 for Patients and Communities Act (21 U.S.C. 829  
8 note) is amended by adding at the end the following  
9 new subsection:

10 “(d) MATERIALS FOR TRAINING ON VERIFICATION  
11 OF IDENTITY.—Not later than 1 year after the date of  
12 enactment of this subsection, the Secretary of Health and  
13 Human Services, after seeking stakeholder input in ac-  
14 cordance with subsection (c), shall—

15 “(1) update the materials developed under sub-  
16 section (a) to include information for pharmacists on  
17 how to verify the identity the patient; and

18 “(2) disseminate, as appropriate, the updated  
19 materials.”.

20 (b) INCENTIVIZING STATES TO FACILITATE RESPON-  
21 SIBLE, INFORMED DISPENSING OF CONTROLLED SUB-  
22 STANCES.—

23 (1) IN GENERAL.—Section 392A of the Public  
24 Health Service Act (42 U.S.C. 280b–1) is amend-  
25 ed—

1 (A) by redesignating subsections (c) and  
2 (d) as subsections (d) and (e), respectively; and  
3 (B) by inserting after subsection (b) the  
4 following new subsection:

5 “(c) PREFERENCE.—In determining the amounts of  
6 grants awarded to States under subsections (a) and (b),  
7 the Director of the Centers for Disease Control and Pre-  
8 vention may give preference to States in accordance with  
9 such criteria as the Director may specify and may choose  
10 to give preference to States that—

11 “(1) maintain a prescription drug monitoring  
12 program;

13 “(2) require prescribers of controlled substances  
14 in schedule II, III, or IV to issue such prescriptions  
15 electronically, and make such requirement subject to  
16 exceptions in the cases listed in section 1860D–  
17 4(e)(7)(B) of the Social Security Act; and

18 “(3) require dispensers of such controlled sub-  
19 stances to enter certain information about the pur-  
20 chase of such controlled substances into the respec-  
21 tive State’s prescription drug monitoring program,  
22 including—

23 “(A) the National Drug Code or, in the  
24 case of compounded medications, compound  
25 identifier;

1 “(B) the quantity dispensed;  
2 “(C) the patient identifier; and  
3 “(D) the date filled.”.

4 (2) DEFINITIONS.—

5 (A) IN GENERAL.—Subsection (d) of sec-  
6 tion 392A of the Public Health Service Act (42  
7 U.S.C. 280b–1), as redesignated by paragraph  
8 (1)(A), is amended to read as follows:

9 “(d) DEFINITIONS.—In this section:

10 “(1) CONTROLLED SUBSTANCE.—The term  
11 ‘controlled substance’ has the meaning given that  
12 term in section 102 of the Controlled Substances  
13 Act.

14 “(2) DISPENSER.—The term ‘dispenser’ means  
15 a physician, pharmacist, or other person that dis-  
16 penses a controlled substance to an ultimate user.

17 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’  
18 has the meaning given that term in section 4 of the  
19 Indian Self-Determination and Education Assistance  
20 Act.”.

21 (B) CONFORMING CHANGE.—Section 392A  
22 of the Public Health Service Act (42 U.S.C.  
23 280b–1) is amended by striking “Indian tribes”  
24 each place it appears and inserting “Indian  
25 Tribes”.

1 **SEC. 272. SYNTHETIC OPIOID DANGER AWARENESS.**

2 (a) SYNTHETIC OPIOIDS PUBLIC AWARENESS CAM-  
3 PAIGN.—Part B of title III of the Public Health Service  
4 Act is amended by inserting after section 317U (42 U.S.C.  
5 247b–23) the following new section:

6 **“SEC. 317V. SYNTHETIC OPIOIDS PUBLIC AWARENESS CAM-**  
7 **PAIGN.**

8 “(a) IN GENERAL.—Not later than one year after the  
9 date of the enactment of this section, the Secretary shall  
10 provide for the planning and implementation of a public  
11 education campaign to raise public awareness of synthetic  
12 opioids (including fentanyl and its analogues). Such cam-  
13 paign shall include the dissemination of information  
14 that—

15 “(1) promotes awareness about the potency and  
16 dangers of fentanyl and its analogues and other syn-  
17 thetic opioids;

18 “(2) explains services provided by the Sub-  
19 stance Abuse and Mental Health Services Adminis-  
20 tration and the Centers for Disease Control and  
21 Prevention (and any entity providing such services  
22 under a contract entered into with such agencies)  
23 with respect to the misuse of opioids, particularly as  
24 such services relate to the provision of alternative,  
25 non-opioid pain management treatments; and

1           “(3) relates generally to opioid use and pain  
2           management.

3           “(b) USE OF MEDIA.—The campaign under sub-  
4           section (a) may be implemented through the use of tele-  
5           vision, radio, internet, in-person public communications,  
6           and other commercial marketing venues and may be tar-  
7           geted to specific age groups.

8           “(c) CONSIDERATION OF REPORT FINDINGS.—In  
9           planning and implementing the public education campaign  
10          under subsection (a), the Secretary shall take into consid-  
11          eration the findings of the report required under section  
12          7001 of the SUPPORT for Patients and Communities Act  
13          (Public Law 115–271).

14          “(d) CONSULTATION.—In coordinating the campaign  
15          under subsection (a), the Secretary shall consult with the  
16          Assistant Secretary for Mental Health and Substance Use  
17          to provide ongoing advice on the effectiveness of informa-  
18          tion disseminated through the campaign.

19          “(e) REQUIREMENT OF CAMPAIGN.—The campaign  
20          implemented under subsection (a) shall not be duplicative  
21          of any other Federal efforts relating to eliminating the  
22          misuse of opioids.

23          “(f) EVALUATION.—

24                 “(1) IN GENERAL.—The Secretary shall ensure  
25                 that the campaign implemented under subsection (a)

1 is subject to an independent evaluation, beginning 2  
2 years after the date of the enactment of this section,  
3 and every 2 years thereafter.

4 “(2) MEASURES AND BENCHMARKS.—For pur-  
5 poses of an evaluation conducted pursuant to para-  
6 graph (1), the Secretary shall—

7 “(A) establish baseline measures and  
8 benchmarks to quantitatively evaluate the im-  
9 pact of the campaign under this section; and

10 “(B) conduct qualitative assessments re-  
11 garding the effectiveness of strategies employed  
12 under this section.

13 “(g) REPORT.—The Secretary shall, beginning 2  
14 years after the date of the enactment of this section, and  
15 every 2 years thereafter, submit to Congress a report on  
16 the effectiveness of the campaign implemented under sub-  
17 section (a) towards meeting the measures and benchmarks  
18 established under subsection (e)(2).

19 “(h) DISSEMINATION OF INFORMATION THROUGH  
20 PROVIDERS.—The Secretary shall develop and implement  
21 a plan for the dissemination of information related to syn-  
22 thetic opioids, to health care providers who participate in  
23 Federal programs, including programs administered by  
24 the Department of Health and Human Services, the In-  
25 dian Health Service, the Department of Veterans Affairs,

1 the Department of Defense, and the Health Resources and  
2 Services Administration, the Medicare program under title  
3 XVIII of the Social Security Act, and the Medicaid pro-  
4 gram under title XIX of such Act.”.

5 (b) TRAINING GUIDE AND OUTREACH ON SYNTHETIC  
6 OPIOID EXPOSURE PREVENTION.—

7 (1) TRAINING GUIDE.—Not later than 18  
8 months after the date of the enactment of this Act,  
9 the Secretary of Health and Human Services shall  
10 design, publish, and make publicly available on the  
11 internet website of the Department of Health and  
12 Human Services, a training guide and webinar for  
13 first responders and other individuals who also may  
14 be at high risk of exposure to synthetic opioids that  
15 details measures to prevent that exposure.

16 (2) OUTREACH.—Not later than 18 months  
17 after the date of the enactment of this Act, the Sec-  
18 retary of Health and Human Services shall also con-  
19 duct outreach about the availability of the training  
20 guide and webinar published under paragraph (1)  
21 to—

22 (A) police and fire managements;

23 (B) sheriff deputies in city and county  
24 jails;

1 (C) ambulance transport and hospital  
2 emergency room personnel;

3 (D) clinicians; and

4 (E) other high-risk occupations, as identi-  
5 fied by the Assistant Secretary for Mental  
6 Health and Substance Use.

7 **SEC. 273. GRANT PROGRAM FOR STATE AND TRIBAL RE-**  
8 **SPONSE TO OPIOID AND STIMULANT USE AND**  
9 **MISUSE.**

10 Section 1003 of the 21st Century Cures Act (42  
11 U.S.C. 290ee–3 note) is amended to read as follows:

12 **“SEC. 1003. GRANT PROGRAM FOR STATE AND TRIBAL RE-**  
13 **SPONSE TO OPIOID AND STIMULANT USE AND**  
14 **MISUSE.**

15 “(a) IN GENERAL.—The Secretary of Health and  
16 Human Services (referred to in this section as the ‘Sec-  
17 retary’) shall carry out the grant program described in  
18 subsection (b) for purposes of addressing opioid and stim-  
19 ulant use and misuse, within States, Indian Tribes, and  
20 populations served by Tribal organizations and Urban In-  
21 dian organizations.

22 “(b) GRANTS PROGRAM.—

23 “(1) IN GENERAL.—Subject to the availability  
24 of appropriations, the Secretary shall award grants  
25 to States, Indian Tribes, Tribal organizations, and

1 Urban Indian organizations for the purpose of ad-  
2 dressing opioid and stimulant use and misuse, within  
3 such States, such Indian Tribes, and populations  
4 served by such Tribal organizations and Urban In-  
5 dian organizations, in accordance with paragraph  
6 (2).

7 “(2) MINIMUM ALLOCATIONS; PREFERENCE.—  
8 In determining grant amounts for each recipient of  
9 a grant under paragraph (1), the Secretary shall—

10 “(A) ensure that each State receives not  
11 less than \$4,000,000; and

12 “(B) give preference to States, Indian  
13 Tribes, Tribal organizations, and Urban Indian  
14 organizations whose populations have an inci-  
15 dence or prevalence of opioid use disorders or  
16 stimulant use or misuse that is substantially  
17 higher relative to the populations of other  
18 States, other Indian Tribes, Tribal organiza-  
19 tions, or Urban Indian organizations, as appli-  
20 cable.

21 “(3) FORMULA METHODOLOGY.—

22 “(A) IN GENERAL.—Before publishing a  
23 funding opportunity announcement with respect  
24 to grants under this section, the Secretary  
25 shall—

1 “(i) develop a formula methodology to  
2 be followed in allocating grant funds  
3 awarded under this section among grant-  
4 ees, which includes performance assess-  
5 ments for continuation awards; and

6 “(ii) not later than 30 days after de-  
7 veloping the formula methodology under  
8 clause (i), submit the formula methodology  
9 to—

10 “(I) the Committee on Energy  
11 and Commerce and the Committee on  
12 Appropriations of the House of Rep-  
13 resentatives; and

14 “(II) the Committee on Health,  
15 Education, Labor, and Pensions and  
16 the Committee on Appropriations of  
17 the Senate.

18 “(B) REPORT.—Not later than two years  
19 after the date of the enactment of the Restoring  
20 Hope for Mental Health and Well-Being Act of  
21 2022, the Comptroller General of the United  
22 States shall submit to the Committee on  
23 Health, Education, Labor, and Pensions of the  
24 Senate and the Committee on Energy and Com-

1           merce of the House of Representatives a report  
2           that—

3                   “(i) assesses how grant funding is al-  
4                   located to States under this section and  
5                   how such allocations have changed over  
6                   time;

7                   “(ii) assesses how any changes in  
8                   funding under this section have affected  
9                   the efforts of States to address opioid or  
10                  stimulant use or misuse; and

11                  “(iii) assesses the use of funding pro-  
12                  vided through the grant program under  
13                  this section and other similar grant pro-  
14                  grams administered by the Substance  
15                  Abuse and Mental Health Services Admin-  
16                  istration.

17                  “(4) USE OF FUNDS.—Grants awarded under  
18                  this subsection shall be used for carrying out activi-  
19                  ties that supplement activities pertaining to opioid  
20                  and stimulant use and misuse, undertaken by the  
21                  State agency responsible for administering the sub-  
22                  stance abuse prevention and treatment block grant  
23                  under subpart II of part B of title XIX of the Public  
24                  Health Service Act (42 U.S.C. 300x–21 et seq.),

1       which may include public health-related activities  
2       such as the following:

3               “(A) Implementing prevention activities,  
4               and evaluating such activities to identify effective  
5               strategies to prevent substance use disorders.  
6               orders.

7               “(B) Establishing or improving prescription  
8               drug monitoring programs.

9               “(C) Training for health care practitioners,  
10              such as best practices for prescribing opioids,  
11              pain management, recognizing potential cases  
12              of substance use disorders, referral of patients  
13              to treatment programs, preventing diversion of  
14              controlled substances, and overdose prevention.

15              “(D) Supporting access to health care  
16              services, including—

17                      “(i) services provided by federally certified  
18                      opioid treatment programs;

19                      “(ii) outpatient and residential substance  
20                      use disorder treatment services that  
21                      utilize medication-assisted treatment, as  
22                      appropriate; or

23                      “(iii) other appropriate health care  
24                      providers to treat substance use disorders.

1           “(E) Recovery support services, includ-  
2           ing—

3                   “(i) community-based services that in-  
4                   clude peer supports;

5                   “(ii) mutual aid recovery programs  
6                   that support medication-assisted treat-  
7                   ment; or

8                   “(iii) services to address housing  
9                   needs and family issues.

10           “(F) Other public health-related activities,  
11           as the State, Indian Tribe, Tribal organization,  
12           or Urban Indian organization determines appro-  
13           priate, related to addressing substance use dis-  
14           orders within the State, Indian Tribe, Tribal or-  
15           ganization, or Urban Indian organization, in-  
16           cluding directing resources in accordance with  
17           local needs related to substance use disorders.

18           “(c) ACCOUNTABILITY AND OVERSIGHT.—A State re-  
19           ceiving a grant under subsection (b) shall include in re-  
20           porting related to substance use disorders submitted to the  
21           Secretary pursuant to section 1942 of the Public Health  
22           Service Act (42 U.S.C. 300x–52), a description of—

23                   “(1) the purposes for which the grant funds re-  
24                   ceived by the State under such subsection for the

1 preceding fiscal year were expended and a descrip-  
2 tion of the activities of the State under the grant;

3 “(2) the ultimate recipients of amounts pro-  
4 vided to the State; and

5 “(3) the number of individuals served through  
6 the grant.

7 “(d) LIMITATIONS.—Any funds made available pur-  
8 suant to subsection (i)—

9 “(1) shall not be used for any purpose other  
10 than the grant program under subsection (b); and

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

16 “(e) INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND  
17 URBAN INDIAN ORGANIZATIONS.—The Secretary, in con-  
18 sultation with Indian Tribes, Tribal organizations, and  
19 Urban Indian organizations, shall identify and establish  
20 appropriate mechanisms for Indian Tribes, Tribal organi-  
21 zations, and Urban Indian organizations to demonstrate  
22 or report the information as required under subsections  
23 (b), (c), and (d).

24 “(f) REPORT TO CONGRESS.—Not later than Sep-  
25 tember 30, 2024, and biennially thereafter, the Secretary

1 shall submit to the Committee on Health, Education,  
2 Labor, and Pensions of the Senate and the Committee on  
3 Energy and Commerce of the House of Representatives,  
4 and the Committees on Appropriations of the House of  
5 Representatives and the Senate, a report that includes a  
6 summary of the information provided to the Secretary in  
7 reports made pursuant to subsections (c) and (e), includ-  
8 ing—

9           “(1) the purposes for which grant funds are  
10       awarded under this section;

11           “(2) the activities of the grant recipients; and

12           “(3) for each State, Indian Tribe, Tribal orga-  
13       nization, and Urban Indian organization that re-  
14       ceives a grant under this section, the funding level  
15       provided to such recipient.

16       “(g) TECHNICAL ASSISTANCE.—The Secretary, in-  
17       cluding through the Tribal Training and Technical Assist-  
18       ance Center of the Substance Abuse and Mental Health  
19       Services Administration, shall provide States, Indian  
20       Tribes, Tribal organizations, and Urban Indian organiza-  
21       tions, as applicable, with technical assistance concerning  
22       grant application and submission procedures under this  
23       section, award management activities, and enhancing out-  
24       reach and direct support to rural and underserved commu-  
25       nities and providers in addressing substance use disorders.

1 “(h) DEFINITIONS.—In this section:

2 “(1) INDIAN TRIBE.—The term ‘Indian Tribe’  
3 has the meaning given the term ‘Indian tribe’ in sec-  
4 tion 4 of the Indian Self-Determination and Edu-  
5 cation Assistance Act (25 U.S.C. 5304).

6 “(2) TRIBAL ORGANIZATION.—The term ‘Tribal  
7 organization’ has the meaning given the term ‘tribal  
8 organization’ in such section 4.

9 “(3) STATE.—The term ‘State’ has the mean-  
10 ing given such term in section 1954(b) of the Public  
11 Health Service Act (42 U.S.C. 300x–64(b)).

12 “(4) URBAN INDIAN ORGANIZATION.—The term  
13 ‘Urban Indian organization’ has the meaning given  
14 such term in section 4 of the Indian Health Care  
15 Improvement Act.

16 “(i) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—For purposes of carrying  
18 out the grant program under subsection (b), there is  
19 authorized to be appropriated \$1,750,000,000 for  
20 each of fiscal years 2023 through 2027, to remain  
21 available until expended.

22 “(2) FEDERAL ADMINISTRATIVE EXPENSES.—  
23 Of the amounts made available for each fiscal year  
24 to award grants under subsection (b), the Secretary  
25 shall not use more than 20 percent for Federal ad-

1       ministrative expenses, training, technical assistance,  
2       and evaluation.

3               “(3) SET ASIDE.—Of the amounts made avail-  
4       able for each fiscal year to award grants under sub-  
5       section (b) for a fiscal year, the Secretary shall—

6               “(A) award 5 percent to Indian Tribes,  
7       Tribal organizations, and Urban Indian organi-  
8       zations; and

9               “(B) of the amount remaining after appli-  
10       cation of subparagraph (A), set aside up to 15  
11       percent for awards to States with the highest  
12       age-adjusted rate of drug overdose death based  
13       on the ordinal ranking of States according to  
14       the Director of the Centers for Disease Control  
15       and Prevention.”.

16       **TITLE III—ACCESS TO MENTAL**  
17       **HEALTH CARE AND COVERAGE**

18               **Subtitle A—Collaborate in an**  
19               **Orderly and Cohesive Manner**

20       **SEC. 301. INCREASING UPTAKE OF THE COLLABORATIVE**  
21               **CARE MODEL.**

22       Section 520K of the Public Health Service Act (42  
23       U.S.C. 290bb–42) is amended to read as follows:

1 **“SEC. 520K. INTEGRATION INCENTIVE GRANTS AND COOP-**  
2 **ERATIVE AGREEMENTS.**

3 “(a) DEFINITIONS.—In this section:

4 “(1) COLLABORATIVE CARE MODEL.—The term  
5 ‘collaborative care model’ means the evidence-based,  
6 integrated behavioral health service delivery method  
7 that includes—

8 “(A) care directed by the primary care  
9 team;

10 “(B) structured care management;

11 “(C) regular assessments of clinical status  
12 using developmentally appropriate, validated  
13 tools; and

14 “(D) modification of treatment as appro-  
15 priate.

16 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-  
17 tity’ means a State, or an appropriate State agency,  
18 in collaboration with—

19 “(A) 1 or more qualified community pro-  
20 grams as described in section 1913(b)(1);

21 “(B) 1 or more health centers (as defined  
22 in section 330(a)), a rural health clinic (as de-  
23 fined in section 1961(aa) of the Social Security  
24 Act), or a Federally qualified health center (as  
25 defined in such section); or

1           “(C) 1 or more primary health care prac-  
2           tices.

3           “(3) INTEGRATED CARE; BIDIRECTIONAL INTE-  
4           GRATED CARE.—

5           “(A) The term ‘integrated care’ means  
6           models or practices for coordinating and jointly  
7           delivering behavioral and physical health serv-  
8           ices, which may include practices that share the  
9           same space in the same facility.

10          “(B) The term ‘bidirectional integrated  
11          care’ means the integration of behavioral health  
12          care and specialty physical health care, as well  
13          as the integration of primary and physical  
14          health care with specialty behavioral health set-  
15          tings, including within primary health care set-  
16          tings.

17          “(4) PRIMARY HEALTH CARE PROVIDER.—The  
18          term ‘primary health care provider’ means a pro-  
19          vider who—

20               “(A) provides health services related to  
21               family medicine, internal medicine, pediatrics,  
22               obstetrics, gynecology, or geriatrics; or

23               “(B) is a doctor of medicine or osteopathy,  
24               physician assistant, or nurse practitioner, who  
25               is licensed to practice medicine by the State in

1           which such physician, assistant, or practitioner  
2           primarily practices, including within primary  
3           health care settings.

4           “(5) PRIMARY HEALTH CARE PRACTICE.—The  
5           term ‘primary health care practice’ means a medical  
6           practice of primary health care providers, including  
7           a practice within a larger health care system.

8           “(6) SPECIAL POPULATION.—The term ‘special  
9           population’, for an eligible entity that is collabo-  
10          rating with an entity described in subparagraph (A)  
11          or (B) of paragraph (3), means—

12               “(A) adults with a serious mental illness  
13               who have a co-occurring physical health condi-  
14               tion or chronic disease;

15               “(B) children and adolescents with a men-  
16               tal illness who have a co-occurring physical  
17               health condition or chronic disease;

18               “(C) individuals with a substance use dis-  
19               order; or

20               “(D) individuals with a mental illness who  
21               have a co-occurring substance use disorder.

22          “(b) GRANTS AND COOPERATIVE AGREEMENTS.—

23               “(1) IN GENERAL.—The Secretary may award  
24               grants and cooperative agreements to eligible entities  
25               to support the improvement of integrated care for

1 physical and behavioral health care in accordance  
2 with paragraph (2).

3 “(2) USE OF FUNDS.—A grant or cooperative  
4 agreement awarded under this section shall be  
5 used—

6 “(A) in the case of an eligible entity that  
7 is collaborating with an entity described in sub-  
8 paragraph (A) or (B) of subsection (a)(2)—

9 “(i) to promote full integration and  
10 collaboration in clinical practices between  
11 physical and behavioral health care for spe-  
12 cial populations including each population  
13 listed in subsection (a)(7);

14 “(ii) to support the improvement of  
15 integrated care models for physical and be-  
16 havioral health care to improve the overall  
17 wellness and physical health status of—

18 “(I) adults with a serious mental  
19 illness or children with a serious emo-  
20 tional disturbance; and

21 “(II) individuals with a substance  
22 use disorder; and

23 “(iii) to promote bidirectional inte-  
24 grated care services including screening,  
25 diagnosis, prevention, treatment, and re-

1 covery of mental and substance use dis-  
2 orders, and co-occurring physical health  
3 conditions and chronic diseases; and

4 “(B) in the case of an eligible entity that  
5 is collaborating with a primary health care  
6 practice, to support the uptake of the collabo-  
7 rative care model, including by—

8 “(i) hiring staff;

9 “(ii) identifying and formalizing con-  
10 tractual relationships with other health  
11 care providers, including providers who will  
12 function as psychiatric consultants and be-  
13 havioral health care managers in providing  
14 behavioral health integration services  
15 through the collaborative care model;

16 “(iii) purchasing or upgrading soft-  
17 ware and other resources needed to appro-  
18 priately provide behavioral health integra-  
19 tion services through the collaborative care  
20 model, including resources needed to estab-  
21 lish a patient registry and implement  
22 measurement-based care; and

23 “(iv) for such other purposes as the  
24 Secretary determines to be necessary.

25 “(c) APPLICATIONS.—

1           “(1) IN GENERAL.—An eligible entity that is  
2       collaborating with an entity described in subpara-  
3       graph (A) or (B) of subsection (a)(2) seeking a  
4       grant or cooperative agreement under subsection  
5       (b)(2)(A) shall submit an application to the Sec-  
6       retary at such time, in such manner, and accom-  
7       panied by such information as the Secretary may re-  
8       quire, including the contents described in paragraph  
9       (2).

10           “(2) CONTENTS.—Any such application of an  
11       eligible entity described in subparagraph (A) or (B)  
12       of subsection (a)(2) shall include—

13           “(A) a description of a plan to achieve  
14       fully collaborative agreements to provide  
15       bidirectional integrated care to special popu-  
16       lations;

17           “(B) a document that summarizes the poli-  
18       cies, if any, that are barriers to the provision of  
19       integrated care, and the specific steps, if appli-  
20       cable, that will be taken to address such bar-  
21       riers;

22           “(C) a description of partnerships or other  
23       arrangements with local health care providers  
24       to provide services to special populations;

1           “(D) an agreement and plan to report to  
 2           the Secretary performance measures necessary  
 3           to evaluate patient outcomes and facilitate eval-  
 4           uations across participating projects;

5           “(E) a description of how validated rating  
 6           scales will be implemented to support the im-  
 7           provement of patient outcomes using measure-  
 8           ment-based care, including those related to de-  
 9           pression screening, patient follow-up, and symp-  
 10          tom remission; and

11          “(F) a plan for sustainability beyond the  
 12          grant or cooperative agreement period under  
 13          subsection (e).

14          “(3) COLLABORATIVE CARE MODEL GRANTS.—  
 15          An eligible entity that is collaborating with a pri-  
 16          mary health care practice seeking a grant pursuant  
 17          to subsection (b)(2)(B) shall submit an application  
 18          to the Secretary at such time, in such manner, and  
 19          accompanied by such information as the Secretary  
 20          may require.

21          “(d) GRANT AND COOPERATIVE AGREEMENT  
 22          AMOUNTS.—

23                 “(1) TARGET AMOUNT.—The target amount  
 24          that an eligible entity may receive for a year through

1 a grant or cooperative agreement under this section  
2 shall be—

3 “(A) \$2,000,000 for an eligible entity de-  
4 scribed in subparagraph (A) or (B) of sub-  
5 section (a)(2); or

6 “(B) \$100,000 or less for an eligible entity  
7 described in subparagraph (C) of subsection  
8 (a)(2).

9 “(2) ADJUSTMENT PERMITTED.—The Sec-  
10 retary, taking into consideration the quality of an el-  
11 igible entity’s application and the number of eligible  
12 entities that received grants under this section prior  
13 to the date of enactment of the Restoring Hope for  
14 Mental Health and Well-Being Act of 2022, may ad-  
15 just the target amount that an eligible entity may  
16 receive for a year through a grant or cooperative  
17 agreement under this section.

18 “(3) LIMITATION.—An eligible entity that is  
19 collaborating with an entity described in subpara-  
20 graph (A) or (B) of subsection (a)(2) receiving fund-  
21 ing under this section—

22 “(A) may not allocate more than 20 per-  
23 cent of the funds awarded to such eligible entity  
24 under this section to administrative functions;  
25 and

1           “(B) shall allocate the remainder of such  
2           funding to health facilities that provide inte-  
3           grated care.

4           “(e) DURATION.—A grant or cooperative agreement  
5           under this section shall be for a period not to exceed 5  
6           years.

7           “(f) REPORT ON PROGRAM OUTCOMES.—An eligible  
8           entity receiving a grant or cooperative agreement under  
9           this section—

10           “(1) that is collaborating with an entity de-  
11           scribed in subparagraph (A) or (B) of subsection  
12           (a)(2) shall submit an annual report to the Sec-  
13           retary that includes—

14           “(A) the progress made to reduce barriers  
15           to integrated care as described in the entity’s  
16           application under subsection (c); and

17           “(B) a description of outcomes with re-  
18           spect to each special population listed in sub-  
19           section (a)(7), including outcomes related to  
20           education, employment, and housing; or

21           “(2) that is collaborating with a primary health  
22           care practice shall submit an annual report to the  
23           Secretary that includes—

24           “(A) the progress made to improve access;

1                   “(B) the progress made to improve patient  
2 outcomes; and

3                   “(C) the progress made to reduce referrals  
4 to specialty care.

5           “(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAV-  
6 IORAL HEALTH CARE INTEGRATION.—

7                   “(1) CERTAIN RECIPIENTS.—The Secretary  
8 may provide appropriate information, training, and  
9 technical assistance to eligible entities that are col-  
10 laborating with an entity described in subparagraph  
11 (A) or (B) of subsection (a)(2) that receive a grant  
12 or cooperative agreement under this section, in order  
13 to help such entities meet the requirements of this  
14 section, including assistance with—

15                   “(A) development and selection of inte-  
16 grated care models;

17                   “(B) dissemination of evidence-based inter-  
18 ventions in integrated care;

19                   “(C) establishment of organizational prac-  
20 tices to support operational and administrative  
21 success; and

22                   “(D) other activities, as the Secretary de-  
23 termines appropriate.

24                   “(2) COLLABORATIVE CARE MODEL RECIPI-  
25 ENTS.—The Secretary shall provide appropriate in-

1       formation, training, and technical assistance to eligi-  
2       ble entities that are collaborating with primary  
3       health care practices that receive funds under this  
4       section to help such entities implement the collabo-  
5       rative care model, including—

6               “(A) developing financial models and budg-  
7               ets for implementing and maintaining a collabo-  
8               rative care model, based on practice size;

9               “(B) developing staffing models for essen-  
10              tial staff roles;

11              “(C) providing strategic advice to assist  
12              practices seeking to utilize other clinicians for  
13              additional psychotherapeutic interventions;

14              “(D) providing information technology ex-  
15              pertise to assist with building the collaborative  
16              care model into electronic health records, in-  
17              cluding assistance with care manager tools, pa-  
18              tient registry, ongoing patient monitoring, and  
19              patient records;

20              “(E) training support for all key staff and  
21              operational consultation to develop practice  
22              workflows;

23              “(F) establishing methods to ensure the  
24              sharing of best practices and operational knowl-  
25              edge among primary health care physicians and

1 primary health care practices that provide be-  
2 havioral health integration services through the  
3 collaborative care model; and

4 “(G) providing guidance and instruction to  
5 primary health care physicians and primary  
6 health care practices on developing and main-  
7 taining relationships with community-based  
8 mental health and substance use disorder facili-  
9 ties for referral and treatment of patients  
10 whose clinical presentation or diagnosis is best  
11 suited for treatment at such facilities.

12 “(3) ADDITIONAL DISSEMINATION OF TECH-  
13 NICAL INFORMATION.—In addition to providing the  
14 assistance described in paragraphs (1) and (2) to re-  
15 cipients of a grant or cooperative agreement under  
16 this section, the Secretary may also provide such as-  
17 sistance to other States and political subdivisions of  
18 States, Indian Tribes and Tribal organizations (as  
19 defined under the Federally Recognized Indian Tribe  
20 List Act of 1994), outpatient mental health and ad-  
21 diction treatment centers, community mental health  
22 centers that meet the criteria under section 1913(c),  
23 certified community behavioral health clinics de-  
24 scribed in section 223 of the Protecting Access to  
25 Medicare Act of 2014, primary care organizations

1       such as Federally qualified health centers or rural  
 2       health clinics as defined in section 1861(aa) of the  
 3       Social Security Act, primary health care practices,  
 4       other community-based organizations, and other en-  
 5       tities engaging in integrated care activities, as the  
 6       Secretary determines appropriate.

7       “(h) AUTHORIZATION OF APPROPRIATIONS.—To  
 8       carry out this section, there is authorized to be appro-  
 9       priated \$60,000,000 for each of fiscal years 2023 through  
 10      2027.”.

## 11       **Subtitle B—Helping Enable Access** 12       **to Lifesaving Services**

### 13       **SEC. 311. REAUTHORIZATION AND PROVISION OF CERTAIN** 14       **PROGRAMS TO STRENGTHEN THE HEALTH** 15       **CARE WORKFORCE.**

16       (a) LIABILITY PROTECTIONS FOR HEALTH PROFES-  
 17       SIONAL VOLUNTEERS.—Section 224(q)(6) of the Public  
 18       Health Service Act (42 U.S.C. 233(q)(6)) is amended by  
 19       striking “October 1, 2022” and inserting “October 1,  
 20       2027”.

21       (b) MINORITY FELLOWSHIPS IN CRISIS CARE MAN-  
 22       AGEMENT.—Section 597(b) of the Public Health Service  
 23       Act (42 U.S.C. 2901l(b)) is amended by striking “in the  
 24       fields of psychiatry,” and inserting “in the fields of crisis  
 25       care management, psychiatry,”.

1       (c) MENTAL AND BEHAVIORAL HEALTH EDUCATION  
2 AND TRAINING GRANTS.—Section 756 of the Public  
3 Health Service Act (42 U.S.C. 294e–1) is amended—

4           (1) in subsection (a)(1), by inserting “(which  
5       may include master’s and doctoral level programs)”  
6       after “occupational therapy”; and

7           (2) in subsection (f), by striking “For each of  
8       fiscal years 2019 through 2023” and inserting “For  
9       each of fiscal years 2023 through 2027”.

10       (d) TRAINING DEMONSTRATION PROGRAM.—Section  
11 760(g) of the Public Health Service Act (42 U.S.C.  
12 294k(g)) is amended by inserting “and \$31,700,000 for  
13 each of fiscal years 2023 through 2027” before the period  
14 at the end.

15 **SEC. 312. REAUTHORIZATION OF MINORITY FELLOWSHIP**  
16 **PROGRAM.**

17       Section 597(c) of the Public Health Service Act (42  
18 U.S.C. 290ll(c)) is amended by striking “\$12,669,000 for  
19 each of fiscal years 2018 through 2022” and inserting  
20 “\$25,000,000 for each of fiscal years 2023 through  
21 2027”.

1 **Subtitle C—Eliminating the Opt-**  
2 **Out for Nonfederal Govern-**  
3 **mental Health Plans**

4 **SEC. 321. ELIMINATING THE OPT-OUT FOR NONFEDERAL**  
5 **GOVERNMENTAL HEALTH PLANS.**

6 Section 2722(a)(2) of the Public Health Service Act  
7 (42 U.S.C. 300gg–21(a)(2)) is amended by adding at the  
8 end the following new subparagraph:

9 “(F) SUNSET OF ELECTION OPTION.—

10 “(i) IN GENERAL.—Notwithstanding  
11 the preceding provisions of this para-  
12 graph—

13 “(I) no election described in sub-  
14 paragraph (A) with respect to section  
15 2726 may be made on or after the  
16 date of the enactment of this subpara-  
17 graph; and

18 “(II) except as provided in clause  
19 (ii), no such election with respect to  
20 section 2726 expiring on or after the  
21 date that is 180 days after the date of  
22 such enactment may be renewed.

23 “(ii) EXCEPTION FOR CERTAIN COL-  
24 LECTIVELY BARGAINED PLANS.—Notwith-  
25 standing clause (i)(II), a plan described in

1           subparagraph (B)(ii) that is subject to  
 2           multiple agreements described in such sub-  
 3           paragraph of varying lengths and that has  
 4           an election described in subparagraph (A)  
 5           with respect to section 2726 in effect as of  
 6           the date of the enactment of this subpara-  
 7           graph that expires on or after the date  
 8           that is 180 days after the date of such en-  
 9           actment may extend such election until the  
 10          date on which the term of the last such  
 11          agreement expires.”.

12       **Subtitle D—Mental Health and**  
 13       **Substance Use Disorder Parity**  
 14       **Implementation**

15       **SEC. 331. GRANTS TO SUPPORT MENTAL HEALTH AND SUB-**  
 16               **STANCE USE DISORDER PARITY IMPLEMEN-**  
 17               **TATION.**

18       (a) IN GENERAL.—Section 2794(c) of the Public  
 19       Health Service Act (42 U.S.C. 300gg–94(c)) (as added by  
 20       section 1003 of the Patient Protection and Affordable  
 21       Care Act (Public Law 111–148)) is amended by adding  
 22       at the end the following:

23               “(3) PARITY IMPLEMENTATION.—

24               “(A) IN GENERAL.—Beginning during the  
 25               first fiscal year that begins after the date of en-

actment of this paragraph, the Secretary shall, out of funds made available pursuant to subparagraph (C), award grants to eligible States to enforce and ensure compliance with the mental health and substance use disorder parity provisions of section 2726.

“(B) ELIGIBLE STATE.—A State shall be eligible for a grant awarded under this paragraph only if such State—

“(i) submits to the Secretary an application for such grant at such time, in such manner, and containing such information as specified by the Secretary; and

“(ii) agrees to request and review from health insurance issuers offering group or individual health insurance coverage the comparative analyses and other information required of such health insurance issuers under subsection (a)(8)(A) of section 2726 relating to the design and application of nonquantitative treatment limitations imposed on mental health or substance use disorder benefits.

“(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appro-

1           priated \$10,000,000 for each of the first five  
 2           fiscal years beginning after the date of the en-  
 3           actment of this paragraph, to remain available  
 4           until expended, for purposes of awarding grants  
 5           under subparagraph (A).”.

6           (b) TECHNICAL AMENDMENT.—Section 2794 of the  
 7   Public Health Service Act (42 U.S.C. 300gg–95), as  
 8   added by section 6603 of the Patient Protection and Af-  
 9   fordable Care Act (Public Law 111–148) is redesignated  
 10 as section 2795.

11 **Subtitle E—Improving Emergency**  
 12 **Department Mental Health Ac-**  
 13 **cess, Services, and Responders**

14 **SEC. 341. HELPING EMERGENCY RESPONDERS OVERCOME.**

15           (a) DATA SYSTEM TO CAPTURE NATIONAL PUBLIC  
 16 SAFETY OFFICER SUICIDE INCIDENCE.—The Public  
 17 Health Service Act is amended by inserting before section  
 18 318 of such Act (42 U.S.C. 247c) the following:

19 **“SEC. 317V. DATA SYSTEM TO CAPTURE NATIONAL PUBLIC**  
 20 **SAFETY OFFICER SUICIDE INCIDENCE.**

21           “(a) IN GENERAL.—The Secretary, in coordination  
 22 with the Director of the Centers for Disease Control and  
 23 Prevention and other agencies as the Secretary determines  
 24 appropriate, may—

1           “(1) develop and maintain a data system, to be  
2           known as the Public Safety Officer Suicide Report-  
3           ing System, for the purposes of—

4                   “(A) collecting data on the suicide inci-  
5                   dence among public safety officers; and

6                   “(B) facilitating the study of successful  
7                   interventions to reduce suicide among public  
8                   safety officers; and

9           “(2) integrate such system into the National  
10          Violent Death Reporting System, so long as the Sec-  
11          retary determines such integration to be consistent  
12          with the purposes described in paragraph (1).

13          “(b) DATA COLLECTION.—In collecting data for the  
14          Public Safety Officer Suicide Reporting System, the Sec-  
15          retary shall, at a minimum, collect the following informa-  
16          tion:

17                   “(1) The total number of suicides in the United  
18                   States among all public safety officers in a given cal-  
19                   endar year.

20                   “(2) Suicide rates for public safety officers in  
21                   a given calendar year, disaggregated by—

22                           “(A) age and gender of the public safety  
23                           officer;

24                           “(B) State;

1           “(C) occupation; including both the indi-  
2           vidual’s role in their public safety agency and  
3           their primary occupation in the case of volun-  
4           teer public safety officers;

5           “(D) where available, the status of the  
6           public safety officer as volunteer, paid-on-call,  
7           or career; and

8           “(E) status of the public safety officer as  
9           active or retired.

10       “(c) CONSULTATION DURING DEVELOPMENT.—In  
11       developing the Public Safety Officer Suicide Reporting  
12       System, the Secretary shall consult with non-Federal ex-  
13       perts to determine the best means to collect data regard-  
14       ing suicide incidence in a safe, sensitive, anonymous, and  
15       effective manner. Such non-Federal experts shall include,  
16       as appropriate, the following:

17           “(1) Public health experts with experience in  
18           developing and maintaining suicide registries.

19           “(2) Organizations that track suicide among  
20           public safety officers.

21           “(3) Mental health experts with experience in  
22           studying suicide and other profession-related trau-  
23           matic stress.

24           “(4) Clinicians with experience in diagnosing  
25           and treating mental health issues.

1           “(5) Active and retired volunteer, paid-on-call,  
2           and career public safety officers.

3           “(6) Relevant national police, and fire and  
4           emergency medical services, organizations.

5           “(d) DATA PRIVACY AND SECURITY.—In developing  
6           and maintaining the Public Safety Officer Suicide Report-  
7           ing System, the Secretary shall ensure that all applicable  
8           Federal privacy and security protections are followed to  
9           ensure that—

10           “(1) the confidentiality and anonymity of sui-  
11           cide victims and their families are protected, includ-  
12           ing so as to ensure that data cannot be used to deny  
13           benefits; and

14           “(2) data is sufficiently secure to prevent unau-  
15           thorized access.

16           “(e) REPORTING.—

17           “(1) ANNUAL REPORT.—Not later than 2 years  
18           after the date of enactment of the Restoring Hope  
19           for Mental Health and Well-Being Act of 2022, and  
20           biannually thereafter, the Secretary shall submit a  
21           report to the Congress on the suicide incidence  
22           among public safety officers. Each such report  
23           shall—

1           “(A) include the number and rate of such  
2           suicide incidence, disaggregated by age, gender,  
3           and State of employment;

4           “(B) identify characteristics and contrib-  
5           uting circumstances for suicide among public  
6           safety officers;

7           “(C) disaggregate rates of suicide by—

8                 “(i) occupation;

9                 “(ii) status as volunteer, paid-on-call,  
10           or career; and

11                “(iii) status as active or retired;

12           “(D) include recommendations for further  
13           study regarding the suicide incidence among  
14           public safety officers;

15           “(E) specify in detail, if found, any obsta-  
16           cles in collecting suicide rates for volunteers  
17           and include recommended improvements to  
18           overcome such obstacles;

19           “(F) identify options for interventions to  
20           reduce suicide among public safety officers; and

21           “(G) describe procedures to ensure the  
22           confidentiality and anonymity of suicide victims  
23           and their families, as described in subsection  
24           (d)(1).

1           “(2) PUBLIC AVAILABILITY.—Upon the submis-  
2           sion of each report to the Congress under paragraph  
3           (1), the Secretary shall make the full report publicly  
4           available on the website of the Centers for Disease  
5           Control and Prevention.

6           “(f) DEFINITION.—In this section, the term ‘public  
7           safety officer’ means—

8           “(1) a public safety officer as defined in section  
9           1204 of the Omnibus Crime Control and Safe  
10          Streets Act of 1968; or

11          “(2) a public safety telecommunicator as de-  
12          scribed in detailed occupation 43–5031 in the Stand-  
13          ard Occupational Classification Manual of the Office  
14          of Management and Budget (2018).

15          “(g) PROHIBITED USE OF INFORMATION.—Notwith-  
16          standing any other provision of law, if an individual is  
17          identified as deceased based on information contained in  
18          the Public Safety Officer Suicide Reporting System, such  
19          information may not be used to deny or rescind life insur-  
20          ance payments or other benefits to a survivor of the de-  
21          ceased individual.”.

22          (b) PEER-SUPPORT BEHAVIORAL HEALTH AND  
23          WELLNESS PROGRAMS WITHIN FIRE DEPARTMENTS AND  
24          EMERGENCY MEDICAL SERVICE AGENCIES.—

1           (1) IN GENERAL.—Part B of title III of the  
2       Public Health Service Act (42 U.S.C. 243 et seq.)  
3       is amended by adding at the end the following:

4       **“SEC. 320C. PEER-SUPPORT BEHAVIORAL HEALTH AND**  
5                       **WELLNESS PROGRAMS WITHIN FIRE DEPART-**  
6                       **MENTS AND EMERGENCY MEDICAL SERVICE**  
7                       **AGENCIES.**

8       “(a) IN GENERAL.—The Secretary may award grants  
9       to eligible entities for the purpose of establishing or en-  
10      hancing peer-support behavioral health and wellness pro-  
11      grams within fire departments and emergency medical  
12      services agencies.

13      “(b) PROGRAM DESCRIPTION.—A peer-support be-  
14      havioral health and wellness program funded under this  
15      section shall—

16           “(1) use career and volunteer members of fire  
17      departments or emergency medical services agencies  
18      to serve as peer counselors;

19           “(2) provide training to members of career, vol-  
20      unteer, and combination fire departments or emer-  
21      gency medical service agencies to serve as such peer  
22      counselors;

23           “(3) purchase materials to be used exclusively  
24      to provide such training; and

1           “(4) disseminate such information and mate-  
2           rials as are necessary to conduct the program.

3           “(c) DEFINITION.—In this section:

4           “(1) The term ‘eligible entity’ means a non-  
5           profit organization with expertise and experience  
6           with respect to the health and life safety of members  
7           of fire and emergency medical services agencies.

8           “(2) The term ‘member’—

9           “(A) with respect to an emergency medical  
10          services agency, means an employee, regardless  
11          of rank or whether the employee receives com-  
12          pensation (as defined in section 1204(7) of the  
13          Omnibus Crime Control and Safe Streets Act of  
14          1968); and

15          “(B) with respect to a fire department,  
16          means any employee, regardless of rank or  
17          whether the employee receives compensation, of  
18          a Federal, State, Tribal, or local fire depart-  
19          ment who is responsible for responding to calls  
20          for emergency service.”.

21          (2) TECHNICAL CORRECTION.—Effective as if  
22          included in the enactment of the Children’s Health  
23          Act of 2000 (Public Law 106–310), the amendment  
24          instruction in section 1603 of such Act is amended  
25          by striking “Part B of the Public Health Service

1 Act” and inserting “Part B of title III of the Public  
2 Health Service Act”.

3 (c) HEALTH CARE PROVIDER BEHAVIORAL HEALTH  
4 AND WELLNESS PROGRAMS.—Part B of title III of the  
5 Public Health Service Act (42 U.S.C. 243 et seq.), as  
6 amended by subsection (b)(1), is further amended by add-  
7 ing at the end the following:

8 **“SEC. 320D. HEALTH CARE PROVIDER BEHAVIORAL**  
9 **HEALTH AND WELLNESS PROGRAMS.**

10 “(a) IN GENERAL.—The Secretary may award grants  
11 to eligible entities for the purpose of establishing or en-  
12 hancing behavioral health and wellness programs for  
13 health care providers.

14 “(b) PROGRAM DESCRIPTION.—A behavioral health  
15 and wellness program funded under this section shall—

16 “(1) provide confidential support services for  
17 health care providers to help handle stressful or  
18 traumatic patient-related events, including coun-  
19 seling services and wellness seminars;

20 “(2) provide training to health care providers to  
21 serve as peer counselors to other health care pro-  
22 viders;

23 “(3) purchase materials to be used exclusively  
24 to provide such training; and

1           “(4) disseminate such information and mate-  
2           rials as are necessary to conduct such training and  
3           provide such peer counseling.

4           “(c) DEFINITIONS.—In this section, the term ‘eligible  
5           entity’ means a hospital, including a critical access hos-  
6           pital (as defined in section 1861(mm)(1) of the Social Se-  
7           curity Act) or a disproportionate share hospital (as defined  
8           under section 1923(a)(1)(A) of such Act), a Federally-  
9           qualified health center (as defined in section  
10          1905(1)(2)(B) of such Act), or any other health care facil-  
11          ity.”.

12          (d) DEVELOPMENT OF RESOURCES FOR EDUCATING  
13          MENTAL HEALTH PROFESSIONALS ABOUT TREATING  
14          FIRE FIGHTERS AND EMERGENCY MEDICAL SERVICES  
15          PERSONNEL.—

16               (1) IN GENERAL.—The Secretary of Health and  
17          Human Services shall develop and make publicly  
18          available resources that may be used by the Federal  
19          Government and other entities to educate mental  
20          health professionals about—

21                       (A) the culture of Federal, State, Tribal,  
22                       and local career, volunteer, and combination  
23                       fire departments and emergency medical serv-  
24                       ices agencies;

1 (B) the different stressors experienced by  
2 firefighters and emergency medical services per-  
3 sonnel, supervisory firefighters and emergency  
4 medical services personnel, and chief officers of  
5 fire departments and emergency medical serv-  
6 ices agencies;

7 (C) challenges encountered by retired fire-  
8 fighters and emergency medical services per-  
9 sonnel; and

10 (D) evidence-based therapies for mental  
11 health issues common to firefighters and emer-  
12 gency medical services personnel within such  
13 departments and agencies.

14 (2) CONSULTATION.—In developing resources  
15 under paragraph (1), the Secretary of Health and  
16 Human Services shall consult with national fire and  
17 emergency medical services organizations.

18 (3) DEFINITIONS.—In this subsection:

19 (A) The term “firefighter” means any em-  
20 ployee, regardless of rank or whether the em-  
21 ployee receives compensation, of a Federal,  
22 State, Tribal, or local fire department who is  
23 responsible for responding to calls for emer-  
24 gency service.

1           (B) The term “emergency medical services  
2           personnel” means any employee, regardless of  
3           rank or whether the employee receives com-  
4           pensation, as defined in section 1204(7) of the  
5           Omnibus Crime Control and Safe Streets Act of  
6           1968 (34 U.S.C. 10284(7)).

7           (C) The term “chief officer” means any in-  
8           dividual who is responsible for the overall oper-  
9           ation of a fire department or an emergency  
10          medical services agency, irrespective of whether  
11          such individual also serves as a firefighter or  
12          emergency medical services personnel.

13          (e) BEST PRACTICES AND OTHER RESOURCES FOR  
14          ADDRESSING POSTTRAUMATIC STRESS DISORDER IN  
15          PUBLIC SAFETY OFFICERS.—

16               (1) DEVELOPMENT; UPDATES.—The Secretary  
17          of Health and Human Services shall—

18               (A) develop and assemble evidence-based  
19               best practices and other resources to identify,  
20               prevent, and treat posttraumatic stress disorder  
21               and co-occurring disorders in public safety offi-  
22               cers; and

23               (B) reassess and update, as the Secretary  
24               determines necessary, such best practices and  
25               resources, including based upon the options for

1 interventions to reduce suicide among public  
2 safety officers identified in the annual reports  
3 required by section 317V(e)(1)(F) of the Public  
4 Health Service Act, as added by subsection (a).

5 (2) CONSULTATION.—In developing, assembling,  
6 and updating the best practices and resources  
7 under paragraph (1), the Secretary of Health and  
8 Human Services shall consult with, at a minimum,  
9 the following:

10 (A) Public health experts.

11 (B) Mental health experts with experience  
12 in studying suicide and other profession-related  
13 traumatic stress.

14 (C) Clinicians with experience in diagnosing  
15 and treating mental health issues.

16 (D) Relevant national police, fire, and  
17 emergency medical services organizations.

18 (3) AVAILABILITY.—The Secretary of Health  
19 and Human Services shall make the best practices  
20 and resources under paragraph (1) available to Federal,  
21 State, and local fire, law enforcement, and  
22 emergency medical services agencies.

23 (4) FEDERAL TRAINING AND DEVELOPMENT  
24 PROGRAMS.—The Secretary of Health and Human  
25 Services shall work with Federal departments and

1 agencies, including the United States Fire Adminis-  
 2 tration, to incorporate education and training on the  
 3 best practices and resources under paragraph (1)  
 4 into Federal training and development programs for  
 5 public safety officers.

6 (5) DEFINITION.—In this subsection, the term  
 7 “public safety officer” means—

8 (A) a public safety officer as defined in  
 9 section 1204 of the Omnibus Crime Control and  
 10 Safe Streets Act of 1968 (34 U.S.C. 10284); or

11 (B) a public safety telecommunicator as  
 12 described in detailed occupation 43–5031 in the  
 13 Standard Occupational Classification Manual of  
 14 the Office of Management and Budget (2018).

## 15 **Subtitle F—Other Provisions**

### 16 **SEC. 351. REPORT ON LAW ENFORCEMENT MENTAL** 17 **HEALTH AND WELLNESS.**

18 (a) IN GENERAL.—Not later than 270 days after the  
 19 date of enactment of this Act, the Attorney General, in  
 20 consultation with the Director of the Federal Bureau of  
 21 Investigation, the Director of the National Institute for  
 22 Justice, and the Assistant Secretary for Mental Health  
 23 and Substance Abuse, shall submit to the Committee on  
 24 Health, Education, Labor, and Pensions and the Com-  
 25 mittee on the Judiciary of the Senate and the Committee

1 on Energy and Commerce and the Committee on the Judi-  
2 ciary of the House of Representatives a report on—

3 (1) the types, frequency, and severity of mental  
4 health and stress-related responses of law enforce-  
5 ment officers to aggressive actions or other trauma-  
6 inducing incidents against law enforcement officers;

7 (2) mental health and stress-related resources  
8 or programs that are available to law enforcement  
9 officers at the Federal, State, and local level, includ-  
10 ing peer-to-peer programs;

11 (3) the extent to which law enforcement officers  
12 use the resources or programs described in para-  
13 graph (2);

14 (4) the availability of, or need for, mental  
15 health screening within Federal, State, and local law  
16 enforcement agencies; and

17 (5) recommendations for Federal, State, and  
18 local law enforcement agencies to improve the men-  
19 tal health and wellness of their officers.

20 (b) DEVELOPMENT.—In developing the report re-  
21 quired under subsection (a), the Attorney General, the Di-  
22 rector of the Federal Bureau of Investigation, the Director  
23 of the National Institute of Justice, and the Assistant Sec-  
24 retary for Mental Health and Substance Abuse shall con-  
25 sult relevant stakeholders, including—

1 (1) Federal, State, Tribal and local law enforce-  
2 ment agencies; and

3 (2) nongovernmental organizations, inter-  
4 national organizations, academies, or other entities.

5 **TITLE IV—CHILDREN AND**  
6 **YOUTH**

7 **Subtitle A—Supporting Children’s**  
8 **Mental Health Care Access**

9 **SEC. 401. PEDIATRIC MENTAL HEALTH CARE ACCESS**  
10 **GRANTS.**

11 Section 330M of the Public Health Service Act (42  
12 U.S.C. 254c–19) is amended—

13 (1) in the section enumerator, by striking  
14 “**330M**” and inserting “**330M.**”;

15 (2) in subsection (a)—

16 (A) by striking “Indian tribes and tribal  
17 organizations” and inserting “Indian Tribes  
18 and Tribal organizations”; and

19 (B) by inserting “or, in the case of a State  
20 that does not submit an application, a nonprofit  
21 entity that has the support of the State” after  
22 “450b))”;

23 (3) in subsection (b)—

24 (A) in paragraph (1)—

1 (i) in subparagraph (G), by inserting  
2 “developmental-behavioral pediatricians,”  
3 after “adolescent psychiatrists,”;

4 (ii) in subparagraph (H), by striking  
5 “; and” at the end and inserting a semi-  
6 colon;

7 (iii) by redesignating subparagraph  
8 (I) as subparagraph (J); and

9 (iv) by inserting after subparagraph  
10 (H) the following:

11 “(I) maintain an up-to-date list of commu-  
12 nity-based supports for children with mental  
13 health problems; and”;

14 (B) by redesignating paragraph (2) as  
15 paragraph (4);

16 (C) by inserting after paragraph (1) the  
17 following:

18 “(2) SUPPORT TO SCHOOLS AND EMERGENCY  
19 DEPARTMENTS.—In addition to the activities re-  
20 quired by paragraph (1), a pediatric mental health  
21 care telehealth access program referred to in sub-  
22 section (a), with respect to which a grant under such  
23 subsection may be used, may provide support to  
24 schools and emergency departments.

1           “(3) PRIORITY.—In awarding grants under this  
2           section, the Secretary shall give priority to appli-  
3           cants proposing to—

4                   “(A) continue existing programs that meet  
5           the requirements of paragraph (1);

6                   “(B) establish a pediatric mental health  
7           care telehealth access program in the jurisdic-  
8           tion of a State, Territory, Indian Tribe, or  
9           Tribal organization that does not yet have such  
10          a program; or

11                  “(C) expand a pediatric mental health care  
12          telehealth access program to include one or  
13          more new sites of care, such as a school or  
14          emergency department.”; and

15                  (D) in paragraph (4), as redesignated by  
16          subparagraph (B), by inserting “Such a team  
17          may include a developmental-behavioral pedia-  
18          trician.” after “mental health counselor.”;

19                  (4) in subsections (c), (d), and (f), by striking  
20          “Indian tribe, or tribal organization” each place it  
21          appears and inserting “Indian Tribe, Tribal organi-  
22          zation, or nonprofit entity”; and

23                  (5) by striking subsection (g) and inserting the  
24          following:

1       “(g) TECHNICAL ASSISTANCE.—The Secretary shall  
 2       award grants or contracts to one or more eligible entities  
 3       (as defined by the Secretary) for the purposes of providing  
 4       technical assistance and evaluation support to grantees  
 5       under subsection (a).

6       “(h) AUTHORIZATION OF APPROPRIATIONS.—To  
 7       carry out this section, there are authorized to be appro-  
 8       priated—

9               “(1) \$14,000,000 for each of fiscal years 2023  
 10       through 2025; and

11              “(2) \$30,000,000 for each of fiscal years 2026  
 12       through 2027.”.

13 **SEC. 402. INFANT AND EARLY CHILDHOOD MENTAL**  
 14                   **HEALTH PROMOTION, INTERVENTION, AND**  
 15                   **TREATMENT.**

16       Section 399Z–2(f) of the Public Health Service Act  
 17       (42 U.S.C. 280h–6(f)) is amended by striking  
 18       “\$20,000,000 for the period of fiscal years 2018 through  
 19       2022” and inserting “\$50,000,000 for the period of fiscal  
 20       years 2023 through 2027”.

21 **SEC. 403. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND**  
 22                   **ADOLESCENTS.**

23       (a) TECHNICAL AMENDMENTS.—The second part G  
 24       (relating to services provided through religious organiza-

1 tions) of title V of the Public Health Service Act (42  
2 U.S.C. 290kk et seq.) is amended—

3 (1) by redesignating such part as part J; and

4 (2) by redesignating sections 581 through 584  
5 as sections 596 through 596C, respectively.

6 (b) SCHOOL-BASED MENTAL HEALTH AND CHIL-  
7 DREN.—Section 581 of the Public Health Service Act (42  
8 U.S.C. 290hh) (relating to children and violence) is  
9 amended to read as follows:

10 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**  
11 **AND ADOLESCENTS.**

12 “(a) IN GENERAL.—The Secretary, in consultation  
13 with the Secretary of Education, shall, through grants,  
14 contracts, or cooperative agreements awarded to eligible  
15 entities described in subsection (c), provide comprehensive  
16 school-based mental health services and supports to assist  
17 children in local communities and schools (including  
18 schools funded by the Bureau of Indian Education) deal-  
19 ing with traumatic experiences, grief, bereavement, risk of  
20 suicide, and violence. Such services and supports shall  
21 be—

22 “(1) developmentally, linguistically, and cul-  
23 turally appropriate;

24 “(2) trauma-informed; and

1           “(3) incorporate positive behavioral interven-  
2           tions and supports.

3           “(b) ACTIVITIES.—Grants, contracts, or cooperative  
4 agreements awarded under subsection (a), shall, as appro-  
5 priate, be used for—

6           “(1) implementation of school and community-  
7           based mental health programs that—

8           “(A) build awareness of individual trauma  
9           and the intergenerational, continuum of impacts  
10          of trauma on populations;

11          “(B) train appropriate staff to identify,  
12          and screen for, signs of trauma exposure, men-  
13          tal health disorders, or risk of suicide; and

14          “(C) incorporate positive behavioral inter-  
15          ventions, family engagement, student treatment,  
16          and multigenerational supports to foster the  
17          health and development of children, prevent  
18          mental health disorders, and ameliorate the im-  
19          pact of trauma;

20          “(2) technical assistance to local communities  
21          with respect to the development of programs de-  
22          scribed in paragraph (1);

23          “(3) facilitating community partnerships among  
24          families, students, law enforcement agencies, edu-  
25          cation agencies, mental health and substance use

1 disorder service systems, family-based mental health  
2 service systems, child welfare agencies, health care  
3 providers (including primary care physicians, mental  
4 health professionals, and other professionals who  
5 specialize in children’s mental health such as child  
6 and adolescent psychiatrists), institutions of higher  
7 education, faith-based programs, trauma networks,  
8 and other community-based systems to address child  
9 and adolescent trauma, mental health issues, and vi-  
10 olence; and

11 “(4) establishing mechanisms for children and  
12 adolescents to report incidents of violence or plans  
13 by other children, adolescents, or adults to commit  
14 violence.

15 “(c) REQUIREMENTS.—

16 “(1) IN GENERAL.—To be eligible for a grant,  
17 contract, or cooperative agreement under subsection  
18 (a), an entity shall be a partnership that includes—

19 “(A) a State educational agency, as de-  
20 fined in section 8101 of the Elementary and  
21 Secondary Education Act of 1965, in coordina-  
22 tion with one or more local educational agen-  
23 cies, as defined in section 8101 of the Elemen-  
24 tary and Secondary Education Act of 1965, or  
25 a consortium of any entities described in sub-

1 paragraph (B), (C), (D), or (E) of section  
2 8101(30) of such Act; and

3 “(B) at least 1 community-based mental  
4 health provider, including a public or private  
5 mental health entity, health care entity, family-  
6 based mental health entity, trauma network, or  
7 other community-based entity, as determined by  
8 the Secretary (and which may include addi-  
9 tional entities such as a human services agency,  
10 law enforcement or juvenile justice entity, child  
11 welfare agency, agency, an institution of higher  
12 education, or another entity, as determined by  
13 the Secretary).

14 “(2) COMPLIANCE WITH HIPAA.—Any patient  
15 records developed by covered entities through activi-  
16 ties under the grant shall meet the regulations pro-  
17 mulgated under section 264(c) of the Health Insur-  
18 ance Portability and Accountability Act of 1996.

19 “(3) COMPLIANCE WITH FERPA.—Section 444  
20 of the General Education Provisions Act (commonly  
21 known as the ‘Family Educational Rights and Pri-  
22 vacy Act of 1974’) shall apply to any entity that is  
23 a member of the partnership in the same manner  
24 that such section applies to an educational agency or  
25 institution (as that term is defined in such section).

1       “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary  
2 shall ensure that grants, contracts, or cooperative agree-  
3 ments under subsection (a) will be distributed equitably  
4 among the regions of the country and among urban and  
5 rural areas.

6       “(e) DURATION OF AWARDS.—With respect to a  
7 grant, contract, or cooperative agreement under sub-  
8 section (a), the period during which payments under such  
9 an award will be made to the recipient shall be 5 years,  
10 with options for renewal.

11       “(f) EVALUATION AND MEASURES OF OUTCOMES.—

12               “(1) DEVELOPMENT OF PROCESS.—The Assist-  
13 ant Secretary shall develop a fiscally appropriate  
14 process for evaluating activities carried out under  
15 this section. Such process shall include—

16                       “(A) the development of guidelines for the  
17 submission of program data by grant, contract,  
18 or cooperative agreement recipients;

19                       “(B) the development of measures of out-  
20 comes (in accordance with paragraph (2)) to be  
21 applied by such recipients in evaluating pro-  
22 grams carried out under this section; and

23                       “(C) the submission of annual reports by  
24 such recipients concerning the effectiveness of  
25 programs carried out under this section.

1           “(2) MEASURES OF OUTCOMES.—The Assistant  
2       Secretary shall develop measures of outcomes to be  
3       applied by recipients of assistance under this section  
4       to evaluate the effectiveness of programs carried out  
5       under this section, including outcomes related to the  
6       student, family, and local educational systems sup-  
7       ported by this Act.

8           “(3) SUBMISSION OF ANNUAL DATA.—An eligi-  
9       ble entity described in subsection (c) that receives a  
10      grant, contract, or cooperative agreement under this  
11      section shall annually submit to the Assistant Sec-  
12      retary a report that includes data to evaluate the  
13      success of the program carried out by the entity  
14      based on whether such program is achieving the pur-  
15      poses of the program. Such reports shall utilize the  
16      measures of outcomes under paragraph (2) in a rea-  
17      sonable manner to demonstrate the progress of the  
18      program in achieving such purposes.

19          “(4) EVALUATION BY ASSISTANT SECRETARY.—  
20      Based on the data submitted under paragraph (3),  
21      the Assistant Secretary shall annually submit to  
22      Congress a report concerning the results and effec-  
23      tiveness of the programs carried out with assistance  
24      received under this section.

1           “(5) LIMITATION.—An eligible entity shall use  
2           not more than 20 percent of amounts received under  
3           a grant under this section to carry out evaluation  
4           activities under this subsection.

5           “(g) INFORMATION AND EDUCATION.—The Sec-  
6           retary shall disseminate best practices based on the find-  
7           ings of the knowledge development and application under  
8           this section.

9           “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF  
10          APPROPRIATIONS.—

11           “(1) AMOUNT OF GRANTS.—A grant under this  
12           section shall be in an amount that is not more than  
13           \$2,000,000 for each of the first 5 fiscal years fol-  
14           lowing the date of enactment of the Restoring Hope  
15           for Mental Health and Well-Being Act of 2022. The  
16           Secretary shall determine the amount of each such  
17           grant based on the population of children up to age  
18           21 of the area to be served under the grant.

19           “(2) AUTHORIZATION OF APPROPRIATIONS.—  
20           There is authorized to be appropriated to carry out  
21           this section, \$130,000,000 for each of fiscal years  
22           2023 through 2027.”.

23           “(c) CONFORMING AMENDMENT.—Part G of title V of  
24           the Public Health Service Act (42 U.S.C. 290hh et seq.),  
25           as amended by subsection (b), is further amended by strik-

1 ing the part designation and heading and inserting the  
2 following:

3 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

4 **SEC. 404. CO-OCCURRING CHRONIC CONDITIONS AND MEN-**  
5 **TAL HEALTH IN YOUTH STUDY.**

6 Not later than 12 months after the date of enactment  
7 of this Act, the Secretary of Health and Human Services  
8 shall—

9 (1) complete a study on the rates of suicidal be-  
10 haviors among children and adolescents with chronic  
11 illnesses, including substance use disorders, auto-  
12 immune disorders, and heritable blood disorders; and

13 (2) submit a report to the Congress on the re-  
14 sults of such study, including recommendations for  
15 early intervention services for such children and ado-  
16 lescents at risk of suicide, the dissemination of best  
17 practices to support the emotional and mental health  
18 needs of youth, and strategies to lower the rates of  
19 suicidal behaviors in children and adolescents de-  
20 scribed in paragraph (1) to reduce any demographic  
21 disparities in such rates.

1 **SEC. 405. BEST PRACTICES FOR BEHAVIORAL INTERVEN-**  
2 **TION TEAMS.**

3 The Public Health Service Act is amended by insert-  
4 ing after section 520H of such Act, as added by section  
5 151, the following new section:

6 **“SEC. 520I. BEST PRACTICES FOR BEHAVIORAL INTERVEN-**  
7 **TION TEAMS.**

8 “(a) IN GENERAL.—The Secretary shall identify and  
9 facilitate the development of best practices to assist ele-  
10 mentary schools, secondary schools, and institutions of  
11 higher education in establishing and using behavioral  
12 intervention teams.

13 “(b) ELEMENTS.—The best practices under sub-  
14 section (a)(1) shall include guidance on the following:

15 “(1) How behavioral intervention teams can op-  
16 erate effectively from an evidence-based, objective  
17 perspective while protecting the constitutional and  
18 civil rights of individuals.

19 “(2) The use of behavioral intervention teams  
20 to identify concerning behaviors, implement interven-  
21 tions, and manage risk through the framework of  
22 the school’s or institution’s rules or code of conduct,  
23 as applicable.

24 “(3) How behavioral intervention teams can,  
25 when assessing an individual—

1           “(A) access training on evidence-based,  
2 threat-assessment rubrics;

3           “(B) ensure that such teams—

4               “(i) have trained, diverse stakeholders  
5 with varied expertise; and

6               “(ii) use cross validation by a wide-  
7 range of individual perspectives on the  
8 team; and

9           “(C) use violence risk assessment.

10          “(4) How behavioral intervention teams can  
11 help mitigate—

12           “(A) inappropriate use of a mental health  
13 assessment;

14           “(B) inappropriate limitations or restric-  
15 tions on law enforcement’s jurisdiction over  
16 criminal matters;

17           “(C) attempts to substitute the behavioral  
18 intervention process in place of a criminal proc-  
19 ess, or impede a criminal process, when an indi-  
20 vidual’s behavior has potential criminal implica-  
21 tions;

22           “(D) endangerment of an individual’s pri-  
23 vacy by failing to ensure that all applicable  
24 Federal and State privacy laws are fully com-  
25 plied with; or

1                   “(E) inappropriate referrals to, or involve-  
2                   ment of, law enforcement when an individual’s  
3                   behavior does not warrant a criminal response.

4           “(c) CONSULTATION.—In carrying out subsection  
5 (a)(1), the Secretary shall consult with—

6                   “(1) the Secretary of Education;

7                   “(2) the Director of the National Threat As-  
8                   sessment Center of the United States Secretary  
9                   Service;

10                  “(3) the Attorney General and the Director of  
11                  the Bureau of Justice Assistance;

12                  “(4) teachers and other educators, principals,  
13                  school administrators, school board members, school  
14                  psychologists, mental health professionals, and par-  
15                  ents of students;

16                  “(5) local law enforcement agencies and campus  
17                  law enforcement administrators;

18                  “(6) privacy experts; and

19                  “(7) other education and mental health profes-  
20                  sionals as the Secretary deems appropriate.

21           “(d) PUBLICATION.—Not later than 2 years after the  
22           date of enactment of this section, the Secretary shall pub-  
23           lish the best practices under subsection (a)(1) on the inter-  
24           net website of the Department of Health and Human  
25           Services.

1       “(e) TECHNICAL ASSISTANCE.—The Secretary shall  
2 provide technical assistance to institutions of higher edu-  
3 cation, elementary schools, and secondary schools to assist  
4 such institutions and schools in implementing the best  
5 practices under subsection (a).

6       “(f) DEFINITIONS.—In this section:

7           “(1) The term ‘behavioral intervention team’  
8 means a team of qualified individuals who—

9           “(A) are responsible for identifying and as-  
10        sessing individuals exhibiting concerning behav-  
11        iors, experiencing distress, or who are at risk of  
12        harm to self or others;

13          “(B) develop and facilitate implementation  
14        of evidence-based interventions to mitigate the  
15        threat of harm to self or others posed by an in-  
16        dividual and address the mental and behavioral  
17        health needs of individuals to reduce risk; and

18          “(C) provide information to students, par-  
19        ents, and school employees on recognizing be-  
20        havior described in this subsection.

21          “(2) The terms ‘elementary school’, ‘parent’,  
22        and ‘secondary school’ have the meanings given to  
23        such terms in section 8101 of the Elementary and  
24        Secondary Education Act of 1965.

1           “(3) The term ‘institution of higher education’  
2           has the meaning given to such term in section 102  
3           of the Higher Education Act of 1965.

4           “(4) The term ‘mental health assessment’  
5           means an evaluation, primarily focused on diagnosis,  
6           determining the need for involuntary commitment,  
7           medication management, and on-going treatment  
8           recommendations.

9           “(5) The term ‘violence risk assessment’ means  
10          a broad determination of the potential risk of vio-  
11          lence based on evidence-based literature.”.

12       **Subtitle B—Continuing Systems of**  
13       **Care for Children**

14       **SEC. 411. COMPREHENSIVE COMMUNITY MENTAL HEALTH**  
15               **SERVICES FOR CHILDREN WITH SERIOUS**  
16               **EMOTIONAL DISTURBANCES.**

17       (a) DEFINITION OF FAMILY.—Section 565(d)(2)(B)  
18       of the Public Health Service Act (42 U.S.C. 290ff–  
19       4(d)(2)(B)) is amended by striking “as appropriate re-  
20       garding mental health services for the child, the parents  
21       of the child (biological or adoptive, as the case may be)  
22       and any foster parents of the child” and inserting “as ap-  
23       propriate regarding mental health services for the child  
24       and the parents or kinship caregivers of the child”.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—Para-  
2 graph (1) of section 565(f) of the Public Health Service  
3 Act (42 U.S.C. 290ff–4(f)) is amended—

4 (1) by moving the margin of such paragraph 2  
5 ems to the right; and

6 (2) by striking “\$119,026,000 for each of fiscal  
7 years 2018 through 2022” and inserting  
8 “\$125,000,000 for each of fiscal years 2023 through  
9 2027”.

10 **SEC. 412. SUBSTANCE USE DISORDER TREATMENT AND**  
11 **EARLY INTERVENTION SERVICES FOR CHIL-**  
12 **DREN AND ADOLESCENTS.**

13 Section 514 of the Public Health Service Act (42  
14 U.S.C. 290bb–7) is amended—

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

18 (2) in subsection (f), by striking “2018 through  
19 2022” and inserting “2023 through 2027”.

1       **Subtitle C—Garrett Lee Smith**  
2       **Memorial Reauthorization**

3       **SEC. 421. SUICIDE PREVENTION TECHNICAL ASSISTANCE**  
4               **CENTER.**

5           (a) TECHNICAL AMENDMENT.—Section 520C of the  
6 Public Health Service Act (42 U.S.C. 290bb–34) is  
7 amended—

8               (1) by striking “tribes” and inserting “Tribes”;  
9           and

10              (2) by striking “tribal” each place it appears  
11           and inserting “Tribal”.

12           (b) AUTHORIZATION OF APPROPRIATIONS.—Section  
13 520C(c) of the Public Health Service Act (42 U.S.C.  
14 290bb–34(c)) is amended by striking “\$5,988,000 for  
15 each of fiscal years 2018 through 2022” and inserting  
16 “\$9,000,000 for each of fiscal years 2023 through 2027”.

17           (c) ANNUAL REPORT.—Section 520C(d) of the Public  
18 Health Service Act (42 U.S.C. 290bb–34(d)) is amended  
19 by striking “Not later than 2 years after the date of enact-  
20 ment of this subsection” and inserting “Not later than  
21 2 years after the date of enactment of the Restoring Hope  
22 for Mental Health and Well-Being Act of 2022”.

1 **SEC. 422. YOUTH SUICIDE EARLY INTERVENTION AND PRE-**  
2 **VENTION STRATEGIES.**

3 Section 520E of the Public Health Service Act (42  
4 U.S.C. 290bb–36) is amended—

5 (1) by striking “tribe” and inserting “Tribe”;

6 (2) by striking “tribal” each place it appears  
7 and inserting “Tribal”;

8 (3) in subsection (a)(1), by inserting “pediatric  
9 health programs,” after “foster care systems,”;

10 (4) by amending subsection (b)(1)(B) to read  
11 as follows:

12 “(B) a public organization or private non-  
13 profit organization designated by a State or In-  
14 dian Tribe (as defined under the Federally Rec-  
15 ognized Indian Tribe List Act of 1994) to de-  
16 velop or direct the State-sponsored statewide or  
17 Tribal youth suicide early intervention and pre-  
18 vention strategy; or”;

19 (5) in subsection (c)—

20 (A) in paragraph (1), by inserting “pedi-  
21 atric health programs,” after “foster care sys-  
22 tems,”;

23 (B) in paragraph (7), by inserting “pedi-  
24 atric health programs,” after “foster care sys-  
25 tems,”;

1 (C) in paragraph (9), by inserting “pedi-  
2 atric health programs,” after “educational insti-  
3 tutions,”;

4 (D) in paragraph (13), by striking “and”  
5 at the end;

6 (E) in paragraph (14), by striking the pe-  
7 riod at the end and inserting “; and”; and

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

9 “(15) provide to parents, legal guardians, and  
10 family members of youth, supplies to securely store  
11 means commonly used in suicide, if applicable, with-  
12 in the household.”;

13 (6) in subsection (d)—

14 (A) in the heading, by striking “DIRECT  
15 SERVICES” and inserting “SUICIDE PREVEN-  
16 TION ACTIVITIES”; and

17 (B) by striking “direct services, of which  
18 not less than 5 percent shall be used for activi-  
19 ties authorized under subsection (a)(3)” and in-  
20 serting “suicide prevention activities”;

21 (7) in subsection (e)(3)(A), by inserting “and  
22 Department of Education” after “Department of  
23 Health and Human Services”;

24 (8) in subsection (g)—

1 (A) in paragraph (1), by striking “18” and  
2 inserting “24”; and

3 (B) in paragraph (2), by striking “2 years  
4 after the date of enactment of Helping Families  
5 in Mental Health Crisis Reform Act of 2016”  
6 and inserting “3 years after December 31,  
7 2022”;

8 (9) in subsection (l)(4), by striking “between 10  
9 and 24 years of age” and inserting “up to 24 years  
10 of age”; and

11 (10) in subsection (m), by striking  
12 “\$30,000,000 for each of fiscal years 2018 through  
13 2022” and inserting “\$40,000,000 for each of fiscal  
14 years 2023 through 2027”.

15 **SEC. 423. MENTAL HEALTH AND SUBSTANCE USE DIS-**  
16 **ORDER SERVICES FOR STUDENTS IN HIGHER**  
17 **EDUCATION.**

18 Section 520E–2 of the Public Health Service Act (42  
19 U.S.C. 290bb–36b) is amended—

20 (1) in the heading, by striking “**ON CAMPUS**”  
21 and inserting “**FOR STUDENTS IN HIGHER EDU-**  
22 **CATION**”; and

23 (2) in subsection (i), by striking “2018 through  
24 2022” and inserting “2023 through 2027”.

1 **SEC. 424. MENTAL AND BEHAVIORAL HEALTH OUTREACH**  
2 **AND EDUCATION AT INSTITUTIONS OF HIGH-**  
3 **ER EDUCATION.**

4 Section 549 of the Public Health Service Act (42  
5 U.S.C. 290ee–4) is amended—

6 (1) in the heading, by striking “**ON COLLEGE**  
7 **CAMPUSES**” and inserting “**AT INSTITUTIONS OF**  
8 **HIGHER EDUCATION**”;

9 (2) in subsection (c)(2), by inserting “, includ-  
10 ing minority-serving institutions as described in sec-  
11 tion 371(a) of the Higher Education Act of 1965  
12 (20 U.S.C. 1067q) and community colleges” after  
13 “higher education”; and

14 (3) in subsection (f), by striking “2018 through  
15 2022” and inserting “2023 through 2027”.

16 **Subtitle D—Media and Mental**  
17 **Health**

18 **SEC. 431. STUDY ON THE EFFECTS OF SMARTPHONE AND**  
19 **SOCIAL MEDIA USE ON ADOLESCENTS.**

20 (a) IN GENERAL.—Not later than 1 year after the  
21 date of enactment of this Act, the Secretary of Health and  
22 Human Services shall conduct or support research on—

23 (1) smartphone and social media use by adoles-  
24 cents; and

25 (2) the effects of such use on—

1 (A) emotional, behavioral, and physical  
2 health and development; and

3 (B) any disparities in the mental health  
4 outcomes of rural, minority, and other under-  
5 served populations.

6 (b) REPORT.—Not later than 5 years after the date  
7 of enactment of this Act, the Secretary of Health and  
8 Human Services shall submit to the Congress, and make  
9 publicly available, a report on the findings of research  
10 under this section.

11 **SEC. 432. RESEARCH ON THE HEALTH AND DEVELOPMENT**  
12 **EFFECTS OF MEDIA ON INFANTS, CHILDREN,**  
13 **AND ADOLESCENTS.**

14 Subpart 7 of part C of title IV of the Public Health  
15 Service Act (42 U.S.C. 285g et seq.) is amended by adding  
16 at the end the following:

17 **“SEC. 452H. RESEARCH ON THE HEALTH AND DEVELOP-**  
18 **MENT EFFECTS OF MEDIA ON INFANTS, CHIL-**  
19 **DREN, AND ADOLESCENTS.**

20 “(a) IN GENERAL.—The Director of the National In-  
21 stitutes of Health, in coordination with or acting through  
22 the Director of the Institute, shall conduct and support  
23 research and related activities concerning the health and  
24 developmental effects of media on infants, children, and  
25 adolescents, which may include the positive and negative

1 effects of exposure to and use of media, such as social  
2 media, applications, websites, television, motion pictures,  
3 artificial intelligence, mobile devices, computers, video  
4 games, virtual and augmented reality, and other media  
5 formats as they become available. Such research shall at-  
6 tempt to better understand the relationships between  
7 media and technology use and individual differences and  
8 characteristics of children and shall include longitudinally  
9 designed studies to assess the impact of media on youth  
10 over time. Such research shall include consideration of  
11 core areas of child and adolescent health and development  
12 including the following:

13           “(1) COGNITIVE.—The role and impact of  
14           media use and exposure in the development of chil-  
15           dren and adolescents within such cognitive areas as  
16           language development, executive functioning, atten-  
17           tion, creative problem solving skills, visual and spa-  
18           tial skills, literacy, critical thinking, and other learn-  
19           ing abilities, and the impact of early technology use  
20           on developmental trajectories.

21           “(2) PHYSICAL.—The role and impact of media  
22           use and exposure on children’s and adolescent’s  
23           physical development and health behaviors, including  
24           diet, exercise, sleeping and eating routines, and  
25           other areas of physical development.

1           “(3) SOCIO-EMOTIONAL.—The role and impact  
2           of media use and exposure on children’s and adoles-  
3           cents’ social-emotional competencies, including self-  
4           awareness, self-regulation, social awareness, relation-  
5           ship skills, empathy, distress tolerance, perception of  
6           social cues, awareness of one’s relationship with the  
7           media, and decision-making, as well as outcomes  
8           such as violations of privacy, perpetration of or ex-  
9           posure to violence, bullying or other forms of aggres-  
10          sion, depression, anxiety, substance use, misuse or  
11          disorder, and suicidal ideation/behavior and self-  
12          harm.

13          “(b) DEVELOPING RESEARCH AGENDA.—The Direc-  
14          tor of the National Institutes of Health, in consultation  
15          with the Director of the Institute, other appropriate na-  
16          tional research institutes, academies, and centers, the  
17          Trans-NIH Pediatric Research Consortium, and non-Fed-  
18          eral experts as needed, shall develop a research agenda  
19          on the health and developmental effects of media on in-  
20          fants, children, and adolescents to inform research activi-  
21          ties under subsection (a). In developing such research  
22          agenda, the Director may use whatever means necessary  
23          (such as scientific workshops and literature reviews) to as-  
24          sess current knowledge and research gaps in this area.

1       “(c) RESEARCH PROGRAM.—In coordination with the  
 2 Institute and other national research institutes and cen-  
 3 ters, and utilizing the National Institutes of Health’s proc-  
 4 ess of scientific peer review, the Director of the National  
 5 Institutes of Health shall fund an expanded research pro-  
 6 gram on the health and developmental effects of media  
 7 on infants, children, and adolescents.

8       “(d) REPORT TO CONGRESS.—Not later than 1 year  
 9 after the date of enactment of this Act, the Director of  
 10 the National Institutes of Health shall submit a report to  
 11 Congress on the progress made in gathering data and ex-  
 12 panding research on the health and developmental effects  
 13 of media on infants, children, and adolescents in accord-  
 14 ance with this section. Such report shall summarize the  
 15 grants and research funded, by year, under this section.”.

## 16       **TITLE V—MEDICAID AND CHIP**

### 17       **SEC. 501. MEDICAID AND CHIP REQUIREMENTS FOR** 18                       **HEALTH SCREENINGS AND REFERRALS FOR** 19                       **ELIGIBLE JUVENILES IN PUBLIC INSTITU-** 20                       **TIONS.**

21       (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
 22 1902 of the Social Security Act (42 U.S.C. 1396a) is  
 23 amended—

24               (1) in subsection (a)(84)—

1 (A) in subparagraph (A), by inserting “,  
2 subject to subparagraph (D),” after “but”;

3 (B) in subparagraph (B), by striking  
4 “and” at the end;

5 (C) in subparagraph (C), by adding “and”  
6 at the end; and

7 (D) by adding at the end the following new  
8 subparagraph:

9 “(D) beginning on the first day of the first  
10 calendar quarter that begins two years after the  
11 date of enactment of this subparagraph, in the  
12 case of individuals who are eligible juveniles de-  
13 scribed in subsection (nn)(2), are within 30  
14 days of the date on which such eligible juvenile  
15 is scheduled to be released from a public insti-  
16 tution following adjudication, the State shall  
17 have in place a plan to ensure, and in accord-  
18 ance with such plan, provide—

19 “(i) for, in the 30 days prior to the  
20 release of such an eligible juvenile from  
21 such public institution (or not later than  
22 one week after release from the public in-  
23 stitution), and in coordination with such  
24 institution—

1           “(I) any screening or diagnostic  
2           service which meets reasonable stand-  
3           ards of medical and dental practice,  
4           as determined by the State, or as in-  
5           dicated as medically necessary, in ac-  
6           cordance with paragraphs (1)(A) and  
7           (5) of section 1905(r); and

8           “(II) a mental health or other be-  
9           havioral health screening that is a  
10          screening service described under sec-  
11          tion 1905(r)(1), or a diagnostic serv-  
12          ice described under paragraph (5) of  
13          such section, if such screening or di-  
14          agnostic service was not otherwise  
15          conducted pursuant to this clause;

16          “(ii) for, not later than one week after  
17          release from the public institution, refer-  
18          rals for such eligible juvenile to the appro-  
19          priate care and services available under the  
20          State plan (or waiver of such plan) in the  
21          geographic region of the home or residence  
22          of such eligible juvenile, based on such  
23          screenings; and

24          “(iii) for, following the release of such  
25          eligible juvenile from such institution, not

1 less than 30 days of targeted case manage-  
 2 ment services furnished by a provider in  
 3 the geographic region of the home or resi-  
 4 dence of such eligible juvenile.”; and

5 (2) in subsection (nn)(3), by striking “(30)”  
 6 and inserting “(31)”.

7 (b) AUTHORIZATION OF FEDERAL FINANCIAL PAR-  
 8 TICIPATION.—The subdivision (A) of section 1905(a) of  
 9 the Social Security Act (42 U.S.C. 1396d(a)) following  
 10 paragraph (31) of such section is amended by inserting  
 11 “, or in the case of an eligible juvenile described in section  
 12 1902(a)(84)(D) with respect to the screenings, diagnostic  
 13 services, referrals, and case management required under  
 14 such subparagraph (D)” after “(except as a patient in a  
 15 medical institution”.

16 (c) CHIP CONFORMING AMENDMENTS.—

17 (1) Section 2103(c) of the Social Security Act  
 18 (42 U.S.C. 1397cc(c)) is amended by adding at the  
 19 end the following new paragraph:

20 “(12) REQUIRED COVERAGE OF SCREENINGS,  
 21 DIAGNOSTIC SERVICES, REFERRALS, AND CASE MAN-  
 22 AGEMENT FOR CERTAIN INMATES PRE-RELEASE.—  
 23 With respect to individuals described in section  
 24 2110(b)(7), the State shall provide screenings, diag-  
 25 nostic services, referrals, and case management oth-

1       erwise covered under the State child health plan (or  
2       waiver of such plan) during the period described in  
3       such section with respect to such screenings, serv-  
4       ices, referrals, and case management.”.

5               (2) Section 2110(b) of the Social Security Act  
6       (42 U.S.C. 1397jj(b)) is amended—

7               (A) in paragraph (2)(A), by inserting “ex-  
8       cept as provided in paragraph (7),” before “a  
9       child who is an inmate of a public institution”;  
10       and

11              (B) by adding at the end the following new  
12       paragraph:

13       “(7) EXCEPTION TO EXCLUSION OF CHILDREN  
14       WHO ARE INMATES OF A PUBLIC INSTITUTION.—A  
15       child shall not be considered to be described in para-  
16       graph (2)(A) if such child is an eligible juvenile (as  
17       described in section 1902(a)(84)(D)) with respect to  
18       the screenings, diagnostic services, referrals, and  
19       case management otherwise covered under the State  
20       child health plan (or waiver of such plan) during the  
21       period with respect to which such screenings, serv-  
22       ices, referrals, and case management is respectively  
23       required under such section.”.

1 **SEC. 502. GUIDANCE ON REDUCING ADMINISTRATIVE BAR-**  
2 **RIERS TO PROVIDING HEALTH CARE SERV-**  
3 **ICES IN SCHOOLS.**

4 (a) IN GENERAL.—Not later than 12 months after  
5 the date of enactment of this Act, the Secretary of Health  
6 and Human Services shall issue guidance to State Med-  
7 icaid agencies, elementary and secondary schools, and  
8 school-based health centers on reducing administrative  
9 barriers to such schools and centers furnishing medical as-  
10 sistance and obtaining payment for such assistance under  
11 titles XIX and XXI of the Social Security Act (42 U.S.C.  
12 1396 et seq., 1397aa et seq.).

13 (b) CONTENTS OF GUIDANCE.—The guidance issued  
14 pursuant to subsection (a) shall—

15 (1) include revisions to the May 2003 Medicaid  
16 School-Based Administrative Claiming Guide, the  
17 1997 Medicaid and Schools Technical Assistance  
18 Guide, and other relevant guidance in effect on the  
19 date of enactment of this Act;

20 (2) provide information on payment under titles  
21 XIX and XXI of the Social Security Act (42 U.S.C.  
22 1396 et seq., 1397aa et seq.) for the provision of  
23 medical assistance, including such assistance pro-  
24 vided in accordance with an individualized education  
25 program or under the policy described in the State

1 Medicaid Director letter on payment for services  
2 issued on December 15, 2014 (#14-006);

3 (3) take into account reasons why small and  
4 rural local education agencies may not provide med-  
5 ical assistance and provide information on best prac-  
6 tices to encourage such agencies to provide such as-  
7 sistance; and

8 (4) include best practices and examples of  
9 methods that State Medicaid agencies and local edu-  
10 cation agencies have used to pay for, and increase  
11 the availability of, medical assistance.

12 (c) DEFINITIONS.—In this Act:

13 (1) INDIVIDUALIZED EDUCATION PROGRAM.—  
14 The term “individualized education program” has  
15 the meaning given such term in section 602(14) of  
16 the Individuals with Disabilities Education Act (20  
17 U.S.C. 1401(14)).

18 (2) SCHOOL-BASED HEALTH CENTER.—The  
19 term “school-based health center” has the meaning  
20 given such term in section 2110(c)(9) of the Social  
21 Security Act (42 U.S.C. 1397jj(c)(9)), and includes  
22 an entity that provides Medicaid-covered services in  
23 school-based settings for which Federal financial  
24 participation is permitted.

1 **SEC. 503. GUIDANCE TO STATES ON SUPPORTING PEDI-**  
2 **ATRIC BEHAVIORAL HEALTH SERVICES**  
3 **UNDER MEDICAID AND CHIP.**

4 Not later than 18 months after the date of enactment  
5 of this Act, the Secretary of Health and Human Services  
6 shall issue guidance to States on how to expand the provi-  
7 sion of, and access to, behavioral health services, including  
8 mental health services, for children covered under State  
9 plans (or waivers of such plans) under title XIX of the  
10 Social Security Act (42 U.S.C. 1396 et seq.), or State  
11 child health plans (or waivers of such plans) under title  
12 XXI of such Act (42 U.S.C. 1397aa et seq.), including  
13 a description of best practices for—

- 14 (1) expanding access to such services;  
15 (2) expanding access to such services in under-  
16 served communities;  
17 (3) flexibilities that States may offer for pedi-  
18 atric hospitals and other pediatric behavioral health  
19 providers to expand access to services; and  
20 (4) recruitment and retention of providers of  
21 such services.

22 **SEC. 504. ENSURING CHILDREN RECEIVE TIMELY ACCESS**  
23 **TO CARE.**

24 (a) GUIDANCE TO STATES ON FLEXIBILITIES TO EN-  
25 SURE PROVIDER CAPACITY TO PROVIDE PEDIATRIC BE-  
26 HAVIORAL HEALTH, INCLUDING MENTAL HEALTH, CRI-

1 SIS CARE.—Not later than 18 months after the date of  
2 enactment of this Act, the Secretary of Health and  
3 Human Services shall provide guidance to States on exist-  
4 ing flexibilities under State plans (or waivers of such  
5 plans) under title XIX of the Social Security Act (42  
6 U.S.C. 1396 et seq.), or State child health plans under  
7 title XXI of such Act (42 U.S.C. 1397aa et seq.), to sup-  
8 port children experiencing a behavioral health crisis or in  
9 need of intensive behavioral health, including mental  
10 health, services.

11 (b) ENSURING CONSISTENT REVIEW AND STATE IM-  
12 PLEMENTATION OF EARLY AND PERIODIC SCREENING,  
13 DIAGNOSTIC, AND TREATMENT SERVICES.—Section  
14 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))  
15 is amended by adding at the end the following: “Not later  
16 than January 1, 2025, and every 5 years thereafter, the  
17 Secretary shall review implementation of the requirements  
18 of this subsection by States, including such requirements  
19 relating to services provided by managed care organiza-  
20 tions, prepaid inpatient health plans, prepaid ambulatory  
21 health plans, and primary care case managers, to identify  
22 and disseminate best practices for ensuring comprehensive  
23 coverage of services, to identify gaps and deficiencies in  
24 meeting Federal requirements, and to provide guidance to  
25 States on addressing identified gaps and disparities and

1 meeting Federal coverage requirements in order to ensure  
2 children have access to health services.”.

3 **SEC. 505. STRATEGIES TO INCREASE ACCESS TO TELE-**  
4 **HEALTH UNDER MEDICAID AND CHIP.**

5 Not later than 1 year after the date of the enactment  
6 of this Act, and in the event updates are available, once  
7 every five years thereafter, the Secretary of Health and  
8 Human Services shall update guidance issued by the Cen-  
9 ters for Medicare & Medicaid Services to States, the State  
10 Medicaid & CHIP Telehealth Toolkit, or any successor  
11 guidance, to describe strategies States may use to over-  
12 come existing barriers and increase access to telehealth  
13 services under the Medicaid program under title XIX of  
14 the Social Security Act (42 U.S.C. 1396 et seq.) and the  
15 Children’s Health Insurance Program under title XXI of  
16 such Act (42 U.S.C. 1397aa et seq.). Such updated guid-  
17 ance shall include examples of and promising practices re-  
18 garding—

- 19 (1) telehealth delivery of covered services;
- 20 (2) recommended voluntary billing codes, modi-  
21 fiers, and place-of-service designations for telehealth  
22 and other virtual health care services;
- 23 (3) strategies States can use for the simplifica-  
24 tion or alignment of provider credentialing and en-  
25 rollment protocols with respect to telehealth across

1 States, State Medicaid plans under title XIX, State  
 2 child health plans under title XXI, Medicaid man-  
 3 aged care organizations, prepaid inpatient health  
 4 plans, prepaid ambulatory health plans, and primary  
 5 care case managers, including during national public  
 6 health emergencies; and

7 (4) strategies States can use to integrate tele-  
 8 health and other virtual health care services into  
 9 value-based health care models.

10 **SEC. 506. REMOVAL OF LIMITATIONS ON FEDERAL FINAN-**  
 11 **CIAL PARTICIPATION FOR INMATES WHO ARE**  
 12 **ELIGIBLE JUVENILES PENDING DISPOSITION**  
 13 **OF CHARGES.**

14 (a) MEDICAID.—

15 (1) IN GENERAL.—The subdivision (A) of sec-  
 16 tion 1905(a) of the Social Security Act (42 U.S.C.  
 17 1396d(a)) following paragraph (31) of such section,  
 18 as amended by section 501(b), is further amended  
 19 by inserting “, or, at the option of the State, for an  
 20 individual who is an eligible juvenile (as defined in  
 21 section 1902(nn)(2)), while such individual is an in-  
 22 mate of a public institution (as defined in section  
 23 1902(nn)(3)) pending disposition of charges” after  
 24 “or in the case of an eligible juvenile described in  
 25 section 1902(a)(84)(D) with respect to the

1 screenings, diagnostic services, referrals, and case  
2 management required under such subparagraph  
3 (D)”.  
4

5 (2) CONFORMING.—Section 1902(a)(84)(A) of  
6 the Social Security Act (42 U.S.C. 1396a(a)(84)(A))  
7 is amended by inserting “(or in the case of a State  
8 electing the option described in the subdivision (A)  
9 following paragraph (31) of section 1905(a), during  
10 such period beginning after the disposition of  
11 charges with respect to such individual)” after “is  
12 such an inmate”.

13 (b) CHIP.—Section 2110(b)(7) of the Social Security  
14 Act (42 U.S.C. 13977jj(b)(7)), as added by section  
15 501(c)(2)(B), is further amended by inserting “or, at the  
16 option of the State, for an individual who is a juvenile,  
17 while such individual is an inmate of a public institution  
18 pending disposition of charges” after “if such child is an  
19 eligible juvenile (as described in section 1902(a)(84)(D))  
20 with respect to screenings, diagnostic services, referrals,  
21 and case management otherwise covered under the State  
22 child health plan (or waiver of such plan)”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall take effect on the first day of the first  
25 calendar quarter that begins after the date that is 18  
months after the date of enactment of this Act and shall

1 apply to items and services furnished for periods beginning  
2 on or after such date.

3       **TITLE VI—MISCELLANEOUS**  
4                               **PROVISIONS**

5       **SEC. 601. DETERMINATION OF BUDGETARY EFFECTS.**

6           The budgetary effects of this Act, for the purpose of  
7 complying with the Statutory Pay-As-You-Go Act of 2010,  
8 shall be determined by reference to the latest statement  
9 titled “Budgetary Effects of PAYGO Legislation” for this  
10 Act, submitted for printing in the Congressional Record  
11 by the Chairman of the House Budget Committee, pro-  
12 vided that such statement has been submitted prior to the  
13 vote on passage.

14       **SEC. 602. OVERSIGHT OF PHARMACY BENEFIT MANAGER**  
15                               **SERVICES.**

16           (a) PHSA.—Title XXVII of the Public Health Serv-  
17 ice Act (42 U.S.C. 300gg et seq.) is amended—

18                       (1) in part D (42 U.S.C. 300gg–111 et seq.),  
19           by adding at the end the following new section:

20       **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFIT MAN-**  
21                               **AGER SERVICES.**

22           “(a) IN GENERAL.—For plan years beginning on or  
23 after January 1, 2024, a group health plan or health in-  
24 surance issuer offering group health insurance coverage  
25 or an entity or subsidiary providing pharmacy benefits

1 management services on behalf of such a plan or issuer  
2 shall not enter into a contract with a drug manufacturer,  
3 distributor, wholesaler, subcontractor, rebate aggregator,  
4 or any associated third party that limits the disclosure of  
5 information to plan sponsors in such a manner that pre-  
6 vents the plan or issuer, or an entity or subsidiary pro-  
7 viding pharmacy benefits management services on behalf  
8 of a plan or issuer, from making the reports described in  
9 subsection (b).

10 “(b) REPORTS.—

11 “(1) IN GENERAL.—For plan years beginning  
12 on or after January 1, 2024, not less frequently  
13 than once every 6 months, a health insurance issuer  
14 offering group health insurance coverage or an enti-  
15 ty providing pharmacy benefits management services  
16 on behalf of a group health plan or an issuer pro-  
17 viding group health insurance coverage shall submit  
18 to the plan sponsor (as defined in section 3(16)(B)  
19 of the Employee Retirement Income Security Act of  
20 1974) of such group health plan or health insurance  
21 coverage a report in accordance with this subsection  
22 and make such report available to the plan sponsor  
23 in a machine-readable format. Each such report  
24 shall include, with respect to the applicable group  
25 health plan or health insurance coverage—

1           “(A) as applicable, information collected  
2           from drug manufacturers by such issuer or en-  
3           tity on the total amount of copayment assist-  
4           ance dollars paid, or copayment cards applied,  
5           that were funded by the drug manufacturer  
6           with respect to the participants and bene-  
7           ficiaries in such plan or coverage;

8           “(B) a list of each drug covered by such  
9           plan, issuer, or entity providing pharmacy ben-  
10          efit management services that was dispensed  
11          during the reporting period, including, with re-  
12          spect to each such drug during the reporting  
13          period—

14               “(i) the brand name, chemical entity,  
15               and National Drug Code;

16               “(ii) the number of participants and  
17               beneficiaries for whom the drug was filled  
18               during the plan year, the total number of  
19               prescription fills for the drug (including  
20               original prescriptions and refills), and the  
21               total number of dosage units of the drug  
22               dispensed across the plan year, including  
23               whether the dispensing channel was by re-  
24               tail, mail order, or specialty pharmacy;

1           “(iii) the wholesale acquisition cost,  
2 listed as cost per days supply and cost per  
3 pill, or in the case of a drug in another  
4 form, per dose;

5           “(iv) the total out-of-pocket spending  
6 by participants and beneficiaries on such  
7 drug, including participant and beneficiary  
8 spending through copayments, coinsurance,  
9 and deductibles; and

10          “(v) for any drug for which gross  
11 spending of the group health plan or  
12 health insurance coverage exceeded  
13 \$10,000 during the reporting period—

14           “(I) a list of all other drugs in  
15 the same therapeutic category or  
16 class, including brand name drugs  
17 and biological products and generic  
18 drugs or biosimilar biological products  
19 that are in the same therapeutic cat-  
20 egory or class as such drug; and

21           “(II) the rationale for preferred  
22 formulary placement of such drug in  
23 that therapeutic category or class, if  
24 applicable;

1           “(C) a list of each therapeutic category or  
2           class of drugs that were dispensed under the  
3           health plan or health insurance coverage during  
4           the reporting period, and, with respect to each  
5           such therapeutic category or class of drugs,  
6           during the reporting period—

7                   “(i) total gross spending by the plan,  
8                   before manufacturer rebates, fees, or other  
9                   manufacturer remuneration;

10                  “(ii) the number of participants and  
11                  beneficiaries who filled a prescription for a  
12                  drug in that category or class;

13                  “(iii) if applicable to that category or  
14                  class, a description of the formulary tiers  
15                  and utilization mechanisms (such as prior  
16                  authorization or step therapy) employed  
17                  for drugs in that category or class;

18                  “(iv) the total out-of-pocket spending  
19                  by participants and beneficiaries, including  
20                  participant and beneficiary spending  
21                  through copayments, coinsurance, and  
22                  deductibles; and

23                  “(v) for each therapeutic category or  
24                  class under which 3 or more drugs are in-

1           cluded on the formulary of such plan or  
2           coverage—

3                   “(I) the amount received, or ex-  
4                   pected to be received, from drug man-  
5                   ufacturers in rebates, fees, alternative  
6                   discounts, or other remuneration—

7                           “(aa) that has been paid, or  
8                           is to be paid, by drug manufac-  
9                           turers for claims incurred during  
10                          the reporting period; or

11                           “(bb) that is related to utili-  
12                          zation of drugs, in such thera-  
13                          peutic category or class;

14                   “(II) the total net spending, after  
15                   deducting rebates, price concessions,  
16                   alternative discounts or other remu-  
17                   neration from drug manufacturers, by  
18                   the health plan or health insurance  
19                   coverage on that category or class of  
20                   drugs; and

21                           “(III) the net price per course of  
22                          treatment or single fill, such as a 30-  
23                          day supply or 90-day supply, incurred  
24                          by the health plan or health insurance  
25                          coverage and its participants and

1 beneficiaries, after manufacturer re-  
2 bates, fees, and other remuneration  
3 for drugs dispensed within such thera-  
4 peutic category or class during the re-  
5 porting period;

6 “(D) total gross spending on prescription  
7 drugs by the plan or coverage during the re-  
8 porting period, before rebates and other manu-  
9 facturer fees or remuneration;

10 “(E) total amount received, or expected to  
11 be received, by the health plan or health insur-  
12 ance coverage in drug manufacturer rebates,  
13 fees, alternative discounts, and all other remu-  
14 nation received from the manufacturer or any  
15 third party, other than the plan sponsor, re-  
16 lated to utilization of drug or drug spending  
17 under that health plan or health insurance cov-  
18 erage during the reporting period;

19 “(F) the total net spending on prescription  
20 drugs by the health plan or health insurance  
21 coverage during the reporting period; and

22 “(G) amounts paid directly or indirectly in  
23 rebates, fees, or any other type of remuneration  
24 to brokers, consultants, advisors, or any other  
25 individual or firm who referred the group health

1           plan’s or health insurance issuer’s business to  
2           the pharmacy benefit manager.

3           “(2) PRIVACY REQUIREMENTS.—Health insur-  
4           ance issuers offering group health insurance cov-  
5           erage and entities providing pharmacy benefits man-  
6           agement services on behalf of a group health plan  
7           shall provide information under paragraph (1) in a  
8           manner consistent with the privacy, security, and  
9           breach notification regulations promulgated under  
10          section 264(c) of the Health Insurance Portability  
11          and Accountability Act of 1996, and shall restrict  
12          the use and disclosure of such information according  
13          to such privacy regulations.

14          “(3) DISCLOSURE AND REDISCLOSURE.—

15                 “(A) LIMITATION TO BUSINESS ASSOCI-  
16                 ATES.—A group health plan receiving a report  
17                 under paragraph (1) may disclose such informa-  
18                 tion only to business associates of such plan as  
19                 defined in section 160.103 of title 45, Code of  
20                 Federal Regulations (or successor regulations).

21                 “(B) CLARIFICATION REGARDING PUBLIC  
22                 DISCLOSURE OF INFORMATION.—Nothing in  
23                 this section prevents a health insurance issuer  
24                 offering group health insurance coverage or an  
25                 entity providing pharmacy benefits management

1 services on behalf of a group health plan from  
2 placing reasonable restrictions on the public dis-  
3 closure of the information contained in a report  
4 described in paragraph (1), except that such  
5 issuer or entity may not restrict disclosure of  
6 such report to the Department of Health and  
7 Human Services, the Department of Labor, the  
8 Department of the Treasury, or applicable  
9 State agencies.

10 “(C) LIMITED FORM OF REPORT.—The  
11 Secretary shall define through rulemaking a  
12 limited form of the report under paragraph (1)  
13 required of plan sponsors who are drug manu-  
14 facturers, drug wholesalers, or other direct par-  
15 ticipants in the drug supply chain, in order to  
16 prevent anti-competitive behavior.

17 “(4) REPORT TO GAO.—A health insurance  
18 issuer offering group health insurance coverage or  
19 an entity providing pharmacy benefits management  
20 services on behalf of a group health plan shall sub-  
21 mit to the Comptroller General of the United States  
22 each of the first 4 reports submitted to a plan spon-  
23 sor under paragraph (1) with respect to such cov-  
24 erage or plan, and other such reports as requested,  
25 in accordance with the privacy requirements under

1 paragraph (2), the disclosure and redisclosure stand-  
2 ards under paragraph (3), the standards specified  
3 pursuant to paragraph (5), and such other informa-  
4 tion that the Comptroller General determines nec-  
5 essary to carry out the study under section 602(d)  
6 of the Restoring Hope for Mental Health and Well-  
7 Being Act of 2022.

8 “(5) STANDARD FORMAT.—Not later than June  
9 1, 2023, the Secretary shall specify through rule-  
10 making standards for health insurance issuers and  
11 entities required to submit reports under paragraph  
12 (4) to submit such reports in a standard format.

13 “(c) ENFORCEMENT.—

14 “(1) IN GENERAL.—The Secretary, in consulta-  
15 tion with the Secretary of Labor and the Secretary  
16 of the Treasury, shall enforce this section.

17 “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
18 TION.—A health insurance issuer or an entity pro-  
19 viding pharmacy benefit management services that  
20 violates subsection (a) or fails to provide information  
21 required under subsection (b), or a drug manufac-  
22 turer that fails to provide information under sub-  
23 section (b)(1)(A) in a timely manner, shall be sub-  
24 ject to a civil monetary penalty in the amount of  
25 \$10,000 for each day during which such violation

1 continues or such information is not disclosed or re-  
2 ported.

3 “(3) FALSE INFORMATION.—A health insurance  
4 issuer, entity providing pharmacy benefit manage-  
5 ment services, or drug manufacturer that knowingly  
6 provides false information under this section shall be  
7 subject to a civil money penalty in an amount not  
8 to exceed \$100,000 for each item of false informa-  
9 tion. Such civil money penalty shall be in addition to  
10 other penalties as may be prescribed by law.

11 “(4) PROCEDURE.—The provisions of section  
12 1128A of the Social Security Act, other than sub-  
13 section (a) and (b) and the first sentence of sub-  
14 section (c)(1) of such section shall apply to civil  
15 monetary penalties under this subsection in the  
16 same manner as such provisions apply to a penalty  
17 or proceeding under section 1128A of the Social Se-  
18 curity Act.

19 “(5) WAIVERS.—The Secretary may waive pen-  
20 alties under paragraph (2), or extend the period of  
21 time for compliance with a requirement of this sec-  
22 tion, for an entity in violation of this section that  
23 has made a good-faith effort to comply with this sec-  
24 tion.

1       “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
 2       tion shall be construed to permit a health insurance issuer,  
 3       group health plan, or other entity to restrict disclosure to,  
 4       or otherwise limit the access of, the Department of Health  
 5       and Human Services to a report described in subsection  
 6       (b)(1) or information related to compliance with sub-  
 7       section (a) by such issuer, plan, or entity.

8       “(e) DEFINITION.—In this section, the term ‘whole-  
 9       sale acquisition cost’ has the meaning given such term in  
 10       section 1847A(c)(6)(B) of the Social Security Act.”; and

11               (2) in section 2723 (42 U.S.C. 300gg–22)—

12                       (A) in subsection (a)—

13                               (i) in paragraph (1), by inserting  
 14                               “(other than subsections (a) and (b) of  
 15                               section 2799A–11)” after “part D”; and

16                               (ii) in paragraph (2), by inserting  
 17                               “(other than subsections (a) and (b) of  
 18                               section 2799A–11)” after “part D”; and

19                       (B) in subsection (b)—

20                               (i) in paragraph (1), by inserting  
 21                               “(other than subsections (a) and (b) of  
 22                               section 2799A–11)” after “part D”;

23                               (ii) in paragraph (2)(A), by inserting  
 24                               “(other than subsections (a) and (b) of  
 25                               section 2799A–11)” after “part D”; and

1 (iii) in paragraph (2)(C)(ii), by insert-  
2 ing “(other than subsections (a) and (b) of  
3 section 2799A–11)” after “part D”.

4 (b) ERISA.—

5 (1) IN GENERAL.—Subtitle B of title I of the  
6 Employee Retirement Income Security Act of 1974  
7 (29 U.S.C. 1021 et seq.) is amended—

8 (A) in subpart B of part 7 (29 U.S.C.  
9 1185 et seq.), by adding at the end the fol-  
10 lowing:

11 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFIT MANAGER**  
12 **SERVICES.**

13 “(a) IN GENERAL.—For plan years beginning on or  
14 after January 1, 2024, a group health plan (or health in-  
15 surance issuer offering group health insurance coverage  
16 in connection with such a plan) or an entity or subsidiary  
17 providing pharmacy benefits management services on be-  
18 half of such a plan or issuer shall not enter into a contract  
19 with a drug manufacturer, distributor, wholesaler, subcon-  
20 tractor, rebate aggregator, or any associated third party  
21 that limits the disclosure of information to plan sponsors  
22 in such a manner that prevents the plan or issuer, or an  
23 entity or subsidiary providing pharmacy benefits manage-  
24 ment services on behalf of a plan or issuer, from making  
25 the reports described in subsection (b).

1 “(b) REPORTS.—

2 “(1) IN GENERAL.—For plan years beginning  
3 on or after January 1, 2024, not less frequently  
4 than once every 6 months, a health insurance issuer  
5 offering group health insurance coverage or an enti-  
6 ty providing pharmacy benefits management services  
7 on behalf of a group health plan or an issuer pro-  
8 viding group health insurance coverage shall submit  
9 to the plan sponsor (as defined in section 3(16)(B))  
10 of such group health plan or group health insurance  
11 coverage a report in accordance with this subsection  
12 and make such report available to the plan sponsor  
13 in a machine-readable format. Each such report  
14 shall include, with respect to the applicable group  
15 health plan or health insurance coverage—

16 “(A) as applicable, information collected  
17 from drug manufacturers by such issuer or en-  
18 tity on the total amount of copayment assist-  
19 ance dollars paid, or copayment cards applied,  
20 that were funded by the drug manufacturer  
21 with respect to the participants and bene-  
22 ficiaries in such plan or coverage;

23 “(B) a list of each drug covered by such  
24 plan, issuer, or entity providing pharmacy ben-  
25 efit management services that was dispensed

1 during the reporting period, including, with re-  
2 spect to each such drug during the reporting  
3 period—

4 “(i) the brand name, chemical entity,  
5 and National Drug Code;

6 “(ii) the number of participants and  
7 beneficiaries for whom the drug was filled  
8 during the plan year, the total number of  
9 prescription fills for the drug (including  
10 original prescriptions and refills), and the  
11 total number of dosage units of the drug  
12 dispensed across the plan year, including  
13 whether the dispensing channel was by re-  
14 tail, mail order, or specialty pharmacy;

15 “(iii) the wholesale acquisition cost,  
16 listed as cost per days supply and cost per  
17 pill, or in the case of a drug in another  
18 form, per dose;

19 “(iv) the total out-of-pocket spending  
20 by participants and beneficiaries on such  
21 drug, including participant and beneficiary  
22 spending through copayments, coinsurance,  
23 and deductibles; and

24 “(v) for any drug for which gross  
25 spending of the group health plan or

1 health insurance coverage exceeded  
2 \$10,000 during the reporting period—

3 “(I) a list of all other drugs in  
4 the same therapeutic category or  
5 class, including brand name drugs  
6 and biological products and generic  
7 drugs or biosimilar biological products  
8 that are in the same therapeutic cat-  
9 egory or class as such drug; and

10 “(II) the rationale for preferred  
11 formulary placement of such drug in  
12 that therapeutic category or class, if  
13 applicable;

14 “(C) a list of each therapeutic category or  
15 class of drugs that were dispensed under the  
16 health plan or health insurance coverage during  
17 the reporting period, and, with respect to each  
18 such therapeutic category or class of drugs,  
19 during the reporting period—

20 “(i) total gross spending by the plan,  
21 before manufacturer rebates, fees, or other  
22 manufacturer remuneration;

23 “(ii) the number of participants and  
24 beneficiaries who filled a prescription for a  
25 drug in that category or class;

1 “(iii) if applicable to that category or  
2 class, a description of the formulary tiers  
3 and utilization mechanisms (such as prior  
4 authorization or step therapy) employed  
5 for drugs in that category or class;

6 “(iv) the total out-of-pocket spending  
7 by participants and beneficiaries, including  
8 participant and beneficiary spending  
9 through copayments, coinsurance, and  
10 deductibles; and

11 “(v) for each therapeutic category or  
12 class under which 3 or more drugs are in-  
13 cluded on the formulary of such plan or  
14 coverage—

15 “(I) the amount received, or ex-  
16 pected to be received, from drug man-  
17 ufacturers in rebates, fees, alternative  
18 discounts, or other remuneration—

19 “(aa) that has been paid, or  
20 is to be paid, by drug manufac-  
21 turers for claims incurred during  
22 the reporting period; or

23 “(bb) that is related to utili-  
24 zation of drugs, in such thera-  
25 peutic category or class;

1                   “(II) the total net spending, after  
2                   deducting rebates, price concessions,  
3                   alternative discounts or other remuneration from drug manufacturers, by  
4                   the health plan or health insurance  
5                   coverage on that category or class of  
6                   drugs; and

8                   “(III) the net price per course of  
9                   treatment or single fill, such as a 30-  
10                  day supply or 90-day supply, incurred  
11                  by the health plan or health insurance  
12                  coverage and its participants and  
13                  beneficiaries, after manufacturer rebates, fees, and other remuneration  
14                  for drugs dispensed within such therapeutic category or class during the reporting period;

15                  “(D) total gross spending on prescription  
16                  drugs by the plan or coverage during the reporting period, before rebates and other manufacturer fees or remuneration;

17                  “(E) total amount received, or expected to  
18                  be received, by the health plan or health insurance coverage in drug manufacturer rebates,  
19                  fees, alternative discounts, and all other remuneration;

1           neration received from the manufacturer or any  
2           third party, other than the plan sponsor, re-  
3           lated to utilization of drug or drug spending  
4           under that health plan or health insurance cov-  
5           erage during the reporting period;

6           “(F) the total net spending on prescription  
7           drugs by the health plan or health insurance  
8           coverage during the reporting period; and

9           “(G) amounts paid directly or indirectly in  
10          rebates, fees, or any other type of remuneration  
11          to brokers, consultants, advisors, or any other  
12          individual or firm who referred the group health  
13          plan’s or health insurance issuer’s business to  
14          the pharmacy benefit manager.

15          “(2) PRIVACY REQUIREMENTS.—Health insur-  
16          ance issuers offering group health insurance cov-  
17          erage and entities providing pharmacy benefits man-  
18          agement services on behalf of a group health plan  
19          shall provide information under paragraph (1) in a  
20          manner consistent with the privacy, security, and  
21          breach notification regulations promulgated under  
22          section 264(c) of the Health Insurance Portability  
23          and Accountability Act of 1996, and shall restrict  
24          the use and disclosure of such information according  
25          to such privacy regulations.

1 “(3) DISCLOSURE AND REDISCLOSURE.—

2 “(A) LIMITATION TO BUSINESS ASSOCI-  
3 ATES.—A group health plan receiving a report  
4 under paragraph (1) may disclose such informa-  
5 tion only to business associates of such plan as  
6 defined in section 160.103 of title 45, Code of  
7 Federal Regulations (or successor regulations).

8 “(B) CLARIFICATION REGARDING PUBLIC  
9 DISCLOSURE OF INFORMATION.—Nothing in  
10 this section prevents a health insurance issuer  
11 offering group health insurance coverage or an  
12 entity providing pharmacy benefits management  
13 services on behalf of a group health plan from  
14 placing reasonable restrictions on the public dis-  
15 closure of the information contained in a report  
16 described in paragraph (1), except that such  
17 issuer or entity may not restrict disclosure of  
18 such report to the Department of Health and  
19 Human Services, the Department of Labor, the  
20 Department of the Treasury, or applicable  
21 State agencies.

22 “(C) LIMITED FORM OF REPORT.—The  
23 Secretary shall define through rulemaking a  
24 limited form of the report under paragraph (1)  
25 required of plan sponsors who are drug manu-

1           facturers, drug wholesalers, or other direct par-  
2           ticipants in the drug supply chain, in order to  
3           prevent anti-competitive behavior.

4           “(4) REPORT TO GAO.—A health insurance  
5           issuer offering group health insurance coverage or  
6           an entity providing pharmacy benefits management  
7           services on behalf of a group health plan shall sub-  
8           mit to the Comptroller General of the United States  
9           each of the first 4 reports submitted to a plan spon-  
10          sor under paragraph (1) with respect to such cov-  
11          erage or plan, and other such reports as requested,  
12          in accordance with the privacy requirements under  
13          paragraph (2), the disclosure and redisclosure stand-  
14          ards under paragraph (3), the standards specified  
15          pursuant to paragraph (5), and such other informa-  
16          tion that the Comptroller General determines nec-  
17          essary to carry out the study under section 602(d)  
18          of the Restoring Hope for Mental Health and Well-  
19          Being Act of 2022.

20          “(5) STANDARD FORMAT.—Not later than June  
21          1, 2023, the Secretary shall specify through rule-  
22          making standards for health insurance issuers and  
23          entities required to submit reports under paragraph  
24          (4) to submit such reports in a standard format.

25          “(c) ENFORCEMENT.—

1           “(1) IN GENERAL.—The Secretary, in consulta-  
2           tion with the Secretary of Health and Human Serv-  
3           ices and the Secretary of the Treasury, shall enforce  
4           this section.

5           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
6           TION.—A health insurance issuer or an entity pro-  
7           viding pharmacy benefit management services that  
8           violates subsection (a) or fails to provide information  
9           required under subsection (b), or a drug manufac-  
10          turer that fails to provide information under sub-  
11          section (b)(1)(A) in a timely manner, shall be sub-  
12          ject to a civil monetary penalty in the amount of  
13          \$10,000 for each day during which such violation  
14          continues or such information is not disclosed or re-  
15          ported.

16          “(3) FALSE INFORMATION.—A health insurance  
17          issuer, entity providing pharmacy benefit manage-  
18          ment services, or drug manufacturer that knowingly  
19          provides false information under this section shall be  
20          subject to a civil money penalty in an amount not  
21          to exceed \$100,000 for each item of false informa-  
22          tion. Such civil money penalty shall be in addition to  
23          other penalties as may be prescribed by law.

24          “(4) PROCEDURE.—The provisions of section  
25          1128A of the Social Security Act, other than sub-

1 section (a) and (b) and the first sentence of sub-  
2 section (c)(1) of such section shall apply to civil  
3 monetary penalties under this subsection in the  
4 same manner as such provisions apply to a penalty  
5 or proceeding under section 1128A of the Social Se-  
6 curity Act.

7 “(5) WAIVERS.—The Secretary may waive pen-  
8 alties under paragraph (2), or extend the period of  
9 time for compliance with a requirement of this sec-  
10 tion, for an entity in violation of this section that  
11 has made a good-faith effort to comply with this sec-  
12 tion.

13 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
14 tion shall be construed to permit a health insurance issuer,  
15 group health plan, or other entity to restrict disclosure to,  
16 or otherwise limit the access of, the Department of Labor  
17 to a report described in subsection (b)(1) or information  
18 related to compliance with subsection (a) by such issuer,  
19 plan, or entity.

20 “(e) DEFINITION.—In this section, the term ‘whole-  
21 sale acquisition cost’ has the meaning given such term in  
22 section 1847A(c)(6)(B) of the Social Security Act.”; and

23 (B) in section 502(b)(3) (29 U.S.C.  
24 1132(b)(3)), by inserting “(other than section  
25 726)” after “part 7”.

1           (2) CLERICAL AMENDMENT.—The table of con-  
2           tents in section 1 of the Employee Retirement In-  
3           come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
4           is amended by inserting after the item relating to  
5           section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefit manager services.”.

6           (c) IRC.—

7           (1) IN GENERAL.—Subchapter B of chapter  
8           100 of the Internal Revenue Code of 1986 is amend-  
9           ed by adding at the end the following:

10   **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER**  
11           **SERVICES.**

12           “(a) IN GENERAL.—For plan years beginning on or  
13   after January 1, 2024, a group health plan or an entity  
14   or subsidiary providing pharmacy benefits management  
15   services on behalf of such a plan shall not enter into a  
16   contract with a drug manufacturer, distributor, whole-  
17   saler, subcontractor, rebate aggregator, or any associated  
18   third party that limits the disclosure of information to  
19   plan sponsors in such a manner that prevents the plan,  
20   or an entity or subsidiary providing pharmacy benefits  
21   management services on behalf of a plan, from making  
22   the reports described in subsection (b).

23           “(b) REPORTS.—

24           “(1) IN GENERAL.—For plan years beginning  
25   on or after January 1, 2024, not less frequently

1       than once every 6 months, an entity providing phar-  
2       macy benefits management services on behalf of a  
3       group health plan shall submit to the plan sponsor  
4       (as defined in section 3(16)(B) of the Employee Re-  
5       tirement Income Security Act of 1974) of such  
6       group health plan a report in accordance with this  
7       subsection and make such report available to the  
8       plan sponsor in a machine-readable format. Each  
9       such report shall include, with respect to the applica-  
10      ble group health plan—

11               “(A) as applicable, information collected  
12              from drug manufacturers by such entity on the  
13              total amount of copayment assistance dollars  
14              paid, or copayment cards applied, that were  
15              funded by the drug manufacturer with respect  
16              to the participants and beneficiaries in such  
17              plan;

18               “(B) a list of each drug covered by such  
19              plan or entity providing pharmacy benefit man-  
20              agement services that was dispensed during the  
21              reporting period, including, with respect to each  
22              such drug during the reporting period—

23                      “(i) the brand name, chemical entity,  
24                      and National Drug Code;

1           “(ii) the number of participants and  
2           beneficiaries for whom the drug was filled  
3           during the plan year, the total number of  
4           prescription fills for the drug (including  
5           original prescriptions and refills), and the  
6           total number of dosage units of the drug  
7           dispensed across the plan year, including  
8           whether the dispensing channel was by re-  
9           tail, mail order, or specialty pharmacy;

10           “(iii) the wholesale acquisition cost,  
11           listed as cost per days supply and cost per  
12           pill, or in the case of a drug in another  
13           form, per dose;

14           “(iv) the total out-of-pocket spending  
15           by participants and beneficiaries on such  
16           drug, including participant and beneficiary  
17           spending through copayments, coinsurance,  
18           and deductibles; and

19           “(v) for any drug for which gross  
20           spending of the group health plan exceeded  
21           \$10,000 during the reporting period—

22                   “(I) a list of all other drugs in  
23                   the same therapeutic category or  
24                   class, including brand name drugs  
25                   and biological products and generic

1 drugs or biosimilar biological products  
2 that are in the same therapeutic cat-  
3 egory or class as such drug; and

4 “(II) the rationale for preferred  
5 formulary placement of such drug in  
6 that therapeutic category or class, if  
7 applicable;

8 “(C) a list of each therapeutic category or  
9 class of drugs that were dispensed under the  
10 health plan during the reporting period, and,  
11 with respect to each such therapeutic category  
12 or class of drugs, during the reporting period—

13 “(i) total gross spending by the plan,  
14 before manufacturer rebates, fees, or other  
15 manufacturer remuneration;

16 “(ii) the number of participants and  
17 beneficiaries who filled a prescription for a  
18 drug in that category or class;

19 “(iii) if applicable to that category or  
20 class, a description of the formulary tiers  
21 and utilization mechanisms (such as prior  
22 authorization or step therapy) employed  
23 for drugs in that category or class;

24 “(iv) the total out-of-pocket spending  
25 by participants and beneficiaries, including

1 participant and beneficiary spending  
2 through copayments, coinsurance, and  
3 deductibles; and

4 “(v) for each therapeutic category or  
5 class under which 3 or more drugs are in-  
6 cluded on the formulary of such plan—

7 “(I) the amount received, or ex-  
8 pected to be received, from drug man-  
9 ufacturers in rebates, fees, alternative  
10 discounts, or other remuneration—

11 “(aa) that has been paid, or  
12 is to be paid, by drug manufac-  
13 turers for claims incurred during  
14 the reporting period; or

15 “(bb) that is related to utili-  
16 zation of drugs, in such thera-  
17 peutic category or class;

18 “(II) the total net spending, after  
19 deducting rebates, price concessions,  
20 alternative discounts or other remu-  
21 nation from drug manufacturers, by  
22 the health plan on that category or  
23 class of drugs; and

24 “(III) the net price per course of  
25 treatment or single fill, such as a 30-

1 day supply or 90-day supply, incurred  
2 by the health plan and its participants  
3 and beneficiaries, after manufacturer  
4 rebates, fees, and other remuneration  
5 for drugs dispensed within such thera-  
6 peutic category or class during the re-  
7 porting period;

8 “(D) total gross spending on prescription  
9 drugs by the plan during the reporting period,  
10 before rebates and other manufacturer fees or  
11 remuneration;

12 “(E) total amount received, or expected to  
13 be received, by the health plan in drug manu-  
14 facturer rebates, fees, alternative discounts, and  
15 all other remuneration received from the manu-  
16 facturer or any third party, other than the plan  
17 sponsor, related to utilization of drug or drug  
18 spending under that health plan during the re-  
19 porting period;

20 “(F) the total net spending on prescription  
21 drugs by the health plan during the reporting  
22 period; and

23 “(G) amounts paid directly or indirectly in  
24 rebates, fees, or any other type of remuneration  
25 to brokers, consultants, advisors, or any other

1 individual or firm who referred the group health  
2 plan's business to the pharmacy benefit man-  
3 ager.

4 “(2) PRIVACY REQUIREMENTS.—Entities pro-  
5 viding pharmacy benefits management services on  
6 behalf of a group health plan shall provide informa-  
7 tion under paragraph (1) in a manner consistent  
8 with the privacy, security, and breach notification  
9 regulations promulgated under section 264(c) of the  
10 Health Insurance Portability and Accountability Act  
11 of 1996, and shall restrict the use and disclosure of  
12 such information according to such privacy regula-  
13 tions.

14 “(3) DISCLOSURE AND REDISCLOSURE.—

15 “(A) LIMITATION TO BUSINESS ASSOCI-  
16 ATES.—A group health plan receiving a report  
17 under paragraph (1) may disclose such informa-  
18 tion only to business associates of such plan as  
19 defined in section 160.103 of title 45, Code of  
20 Federal Regulations (or successor regulations).

21 “(B) CLARIFICATION REGARDING PUBLIC  
22 DISCLOSURE OF INFORMATION.—Nothing in  
23 this section prevents an entity providing phar-  
24 macy benefits management services on behalf of  
25 a group health plan from placing reasonable re-

1            restrictions on the public disclosure of the infor-  
2            mation contained in a report described in para-  
3            graph (1), except that such entity may not re-  
4            strict disclosure of such report to the Depart-  
5            ment of Health and Human Services, the De-  
6            partment of Labor, the Department of the  
7            Treasury, or applicable State agencies.

8            “(C) LIMITED FORM OF REPORT.—The  
9            Secretary shall define through rulemaking a  
10          limited form of the report under paragraph (1)  
11          required of plan sponsors who are drug manu-  
12          facturers, drug wholesalers, or other direct par-  
13          ticipants in the drug supply chain, in order to  
14          prevent anti-competitive behavior.

15          “(4) REPORT TO GAO.—An entity providing  
16          pharmacy benefits management services on behalf of  
17          a group health plan shall submit to the Comptroller  
18          General of the United States each of the first 4 re-  
19          ports submitted to a plan sponsor under paragraph  
20          (1) with respect to such plan, and other such reports  
21          as requested, in accordance with the privacy require-  
22          ments under paragraph (2), the disclosure and re-  
23          disclosure standards under paragraph (3), the stand-  
24          ards specified pursuant to paragraph (5), and such  
25          other information that the Comptroller General de-

1 termines necessary to carry out the study under sec-  
2 tion 602(d) of the Restoring Hope for Mental  
3 Health and Well-Being Act of 2022.

4 “(5) STANDARD FORMAT.—Not later than June  
5 1, 2023, the Secretary shall specify through rule-  
6 making standards for entities required to submit re-  
7 ports under paragraph (4) to submit such reports in  
8 a standard format.

9 “(c) ENFORCEMENT.—

10 “(1) IN GENERAL.—The Secretary, in consulta-  
11 tion with the Secretary of Labor and the Secretary  
12 of Health and Human Services, shall enforce this  
13 section.

14 “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
15 TION.—An entity providing pharmacy benefit man-  
16 agement services that violates subsection (a) or fails  
17 to provide information required under subsection  
18 (b), or a drug manufacturer that fails to provide in-  
19 formation under subsection (b)(1)(A) in a timely  
20 manner, shall be subject to a civil monetary penalty  
21 in the amount of \$10,000 for each day during which  
22 such violation continues or such information is not  
23 disclosed or reported.

24 “(3) FALSE INFORMATION.—An entity pro-  
25 viding pharmacy benefit management services, or

1 drug manufacturer that knowingly provides false in-  
2 formation under this section shall be subject to a  
3 civil money penalty in an amount not to exceed  
4 \$100,000 for each item of false information. Such  
5 civil money penalty shall be in addition to other pen-  
6 alties as may be prescribed by law.

7 “(4) PROCEDURE.—The provisions of section  
8 1128A of the Social Security Act, other than sub-  
9 section (a) and (b) and the first sentence of sub-  
10 section (c)(1) of such section shall apply to civil  
11 monetary penalties under this subsection in the  
12 same manner as such provisions apply to a penalty  
13 or proceeding under section 1128A of the Social Se-  
14 curity Act.

15 “(5) WAIVERS.—The Secretary may waive pen-  
16 alties under paragraph (2), or extend the period of  
17 time for compliance with a requirement of this sec-  
18 tion, for an entity in violation of this section that  
19 has made a good-faith effort to comply with this sec-  
20 tion.

21 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
22 tion shall be construed to permit a group health plan or  
23 other entity to restrict disclosure to, or otherwise limit the  
24 access of, the Department of the Treasury to a report de-

1 scribed in subsection (b)(1) or information related to com-  
 2 pliance with subsection (a) by such plan or entity.

3 “(e) DEFINITION.—In this section, the term ‘whole-  
 4 sale acquisition cost’ has the meaning given such term in  
 5 section 1847A(c)(6)(B) of the Social Security Act.”.

6 (2) CLERICAL AMENDMENT.—The table of sec-  
 7 tions for subchapter B of chapter 100 of the Inter-  
 8 nal Revenue Code of 1986 is amended by adding at  
 9 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefit manager services.”.

10 (d) GAO STUDY.—

11 (1) IN GENERAL.—Not later than 3 years after  
 12 the date of enactment of this Act, the Comptroller  
 13 General of the United States shall submit to Con-  
 14 gress a report on—

15 (A) pharmacy networks of group health  
 16 plans, health insurance issuers, and entities  
 17 providing pharmacy benefit management serv-  
 18 ices under such group health plan or group or  
 19 individual health insurance coverage, including  
 20 networks that have pharmacies that are under  
 21 common ownership (in whole or part) with  
 22 group health plans, health insurance issuers, or  
 23 entities providing pharmacy benefit manage-  
 24 ment services or pharmacy benefit administra-

1           tive services under group health plan or group  
2           or individual health insurance coverage;

3           (B) as it relates to pharmacy networks  
4           that include pharmacies under common owner-  
5           ship described in subparagraph (A)—

6                   (i) whether such networks are de-  
7                   signed to encourage enrollees of a plan or  
8                   coverage to use such pharmacies over other  
9                   network pharmacies for specific services or  
10                  drugs, and if so, the reasons the networks  
11                  give for encouraging use of such phar-  
12                  macies; and

13                  (ii) whether such pharmacies are used  
14                  by enrollees disproportionately more in the  
15                  aggregate or for specific services or drugs  
16                  compared to other network pharmacies;

17           (C) whether group health plans and health  
18           insurance issuers offering group or individual  
19           health insurance coverage have options to elect  
20           different network pricing arrangements in the  
21           marketplace with entities that provide phar-  
22           macy benefit management services, the preva-  
23           lence of electing such different network pricing  
24           arrangements;

1           (D) pharmacy network design parameters  
2           that encourage enrollees in the plan or coverage  
3           to fill prescriptions at mail order, specialty, or  
4           retail pharmacies that are wholly or partially-  
5           owned by that issuer or entity; and

6           (E) the degree to which mail order, spe-  
7           cialty, or retail pharmacies that dispense pre-  
8           scription drugs to an enrollee in a group health  
9           plan or health insurance coverage that are  
10          under common ownership (in whole or part)  
11          with group health plans, health insurance  
12          issuers, or entities providing pharmacy benefit  
13          management services or pharmacy benefit ad-  
14          ministrative services under group health plan or  
15          group or individual health insurance coverage  
16          receive reimbursement that is greater than the  
17          median price charged to the group health plan  
18          or health insurance issuer when the same drug  
19          is dispensed to enrollees in the plan or coverage  
20          by other pharmacies included in the pharmacy  
21          network of that plan, issuer, or entity that are  
22          not wholly or partially owned by the health in-  
23          surance issuer or entity providing pharmacy  
24          benefit management services.

1           (2) REQUIREMENT.—The Comptroller General  
2           of the United States shall ensure that the report  
3           under paragraph (1) does not contain information  
4           that would allow a reader to identify a specific plan  
5           or entity providing pharmacy benefits management  
6           services or otherwise contain commercial or financial  
7           information that is privileged or confidential.

8           (3) DEFINITIONS.—In this subsection, the  
9           terms “group health plan”, “health insurance cov-  
10          erage”, and “health insurance issuer” have the  
11          meanings given such terms in section 2791 of the  
12          Public Health Service Act (42 U.S.C. 300gg–91).

13 **SEC. 603. MEDICARE IMPROVEMENT FUND.**

14          Section 1898(b)(1) of the Social Security Act (42  
15          U.S.C. 1395iii(b)(1)) is amended by striking  
16          “\$5,000,000” and inserting “\$1,029,000,000”.

17 **SEC. 604. LIMITATIONS ON AUTHORITY.**

18          In carrying out any program of the Substance Abuse  
19          and Mental Health Services Administration whose statu-  
20          tory authorization is enacted or amended by this Act, the  
21          Secretary of Health and Human Services shall not allocate  
22          funding, or require award recipients to prioritize, dedicate,  
23          or allocate funding, without consideration of the incidence,  
24          prevalence, or determinants of mental health or substance

- 1 use issues, unless such allocation or requirement is con-
- 2 sistent with statute, regulation, or other Federal law.

Passed the House of Representatives June 22, 2022.

Attest:

*Clerk.*

117TH CONGRESS  
2D SESSION

# H. R. 7666

## AN ACT

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