[Roll No. 280]

YEAS—214

Adams
Aguilar
Allred
Auchincloss
Axne
Barragán
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
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Boyle, Brendan F.
Brown (MD)
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Clark (MA)
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Courtney
Craig
Crist
Crow
Cuellar
Davids (KS)
Davis, Danny K.
Dean
DeFazio
DeGette
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Escobar
Eshoo
Espaillat
Evans
Fletcher
Foster
Frankel, Lois
Gallego
Garamendi
García (IL)
Garcia (TX)
Golden
Gomez
Gonzalez, Vicente
Gottheimer
Green, Al (TX)
Grijalva
Harder (CA)
Hayes
Higgins (NY)
Himes
Horsford
Houlahan
Huffman
Jackson Lee
Jacobs (CA)
Jayapal
Jeffries
Johnson (GA)
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Kelly (IL)
Khanna
Kildee
Kilmer
Kim (NJ)
Kind
Kirkpatrick
Krishnamoorthi
Kuster
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Lee (CA)
Lee (NV)
Leger Fernandez
Levin (CA)
Levin (MI)
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Lowenthal
Luria
Lynch
Malinowski
Maloney, Carolyn B.
Maloney, Sean
Manning
Matsui
McBath
McCollum
McEachin
McGovern
McNerney
Meeks
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Moore (WI)
Morelle
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Mrvan
Murphy (FL)
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O'Halleran
Ocasio-Cortez
Omar
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Pocan
Porter
Pressley
Price (NC)
Quigley
Raskin
Rice (NY)
Ross
Roybal-Allard
Ruiz
Rush
Ryan
Sánchez
Sarbanes
Scanlon
Schakowsky
Schiff
Schneider
Schrader
Schrier
Scott (VA)
Scott, David
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Smith (WA)
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Speier
Stansbury
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Stevens
Strickland
Suozzi
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Thompson (CA)
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Tonko
Torres (CA)
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Vargas
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Velázquez
Wasserman Schultz
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Watson Coleman
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NAYS—202

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Balderson
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Bishop (NC)
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Brady
Buchanan
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Calvert
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Carey
Carl
Carter (GA)
Carter (TX)
Cawthorn
Chabot
Cheney
Cline
Cloud
Clyde
Cole
Comer
Crawford
Crenshaw
Curtis
Davidson
Davis, Rodney
DesJarlais
Diaz-Balart
Donalds
Duncan
Dunn
Ellzey
Emmer
Estes
Fallon
Feenstra
Ferguson
Fischbach
Fitzgerald
Fitzpatrick
Fleischmann
Flores
Foxx
Franklin, C. Scott
Fulcher
Gaetz
Gallagher
Garbarino
Garcia (CA)
Gibbs
Gimenez
Gohmert
Gonzales, Tony
Gonzalez (OH)
Good (VA)
Gooden (TX)
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Graves (LA)
Graves (MO)
Green (TN)
Greene (GA)
Griffith
Grothman
Guest
Guthrie
Harris
Harshbarger
Hartzler
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Herrell
Herrera Beutler
Higgins (LA)
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Hinson
Hollingsworth
Hudson
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Issa
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Jacobs (NY)
Johnson (LA)
Johnson (OH)
Johnson (SD)
Jordan
Joyce (OH)
Joyce (PA)
Katko
Keller
Kelly (MS)
Kelly (PA)
Kim (CA)
Kustoff
LaHood
LaMalfa
Lamborn
Latta
LaTurner
Lesko
Letlow
Long
Loudermilk
Lucas
Luetkemeyer
Mace
Malliotakis
Mann
Massie
Mast
McCarthy
McCaul
McClain
McClintock
McHenry
McKinley
Meijer
Meuser
Miller (WV)
Miller-Meeks
Moolenaar
Mooney
Moore (AL)
Moore (UT)
Mullin
Murphy (NC)
Nehls
Newhouse
Norman
Obernolte
Owens
Palazzo
Palmer
Perry
Pfluger
Posey
Reschenthaler
Rice (SC)
Rodgers (WA)
Rogers (AL)
Rogers (KY)
Rose
Rosendale
Rouzer
Roy
Rutherford
Salazar
Scalise
Schweikert
Scott, Austin
Sessions
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smucker
Spartz
Stauber
Steel
Stefanik
Steil
Steube
Stewart
Taylor
Tenney
Thompson (PA)
Tiffany
Timmons
Turner
Upton
Valadao
Van Drew
Van Duyne
Wagner
Walberg
Walorski
Waltz
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams (TX)
Wilson (SC)
Womack

NOT VOTING—13

Bass
Brooks
Conway
Hice (GA)
Hoyer
Kinzinger
Mfume
Miller (IL)
Norcross
Pence
Ruppersberger
Wittman
Zeldin

□ 1353

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. RUPPERSBERGER. Madam Speaker, due to my attendance at an Appropriations hearing, I was unable to make rollcall vote No. 280. Had I been present, I would have voted "yea."

MEMBERS RECORDED PURSUANT TO HOUSE RESOLUTION 8, 117TH CONGRESS

Allred (Takano)
Bonamici (Manning)
Bourdeaux (Correa)
Bush (Takano)
Carter (LA) (Williams (GA))
Carter (TX) (Weber (TX))
Cohen (Beyer)
Connolly (Beyer)
Costa (Correa)
Crist (Wasserman Schultz)
Davis, Danny K. (Gomez)
DeSaulnier (Beyer)
Gosar (Boebert)
Guest (Fleischmann)
Hayes (Neguse)
Huffman (Gomez)
Jayapal (Takano)
Jeffries (Kelly (IL))
Johnson (GA) (Manning)
Johnson (TX) (Stevens)
Katko (Meijer)
Keating (Neguse)
Kirkpatrick (Pallone)
Lawson (FL) (Wasserman Schultz)
Lowenthal (Beyer)
McCaul (Pfluger)
Moore (WI) (Beyer)
Nadler (Pallone)
Newman (Beyer)
Palazzo (Fleischmann)
Payne (Pallone)
Porter (Neguse)
Price (NC) (Manning)
Rice (SC) (Meijer)
Rogers (KY) (Reschenthaler)
Rush (Neguse)
Salazar (Diaz-Balart)
Scott, David (Neguse)
Sires (Pallone)
Stansbury (Stevens)
Strickland (Neguse)
Suozzi (Neguse)
Tlaib (Gomez)
Walorski (Baird)
Watson Coleman (Pallone)

□ 1400

RESTORING HOPE FOR MENTAL HEALTH AND WELL-BEING ACT OF 2022

Mr. PALLONE. Mr. Speaker, pursuant to House Resolution 1191, I call up the bill (H.R. 7666) to amend the Public Health Service Act to reauthorize certain programs relating to mental health and substance use disorders, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. CLEAVER). Pursuant to House Resolution 1191, in lieu of the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce printed in the bill, an amendment in the nature of a substitute consisting of the text of Rules Committee print 117–51, modified by the amendment printed in part D of House Report 117–381, is adopted and the bill, as amended, is considered read.

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

H.R. 7666

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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.

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

''SEC. 506B. BEHAVIORAL HEALTH CRISIS COORDINATING OFFICE.

''(a) IN GENERAL.—The Secretary shall establish, within the Substance Abuse and Mental Health Services Administration, an office to coordinate work relating to behavioral health crisis care across the operating divisions and agencies of the Department of Health and Human Services, including the Substance Abuse and Mental Health Services Administration, the Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration, and external stakeholders.

''(b) DUTY.—The office established under subsection (a) shall—

''(1) convene Federal, State, Tribal, local, and private partners;

''(2) launch and manage Federal workgroups charged with making recommendations regarding behavioral health crisis issues, including with respect to health care best practices, workforce development, mental health disparities, data collection, technology, program oversight, public awareness, and engagement; and

''(3) support technical assistance, data analysis, and evaluation functions in order to assist States, localities, Territories, Tribes, and Tribal communities to develop crisis care systems and establish nationwide best practices with the objective of expanding the capacity of, and access to, local crisis call centers, mobile crisis care, crisis stabilization, psychiatric emergency services, and rapid post-crisis follow-up care provided by—

''(A) the National Suicide Prevention and Mental Health Crisis Hotline and Response System;

''(B) community mental health centers (as defined in section 1861(ff)(3)(B) of the Social Security Act);

''(C) certified community behavioral health clinics, as described in section 223 of the Protecting Access to Medicare Act of 2014; and

''(D) other community mental health and substance use disorder providers.

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

SEC. 102. CRISIS RESPONSE CONTINUUM OF CARE.

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

''SEC. 520N. CRISIS RESPONSE CONTINUUM OF CARE.

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

''(b) BEST PRACTICES.—

''(1) SCOPE OF BEST PRACTICES.—The best practices published under subsection (a) shall define—

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

''(i) do not require prior authorization from an insurance provider or group health plan nor a referral from a health care provider prior to the delivery of services;

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

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

''(iv) provide for care and support through resources described in paragraph (2)(A) until the individual has been stabilized or transferred to the next level of crisis care; and

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

''(i) individuals screened over the phone; and

''(ii) individuals stabilized on the scene by mobile teams.

''(2) IDENTIFICATION OF ESSENTIAL FUNCTIONS.—The best practices published under subsection (a) shall identify the essential functions of each service in the crisis response continuum, which shall include at least the following:

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

''(B) Delineation of access and entry points to services within the crisis response continuum.

''(C) Development of protocols and agreements for the transfer and receipt of individuals to and from other segments of the crisis response continuum segments as needed, and from outside referrals including health care providers, first responders including law enforcement, paramedics, and firefighters, education institutions, and community-based organizations.

''(D) Description of the qualifications of crisis services staff, including roles for physicians, licensed clinicians, case managers, and peers (in accordance with State licensing requirements or

requirements applicable to Tribal health professionals).

''(E) The convening of collaborative meetings of crisis response service providers, first responders including law enforcement, paramedics, and firefighters, and community partners (including National Suicide Prevention Lifeline or 9–8–8 call centers, 9–1–1 public service answering points, and local mental health and substance use disorder treatment providers) operating in a common region for the discussion of case management, best practices, and general performance improvement.

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

''(A) adequate volume of services to meet population need;

''(B) appropriate timely response; and

''(C) capacity to meet the needs of different patient populations that may experience a mental health or substance use crisis, including children, families, and all age groups, cultural and linguistic minorities, individuals with co-occurring mental health and substance use disorders, individuals with cognitive disabilities, individuals with developmental delays, and individuals with chronic medical conditions and physical disabilities.

''(4) IMPLEMENTATION TIMEFRAME.—The Secretary shall—

''(A) not later than 1 year after the date of enactment of this section, publish and maintain the best practices required by subsection (a); and

''(B) every two years thereafter, publish updates.

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

''(A) a reduction in reliance on law enforcement response, as appropriate, to individuals in crisis who would be more appropriately served by a mobile crisis team capable of responding to mental health and substance-related crises;

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

''(C) evidence of adequate access to crisis care centers and crisis bed services; and

''(D) evidence of adequate linkage to appropriate post-crisis care and longitudinal treatment for mental health or substance use disorder when relevant.''.

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.

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

*(1) in the section heading, by striking ''**MATERNAL DEPRESSION**'' and inserting ''**MATERNAL MENTAL HEALTH AND SUBSTANCE USE DISORDERS**''; and*

(2) in subsection (a)—

(A) by inserting '', Indian Tribes and Tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act), and Urban Indian organizations (as such term is defined under the Federally Recognized Indian Tribe List Act of 1994)'' after ''States''; and

(B) by striking ''for women who are pregnant, or who have given birth within the preceding 12 months, for maternal depression'' and inserting ''for women who are postpartum, pregnant, or have given birth within the preceding 12 months, for maternal mental health and substance use disorders''.

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

(1) by striking ''a State shall submit'' and inserting ''an entity listed in subsection (a) shall submit''; and

(2) in paragraphs (1) and (2), by striking ''maternal depression'' each place it appears and inserting ''maternal mental health and substance use disorders''.

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

(1) by striking ''may give priority to States proposing to improve or enhance access to screening'' and inserting the following: ''shall give priority to entities listed in subsection (a) that—

''(1) are proposing to create, improve, or enhance screening, prevention, and treatment'';

(2) by striking ''maternal depression'' and inserting ''maternal mental health and substance use disorders'';

(3) by striking the period at the end of paragraph (1), as so designated, and inserting a semicolon; and

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

''(2) are currently partnered with, or will partner with, a community-based organization to address maternal mental health and substance use disorders;

''(3) are located in an area with high rates of adverse maternal health outcomes or significant health, economic, racial, or ethnic disparities in maternal health and substance use disorder outcomes; and

''(4) operate in a health professional shortage area designated under section 332.''.

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

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ''to health care providers; and'' and inserting ''on maternal mental health and substance use disorder screening, brief intervention, treatment (as applicable for health care providers), and referrals for treatment to health care providers in the primary care setting and nonclinical perinatal support workers;'';

(B) in subparagraph (B), by striking ''to health care providers, including information on maternal depression screening, treatment, and followup support services, and linkages to community-based resources; and'' and inserting ''on maternal mental health and substance use disorder screening, brief intervention, treatment (as applicable for health care providers) and referrals for treatment, follow-up support services, and linkages to community-based resources to health care providers in the primary care setting and clinical perinatal support workers; and''; and

(C) by adding at the end the following:

''(C) enabling health care providers (such as obstetrician-gynecologists, nurse practitioners, nurse midwives, pediatricians, psychiatrists, mental and other behavioral health care providers, and adult primary care clinicians) to provide or receive real-time psychiatric consultation (in-person or remotely), including through the use of technology-enabled collaborative 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 and State, local, and Tribal governments, including child psychiatric access programs;

''(E) conducting public outreach and awareness regarding grants under subsection (a);

''(F) creating multistate consortia to carry out the activities required or authorized under this subsection; and

''(G) training health care providers in the primary care setting and nonclinical perinatal support workers on trauma-informed care, culturally and linguistically appropriate services, and best practices related to training to improve the provision of maternal mental health and substance use disorder care for racial and ethnic minority populations, including with respect to perceptions and biases that may affect the approach to, and provision of, care.''.

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

(1) by redesignating subsection (e) as subsection (h); and

(2) by inserting after subsection (d) the following:

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

''(f) DISSEMINATION OF BEST PRACTICES.—The Secretary, based on evaluation of the activities funded pursuant to this section, shall identify and disseminate evidence-based or evidence-informed best practices for screening, assessment, and treatment services for maternal mental health and substance use disorders, including culturally and linguistically appropriate services, for women during pregnancy and 12 months following pregnancy.

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

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

(1) by striking ''$5,000,000'' and inserting ''$24,000,000''; and

(2) by striking ''2018 through 2022'' and inserting ''2023 through 2027''.

SEC. 112. MATERNAL MENTAL HEALTH HOTLINE.

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

''SEC. 399V–7. MATERNAL MENTAL HEALTH HOTLINE.

''(a) IN GENERAL.—The Secretary shall maintain, directly or by grant or contract, a national hotline to provide emotional support, information, brief intervention, and mental health and substance use disorder resources to pregnant and postpartum women at risk of, or affected by, maternal mental health and substance use disorders, and to their families or household members.

''(b) REQUIREMENTS FOR HOTLINE.—The hotline under subsection (a) shall—

''(1) be a 24/7 real-time hotline;

''(2) provide voice and text support;

''(3) be staffed by certified peer specialists, licensed health care professionals, or licensed mental health professionals who are trained on—

''(A) maternal mental health and substance use disorder prevention, identification, and intervention; and

''(B) providing culturally and linguistically appropriate support; and

''(4) provide maternal mental health and substance use disorder assistance and referral services to meet the needs of underserved populations, individuals with disabilities, and family and household members of pregnant or postpartum women at risk of experiencing maternal mental health and substance use disorders.

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

''(1) consult with the Domestic Violence Hotline, National Suicide Prevention Lifeline, and Veterans Crisis Line to ensure that pregnant and postpartum women are connected in real-time to the appropriate specialized hotline service, when applicable;

''(2) conduct a public awareness campaign for the hotline; and

''(3) consult with Federal departments and agencies, including the Centers of Excellence of the Substance Abuse and Mental Health Services Administration and the Department of Veterans Affairs, to increase awareness regarding the hotline.

''(d) ANNUAL REPORT.—The Secretary shall submit an annual report to the Congress on the hotline under subsection (a) and implementation of this section, including—

''(1) an evaluation of the effectiveness of activities conducted or supported under subsection (a);

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

''(3) such additional information as the Secretary determines appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.''.

SEC. 113. TASK FORCE ON MATERNAL MENTAL HEALTH.

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

''SEC. 317L–2. TASK FORCE ON MATERNAL MENTAL HEALTH.

''(a) ESTABLISHMENT.—Not later than 180 days after the date of enactment of the Restoring Hope for the Mental Health and Well-Being Act of 2022, the Secretary, for purposes of identifying, evaluating, and making recommendations to coordinate and improve Federal responses to maternal mental health conditions, shall—

''(1) establish a task force to be known as the Task Force on Maternal Mental Health (in this section referred to as the 'Task Force'); or

''(2) incorporate the duties, public meetings, and reports specified in subsections (c) through (f) into existing Federal policy forums, including the Maternal Health Interagency Policy Committee and the Maternal Health Working Group, as appropriate.

''(b) MEMBERSHIP.—

''(1) COMPOSITION.—The Task Force shall be composed of—

''(A) the Federal members under paragraph (2); and

''(B) the non-Federal members under paragraph (3).

''(2) FEDERAL MEMBERS.—The Federal members of the Task Force shall consist of the following heads of Federal departments and agencies (or their designees):

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

''(B) The Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

''(C) The Assistant Secretary of the Administration for Children and Families.

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

''(E) The Administrator of the Centers for Medicare & Medicaid Services.

''(F) The Administrator of the Health Resources and Services Administration.

''(G) The Director of the Indian Health Service.

''(H) The Assistant Secretary for Mental Health and Substance Use.

''(I) Such other Federal departments and agencies as the Secretary determines appropriate that serve individuals with maternal mental health conditions.

''(3) NON-FEDERAL MEMBERS.—The non-Federal members of the Task Force shall—

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

''(B) be appointed by the Secretary; and

''(C) include—

''(i) representatives of medical societies with expertise in maternal or mental health;

''(ii) representatives of nonprofit organizations with expertise in maternal or mental health;

''(iii) relevant industry representatives; and

''(iv) other representatives, as appropriate.

''(4) DEADLINE FOR DESIGNATING DESIGNEES.—If the Assistant Secretary for Health, or the head of a Federal department or agency serving as a member of the Task Force under paragraph (2), chooses to be represented on the Task Force by a designee, the Assistant Secretary or department or agency head shall designate such designee not later than 90 days after the date of the enactment of this section.

''(c) DUTIES.—The Task Force shall—

''(1) prepare and regularly update a report that analyzes and evaluates the state of national maternal mental health policy and programs at the Federal, State, and local levels, and identifies best practices with respect to maternal mental health policy, including—

''(A) a set of evidence-based, evidence-informed, and promising practices with respect to—

''(i) prevention strategies for individuals at risk of experiencing a maternal mental health condition, including strategies and recommendations to address health inequities;

''(ii) the identification, screening, diagnosis, intervention, and treatment of individuals and families affected by a maternal mental health condition;

''(iii) the expeditious referral to, and implementation of, practices and supports that prevent and mitigate the effects of a maternal mental health condition, including strategies and recommendations to eliminate the racial and ethnic disparities that exist in maternal mental health; and

''(iv) community-based or multigenerational practices that support individuals and families affected by a maternal mental health condition; and

''(B) Federal and State programs and activities to prevent, screen, diagnose, intervene, and treat maternal mental health conditions;

''(2) develop and regularly update a national strategy for maternal mental health, taking into consideration the findings of the report under paragraph (1), on how the Task Force and Federal departments and agencies represented on the Task Force may prioritize options for, and may implement a coordinated approach to, addressing maternal mental health conditions, including by—

''(A) increasing prevention, screening, diagnosis, intervention, treatment, and access to care, including clinical and nonclinical care such as peer-support and community health workers, through the public and private sectors;

''(B) providing support for pregnant or postpartum individuals who are at risk for or experiencing a maternal mental health condition, and their families, as appropriate;

''(C) reducing racial, ethnic, geographic, and other health disparities for prevention, diagnosis, intervention, treatment, and access to care;

''(D) identifying options for modifying, strengthening, and coordinating Federal programs and activities, such as the Medicaid program under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act, including existing infant and maternity programs, in order to increase research, prevention, identification, intervention, and treatment with respect to maternal mental health; and

''(E) planning, data sharing, and communication within and across Federal departments, agencies, offices, and programs;

''(3) solicit public comments from stakeholders for the report under paragraph (1) and the national strategy under paragraph (2), including comments from frontline service providers, mental health professionals, researchers, experts in maternal mental health, institutions of higher education, public health agencies (including maternal and child health programs), and industry representatives, in order to inform the activities and reports of the Task Force; and

''(4) disaggregate any data collected under this section by race, ethnicity, geographical location, age, marital status, socioeconomic level, and other factors, as the Secretary determines appropriate.

''(d) MEETINGS.—The Task Force shall—

''(1) meet not less than two times each year; and

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

''(e) REPORTS TO PUBLIC AND FEDERAL LEADERS.—The Task Force shall make publicly available and submit to the heads of relevant Federal departments and agencies, the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Education, Labor, and Pensions of the Senate, and other relevant congressional committees, the following:

''(1) Not later than 1 year after the first meeting of the Task Force, an initial report under subsection (c)(1).

''(2) Not later than 2 years after the first meeting of the Task Force, an initial national strategy under subsection (c)(2).

''(3) Each year thereafter—

''(A) an updated report under subsection (c)(1);

''(B) an updated national strategy under subsection (c)(2); or

''(C) if no update is made under subsection (c)(1) or (c)(2), a report summarizing the activities of the Task Force.

''(f) REPORTS TO GOVERNORS.—Upon finalizing the initial national strategy under subsection (c)(2), and upon making relevant updates to such strategy, the Task Force shall submit a report to the Governors of all States describing opportunities for local- and State-level partnerships identified under subsection (c)(2)(D).

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

''(h) NONDUPLICATION OF FEDERAL EFFORTS.—The Secretary may relieve the Task Force, in carrying out subsections (c) through (f), from responsibility for carrying out such activities as may be specified by the Secretary as duplicative with other activities carried out by the Department of Health and Human Services.''.

Subtitle C—Reaching Improved Mental Health Outcomes for Patients

SEC. 121. INNOVATION FOR MENTAL HEALTH.

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

(1) in subsection (e)(1), by striking ''Indian tribes or tribal organizations'' and inserting ''Indian Tribes or Tribal organizations'';

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

(3) by adding at the end the following:

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.''.

(b) INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.—

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

''SEC. 501B. INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services, or the designee of the Secretary, shall establish a committee to be known as the Interdepartmental Serious Mental Illness Coordinating Committee (in this section referred to as the 'Committee').

''(2) FEDERAL ADVISORY COMMITTEE ACT.—Except as provided in this section, the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Committee.

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

''(c) RESPONSIBILITIES.—The Committee shall submit, on a biannual basis, to Congress and any other relevant Federal department or agency a report including—

''(1) a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of serious mental illnesses, serious emotional disturbances, and advances in access to services and support for adults with a serious mental illness or children with a serious emotional disturbance;

''(2) an evaluation of the effect Federal programs related to serious mental illness have on public health, including public health outcomes such as—

''(A) rates of suicide, suicide attempts, incidence and prevalence of serious mental illnesses, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, interaction with the criminal justice system, homelessness, and unemployment;

''(B) increased rates of employment and enrollment in educational and vocational programs;

''(C) quality of mental and substance use disorders treatment services; or

''(D) any other criteria as may be determined by the Secretary; and

''(3) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance.

''(d) MEMBERSHIP.—

''(1) FEDERAL MEMBERS.—The Committee shall be composed of the following Federal representatives, or the designees of such representatives—

''(A) the Secretary of Health and Human Services, who shall serve as the Chair of the Committee;

''(B) the Assistant Secretary for Mental Health and Substance Use;

''(C) the Attorney General;

''(D) the Secretary of Veterans Affairs;

''(E) the Secretary of Defense;

''(F) the Secretary of Housing and Urban Development;

''(G) the Secretary of Education;

''(H) the Secretary of Labor;

''(I) the Administrator of the Centers for Medicare & Medicaid Services; and

''(J) the Commissioner of Social Security.

''(2) NON-FEDERAL MEMBERS.—The Committee shall also include not less than 14 non-Federal public members appointed by the Secretary of Health and Human Services, of which—

''(A) at least 2 members shall be an individual who has received treatment for a diagnosis of a serious mental illness;

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

''(C) at least 1 member shall be a representative of a leading research, advocacy, or service organization for adults with a serious mental illness;

''(D) at least 2 members shall be—

''(i) a licensed psychiatrist with experience in treating serious mental illnesses;

''(ii) a licensed psychologist with experience in treating serious mental illnesses or serious emotional disturbances;

''(iii) a licensed clinical social worker with experience treating serious mental illnesses or serious emotional disturbances; or

''(iv) a licensed psychiatric nurse, nurse practitioner, or physician assistant with experience in treating serious mental illnesses or serious emotional disturbances;

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

''(F) at least 1 member shall be a mental health professional who has research or clinical mental health experience in working with minorities;

''(G) at least 1 member shall be a mental health professional who has research or clinical mental health experience in working with medically underserved populations;

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

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

''(J) at least 1 member shall be a law enforcement officer or corrections officer with extensive experience in interfacing with adults with a serious mental illness, children with a serious emotional disturbance, or individuals in a mental health crisis; and

''(K) at least 1 member shall have experience providing services for homeless individuals and working with adults with a serious mental illness, children with a serious emotional disturbance, or individuals in a mental health crisis.

''(3) TERMS.—A member of the Committee appointed under paragraph (2) shall serve for a term of 3 years, and may be reappointed for 1 or more additional 3-year terms. Any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve after the expiration of the member's term until a successor has been appointed.

''(e) WORKING GROUPS.—In carrying out its functions, the Committee may establish working groups. Such working groups shall be composed of Committee members, or their designees, and may hold such meetings as are necessary.

''(f) SUNSET.—The Committee shall terminate on September 30, 2027.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 501(l)(2) of the Public Health Service Act (42 U.S.C. 290aa(l)(2)) is amended by striking ''section 6031 of such Act'' and inserting ''section 501B of this Act''.

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

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

(1) in subsection (a), by striking ''Indian tribes or tribal organizations'' and inserting ''Indian Tribes or Tribal organizations''; and

(2) in subsection (f), by striking ''$394,550,000 for each of fiscal years 2018 through 2022'' and inserting ''$599,036,000 for each of fiscal years 2023 through 2027''.

SEC. 122. CRISIS CARE COORDINATION.

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

''SEC. 520F. MENTAL HEALTH CRISIS RESPONSE PARTNERSHIP PILOT PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish a pilot program under which the Secretary will award competitive grants to States, localities, territories, Indian Tribes, and Tribal organizations to establish new, or enhance existing, mobile crisis response teams that divert the response for mental health and substance use crises from law enforcement to mobile crisis teams, as described in subsection (b).

''(b) MOBILE CRISIS TEAMS DESCRIBED.—A mobile crisis team described in this subsection is a team of individuals—

''(1) that is available to respond to individuals in crisis and provide immediate stabilization, referrals to community-based mental health and substance use disorder services and supports, and triage to a higher level of care if medically necessary;

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

''(3) which may provide support to divert behavioral health crisis calls from the 9–1–1 system to the 9–8–8 system.

''(c) PRIORITY.—In awarding grants under this section, the Secretary shall prioritize applications which account for the specific needs of the communities to be served, including children and families, veterans, rural and underserved populations, and other groups at increased risk of death from suicide or overdose.

''(d) REPORT.—

''(1) INITIAL REPORT.—Not later than September 30, 2024, the Secretary shall submit to Congress a report on steps taken by the entities specified in subsection (a) as of such date of enactment to strengthen the partnerships among mental health providers, substance use disorder treatment providers, primary care physicians, mental health and substance use crisis teams, paramedics, law enforcement officers, and other first responders.

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

''(A) impact data on the teams and people served by such programs, including demographic information of individuals served, volume, and types of service utilization;

''(B) outcomes of the number of linkages to community-based resources, short-term crisis receiving and stabilization facilities, and diversion from law enforcement or hospital emergency department settings;

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

''(D) the Secretary's recommendations and best practices for—

''(i) States and localities providing mobile crisis response and stabilization services for youth and adults; and

''(ii) improvements to the program established under this section.

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

(b) MENTAL HEALTH AWARENESS TRAINING GRANTS.—

(1) IN GENERAL.—Section 520J(b) of the Public Health Service Act (42 U.S.C. 290bb–41(b)) is amended—

(A) in paragraph (1), by striking ''Indian tribes, tribal organizations'' and inserting ''Indian Tribes, Tribal organizations'';

(B) in paragraph (4), by striking ''Indian tribe, tribal organization'' and inserting ''Indian Tribe, Tribal organization'';

(C) in paragraph (5)—

(i) by striking ''Indian tribe, tribal organization'' and inserting ''Indian Tribe, Tribal organization'';

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

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

(iv) by adding at the end the following:

''(C) suicide intervention and prevention, including recognizing warning signs and how to refer someone for help.'';

(D) in paragraph (6), by striking ''Indian tribe, tribal organization'' and inserting ''Indian Tribe, Tribal organization''; and

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

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

(A) in the heading of paragraph (2), by striking ''EMERGENCY SERVICES PERSONNEL'' and inserting ''EMERGENCY services personnel''; and

(B) in the heading of paragraph (3), by striking ''DISTRIBUTION OF AWARDS'' and inserting ''DISTRIBUTION OF AWARDS''.

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

(1) in subsection (a)—

(A) in paragraph (2)—

(i) by striking ''Indian tribe'' each place it appears and inserting ''Indian Tribe''; and

(ii) by striking ''tribal organization'' each place it appears and inserting ''Tribal organization''; and

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

''(C) Raising awareness of suicide prevention resources, promoting help seeking among those at risk for suicide.''; and

(2) in subsection (d), by striking ''$30,000,000 for the period of fiscal years 2018 through 2022'' and inserting ''$30,000,000 for each of fiscal years 2023 through 2027''.

SEC. 123. TREATMENT OF SERIOUS MENTAL ILLNESS.

(a) ASSERTIVE COMMUNITY TREATMENT GRANT PROGRAM.—

(1) TECHNICAL AMENDMENT.—Section 520M(b) of the Public Health Service Act (42 U.S.C. 290bb–44(b)) is amended by striking ''Indian tribe or tribal organization'' and inserting ''Indian Tribe or Tribal organization''.

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

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

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

''SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

''(b) CONSULTATION.—The Secretary shall carry out this section in consultation with the Director of the National Institute of Mental Health, the Attorney General of the United States, the Administrator of the Administration for Community Living, and the Assistant Secretary for Mental Health and Substance Use.

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

''(1) may give preference to applicants that have not previously implemented an assisted outpatient treatment program; and

''(2) shall evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patient.

''(d) PROGRAM REQUIREMENTS.—An assisted outpatient treatment program funded with a grant awarded under this section shall include—

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

''(2) preparing and executing treatment plans for such patients that—

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

''(B) provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens;

''(3) providing for case management services that support the treatment plan;

''(4) ensuring appropriate referrals to medical and social services providers;

''(5) evaluating the process for implementing the program to ensure consistency with the patient's needs and State law; and

''(6) measuring treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

''(e) REPORT.—Not later than the end of fiscal year 2027, the Secretary shall submit a report to the appropriate congressional committees on the grant program under this section. Such report shall include an evaluation of the following:

''(1) Cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services.

''(2) Rates of incarceration of patients.

''(3) Rates of homelessness of patients.

''(4) Patient and family satisfaction with program participation.

''(5) Demographic information regarding participation of those served by the grant compared to demographic information in the population of the grant recipient.

''(f) DEFINITIONS.—In this section:

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

''(2) The term 'eligible entity' means a county, city, mental health system, mental health court, or any other entity with authority under the law of the State in which the entity is located to implement, monitor, and oversee an assisted outpatient treatment program.

''(g) FUNDING.—

''(1) AMOUNT OF GRANTS.—

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

''(B) DETERMINATION.—Subject to subparagraph (A), the Secretary shall determine the amount of each grant under this section based on the population of the area to be served through the grant and an estimate of the number of patients to be served.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $22,000,000 for each of fiscal years 2023 through 2027.''.

Subtitle D—Anna Westin Legacy

SEC. 131. MAINTAINING EDUCATION AND TRAINING ON EATING DISORDERS.

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

''SEC. 520O. CENTER OF EXCELLENCE FOR EATING DISORDERS FOR EDUCATION AND TRAINING ON EATING DISORDERS.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall maintain, by competitive grant or contract, a Center of Excellence for Eating Disorders (referred to in this section as the 'Center') to improve the identification of, interventions for, and treatment of eating disorders in a manner that is developmentally, culturally, and linguistically appropriate.

''(b) SUBGRANTS AND SUBCONTRACTS.—The Center shall coordinate and implement the activities under subsection (c), in whole or in part, by awarding competitive subgrants or subcontracts—

''(1) across geographical regions; and

''(2) in a manner that is not duplicative.

''(c) ACTIVITIES.—The Center—

''(1) shall—

''(A) provide training and technical assistance for—

''(i) primary care and behavioral health care providers to carry out screening, brief intervention, and referral to treatment for individuals experiencing, or at risk for, eating disorders; and

''(ii) nonclinical community support workers to identify and support individuals with, or at disproportionate risk for, eating disorders;

''(B) develop and provide training materials to health care providers, including primary care and behavioral health care providers, in the effective treatment and ongoing support of individuals with eating disorders, including children and marginalized populations at disproportionate risk for eating disorders;

''(C) provide collaboration and coordination to other centers of excellence, technical assistance centers, and psychiatric consultation lines of the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration on the identification, effective treatment, and ongoing support of individuals with eating disorders; and

''(D) coordinate with the Director of the Centers for Disease Control and Prevention and the Administrator of the Health Resources and Services Administration to disseminate training to primary care and behavioral health care providers; and

''(2) may—

''(A) coordinate with electronic health record systems for the integration of protocols pertaining to screening, brief intervention, and referral to treatment for individuals experiencing, or at risk for, eating disorders;

''(B) develop and provide training materials to health care providers, including primary care and behavioral health care providers, in the effective treatment and ongoing support for members of the Armed Forces and veterans experiencing, or at risk for, eating disorders; and

''(C) consult with the Secretary of Defense and the Secretary of Veterans Affairs on prevention, identification, intervention for, and treatment of eating disorders.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $1,000,000 for each of fiscal years 2023 through 2027.''.

Subtitle E—Community Mental Health Services Block Grant Reauthorization

SEC. 141. REAUTHORIZATION OF BLOCK GRANTS FOR COMMUNITY MENTAL HEALTH SERVICES.

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

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

''(d) CRISIS CARE.—

''(1) IN GENERAL.—Except as provided in paragraph (3), a State shall expend at least 5 percent of the amount the State receives pursuant to

section 1911 for each fiscal year to support evidenced-based programs that address the crisis care needs of—

''(A) individuals, including children and adolescents, experiencing mental health crises, substance-related crises, or crises arising from co-occurring disorders; and

''(B) persons with intellectual and developmental disabilities.

''(2) CORE ELEMENTS.—At the discretion of the single State agency responsible for the administration of the program of the State under a grant under section 1911, funds expended pursuant to paragraph (1) may be used to fund some or all of the core crisis care service components, delivered according to evidence-based principles, including the following:

''(A) Crisis call centers.

''(B) 24/7 mobile crisis services.

''(C) Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by the Substance Abuse and Mental Health Services Administration, with referrals to inpatient or outpatient care.

''(3) STATE FLEXIBILITY.—In lieu of expending 5 percent of the amount the State receives pursuant to section 1911 for a fiscal year to support evidence-based programs as required by paragraph (1), a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

''(4) RULE OF CONSTRUCTION.—With respect to funds expended pursuant to the set-aside in paragraph (1), section 1912(b)(1)(A)(vi) shall not apply.''.

(c) EARLY INTERVENTION.—

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

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

(B) in subclause (IV), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(V) a description of any evidence-based early intervention strategies and programs the State provides to prevent, delay, or reduce the severity and onset of mental illness and behavioral problems, including for children and adolescents, irrespective of experiencing a serious mental illness or serious emotional disturbance, as defined under subsection (c)(1).''.

(2) ALLOCATION ALLOWANCE; REPORTS.—Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9), as amended by subsection (c), is further amended by adding at the end the following:

''(e) EARLY INTERVENTION SERVICES.—In the case of a State with a State plan that provides for strategies and programs specified in section 1912(b)(1)(A)(vii)(VI), such State may expend not more than 5 percent of the amount of the allotment of the State pursuant to a funding agreement under section 1911 for each fiscal year to support such strategies and programs.

''(f) REPORTS TO CONGRESS.—Not later than September 30, 2025, and biennially thereafter, the Secretary shall provide a report to the Congress on the crisis care and early intervention strategies and programs pursued by States pursuant to subsections (d) and (e). Each such report shall include—

''(1) a description of the each State's crisis care and early intervention activities;

''(2) the population served, including information on demographics, including age;

''(3) the outcomes of such activities, including—

''(A) how such activities reduced hospitalizations and hospital stays;

''(B) how such activities reduced incidents of suicidal ideation and behaviors; and

''(C) how such activities reduced the severity of onset of serious mental illness and serious emotional disturbance; and

''(4) any other relevant information the Secretary deems necessary.''.

Subtitle F—Peer-Supported Mental Health Services

SEC. 151. PEER-SUPPORTED MENTAL HEALTH SERVICES.

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

''SEC. 520H. PEER-SUPPORTED MENTAL HEALTH SERVICES.

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

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to develop, expand, and enhance national, statewide, or community-focused programs, including virtual peer-support services and infrastructure, including by—

''(1) carrying out workforce development, recruitment, and retention activities, to train, recruit, and retain peer-support providers;

''(2) building connections between mental health treatment programs, including between community organizations and peer-support networks, including virtual peer-support networks, and with other mental health support services;

''(3) reducing stigma associated with mental health disorders;

''(4) expanding and improving virtual peer mental health support services, including adoption of technologies to expand access to virtual peer mental health support services, including by acquiring—

''(A) appropriate physical hardware for such virtual services;

''(B) software and programs to efficiently run peer-support services virtually; and

''(C) other technology for establishing virtual waiting rooms and virtual video platforms for meetings; and

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

''(A) the signs of mental illness;

''(B) the resources available to individuals with mental illness and to their families; and

''(C) the resources available to help support individuals living with mental illness.

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

''(d) DEFINITION.—In this section, the term 'eligible entity' means—

''(1) a nonprofit consumer-run organization that—

''(A) is principally governed by people living with a mental health condition; and

''(B) mobilizes resources within and outside of the mental health community, which may include through peer-support networks, to increase the prevalence and quality of long-term wellness of individuals living with a mental health condition, including those with a co-occurring substance use disorder; or

''(2) a Federally recognized Tribe, Tribal organization, Urban Indian organization, or consortium of Tribes or Tribal organizations.

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

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.

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

''SEC. 506A. BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES FOR NATIVE AMERICANS.

''(a) DEFINITIONS.—In this section:

''(1) The term 'eligible entity' means an Indian Tribe, a Tribal organization, an Urban Indian organization, and a Native Hawaiian health organization.

''(2) The terms 'Indian Tribe', 'Tribal organization', and 'Urban Indian organization' have the meanings given to the terms 'Indian tribe', 'tribal organization', and 'Urban Indian organization' in section 4 of the Indian Health Care Improvement Act.

''(3) The term 'Native Hawaiian health organization' means 'Papa Ola Lokahi' as defined in section 12 of the Native Hawaiian Health Care Improvement Act.

''(b) FORMULA FUNDS.—

''(1) IN GENERAL.—The Secretary, in consultation with the Director of the Indian Health Service, as appropriate, shall award funds to eligible entities, in amounts determined pursuant to the formula described in paragraph (2), to be used by the eligible entity to provide culturally appropriate mental health and substance use disorder prevention, treatment, and recovery services to American Indians, Alaska Natives, and Native Hawaiians.

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

''(c) TECHNICAL ASSISTANCE AND PROGRAM EVALUATION.—

''(1) IN GENERAL.—The Secretary shall—

''(A) provide technical assistance to applicants and awardees under this section; and

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

''(2) CONSULTATION ON EVALUATION MEASURES, AND DATA SUBMISSION AND REPORTING REQUIREMENTS.—The Secretary shall, using the process described in subsection (d), develop evaluation measures and data submission and reporting requirements for purposes of the collection and evaluation of information.

''(3) DATA SUBMISSION AND REPORTING.—As a condition on receipt of funds under this section, an applicant shall agree to submit data and reports in a timely manner consistent with the evaluation measures and data submission and reporting requirements developed under subsection (d).

''(d) REGULATIONS.—

''(1) PROMULGATION.—Not later than 180 days after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations as are necessary to carry out this section, including development of the funding formula described in subsection (b) and the program evaluation and reporting requirements under subsection (c).

''(2) PUBLICATION.—Not later than 18 months after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, the Secretary shall publish in the Federal Register proposed regulations to implement this section.

''(3) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this subsection shall have as its members only representatives of the Federal Government, Tribal Governments, and Urban Indian organizations. For purposes of such rulemaking, the Indian Health Service shall be the lead agency for the Department.

''(4) ADAPTATION OF PROCEDURES.—In carrying out this subsection, the Secretary shall

adapt any negotiated rulemaking procedures to the unique context of the government-to-government relationship between the United States and Indian Tribes.

''(5) EFFECT.—The lack of promulgated regulations under this subsection shall not limit the effect or implementation of this section.

''(e) APPLICATION.—An entity desiring an award under subsection (b) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

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

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

Subtitle B—Summer Barrow Prevention, Treatment, and Recovery

SEC. 211. GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS.

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

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

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

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

(2) in subsection (a)—

(A) by striking ''tribes and tribal organizations (as the terms 'Indian tribes' and 'tribal organizations' are defined'' and inserting ''Tribes and Tribal organizations (as such terms are defined''; and

(B) in paragraph (3), by striking ''in substance abuse'';

(3) in subsection (b), in the subsection heading, by striking ''ABUSE'' and inserting ''USE DISORDER''; and

(4) in subsection (f), by striking ''$333,806,000 for each of fiscal years 2018 through 2022'' and inserting ''$521,517,000 for each of fiscal years 2023 through 2027''.

SEC. 213. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

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

(1) in subsection (a)(1)—

(A) by striking ''substance abuse'' and inserting ''substance use disorder'';

(B) by striking ''tribes and tribal organizations'' and inserting ''Tribes and Tribal organizations''; and

(C) by striking ''addiction'' and inserting ''substance use disorders'';

(2) in subsection (e)(3), by striking ''tribes and tribal organizations'' and inserting ''Tribes and Tribal organizations''; and

(3) in subsection (f), by striking ''2017 through 2021'' and inserting ''2023 through 2027''.

SEC. 214. PRIORITY SUBSTANCE USE DISORDER PREVENTION NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

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

(1) in subsection (a)—

(A) in paragraph (3), by striking ''abuse'' and inserting ''use''; and

(B) in the matter following paragraph (3), by striking ''tribes or tribal organizations'' and inserting ''Tribes or Tribal organizations'';

(2) in subsection (b), in the subsection heading, by striking ''ABUSE'' and inserting ''USE DISORDER''; and

(3) in subsection (f), by striking ''$211,148,000 for each of fiscal years 2018 through 2022'' and inserting ''$218,219,000 for each of fiscal years 2023 through 2027''.

SEC. 215. SOBER TRUTH ON PREVENTING (STOP) UNDERAGE DRINKING REAUTHORIZATION.

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

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

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

''(1) The term 'alcohol beverage industry' means the brewers, vintners, distillers, importers, distributors, and retail or online outlets that sell or serve beer, wine, and distilled spirits.

''(2) The term 'school-based prevention' means programs, which are institutionalized, and run by staff members or school-designated persons or organizations in any grade of school, kindergarten through 12th grade.

''(3) The term 'youth' means persons under the age of 21.''; and

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

''(c) INTERAGENCY COORDINATING COMMITTEE; ANNUAL REPORT ON STATE UNDERAGE DRINKING PREVENTION AND ENFORCEMENT ACTIVITIES.—

''(1) INTERAGENCY COORDINATING COMMITTEE ON THE PREVENTION OF UNDERAGE DRINKING.—

''(A) IN GENERAL.—The Secretary, in collaboration with the Federal officials specified in subparagraph (B), shall continue to support and enhance the efforts of the interagency coordinating committee, that began operating in 2004, focusing on underage drinking (referred to in this subsection as the 'Committee').

''(B) OTHER AGENCIES.—The officials referred to in subparagraph (A) are the Secretary of Education, the Attorney General, the Secretary of Transportation, the Secretary of the Treasury, the Secretary of Defense, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Director of the National Institute on Alcohol Abuse and Alcoholism, the Assistant Secretary for Mental Health and Substance Use, the Director of the National Institute on Drug Abuse, the Assistant Secretary for Children and Families, the Director of the Office of National Drug Control Policy, the Administrator of the National Highway Traffic Safety Administration, the Administrator of the Office of Juvenile Justice and Delinquency Prevention, the Chairman of the Federal Trade Commission, and such other Federal officials as the Secretary of Health and Human Services determines to be appropriate.

''(C) CHAIR.—The Secretary of Health and Human Services shall serve as the chair of the Committee.

''(D) DUTIES.—The Committee shall guide policy and program development across the Federal Government with respect to underage drinking, provided, however, that nothing in this section shall be construed as transferring regulatory or program authority from an Agency to the Coordinating Committee.

''(E) CONSULTATIONS.—The Committee shall actively seek the input of and shall consult with all appropriate and interested parties, including States, public health research and interest groups, foundations, and alcohol beverage industry trade associations and companies.

''(F) ANNUAL REPORT.—

''(i) IN GENERAL.—The Secretary, on behalf of the Committee, shall annually submit to the Congress a report that summarizes—

''(I) all programs and policies of Federal agencies designed to prevent and reduce underage drinking, focusing particularly on programs and policies that support the adoption and enforcement of State policies designed to prevent and reduce underage drinking as specified in paragraph (2);

''(II) the extent of progress in preventing and reducing underage drinking at State and national levels;

''(III) data that the Secretary shall collect with respect to the information specified in clause (ii); and

''(IV) such other information regarding underage drinking as the Secretary determines to be appropriate.

''(ii) CERTAIN INFORMATION.—The report under clause (i) shall include information on the following:

''(I) Patterns and consequences of underage drinking as reported in research and surveys such as, but not limited to, Monitoring the Future, Youth Risk Behavior Surveillance System, the National Survey on Drug Use and Health, and the Fatality Analysis Reporting System.

''(II) Measures of the availability of alcohol from commercial and non-commercial sources to underage populations.

''(III) Measures of the exposure of underage populations to messages regarding alcohol in advertising, social media, and the entertainment media.

''(IV) Surveillance data, including information on the onset and prevalence of underage drinking, consumption patterns, beverage preferences, prevalence of drinking among students at institutions of higher education, correlations between adult and youth drinking, and the means of underage access, including trends over time for these surveillance data. The Secretary shall develop a plan to improve the collection, measurement, and consistency of reporting Federal underage alcohol data.

''(V) Any additional findings resulting from research conducted or supported under subsection (f).

''(VI) Evidence-based best practices to prevent and reduce underage drinking including a review of the research literature related to State laws, regulations, and policies designed to prevent and reduce underage drinking, as described in paragraph (2)(B)(i).

''(2) ANNUAL REPORT ON STATE UNDERAGE DRINKING PREVENTION AND ENFORCEMENT ACTIVITIES.—

''(A) IN GENERAL.—The Secretary shall, with input and collaboration from other appropriate Federal agencies, States, Indian Tribes, territories, and public health, consumer, and alcohol beverage industry groups, annually issue a report on each State's performance in enacting, enforcing, and creating laws, regulations, and policies to prevent or reduce underage drinking based on an assessment of best practices developed pursuant to paragraph (1)(F)(ii)(VI) and subparagraph (B)(i). For purposes of this paragraph, each such report, with respect to a year, shall be referred to as the 'State Report'. Each State Report shall be designed as a resource tool for Federal agencies assisting States in the their underage drinking prevention efforts, State public health and law enforcement agencies, State and local policymakers, and underage drinking prevention coalitions including those receiving grants pursuant to subsection (e).

''(B) STATE PERFORMANCE MEASURES.—

''(i) IN GENERAL.—The Secretary shall develop, in consultation with the Committee, a set of measures to be used in preparing the State Report on best practices as they relate to State laws, regulations, policies, and enforcement practices.

''(ii) STATE REPORT CONTENT.—The State Report shall include updates on State laws, regulations, and policies included in previous reports to Congress, including with respect to the following:

''(I) Whether or not the State has comprehensive anti-underage drinking laws such as for the illegal sale, purchase, attempt to purchase, consumption, or possession of alcohol; illegal use of fraudulent ID; illegal furnishing or obtaining of alcohol for an individual under 21 years; the degree of strictness of the penalties for such offenses; and the prevalence of the enforcement of each of these infractions.

''(II) Whether or not the State has comprehensive liability statutes pertaining to underage access to alcohol such as dram shop, social host,

and house party laws, and the prevalence of enforcement of each of these laws.

''(III) Whether or not the State encourages and conducts comprehensive enforcement efforts to prevent underage access to alcohol at retail outlets, such as random compliance checks and shoulder tap programs, and the number of compliance checks within alcohol retail outlets measured against the number of total alcohol retail outlets in each State, and the result of such checks.

''(IV) Whether or not the State encourages training on the proper selling and serving of alcohol for all sellers and servers of alcohol as a condition of employment.

''(V) Whether or not the State has policies and regulations with regard to direct sales to consumers and home delivery of alcoholic beverages.

''(VI) Whether or not the State has programs or laws to deter adults from purchasing alcohol for minors; and the number of adults targeted by these programs.

''(VII) Whether or not the State has enacted graduated drivers licenses and the extent of those provisions.

''(iii) ADDITIONAL CATEGORIES.—In addition to the updates on State laws, regulations, and policies listed in clause (ii), the Secretary shall consider the following:

''(I) Whether or not States have adopted laws, regulations, and policies that deter underage alcohol use, as described in 'The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking' issued in 2007 and 'Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health' issued in 2016, including restrictions on low-price, high-volume drink specials, and wholesaler pricing provisions.

''(II) Whether or not States have adopted laws, regulations, and policies designed to reduce alcohol advertising messages attractive to youth and youth exposure to alcohol advertising and marketing in measured and unmeasured media and digital and social media.

''(III) Whether or not States have laws and policies that promote underage drinking prevention policy development by local jurisdictions.

''(IV) Whether or not States have adopted laws, regulations, and policies to restrict youth access to alcoholic beverages that may pose special risks to youth, including but not limited to alcoholic mists, gelatins, freezer pops, premixed caffeinated alcoholic beverages, and flavored malt beverages.

''(V) Whether or not States have adopted uniform best practices protocols for conducting compliance checks and shoulder tap programs.

''(VI) Whether or not States have adopted uniform best practices penalty protocols for violations of laws prohibiting retail licensees from selling or furnishing of alcohol to minors.

''(iv) UNIFORM DATA SYSTEM.—For performance measures related to enforcement of underage drinking laws as specified in clauses (ii) and (iii), the Secretary shall develop and test a uniform data system for reporting State enforcement data, including the development of a pilot program for this purpose. The pilot program shall include procedures for collecting enforcement data from both State and local law enforcement jurisdictions.

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

''(d) NATIONAL MEDIA CAMPAIGN TO PREVENT UNDERAGE DRINKING.—

''(1) IN GENERAL.—The Secretary, in consultation with the National Highway Traffic Safety Administration, shall develop an intensive, multifaceted, adult-oriented national media campaign to reduce underage drinking by influencing attitudes regarding underage drinking, increasing the willingness of adults to take actions to reduce underage drinking, and encouraging public policy changes known to decrease underage drinking rates.

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

''(A) Instill a broad societal commitment to reduce underage drinking.

''(B) Increase specific actions by adults that are meant to discourage or inhibit underage drinking.

''(C) Decrease adult conduct that tends to facilitate or condone underage drinking.

''(3) COMPONENTS.—When implementing the national media campaign described in this section, the Secretary shall—

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

''(B) educate the public about the negative consequences of underage drinking;

''(C) promote specific actions by adults that are meant to discourage or inhibit underage drinking, including positive behavior modeling, general parental monitoring, and consistent and appropriate discipline;

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

''(E) establish collaborative relationships with local and national organizations and institutions to further the goals of the campaign and assure that the messages of the campaign are disseminated from a variety of sources;

''(F) conduct the campaign through multimedia sources; and

''(G) conduct the campaign with regard to changing demographics and cultural and linguistic factors.

''(4) CONSULTATION REQUIREMENT.—In developing and implementing the national media campaign described in this section, the Secretary shall consult recommendations for reducing underage drinking published by the National Academy of Sciences and the Surgeon General. The Secretary shall also consult with interested parties including medical, public health, and consumer and parent groups, law enforcement, institutions of higher education, community organizations and coalitions, and other stakeholders supportive of the goals of the campaign.

''(5) ANNUAL REPORT.—The Secretary shall produce an annual report on the progress of the development or implementation of the media campaign described in this subsection, including expenses and projected costs, and, as such information is available, report on the effectiveness of such campaign in affecting adult attitudes toward underage drinking and adult willingness to take actions to decrease underage drinking.

''(6) RESEARCH ON YOUTH-ORIENTED CAMPAIGN.—The Secretary may, based on the availability of funds, conduct research on the potential success of a youth-oriented national media campaign to reduce underage drinking. The Secretary shall report any such results to Congress with policy recommendations on establishing such a campaign.

''(7) ADMINISTRATION.—The Secretary may enter into a subcontract with another Federal agency to delegate the authority for execution and administration of the adult-oriented national media campaign.

''(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,500,000 for each of fiscal years 2023 through 2027.

''(e) COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO PREVENT UNDERAGE DRINKING.—

''(1) AUTHORIZATION OF PROGRAM.—The Assistant Secretary for Mental Health and Substance Use, in consultation with the Director of the Office of National Drug Control Policy, shall award enhancement grants to eligible entities to design, implement, evaluate, and disseminate comprehensive strategies to maximize the effectiveness of community-wide approaches to preventing and reducing underage drinking. This subsection is subject to the availability of appropriations.

''(2) PURPOSES.—The purposes of this subsection are to—

''(A) prevent and reduce alcohol use among youth in communities throughout the United States;

''(B) strengthen collaboration among communities, the Federal Government, Tribal Governments, and State and local governments;

''(C) enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth;

''(D) serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that first demonstrates a long-term commitment to reducing alcohol use among youth;

''(E) implement state-of-the-art science-based strategies to prevent and reduce underage drinking by changing local conditions in communities; and

''(F) enhance, not supplant, effective local community initiatives for preventing and reducing alcohol use among youth.

''(3) APPLICATION.—An eligible entity desiring an enhancement grant under this subsection shall submit an application to the Assistant Secretary at such time, and in such manner, and accompanied by such information and assurances, as the Assistant Secretary may require. Each application shall include—

''(A) a complete description of the entity's current underage alcohol use prevention initiatives and how the grant will appropriately enhance the focus on underage drinking issues; or

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

''(4) USES OF FUNDS.—Each eligible entity that receives a grant under this subsection shall use the grant funds to carry out the activities described in such entity's application submitted pursuant to paragraph (3) and obtain specialized training and technical assistance by the entity funded under section 4 of Public Law 107–82, as amended (21 U.S.C. 1521 note). Grants under this subsection shall not exceed $60,000 per year and may not exceed four years.

''(5) SUPPLEMENT NOT SUPPLANT.—Grant funds provided under this subsection shall be used to supplement, not supplant, Federal and non-Federal funds available for carrying out the activities described in this subsection.

''(6) EVALUATION.—Grants under this subsection shall be subject to the same evaluation requirements and procedures as the evaluation requirements and procedures imposed on recipients of drug-free community grants.

''(7) DEFINITIONS.—For purposes of this subsection, the term 'eligible entity' means an organization that is currently receiving or has received grant funds under the Drug-Free Communities Act of 1997.

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

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

''(f) GRANTS TO PROFESSIONAL PEDIATRIC PROVIDER ORGANIZATIONS TO REDUCE UNDERAGE DRINKING THROUGH SCREENING AND BRIEF INTERVENTIONS.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall make one or more grants to professional pediatric provider organizations to increase among the members of such organizations effective practices to reduce the prevalence of alcohol use among individuals under the age of 21, including college students.

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

''(A) screening adolescents for alcohol use;

''(B) offering brief interventions to adolescents to discourage such use;

''(C) educating parents about the dangers of and methods of discouraging such use;

''(D) diagnosing and treating alcohol use disorders; and

''(E) referring patients, when necessary, to other appropriate care.

''(3) USE OF FUNDS.—A professional pediatric provider organization receiving a grant under this section may use the grant funding to promote the practices specified in paragraph (2) among its members by—

''(A) providing training to health care providers;

''(B) disseminating best practices, including culturally and linguistically appropriate best practices, and developing, printing, and distributing materials; and

''(C) supporting other activities approved by the Assistant Secretary.

''(4) APPLICATION.—To be eligible to receive a grant under this subsection, a professional pediatric provider organization shall submit an application to the Assistant Secretary at such time, and in such manner, and accompanied by such information and assurances as the Secretary may require. Each application shall include—

''(A) a description of the pediatric provider organization;

''(B) a description of the activities to be completed that will promote the practices specified in paragraph (2);

''(C) a description of the organization's qualifications for performing such practices; and

''(D) a timeline for the completion of such activities.

''(5) DEFINITIONS.—For the purpose of this subsection:

''(A) BRIEF INTERVENTION.—The term 'brief intervention' means, after screening a patient, providing the patient with brief advice and other brief motivational enhancement techniques designed to increase the insight of the patient regarding the patient's alcohol use, and any realized or potential consequences of such use to effect the desired related behavioral change.

''(B) ADOLESCENTS.—The term 'adolescents' means individuals under 21 years of age.

''(C) PROFESSIONAL PEDIATRIC PROVIDER ORGANIZATION.—The term 'professional pediatric provider organization' means an organization or association that—

''(i) consists of or represents pediatric health care providers; and

''(ii) is qualified to promote the practices specified in paragraph (2).

''(D) SCREENING.—The term 'screening' means using validated patient interview techniques to identify and assess the existence and extent of alcohol use in a patient.

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

''(g) DATA COLLECTION AND RESEARCH.—

''(1) ADDITIONAL RESEARCH ON UNDERAGE DRINKING.—

''(A) IN GENERAL.—The Secretary shall, subject to the availability of appropriations, collect data, and conduct or support research that is not duplicative of research currently being conducted or supported by the Department of Health and Human Services, on underage drinking, with respect to the following:

''(i) Improve data collection in support of evaluation of the effectiveness of comprehensive community-based programs or strategies and statewide systems to prevent and reduce underage drinking, across the underage years from early childhood to age 21, such as programs funded and implemented by governmental entities, public health interest groups and foundations, and alcohol beverage companies and trade associations, through the development of models of State-level epidemiological surveillance of underage drinking by funding in States or large metropolitan areas new epidemiologists focused on excessive drinking including underage alcohol use.

''(ii) Obtain and report more precise information than is currently collected on the scope of the underage drinking problem and patterns of underage alcohol consumption, including improved knowledge about the problem and progress in preventing, reducing, and treating underage drinking, as well as information on the rate of exposure of youth to advertising and other media messages encouraging and discouraging alcohol consumption.

''(iii) Synthesize, expand on, and widely disseminate existing research on effective strategies for reducing underage drinking, including translational research, and make this research easily accessible to the general public.

''(iv) Improve and conduct public health surveillance on alcohol use and alcohol-related conditions in States by increasing the use of surveys, such as the Behavioral Risk Factor Surveillance System, to monitor binge and excessive drinking and related harms among individuals who are at least 18 years of age, but not more than 20 years of age, including harm caused to self or others as a result of alcohol use that is not duplicative of research currently being conducted or supported by the Department of Health and Human Services.

''(B) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this paragraph $5,000,000 for each of fiscal years 2023 through 2027.

''(2) NATIONAL ACADEMY OF SCIENCES STUDY.—

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

''(i) contract with the National Academy of Sciences to study developments in research on underage drinking and the public policy implications of these developments; and

''(ii) report to the Congress on the results of such review.

''(B) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this paragraph $500,000 for fiscal year 2023.''.

SEC. 216. GRANTS FOR JAIL DIVERSION PROGRAMS.

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

(1) in subsection (a)—

(A) by striking ''up to 125''; and

(B) by striking ''tribes and tribal organizations'' and inserting ''Tribes and Tribal organizations'';

(2) in subsection (b)(2), by striking ''tribes, and tribal organizations'' and inserting ''Tribes, and Tribal organizations'';

(3) in subsection (c)—

(A) in paragraph (1), by striking ''tribe or tribal organization'' and inserting ''Tribe or Tribal organization, health facility or program described in subsection (a), or public or nonprofit entity referred to in subsection (a)''; and

(B) in paragraph (2)(A)(iii), by striking ''tribe, or tribal organization'' and inserting ''Tribe, or Tribal organization'';

(4) in subsection (e)—

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

(B) in paragraph (5), by striking ''or arrest'' and inserting '', arrest, or release'';

(5) in subsection (f), by striking ''tribe, or tribal organization'' each place it appears and inserting ''Tribe, or Tribal organization'';

(6) in subsection (h), by striking ''tribe, or tribal organization'' and inserting ''Tribe, or Tribal organization''; and

(7) in subsection (j), by striking ''$4,269,000 for each of fiscal years 2018 through 2022'' and inserting ''$14,000,000 for each of fiscal years 2023 through 2027''.

SEC. 217. FORMULA GRANTS TO STATES.

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

SEC. 218. PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS.

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

SEC. 219. GRANTS FOR REDUCING OVERDOSE DEATHS.

(a) GRANTS.—

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

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

''(2) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' means a State, Territory, locality, Indian Tribe (as defined in the Federally Recognized Indian Tribe List Act of 1994), Tribal organization, or Urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

''(3) SUBGRANTS.—For the purposes for which a grant is awarded under this section, the eligible entity receiving the grant may award subgrants to a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), an opioid treatment program (as defined in section 8.2 of title 42, Code of Federal Regulations (or any successor regulations)), any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act, or any nonprofit organization that the Secretary deems appropriate.''.

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

(A) in subparagraph (A), by inserting '', including patients prescribed with both an opioid and a benzodiazepine'' before the semicolon at the end; and

(B) in subparagraph (D), by striking ''drug overdose'' and inserting ''substance overdose''.

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

''(5) To establish protocols to connect patients who have experienced an overdose with appropriate treatment, including overdose reversal medications, medication assisted treatment, and appropriate counseling and behavioral therapies.''.

(5) IMPROVING ACCESS TO OVERDOSE TREATMENT.—Section 544 of the Public Health Service Act (42 U.S.C. 290dd–3) is amended—

(A) by redesignating subsections (d) through (f) as subsections (e) through (g), respectively;

(B) in subsection (f), as so redesignated, by striking ''subsection (d)'' and inserting ''subsection (e)''; and

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

''(d) IMPROVING ACCESS TO OVERDOSE TREATMENT.—

''(1) INFORMATION ON BEST PRACTICES.—

''(A) HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services may provide information to States, localities, Indian Tribes, Tribal organizations, and Urban Indian organizations on best practices for prescribing or co-prescribing a drug or device approved, cleared, or otherwise authorized under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

''(B) DEFENSE.—The Secretary of Defense may provide information to prescribers within Department of Defense medical facilities on best practices for prescribing or co-prescribing a drug or device approved, cleared, or otherwise authorized under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

''(C) VETERANS AFFAIRS.—The Secretary of Veterans Affairs may provide information to prescribers within Department of Veterans Affairs medical facilities on best practices for prescribing or co-prescribing a drug or device approved, cleared, or otherwise authorized under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

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

(6) AUTHORIZATION OF APPROPRIATIONS.—Section 544(g) of the Public Health Service Act (42 U.S.C. 290dd–3), as redesignated, is amended by striking ''fiscal years 2017 through 2021'' and inserting ''fiscal years 2023 through 2027''.

(7) TECHNICAL AMENDMENTS.—

(A) Section 544 of the Public Health Service Act (42 U.S.C. 290dd–3), as amended, is further amended by striking ''approved or cleared'' each place it appears and inserting ''approved, cleared, or otherwise authorized''.

(B) Section 107 of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198) is amended by striking subsection (b).

SEC. 220. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

(a) GRANTS.—Section 545 of the Public Health Service Act (42 U.S.C. 290ee) is amended—

(1) in the section heading, by striking ''**ACCESS AND EDUCATION GRANT PROGRAMS**'' and inserting ''**ACCESS, EDUCATION, AND CO-PRESCRIBING GRANT PROGRAMS**'';

(2) in the heading of subsection (a), by striking ''GRANTS TO STATES'' and inserting ''GRANTS'';

(3) in subsection (a), by striking ''shall make grants to States'' and inserting ''shall make grants to States, localities, Indian Tribes (as defined by the Federally Recognized Indian Tribe List Act of 1994), Tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act)'';

(4) in subsection (a)(1), by striking ''implement strategies for pharmacists to dispense a drug or device'' and inserting ''implement strategies that increase access to drugs or devices'';

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

(6) by inserting after paragraph (2) the following:

''(3) encourage health care providers to co-prescribe, as appropriate, 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;''.

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

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

''(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**'';

(2) in subsection (b)—

(A) in the subsection heading, by striking ''ABUSE'' and inserting ''USE DISORDER'';

(B) in paragraph (1), by striking ''abuse'' and inserting ''use disorder'';

(C) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''abuse'' and inserting ''use disorder'';

(ii) in subparagraph (A), by striking ''opioid use, treatment, and addiction recovery'' and inserting ''opioid use disorders, and treatment for, and recovery from opioid use disorders'';

(iii) in subparagraph (C), by striking ''addiction'' each place it appears and inserting ''use disorder'';

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

''(D) developing, implementing, and expanding efforts to prevent overdose death from opioid or other prescription medication use disorders; and''; and

(v) in subparagraph (E), by striking ''abuse'' and inserting ''use disorders''; and

(D) in paragraph (4), by striking ''abuse'' each place it appears and inserting ''use disorders''; and

(3) by striking ''2017 through 2021'' and inserting ''2023 through 2027''.

SEC. 222. EMERGENCY DEPARTMENT ALTERNATIVES TO OPIOIDS.

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

(1) in the section heading, by striking ''**DEMONSTRATION**'' (and by conforming the item relating to such section in the table of contents in section 1(b));

(2) in subsection (a)—

(A) by amending the subsection heading to read as follows: ''GRANT PROGRAM''; and

(B) in paragraph (1), by striking ''demonstration'';

(3) in subsection (b), in the subsection heading, by striking ''DEMONSTRATION'';

(4) in subsection (d)(4), by striking ''tribal'' and inserting ''Tribal'';

(5) in subsection (f), by striking ''Not later than 1 year after completion of the demonstration program under this section, the Secretary shall submit a report to the Congress on the results of the demonstration program'' and inserting ''Not later than the end of each of fiscal years 2024 and 2027, the Secretary shall submit to the Congress a report on the results of the program''; and

(6) in subsection (g), by striking ''2019 through 2021'' and inserting ''2023 through 2027''.

Subtitle C—Excellence in Recovery Housing

SEC. 231. CLARIFYING THE ROLE OF SAMHSA IN PROMOTING THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

(1) in paragraph (24)(E), by striking ''and'' at the end;

(2) in paragraph (25), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(26) collaborate with national accrediting entities, reputable providers, organizations or individuals with established expertise in delivery of recovery housing services, States, Federal agencies (including the Department of Health and Human Services, the Department of Housing and Urban Development, and the agencies listed in section 550(e)(2)(B)), and other relevant stakeholders, to promote the availability of high-quality recovery housing and services for individuals with a substance use disorder.''.

SEC. 232. DEVELOPING GUIDELINES FOR STATES TO PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOVERY HOUSING.

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

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

''(1) IN GENERAL.—The Secretary, in consultation with the individuals and entities specified in paragraph (2), shall build on existing best practices and previously developed guidelines to develop and periodically update consensus-based best practices, which may include model laws for implementing suggested minimum standards for operating, and promoting the availability of, high-quality recovery housing.'';

(2) in paragraph (2)—

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

''(A) Officials representing the agencies described in subsection (e)(2).''; and

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

(3) by adding at the end the following:

''(3) AVAILABILITY.—The best practices referred to in paragraph (1) shall be—

''(A) made publicly available; and

''(B) published on the public website of the Substance Abuse and Mental Health Services Administration.

''(4) EXCLUSION OF GUIDELINE ON TREATMENT SERVICES.—In developing the guidelines under paragraph (1), the Secretary may not include any guidelines with respect to substance use disorder treatment services.''.

SEC. 233. COORDINATION OF FEDERAL ACTIVITIES TO PROMOTE THE AVAILABILITY OF RECOVERY HOUSING.

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

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

(2) by inserting after subsection (d) the following:

''(e) COORDINATION OF FEDERAL ACTIVITIES TO PROMOTE THE AVAILABILITY OF HOUSING FOR INDIVIDUALS EXPERIENCING HOMELESSNESS, INDIVIDUALS WITH A MENTAL ILLNESS, AND INDIVIDUALS WITH A SUBSTANCE USE DISORDER.—

''(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, and the Secretary of Housing and Urban Development shall convene an interagency working group for the following purposes:

''(A) To increase collaboration, cooperation, and consultation among the Department of Health and Human Services, the Department of Housing and Urban Development, and the Federal agencies listed in paragraph (2)(B), with respect to promoting the availability of housing, including recovery housing, for individuals experiencing homelessness, individuals with mental illnesses, and individuals with substance use disorder.

''(B) To align the efforts of such agencies and avoid duplication of such efforts by such agencies.

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

''(D) To coordinate enforcement of fair housing practices, as appropriate, among Federal and State agencies.

''(E) To coordinate data collection on the quality of recovery housing.

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

''(A) the Secretary, acting through the Assistant Secretary, and the Secretary of Housing and Urban Development, who shall serve as the co-chairs; and

''(B) representatives of each of the following Federal agencies:

''(i) The Centers for Medicare & Medicaid Services.

''(ii) The Substance Abuse and Mental Health Services Administration.

''(iii) The Health Resources and Services Administration.

''(iv) The Office of Inspector General.

''(v) The Indian Health Service.

''(vi) The Department of Agriculture.

''(vii) The Department of Justice.

''(viii) The Office of National Drug Control Policy.

''(ix) The Bureau of Indian Affairs.

''(x) The Department of Labor.

''(xi) The Department of Veterans Affairs.

''(xii) Any other Federal agency as the co-chairs determine appropriate.

''(3) MEETINGS.—The working group shall meet on a quarterly basis.

''(4) REPORTS TO CONGRESS.—Not later than 4 years after the date of the enactment of this section, the working group shall submit to the Committee on Energy and Commerce, the Committee on Ways and Means, the Committee on Agriculture, and the Committee on Financial Services of the House of Representatives and the Committee on Health, Education, Labor, and Pensions, the Committee on Agriculture, Nutrition, and Forestry, and the Committee on Finance of the Senate a report describing the work of the working group and any recommendations of the working group to improve Federal, State, and local coordination with respect to recovery housing and other housing resources and operations for individuals experiencing homelessness, individuals with a mental illness, and individuals with a substance use disorder.''.

SEC. 234. NAS STUDY AND REPORT.

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

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

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

(B) to identify recommendations to promote the availability of high-quality recovery housing; and

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

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

SEC. 235. GRANTS FOR STATES TO PROMOTE THE AVAILABILITY OF RECOVERY HOUSING AND SERVICES.

Section 550 of the Public Health Service Act (42 U.S.C. 290ee–5) (relating to national recovery housing best practices), as amended by sections 232 and 233, is further amended by inserting after subsection (e) (as inserted by section 233) the following:

''(f) GRANTS FOR IMPLEMENTING NATIONAL RECOVERY HOUSING BEST PRACTICES.—

''(1) IN GENERAL.—The Secretary shall award grants to States (and political subdivisions thereof), Tribes, and territories—

''(A) for the provision of technical assistance to implement the guidelines and recommendations developed under subsection (a); and

''(B) to promote—

''(i) the availability of recovery housing for individuals with a substance use disorder; and

''(ii) the maintenance of recovery housing in accordance with best practices developed under this section.

''(2) STATE PROMOTION PLANS.—Not later than 90 days after receipt of a grant under paragraph (1), and every 2 years thereafter, each State (or political subdivisions thereof,) Tribe, or territory receiving a grant under paragraph (1) shall submit to the Secretary, and publish on a publicly accessible internet website of the State (or political subdivisions thereof), Tribe, or territory—

''(A) the plan of the State (or political subdivisions thereof), Tribe, or territory, with respect to the promotion of recovery housing for individuals with a substance use disorder located within the jurisdiction of such State (or political subdivisions thereof), Tribe, or territory; and

''(B) a description of how such plan is consistent with the best practices developed under this section.''.

SEC. 236. FUNDING.

Subsection (i) of section 550 of the Public Health Service Act (42 U.S.C. 290ee–5) (relating to national recovery housing best practices), as redesignated by section 233, is amended by striking ''$3,000,000 for the period of fiscal years 2019 through 2021'' and inserting ''$5,000,000 for the period of fiscal years 2023 through 2027''.

SEC. 237. TECHNICAL CORRECTION.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended—

(1) by redesignating section 550 (relating to Sobriety Treatment and Recovery Teams) (42 U.S.C. 290ee–10), as added by section 8214 of Public Law 115–271, as section 550A; and

(2) by moving such section so it appears after section 550 (relating to national recovery housing best practices).

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

SEC. 241. ELIMINATING STIGMATIZING LANGUAGE RELATING TO SUBSTANCE USE.

(a) BLOCK GRANTS FOR PREVENTION AND TREATMENT OF SUBSTANCE USE.—Part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) is amended—

(1) in the part heading, by striking ''**SUBSTANCE ABUSE**'' and inserting ''**SUBSTANCE USE**'';

(2) in subpart II, by amending the subpart heading to read as follows: ''***Block Grants for Substance Use Prevention, Treatment, and Recovery Services***'';

(3) in section 1922(a) (42 U.S.C. 300x–22(a))—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(B) by striking ''such abuse'' each place it appears in paragraphs (1) and (2) and inserting ''such disorders'';

(4) in section 1923 (42 U.S.C. 300x–23)—

(A) in the section heading, by striking ''**SUBSTANCE ABUSE**'' and inserting ''**SUBSTANCE USE**''; and

(B) in subsection (a), by striking ''drug abuse'' and inserting ''substance use disorders'';

(5) in section 1925(a)(1) (42 U.S.C. 300x–25(a)(1)), by striking ''alcohol or drug abuse'' and inserting ''alcohol or other substance use disorders'';

(6) in section 1926(b)(2)(B) (42 U.S.C. 300x–26(b)(2)(B)), by striking ''substance abuse'';

(7) in section 1931(b)(2) (42 U.S.C. 300x–31(b)(2)), by striking ''substance abuse'' and inserting ''substance use disorders'';

(8) in section 1933(d)(1) (42 U.S.C. 300x–33(d)), in the matter following subparagraph (B), by striking ''abuse of alcohol and other drugs'' and inserting ''use of substances'';

(9) by amending paragraph (4) of section 1934 (42 U.S.C. 300x–34) to read as follows:

''(4) The term 'substance use disorder' means the recurrent use of alcohol or other drugs that causes clinically significant impairment.'';

(10) in section 1935 (42 U.S.C. 300x–35)—

(A) in subsection (a), by striking ''substance abuse'' and inserting ''substance use disorders''; and

(B) in subsection (b)(1), by striking ''substance abuse'' each place it appears and inserting ''substance use disorders'';

(11) in section 1949 (42 U.S.C. 300x–59), by striking ''substance abuse'' each place it appears in subsections (a) and (d) and inserting ''substance use disorders'';

(12) in section 1954(b)(4) (42 U.S.C. 300x–64(b)(4))—

(A) by striking ''substance abuse'' and inserting ''substance use disorders''; and

(B) by striking ''such abuse'' and inserting ''such disorders'';

(13) in section 1955 (42 U.S.C. 300x–65), by striking ''substance abuse'' each place it appears and inserting ''substance use disorder''; and

(14) in section 1956 (42 U.S.C. 300x–66), by striking ''substance abuse'' and inserting ''substance use disorders''.

(b) CERTAIN PROGRAMS REGARDING MENTAL HEALTH AND SUBSTANCE ABUSE.—Part C of title XIX of the Public Health Service Act (42 U.S.C. 300y et seq.) is amended—

(1) in the part heading, by striking ''**SUBSTANCE ABUSE**'' and inserting ''**SUBSTANCE USE**'';

(2) in section 1971 (42 U.S.C. 300y), by striking ''substance abuse'' each place it appears in subsections (a), (b), and (f) and inserting ''substance use''; and

(3) in section 1976 (42 U.S.C. 300y–11), by striking ''intravenous abuse'' each place it appears and inserting ''intravenous use''.

SEC. 242. AUTHORIZED ACTIVITIES.

Section 1921(b) of the Public Health Service Act (42 U.S.C. 300x–21(b)) is amended by striking ''prevent and treat substance use disorders'' and inserting ''prevent, treat, and provide recovery support services for substance use disorders''.

SEC. 243. REQUIREMENTS RELATING TO CERTAIN INFECTIOUS DISEASES AND HUMAN IMMUNODEFICIENCY VIRUS.

Section 1924 of the Public Health Service Act (42 U.S.C. 300x–24) is amended—

(1) in the section heading, by striking ''**TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS**'' and inserting ''**TUBERCULOSIS, VIRAL HEPATITIS, AND HUMAN IMMUNODEFICIENCY VIRUS**'';

(2) by amending subsection (a)(2) to read as follows:

''(2) DESIGNATED STATES.—

''(A) FISCAL YEARS THROUGH FISCAL YEAR 2024.—For purposes of this subsection, through September 30, 2024, a State described in this paragraph is any State whose rate of cases of acquired immune deficiency syndrome is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the most recent calendar year for which such data are available).

''(B) FISCAL YEAR 2025 AND SUCCEEDING FISCAL YEARS.—

''(i) IN GENERAL.—Beginning with fiscal year 2025, for purposes of this subsection, a State described in this paragraph is any State whose rate of cases of human immunodeficiency virus is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases newly reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the most recent calendar year for which such data are available).

''(ii) CONTINUATION OF DESIGNATED STATE STATUS.—In the case of a State whose rate of cases of human immunodeficiency virus falls below the threshold specified in clause (i) for a calendar year, such State shall, notwithstanding clause (i), continue to be described in this paragraph unless the rate of cases falls below such threshold for three consecutive calendar years.''.

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

(4) by inserting after subsection (b) the following:

''(c) VIRAL HEPATITIS.—

''(1) IN GENERAL.—A funding agreement for a grant under section 1921 is that the State involved will require that any entity receiving amounts from the grant for operating a program of treatment for substance use disorders—

''(A) will, directly or through arrangements with other public or nonprofit private entities, routinely make available viral hepatitis services to each individual receiving treatment for such disorders; and

''(B) in the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of viral hepatitis services.

''(2) VIRAL HEPATITIS SERVICES.—For purposes of paragraph (1), the term 'viral hepatitis services', with respect to an individual, means—

''(A) screening the individual for viral hepatitis; and

''(B) referring the individual to a provider whose practice includes viral hepatitis vaccination and treatment.''.

SEC. 244. STATE PLAN REQUIREMENTS.

Section 1932(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300x–32(b)(1)(A)) is amended—

(1) by redesignating clauses (vi) through (ix) as clauses (vii) through (x), respectively; and

(2) by inserting after clause (v) the following:

''(vi) provides a description of—

''(I) the State's comprehensive statewide recovery support services activities, including the number of individuals being served, target populations, and priority needs; and

''(II) the amount of funds received under this subpart expended on recovery support services, disaggregated by the amount expended for type of service activity;''.

SEC. 245. UPDATING CERTAIN LANGUAGE RELATING TO TRIBES.

Section 1933(d) of the Public Health Service Act (42 U.S.C. 300x–33(d)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking ''of an Indian tribe or tribal organization'' and inserting ''of an Indian Tribe or Tribal organization''; and

(ii) by striking ''such tribe'' and inserting ''such Tribe'';

(B) in subparagraph (B)—

(i) by striking ''tribe or tribal organization'' and inserting ''Tribe or Tribal organization''; and

(ii) by striking ''Secretary under this'' and inserting ''Secretary under this subpart''; and

(C) in the matter following subparagraph (B), by striking ''tribe or tribal organization'' and inserting ''Tribe or Tribal organization'';

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

''(2) INDIAN TRIBE OR TRIBAL ORGANIZATION AS GRANTEE.—The amount reserved by the Secretary on the basis of a determination under this subsection shall be granted to the Indian Tribe or Tribal organization serving the individuals for whom such a determination has been made.'';

(3) in paragraph (3), by striking ''tribe or tribal organization'' and inserting ''Tribe or Tribal organization''; and

(4) in paragraph (4)—

(A) in the paragraph heading, by striking ''DEFINITION'' and inserting ''DEFINITIONS''; and

(B) by striking ''The terms'' and all that follows through ''given such terms'' and inserting the following: ''The terms 'Indian Tribe' and 'Tribal organization' have the meanings given the terms 'Indian tribe' and 'tribal organization' ''.

SEC. 246. BLOCK GRANTS FOR SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES.

(a) IN GENERAL.—Section 1935(a) of the Public Health Service Act (42 U.S.C. 300x–35(a)), as amended by section 241, is further amended by striking ''appropriated'' and all that follows through ''2022..'' and inserting the following: ''appropriated $1,908,079,000 for each of fiscal years 2023 through 2027.''.

(b) TECHNICAL CORRECTIONS.—Section 1935(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300x–35(b)(1)(B)) is amended by striking ''the collection of data in this paragraph is''.

SEC. 247. REQUIREMENT OF REPORTS AND AUDITS BY STATES.

Section 1942(a) of the Public Health Service Act (42 U.S.C. 300x–52(a)) is amended—

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

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

(3) by adding at the end the following:

''(3) the amount provided to each recipient in the previous fiscal year.''.

SEC. 248. STUDY ON ASSESSMENT FOR USE IN DISTRIBUTION OF LIMITED STATE RESOURCES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use (in this section referred to as the ''Secretary''), shall, in consultation with States and other local entities providing prevention, treatment, or recovery support services related to substance use, conduct a study to develop a model needs assessment process for States to consider to help determine how best to allocate block grant funding received under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21) to provide services to substance use disorder prevention, treatment, and recovery support. The study shall include cost estimates with each model needs assessment process.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the 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.

(b) PRIVACY.—The section does not authorize the disclosure by the Department of Health and Human Services of individually identifiable information about patients.

(c) FEEDBACK.—In conducting the study under subsection (a), the Assistant Secretary for Mental Health and Substance Use shall gather feedback from the States and opioid treatment programs on their experiences in implementing exemptions described in subsection (a).

(d) REPORT.—Not later than 180 days after the end of the period described in subsection (a)(3)(B), and subject to subsection (c), the Assistant Secretary for Mental Health and Substance Use shall publish a report on the results of the study under this section.

SEC. 252. CHANGES TO FEDERAL OPIOID TREATMENT STANDARDS.

(a) MOBILE MEDICATION UNITS.—Section 302(e) of the Controlled Substances Act (21 U.S.C. 822(e)) is amended by adding at the end the following:

''(3) Notwithstanding paragraph (1), a registrant that is dispensing pursuant to section 303(g) narcotic drugs to individuals for maintenance treatment or detoxification treatment shall not be required to have a separate registration to incorporate one or more mobile medication units into the registrant's practice to dispense such narcotics at locations other than the registrant's principal place of business or professional practice described in paragraph (1), so long as the registrant meets such standards for operation of a mobile medication unit as the Attorney General may establish.''.

(b) REVISE OPIOID TREATMENT PROGRAM ADMISSION CRITERIA TO ELIMINATE REQUIREMENT THAT PATIENTS HAVE AN OPIOID USE DISORDER FOR AT LEAST 1 YEAR.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall revise section 8.12(e)(1) of title 42, Code of Federal Regulations (or successor regulations), to eliminate the requirement that an opioid treatment program only admit an individual for treatment under the program if the individual has been addicted to opioids for at least 1 year before being so admitted for treatment.

(c) FINAL REGULATION ON PERIODS FOR TAKE-HOME SUPPLY REQUIREMENTS.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate a final regulation amending paragraphs (i)(3)(i) through (i)(3)(vi) of section 8.12 of title 42, Code of Federal Regulations, as appropriate based on the findings of the study under section 251 of this Act.

(2) CRITERIA.—The regulation under paragraph (1) shall establish relevant criteria for the medical director or an appropriately licensed practitioner of an opioid treatment program, to determine whether a patient is stable and may qualify for unsupervised use, which criteria may allow for consideration of each of the following:

(A) Whether the benefits of providing unsupervised doses to a patient outweigh the risks.

(B) The patient's demonstrated adherence to their treatment plan.

(C) The patient's history of negative toxicology tests.

(D) Whether there is an absence of serious behavioral problems.

(E) The patient's stability in living arrangements and social relationships.

(F) Whether there is an absence of substance misuse-related behaviors.

(G) Whether there is an absence of recent diversion activity.

(H) Whether there is an assurance that the medication can be safely stored by the patient.

(I) Any other criterion the Secretary of Health and Human Services determines appropriate.

(3) PROHIBITED SOLE CONSIDERATION.—The regulation under paragraph (1) shall prohibit the medical director of an opioid treatment program from considering, as the sole consideration in determining whether a patient is sufficiently responsible in handling opioid drugs for unsupervised use, whether the patient has an absence of recent misuse of drugs (whether narcotic or nonnarcotic), including alcohol.

Subtitle F—Additional Provisions Relating to Addiction Treatment

SEC. 261. PROHIBITION.

Notwithstanding any provision of this Act and the amendments made by this Act, no funds

made available to carry out this Act or any amendment made by this Act shall be used to purchase, procure, or distribute pipes or cylindrical objects intended to be used to smoke or inhale illegal scheduled substances.

SEC. 262. ELIMINATING ADDITIONAL REQUIREMENTS FOR DISPENSING NARCOTIC DRUGS IN SCHEDULE III, IV, AND V FOR MAINTENANCE OR DETOXIFICATION TREATMENT.

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

(1) by striking paragraph (2);

(2) by striking ''(g)(1) Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment'' and inserting ''(g) Practitioners who dispense narcotic drugs (other than narcotic drugs in schedule III, IV, or V) to individuals for maintenance treatment or detoxification treatment'';

(3) by redesignating subparagraphs (A), (B), and (C) as paragraphs (1), (2), and (3), respectively; and

(4) in paragraph (2), as so redesignated—

(A) by striking ''(i) security of stocks'' and inserting ''(A) security of stocks''; and

(B) by striking ''(ii) the maintenance of records'' and inserting ''(B) the maintenance of records''.

(b) CONFORMING CHANGES.—

(1) Subsections (a) and (d)(1) of section 304 of the Controlled Substances Act (21 U.S.C. 824) are each amended by striking ''303(g)(1)'' each place it appears and inserting ''303(g)''.

(2) Section 309A(a)(2) of the Controlled Substances Act (21 U.S.C. 829a) is amended—

(A) in the matter preceding subparagraph (A), by striking ''the controlled substance is to be administered for the purpose of maintenance or detoxification treatment under section 303(g)(2)'' and inserting ''the controlled substance is a narcotic drug in schedule III, IV, or V to be administered for the purpose of maintenance or detoxification treatment''; and

(B) by striking ''and—'' and all that follows through ''is to be administered by injection or implantation;'' and inserting ''and is to be administered by injection or implantation;''.

(3) Section 520E–4(c) of the Public Health Service Act (42 U.S.C. 290bb–36d(c)) is amended by striking ''information on any qualified practitioner that is certified to prescribe medication for opioid dependency under section 303(g)(2)(B) of the Controlled Substances Act'' and inserting ''information on any practitioner who prescribes narcotic drugs in schedule III, IV, or V of section 202 of the Controlled Substances Act for the purpose of maintenance or detoxification treatment''.

(4) Section 544(a)(3) of the Public Health Service Act (42 U.S.C. 290dd–3), as added by section 219(a)(2), is amended by striking ''any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act'' and inserting ''any practitioner dispensing narcotic drugs for the purpose of maintenance or detoxification treatment''.

(5) Section 1833(bb)(3)(B) of the Social Security Act (42 U.S.C. 1395l(bb)(3)(B)) is amended by striking ''first receives a waiver under section 303(g) of the Controlled Substances Act on or after January 1, 2019'' and inserting ''first begins prescribing narcotic drugs in schedule III, IV, or V of section 202 of the Controlled Substances Act for the purpose of maintenance or detoxification treatment on or after January 1, 2021''.

(6) Section 1834(o)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(o)(3)(C)(ii)) is amended by striking ''first receives a waiver under section 303(g) of the Controlled Substances Act on or after January 1, 2019'' and inserting ''first begins prescribing narcotic drugs in schedule III, IV, or V of section 202 of the Controlled Substances Act for the purpose of maintenance or detoxification treatment on or after January 1, 2021''.

(7) Section 1866F(c)(3) of the Social Security Act (42 U.S.C. 1395cc–6(c)(3)) is amended—

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

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

(C) by striking subparagraph (C).

(8) Section 1903(aa)(2)(C) of the Social Security Act (42 U.S.C. 1396b(aa)(2)(C)) is amended—

(A) in clause (i), by adding ''and'' at the end;

(B) by striking clause (ii); and

(C) by redesignating clause (iii) as clause (ii).

SEC. 263. REQUIRING PRESCRIBERS OF CONTROLLED SUBSTANCES TO COMPLETE TRAINING.

Section 303 of the Controlled Substances Act (21 U.S.C. 823) is amended by adding at the end the following:

''(l) REQUIRED TRAINING FOR PRESCRIBERS.—

''(1) TRAINING REQUIRED.—As a condition on registration under this section to dispense controlled substances in schedule II, III, IV, or V, the Attorney General shall require any qualified practitioner, beginning with the first applicable registration for the practitioner, to meet the following:

''(A) If the practitioner is a physician is a physician (as defined under section 1861(r) of the Social Security Act), the practitioner meets one ore more of the following conditions:

''(i) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.

''(ii) The physician holds a board certification from the American Board of Addiction Medicine.

''(iii) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

''(iv) The physician has, with respect to the treatment and management of patients with opioid or other substance use disorders, of the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid or other substance use disorders, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise that is provided by—

''(I) the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Dental Association, the American Association of Oral and Maxillofacial Surgeons, the American Psychiatric Assocation, or any other organization accredited by the Accreditation Council for Continuing Medical Education (commonly known as the 'ACCME') or the Commission on Dental Accreditation;

''(II) any organization accredited by a State medical society accreditor that is recognized by the ACCME or the Commission on Dental Accreditation;

''(III) any organization accredited by the American Osteopathic Association to provide continuing medical education; or

''(IV) any organization approved by the Assistant Secretary for Mental Health and Substance Abuse or the ACCME, of the Commission on Dental Accreditation.

''(v) The physician graduated in good standing from an accredited school of allopathic medicine or osteopathic medicine, dental surgery, or dental medicine in the United States during the 5-year period immediately preceding the date on which the physician first registers or renews under this section and has successfully completed a comprehensive allopathic or osteopathic medicine curriculum or accredited medical residency or dental surgery or dental medicine curriculum that included not less than 8 hours of training on—hat included not less than 8 hours of training on treating and managing patients with opioid and other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder.

''(I) treating and managing patents with opioid and other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder; or

''(II) the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid and other substance us disorders.

''(B) If the practitioner is not a physician (as defined under section 1861(r) of the Social Security Act), the practitioner meets one or more of the following conditions:

''(i) The practitioner has completed not fewer than 8 hours of training with respect to the treatment and management of patients with opioid or other substance use disorders (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Associates, or any other organization approved or accredited by the Assistant Secretary for Mental Health and Substance Abuse or the or the Accreditation Council for Continuing Medical Education.

''(ii) The practitioner has graduated in good standing from an accredited physician assistant school or accredited school of advanced practice nursing in the United States during the 5-year period immediately preceding the date on which the practitioner first registers or renews under this section and has successfully completed a comprehensive physician assistant or advanced practice nursing curriculum that included not fewer than 8 hours of training on treating and managing patients with opioid and other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder.

''(2) ONE-TIME TRAINING.—

''(A) IN GENERAL.—The Attorney General shall not require any qualified practitioner to complete the training described in clause (iv) or (v) of paragraph (1)(A) or clause (i) or (ii) of paragraph (1)(B) more than once.

''(B) Notification.—Not later than 90 days after the date of the enactment of the Restoring Hope for mental health and Well-Being Act of 2022, the Attorney General shall provide to qualified practitioners a single written, electronic notification of the training described in clauses (i) and (ii) of paragraph (1)(B).

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to preclude the use, by a qualified practitioner, of training received pursuant to this subsection to satisfy registration requirements of a State or for some other lawful purpose.

''(4) DEFINITIONS.—In this section:

''(A) FIRST APPLICABLE REGISTRATION.—The term 'first applicable registration' means the first registration or renewal of registration by a qualified practitioner under this section that occurs on or after the date that is 180 days after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022.

''(B) QUALIFIED PRACTITIONER.—In this subsection, the term 'qualified practitioner' means a practitioner who—

''(i) is licensed under State law to prescribe controlled substances; and

''(ii) is not solely a veterinarian.''.

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.

Section 520K of the Public Health Service Act (42 U.S.C. 290bb–42) is amended to read as follows:

"SEC. 520K. INTEGRATION INCENTIVE GRANTS AND COOPERATIVE AGREEMENTS.

''(a) DEFINITIONS.—In this section:

''(1) COLLABORATIVE CARE MODEL.—The term 'collaborative care model' means the evidence-based, integrated behavioral health service delivery method that includes—

''(A) care directed by the primary care team;

''(B) structured care management;

''(C) regular assessments of clinical status using developmentally appropriate, validated tools; and

''(D) modification of treatment as appropriate.

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, or an appropriate State agency, in collaboration with—

''(A) 1 or more qualified community programs as described in section 1913(b)(1);

''(B) 1 or more health centers (as defined in section 330(a)), a rural health clinic (as defined in section 1961(aa) of the Social Security Act), or a Federally qualified health center (as defined in such section); or

''(C) 1 or more primary health care practices.

''(3) INTEGRATED CARE; BIDIRECTIONAL INTEGRATED CARE.—

''(A) The term 'integrated care' means models or practices for coordinating and jointly delivering behavioral and physical health services, which may include practices that share the same space in the same facility.

''(B) The term 'bidirectional integrated care' means the integration of behavioral health care and specialty physical health care, as well as the integration of primary and physical health care with specialty behavioral health settings, including within primary health care settings.

''(4) PRIMARY HEALTH CARE PROVIDER.—The term 'primary health care provider' means a provider who—

''(A) provides health services related to family medicine, internal medicine, pediatrics, obstetrics, gynecology, or geriatrics; or

''(B) is a doctor of medicine or osteopathy, physician assistant, or nurse practitioner, who is licensed to practice medicine by the State in which such physician, assistant, or practitioner primarily practices, including within primary health care settings.

''(5) PRIMARY HEALTH CARE PRACTICE.—The term 'primary health care practice' means a medical practice of primary health care providers, including a practice within a larger health care system.

''(6) SPECIAL POPULATION.—The term 'special population', for an eligible entity that is collaborating with an entity described in subparagraph (A) or (B) of paragraph (3), means—

''(A) adults with a serious mental illness who have a co-occurring physical health condition or chronic disease;

''(B) children and adolescents with a mental illness who have a co-occurring physical health condition or chronic disease;

''(C) individuals with a substance use disorder; or

''(D) individuals with a mental illness who have a co-occurring substance use disorder.

''(b) GRANTS AND COOPERATIVE AGREEMENTS.—

''(1) IN GENERAL.—The Secretary may award grants and cooperative agreements to eligible entities to support the improvement of integrated care for physical and behavioral health care in accordance with paragraph (2).

''(2) USE OF FUNDS.—A grant or cooperative agreement awarded under this section shall be used—

''(A) in the case of an eligible entity that is collaborating with an entity described in subparagraph (A) or (B) of subsection (a)(2)—

''(i) to promote full integration and collaboration in clinical practices between physical and behavioral health care for special populations including each population listed in subsection (a)(7);

''(ii) to support the improvement of integrated care models for physical and behavioral health care to improve the overall wellness and physical health status of—

''(I) adults with a serious mental illness or children with a serious emotional disturbance; and

''(II) individuals with a substance use disorder; and

''(iii) to promote bidirectional integrated care services including screening, diagnosis, prevention, treatment, and recovery of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases; and

''(B) in the case of an eligible entity that is collaborating with a primary health care practice, to support the uptake of the collaborative care model, including by—

''(i) hiring staff;

''(ii) identifying and formalizing contractual relationships with other health care providers, including providers who will function as psychiatric consultants and behavioral health care managers in providing behavioral health integration services through the collaborative care model;

''(iii) purchasing or upgrading software and other resources needed to appropriately provide behavioral health integration services through the collaborative care model, including resources needed to establish a patient registry and implement measurement-based care; and

''(iv) for such other purposes as the Secretary determines to be necessary.

''(c) APPLICATIONS.—

''(1) IN GENERAL.—An eligible entity that is collaborating with an entity described in subparagraph (A) or (B) of subsection (a)(2) seeking a grant or cooperative agreement under subsection (b)(2)(A) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require, including the contents described in paragraph (2).

''(2) CONTENTS.—Any such application of an eligible entity described in subparagraph (A) or (B) of subsection (a)(2) shall include—

''(A) a description of a plan to achieve fully collaborative agreements to provide bidirectional integrated care to special populations;

''(B) a document that summarizes the policies, if any, that are barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers;

''(C) a description of partnerships or other arrangements with local health care providers to provide services to special populations;

''(D) an agreement and plan to report to the Secretary performance measures necessary to evaluate patient outcomes and facilitate evaluations across participating projects;

''(E) a description of how validated rating scales will be implemented to support the improvement of patient outcomes using measurement-based care, including those related to depression screening, patient follow-up, and symptom remission; and

''(F) a plan for sustainability beyond the grant or cooperative agreement period under subsection (e).

''(3) COLLABORATIVE CARE MODEL GRANTS.—An eligible entity that is collaborating with a primary health care practice seeking a grant pursuant to subsection (b)(2)(B) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) GRANT AND COOPERATIVE AGREEMENT AMOUNTS.—

''(1) TARGET AMOUNT.—The target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section shall be—

''(A) $2,000,000 for an eligible entity described in subparagraph (A) or (B) of subsection (a)(2); or

''(B) $100,000 or less for an eligible entity described in subparagraph (C) of subsection (a)(2).

''(2) ADJUSTMENT PERMITTED.—The Secretary, taking into consideration the quality of an eligible entity's application and the number of eligible entities that received grants under this section prior to the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, may adjust the target amount that an eligible entity may receive for a year through a grant or cooperative agreement under this section.

''(3) LIMITATION.—An eligible entity that is collaborating with an entity described in subparagraph (A) or (B) of subsection (a)(2) receiving funding under this section—

''(A) may not allocate more than 20 percent of the funds awarded to such eligible entity under this section to administrative functions; and

''(B) shall allocate the remainder of such funding to health facilities that provide integrated care.

''(e) DURATION.—A grant or cooperative agreement under this section shall be for a period not to exceed 5 years.

''(f) REPORT ON PROGRAM OUTCOMES.—An eligible entity receiving a grant or cooperative agreement under this section—

''(1) that is collaborating with an entity described in subparagraph (A) or (B) of subsection (a)(2) shall submit an annual report to the Secretary that includes—

''(A) the progress made to reduce barriers to integrated care as described in the entity's application under subsection (c); and

''(B) a description of outcomes with respect to each special population listed in subsection (a)(7), including outcomes related to education, employment, and housing; or

''(2) that is collaborating with a primary health care practice shall submit an annual report to the Secretary that includes—

''(A) the progress made to improve access;

''(B) the progress made to improve patient outcomes; and

''(C) the progress made to reduce referrals to specialty care.

''(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAVIORAL HEALTH CARE INTEGRATION.—

''(1) CERTAIN RECIPIENTS.—The Secretary may provide appropriate information, training, and technical assistance to eligible entities that are collaborating with an entity described in subparagraph (A) or (B) of subsection (a)(2) that receive a grant or cooperative agreement under this section, in order to help such entities meet the requirements of this section, including assistance with—

''(A) development and selection of integrated care models;

''(B) dissemination of evidence-based interventions in integrated care;

''(C) establishment of organizational practices to support operational and administrative success; and

''(D) other activities, as the Secretary determines appropriate.

''(2) COLLABORATIVE CARE MODEL RECIPIENTS.—The Secretary shall provide appropriate information, training, and technical assistance to eligible entities that are collaborating with primary health care practices that receive funds under this section to help such entities implement the collaborative care model, including—

''(A) developing financial models and budgets for implementing and maintaining a collaborative care model, based on practice size;

''(B) developing staffing models for essential staff roles;

''(C) providing strategic advice to assist practices seeking to utilize other clinicians for additional psychotherapeutic interventions;

''(D) providing information technology expertise to assist with building the collaborative care

model into electronic health records, including assistance with care manager tools, patient registry, ongoing patient monitoring, and patient records;

''(E) training support for all key staff and operational consultation to develop practice workflows;

''(F) establishing methods to ensure the sharing of best practices and operational knowledge among primary health care physicians and primary health care practices that provide behavioral health integration services through the collaborative care model; and

''(G) providing guidance and instruction to primary health care physicians and primary health care practices on developing and maintaining relationships with community-based mental health and substance use disorder facilities for referral and treatment of patients whose clinical presentation or diagnosis is best suited for treatment at such facilities.

''(3) ADDITIONAL DISSEMINATION OF TECHNICAL INFORMATION.—In addition to providing the assistance described in paragraphs (1) and (2) to recipients of a grant or cooperative agreement under this section, the Secretary may also provide such assistance to other States and political subdivisions of States, Indian Tribes and Tribal organizations (as defined under the Federally Recognized Indian Tribe List Act of 1994), outpatient mental health and addiction treatment centers, community mental health centers that meet the criteria under section 1913(c), certified community behavioral health clinics described in section 223 of the Protecting Access to Medicare Act of 2014, primary care organizations such as Federally qualified health centers or rural health clinics as defined in section 1861(aa) of the Social Security Act, primary health care practices, other community-based organizations, and other entities engaging in integrated care activities, as the Secretary determines appropriate.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2023 through 2027.''.

Subtitle B—Helping Enable Access to Lifesaving Services

SEC. 311. REAUTHORIZATION AND PROVISION OF CERTAIN PROGRAMS TO STRENGTHEN THE HEALTH CARE WORKFORCE.

(a) LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS.—Section 224(q)(6) of the Public Health Service Act (42 U.S.C. 233(q)(6)) is amended by striking ''October 1, 2022'' and inserting ''October 1, 2027''.

(b) MINORITY FELLOWSHIPS IN CRISIS CARE MANAGEMENT.—Section 597(b) of the Public Health Service Act (42 U.S.C. 290ll(b)) is amended by striking ''in the fields of psychiatry,'' and inserting ''in the fields of crisis care management, psychiatry,''.

(c) MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.—Section 756 of the Public Health Service Act (42 U.S.C. 294e–1) is amended—

(1) in subsection (a)(1), by inserting ''(which may include master's and doctoral level programs)'' after ''occupational therapy''; and

(2) in subsection (f), by striking ''For each of fiscal years 2019 through 2023'' and inserting ''For each of fiscal years 2023 through 2027''.

(d) TRAINING DEMONSTRATION PROGRAM.—Section 760(g) of the Public Health Service Act (42 U.S.C. 294k(g)) is amended by inserting ''and $31,700,000 for each of fiscal years 2023 through 2027'' before the period at the end.

SEC. 312. REAUTHORIZATION OF MINORITY FELLOWSHIP PROGRAM.

Section 597(c) of the Public Health Service Act (42 U.S.C. 290ll(c)) is amended by striking ''$12,669,000 for each of fiscal years 2018 through 2022'' and inserting $25,000,000 for each fiscal years 2023 through 2027''.

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

SEC. 321. ELIMINATING THE OPT-OUT FOR NONFEDERAL GOVERNMENTAL HEALTH PLANS.

Section 2722(a)(2) of the Public Health Service Act (42 U.S.C. 300gg–21(a)(2)) is amended by adding at the end the following new subparagraph:

''(F) SUNSET OF ELECTION OPTION.—

''(i) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph—

''(I) no election described in subparagraph (A) with respect to section 2726 may be made on or after the date of the enactment of this subparagraph; and

''(II) except as provided in clause (ii), no such election with respect to section 2726 expiring on or after the date that is 180 days after the date of such enactment may be renewed.

''(ii) EXCEPTION FOR CERTAIN COLLECTIVELY BARGAINED PLANS.—Notwithstanding clause (i)(II), a plan described in subparagraph (B)(ii) that is subject to multiple agreements described in such subparagraph of varying lengths and that has an election described in subparagraph (A) with respect to section 2726 in effect as of the date of the enactment of this subparagraph that expires on or after the date that is 180 days after the date of such enactment may extend such election until the date on which the term of the last such agreement expires.''.

Subtitle D—Mental Health and Substance Use Disorder Parity Implementation

SEC. 331. GRANTS TO SUPPORT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION.

(a) IN GENERAL.—Section 2794(c) of the Public Health Service Act (42 U.S.C. 300gg–94(c)) (as added by section 1003 of the Patient Protection and Affordable Care Act (Public Law 111–148)) is amended by adding at the end the following:

''(3) PARITY IMPLEMENTATION.—

''(A) IN GENERAL.—Beginning during the first fiscal year that begins after the date of enactment 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 appropriated $10,000,000 for each of the first five fiscal years beginning after the date of the enactment of this paragraph, to remain available until expended, for purposes of awarding grants under subparagraph (A).''.

(b) TECHNICAL AMENDMENT.—Section 2794 of the Public Health Service Act (42 U.S.C. 300gg–95), as added by section 6603 of the Patient Protection and Affordable Care Act (Public Law 111–148) is redesignated as section 2795.

TITLE IV—CHILDREN AND YOUTH

Subtitle A—Supporting Children's Mental Health Care Access

SEC. 401. PEDIATRIC MENTAL HEALTH CARE ACCESS GRANTS.

Section 330M of the Public Health Service Act (42 U.S.C. 254c–19) is amended—

(1) in the section enumerator, by striking ''**330M**'' and inserting ''**330M.**'';

(2) in subsection (a)—

(A) by striking ''Indian tribes and tribal organizations'' and inserting ''Indian Tribes and Tribal organizations''; and

(B) by inserting ''or, in the case of a State that does not submit an application, a nonprofit entity that has the support of the State'' after ''450b))'';

(3) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (G), by inserting ''developmental-behavioral pediatricians,'' after ''adolescent psychiatrists,'';

(ii) in subparagraph (H), by striking ''; and'' at the end and inserting a semicolon;

(iii) by redesignating subparagraph (I) as subparagraph (J); and

(iv) by inserting after subparagraph (H) the following:

''(I) maintain an up-to-date list of community-based supports for children with mental health problems; and'';

(B) by redesignating paragraph (2) as paragraph (4);

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

''(2) SUPPORT TO SCHOOLS AND EMERGENCY DEPARTMENTS.—In addition to the activities required by paragraph (1), a pediatric mental health care telehealth access program referred to in subsection (a), with respect to which a grant under such subsection may be used, may provide support to schools and emergency departments.

''(3) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to applicants proposing to—

''(A) continue existing programs that meet the requirements of paragraph (1);

''(B) establish a pediatric mental health care telehealth access program in the jurisdiction of a State, Territory, Indian Tribe, or Tribal organization that does not yet have such a program; or

''(C) expand a pediatric mental health care telehealth access program to include one or more new sites of care, such as a school or emergency department.''; and

(D) in paragraph (4), as redesignated by subparagraph (B), by inserting ''Such a team may include a developmental-behavioral pediatrician.'' after ''mental health counselor.'';

(4) in subsections (c), (d), and (f), by striking ''Indian tribe, or tribal organization'' each place it appears and inserting ''Indian Tribe, Tribal organization, or nonprofit entity''; and

(5) by striking subsection (g) and inserting the following:

''(g) TECHNICAL ASSISTANCE.—The Secretary shall award grants or contracts to one or more eligible entities (as defined by the Secretary) for the purposes of providing technical assistance and evaluation support to grantees under subsection (a).

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated—

''(1) $14,000,000 for each of fiscal years 2023 through 2025; and

''(2) $30,000,000 for each of fiscal years 2026 through 2027.''.

SEC. 402. INFANT AND EARLY CHILDHOOD MENTAL HEALTH PROMOTION, INTERVENTION, AND TREATMENT.

Section 399Z–2(f) of the Public Health Service Act (42 U.S.C. 280h–6(f)) is amended by striking ''$20,000,000 for the period of fiscal years 2018 through 2022'' and inserting ''$50,000,000 for the period of fiscal years 2023 through 2027''.

Subtitle B—Continuing Systems of Care for Children

SEC. 411. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

(a) DEFINITION OF FAMILY.—Section 565(d)(2)(B) of the Public Health Service Act (42

U.S.C. 290ff–4(d)(2)(B)) is amended by striking ''as appropriate regarding mental health services for the child, the parents of the child (biological or adoptive, as the case may be) and any foster parents of the child'' and inserting ''as appropriate regarding mental health services for the child and the parents or kinship caregivers of the child''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Paragraph (1) of section 565(f) of the Public Health Service Act (42 U.S.C. 290ff–4(f)) is amended—

(1) by moving the margin of such paragraph 2 ems to the right; and

(2) by striking ''$119,026,000 for each of fiscal years 2018 through 2022'' and inserting ''$125,000,000 for each of fiscal years 2023 through 2027''.

SEC. 412. SUBSTANCE USE DISORDER TREATMENT AND EARLY INTERVENTION SERVICES FOR CHILDREN AND ADOLESCENTS.

Section 514 of the Public Health Service Act (42 U.S.C. 290bb–7) is amended—

(1) in subsection (a), by striking ''Indian tribes or tribal organizations'' and inserting ''Indian Tribes or Tribal organizations''; and

(2) in subsection (f), by striking ''2018 through 2022'' and inserting ''2023 through 2027''.

Subtitle C—Garrett Lee Smith Memorial Reauthorization

SEC. 421. SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.

(a) TECHNICAL AMENDMENT.—Section 520C of the Public Health Service Act (42 U.S.C. 290bb–34) is amended—

(1) by striking ''tribes'' and inserting ''Tribes''; and

(2) by striking ''tribal'' each place it appears and inserting ''Tribal''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 520C(c) of the Public Health Service Act (42 U.S.C. 290bb–34(c)) is amended by striking ''$5,988,000 for each of fiscal years 2018 through 2022'' and inserting ''$9,000,000 for each of fiscal years 2023 through 2027''.

(c) ANNUAL REPORT.—Section 520C(d) of the Public Health Service Act (42 U.S.C. 290bb–34(d)) is amended by striking ''Not later than 2 years after the date of enactment of this subsection'' and inserting ''Not later than 2 years after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022''.

SEC. 422. YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.

Section 520E of the Public Health Service Act (42 U.S.C. 290bb–36) is amended—

(1) by striking ''tribe'' and inserting ''Tribe'';

(2) by striking ''tribal'' each place it appears and inserting ''Tribal'';

(3) in subsection (a)(1), by inserting ''pediatric health programs,'' after ''foster care systems,'';

(4) by amending subsection (b)(1)(B) to read as follows:

''(B) a public organization or private nonprofit organization designated by a State or Indian Tribe (as defined under the Federally Recognized Indian Tribe List Act of 1994) to develop or direct the State-sponsored statewide or Tribal youth suicide early intervention and prevention strategy; or'';

(5) in subsection (c)—

(A) in paragraph (1), by inserting ''pediatric health programs,'' after ''foster care systems,'';

(B) in paragraph (7), by inserting ''pediatric health programs,'' after ''foster care systems,'';

(C) in paragraph (9), by inserting ''pediatric health programs,'' after ''educational institutions,'';

(D) in paragraph (13), by striking ''and'' at the end;

(E) in paragraph (14), by striking the period at the end and inserting ''; and''; and

(F) by adding at the end the following:

''(15) provide to parents, legal guardians, and family members of youth, supplies to securely store means commonly used in suicide, if applicable, within the household.'';

(6) in subsection (d)—

(A) in the heading, by striking ''DIRECT SERVICES'' and inserting ''SUICIDE PREVENTION ACTIVITIES''; and

(B) by striking ''direct services, of which not less than 5 percent shall be used for activities authorized under subsection (a)(3)'' and inserting ''suicide prevention activities'';

(7) in subsection (e)(3)(A), by inserting ''and Department of Education'' after ''Department of Health and Human Services'';

(8) in subsection (g)—

(A) in paragraph (1), by striking ''18'' and inserting ''24''; and

(B) in paragraph (2), by striking ''2 years after the date of enactment of Helping Families in Mental Health Crisis Reform Act of 2016'' and inserting ''3 years after December 31, 2022'';

(9) in subsection (l)(4), by striking ''between 10 and 24 years of age'' and inserting ''up to 24 years of age''; and

(10) in subsection (m), by striking ''$30,000,000 for each of fiscal years 2018 through 2022'' and inserting ''$40,000,000 for each of fiscal years 2023 through 2027''.

SEC. 423. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES FOR STUDENTS IN HIGHER EDUCATION.

Section 520E–2 of the Public Health Service Act (42 U.S.C. 290bb–36b) is amended—

*(1) in the heading, by striking ''**ON CAMPUS**'' and inserting ''**FOR STUDENTS IN HIGHER EDUCATION**''; and*

(2) in subsection (i), by striking ''2018 through 2022'' and inserting ''2023 through 2027''.

SEC. 424. MENTAL AND BEHAVIORAL HEALTH OUTREACH AND EDUCATION AT INSTITUTIONS OF HIGHER EDUCATION.

Section 549 of the Public Health Service Act (42 U.S.C. 290ee–4) is amended—

*(1) in the heading, by striking ''**ON COLLEGE CAMPUSES**'' and inserting ''**AT INSTITUTIONS OF HIGHER EDUCATION**'';*

(2) in subsection (c)(2), by inserting '', including minority-serving institutions as described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q) and community colleges'' after ''higher education''; and

(3) in subsection (f), by striking ''2018 through 2022'' and inserting ''2023 through 2027''.

Subtitle D—Media and Mental Health

SEC. 431. STUDY ON THE EFFECTS OF SMARTPHONE AND SOECIAL MEDIA USE OF ADOLESCENTS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct or support research on—

(1) smartphone and social media use by adolescents; and

(2) the effects of such use on—

(A) emotional, behavioral, and physical health and development; and

(B) any disparities in the mental health outcomes of rural, minority, and other under-served populations.

(b) REPORT.—Not later than 5 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress, and make publicly available, a report on the findings of research under this section.

SEC. 432. RESEARCH ON THE HEALTH AND DEVELOPMENT EFFECTS OF MEDIA ON INFANTS, CHILDREN, AND ADOLESCENTS.

Subpart 7 of part C of title IV of the Public Health Service Act (42 U.S.C. 285g et seq.) is amended by adding at the end the following:

SEC. 452H. RESEARCH ON THE HEALTH AND DEVELOPMENT EFFECTS OF MEDIA ON INFANTS, CHILDREN, AND ADOLESCENTS.

''(a) IN GENERAL.—The Director of the National Institutes of Health, in coordination with or acting through the Director of the Institute, shall conduct and support research and related activities concerning the health and developmental effects of media on infants, children, and adolescents, which may include the positive and negative effects of exposure to and use of media, such as social media, applications, websites, television, motion pictures, artificial intelligence, mobile devices, computers, video games, virtual and augmented reality, and other media formats as they become available. Such research shall attempt to better understand the relationships between media and technology use and individual differences and characteristics of children and shall include longitudinally designed studies to assess the impact of media on youth over time. Such research shall include consideration of core areas of child and adolescent health and development including the following:

''(1) COGNITIVE.—The role and impact of media use and exposure in the development children and adolescents within such cognitive areas as language development, executive functioning, attention, creative program solving skills, visual and spatial skills, literacy, critical thinking, and other learning abilities, and the impact of early technology use on developmental trajectories.

''(2) PHYSICAL—The role and impact of media use and exposure on children's and adolescent's physical development and health behaviors, including diet, exercise, sleeping and eating routines, and other areas of physical development.

''(3) SOCIO-EMOTIONAL.—The role and impact of media use and exposure on children's and adolescents' social-emotional competencies, including self-awareness, self-regulation, social awareness, relationship skills, empathy, distress tolerance, perception of social cues, awareness of one's relationship with the media, and decision-making, as well as outcomes such as violations of privacy, perpetration of or exposure to violence, bullying or other forms of aggression, depression, anxiety, substance use, misuse or disorder, and suicidal ideation/behavior and self-harm.

''(b) DEVELOPING RESEARCH AGENDA.—The Director of the National Institutes of Health, in consultation with the Director of the Institute, other appropriate national research institutes, academies, and centers, the Trans-NIH Pediatric Research Consortium, and non-Federal exports as needed, shall develop a research agenda on the health and development effects of media on infants, children, and adolescents to inform research activities under subsection (a). In developing such research agenda, the Director may use whatever means necessary (such as scientific workshops and literature reviews) to assess current knowledge and research gaps in this area.

''(c) RESEARCH PROGRAM.—In coordination with the Institute and other national research institutes and centers, and utilizing the National Institutes of Health's process of scientific peer review, the Director of the National Institutes of Health shall fund an expanded research program on the health and developmental effects of media on infants, children, and adolescents.

''(d) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment o this Act, the Director of the National Institutes of Health shall submit a report to Congress on the progress made in gathering data and expanding research on the health and developmental effects of media on infants, children, and adolescents in accordance with this section. Such report shall summarize the grants and research funded, by year, under this section''.

TITLE V—MEDICAID AND CHIP

SEC. 501. MEDICAID AND CHIP REQUIREMENTS FOR HEALTH SCREENINGS AND REFERRALS FOR ELIGIBLE JUVENILES IN PUBLIC INSTITUTIONS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(84)—

(A) in subparagraph (A), by inserting ``, subject to subparagraph (D),'' after ``but'';

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

(C) in subparagraph (C), by adding ``and'' at the end; and

(D) by adding at the end the following new subparagraph:

``(D) beginning on the first day of the first calendar quarter that begins two years after the date of enactment of this subparagraph, in the case of individuals who are eligible juveniles described in subsection (nn)(2), are within 30 days of the date on which such eligible juvenile is scheduled to be released from a public institution following adjudication, the State shall have in place a plan to ensure, and in accordance with such plan, provide—

``(i) for, in the 30 days prior to the release of such an eligible juvenile from such public institution (or not later than one week after release from the public institution), and in coordination with such institution—

``(I) any screening or diagnostic service which meets reasonable standards of medical and dental practice, as determined by the State, or as indicated as medically necessary, in accordance with paragraphs (1)(A) and (5) of section 1905(r); and

``(II) a mental health or other behavioral health screening that is a screening service described under section 1905(r)(1), or a diagnostic service described under paragraph (5) of such section, if such screening or diagnostic service was not otherwise conducted pursuant to this clause;

``(ii) for, not later than one week after release from the public institution, referrals for such eligible juvenile to the appropriate care and services available under the State plan (or waiver of such plan) in the geographic region of the home or residence of such eligible juvenile, based on such screenings; and

``(iii) for, following the release of such eligible juvenile from such institution, not less than 30 days of targeted case management services furnished by a provider in the geographic region of the home or residence of such eligible juvenile.''; and

(2) in subsection (nn)(3), by striking ``(30)'' and inserting ``(31)''.

(b) AUTHORIZATION OF FEDERAL FINANCIAL PARTICIPATION.—The subdivision (A) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) following paragraph (31) of such section is amended by inserting ``, or in the case of an eligible juvenile described in section 1902(a)(84)(D) with respect to the screenings, diagnostic services, referrals, and case management required under such subparagraph (D)'' after ``(except as a patient in a medical institution''.

(c) CHIP CONFORMING AMENDMENTS.—

(1) Section 2103(c) of the Social Security Act (42 U.S.C. 1397cc(c)) is amended by adding at the end the following new paragraph:

``(12) REQUIRED COVERAGE OF SCREENINGS, DIAGNOSTIC SERVICES, REFERRALS, AND CASE MANAGEMENT FOR CERTAIN INMATES PRE-RELEASE.—With respect to individuals described in section 2110(b)(7), the State shall provide screenings, diagnostic services, referrals, and case management otherwise covered under the State child health plan (or waiver of such plan) during the period described in such section with respect to such screenings, services, referrals, and case management.''.

(2) Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(A) in paragraph (2)(A), by inserting ``except as provided in paragraph (7),'' before ``a child who is an inmate of a public institution''; and

(B) by adding at the end the following new paragraph:

``(7) EXCEPTION TO EXCLUSION OF CHILDREN WHO ARE INMATES OF A PUBLIC INSTITUTION.—A child shall not be considered to be described in paragraph (2)(A) if such child is an eligible juvenile (as described in section 1902(a)(84)(D)) with respect to the screenings, diagnostic services, referrals, and case management otherwise covered under the State child health plan (or waiver of such plan) during the period with respect to which such screenings, services, referrals, and case management is respectively required under such section.''.

SEC. 502. GUIDANCE ON REDUCING ADMINISTRATIVE BARRIERS TO PROVIDING HEALTH CARE SERVICES IN SCHOOLS.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance to State Medicaid agencies, elementary and secondary schools, and school-based health centers on reducing administrative barriers to such schools and centers furnishing medical assistance and obtaining payment for such assistance under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.).

(b) CONTENTS OF GUIDANCE.—The guidance issued pursuant to subsection (a) shall—

(1) include revisions to the May 2003 Medicaid School-Based Administrative Claiming Guide, the 1997 Medicaid and Schools Technical Assistance Guide, and other relevant guidance in effect on the date of enactment of this Act;

(2) provide information on payment under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) for the provision of medical assistance, including such assistance provided in accordance with an individualized education program or under the policy described in the State Medicaid Director letter on payment for services issued on December 15, 2014 (#14-006);

(3) take into account reasons why small and rural local education agencies may not provide medical assistance and provide information on best practices to encourage such agencies to provide such assistance; and

(4) include best practices and examples of methods that State Medicaid agencies and local education agencies have used to pay for, and increase the availability of, medical assistance.

(c) DEFINITIONS.—In this Act:

(1) INDIVIDUALIZED EDUCATION PROGRAM.—The term ``individualized education program'' has the meaning given such term in section 602(14) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(14)).

(2) SCHOOL-BASED HEALTH CENTER.—The term ``school-based health center'' has the meaning given such term in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)), and includes an entity that provides Medicaid-covered services in school-based settings for which Federal financial participation is permitted.

SEC. 503. GUIDANCE TO STATES ON SUPPORTING PEDIATRIC BEHAVIORAL HEALTH SERVICES UNDER MEDICAID AND CHIP.

Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance to States on how to expand the provision of, and access to, behavioral health services, including mental health services, for children covered under State plans (or waivers of such plans) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or State child health plans (or waivers of such plans) under title XXI of such Act (42 U.S.C. 1397aa et seq.), including a description of best practices for—

(1) expanding access to such services;

(2) expanding access to such services in underserved communities;

(3) flexibilities that States may offer for pediatric hospitals and other pediatric behavioral health providers to expand access to services; and

(4) recruitment and retention of providers of such services.

SEC. 504. ENSURING CHILDREN RECEIVE TIMELY ACCESS TO CARE.

(a) GUIDANCE TO STATES ON FLEXIBILITIES TO ENSURE PROVIDER CAPACITY TO PROVIDE PEDIATRIC BEHAVIORAL HEALTH, INCLUDING MENTAL HEALTH, CRISIS CARE.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall provide guidance to States on existing flexibilities under State plans (or waivers of such plans) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), to support children experiencing a behavioral health crisis or in need of intensive behavioral health, including mental health, services.

(b) ENSURING CONSISTENT REVIEW AND STATE IMPLEMENTATION OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES.—Section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r)) is amended by adding at the end the following: ``Not later than January 1, 2025, and every 5 years thereafter, the Secretary shall review implementation of the requirements of this subsection by States, including such requirements relating to services provided by managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, to identify and disseminate best practices for ensuring comprehensive coverage of services, to identify gaps and deficiencies in meeting Federal requirements, and to provide guidance to States on addressing identified gaps and disparities and meeting Federal coverage requirements in order to ensure children have access to health services.''.

SEC. 505. STRATEGIES TO INCREASE ACCESS TO TELEHEALTH UNDER MEDICAID AND CHIP.

Not later than 1 year after the date of the enactment of this Act, and in the event updates are available, once every five years thereafter, the Secretary of Health and Human Services shall update guidance issued by the Centers for Medicare & Medicaid Services to States, the State Medicaid & CHIP Telehealth Toolkit, or any successor guidance, to describe strategies States may use to overcome existing barriers and increase access to telehealth services under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.). Such updated guidance shall include examples of and promising practices regarding—

(1) telehealth delivery of covered services;

(2) recommended voluntary billing codes, modifiers, and place-of-service designations for telehealth and other virtual health care services;

(3) strategies States can use for the simplification or alignment of provider credentialing and enrollment protocols with respect to telehealth across States, State Medicaid plans under title XIX, State child health plans under title XXI, Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers, including during national public health emergencies; and

(4) strategies States can use to integrate telehealth and other virtual health care services into value-based health care models.

SEC. 506. REMOVAL OF LIMITATIONS ON FEDERAL FINANCIAL PARTICIPATION FOR INMATES WHO ARE ELIGIBLE JUVENILES PENDING DISPOSITION OF CHARGES.

(a) MEDICAID.—

(1) IN GENERAL.—The subdivision (A) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) following paragraph (31) of such section, as amended by section 501(b), is further amended by inserting ``, or, at the option of the State, for an individual who is an eligible juvenile (as defined in section 1902(nn)(2)), while such individual is an inmate of a public institution (as defined in section 1902(nn)(3)) pending disposition of charges'' after ``or in the case of an eligible juvenile described in section

1902(a)(84)(D) with respect to the screenings, diagnostic services, referrals, and case management required under such subparagraph (D)''.

(2) CONFORMING.—Section 1902(a)(84)(A) of the Social Security Act (42 U.S.C. 1396a(a)(84)(A)) is amended by inserting ''(or in the case of a State electing the option described in the subdivision (A) following paragraph (31) of section 1905(a), during such period beginning after the disposition of charges with respect to such individual)'' after ''is such an inmate''.

(b) CHIP.—Section 2110(b)(7) of the Social Security Act (42 U.S.C. 13977jj(b)(7)), as added by section 501(c)(2)(B), is further amended by inserting ''or, at the option of the State, for an individual who is a juvenile, while such individual is an inmate of a public institution pending disposition of charges'' after ''if such child is an eligible juvenile (as described in section 1902(a)(84)(D)) with respect to screenings, diagnostic services, referrals, and case management otherwise covered under the State child health plan (or waiver of such plan)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar quarter that begins after the date that is 18 months after the date of enactment of this Act and shall apply to items and services furnished for periods beginning on or after such date.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. DETERMINATION OF BUDGETARY EFFECTS.

The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled ''Budgetary Effects of PAYGO Legislation'' for this Act, submitted for printing in the Congressional Record by the Chairman of the House Budget Committee, provided that such statement has been submitted prior to the vote on passage.

SEC. 602. OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

(a) PHSA.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in part D (42 U.S.C. 300gg–111 et seq.), by adding at the end the following new section:

''SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after January 1, 2024, a group health plan or health insurance issuer offering group health insurance coverage or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2024, not less frequently than once every 6 months, a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage shall submit to the plan sponsor (as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974) of such group health plan or health insurance coverage a report in accordance with this subsection and make such report available to the plan sponsor in a machine-readable format. Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

''(A) as applicable, information collected from drug manufacturers by such issuer or entity on the total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan or coverage;

''(B) a list of each drug covered by such plan, issuer, or entity providing pharmacy benefit management services that was dispensed during the reporting period, including, with respect to each such drug during the reporting period—

''(i) the brand name, chemical entity, and National Drug Code;

''(ii) the number of participants and beneficiaries for whom the drug was filled during the plan year, the total number of prescription fills for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, including whether the dispensing channel was by retail, mail order, or specialty pharmacy;

''(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dose;

''(iv) the total out-of-pocket spending by participants and beneficiaries on such drug, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for any drug for which gross spending of the group health plan or health insurance coverage exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

''(II) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs, during the reporting period—

''(i) total gross spending by the plan, before manufacturer rebates, fees, or other manufacturer remuneration;

''(ii) the number of participants and beneficiaries who filled a prescription for a drug in that category or class;

''(iii) if applicable to that category or class, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that category or class;

''(iv) the total out-of-pocket spending by participants and beneficiaries, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for each therapeutic category or class under which 3 or more drugs are included on the formulary of such plan or coverage—

''(I) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; or

''(bb) that is related to utilization of drugs, in such therapeutic category or class;

''(II) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

''(III) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan or health insurance coverage and its participants and beneficiaries, after manufacturer rebates, fees, and other remuneration for drugs dispensed within such therapeutic category or class during the reporting period;

''(D) total gross spending on prescription drugs by the plan or coverage during the reporting period, before rebates and other manufacturer fees or remuneration;

''(E) total amount received, or expected to be received, by the health plan or health insurance coverage in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan or health insurance coverage during the reporting period;

''(F) the total net spending on prescription drugs by the health plan or health insurance coverage during the reporting period; and

''(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm who referred the group health plan's or health insurance issuer's business to the pharmacy benefit manager.

''(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or applicable State agencies.

''(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

''(4) REPORT TO GAO.—A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other information that the Comptroller General determines necessary to carry out the study under section 602(d) of the Restoring Hope for Mental Health and Well-Being Act of 2022.

''(5) STANDARD FORMAT.—Not later than June 1, 2023, the Secretary shall specify through rulemaking standards for health insurance issuers and entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall enforce this section.

''(2) FAILURE TO PROVIDE TIMELY INFORMATION.—A health insurance issuer or an entity providing pharmacy benefit management services that violates subsection (a) or fails to provide information required under subsection (b), or a drug manufacturer that fails to provide information under subsection (b)(1)(A) in a timely manner, shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—A health insurance issuer, entity providing pharmacy benefit management services, or drug manufacturer that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Health and Human Services to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

''(e) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''; and

(2) in section 2723 (42 U.S.C. 300gg–22)—

(A) in subsection (a)—

(i) in paragraph (1), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(ii) in paragraph (2), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(B) in subsection (b)—

(i) in paragraph (1), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D'';

(ii) in paragraph (2)(A), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(iii) in paragraph (2)(C)(ii), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''.

(b) ERISA.—

(1) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended—

(A) in subpart B of part 7 (29 U.S.C. 1185 et seq.), by adding at the end the following:

''SEC. 726. OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after January 1, 2024, a group health plan (or health insurance issuer offering group health insurance coverage in connection with such a plan) or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2024, not less frequently than once every 6 months, a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage shall submit to the plan sponsor (as defined in section 3(16)(B)) of such group health plan or group health insurance coverage a report in accordance with this subsection and make such report available to the plan sponsor in a machine-readable format. Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

''(A) as applicable, information collected from drug manufacturers by such issuer or entity on the total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan or coverage;

''(B) a list of each drug covered by such plan, issuer, or entity providing pharmacy benefit management services that was dispensed during the reporting period, including, with respect to each such drug during the reporting period—

''(i) the brand name, chemical entity, and National Drug Code;

''(ii) the number of participants and beneficiaries for whom the drug was filled during the plan year, the total number of prescription fills for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, including whether the dispensing channel was by retail, mail order, or specialty pharmacy;

''(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dose;

''(iv) the total out-of-pocket spending by participants and beneficiaries on such drug, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for any drug for which gross spending of the group health plan or health insurance coverage exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

''(II) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs, during the reporting period—

''(i) total gross spending by the plan, before manufacturer rebates, fees, or other manufacturer remuneration;

''(ii) the number of participants and beneficiaries who filled a prescription for a drug in that category or class;

''(iii) if applicable to that category or class, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that category or class;

''(iv) the total out-of-pocket spending by participants and beneficiaries, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for each therapeutic category or class under which 3 or more drugs are included on the formulary of such plan or coverage—

''(I) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; or

''(bb) that is related to utilization of drugs, in such therapeutic category or class;

''(II) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

''(III) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan or health insurance coverage and its participants and beneficiaries, after manufacturer rebates, fees, and other remuneration for drugs dispensed within such therapeutic category or class during the reporting period;

''(D) total gross spending on prescription drugs by the plan or coverage during the reporting period, before rebates and other manufacturer fees or remuneration;

''(E) total amount received, or expected to be received, by the health plan or health insurance coverage in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan or health insurance coverage during the reporting period;

''(F) the total net spending on prescription drugs by the health plan or health insurance coverage during the reporting period; and

''(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm who referred the group health plan's or health insurance issuer's business to the pharmacy benefit manager.

''(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or applicable State agencies.

''(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

''(4) REPORT TO GAO.—A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such coverage or plan, and other

such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other information that the Comptroller General determines necessary to carry out the study under section 602(d) of the Restoring Hope for Mental Health and Well-Being Act of 2022.

''(5) STANDARD FORMAT.—Not later than June 1, 2023, the Secretary shall specify through rulemaking standards for health insurance issuers and entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, shall enforce this section.

''(2) FAILURE TO PROVIDE TIMELY INFORMATION.—A health insurance issuer or an entity providing pharmacy benefit management services that violates subsection (a) or fails to provide information required under subsection (b), or a drug manufacturer that fails to provide information under subsection (b)(1)(A) in a timely manner, shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—A health insurance issuer, entity providing pharmacy benefit management services, or drug manufacturer that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Labor to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

''(e) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''; and

(B) in section 502(b)(3) (29 U.S.C. 1132(b)(3)), by inserting ''(other than section 726)'' after ''part 7''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 725 the following new item:

''Sec. 726. Oversight of pharmacy benefit manager services.''.

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after January 1, 2024, a group health plan or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan, from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2024, not less frequently than once every 6 months, an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the plan sponsor (as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974) of such group health plan a report in accordance with this subsection and make such report available to the plan sponsor in a machine-readable format. Each such report shall include, with respect to the applicable group health plan—

''(A) as applicable, information collected from drug manufacturers by such entity on the total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan;

''(B) a list of each drug covered by such plan or entity providing pharmacy benefit management services that was dispensed during the reporting period, including, with respect to each such drug during the reporting period—

''(i) the brand name, chemical entity, and National Drug Code;

''(ii) the number of participants and beneficiaries for whom the drug was filled during the plan year, the total number of prescription fills for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, including whether the dispensing channel was by retail, mail order, or specialty pharmacy;

''(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dose;

''(iv) the total out-of-pocket spending by participants and beneficiaries on such drug, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for any drug for which gross spending of the group health plan exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

''(II) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan during the reporting period, and, with respect to each such therapeutic category or class of drugs, during the reporting period—

''(i) total gross spending by the plan, before manufacturer rebates, fees, or other manufacturer remuneration;

''(ii) the number of participants and beneficiaries who filled a prescription for a drug in that category or class;

''(iii) if applicable to that category or class, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that category or class;

''(iv) the total out-of-pocket spending by participants and beneficiaries, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

''(v) for each therapeutic category or class under which 3 or more drugs are included on the formulary of such plan—

''(I) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; or

''(bb) that is related to utilization of drugs, in such therapeutic category or class;

''(II) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan on that category or class of drugs; and

''(III) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan and its participants and beneficiaries, after manufacturer rebates, fees, and other remuneration for drugs dispensed within such therapeutic category or class during the reporting period;

''(D) total gross spending on prescription drugs by the plan during the reporting period, before rebates and other manufacturer fees or remuneration;

''(E) total amount received, or expected to be received, by the health plan in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan during the reporting period;

''(F) the total net spending on prescription drugs by the health plan during the reporting period; and

''(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm who referred the group health plan's business to the pharmacy benefit manager.

''(2) PRIVACY REQUIREMENTS.—Entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or applicable State agencies.

''(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

''(4) REPORT TO GAO.—An entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other

information that the Comptroller General determines necessary to carry out the study under section 602(d) of the Restoring Hope for Mental Health and Well-Being Act of 2022.

''(5) STANDARD FORMAT.—Not later than June 1, 2023, the Secretary shall specify through rulemaking standards for entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and the Secretary of Health and Human Services, shall enforce this section.

''(2) FAILURE TO PROVIDE TIMELY INFORMATION.—An entity providing pharmacy benefit management services that violates subsection (a) or fails to provide information required under subsection (b), or a drug manufacturer that fails to provide information under subsection (b)(1)(A) in a timely manner, shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—An entity providing pharmacy benefit management services, or drug manufacturer that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a group health plan or other entity to restrict disclosure to, or otherwise limit the access of, the Department of the Treasury to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such plan or entity.

''(e) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9826. Oversight of pharmacy benefit manager services.''.

(d) GAO STUDY.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on—

(A) pharmacy networks of group health plans, health insurance issuers, and entities providing pharmacy benefit management services under such group health plan or group or individual health insurance coverage, including networks that have pharmacies that are under common ownership (in whole or part) with group health plans, health insurance issuers, or entities providing pharmacy benefit management services or pharmacy benefit administrative services under group health plan or group or individual health insurance coverage;

(B) as it relates to pharmacy networks that include pharmacies under common ownership described in subparagraph (A)—

(i) whether such networks are designed to encourage enrollees of a plan or coverage to use such pharmacies over other network pharmacies for specific services or drugs, and if so, the reasons the networks give for encouraging use of such pharmacies; and

(ii) whether such pharmacies are used by enrollees disproportionately more in the aggregate or for specific services or drugs compared to other network pharmacies;

(C) whether group health plans and health insurance issuers offering group or individual health insurance coverage have options to elect different network pricing arrangements in the marketplace with entities that provide pharmacy benefit management services, the prevalence of electing such different network pricing arrangements;

(D) pharmacy network design parameters that encourage enrollees in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are wholly or partially-owned by that issuer or entity; and

(E) the degree to which mail order, specialty, or retail pharmacies that dispense prescription drugs to an enrollee in a group health plan or health insurance coverage that are under common ownership (in whole or part) with group health plans, health insurance issuers, or entities providing pharmacy benefit management services or pharmacy benefit administrative services under group health plan or group or individual health insurance coverage receive reimbursement that is greater than the median price charged to the group health plan or health insurance issuer when the same drug is dispensed to enrollees in the plan or coverage by other pharmacies included in the pharmacy network of that plan, issuer, or entity that are not wholly or partially owned by the health insurance issuer or entity providing pharmacy benefit management services.

(2) REQUIREMENT.—The Comptroller General of the United States shall ensure that the report under paragraph (1) does not contain information that would allow a reader to identify a specific plan or entity providing pharmacy benefits management services or otherwise contain commercial or financial information that is privileged or confidential.

(3) DEFINITIONS.—In this subsection, the terms ''group health plan'', ''health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 603. MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$5,000,000'' and inserting ''$1,029,000,000''.

SEC. 604. LIMITATIONS ON AUTHORITY.

In carrying out any program of the Substance Abuse and Mental Health Services Administration whose statutory authorization is enacted or amended by this Act, the Secretary of Health and Human Services shall not allocate funding, or require award recipients to prioritize, dedicate, or allocate funding, without consideration of the incidence, prevalence, or determinants of mental health or substance use issues, unless such allocation or requirement is consistent with statute, regulation, or other Federal law.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce or their respective designees.

The gentleman from New Jersey (Mr. PALLONE) and the gentlewoman from Washington (Mrs. RODGERS) each will control 30 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and add extraneous material on H.R. 7666.

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

There was no objection.

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

Mr. Speaker, I rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022, and I thank Ranking Member RODGERS for working with me these past few months to develop this comprehensive legislation that will help address the mental health and substance use disorder crisis facing millions of Americans.

This bill is needed today more than ever. Americans report rising anxiety and depression and increased use of alcohol, opiates, and other substances. One in five adults are battling a mental illness. Suicide is now the second leading cause of death for children ages 10 to 14, and earlier this year the Centers for Disease Control and Prevention released a report finding that 4 in 10 high school students said they felt persistently sad or hopeless during the COVID–19 pandemic. The opioid crisis also continues to devastate families and communities all around the Nation. 108,000 people lost their lives due to drug overdoses just last year alone.

The Restoring Hope for Mental Health and Well-Being Act will help restore hope for millions of Americans. The bill strengthens and expands more than 30 critical programs that collectively support mental health care and substance use disorder prevention, care, treatment, and recovery support services in communities across the Nation.

As the Nation prepares for the launch of the 988 National Suicide Prevention Lifeline dialing code next month, H.R. 7666 provides key crisis response efforts, establishing the Substance Abuse and Mental Health Services Behavioral Health Crisis Coordination Office and requiring the development of crisis response best practices. The legislation also continues investments in critical mental health and substance use services block grant funding to States, territories, and Tribes.

The Restoring Hope Act includes crucial provisions to meet the challenges of the Nation's opioid epidemic, expanding and ensuring timely patient access to lifesaving treatment for opioid use disorders through the elimination of barriers to treatment. It includes Representative TONKO's MAT Act, which eliminates the X-waiver, a burdensome registration requirement that establishes arbitrary caps on the number of patients a provider can treat for opioid use disorder using buprenorphine.

This bill also establishes a one-time, 8-hour training requirement on treating and identifying substance use disorders that providers must complete

before their first registration or renewal of a license to dispense controlled substances.

H.R. 7666 also helps bolster the behavioral health workforce capacity and training. It also increases access to mental health and substance use disorder care and coverage by applying the mental health parity law to State and local government workers, such as teachers and frontline workers.

The legislation also supports the mental health of children and young people. It continues investment in the integration of behavioral health into pediatric primary care through Pediatric Mental Health Access Grants and enhances research at the National Institutes of Health on the cognitive, physical, and socioemotional impacts of modern technology and multimedia on infants, children, and adolescents.

I can't stress enough that this is an epidemic that focuses a lot on children and adolescents. Older youth need help with suicide prevention and other mental health support and substance use disorder services. Students in higher education need that help, and they get it through a program called the Garrett Lee Smith Memorial Act.

The bill also ensures that State Medicaid programs have resources to implement and strengthen school-based mental health services while preserving the continuity of coverage for justice-involved youth. These important provisions will increase children's access to care.

Mr. Speaker, the scope and reach of this bipartisan legislation—and I stress that. This was reported out of the Energy and Commerce Committee unanimously, Mr. Speaker. It is truly bipartisan. It is going to help to support the mental health and well-being of millions of Americans, their families, and communities for years to come.

I thank Members on both sides of the aisle, not only Ranking Member RODGERS, but the subcommittee leadership as well, both Democrat and Republican.

The reason that we try to do this on a bipartisan level and get everybody's support is because we have a good chance of passing this in the Senate, which is also acting on similar legislation. We are hopeful that as a result of a large vote today, that will spur the Senate into action, and we can actually get this bill signed into law.

Mr. Speaker, I urge my colleagues to support the bill, and I reserve the balance of my time.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, June 10, 2022.

Hon. FRANK PALLONE, Jr.,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR CHAIRMAN PALLONE: This letter is to advise you that the Committee on the Judiciary has now had an opportunity to review the provisions in H.R. 7666, the ''Restoring Hope for Mental Health and Well-Being Act of 2022,'' that fall within our Rule X jurisdiction. I appreciate your consulting with us on those provisions. The Judiciary Committee has no objection to your including them in the bill for consideration on the House floor, and to expedite that consideration is willing to forgo action on H.R. 7666, with the understanding that we do not thereby waive any future jurisdictional claim over those provisions or their subject matters.

In the event a House-Senate conference on this or similar legislation is convened, the Judiciary Committee reserves the right to request an appropriate number of conferees to address any concerns with these or similar provisions that may arise in conference.

Please place this letter into the Congressional Record during consideration of the measure on the House floor. Thank you for the cooperative spirit in which you have worked regarding this matter and others between our committees.

Sincerely,

JERROLD NADLER,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, June 13, 2022.

Hon. JERROLD NADLER,
Chairman, Committee on Judiciary, Washington, DC.

DEAR CHAIRMAN NADLER: Thank you for consulting with the Committee on Energy and Commerce and agreeing to be discharged from further consideration of H.R. 7666, the ''Restoring Hope for Mental Health and Well-Being Act of 2022,'' so that the bill may proceed expeditiously to the House floor.

I agree that your forgoing further action on this measure does not in any way diminish or alter the jurisdiction of your committee or prejudice its jurisdictional prerogatives on this measure or similar legislation in the future. I would support your effort to seek appointment of an appropriate number of conferees from your committee to any House-Senate conference on this legislation.

I will ensure our letters on H.R. 7666 are included in the report for this bill and entered into the Congressional Record during floor consideration of the bill. I appreciate your cooperation regarding this legislation and look forward to continuing to work together as this measure moves through the legislative process.

Sincerely,

FRANK PALLONE, Jr.,
Chairman.

Mrs. RODGERS of Washington. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act.

We are taking urgent action to help States and communities provide life-saving mental health care to people in need, especially for our children and those suffering from severe mental illness.

I think about Austin, a 9-year-old boy who struggled to cope when his school was shut down, and his parents were going through a divorce. He was socially isolated and didn't know where to turn. When he confessed suicidal thoughts to his mom, they faced long waiting lists and no beds for the care that he needed.

Cases like Austin's can't be ignored. Parents, teachers, and medical professionals are talking about this everywhere I go.

In Spokane, Washington, we are seeing more violence in our schools and rising crime. Drug overdose deaths and fentanyl poisoning were up 300 percent last year. There is an overwhelming sense of despair, anxiety, fear, and isolation. This has been heightened by the horrific shootings in Uvalde and Buffalo. Especially for our children, we need to deliver hope and healing in every community in our country.

This bill will help children in crisis and improve school safety. For example, Congresswoman ASHLEY HINSON is leading with RICHARD HUDSON on a provision that will expand access to behavioral and mental health services to kids in schools.

It also includes a solution I led on with Congresswoman YOUNG KIM to reauthorize the Garrett Lee Smith Memorial Act, which supports community-based youth and young adult suicide prevention programs.

Like with Representative FRENCH HILL's solution in this, we are removing red tape, boosting treatment access, and making sure communities have resources to combat the substance use disorder epidemic in America.

More than 100,000 people are dying a year, and our communities are in desperate need of help to prevent, treat, and rescue people from overdoses and despair.

The priorities in this bill are targeted to responsibly address our most urgent needs so we can build stronger families, communities, and a brighter future. We are accomplishing this by stopping duplicative programs and cutting the deficit by $200 million. The bulk of the programs in this bill are block grants that have been successful in providing our States and communities with the resources and flexibilities to meet the specific and unique needs in combating mental illness and addiction while keeping the Federal Government out of the decisionmaking process for treatments and care.

By protecting charitable choice, we are also making sure faith-based and religious organizations are competing on an equal footing. This is a victory for conscience protections.

The provisions in this bill also support care for maternal mental health and substance use disorders, which are among the leading causes of death for pregnant and postpartum women. We are saving lives and caring for women at every stage of pregnancy and beyond.

Mr. Speaker, I again urge support for this legislation. I thank Chairman PALLONE for his leadership and for working with us on solutions from our colleagues on both sides of the aisle.

While families and communities will lead the way to address the root causes of despair, isolation, violence, and overdose deaths that are tearing nearly every community apart and destroying people's lives, this bill takes an important step forward to help them in these efforts.

We are taking action to turn this despair into hope. Children like Austin in communities like mine in eastern Washington are counting on it. Let's

deliver today and keep building on this work.

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

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. SCHAKOWSKY), who chairs our Subcommittee on Consumer Protection and Commerce.

Ms. SCHAKOWSKY. Mr. Speaker, I am so happy about this bipartisan legislation and really excited about the changes that are going to be made, because for all 24 years that I have been in Congress, I have not had a townhall meeting or a meeting with my constituents where the issue of access and affordability of mental health services has not come up.

Right now, our country is facing a mental health crisis like we have not seen before. We are seeing that families are losing loved ones to COVID, to suicide, and to overdoses.

This bill will provide vital services in substance abuse and mental health, four things mainly. We will see a strengthening of parity. We voted for parity a long time ago, and now we are going to make sure that mental health and physical health are on the same page.

We are going to have 30 programs that are going to strengthen and reauthorize mental health services. We are going to have more education for doctors. We are going to have doctors be able to have more patients for certain mental assistance treatment.

This is a great bill. We should all be proud to vote for it.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. EMMER), who has led on important provisions for children in this bill.

Mr. EMMER. Mr. Speaker, I thank the ranking member, soon to be chair, for yielding.

I rise in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act.

After years of lockdowns and social isolation, the mental health of our Nation's citizens, and especially our youth, is at an all-time low. But H.R. 7666 begins to return us to a better path, so I thank the chairman and ranking member for all their hard work to make this a reality.

I am especially pleased that portions of two bills that I had the pleasure of working on with my colleague from Maryland were included in this legislation. One such provision would amend the Medicaid Inmate Exclusion Policy to allow incarcerated juveniles who have been detained pending trial to continue to receive Medicaid coverage. Pretrial detainees are, by definition, presumed innocent. As a matter of due process, we should not be denying critical health benefits to anyone who has not been convicted of a crime.

From a practical standpoint, reforms to the Medicaid Inmates Exclusion Policy will help our local law enforcement better manage the shockingly high percentage of inmates who suffer from mental illness.

H.R. 7666 also includes language to create a behavioral health coordinating office, another issue that I have had the pleasure of working on. Many Federal programs to address the mental health crisis currently lack clear, unified direction and coordination, which is a recipe for redundancy and waste.

□ 1415

The reforms in today's bill will bring all the major agencies into the room, including the Secretary of Education, the Secretary of Health and Human Services, and the Director of National Drug Control Policy to develop a unified approach to addressing topics ranging from substance abuse care to delivery of better telehealth.

There is always more work to be done to improve the mental health of our Nation, but H.R. 7666 is an important step, and one we need now more than ever.

Madam Speaker, I once again urge my colleagues to support this critical legislation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. SARBANES), who has been involved with these health and behavioral issues for a long time.

Mr. SARBANES. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I, too, rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022.

Our Nation, as you know, is facing a continuing mental health and substance use crisis that has only been exacerbated by the COVID–19 pandemic. This crisis touches the lives of individuals in each and every corner of our country and has a particularly acute impact on children and teens.

Recognizing this, last October, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health.

To wrap our arms as a society around children facing mental and behavioral health challenges, I recently joined in introducing H.R. 7248, the Continuing Systems of Care for Children Act, with my colleagues Representatives Joyce, Underwood, and Gimenez, a bipartisan bill that I am proud is included in H.R. 7666 today.

This legislation would reauthorize for 5 years two important grant programs; one that provides comprehensive community mental health services for children with serious emotional disturbances, as well as the Youth and Family TREE Program.

These programs connect children and teenagers to services that meet their individual needs and have a sustained positive impact on their well-being.

As we confront the compounding challenges posed by our mental health and behavioral health crisis and our national gun violence crisis, Congress must provide our children every resource they need to lead safe and healthy lives.

That is why it is so important that we pass the Restoring Hope for Mental Health and Well-Being Act today to bolster mental health services and better support our communities now and into the future.

Mr. Speaker, I urge my colleagues to vote ''yes'' on this legislation.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky (Mr. GUTHRIE), our lead on the Subcommittee on Health.

Mr. GUTHRIE. Mr. Speaker, I thank the gentlewoman for yielding.

Mr. Speaker, H.R. 7666 the Restoring Hope for Mental Health and Well-Being Act is a significant bill that will help support our mental health workforce, increase access to pediatric mental health treatment, and help make schools safer.

This bill will bolster substance use disorder prevention, treatment, and recovery resources. The Committee on Energy and Commerce has worked on this for many months, held hearings, and reported it out by a voice vote in May.

Recognizing children's mental health has been negatively impacted by school closures, ineffective lockdowns, and increased violence. This bill provides specific resources to help communities respond to the children's mental health crisis. This legislation also supports community mental health services for children with serious emotional disturbances through crisis-care service and early intervention activities.

The need to strengthen resources for children's mental health has been further heightened after the horrific school violence we have seen in Uvalde.

This bill also works to reauthorize the Garrett Lee Smith Suicide Prevention Program, provide funding for a suicide prevention lifeline, and update a major block grant that States use to provide support to those with serious mental illness.

In addition to supporting those with mental illness, the legislation helps those with substance use disorders. Kentucky has seen a drastic rise in overdoses throughout the pandemic and, nationally, the CDC estimates that drug overdoses exceeded 107,000 between November 2020 and November 2021.

Many of these drug overdoses have been caused by synthetic opioids, like illicit fentanyl poisoning, which were involved in about 70 percent of all Kentucky overdoses in 2021.

Ultimately, fighting the drug overdose epidemic will require a two-pronged approach: Equipping our law enforcement with the tools they need to keep these deadly poisons off our streets and providing recovery and treatment resources.

Through the passage of this bill, we are advancing the second part of this

approach by increasing access to critical treatment and recovery resources for people from all walks of life and every stage of life. This includes resources for moms and pregnant women by supporting care for maternal health and substance use disorders, which are among the leading cause of death for pregnant and postpartum women.

In addition, this legislation also has a provision led by Representative BUCSHON, alongside Representatives Miller-Meeks, Axne, and Pappas, to remove unnecessary regulatory barriers to help those with opioid use disorder seek the care that they need as quickly as possible.

The Timely Treatment for Opioid Use Disorder Act removes a Federal requirement of having to live with opioid disorder for more than 1 year to be admitted for in-person treatment. I am proud that my bill, the Substance Use Prevention, Treatment, and Recovery Services Block Grant Act of 2022, which I have worked together with my colleagues, Messrs. TONKO, MCKINLEY, and Ms. WILD, is also included in this bill.

The legislation would deliver more coordinated substance use disorder care as well as explicitly reauthorizing funding for recovery support services, which include workforce training and others.

Mr. Speaker, I encourage my colleagues to vote for this bill.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TONKO), who chairs our Environment and Climate Change Subcommittee.

Mr. TONKO. Mr. Speaker, I rise in strong support of the Restoring Hope for Mental Health and Well-Being Act.

I offer my thanks to Chairman PALLONE and Ranking Member RODGERS and their staffs for their tireless work on this bill. It is yet another example of the profound good our committee can produce when we work together in a collaborative and bipartisan fashion.

This strongly bipartisan legislation will take several steps to improve mental health and substance use care.

Importantly, H.R. 7666 includes my Mainstreaming Addiction Treatment Act, which will eliminate outdated barriers that prevent more people in need from having access to buprenorphine, a lifesaving drug. I have worked on this legislation for years and was pleased to see it advance out of committee with a strong bipartisan majority.

By passing this legislation, we will vastly expand access to addiction medicine and move us toward a system of treatment on demand for those struggling with addiction.

It is not hyperbole to say this is one of the most meaningful steps that Congress has taken to date to address the opioid epidemic. It will save countless lives, and I am indeed grateful for the bipartisan push here to get it over the finish line.

H.R. 7666 also includes a bill that I authored to reauthorize and strengthen the Substance Use Prevention and Treatment Block Grant, which serves as the foundation for State's substance use prevention and treatment programs.

We made important improvements to the block grant, including clarifying that recovery support services are eligible for funding through this program.

We are going to keep working to increase funding levels and hopefully implement a recovery set-aside, ensuring that all States invest in critical recovery services.

Taken together, the pieces of the Restoring Hope for Mental Health and Well-Being Act will truly make a difference to families and communities struggling with mental health and substance use challenges.

Mr. Speaker, I urge all my colleagues to support this critically important legislation that delivers hope to our communities, delivers hope to the doorstep of our families.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Arkansas (Mr. HILL), a leader on this issue, who sponsored the underlying bill that is incorporated in this package.

Mr. HILL of Arkansas. Mr. Speaker, I thank Mr. PALLONE and Mrs. MCMORRIS RODGERS for their excellent bipartisan leadership in bringing these bills to the floor. It is the way Congress is supposed to work.

Mr. Speaker, I didn't know anyone who died of a drug overdose when I was in high school or college. But my two sweet kids can count five or six of their peers who have been lost to suicide, drug overdose-related. It is heartbreaking. Everybody in this House knows the horrifying 107,000 losses we have seen from opioid deaths last year.

So I do, in fact, rise in support of H.R. 7666, and to discuss my co-prescribing legislation that was included in this mental health package. My bill seeks to prevent opioid overdoses through co-prescription. This effort was inspired by my home State of Arkansas, which is one of 14 States that has co-prescribing now.

Co-prescribing is when a doctor prescribes an opioid overdose reversal drug like naloxone along with the prescription. My legislation encourages co-prescribing when medically appropriate. It also supports existing standing orders to increase laypersons' access to opioid overdose reversal drugs like naloxone.

Statistical modeling reported to the International Journal of Drug Policy suggests that high rates of naloxone distribution among laypersons and emergency personnel could avert 21 percent of opioid overdose deaths. The majority of overdose death reduction would be as a result of that increased naloxone distribution to patients.

Mr. Speaker, in 2021, 551 of our citizens of Arkansas are alive today because of a co-prescription legislation.

Mr. Speaker, the data is clear. Co-prescribing saves lives, and that is why I urge my colleagues to support H.R. 7666.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. O'HALLERAN), a member of the Committee on Energy and Commerce.

Mr. O'HALLERAN. Mr. Speaker, I thank the chairman for yielding.

Mr. Speaker, I rise in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act, legislation that works to increase the accessibility of our mental health care system and breaks down the unique barriers to care for rural communities that are facing it.

Each year, hundreds of thousands of Arizonians do not receive the mental health care they need. Without access to this essential care, our families and our communities suffer.

In recent years, we have lost too many loved ones to opioid abuse, suicide, and senseless violence in our communities. It has gone on far too long. As a homicide investigator in Chicago, I can tell you of the hundreds and hundreds of these types of cases I saw day in and day out.

Affordable, accessible mental health care plays an important role in holistically addressing each one of these issues. That is why I worked with my colleagues on the Committee on Energy and Commerce, a bipartisan effort, to bring this urgently needed legislation to the House floor for a vote.

By investing in workforce education and training, and supporting critical mental health programs, the Restoring Hope for Mental Health and Well-Being Act works to address the provider shortage millions of Americans are experiencing and expands access to the care our vulnerable and underserved communities need.

I am pleased to see the initiative to reauthorize and improve critical SAMHSA programs included in this bill. In Arizona, more than five people die every day from overdoses. This crisis is tearing entire families and communities apart.

Our legislation would assist in developing coordinated local opioid response plans, expand access to medications that reverse an opioid overdose, and improve substance use disorder and mental health treatment for homeless individuals.

Our bill also invests in mental health care for our children through programs that serve a wide range of ages and mental health needs, including suicide prevention for students.

Mr. Speaker, it is time we fill those gaps, and I urge my colleagues to vote for this bill.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. TONY GONZALES), whose community understands the importance of hope and healing like no other right now.

Mr. TONY GONZALES of Texas. Mr. Speaker, I rise today to support H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022.

One month ago, a gunman fired on Robb Elementary School in Uvalde,

Texas, 38 miles from where I grew up. This despicable crime led to the death of 19 innocent children and two teachers. As a father of six, I am absolutely heartbroken.

As a Congressman who represents Uvalde, I am focusing on delivering change. The change starts with addressing the serious lack of mental health resources in our country.

□ 1430

In a 2022 report by Mental Health America, Texas was ranked as the worst State for access to mental health care. In rural communities, that gap is felt even more intensely.

It is in places like Uvalde that mental health clinicians are few and far between, and parents have to drive more than 4 hours roundtrip for access to inpatient care. Communities like Uvalde are desperately in need of mental health resources now and well into the future.

That is why I am proud to support this bipartisan package that will commit significant resources to mental health awareness, training, and treatment.

It is time for Congress to address the solution to the mental health crisis in America, and that starts with supporting H.R. 7666.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from New Hampshire (Ms. KUSTER), a member of the Energy and Commerce Committee.

Ms. KUSTER. Mr. Speaker, I rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022.

It has never been more urgent to pass this comprehensive legislation that will help deliver essential mental health and substance use disorder treatment and support to communities across this country.

Americans continue to lose loved ones to addiction and mental health struggles every day. Mr. Speaker, 2021 marked the deadliest year yet, with nearly 108,000 overdose deaths here in the United States. In Nashua, New Hampshire, in my district, the rate of fatal overdoses doubled from March to April just this year, and it is on track to reach the highest number of opioid deaths since the epidemic began.

We cannot wait another day to pass this critical legislation.

As founder and co-chair of the Bipartisan Addiction and Mental Health Task Force, I am pleased to see the Restoring Hope for Mental Health and Well-Being Act include many of the bills from our task force agenda, bills like the Mainstreaming Addiction Treatment Act to remove outdated barriers that prevent healthcare providers from prescribing essential treatment for substance use disorder.

I am also pleased to see the Restoring Hope for Mental Health and Well-Being Act include the KIDS CARE Act, legislation I introduced with Congressman HUDSON to improve Medicaid in schools and provide mental health screenings for justice-involved youth.

Importantly, H.R. 7666 addresses the many unmet needs of communities that have suffered because of inadequate mental health resources, from bolstering grants for depression screening and suicide prevention to strengthening the behavioral health workforce.

I support this legislation because it responds to the urgency of today's crisis and will improve mental health and addiction care all across the country.

Mr. Speaker, I thank Chairman PALLONE and his staff for his leadership on this bill and the Speaker for giving us the opportunity to discuss this legislation. I urge a ''yes'' vote.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentlemen from North Dakota (Mr. ARMSTRONG), a leader on the committee.

Mr. ARMSTRONG. Mr. Speaker, I rise today in strong support of the Restoring Hope for Mental Health and Well-Being Act.

This bipartisan mental health package includes my legislation, the Summer Barrow Prevention, Treatment, and Recovery Act. This bill reauthorizes several substance use disorder programs administered by SAMHSA that help local communities provide substance use disorder and mental health services to those most in need.

This is particularly important for rural States like North Dakota, where individuals struggle to access all treatment options that may work for them.

The package also includes the Mainstreaming Addiction Treatment Act, or MAT Act. The MAT Act would remove the burdensome requirement that a healthcare practitioner apply for a separate waiver, known as the X waiver, through the Drug Enforcement Agency to prescribe certain drugs for substance use disorder treatment.

The X waiver requirement limits access to lifesaving treatment, which is particularly painful considering recent news that drug overdose deaths hit a record high of more than 107,000 in 2021.

Lastly, I offer my support for an amendment I offered with my friend Congressman TRONE of Maryland that will come to the floor soon. Our amendment would add the State Opioid Response Grants Act to this program.

This amendment will provide $8.75 billion over 5 years in flexible financing for State Opioid Response grants and Tribal Opioid Response grants, providing States and Tribes certainty and stability to implement prevention, treatment, and recovery.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. HOYER), the House majority leader.

Mr. HOYER. Mr. Speaker, I thank the chairman and ranking member for the work they have done together and with the committee to bring this very important bipartisan bill to the floor. I thank them both for their hard work, and the committee for its hard work, in compiling this bipartisan package to combat two of the most important issues, Mr. Speaker, facing communities today: mental health and drug addiction.

The COVID–19 pandemic exacerbated mental health and addiction challenges that were already present in our communities. For those already experiencing severe depression, anxiety, or even substance abuse and addiction disorders, the pandemic made it harder to access mental health care and essential help and resources, and it created, of course, much greater anxiety.

This bill would reauthorize key mental health and addiction programs while helping to strengthen communities' crisis response.

There are many important programs included, but I will highlight just a few.

Mr. Speaker, among them is legislation from my friend Representative DAVID TRONE to help States expand the availability of high-quality recovery housing for treatment from substance abuse. Representative TRONE has been a leader on this issue as co-chair of the Bipartisan Addiction and Mental Health Task Force.

Mr. Speaker, also included is legislation from my friends Representatives CINDY AXNE and CHRIS PAPPAS to revise opioid treatment program criteria to help those in need of treatment access it more quickly.

Our in-house pediatrician, Representative KIM SCHRIER, authored a provision to help children and teens who have had their lives upended by the pandemic access the mental health care and services that they so badly need.

Mr. Speaker, I also mention a critical section added by Representative SUSIE LEE to provide important resources for virtual peer support programs. Representative LEE knows how much her constituents have benefited from these types of programs and how much more good they can do if given the proper resources.

Representative TONKO from New York, included legislation to expand access to prescription medications that help patients overcome addiction disorders.

Mr. Speaker, these are just a few of the very beneficial policies included in this legislation that will improve lives and, indeed, save lives.

I am so proud of the Energy and Commerce Committee and all the Members whose legislation is included in this bipartisan package, which demonstrates how we can join together, Democrats and Republicans, to pass important legislation and show those we serve they are not alone in facing these challenges.

Mr. Speaker, I hope this strong vote today will help move these critical policies through the Senate and see them quickly enacted into law.

Mr. Speaker, I urge a ''yes'' vote.

Mrs. RODGERS of Washington. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from

Washington (Ms. SCHRIER), a member of the Energy and Commerce Committee.

Ms. SCHRIER. Mr. Speaker, I express my support for H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022.

In over 20 years as a pediatrician, I saw steadily escalating levels of mental illness in my patients. There was a big uptick after 2007 that many associate with ubiquitous social media use. Of course, the pandemic further accelerated rates of depression, anxiety, eating disorders, and self-harm. We are seeing 9-year-olds with eating disorders and 10-year-olds with suicidal ideation. This is alarming.

We all agree that our children need help, but resources are limited. There just aren't enough behavioral health specialists out there to meet the need, particularly in rural areas like some of those I represent.

There are ways to extend the reach of people who have dedicated their lives to supporting our mental health, to leverage those resources so they stretch a little further. One example is the Partnership Access Line, or PAL, that I was able to access as a pediatrician. If I was seeing a patient with a more complicated behavioral health concern, something really beyond the scope of a general pediatrician, I could get a psychiatrist on the line and in-the-moment advice on how to treat that patient.

Another example is integrative care, where a mental worker works alongside physicians and other healthcare providers, providing support as needed throughout the day for patients who are struggling with mental illness.

These programs and more are supported in the package of bills we will be voting on this week, including mine, the Supporting Children's Mental Health Care Access Act.

Mr. Speaker, I encourage my colleagues to vote ''yes'' on this excellent bill.

Mrs. RODGERS of Washington. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Michigan (Mrs. DINGELL), a member of the committee.

Mrs. DINGELL. Mr. Speaker, I rise in support of the Restoring Hope for Mental Health and Well-Being Act of 2022.

I thank all of my committee members on both sides for months of work on this important bipartisan legislation, which reauthorizes and strengthens critical mental and behavioral health programs that will help address public health issues like the opioid epidemic, which claimed over 107,000 lives in the United States last year alone.

The mental health package before us contains strong mental health parity provisions that my colleague Congresswoman KATIE PORTER and I led. This will close a critical gap in healthcare coverage for mental health and substance abuse treatment for thousands of frontline workers across the country.

It also includes a provision I worked on with my friend and colleague, Congressman FRENCH HILL, that provides incentives for co-prescribing when a doctor pairs an opioid prescription with a prescription of an opioid overdose reversal drug like naloxone. This is a proven method to reduce overdose deaths.

Finally, it is good to see consideration of an amendment I coauthored with Congressman MCKINLEY cracking down on suspicious orders of opioids, which will help further curb abuses and save lives.

Mr. Speaker, all of us have had family members or know someone who has had a mental health crisis or issue or suffered from depression. For too long, people have been afraid to even acknowledge it, to seek help, or to get help. There has been a stigma associated with it. Today, all of us on both sides of this aisle need to help remove that stigma.

My sister died of a drug overdose, and my father was a drug addict. Perhaps we wouldn't have suffered some of the traumas had people not been afraid to speak of it.

Mr. Speaker, this is a strong package that will improve our national response, and I urge my colleagues to support this bill.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), a leader on the committee and on this legislation.

Mr. BILIRAKIS. Mr. Speaker, I thank the ranking member and the chairman for this very important bill.

I rise in strong support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act, which reauthorizes and improves key SAMHSA block grant programs for mental health and substance use disorder prevention and treatment services. These are all targeted toward helping our constituents who have struggled with anxiety, stress, and isolation.

Sadly, our Nation is experiencing an unprecedented mental health crisis, particularly among our children and teens. It has only gotten worse during the COVID pandemic, Mr. Speaker. We have seen a disturbing spike in rates of depression, self-harm, suicide attempts, and death among teens. Teen depression, in particular, has risen by 60 percent.

We cannot afford to wait any longer to address this mental health and addiction crisis, and this package presents much-needed solutions that will enact meaningful changes to help combat the trends we have seen.

Specifically, I am very glad to see in the manager's amendment a provision I have long advocated for that will require HHS to conduct research on smartphone and social media use by adolescents and the effects of such use on emotional and behavioral health.

□ 1445

All of us agree on the need to better protect our children and their mental health from social media, and this is an excellent start. We are also going to consider an amendment I am proud to support with my good friend RODNEY DAVIS that will contain H.R. 2355, the Opioid Prescription Verification Act, to help prevent opioid abuse through e-prescribing.

In closing, this is a strong, bipartisan package, and I urge my colleagues to fully support it.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Mrs. FLETCHER), who is also a member of the Energy and Commerce Committee.

Mrs. FLETCHER. Mr. Speaker, I thank the chairman for his leadership and support and making it possible for us to be here today to pass the Restoring Hope for Mental Health and Well-Being Act of 2022. It is an important effort, and I am so glad that the bipartisan bill that I introduced last year with Congresswoman JAIME HERRERA BEUTLER, the Collaborate in an Orderly and Cohesive Manner Act, H.R. 5218, is included in it.

Many people first display symptoms of a mental health condition or substance use disorder in the primary care setting. Often they can't access the necessary follow-up treatment, it is either too expensive or too difficult for them to find the necessary mental health professional or overcome other obstacles, including stigma.

That is why enabling patients to access behavioral health treatment at their first point of care is critical, and that is what this bill does.

The collaborative care model addresses obstacles including stigma, a shortage of mental health professionals, and cost by integrating behavioral healthcare within the primary care setting, with their trusted family doctors, which allows patients to access the care they need in a setting where they feel most comfortable.

The collaborative care model is a measurement-based model featuring a primary care physician, a psychiatric consultant, and care manager all working together to provide mental health care for patients and ensuring that that care is delivered effectively.

There are more than 90 published trials demonstrating its success in different settings for both adults and children. It extends the reach of our psychiatrists, which is essential as we work to address demand in the face of workforce shortages. It is covered by Medicare, most private insurers, and many State Medicaid programs, alleviating the huge financial burden that can often be associated with accessing mental health care.

Despite its proven effectiveness, implementation of the collaborative care model remains low because of the upfront costs and lack of technical assistance for providers. This bill addresses this roadblock by providing grant funding for States to work with primary

care physicians and practices looking to adopt this model.

Mr. Speaker, I thank my colleagues, Congresswomen HERRERA BEUTLER and ESHOO and Chairman PALLONE for addressing the mental health crisis in this country.

Mrs. RODGERS of Washington. Mr. Speaker, may I inquire as to how much time is remaining.

The SPEAKER pro tempore. The gentlewoman from Washington has 14½ minutes remaining. The gentleman from New Jersey has 8½ minutes remaining.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Mrs. KIM), who is a leader on a provision within the larger package.

Mrs. KIM of California. Mr. Speaker, I thank Ranking Member RODGERS for yielding. I rise today in support of the Restoring Hope for Mental Health and Well-Being Act of 2022.

The pandemic and shutdowns left many Americans, especially women and children, feeling isolated, anxious, and alone. Depression, self-harm, substance abuse, and suicide have reached crisis levels.

I am glad we can help provide meaningful, targeted hope and healing to communities who need it. I am proud that two bills that I worked on, the Into the Light for Maternal Mental Health Act and the Garrett Lee Smith Memorial Act, were included in this package to prevent student suicide and support women facing mental health and substance abuse disorders during pregnancy.

We must keep working to turn despair into hope.

As a mom of four and a new grandma, I will always fight for the health and well-being of communities in southern California and across our Nation.

Mr. Speaker, I urge my colleagues to pass this commonsense, bipartisan H.R. 7666.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I am pleased we are taking up this bipartisan legislation today to reauthorize critical programs to address mental health.

We cannot, however, address mental health without acknowledging and addressing the climate impact. Our children are experiencing twin crises of mental health and climate change anxiety.

Last week, the Oregon Health Authority released a report raising the alarm of the effect of climate change on our youth. From the impact of climate-related disasters to climate anxiety, our children are facing stress and trauma that we need to address with them.

If we want to invest in our youth and their mental health, we must acknowledge the impact and give them hope that we understand and are working to reduce that threat. We simply cannot leave climate out of the conversation.

I appreciate the work that Chairman PALLONE has done for both youth mental health and climate, and I look forward to working with him to address both these critical issues.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. CARTER), who is a leader on the issue.

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentlewoman for yielding.

Mr. Speaker, we are all witnessing the decline in America's mental health brought about by the COVID–19 pandemic. Between family members and friends, we all are either affected ourselves or we know someone with a mental health condition. I am a father and a grandfather, and there is nothing more important to me than the safety and well-being of my children and grandchildren.

The urgency to address this mental health crisis has become more dire as we are seeing how fear, anxiety, and particularly isolation have compounded these issues. We owe it to our constituents to turn despair into hope and keep our children safe at school and in their community.

The Restoring Hope for Mental Health and Well-Being Act will help communities provide much-needed lifesaving care to our children. America's children are our Nation's future. It is time we take action and protect our loved ones and pass the Restoring Hope for Mental Health and Well-Being Act.

Mr. Speaker, I support this bill, and I encourage my colleagues to do the same.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. BEYER).

Mr. BEYER. Mr. Speaker, the pandemic magnified suicide risk, anxiety, and depression with two out of five adults reporting symptoms of anxiety and depression. The Kaiser Family Foundation released a report this morning that found that suicide death rates rose by 12 percent from 2010 to 2020—with rates rising fastest among people of color, younger people, and our good citizens in rural areas.

Help can't come fast enough.

I thank the Rules Committee for allowing the Katko-Napolitano-Beyer amendment to be included in the first en bloc today. This reauthorizes and ensures sufficient funding and provides oversight of the National Suicide Prevention Lifeline.

As the House and Senate finalize any mental health package to be signed into law, I want to flag my bill with ADAM KINZINGER—the Campaign to Prevent Suicide—which was passed by the committee and the House last year. It would help educate the American public both on the new 988 suicide lifeline number and also change the culture from one in crisis and avoidance to one that connects to resources.

SAMHSA has stated that the campaign is crucial to the success of 988. We can save an untold number of lives. 988 can be among the most important bipartisan success we have ever had.

Mr. Speaker, I thank Chair PALLONE, CATHY MCMORRIS RODGERS, and the committee staff for their commitment to tackling mental health. It is 2022, and we know far, far more than ever before in human history. It is time to put our healing knowledge to work.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Iowa (Mrs. MILLER-MEEKS).

Mrs. MILLER-MEEKS. Mr. Speaker, I thank Ranking Member MCMORRIS RODGERS for yielding time.

Mr. Speaker, I rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act.

This bill takes serious action to address mental health and substance use disorder, especially as we are coming out of the COVID–19 pandemic. I am pleased that the House was able to come together to create a bipartisan solution to deliver real results to the American people, both adults and children.

I also thank Ms. SCHRIER for partnering with me as we introduced the Supporting Children's Mental Health Care Access Act, which is included in this bipartisan package. This bill reauthorizes two grant programs that support pediatric mental and behavioral health services and interventions. Reauthorizing the pediatric mental health care access grant program is an important step in ensuring that our students have equal access to quality mental health care.

I would also like to thank Representatives AXNE, BUCSHON, and PAPPAS for joining me to introduce the Timely Treatment for Opioid Use Disorder Act which is also included in H.R. 7666. This bill increases access to treatment for individuals suffering from opioid use disorder. Opioid addiction does not have a timeline and does not discriminate. Patients should be able to begin treatment for opioid addiction as soon as possible.

I strongly encourage all of my colleagues to join me in supporting H.R. 7666, the bipartisan, results driven, and commonsense Restoring Hope for Mental Health and Well-Being Act.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. Mr. Speaker, I thank the chairman for yielding. As I begin—I am going to ask the chairman to enter into a colloquy—but, first, let me express my strong support for H.R. 7666 and the work that has been done in a bipartisan manner by both the chairman and the ranking member, and the importance of the issue of dealing with opioid addictions and other addictions that require this additional work. I am gratified to rise to support that.

I thank Chairman PALLONE, and ask, as I said, that he engages in a colloquy with me on the need to support the mental health needs of trauma victims impacted by trauma and, yes, mass

shootings. I think I have been here in the United States Congress during Columbine, Virginia Tech, Sandy Hook, Mother Emanuel, Santa Fe, Parkland—and the list goes on—and tragically Uvalde with 19 children, 2 adults, and 1 individual who died of heartbreak. I was in Uvalde, and I saw the impact on our children, to see 9-year-olds—9-year-olds—crying and saying that because I spoke to them, they said you are making me happy because you spoke to me, and you said you care. Out of the mouth of a 9-year-old.

So we know there is a mental health crisis as relates to the trauma of those who certainly are survivors and those who are in the community.

We also know that too many families and children in this country are hurting from the preventable epidemic of gun violence, shootings, and mass casualty events. These tragic events have lasting scars on the families, friends, and communities. I have seen this pain with my own eyes. And so I am interested in—as my amendment that I withdrew indicated—is there a prioritization of those children who are impacted by trauma?

Madam Speaker, I would like to be able to work with Chairman PALLONE on this issue. Will the gentleman yield for the purpose of a colloquy?

Mr. PALLONE. Madam Speaker, I just wanted to stress that H.R. 7666 includes programs focused on supporting youth mental health.

The SPEAKER pro tempore (Mrs. BEATTY). The time of the gentlewoman has expired.

Mr. PALLONE. I thank the gentlewoman for her leadership on this issue. In fact, H.R. 7666 includes programs focused on supporting youth mental health including due to such traumatic events that were mentioned by the gentlewoman.

The SAMHSA Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Program, for instance, and HRSA's Pediatric Mental Health Care Access program, which helps integrate behavioral health into pediatric primary care, extends resources to support Project AWARE, building student, families, and school behavioral health resiliency. Further, the bill provides support to complement SAMHSA's launch of the new 988 National Suicide Prevention Lifeline dialing code next month that will expand access to crisis care support through call, text, or chat functions for millions of Americans.

Madam Speaker, I yield an additional 1 minute to the gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. I thank the chairman for answering my questions regarding the Restoring Hope Act that there will be provisions for mental health care and services for children, families, and communities who experience these traumatic and violent events.

I look forward working with the chairman on these vital resources. With your partnership I would like to continue to work with you and the administration to ensure that when this legislation is enacted, the needs of the vulnerable victims and those closest to them are in the front of our minds.

Will the gentleman commit to working with me on this matter?

The SPEAKER pro tempore. The time of the gentlewoman has again expired.

Mr. PALLONE. Let me just add, I am pleased to work with the gentlewoman from Texas on this critical matter.

I thank her for her support in ensuring children and families have access to the mental health support and services they need to lead healthy and hopeful lives.

Madam Speaker, I yield an additional 30 seconds to the gentlewoman from Texas.

Ms. JACKSON LEE. Madam Speaker, I thank the chairman for his support. I will support this legislation.

Mr. Speaker, I rise as a staunch advocate for mental health services to speak in favor of the Restoring Hope for Mental Health and Well-Being Act of 2022.

This bill amends the Public Health Service Act to reauthorize critical mental health programs for those dealing with mental health or substance abuse disorders.

H.R. 7666 works to mitigate some of the most pressing issues of our time by designating grants, expanding the availability of high-quality recovery housing, reauthorizing treatment programs, and combatting substance abuse.

In 2019, an estimated 10.1 million people in the U.S. aged 12 or older misused opioids in the past year. Specifically, 9.7 million people misused prescription pain relievers and 745,000 people used heroin.

The bill eliminates a key restrictive classification of opioid addiction so that access to treatment programs is expanded.

These issues disproportionately impact tribal communities. According to the American Addiction Centers, 10% of Native Americans have a substance use disorder.

H.R. 7666 specifically funds the prevention and treatment of mental health and substance use disorders for tribal populations.

This is a needed step in protecting a community with a history of being mistreated by the Federal government.

This bill's expansion of access to mental health care services, most importantly of all, would make these services much more available to children and adolescents, who must always be our top priority.

For example, this bill increases mental health services for our youth by integrating behavioral health into public education in primary schools and creating a grant for pediatric mental health services.

This legislation also addresses another pressing issue that afflicts young Americans: eating disorders. As many as 10 in 100 young women suffer from an eating disorder.

H.R. 7666 provides federal funding for the identification and treatment of eating disorders.

But, above all, Mr. Speaker, who among all of our children, need mental health services more than those who have just experienced the unconscionable? Senseless shootings leave our students, some as young as five years old, devastated and vulnerable.

As adults, the thought of having our peers murdered in front of us is disturbing. How much more traumatizing would that be for preschool students?

This bill acts as a conduit for protecting children who are victims of a mass shooting or mass casualty event.

Mass shootings, especially school shootings, can leave lethal and obvious physical wounds on victims.

However, the long-lasting and subtle mental trauma is the invisible scar left on many survivors. Friends, family, and classmates often suffer with extreme guilt and sadness.

There have been 278 mass shooting in this year alone. Firearms are now the leading cause of death for children and teens.

In addition to those tragically killed, millions more are left behind, coping with these deaths. An estimated 3 million children in the US are exposed to shootings per year.

Since Columbine, there have been 337 school shootings and 311,000 students have experienced gun violence at school. Even more disturbing, just since Uvalde, there have been 65 mass shootings.

This is not a one-state issue. From the 28 killed at Sandy Hook in Connecticut, to the 17 killed at Marjorie Stoneman-Douglas in Florida, to the 10 killed at Red Lake in Minnesota, to the 22 killed at Robb Elementary in my home state of Texas, school shootings have become a disgusting norm.

Children exposed to violence, crime, and abuse are more likely to abuse drugs and alcohol; suffer from depression, anxiety, and posttraumatic stress disorder; fail or have difficulties in school; and engage in criminal activity.

These children don't stay children forever. These mental health struggles translate to a life of pain and suffering where crime, drug use, and suicide are more likely.

This trauma has real consequences: in the year following the 2018 massacre at Stoneman-Douglas High school, two students took their own life after suffering with the mental anguish of the events they had lived through.

Passage of this bill will not solve the gun crisis or mass shootings in this country. Only common-sense gun-control will do that.

However, this bill will set a foundation for the government to address the toll of gun violence on children's mental health.

Additionally, enactment of this legislation demonstrates Congress' support of victims of mass casualty events by prioritizing access to mental health services.

Children are the future of our country. Far too many of them have their hopes and dreams stripped away by senseless shootings.

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Mrs. RODGERS of Washington. Madam Speaker, I yield 1½ minutes to the gentleman from Kentucky (Mr. COMER).

Mr. COMER. Madam Speaker, I have become increasingly concerned that the consolidation and monopolistic nature of pharmacy benefit managers, or PBMs has negatively impacted competition in the pharmaceutical marketplace, leading Americans to spend more on prescription drugs than any

other country. These PBMs not only raise patient costs but are potentially engaged in anticompetitive behavior.

The legislation before us today includes language requiring PBMs to issue reports to employer sponsors of health plans outlining information that they have been unwilling to provide to their customers, including copays applied by insurers to drug manufacturer costs, rebates received from manufacturers, and the PBM's rationale for choosing certain brand name drugs over more affordable biosimilars, generics, or therapeutics for their formularies.

Simply providing this information to the participants in group health plans is expected to save over $2 billion over 10 years. These biannual, employer or sponsor-specific reports will allow participants in group health plans to make informed decisions about the services their PBM is providing and reduce patient costs for prescription drugs.

We cannot have a serious conversation about lowering drug prices in America without examining PBMs' ever-growing influence.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. LEVIN).

Mr. LEVIN of California. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, the substance use disorder crisis has touched almost every American in one way or another. Too many families have felt the extraordinary pain of burying a son or daughter, a father or a mother who struggled with the disease of addiction.

Tragically, many families have also experienced the heartbreak and deep frustration that comes after a loved one enters a residential recovery home that ultimately doesn't provide them with adequate care to get and stay on the path toward recovery.

We must ensure that residential recovery homes meet a high standard of care and provide those who are struggling with the support they need to recover.

We can and must do better. That is why I introduced the SOBER Homes Act, parts of which are included in H.R. 7666, the legislation we are voting on today. It includes $1.5 million for a Federal study of the effectiveness of recovery housing and to identify recommendations promoting the availability of high-quality recovery housing.

This legislation will help us better understand where these facilities are falling short and how we can improve them to ensure everyone in recovery housing receives the help they need and deserve.

Finally, I thank all the advocates who have been fighting so hard on this issue. The information from this effort will save lives, which is why I implore my colleagues to support this bill and vote ''aye.''

Mrs. RODGERS of Washington. Madam Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. JOYCE), a member of the Committee on Energy and Commerce.

Mr. JOYCE of Pennsylvania. Madam Speaker, I thank the gentlewoman for yielding.

Right now, today, as we all are here in the Halls of Congress, our Nation is facing a mental health crisis. And this crisis followed 2 years of lockdowns and remote learning that have left so many Americans feeling isolated, lost, and, in some cases, hopeless. Particularly, our young Americans feel all of these emotions.

I rise today in support of this legislation that would help to address this crisis head-on by helping to ensure that those who are struggling can receive the help that they so desperately need, that they need, and they need our attention to it right now.

The Restoring Hope for Mental Health and Well-Being Act of 2022 expands access to care for millions of Americans, including children and teenagers who are desperately in need of this assistance.

As a doctor, I have treated patients who have later lost their lives to mental illness. Just last week, we had physicians here on the Hill, pediatricians, family doctors, telling us that they have seen the shift of the pendulum; that they see on a daily basis more and more cases in their patients, specifically involving mental health.

And there is not a single American who has not in some way been impacted by the effects that mental illness is having today.

In the past year, over 107,000 Americans have lost their lives to drug overdoses. Far too many grandparents, far too many fathers, mothers, sons, and daughters are dying. We cannot wait to act any longer. We need to act and vote on this legislation.

To help address the tragedy of addiction, this bill increases support for opioid recovery programs that will help people who are struggling to receive the care that they need.

This bill would go on to make mental health screenings a part of each person's annual physical exam and evaluation and help to ensure that everyone who sees a doctor is able to have a conversation frankly, concisely, clearly, about their mental health and the mental health issues that they are facing.

Most importantly, this bill would provide a whole-of-care approach that would fund prevention, treatment, and recovery services for the people who are suffering with addiction. We have worked as a committee, as a conference addressing these important issues.

I urge all of my colleagues to vote to pass this important piece of legislation.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. CICILLINE).

Mr. CICILLINE. Madam Speaker, for too long, Americans, including children, struggling with mental illness and substance abuse, have suffered in silence, intimidated by stigma and unable to access treatment.

The 2019 Rhode Island Youth Risk Behavior Survey found that 15 percent of Rhode Island high school students reported attempting suicide one or more times in the previous 12 months. That is 4 students in a class of 25.

There is a mental health crisis in Rhode Island and throughout our country, and we have to address it now.

The Restoring Hope for Mental Health and Well-Being Act will save lives by expanding access to mental health and substance abuse disorder treatment through: Establishing the Behavioral Health Crisis Coordination Office; reauthorizing critical public health programs to prevent suicide and expand access to mental health and substance use disorder treatment; and eliminating unnecessary limits on providers' ability to prescribe treatments for opioid use disorder.

I urge my colleagues to join with me in support of this critical legislation to save lives and to help us address addiction all across our country.

Mrs. RODGERS of Washington. Madam Speaker, I yield 1 minute to the gentleman from Ohio (Mr. BALDERSON).

Mr. BALDERSON. Madam Speaker, I thank Ranking Member RODGERS for this work.

Madam Speaker, I rise today in support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act.

Lockdowns, isolations, economic instability, disruptions to learning and daily routines. For well over a year, school closures, mask mandates, and online learning became the new normal for far too many young Americans.

As a result, a new crisis is afoot in our country, one with potentially dire consequences for our future, a mental health crisis among younger Americans.

Today, nearly 7 in 10 parents of young children in Ohio are worried about their kids' mental or emotional health. Drug overdose is now the leading cause of death of Americans ages 18 to 45. Our kids are counting on us, and we are counting on them.

Madam Speaker, I urge a ''yes'' vote on H.R. 7666.

Mr. PALLONE. Madam Speaker, I have no additional speakers. I am prepared to close. I reserve the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Madam Speaker, I rise today in support of H.R. 7666, the Restore Hope for Mental Health and Well-Being Act of 2022.

I am proud to be a member of a committee that works in a bipartisan way to help solve the problems facing our constituents every day. Right now, that means addressing the Nation's mental health crisis.

Though many challenges existed before the start of the COVID–19 pandemic, 2½ years of widespread fear, social isolation, and financial uncertainty has further increased Americans' need for mental health support systems.

This bill reauthorizes many of the critical mental health programs Americans currently rely on, but also provides for new measures.

Especially important to me is the inclusion of the TRIUMPH for New Moms Act, a bipartisan bill I coauthored with Representative BARRAGÁN. It aims to establish a no-cost, interdepartmental task force to address the U.S. maternal mental health crisis by eliminating duplication and coordinating Federal resources toward maternal mental health.

This task force would also work closely with State Governors to alleviate the maternal mental health challenges in their States.

Current Federal efforts to support women suffering from maternal mental health conditions lack coordinated action and organization toward this issue. And, as a result, 50 percent of these new moms never receive treatment.

This bill will increase mental health support for pregnant and new mothers by offering targeted solutions that have proven success, a fact that is particularly important to me, given Indiana's maternal mortality rate, which is one of the highest in the Nation.

Passing this bill will help provide better support for future generations of mothers and children.

Again, I thank the chair and ranking member of the Energy and Commerce Committee for their dedication to these issues, and I look forward to passage of H.R. 7666.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, I want to again just express appreciation to the chairman of the committee, all the Members that have participated in helping bring this package of very important mental health proposals to the House today. I urge a strong ''yes'' vote.

As many have said, we have a mental health crisis. At a time when there is so much fear and anxiety and stress, we see increased suicide. We see drug overdoses, and it is time that we act, and act in a way that is really going to make a difference for America's families and our youth in particular.

Madam Speaker, I urge support, and I yield back the balance of my time.

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

Let me just reiterate what the ranking member said. This was really a bipartisan bill. I thank Mrs. RODGERS, Mr. GUTHRIE, Ms. ANNA ESHOO, and all the staff that worked so hard on this legislation.

It is important that we have as big a vote as possible because this bill has a real chance of passing the Senate and getting to the President's desk and will really address the mental health and substance abuse concerns that we have and the crisis that we have. So I urge everyone to vote ''yes.''

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

Mrs. NAPOLITANO. Madam Speaker, I rise today in strong support of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act. I am honored to have my bill, H.R. 721, the Mental Health Services for Students Act, included in this package. Today is a historic day in recognizing the need for more comprehensive school-based mental health resources.

The COVID–19 pandemic has upended the lives of our nation's children and youth and added additional stressors that have significantly strained and continues to strain their mental health and well-being. Children and youth across the nation continue to confront the traumatic challenges of this pandemic, including disruptions to their lives, fear and anxiety about the virus, and the tragic death of loved ones. According to the Centers for Disease Control and Prevention (CDC), mental health disorders are chronic conditions that, without proper diagnosis and treatment, can lead to problems for children at home and in school, interfering with their health and future development.

H.R. 721 acknowledges this problem by providing $130 million in competitive grants for school-based mental health programs nationwide. It expands the scope of the Project AWARE program by providing onsite licensed mental health professionals in schools across the country.

H.R. 721 is based on the successful Youth Suicide Prevention Program that I helped establish with Pacific Clinics in Los Angeles County in 2001, after learning 1 in 3 Latina adolescents, age 9 to 11, had contemplated suicide. We need to secure the long-term availability of mental health services to ensure a bright future for our students, which my bill would help accomplish.

I would like to thank the many advocates in and outside of Congress who have played an integral role in this legislation. H.R. 721 has 86 bipartisan co-sponsors and has the support of over 50 mental health organizations, as well as local governments and teacher unions. I would also like to thank my co-lead Rep. JOHN KATKO, Chairman PALLONE and his staff, and my own staff who contributed toward today's passage.

Madam Speaker, I ask my colleagues to support the underlying bill, H.R. 7666, which will help address our ongoing mental health crisis. it is now time to act on this bill and provide the necessary funding and resources to reach children and youth early on in life.

Ms. ROYBAL-ALLARD. Madam Speaker, I rise in support of this bill, which seeks to address our national mental health and substance use crisis. I thank Congressman PALLONE for this package of bills, which includes my bill, H.R. 7105, known as the STOP Act.

The STOP Act advances a comprehensive and effective national effort on underage drinking prevention, which includes a national adult-oriented media campaign and grants for community-based prevention coalitions.

The legislation recognizes the importance of alcohol regulation and the fact that alcohol is different than other consumer products and is best regulated by states, consistent with the 21st Amendment.

Since the passage of the original STOP Act in 2006, we have witnessed a 12.7 percent decrease in alcohol use amongst 12-to-20-year-olds. Yet, alcohol continues to be the most widely used substance amongst youth, accounting for 3,900 deaths and 225,000 years of potential life lost annually.

We must continue to lead efforts to reduce underage alcohol use and ensure the safety of our youth. I urge my colleagues to vote YES on this bill.

Ms. MOORE of Wisconsin. Madam Speaker, today, I rise in support of H.R. 7666, a bipartisan response to rising substance use disorders and mental health needs in our communities.

The need for this bill is clear.

We've heard about the growing mental health crisis, including about alarming rates of mental health hospitalizations, suicide rates and depression. The need for mental health services continues to grow, including among our children. In my district, the emergency department at Children's Wisconsin saw a 60 percent increase in young patients who attempted suicide between 2020 and 2021.

Substance misuse also remains a crisis in our communities. Milwaukee county has among the highest rates of overdose deaths in Wisconsin and has seen high numbers of emergency calls related to overdoses in the past few years. According to Milwaukee County, from 2014 to 2020, the opioid overdose fatality rate in the country was 30.9 per 100,000 persons, more than twice the rate statewide.

This bill includes strong provisions to reauthorize and revitalize federal programs that support access to treatment and services, while boosting access to crisis services. The whole continuum of services needs to be strengthened to ensure that no one in need of help goes without.

The bill would also reauthorize and increase funding for the Mental Health First Aid grant program. Mental Health First Aid is an evidenced-based program that teaches ordinary people how to identify, understand, and respond to the signs of mental illness and substance use disorder.

The bill would also reauthorize the Pediatric Mental Health Care Access Grant, a program that supports the ability of pediatric primary care providers to deliver mental health care with the help of rapid consultation with psychiatrists, social workers, and/or psychologists. The program also provides training and education on early identification, diagnosis, and treatment of behavioral health condition, allowing more families to access high-quality mental health treatment in their pediatrician's office.

I am pleased to offer an amendment that will improve this bill by ensuring that state and local officials who administer programs serving pregnant and postpartum individuals are consulted by those operating the new maternal mental health hotline. This hotline will provide free and confidential support before, during, and after pregnancy providing yet another tool for those in need.

Through programs such as WIC, SNAP and the Maternal and Child Health Service Block grant, among others, the federal government reaches numerous pregnant and postpartum individuals. State and local officials are key

partners in the operations of those programs and often are on the frontlines of reaching and serving populations that would immensely benefit from access to this important new resource. It only makes sense that they be involved in efforts related to making this hotline truly effective and that individuals know about the resources it offers.

I thank the chairman and Ranking Member for their support of my amendment. I urge my colleagues to support it and the underlying bill.

The SPEAKER pro tempore. All time for debate has expired.

Each further amendment printed in part E of House Report 117–381 not earlier considered as part of the amendments en bloc pursuant to section 6 of House Resolution 1191 shall be considered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, may be withdrawn by the proponent at any time before the question is put thereon, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

It shall be in order at any time for the chair of the Committee on Energy and Commerce or his designee to offer amendments en bloc consisting of further amendments printed in part E of House Report 117–381, not earlier disposed of. Amendments en bloc shall be considered as read, shall be debatable for 20 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce or their respective designees, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

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AMENDMENTS EN BLOC NO. 1 OFFERED BY MR. PALLONE OF NEW JERSEY

Mr. PALLONE. Madam Speaker, pursuant to House Resolution No. 1191, I rise to offer amendments en bloc No. 1.

The SPEAKER pro tempore. The Clerk will designate the amendments en bloc.

Amendments en bloc No. 1 consisting of amendment Nos. 1, 5, 9, 10, 13, 14, 15, and 16, printed in part E of House Report 117–381, offered by Mr. PALLONE of New Jersey:

AMENDMENT NO. 1 OFFERED BY MR. BERA OF CALIFORNIA

After section 331, insert the following new subtitle:

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

SEC. 341. HELPING EMERGENCY RESPONDERS OVERCOME.

(a) DATA SYSTEM TO CAPTURE NATIONAL PUBLIC SAFETY OFFICER SUICIDE INCIDENCE.—The Public Health Service Act is amended by inserting before section 318 of such Act (42 U.S.C. 247c) the following:

"SEC. 317V. DATA SYSTEM TO CAPTURE NATIONAL PUBLIC SAFETY OFFICER SUICIDE INCIDENCE.

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

''(1) develop and maintain a data system, to be known as the Public Safety Officer Suicide Reporting System, for the purposes of—

''(A) collecting data on the suicide incidence among public safety officers; and

''(B) facilitating the study of successful interventions to reduce suicide among public safety officers; and

''(2) integrate such system into the National Violent Death Reporting System, so long as the Secretary determines such integration to be consistent with the purposes described in paragraph (1).

''(b) DATA COLLECTION.—In collecting data for the Public Safety Officer Suicide Reporting System, the Secretary shall, at a minimum, collect the following information:

''(1) The total number of suicides in the United States among all public safety officers in a given calendar year.

''(2) Suicide rates for public safety officers in a given calendar year, disaggregated by—

''(A) age and gender of the public safety officer;

''(B) State;

''(C) occupation; including both the individual's role in their public safety agency and their primary occupation in the case of volunteer public safety officers;

''(D) where available, the status of the public safety officer as volunteer, paid-on-call, or career; and

''(E) status of the public safety officer as active or retired.

''(c) CONSULTATION DURING DEVELOPMENT.—In developing the Public Safety Officer Suicide Reporting System, the Secretary shall consult with non-Federal experts to determine the best means to collect data regarding suicide incidence in a safe, sensitive, anonymous, and effective manner. Such non-Federal experts shall include, as appropriate, the following:

''(1) Public health experts with experience in developing and maintaining suicide registries.

''(2) Organizations that track suicide among public safety officers.

''(3) Mental health experts with experience in studying suicide and other profession-related traumatic stress.

''(4) Clinicians with experience in diagnosing and treating mental health issues.

''(5) Active and retired volunteer, paid-on-call, and career public safety officers.

''(6) Relevant national police, and fire and emergency medical services, organizations.

''(d) DATA PRIVACY AND SECURITY.—In developing and maintaining the Public Safety Officer Suicide Reporting System, the Secretary shall ensure that all applicable Federal privacy and security protections are followed to ensure that—

''(1) the confidentiality and anonymity of suicide victims and their families are protected, including so as to ensure that data cannot be used to deny benefits; and

''(2) data is sufficiently secure to prevent unauthorized access.

''(e) REPORTING.—

''(1) ANNUAL REPORT.—Not later than 2 years after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, and biannually thereafter, the Secretary shall submit a report to the Congress on the suicide incidence among public safety officers. Each such report shall—

''(A) include the number and rate of such suicide incidence, disaggregated by age, gender, and State of employment;

''(B) identify characteristics and contributing circumstances for suicide among public safety officers;

''(C) disaggregate rates of suicide by—

''(i) occupation;

''(ii) status as volunteer, paid-on-call, or career; and

''(iii) status as active or retired;

''(D) include recommendations for further study regarding the suicide incidence among public safety officers;

''(E) specify in detail, if found, any obstacles in collecting suicide rates for volunteers and include recommended improvements to overcome such obstacles;

''(F) identify options for interventions to reduce suicide among public safety officers; and

''(G) describe procedures to ensure the confidentiality and anonymity of suicide victims and their families, as described in subsection (d)(1).

''(2) PUBLIC AVAILABILITY.—Upon the submission of each report to the Congress under paragraph (1), the Secretary shall make the full report publicly available on the website of the Centers for Disease Control and Prevention.

''(f) DEFINITION.—In this section, the term 'public safety officer' means—

''(1) a public safety officer as defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968; or

''(2) a public safety telecommunicator as described in detailed occupation 43–5031 in the Standard Occupational Classification Manual of the Office of Management and Budget (2018).

''(g) PROHIBITED USE OF INFORMATION.—Notwithstanding any other provision of law, if an individual is identified as deceased based on information contained in the Public Safety Officer Suicide Reporting System, such information may not be used to deny or rescind life insurance payments or other benefits to a survivor of the deceased individual.''.

(b) PEER-SUPPORT BEHAVIORAL HEALTH AND WELLNESS PROGRAMS WITHIN FIRE DEPARTMENTS AND EMERGENCY MEDICAL SERVICE AGENCIES.—

(1) IN GENERAL.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

"SEC. 320C. PEER-SUPPORT BEHAVIORAL HEALTH AND WELLNESS PROGRAMS WITHIN FIRE DEPARTMENTS AND EMERGENCY MEDICAL SERVICE AGENCIES.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities for the purpose of establishing or enhancing peer-support behavioral health and wellness programs within fire departments and emergency medical services agencies.

''(b) PROGRAM DESCRIPTION.—A peer-support behavioral health and wellness program funded under this section shall—

''(1) use career and volunteer members of fire departments or emergency medical services agencies to serve as peer counselors;

''(2) provide training to members of career, volunteer, and combination fire departments or emergency medical service agencies to serve as such peer counselors;

''(3) purchase materials to be used exclusively to provide such training; and

''(4) disseminate such information and materials as are necessary to conduct the program.

''(c) DEFINITION.—In this section:

''(1) The term 'eligible entity' means a nonprofit organization with expertise and experience with respect to the health and life safety of members of fire and emergency medical services agencies.

''(2) The term 'member'—

''(A) with respect to an emergency medical services agency, means an employee, regardless of rank or whether the employee receives compensation (as defined in section

1204(7) of the Omnibus Crime Control and Safe Streets Act of 1968); and

''(B) with respect to a fire department, means any employee, regardless of rank or whether the employee receives compensation, of a Federal, State, Tribal, or local fire department who is responsible for responding to calls for emergency service.''.

(2) TECHNICAL CORRECTION.—Effective as if included in the enactment of the Children's Health Act of 2000 (Public Law 106–310), the amendment instruction in section 1603 of such Act is amended by striking ''Part B of the Public Health Service Act'' and inserting ''Part B of title III of the Public Health Service Act''.

(c) HEALTH CARE PROVIDER BEHAVIORAL HEALTH AND WELLNESS PROGRAMS.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by subsection (b)(1), is further amended by adding at the end the following:

''SEC. 320D. HEALTH CARE PROVIDER BEHAVIORAL HEALTH AND WELLNESS PROGRAMS.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities for the purpose of establishing or enhancing behavioral health and wellness programs for health care providers.

''(b) PROGRAM DESCRIPTION.—A behavioral health and wellness program funded under this section shall—

''(1) provide confidential support services for health care providers to help handle stressful or traumatic patient-related events, including counseling services and wellness seminars;

''(2) provide training to health care providers to serve as peer counselors to other health care providers;

''(3) purchase materials to be used exclusively to provide such training; and

''(4) disseminate such information and materials as are necessary to conduct such training and provide such peer counseling.

''(c) DEFINITIONS.—In this section, the term 'eligible entity' means a hospital, including a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act) or a disproportionate share hospital (as defined under section 1923(a)(1)(A) of such Act), a Federally-qualified health center (as defined in section 1905(1)(2)(B) of such Act), or any other health care facility.''.

(d) DEVELOPMENT OF RESOURCES FOR EDUCATING MENTAL HEALTH PROFESSIONALS ABOUT TREATING FIRE FIGHTERS AND EMERGENCY MEDICAL SERVICES PERSONNEL.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop and make publicly available resources that may be used by the Federal Government and other entities to educate mental health professionals about—

(A) the culture of Federal, State, Tribal, and local career, volunteer, and combination fire departments and emergency medical services agencies;

(B) the different stressors experienced by firefighters and emergency medical services personnel, supervisory firefighters and emergency medical services personnel, and chief officers of fire departments and emergency medical services agencies;

(C) challenges encountered by retired firefighters and emergency medical services personnel; and

(D) evidence-based therapies for mental health issues common to firefighters and emergency medical services personnel within such departments and agencies.

(2) CONSULTATION.—In developing resources under paragraph (1), the Secretary of Health and Human Services shall consult with national fire and emergency medical services organizations.

(3) DEFINITIONS.—In this subsection:

(A) The term ''firefighter'' means any employee, regardless of rank or whether the employee receives compensation, of a Federal, State, Tribal, or local fire department who is responsible for responding to calls for emergency service.

(B) The term ''emergency medical services personnel'' means any employee, regardless of rank or whether the employee receives compensation, as defined in section 1204(7) of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10284(7)).

(C) The term ''chief officer'' means any individual who is responsible for the overall operation of a fire department or an emergency medical services agency, irrespective of whether such individual also serves as a firefighter or emergency medical services personnel.

(e) BEST PRACTICES AND OTHER RESOURCES FOR ADDRESSING POSTTRAUMATIC STRESS DISORDER IN PUBLIC SAFETY OFFICERS.—

(1) DEVELOPMENT; UPDATES.—The Secretary of Health and Human Services shall—

(A) develop and assemble evidence-based best practices and other resources to identify, prevent, and treat posttraumatic stress disorder and co-occurring disorders in public safety officers; and

(B) reassess and update, as the Secretary determines necessary, such best practices and resources, including based upon the options for interventions to reduce suicide among public safety officers identified in the annual reports required by section 317V(e)(1)(F) of the Public Health Service Act, as added by subsection (a).

(2) CONSULTATION.—In developing, assembling, and updating the best practices and resources under paragraph (1), the Secretary of Health and Human Services shall consult with, at a minimum, the following:

(A) Public health experts.

(B) Mental health experts with experience in studying suicide and other profession-related traumatic stress.

(C) Clinicians with experience in diagnosing and treating mental health issues.

(D) Relevant national police, fire, and emergency medical services organizations.

(3) AVAILABILITY.—The Secretary of Health and Human Services shall make the best practices and resources under paragraph (1) available to Federal, State, and local fire, law enforcement, and emergency medical services agencies.

(4) FEDERAL TRAINING AND DEVELOPMENT PROGRAMS.—The Secretary of Health and Human Services shall work with Federal departments and agencies, including the United States Fire Administration, to incorporate education and training on the best practices and resources under paragraph (1) into Federal training and development programs for public safety officers.

(5) DEFINITION.—In this subsection, the term ''public safety officer'' means—

(A) a public safety officer as defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10284); or

(B) a public safety telecommunicator as described in detailed occupation 43–5031 in the Standard Occupational Classification Manual of the Office of Management and Budget (2018).

AMENDMENT NO. 5 OFFERED BY MR. FEENSTRA OF IOWA

Page 5, after line 21, insert the following new subparagraph (and redesignate the subsequent subparagraphs accordingly):

''(B) the Veterans Crisis Line;

AMENDMENT NO. 9 OFFERED BY MR. JOYCE OF OHIO

At the end of title I, add the following new subtitle:

Subtitle G—Military Suicide Prevention in the 21st Century

SEC. 155. PILOT PROGRAM ON PRE-PROGRAMMING OF SUICIDE PREVENTION RESOURCES INTO SMART DEVICES ISSUED TO MEMBERS OF THE ARMED FORCES.

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

(1) pre-downloads the Virtual Hope Box application of the Defense Health Agency, or such successor application, on smart devices individually issued to members of the Armed Forces;

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

(3) provides training, as part of training on suicide awareness and prevention conducted throughout the Department of Defense, on the preventative resources described in paragraphs (1) and (2).

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

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

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

(e) REPORT.—Not later than 30 days after completing the pilot program under this section, the Secretary shall submit to the Committee on Armed Services of the Senate and the Committee on Armed Services of the House of Representatives a report on the pilot program.

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

AMENDMENT NO. 10 OFFERED BY MR. KATKO OF NEW YORK

After section 102, insert the following new section:

SEC. 103. SUICIDE PREVENTION LIFELINE IMPROVEMENT.

(a) SUICIDE PREVENTION LIFELINE.—

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

(A) by redesignating subsection (c) as subsection (e); and

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

''(c) PLAN.—

''(1) IN GENERAL.—For purposes of maintaining the suicide prevention hotline under subsection (b)(2), the Secretary shall develop and implement a plan to ensure the provision of high-quality service.

''(2) CONTENTS.—The plan required by paragraph (1) shall include the following:

''(A) Quality assurance provisions, including—

''(i) clearly defined and measurable performance indicators and objectives to improve the responsiveness and performance of the hotline, including at backup call centers; and

''(ii) quantifiable timeframes to track the progress of the hotline in meeting such performance indicators and objectives.

''(B) Standards that crisis centers and backup centers must meet—

''(i) to participate in the network under subsection (b)(1); and

''(ii) to ensure that each telephone call, online chat message, and other communication received by the hotline, including at backup call centers, is answered in a timely manner by a person, consistent with the guidance established by the American Association of Suicidology or other guidance determined by the Secretary to be appropriate.

''(C) Guidelines for crisis centers and backup centers to implement evidence-based practices including with respect to followup and referral to other health and social services resources.

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

''(E) Guidelines to carry out periodic testing of the hotline, including at crisis centers and backup centers, during each fiscal year to identify and correct any problems in a timely manner.

''(F) Guidelines to operate in consultation with the State department of health, local governments, Indian tribes, and tribal organizations.

''(3) INITIAL PLAN; UPDATES.—The Secretary shall—

''(A) not later than 6 months after the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, complete development of the initial version of the plan required by paragraph (1), begin implementation of such plan, and make such plan publicly available; and

''(B) periodically thereafter, update such plan and make the updated plan publicly available.''.

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

''(d) TRANSMISSION OF DATA TO CDC.—The Secretary shall formalize and strengthen agreements between the National Suicide Prevention Lifeline program and the Centers for Disease Control and Prevention to transmit any necessary epidemiological data from the program to the Centers, including local call center data, to assist the Centers in suicide prevention efforts.''.

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—

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

''(2) ALLOCATION.—Of the amount authorized to be appropriated by paragraph (1) for each of fiscal years 2023 through 2027—

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

''(B) not more than 10 percent may be used for carrying out the pilot program in section 103(b)(1) of the Restoring Hope for Mental Health and Well-Being Act of 2022.''.

(b) PILOT PROGRAM ON INNOVATIVE TECHNOLOGIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall carry out a pilot program to research, analyze, and employ various technologies and platforms of communication (including social media platforms, texting platforms, and email platforms) for suicide prevention in addition to the telephone and online chat service provided by the Suicide Prevention Lifeline.

(2) REPORT.—Not later than 24 months after the date on which the pilot program under paragraph (1) commences, the Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall submit to the Congress a report on the pilot program. With respect to each platform of communication employed pursuant to the pilot program, the report shall include—

(A) a full description of the program;

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

(C) the average wait time for each individual to receive a response;

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

(E) any other information the Secretary determines appropriate.

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

(1) complete a study on—

(A) the implementation of such plan, including the progress towards meeting the objectives identified pursuant to paragraph (2)(A)(i) of such section 520E–3(c) by the timeframes identified pursuant to paragraph (2)(A)(ii) of such section 520E–3(c); and

(B) in consultation with the Director of the Centers for Disease Control and Prevention, options to expand data gathering from calls to the Suicide Prevention Lifeline in order to better track aspects of usage such as repeat calls, consistent with applicable Federal and State privacy laws; and

(2) submit a report to the Congress on the results of such study, including recommendations on whether additional legislation or appropriations are needed.

(d) GAO STUDY AND REPORT.—

(1) IN GENERAL.—Not later than 24 months after the Secretary of Health and Human Services begins implementation of the plan required by section 520E–3(c) of the Public Health Service Act, as added by subsection (a)(1)(B), the Comptroller General of the United States shall—

(A) complete a study on the Suicide Prevention Lifeline; and

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

(2) ISSUES TO BE STUDIED.—The study required by paragraph (1) shall address—

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

(B) operation shortcomings of the Suicide Prevention Lifeline;

(C) geographic coverage of each crisis call center;

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

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

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

(G) funding avenues of each crisis call center;

(H) the implementation of the plan under section 520E–3(c) of the Public Health Service Act, as added by subsection (a)(1)(B), including the progress towards meeting the objectives identified pursuant to paragraph (2)(A)(i) of such section 520E–3(c) by the timeframes identified pursuant to paragraph (2)(A)(ii) of such section 520E–3(c); and

(I) service to individuals requesting a foreign language speaker, including—

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

(ii) the capacity of the Lifeline to handle these calls or chats; and

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

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

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

AMENDMENT NO. 13 OFFERED BY MS. MOORE OF WISCONSIN

Page 20, line 4, strike ''and''.

Page 20, line 9, strike the period at the end and insert ''; and''.

Page 20, after line 9, add the following:

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

AMENDMENT NO. 14 OFFERED BY MRS. NAPOLITANO OF CALIFORNIA

After section 402, insert the following new section:

SEC. 403. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND ADOLESCENTS.

(a) TECHNICAL AMENDMENTS.—The second part G (relating to services provided through religious organizations) of title V of the Public Health Service Act (42 U.S.C. 290kk et seq.) is amended—

(1) by redesignating such part as part J; and

(2) by redesignating sections 581 through 584 as sections 596 through 596C, respectively.

(b) SCHOOL-BASED MENTAL HEALTH AND CHILDREN.—Section 581 of the Public Health Service Act (42 U.S.C. 290hh) (relating to children and violence) is amended to read as follows:

''SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND ADOLESCENTS.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall, through grants, contracts, or cooperative agreements awarded to eligible entities described in subsection (c), provide comprehensive school-based mental health services and supports to assist children in local communities and schools (including schools funded by the Bureau of Indian Education) dealing with traumatic experiences, grief, bereavement, risk of suicide, and violence. Such services and supports shall be—

''(1) developmentally, linguistically, and culturally appropriate;

''(2) trauma-informed; and

''(3) incorporate positive behavioral interventions and supports.

''(b) ACTIVITIES.—Grants, contracts, or cooperative agreements awarded under subsection (a), shall, as appropriate, be used for—

''(1) implementation of school and community-based mental health programs that—

''(A) build awareness of individual trauma and the intergenerational, continuum of impacts of trauma on populations;

''(B) train appropriate staff to identify, and screen for, signs of trauma exposure, mental health disorders, or risk of suicide; and

''(C) incorporate positive behavioral interventions, family engagement, student treatment, and multigenerational supports to foster the health and development of children, prevent mental health disorders, and ameliorate the impact of trauma;

''(2) technical assistance to local communities with respect to the development of programs described in paragraph (1);

''(3) facilitating community partnerships among families, students, law enforcement agencies, education agencies, mental health and substance use disorder service systems, family-based mental health service systems, child welfare agencies, health care providers (including primary care physicians, mental health professionals, and other professionals

who specialize in children's mental health such as child and adolescent psychiatrists), institutions of higher education, faith-based programs, trauma networks, and other community-based systems to address child and adolescent trauma, mental health issues, and violence; and

''(4) establishing mechanisms for children and adolescents to report incidents of violence or plans by other children, adolescents, or adults to commit violence.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall be a partnership that includes—

''(A) a State educational agency, as defined in section 8101 of the Elementary and Secondary Education Act of 1965, in coordination with one or more local educational agencies, as defined in section 8101 of the Elementary and Secondary Education Act of 1965, or a consortium of any entities described in subparagraph (B), (C), (D), or (E) of section 8101(30) of such Act; and

''(B) at least 1 community-based mental health provider, including a public or private mental health entity, health care entity, family-based mental health entity, trauma network, or other community-based entity, as determined by the Secretary (and which may include additional entities such as a human services agency, law enforcement or juvenile justice entity, child welfare agency, agency, an institution of higher education, or another entity, as determined by the Secretary).

''(2) COMPLIANCE WITH HIPAA.—Any patient records developed by covered entities through activities under the grant shall meet the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(3) COMPLIANCE WITH FERPA.—Section 444 of the General Education Provisions Act (commonly known as the 'Family Educational Rights and Privacy Act of 1974') shall apply to any entity that is a member of the partnership in the same manner that such section applies to an educational agency or institution (as that term is defined in such section).

''(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts, or cooperative agreements under subsection (a) will be distributed equitably among the regions of the country and among urban and rural areas.

''(e) DURATION OF AWARDS.—With respect to a grant, contract, or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the recipient shall be 5 years, with options for renewal.

''(f) EVALUATION AND MEASURES OF OUTCOMES.—

''(1) DEVELOPMENT OF PROCESS.—The Assistant Secretary shall develop a fiscally appropriate process for evaluating activities carried out under this section. Such process shall include—

''(A) the development of guidelines for the submission of program data by grant, contract, or cooperative agreement recipients;

''(B) the development of measures of outcomes (in accordance with paragraph (2)) to be applied by such recipients in evaluating programs carried out under this section; and

''(C) the submission of annual reports by such recipients concerning the effectiveness of programs carried out under this section.

''(2) MEASURES OF OUTCOMES.—The Assistant Secretary shall develop measures of outcomes to be applied by recipients of assistance under this section to evaluate the effectiveness of programs carried out under this section, including outcomes related to the student, family, and local educational systems supported by this Act.

''(3) SUBMISSION OF ANNUAL DATA.—An eligible entity described in subsection (c) that receives a grant, contract, or cooperative agreement under this section shall annually submit to the Assistant Secretary a report that includes data to evaluate the success of the program carried out by the entity based on whether such program is achieving the purposes of the program. Such reports shall utilize the measures of outcomes under paragraph (2) in a reasonable manner to demonstrate the progress of the program in achieving such purposes.

''(4) EVALUATION BY ASSISTANT SECRETARY.—Based on the data submitted under paragraph (3), the Assistant Secretary shall annually submit to Congress a report concerning the results and effectiveness of the programs carried out with assistance received under this section.

''(5) LIMITATION.—An eligible entity shall use not more than 20 percent of amounts received under a grant under this section to carry out evaluation activities under this subsection.

''(g) INFORMATION AND EDUCATION.—The Secretary shall disseminate best practices based on the findings of the knowledge development and application under this section.

''(h) AMOUNT OF GRANTS AND AUTHORIZATION OF APPROPRIATIONS.—

''(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than $2,000,000 for each of the first 5 fiscal years following the date of enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022. The Secretary shall determine the amount of each such grant based on the population of children up to age 21 of the area to be served under the grant.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $130,000,000 for each of fiscal years 2023 through 2027.''.

(c) CONFORMING AMENDMENT.—Part G of title V of the Public Health Service Act (42 U.S.C. 290hh et seq.), as amended by subsection (b), is further amended by striking the part designation and heading and inserting the following:

''PART G—SCHOOL-BASED MENTAL HEALTH''.

AMENDMENT NO. 15 OFFERED BY MS. PRESSLEY OF MASSACHUSETTS

After section 402, insert the following new section:

SEC. 403. CO-OCCURRING CHRONIC CONDITIONS AND MENTAL HEALTH IN YOUTH STUDY.

Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) complete a study on the rates of suicidal behaviors among children and adolescents with chronic illnesses, including substance use disorders, autoimmune disorders, and heritable blood disorders; and

(2) submit a report to the Congress on the results of such study, including recommendations for early intervention services for such children and adolescents at risk of suicide, the dissemination of best practices to support the emotional and mental health needs of youth, and strategies to lower the rates of suicidal behaviors in children and adolescents described in paragraph (1) to reduce any demographic disparities in such rates.

AMENDMENT NO. 16 OFFERED BY MR. RESCHENTHALER OF PENNSYLVANIA

At the end of subtitle C of title I, add the following new section:

SEC. 124. STUDY ON THE COSTS OF SERIOUS MENTAL ILLNESS.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Assistant Secretary for Mental Health and Substance Use, the Assistant Secretary for Planning and Evaluation, the Attorney General of the United States, the Secretary of Labor, and the Secretary of Housing and Urban Development, shall conduct a study on the direct and indirect costs of serious mental illness with respect to—

(1) nongovernmental entities; and

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

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

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

(A) office-based physician visits;

(B) residential and inpatient treatment programs;

(C) outpatient treatment programs;

(D) emergency room visits;

(E) crisis stabilization programs;

(F) home health care;

(G) skilled nursing and long-term care facilities;

(H) prescription drugs and digital therapeutics; and

(I) any other relevant health services.

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

(A) homeless shelters;

(B) street outreach activities;

(C) crisis response center visits; and

(D) other supportive services.

(3) The costs of structured residential facilities and other supportive housing for residential and custodial care services.

(4) The costs of law enforcement encounters and encounters with the criminal justice system, including with respect to—

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

(B) criminal and judicial proceedings;

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

(D) incarceration.

(5) The costs of serious mental illness on employment.

(6) With respect to family members and caregivers, the costs of caring for an individual with a serious mental illness.

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

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

(1) disaggregate data by—

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

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

(C) demographic characteristics, including race, ethnicity, sex, age (including pediatric subgroups), and other characteristics determined by the Secretary; and

(2) include an estimate of—

(A) the total number of individuals with a serious mental illness in the United States, including in traditional and nontraditional housing; and

(B) the percentage of such individuals in—

(i) homeless shelters;

(ii) penal facilities, including Federal prisons, State prisons, and county and municipal jails; and

(iii) nursing facilities.

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

(1) submit to the Congress a report containing the results of the study conducted under this section; and

(2) make such report publicly available.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the gentleman from New Jersey (Mr. PALLONE) and the gentlewoman from Washington (Mrs. RODGERS) each will control 10 minutes.

The Chair recognizes the gentleman from New Jersey.

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

Madam Speaker, I rise in support of the eight mental health amendments under this en bloc consideration. Collectively, these amendments further strengthen the bipartisan nature of the underlying comprehensive bill, the Restoring Hope for Mental Health and Well-Being Act of 2022.

I thank my colleagues for their leadership and contributions to furthering the health of the American people and wish to speak in strong support of their adoption into H.R. 7666.

Many of these amendments, Madam Speaker, include provisions from bills that previously passed the House this Congress on suspension that the Senate has yet to act upon.

I am pleased that we have the opportunity to, once again, emphasize their importance by including them in this crucial legislative package.

The amendment offered by Congressman BERA and Congressman FITZPATRICK is just such an amendment. Like the bill it reflects, the HERO Act, which passed the House last year, it will improve data collection and services to ensure our first responders and public safety officers receive the mental health care services they need.

Additionally, Congresswoman NAPOLITANO and Congressman KATKO submitted an amendment which extends and revises SAMHSA's Project AWARE program providing school-based mental health services, including screening, treatment, and outreach programs, provisions that likewise passed the House last year in H.R. 721, the Mental Health Services for Students Act of 2021.

Representatives KATKO and NAPOLITANO were also joined by Congressmen BEYER, RASKIN, CÁRDENAS, and FITZPATRICK in offering an additional amendment that includes provisions from H.R. 2981, the Suicide Prevention Lifeline Improvement Act of 2021, which also passed the House last year.

The amendment extends funding for SAMHSA's Lifeline—crucial in this Nation's moment of mental health crisis, supporting crisis care response and support as we prepare for the launch of the new 988 dialing code next month.

I appreciate the additional focus on the particular needs of certain communities in our country that several amendments add to the underlying bill.

I thank Representatives RESCHENTHALER, MORELLE, WILD, and DEAN for their amendment requiring a study to determine the true cost of untreated serious mental illness on families, healthcare systems, public housing, and law enforcement in America.

In addition, we certainly cannot do enough to support the men and women who have valiantly served our Nation in the Armed Forces.

I thank Congressman JOYCE for his amendment that requires the Department of Defense to carry out a 2-year pilot program aimed at preventing suicides amongst Active-Duty members of the Armed Forces.

I also appreciate and support the amendment submitted by Congressman FEENSTRA requiring the new Behavioral Health Crisis Coordinating Office established within SAMHSA by H.R. 7666, to provide technical assistance and support to the Veterans Crisis Line.

Further, Madam Speaker, I support the mental health and well-being of those who are pregnant or postpartum. The amendment offered by Congresswoman MOORE makes important improvements to the Maternal Mental Health Hotline authorization to ensure those implementing the hotline consult with appropriate State, local, and Tribal public officials and those working with low-income people.

I am particularly pleased that H.R. 7666 would establish a new authorization for a Maternal Mental Health Hotline, and I appreciate Representative MOORE's amendment that will serve to improve the underlying legislation.

Finally, Madam Speaker, while we know children in this country are facing a mental health crisis, unfortunately, we know that all too many also experience other chronic health challenges.

I am grateful to Representative PRESSLEY for her amendment requiring the Secretary of Health and Human Services conduct a study on the rates and risks of suicidal behaviors among youth with chronic illnesses and to provide Congress with recommendations for ways to provide early intervention, best practices, and strategies to address disparities.

I am pleased to support these amendments and encourage my colleagues to do the same.

Madam Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I yield myself such time as I may consume. I rise in support of the amendments offered en bloc. I rise today to express my strong support for this group of amendments. Included in this en bloc are important bills that have already overwhelmingly passed the House, including Representative KATKO's Suicide Prevention Lifeline Improvement Act, which reauthorizes the National Suicide Prevention Lifeline program and ensures resources are available for the continued operation of the hotline, especially with 9–8-8 going live next month.

Representative KATKO also has included in this en bloc the Mental Health Services for Students Act, which provides an authorization for the Substance Abuse and Mental Health Services Administration's Project AWARE grant.

Project AWARE is a successful program which supports partnerships between the State and local systems in increasing awareness of mental health issues among school-aged youth; providing training for school personnel to detect and respond to mental health issues; and connecting students with behavioral health issues and their families to needed services.

The en bloc also includes the Reschenthaler amendment, which would authorize a study on the cost of untreated serious mental illness on families, the health system, the justice system, and the economy.

While very treatable, serious mental illness remains a neglected health issue, and I am hopeful that the data gleaned from this study will convince policymakers to do more to address this condition, including addressing the IMD exclusion.

This group of amendments demonstrates the good work Congress can do when both parties come together to find meaningful solutions to address mental health in America.

Madam Speaker, I urge adoption, and I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 4 minutes to the gentlewoman from Massachusetts (Ms. PRESSLEY), who has one of the important amendments included in this en bloc.

Ms. PRESSLEY. Madam Speaker, I rise today in support of my amendment to require the Secretary of Health and Human Services to study the suicide crises among children living with chronic illnesses and conditions, including autoimmune diseases like alopecia.

Across this Nation, our children are carrying unprecedented amounts of trauma and grief in their emotional backpacks.

For an entire generation of youngsters living with chronic conditions, the solitude, grief, and uncertainty of the past 2 years have only exacerbated the emotional and mental health challenges that already weighed so heavily.

Like millions of Americans, I am living with the autoimmune disease alopecia. There are several forms of alopecia. I am living with alopecia universalis.

Navigating the world as a bald woman is disruptive to many. I am 48 years old, I am an adult, and I have built up some pretty thick skin, but there are days that even bring me to my knees because of the social stigmatization, the bullying, the taunting that I experience as an adult.

Although this does not threaten my life, that does not mean that it does not impact it. I was a caregiver to my mother in her cancer battle, and her very first concern and worry—even though she was fighting for her life—was, am I going to lose my hair.

This is something much more than cosmetic for all who are living with

this. Certainly, for women and girls, there is an added layer, in that this challenge defies societal norms of what is feminine, what is pretty, what is acceptable, and what is appropriate.

For the millions of children—again, I am a 48-year-old adjusted woman, but for the millions of children living with this disease, the challenges may sometimes feel too much to bear.

While there are public misconceptions that alopecia areata is purely cosmetic, the fact is the National Institute of Mental Health has found that alopecia areata has been linked to higher rates of depression, sadness, anxiety, and other mental challenges.

Some have offered: Why not just wear a wig? Well, I am working on that, too, because many of our children can't afford a medically durable wig. So for children who are just beginning their journey, growing comfortable in their own skin and finding their place in the world, these challenges can feel even harder.

Earlier this year, our alopecia community lost one of our own. She is not the first, but one of the most recent: Miss Rio Allred. May she rest in peace. She was 12 years old, and took her life by suicide because of the emotional turmoil and relentless bullying she faced every day in school due to her alopecia.

I have spoken to Rio's mother. I have heard her express the pain no parent should ever know. I asked her to tell me about Rio. She was a great big sister, a writer, a reader, was funny, and a light to the world and all around her.

Her mother has now established Rio's Rainbow, a foundation in her honor, and the mission of that, in Rio's honor, is that kids should feel safe being who they are. One life lost to the emotional distress associated with this disease, and any chronic condition for that matter, is one too many.

I make no appeal today for sympathy, but for empathy, for support, to be seen. I am not here just to take up space. I am here to create it. I choose not to wear a wig because I know what that representation means to the millions of Americans that are living with alopecia.

It is long past time that we study the troubling suicide crisis among children living with chronic illnesses and conditions, including those within our alopecia community, and invest in the early interventions and best practices necessary to save lives. I urge my colleagues to support this amendment, which would do just that.

Mrs. RODGERS of Washington. Madam Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. JOYCE).

Mr. JOYCE of Ohio. Madam Speaker, I rise today in support of my amendment to H.R. 7666 which would add the text of the Military Suicide Prevention in the 21st Century Act to the underlying bill.

The men and the women of America's Armed Forces dedicate their lives in service to this Nation. Unfortunately, countless servicemembers are left with scars that linger long after they return home.

Rates of serious mental illness experienced by those in the Armed Forces are on the rise, and tragically, so too is the number of soldiers who ultimately take their lives.

According to DOD's most recent report, suicide in the military community is at its highest rate since 1938. An estimated 7,000 servicemembers have died in combat or training exercises since 9/11.

During that same time, over 30,000 Active-Duty personnel and veterans who recently served died by suicide. Those numbers should bring pause to every Member in this Chamber. More importantly, they should spur us into action.

That is why I introduced the Military Suicide Prevention in the 21st Century Act. This commonsense bill would direct the DOD to utilize modern technology to prevent suicides in our military community.

In addition to requiring the National Suicide Hotline and the Veterans Crisis Hotline to be preprogrammed into government-issued smart devices such as phones, tablets, and laptops, the bill would require the DOD to proactively download the Virtual Hope Box app onto these devices.

This app can be set up with the photos of friends and family, sound bites of loved ones, videos of special moments, music, relaxation exercises, games, and reminders of reasons for living.

Nothing we do here in Washington will ever truly repay the sacrifices made by our Nation's servicemembers, but by passing this legislation, we can help make a meaningful difference in the lives of countless American heroes and their families.

We owe an incredible debt to the men and women of our Armed Forces who risk their lives fighting for our freedoms and our security. It is past time Congress do more to fight for them here at home.

I urge my colleagues to support my amendment so we can make real progress toward providing improved support for America's servicemembers struggling with their mental health.

Mr. PALLONE. Madam Speaker, I have no additional speakers, and I yield back the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the previous question is ordered on the amendments en bloc offered by the gentleman from New Jersey (Mr. PALLONE).

The question is on the amendments en bloc.

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

Mr. TIFFANY. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question are postponed.

□ 1530

AMENDMENTS EN BLOC NO. 2 OFFERED BY MR. PALLONE OF NEW JERSEY

Mr. PALLONE. Madam Speaker, pursuant to House Resolution 1191, I rise to offer amendments en bloc No. 2.

The SPEAKER pro tempore. The Clerk will designate the amendments en bloc.

Amendments en bloc No. 2 consisting of amendment Nos. 2, 3, 7, 11, 12, and 17, printed in part E of House Report 117–381, offered by Mr. PALLONE of New Jersey:

AMENDMENT NO. 2 OFFERED BY MR. RODNEY DAVIS OF ILLINOIS

At the end of title II, add the following new subtitle:

Subtitle G—Opioid Epidemic Response

SEC. 271. OPIOID PRESCRIPTION VERIFICATION.

(a) MATERIALS FOR TRAINING PHARMACISTS ON CERTAIN CIRCUMSTANCES UNDER WHICH A PHARMACIST MAY DECLINE TO FILL A PRESCRIPTION.—

(1) UPDATES TO MATERIALS.—Section 3212(a) of the SUPPORT for Patients and Communities Act (21 U.S.C. 829 note) is amended by striking ''Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, Commissioner of Food and Drugs, Director of the Centers for Disease Control and Prevention, and Assistant Secretary for Mental Health and Substance Use, shall develop and disseminate'' and inserting ''The Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, Commissioner of Food and Drugs, Director of the Centers for Disease Control and Prevention, and Assistant Secretary for Mental Health and Substance Use, shall develop and disseminate not later than 1 year after the date of enactment of this Act, and update periodically thereafter''.

(2) MATERIALS INCLUDED.—Section 3212(b) of the SUPPORT for Patients and Communities Act (21 U.S.C. 829 note) is amended—

(A) by redesignating paragraphs (1) and (2) as paragraphs (2) and (3), respectively; and

(B) by inserting before paragraph (2), as so redesignated, the following new paragraph:

''(1) pharmacists on how to verify the identity of the patient;''.

(3) MATERIALS FOR TRAINING ON PATIENT VERIFICATION .—Section 3212 of the SUPPORT for Patients and Communities Act (21 U.S.C. 829 note) is amended by adding at the end the following new subsection:

''(d) MATERIALS FOR TRAINING ON VERIFICATION OF IDENTITY.—Not later than 1 year after the date of enactment of this subsection, the Secretary of Health and Human Services, after seeking stakeholder input in accordance with subsection (c), shall—

''(1) update the materials developed under subsection (a) to include information for pharmacists on how to verify the identity the patient; and

''(2) disseminate, as appropriate, the updated materials.''.

(b) INCENTIVIZING STATES TO FACILITATE RESPONSIBLE, INFORMED DISPENSING OF CONTROLLED SUBSTANCES.—

(1) IN GENERAL.—Section 392A of the Public Health Service Act (42 U.S.C. 280b–1) is amended—

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

(B) by inserting after subsection (b) the following new subsection:

''(c) PREFERENCE.—In determining the amounts of grants awarded to States under subsections (a) and (b), the Director of the Centers for Disease Control and Prevention may give preference to States in accordance with such criteria as the Director may specify and may choose to give preference to States that—

''(1) maintain a prescription drug monitoring program;

''(2) require prescribers of controlled substances in schedule II, III, or IV to issue such prescriptions electronically, and make such requirement subject to exceptions in the cases listed in section 1860D–4(e)(7)(B) of the Social Security Act; and

''(3) require dispensers of such controlled substances to enter certain information about the purchase of such controlled substances into the respective State's prescription drug monitoring program, including—

''(A) the National Drug Code or, in the case of compounded medications, compound identifier;

''(B) the quantity dispensed;

''(C) the patient identifier; and

''(D) the date filled.''.

(2) DEFINITIONS.—

(A) IN GENERAL.—Subsection (d) of section 392A of the Public Health Service Act (42 U.S.C. 280b–1), as redesignated by paragraph (1)(A), is amended to read as follows:

''(d) DEFINITIONS.—In this section:

''(1) CONTROLLED SUBSTANCE.—The term 'controlled substance' has the meaning given that term in section 102 of the Controlled Substances Act.

''(2) DISPENSER.—The term 'dispenser' means a physician, pharmacist, or other person that dispenses a controlled substance to an ultimate user.

''(3) INDIAN TRIBE.—The term 'Indian Tribe' has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act.''.

(B) CONFORMING CHANGE.—Section 392A of the Public Health Service Act (42 U.S.C. 280b–1) is amended by striking ''Indian tribes'' each place it appears and inserting ''Indian Tribes''.

AMENDMENT NO. 3 OFFERED BY MS. DEAN OF PENNSYLVANIA

After section 263, insert the following new section:

SEC. 264. INCREASE IN NUMBER OF DAYS BEFORE WHICH CERTAIN CONTROLLED SUBSTANCES MUST BE ADMINISTERED.

Section 309A(a)(5) of the Controlled Substances Act (21 U.S.C. 829a(a)(5)) is amended by striking ''14 days'' and inserting ''60 days''.

AMENDMENT NO. 7 OFFERED BY MR. GOTTHEIMER OF NEW JERSEY

Page 9, line 22, insert ''veterans,'' after ''minorities,''.

AMENDMENT NO. 11 OFFERED BY MR. KIM OF NEW JERSEY

At the end of title II, add the following new subtitle:

Subtitle G—Opioid Epidemic Response

SEC. 271. SYNTHETIC OPIOID DANGER AWARENESS.

(a) SYNTHETIC OPIOIDS PUBLIC AWARENESS CAMPAIGN.—Part B of title III of the Public Health Service Act is amended by inserting after section 317U (42 U.S.C. 247b–23) the following new section:

''SEC. 317V. SYNTHETIC OPIOIDS PUBLIC AWARENESS CAMPAIGN.

''(a) IN GENERAL.—Not later than one year after the date of the enactment of this section, the Secretary shall provide for the planning and implementation of a public education campaign to raise public awareness of synthetic opioids (including fentanyl and its analogues). Such campaign shall include the dissemination of information that—

''(1) promotes awareness about the potency and dangers of fentanyl and its analogues and other synthetic opioids;

''(2) explains services provided by the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention (and any entity providing such services under a contract entered into with such agencies) with respect to the misuse of opioids, particularly as such services relate to the provision of alternative, non-opioid pain management treatments; and

''(3) relates generally to opioid use and pain management.

''(b) USE OF MEDIA.—The campaign under subsection (a) may be implemented through the use of television, radio, internet, in-person public communications, and other commercial marketing venues and may be targeted to specific age groups.

''(c) CONSIDERATION OF REPORT FINDINGS.—In planning and implementing the public education campaign under subsection (a), the Secretary shall take into consideration the findings of the report required under section 7001 of the SUPPORT for Patients and Communities Act (Public Law 115–271).

''(d) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Assistant Secretary for Mental Health and Substance Use to provide ongoing advice on the effectiveness of information disseminated through the campaign.

''(e) REQUIREMENT OF CAMPAIGN.—The campaign implemented under subsection (a) shall not be duplicative of any other Federal efforts relating to eliminating the misuse of opioids.

''(f) EVALUATION.—

''(1) IN GENERAL.—The Secretary shall ensure that the campaign implemented under subsection (a) is subject to an independent evaluation, beginning 2 years after the date of the enactment of this section, and every 2 years thereafter.

''(2) MEASURES AND BENCHMARKS.—For purposes of an evaluation conducted pursuant to paragraph (1), the Secretary shall—

''(A) establish baseline measures and benchmarks to quantitatively evaluate the impact of the campaign under this section; and

''(B) conduct qualitative assessments regarding the effectiveness of strategies employed under this section.

''(g) REPORT.—The Secretary shall, beginning 2 years after the date of the enactment of this section, and every 2 years thereafter, submit to Congress a report on the effectiveness of the campaign implemented under subsection (a) towards meeting the measures and benchmarks established under subsection (e)(2).

''(h) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary shall develop and implement a plan for the dissemination of information related to synthetic opioids, to health care providers who participate in Federal programs, including programs administered by the Department of Health and Human Services, the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, the Medicare program under title XVIII of the Social Security Act, and the Medicaid program under title XIX of such Act.''.

(b) TRAINING GUIDE AND OUTREACH ON SYNTHETIC OPIOID EXPOSURE PREVENTION.—

(1) TRAINING GUIDE.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall design, publish, and make publicly available on the internet website of the Department of Health and Human Services, a training guide and webinar for first responders and other individuals who also may be at high risk of exposure to synthetic opioids that details measures to prevent that exposure.

(2) OUTREACH.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall also conduct outreach about the availability of the training guide and webinar published under paragraph (1) to—

(A) police and fire managements;

(B) sheriff deputies in city and county jails;

(C) ambulance transport and hospital emergency room personnel;

(D) clinicians; and

(E) other high-risk occupations, as identified by the Assistant Secretary for Mental Health and Substance Use.

AMENDMENT NO. 12 OFFERED BY MR. MCKINLEY OF WEST VIRGINIA

After section 263, insert the following new section:

SEC. 264. BLOCK, REPORT, AND SUSPEND SUSPICIOUS SHIPMENTS.

(a) CLARIFICATION OF PROCESS FOR REGISTRANTS TO EXERCISE DUE DILIGENCE UPON DISCOVERING A SUSPICIOUS ORDER.—Paragraph (3) of section 312(a) of the Controlled Substances Act (21 U.S.C. 832(a)) is amended to read as follows:

''(3) upon discovering a suspicious order or series of orders, and in a manner consistent with the other requirements of this section—

''(A) exercise due diligence as appropriate;

''(B) establish and maintain (for not less than a period to be determined by the Administrator of the Drug Enforcement Administration) a record of the due diligence that was performed;

''(C) decline to fill the order or series of orders if the due diligence fails to dispel all of the indicators that give rise to the suspicion that, if the order or series of orders is filled, the drugs that are the subject of the order or series of orders are likely to be diverted; and

''(D) notify the Administrator of the Drug Enforcement Administration and the Special Agent in Charge of the Division Office of the Drug Enforcement Administration for the area in which the registrant is located or conducts business of—

''(i) each suspicious order or series of orders discovered by the registrant; and

''(ii) the indicators giving rise to the suspicion that, if the order or series of orders is filled, the drugs that are the subject of the order or series of orders are likely to be diverted.''.

(b) RESOLUTION OF SUSPICIOUS INDICATORS.—Section 312 of the Controlled Substances Act (21 U.S.C. 832) is amended—

(1) by redesignating subsection (b) and (c) as subsections (c) and (d), respectively; and

(2) by inserting after subsection (a) the following:

''(b) RESOLUTION OF SUSPICIOUS INDICATORS.—If a registrant resolves all of the indicators giving rise to suspicion about an order or series of orders under subsection (a)(3)—

''(1) notwithstanding subsection (a)(3)(C), the registrant may choose to fill the order or series of orders; and

''(2) notwithstanding subsection (a)(3)(D), the registrant may choose not to make the notification otherwise required by such subsection.''.

(c) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, for purposes of subsections (a)(3) and (b) of section 312 of the Controlled Substances Act, as

amended or inserted by subsection (a), the Attorney General of the United States shall promulgate a final regulation specifying the indicators that give rise to a suspicion that, if an order or series of orders is filled, the drugs that are the subject of the order or series of orders are likely to be diverted.

(d) APPLICABILITY.—Subsections (a)(3) and (b) of section 312 of the Controlled Substances Act, as amended or inserted by subsection (a), shall apply beginning on the day that is 1 year after the date of enactment of this Act. Until such day, section 312(a)(3) of the Controlled Substances Act shall apply as such section 312(a)(3) was in effect on the day before the date of enactment of this Act.

AMENDMENT NO. 17 OFFERED BY MR. TRONE OF MARYLAND

At the end of title II, add the following new subtitle:

Subtitle I—Opioid Epidemic Response

SEC. 271. GRANT PROGRAM FOR STATE AND TRIBAL RESPONSE TO OPIOID AND STIMULANT USE AND MISUSE.

Section 1003 of the 21st Century Cures Act (42 U.S.C. 290ee–3 note) is amended to read as follows:

"SEC. 1003. GRANT PROGRAM FOR STATE AND TRIBAL RESPONSE TO OPIOID AND STIMULANT USE AND MISUSE.

''(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall carry out the grant program described in subsection (b) for purposes of addressing opioid and stimulant use and misuse, within States, Indian Tribes, and populations served by Tribal organizations and Urban Indian organizations.

''(b) GRANTS PROGRAM.—

''(1) IN GENERAL.—Subject to the availability of appropriations, the Secretary shall award grants to States, Indian Tribes, Tribal organizations, and Urban Indian organizations for the purpose of addressing opioid and stimulant use and misuse, within such States, such Indian Tribes, and populations served by such Tribal organizations and Urban Indian organizations, in accordance with paragraph (2).

''(2) MINIMUM ALLOCATIONS; PREFERENCE.—In determining grant amounts for each recipient of a grant under paragraph (1), the Secretary shall—

''(A) ensure that each State receives not less than $4,000,000; and

''(B) give preference to States, Indian Tribes, Tribal organizations, and Urban Indian organizations whose populations have an incidence or prevalence of opioid use disorders or stimulant use or misuse that is substantially higher relative to the populations of other States, other Indian Tribes, Tribal organizations, or Urban Indian organizations, as applicable.

''(3) FORMULA METHODOLOGY.—

''(A) IN GENERAL.—Before publishing a funding opportunity announcement with respect to grants under this section, the Secretary shall—

''(i) develop a formula methodology to be followed in allocating grant funds awarded under this section among grantees, which includes performance assessments for continuation awards; and

''(ii) not later than 30 days after developing the formula methodology under clause (i), submit the formula methodology to—

''(I) the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives; and

''(II) the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate.

''(B) REPORT.—Not later than two years after the date of the enactment of the Restoring Hope for Mental Health and Well-Being Act of 2022, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that—

''(i) assesses how grant funding is allocated to States under this section and how such allocations have changed over time;

''(ii) assesses how any changes in funding under this section have affected the efforts of States to address opioid or stimulant use or misuse; and

''(iii) assesses the use of funding provided through the grant program under this section and other similar grant programs administered by the Substance Abuse and Mental Health Services Administration.

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

''(A) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent substance use disorders.

''(B) Establishing or improving prescription drug monitoring programs.

''(C) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance use disorders, referral of patients to treatment programs, preventing diversion of controlled substances, and overdose prevention.

''(D) Supporting access to health care services, including—

''(i) services provided by federally certified opioid treatment programs;

''(ii) outpatient and residential substance use disorder treatment services that utilize medication-assisted treatment, as appropriate; or

''(iii) other appropriate health care providers to treat substance use disorders.

''(E) Recovery support services, including—

''(i) community-based services that include peer supports;

''(ii) mutual aid recovery programs that support medication-assisted treatment; or

''(iii) services to address housing needs and family issues.

''(F) Other public health-related activities, as the State, Indian Tribe, Tribal organization, or Urban Indian organization determines appropriate, related to addressing substance use disorders within the State, Indian Tribe, Tribal organization, or Urban Indian organization, including directing resources in accordance with local needs related to substance use disorders.

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

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

''(2) the ultimate recipients of amounts provided to the State; and

''(3) the number of individuals served through the grant.

''(d) LIMITATIONS.—Any funds made available pursuant to subsection (i)—

''(1) shall not be used for any purpose other than the grant program under subsection (b); and

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

''(e) INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—The Secretary, in consultation with Indian Tribes, Tribal organizations, and Urban Indian organizations, shall identify and establish appropriate mechanisms for Indian Tribes, Tribal organizations, and Urban Indian organizations to demonstrate or report the information as required under subsections (b), (c), and (d).

''(f) REPORT TO CONGRESS.—Not later than September 30, 2024, and biennially thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, and the Committees on Appropriations of the House of Representatives and the Senate, a report that includes a summary of the information provided to the Secretary in reports made pursuant to subsections (c) and (e), including—

''(1) the purposes for which grant funds are awarded under this section;

''(2) the activities of the grant recipients; and

''(3) for each State, Indian Tribe, Tribal organization, and Urban Indian organization that receives a grant under this section, the funding level provided to such recipient.

''(g) TECHNICAL ASSISTANCE.—The Secretary, including through the Tribal Training and Technical Assistance Center of the Substance Abuse and Mental Health Services Administration, shall provide States, Indian Tribes, Tribal organizations, and Urban Indian organizations, as applicable, with technical assistance concerning grant application and submission procedures under this section, award management activities, and enhancing outreach and direct support to rural and underserved communities and providers in addressing substance use disorders.

''(h) DEFINITIONS.—In this section:

''(1) INDIAN TRIBE.—The term 'Indian Tribe' has the meaning given the term 'Indian tribe' in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

''(2) TRIBAL ORGANIZATION.—The term 'Tribal organization' has the meaning given the term 'tribal organization' in such section 4.

''(3) STATE.—The term 'State' has the meaning given such term in section 1954(b) of the Public Health Service Act (42 U.S.C. 300x–64(b)).

''(4) URBAN INDIAN ORGANIZATION.—The term 'Urban Indian organization' has the meaning given such term in section 4 of the Indian Health Care Improvement Act.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out the grant program under subsection (b), there is authorized to be appropriated $1,750,000,000 for each of fiscal years 2023 through 2027, to remain available until expended.

''(2) FEDERAL ADMINISTRATIVE EXPENSES.—Of the amounts made available for each fiscal year to award grants under subsection (b), the Secretary shall not use more than 20 percent for Federal administrative expenses, training, technical assistance, and evaluation.

''(3) SET ASIDE.—Of the amounts made available for each fiscal year to award grants under subsection (b) for a fiscal year, the Secretary shall—

''(A) award 5 percent to Indian Tribes, Tribal organizations, and Urban Indian organizations; and

''(B) of the amount remaining after application of subparagraph (A), set aside up to 15

percent for awards to States with the highest age-adjusted rate of drug overdose death based on the ordinal ranking of States according to the Director of the Centers for Disease Control and Prevention.''.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the gentleman from New Jersey (Mr. PALLONE) and the gentlewoman from Washington (Mrs. RODGERS) each will control 10 minutes.

The Chair recognizes the gentleman from New Jersey.

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

Madam Speaker, I rise in support of this en bloc amendment. This package includes bipartisan bills and policies that will increase access to substance use disorder prevention, treatment, and recovery support services.

The amendment introduced by Representatives RODNEY DAVIS, BILIRAKIS, O'HALLERAN, WAGNER, and KUSTER reflects H.R. 2355, the Opioid Prescription Verification Act of 2021, which has previously passed the House. The amendment, like the bill it is drawn from, encourages the use of e-prescribing for opioids and incentivizes States to maintain and utilize prescription drug monitoring programs.

Likewise, the amendment offered by Representatives ANDY KIM and DAVIDS also reflects a previously House-passed bill, H.R. 2364, the Synthetic Opioid Danger Awareness Act. Their amendment requires the Department of Health and Human Services to conduct a public education campaign about synthetic opioids, including fentanyl and its analogues, and disseminate information about synthetic opioids to healthcare providers.

Continuing the theme of bipartisanship, Representatives MCKINLEY and DINGELL introduced an amendment that amends the Controlled Substances Act to clarify the process for registrants to exercise due diligence upon discovering a suspicious order. Like the prior amendments, this, too, is drawn from a prior House-passed bill, H.R. 768, the Block, Report, And Suspend Suspicious Shipments Act of 2021.

Further, the amendment offered by Representatives TRONE, ARMSTRONG, and SHERRILL also draws from a prior House-passed bill extending a critical authorization for the State Opioid Response grants and Tribal Opioid Response grants for 5 years.

Another amendment introduced by Representatives DEAN, SPARTZ, SCANLON, and FITZPATRICK reflects H.R. 5950, the Improving Patient Access to Care and Treatment Act. This amendment increases the time from 14 to 60 days that healthcare providers can hold long-acting injectable buprenorphine before administering it to a patient, giving patients and practitioners greater flexibility when accessing opioid use disorder treatment.

Finally, this amendment package includes an amendment offered by Representative GOTTHEIMER that would ensure that veterans are included within the crisis response continuum of best practices included in H.R. 7666.

I thank the sponsors of these provisions. These bipartisan amendments provide strong tools to address the ongoing overdose crisis and will save lives. I urge my colleagues to support this package of amendments and include them in the overall bill.

Madam Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I rise in support of the amendments offered en bloc and yield myself such time as I may consume.

Madam Speaker, I rise today to express my strong support for this group of amendments addressing substance use disorder.

Included in this en bloc are important bills that have already passed with overwhelming support, including Representative RODNEY DAVIS' Opioid Prescription Verification Act, which incentivizes States to use prescription drug monitoring programs; requires certain controlled substances to be prescribed electronically; and directs Federal agencies to develop, disseminate, and periodically update training materials to help pharmacists identify and report potential cases of bad actors who attempt to illegally buy and sell controlled substances.

Also included is Representative DAVID MCKINLEY's Block, Report, And Suspend Suspicious Shipments Act, which places additional obligations on drug manufacturers and distributors to identify and stop suspicious orders of controlled substances.

We have seen a devastating increase in overdose deaths that I think should be called poisonings, teens buying one pill via Snapchat and immediately overdosing because of a small amount of fentanyl in those pills. Just because it looks like a pill and someone says it was from a pharmacy does not make it so. We need to do more to stop both diversion of legitimate medication and counterfeits that are devastating our communities.

These amendments are a good step in that direction, and I urge adoption.

Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I yield 3 minutes to the gentleman from West Virginia (Mr. MCKINLEY), who has been a longtime leader on the issues of substance abuse.

Mr. MCKINLEY. Madam Speaker, I rise in support of en bloc No. 2, which includes an amendment to report, track, and take action on suspicious orders.

While the COVID–19 pandemic raged through our population and dominated the headlines, the opioid epidemic exploded exponentially, silently claiming the lives of tens of thousands of Americans every year. Recent CDC data shows that the overdose death rate for last year was over 103,000 citizens.

In 2017, the Energy and Commerce Committee conducted a comprehensive bipartisan investigation into opioid dumping in West Virginia. Outrageous details came to light, exposing how drug shipments in rural West Virginia went unconstrained. For example, over 2 million opioids were sent to a little town of 3,000 people.

Another example: Even after a distributor found numerous red flags during his site visit, nearly 1.5 million doses of opioids were still shipped to a single pharmacy in Kermit, West Virginia, with a population of 406.

The report that was filed by the Energy and Commerce Committee details failures on the part of both DEA and the distributors to identify and halt suspicious orders. Distributors felt they didn't have the authority to halt suspicious orders and could have been subject to lawsuits.

As recommended in the report, this amendment not only requires the distributors to report suspicious orders but also to investigate the situation and decline to fill the order if it is warranted.

American communities deserve to be treated better. This influx of illegal drugs must be stopped, and this amendment is a step in the right direction.

Madam Speaker, I urge Members to adopt this amendment.

Mrs. RODGERS of Washington. Madam Speaker, I yield back the balance of my time.

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

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the previous question is ordered on the amendments en bloc offered by the gentleman from New Jersey (Mr. PALLONE).

The question is on the amendments en bloc.

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

Mr. TIFFANY. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question are postponed.

AMENDMENT NO. 4 OFFERED BY MRS. DEMINGS

The SPEAKER pro tempore. It is now in order to consider amendment No. 4 printed in part E of House Report 117–381.

Mrs. DEMINGS. Madam Speaker, I have an amendment at the desk.

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

The text of the amendment is as follows:

At the end of title III, add the following new subtitle:

Subtitle E—Other Provisions

SEC. 341. REPORT ON LAW ENFORCEMENT MENTAL HEALTH AND WELLNESS.

(a) IN GENERAL.—Not later than 270 days after the date of enactment of this Act, the Attorney General, in consultation with the

Director of the Federal Bureau of Investigation, the Director of the National Institute for Justice, and the Assistant Secretary for Mental Health and Substance Abuse, shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on the Judiciary of the Senate and the Committee on Energy and Commerce and the Committee on the Judiciary of the House of Representatives a report on—

(1) the types, frequency, and severity of mental health and stress-related responses of law enforcement officers to aggressive actions or other trauma-inducing incidents against law enforcement officers;

(2) mental health and stress-related resources or programs that are available to law enforcement officers at the Federal, State, and local level, including peer-to-peer programs;

(3) the extent to which law enforcement officers use the resources or programs described in paragraph (2);

(4) the availability of, or need for, mental health screening within Federal, State, and local law enforcement agencies; and

(5) recommendations for Federal, State, and local law enforcement agencies to improve the mental health and wellness of their officers.

(b) DEVELOPMENT.—In developing the report required under subsection (a), the Attorney General, the Director of the Federal Bureau of Investigation, the Director of the National Institute of Justice, and the Assistant Secretary for Mental Health and Substance Abuse shall consult relevant stakeholders, including—

(1) Federal, State, Tribal and local law enforcement agencies; and

(2) nongovernmental organizations, international organizations, academies, or other entities.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the gentlewoman from Florida (Mrs. DEMINGS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Florida.

Mrs. DEMINGS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, the underlying bill is a significant step forward in supporting community mental health efforts, which I applaud.

As a former social worker and former law enforcement officer, I have seen the devastating impact when communities fall short of meeting the needs of persons struggling with mental health and substance addiction.

Florida is 49th in the Nation on access to mental health care. It is not a position we are proud of, but many States across the Nation have failed to adequately address these issues.

Law enforcement officers, as we all know, have a tough and dangerous job, and I was proud to co-lead the Law Enforcement Mental Health and Wellness Act, signed into law by President Trump, which recognizes that addressing mental and psychological health is just as important as good physical health.

My amendment is a simple one. It will insert reporting requirements on available mental health and stress-related programs for law enforcement officers and recommend additional tools that may be helpful or necessary to identify, access, monitor, and improve the overall well-being of our law enforcement officers.

I am proud to support this bill, as it is critical that we support our community by boldly addressing mental health issues. I am proud to offer this amendment that will support the men and women in blue who support, protect, and serve us.

Madam Speaker, I urge adoption of the amendment, and I yield back the balance of my time.

Mrs. RODGERS of Washington. Madam Speaker, I claim the time in opposition, but I urge adoption of the amendment.

The SPEAKER pro tempore. Without objection, the gentlewoman is recognized for 5 minutes.

There was no objection.

Mrs. RODGERS of Washington. Madam Speaker, I rise to urge adoption of the Demings amendment, which requires a report on the mental health issues experienced by law enforcement and the available resources or programs that are available to law enforcement officers to address mental health and stress.

According to the National Alliance on Mental Illness, law enforcement officers report high rates of depression, anxiety, and post-traumatic stress disorders, with nearly one in four having considered suicide. In fact, more officers die from suicide than do in the line of duty.

The report will include recommendations to Federal, State, and local law enforcement agencies on how to improve the mental health and well-being of our officers.

It is a necessary first step in helping us understand what resources are available to improve the mental health and wellness of law enforcement officials. Those risking their lives to keep America safe deserve passage of this amendment.

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

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the previous question is ordered on the amendment offered by the gentlewoman from Florida (Mrs. DEMINGS).

The question is on the amendment offered by the gentlewoman from Florida (Mrs. DEMINGS).

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

Mr. PALLONE. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question are postponed.

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AMENDMENT NO. 6 OFFERED BY MRS. RODGERS OF WASHINGTON

The SPEAKER pro tempore. It is now in order to consider amendment No. 6 printed in part E of House Report 117–381.

Mrs. RODGERS of Washington. Madam Speaker, as the designee of the gentleman from Georgia (Mr. FERGUSON), I have an amendment at the desk.

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

The text of the amendment is as follows:

At the end of subtitle A of title IV, add the following new section:

SEC. 403. BEST PRACTICES FOR BEHAVIORAL INTERVENTION TEAMS.

The Public Health Service Act is amended by inserting after section 520H of such Act, as added by section 151, the following new section:

"SEC. 520I. BEST PRACTICES FOR BEHAVIORAL INTERVENTION TEAMS.

''(a) IN GENERAL.—The Secretary shall identify and facilitate the development of best practices to assist elementary schools, secondary schools, and institutions of higher education in establishing and using behavioral intervention teams.

''(b) ELEMENTS.—The best practices under subsection (a)(1) shall include guidance on the following:

''(1) How behavioral intervention teams can operate effectively from an evidence-based, objective perspective while protecting the constitutional and civil rights of individuals.

''(2) The use of behavioral intervention teams to identify concerning behaviors, implement interventions, and manage risk through the framework of the school's or institution's rules or code of conduct, as applicable.

''(3) How behavioral intervention teams can, when assessing an individual—

''(A) access training on evidence-based, threat-assessment rubrics;

''(B) ensure that such teams—

''(i) have trained, diverse stakeholders with varied expertise; and

''(ii) use cross validation by a wide-range of individual perspectives on the team; and

''(C) use violence risk assessment.

''(4) How behavioral intervention teams can help mitigate—

''(A) inappropriate use of a mental health assessment;

''(B) inappropriate limitations or restrictions on law enforcement's jurisdiction over criminal matters;

''(C) attempts to substitute the behavioral intervention process in place of a criminal process, or impede a criminal process, when an individual's behavior has potential criminal implications;

''(D) endangerment of an individual's privacy by failing to ensure that all applicable Federal and State privacy laws are fully complied with; or

''(E) inappropriate referrals to, or involvement of, law enforcement when an individual's behavior does not warrant a criminal response.

''(c) CONSULTATION.—In carrying out subsection (a)(1), the Secretary shall consult with—

''(1) the Secretary of Education;

''(2) the Director of the National Threat Assessment Center of the United States Secretary Service;

''(3) the Attorney General and the Director of the Bureau of Justice Assistance;

''(4) teachers and other educators, principals, school administrators, school board members, school psychologists, mental health professionals, and parents of students;

''(5) local law enforcement agencies and campus law enforcement administrators;

''(6) privacy experts; and

''(7) other education and mental health professionals as the Secretary deems appropriate.

''(d) PUBLICATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall publish the best practices under subsection (a)(1) on the internet website of the Department of Health and Human Services.

''(e) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to institutions of higher education, elementary schools, and secondary schools to assist such institutions and schools in implementing the best practices under subsection (a).

''(f) DEFINITIONS.—In this section:

''(1) The term 'behavioral intervention team' means a team of qualified individuals who—

''(A) are responsible for identifying and assessing individuals exhibiting concerning behaviors, experiencing distress, or who are at risk of harm to self or others;

''(B) develop and facilitate implementation of evidence-based interventions to mitigate the threat of harm to self or others posed by an individual and address the mental and behavioral health needs of individuals to reduce risk; and

''(C) provide information to students, parents, and school employees on recognizing behavior described in this subsection.

''(2) The terms 'elementary school', 'parent', and 'secondary school' have the meanings given to such terms in section 8101 of the Elementary and Secondary Education Act of 1965.

''(3) The term 'institution of higher education' has the meaning given to such term in section 102 of the Higher Education Act of 1965.

''(4) The term 'mental health assessment' means an evaluation, primarily focused on diagnosis, determining the need for involuntary commitment, medication management, and on-going treatment recommendations.

''(5) The term 'violence risk assessment' means a broad determination of the potential risk of violence based on evidence-based literature.''.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the gentlewoman from Washington (Mrs. RODGERS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Washington.

Mrs. RODGERS of Washington. Mr. Speaker, I yield myself such time as I may consume.

I rise to express my strong support for the Ferguson amendment, which would incorporate the language of the bipartisan, House-passed Behavioral Intervention Guidelines Act to the underlying package.

This important amendment authorizes the Substance Abuse and Mental Health Services Administration to develop best practices for establishing and appropriately using behavioral intervention teams in schools.

Behavioral intervention teams are multidisciplinary teams that support students' mental health and wellness by identifying students experiencing stress, anxiety, or other behavioral disturbances, and conducting intervention and outreach to these students to help manage risk.

These teams are already active in some educational settings, such as Texas Tech and the University of California, Los Angeles.

By acting in a proactive manner to assist students and connecting them with needed resources, behavioral intervention teams help schools create a safe environment for their students and improve mental health outcomes in young people.

It is more important now than ever that schools and communities have guidance on how to provide behavioral health resources and interventions for their students to facilitate the early intervention and treatment of mental health conditions.

This amendment will help children get help before their conditions worsen or reach a crisis level. I strongly urge a ''yes'' vote on this amendment, and I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I claim the time in opposition to the amendment, but I do not oppose the amendment.

The SPEAKER pro tempore. Without objection, the gentleman from New Jersey is recognized for 5 minutes.

There was no objection.

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

Madam Speaker, I rise in support of this amendment. Like the bill that passed the House last year, H.R. 2877, and other House-passed provisions we hope to include through amendment into the Restoring Hope Act, this bipartisan amendment is part of the bipartisan approach Ranking Member RODGERS and I have taken since day one with this critical bill.

This amendment requires the Secretary to consult with a range of experts, including mental health and education professionals, to develop best practices for schools and universities to establish behavioral intervention teams to identify concerning behaviors and manage risks among students. The guidance must determine how these teams can operate effectively while relying on evidence-based, objective protection of the constitutional and civil rights of students and staff.

Madam Speaker, I understand that some disability and civil rights organizations have concerns about the provisions of this amendment and opposed the original bill. I agree that we must be sensitive to the concerns of these organizations and not inadvertently perpetuate a false association of psychiatric disability and gun violence, nor promote the preemptive use of law enforcement to address problematic student behaviors, particularly among students with disabilities and/or students of color, who are already disproportionately excessively disciplined compared to their peers.

At the same time, I think there is merit to the idea of teams of behavioral health specialists working in concert with educators to identify youth and college students who may be at risk of harming themselves or others and making sure they get the support they need.

This bill has passed the full House twice, as I said, on suspension, both this Congress and last Congress. My understanding is that the bill's sponsors have made changes when reintroducing the bill this Congress to address some of the stakeholders' concerns by including more robust privacy protections and inappropriate referral protections. I think these changes improve the bill.

I understand the stakeholders would like to see additional changes, and as I have indicated in the past, I am committed to examining ways to address these concerns and add additional guardrails as the bill progresses through negotiations with our Senate counterparts, including this amendment for consideration for adoption into H.R. 7666, but we need to pass the amendment to allow those kinds of negotiations with the Senate.

I look forward to working closely with stakeholders, Congressman FERGUSON, and the other original leads of H.R. 2877, and, of course, our ranking member, to strike the right balance that protects the health, privacy, and rights of all students.

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

Mrs. RODGERS of Washington. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the previous question is ordered on the amendment offered by the gentlewoman from Washington (Mrs. RODGERS).

The question is on the amendment offered by the gentlewoman from Washington (Mrs. RODGERS).

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

Mr. PALLONE. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question are postponed.

AMENDMENT NO. 8 OFFERED BY MR. GRIFFITH

The SPEAKER pro tempore. It is now in order to consider amendment No. 8 printed in part E of House Report 117–381.

Mr. GRIFFITH. Madam Speaker, I rise to offer my amendment.

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

The text of the amendment is as follows:

Page 130, after line 3, insert the following:
(c) APPLICABILITY.—The amendments made by this section shall not apply until January 1, 2024.

The SPEAKER pro tempore. Pursuant to House Resolution 1191, the gentleman from Virginia (Mr. GRIFFITH) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Virginia.

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

I appreciate the opportunity to present this amendment. This amendment would delay the implementation of the MAT Act, section 262, until January of 2024.

Currently, the Act would eliminate the patient cap on the number of patients a single healthcare provider can provide buprenorphine to. This cap was created originally in 2000 in the Drug Addiction Treatment Act, which initially set the cap at 30 patients. Since 2000, the cap has been increased several times, and the current law is 275 patients per healthcare practitioner.

This patient cap has never been lifted before or even studied as to what the effects would be if it was lifted. This is a complex treatment area. Patients don't just need buprenorphine, or its less addictive form known by the trade name Suboxone. They need behavioral healthcare treatment. They need hands-on, detailed guidance. They need to do a long, step-down process, slowly reducing and then eliminating all of the opioids that they are using or have used.

Buprenorphine is also an opioid. It is better than heroin or fentanyl, and it can be used as a treatment very effectively. But it still can be addictive. There are reports of its sale on the street. With no cap on the number of patients, I fear we could see abuse.

But if we feel this should be a matter for the States to define through their medical processes, their medical boards, or their legislatures, we need to give them time to take that action. Most State legislatures are not currently in session, so the amendment gives the States time to take action if they choose to do so.

The overall bill is good, but I don't want us to be inadvertently creating more problems down the road related to buprenorphine.

Delaying the implementation of the new MAT language until 2024 will allow States to analyze what they think is a good cap for their population, if they choose to do so at all, but they need the time in order to make that decision.

Accordingly, Madam Speaker, I would ask that we vote ''yes'' on this important amendment, and I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I claim the time in opposition to the amendment.

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

Mr. PALLONE. Madam Speaker, I yield myself 2 minutes.

Madam Speaker, I thank the gentleman from Virginia for expressing his concerns relating to the MAT Act, but I respectfully disagree with his proposal.

First of all, I take issue with some of his characterizations regarding buprenorphine. Buprenorphine is not broadly available to all Americans who need it. In fact, only 1 in 10 individuals with opioid use disorder receive medications for their condition, including buprenorphine.

Over half of all rural counties in the United States do not have a single waivered buprenorphine provider, and 40 percent of all counties in the United States don't have a single waivered provider, according to the HHS-OIG.

This is a huge treatment gap. A treatment gap for opioid use disorders means lives are lost every day unnecessarily when there is treatment available. This is tragic and not acceptable.

Second, the gentleman has made the argument that buprenorphine is not effective against fentanyl, but that is not accurate. Buprenorphine is proven to reduce fentanyl use and overdose deaths, according to the National Academies of Sciences Consensus Report on Medications for Opioid Use Disorders and the United States Commission on Combating Synthetic Opioid Trafficking.

Delaying the elimination of the X waiver to 2024 means extending the time in which a barrier to treatment is in place, leading to an increased risk of overdose and death.

It is clear that we are experiencing record numbers of overdose deaths in America. This is a public health emergency and needs to be addressed immediately.

Buprenorphine is a proven, evidence-based treatment for opioid use disorder. Buprenorphine prevents painful withdrawal symptoms, reduces opioid cravings, and cuts the risk of overdose in half. This is due to buprenorphine's ceiling effect, which makes it nearly impossible to overdose on the medication. For these reasons, it is considered safer than commonly prescribed medications like insulin and blood thinners.

Madam Speaker, eliminating the X waiver is a cornerstone of the Restoring Hope Act. The MAT Act amendment to this package was adopted at markup by a vote of 45–10. It received support from the majority of Republicans and Democrats on the committee.

Further, nothing in this bill limits the ability of States to prepare and act on the overdose crisis.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PALLONE. Madam Speaker, I yield myself an additional 30 seconds.

To the contrary, this legislation empowers States to determine the appropriate training, licensing requirements, and tools for providers who dispense controlled substances and treat patients with substance use disorders. All the MAT Act does is remove an unnecessary and outdated Federal barrier to States effectively addressing the opioid overdose crisis.

If we don't act now, we risk tens of thousands of additional overdoses and unnecessary loss of life. I urge my colleagues to reject this amendment, and I reserve the balance of my time.

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

Mr. FERGUSON. Madam Speaker, I thank my colleague from Virginia for yielding.

Madam Speaker, while I do, in fact, support his amendment, I would also like to speak for just a minute on the previous amendment offered to H.R. 7666, the BIG Act.

We have seen over the past couple of years a significant rise in mental health issues with our students, whether it is in high school, whether it is in middle school, or whether it is in college. We have seen the effects of the pandemic, but there are a lot of other things that have created this mental health crisis for our children around America.

What our children need are resources, and they need resources at a very early age. So what the BIG Act does is it accumulates best practices from different schools around the country, and it makes sure that we intervene with students early. We want to get these young people the resources that they need.

□ 1600

There are a couple of things about this that we think are very important:

Number one, early intervention has been proven to show that we can prevent a catastrophic event. We want students to be healthy and happy and functioning. What we would also like to do is limit the interaction with law enforcement. We want to make sure that the students are getting these resources across the board.

So this body passed the BIG Act last year, and they did it with wide bipartisan support; however, the Senate did not take this bill up. So I say, let's do it again. Let's pass it as part of this important package.

Madam Speaker, I thank the chairman and our ranking members for making such an effort to get this important piece of legislation across the finish line.

Mr. GRIFFITH. Madam Speaker, may I inquire how much time is remaining?

The SPEAKER pro tempore. The gentleman has 1 minute remaining.

Mr. GRIFFITH. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield such time as he may consume to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Madam Speaker, I rise in strong opposition to the Griffith amendment. Not only does this amendment needlessly delay the implementation of the MAT Act by another year, it does so with the intent of encouraging States to enact more restrictions on buprenorphine in the interim, running directly contrary to the intent of the underlying bill.

Let's remember the facts here. We are in the middle of an unprecedented crisis. Last year alone, 107,000 were taken from us too early by drug overdoses. One all-too-common theme in these deaths is a lack of access to

treatment. Despite being recognized as the gold standard of care that can cut the risk of overdose in half, only about 1 in 10 individuals with opioid use disorder received medications like buprenorphine to treat their addiction. That is a glaring systemic failure.

H.R. 7666 takes a strong step to address that failure by expanding access to safe and effective addiction treatment through eliminating the outdated and redundant requirement that healthcare providers obtain a special waiver from the DEA to prescribe buprenorphine for the treatment of addiction.

Despite the lifesaving potential this legislation can bring, this amendment raises concerns about the impact the MAT Act will have on safety, abuse, and diversion, and I would take a moment to directly address these concerns.

Let's start with the basic facts on safety.

Unlike heroin and fentanyl that are causing overdose deaths, buprenorphine is a safe medication that is highly effective at protecting people from overdose.

Due to its ceiling effect, buprenorphine does not cause people to feel high and is unlikely to result in substance use disorder or be a cause of overdose deaths.

With regard to diversion and abuse, the DEA, which is responsible for policing illicit diversion, has specifically looked at this issue and found that the primary reason for buprenorphine diversion is the failure to access legitimate treatment, and that increasing, not limiting, buprenorphine treatment may be an effective response to diversion.

Indeed, as buprenorphine access has increased over the last 5 years through legislation passed by this Congress, misuse of the medication has decreased.

So I would say that it is important for us to be responsible here. We are in the midst of a pandemic, an epidemic that is causing great pain, great suffering, great death, every day, every week. Every moment we circumvent our responsibilities, someone is paying the price for that.

Madam Speaker, I strongly oppose this amendment.

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

Mr. GRIFFITH. Madam Speaker, I yield 1 minute to the gentlewoman from Washington (Mrs. RODGERS).

Mrs. RODGERS of Washington. Madam Speaker, I appreciate the gentleman for yielding.

Madam Speaker, I rise in support of the Griffith amendment which provides additional time for implementation of the provisions of the Mainstreaming Addiction Treatment Act included in this bill.

I supported the inclusion of this language at committee, as I believe it will help increase access to substance use disorder treatment, the underlying language. However, enacting this language will be a huge policy change from the status quo.

Furthermore, States do regulate the practice of medicine, and each State has unique, individual regulations and procedures regarding the dispensing and the prescribing of scheduled narcotics. States could use the additional time to update their laws with any changes they may want now that Federal restrictions will be removed.

This is exactly what Mr. GRIFFITH's amendment does. It sets the implementation date for removing the X waiver requirement to take effective on January 1, 2024.

Madam Speaker, I support this commonsense amendment that will ensure that the Mainstreaming Addiction Treatment Act gets appropriately implemented.

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

The SPEAKER pro tempore. Pursuant to House Resolution Number 1191, the previous question is ordered on the amendment offered by the gentleman from Virginia (Mr. GRIFFITH).

The question is on the amendment.

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

Mr. GRIFFITH. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3(s) of House Resolution 8, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question are postponed.

Pursuant to clause 1(c) of rule XIX, further consideration of H.R. 7666 is postponed.

ADVANCED RESEARCH PROJECTS AGENCY–HEALTH ACT

Mr. PALLONE. Mr. Speaker, pursuant to House Resolution 1191, I call up the bill (H.R. 5585) to establish the Advanced Research Projects Agency–Health, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. CARSON). Pursuant to House Resolution 1191, the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce printed in the bill is adopted, and the bill, as amended, is considered read.

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

H.R. 5585

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Advanced Research Projects Agency–Health Act'' or the ''ARPA–H Act''.

SEC. 2. ADVANCED RESEARCH PROJECTS AGENCY–HEALTH.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end the following:

''PART J—ADVANCED RESEARCH PROJECTS AGENCY–HEALTH

''SEC. 499A. ADVANCED RESEARCH PROJECTS AGENCY–HEALTH.

''(a) ESTABLISHMENT.—There is established, as an independent operating division within the Department of Health and Human Services, the Advanced Research Projects Agency–Health (in this part referred to as 'ARPA–H'). Not later than 180 days after the date of enactment of this part, the Secretary shall transfer all functions, personnel, missions, activities, authorities, and funds of the Advanced Research Projects Agency for Health within the National Institutes of Health, as in existence on the date of enactment of this part, to ARPA–H established by the preceding sentence.

''(b) GOALS AND METHODS.—

''(1) GOALS.—The goals of ARPA–H shall be to—

''(A) foster the development of new, breakthrough capabilities, technologies, systems, and platforms to accelerate innovations in health and medicine that are not being met by Federal programs or private entities;

''(B) revolutionize detection, diagnosis, mitigation, prevention, treatment, and curing of serious diseases and medical conditions through the development of transformative health technologies;

''(C) promote high-risk, high-reward innovation for the development and translation of transformative health technologies; and

''(D) contribute to ensuring the United States maintains—

''(i) global leadership in science and innovation;

''(ii) the highest quality of life and health for its citizens; and

''(iii) an aggressive agenda for innovations to address global health threats that place United States citizens at risk.

''(2) METHODS.—ARPA–H shall achieve the goals specified in paragraph (1) by—

''(A) discovering, identifying, and promoting revolutionary advances in health sciences;

''(B) translating scientific discoveries into transformative health technologies;

''(C) providing resources and support to create platform capabilities that draw on multiple disciplines;

''(D) using researchers in a wide range of disciplines, including the life sciences, the physical sciences, engineering, and the computational sciences;

''(E) delivering advanced proofs of concept that demonstrate potentially clinically meaningful advances;

''(F) developing new capabilities, advanced computational tools, predictive models, or analytical techniques to identify potential targets and technological strategies for early disease detection and intervention;

''(G) accelerating transformational technological advances in areas with limited technical certainty; and

''(H) prioritizing investments based on such considerations as—

''(i) scientific opportunity and uniqueness of fit to the strategies and operating practices of ARPA–H;

''(ii) the effect on disease burden, including unmet patient need, quality and disparity gaps, and the potential to preempt progression of serious disease; and

''(iii) the effect on the fiscal liability of the Federal Government with respect to health care and the ability to reduce the cost of care through innovation.

''(c) DIRECTOR.—

''(1) IN GENERAL.—The President shall appoint with the advice and consent of the Senate, a director of ARPA–H (in this part referred to as the 'Director').

''(2) QUALIFICATIONS.—The Director shall be an individual who, by reason of professional background and experience, is especially qualified to manage—