117TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
117–381

PROVIDING FOR CONSIDERATION OF THE BILL (H.R. 4176) TO IMPROVE FEDERAL POPULATION SURVEYS BY REQUIRING THE COLLECTION OF VOLUNTARY, SELF-DISCLOSED INFORMATION ON SEXUAL ORIENTATION AND GENDER IDENTITY IN CERTAIN SURVEYS, AND FOR OTHER PURPOSES; PROVIDING FOR CONSIDERATION OF THE BILL (H.R. 5585) TO ESTABLISH THE ADVANCED RESEARCH PROJECTS AGENCY-HEALTH, AND FOR OTHER PURPOSES; PROVIDING FOR CONSIDERATION OF 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 FOR OTHER PURPOSES

JUNE 21, 2022.—Referred to the House Calendar and ordered to be printed

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Ms. ROSS, from the Committee on Rules,
submitted the following

R E P O R T

[To accompany H. Res. 1191]

The Committee on Rules, having had under consideration House Resolution 1191, by a record vote of 9 to 4, report the same to the House with the recommendation that the resolution be adopted.

SUMMARY OF PROVISIONS OF THE RESOLUTION

The resolution provides for consideration of H.R. 4176, the LGBTQI+ Data Inclusion Act, under a structured rule. The resolution provides one hour of general debate equally divided and controlled by the chair and ranking minority member of the Committee on Oversight and Reform or their designees. The resolution waives all points of order against consideration of the bill. The resolution provides that an amendment in the nature of a substitute consisting of the text of Rules Committee Print 117–52, modified by the amendment printed in part A of this report, shall be considered as adopted and the bill, as amended, shall be considered as read. The resolution waives all points of order against provisions in the bill, as amended.

The resolution makes in order only those further amendments to H.R. 4176 printed in part B of this report. Each such amendment may be offered only in the order printed in this report, may be offered only by a Member designated in this report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent,

shall not be subject to amendment, and shall not be subject to a demand for division of the question. The resolution waives all points of order against the amendments printed in part B of the report. The resolution provides for one motion to recommit. The resolution provides for consideration of H.R. 5585, the Advanced Research Projects Agency—Health Act, under a structured rule. The resolution provides one hour of general debate on the bill equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce or their designees. The resolution waives all points of order against consideration of the bill. The resolution provides that the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce now printed in the bill shall be considered as adopted and the bill, as amended, shall be considered as read. The resolution waives all points of order against provisions in the bill, as amended. The resolution makes in order the further amendment to H.R. 5585 printed in part C of this report, if offered by the Member designated in this report, which 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, and shall not be subject to a demand for division of the question. The resolution waives all points of order against the amendment printed in part C of this report. The resolution provides one motion to recommit. The resolution also provides for consideration of H.R. 7666, the Restoring Hope for Mental Health and Well-Being Act of 2022, under a structured rule. The resolution provides one hour of general debate on the bill equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce or their designees. The resolution waives all points of order against consideration of the bill. The resolution provides that 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 this report, shall be considered as adopted and the bill, as amended, shall be considered as read. The resolution waives all points of order against provisions in the bill, as amended. The resolution provides that following debate, each further amendment printed in part E of this report not earlier considered as part of amendments en bloc pursuant to section 6 shall be considered only in the order printed in this report, may be offered only by a Member designated in this report, shall be considered as read, shall be debatable for the time specified in this 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. Section 6 of the resolution provides that at any time after debate the chair of the Committee on Energy and Commerce or his designee may offer amendments en bloc consisting of further amendments printed in part E this report 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 designees, shall not be subject to amendment, and shall not be subject to a demand for division of the question. The resolution waives all points of order against the amendments printed in part E of this report and

amendments en bloc described in section 6 of the resolution. The resolution provides one motion to recommit. The resolution provides that House Resolution 188, agreed to March 8, 2021 (as most recently amended by House Resolution 1170, agreed to June 14, 2022), is amended by striking "June 22, 2022" each place it appears and inserting (in each instance) "July 13, 2022". The resolution provides that proceedings may be postponed through July 15, 2022, on measures that were the object of motions to suspend the rules on the legislative days of June 21, 2022, June 22, 2022, June 23, 2022, or June 24, 2022, and on which the yeas and nays were ordered.

EXPLANATION OF WAIVERS

The waiver of all points of order against consideration of H.R. 4176 includes a waiver of clause 3(d)(1) of rule XIII of the Congressional Budget Act, which requires the inclusion of committee cost estimate in a committee report. A CBO cost estimate on H.R. 4176 was not available at the time the Committee on the Oversight and Reform filed its report.

Although the resolution waives all points of order against provisions in H.R. 4176, as amended, the Committee is not aware of any points of order. The waiver is prophylactic in nature.

Although the resolution waives all points of order against the amendments to H.R. 4176 printed in part B of this report, the Committee is not aware of any points of order. The waiver is prophylactic in nature.

Although the resolution waives all points of order against consideration of H.R. 5585, the Committee is not aware of any points of order. The waiver is prophylactic in nature.

The waiver of all points of order against provisions in H.R. 5585, as amended, includes a waiver of clause 4 of rule XXI, which prohibits reporting a bill carrying an appropriation from a committee not having jurisdiction to report an appropriation.

Although the resolution waives all points of order against the amendment to H.R. 5585 printed in part C of this report, the Committee is not aware of any points of order. The waiver is prophylactic in nature.

The waiver of all points of order against consideration of H.R. 7666 includes waivers of the following:

—Clause 10 of rule XXI, which prohibits consideration of a measure that has a net effect of increasing the deficit or reducing the surplus over the five- or 10-year period; however, the budgetary effects of the bill are fully offset over the 10-year period.

—Section 302(f) of the Congressional Budget Act, which prohibits consideration of a bill if it has the net effect of increasing mandatory spending over the five- or ten-year period.

The waiver of all points of order against provisions in H.R. 7666, as amended, includes waivers of the following:

—Clause 4 of rule XXI, which prohibits reporting a bill carrying an appropriation from a committee not having jurisdiction to report an appropriation.

—Clause 5(a) of rule XXI, which prohibits a bill or joint resolution carrying a tax or tariff measure from being reported by a committee not having jurisdiction to report tax or tariff measures.

Although the resolution waives all points of order against the amendments to H.R. 7666 printed in part E of this report and amendments en bloc described in section 6 of the resolution, the Committee is not aware of any points of order. The waiver is prophylactic in nature.

COMMITTEE VOTES

The results of each record vote on an amendment or motion to report, together with the names of those voting for and against, are printed below:

Rules Committee record vote No. 240

Motion by Mr. Cole to add language to the rule that would eliminate the ability to vote remotely by proxy. Defeated: 4–9

Majority Members	Vote	Minority Members	Vote
Mrs. Torres	Nay	Mr. Cole	Yea
Mr. Perlmutter	Nay	Mr. Burgess	Yea
Mr. Raskin	Nay	Mr. Reschenthaler	Yea
Ms. Scanlon	Nay	Mrs. Fischbach	Yea
Mr. Morelle	Nay		
Mr. DeSaulnier	Nay		
Ms. Ross	Nay		
Mr. Neguse	Nay		
Mr. McGovern, Chairman	Nay		

Rules Committee record vote No. 241

Motion by Mr. Burgess to amend the rule to H.R. 5585 to make in order amendment #2, offered by Rep. Burgess (TX), which would ensure that nothing in this Act or the amendments made by this Act shall be construed to impede or interfere in any way with the innovation, development, or distribution of transformative health technologies, including diagnostic tests for early disease detection and intervention. Defeated: 4–9

Majority Members	Vote	Minority Members	Vote
Mrs. Torres	Nay	Mr. Cole	Yea
Mr. Perlmutter	Nay	Mr. Burgess	Yea
Mr. Raskin	Nay	Mr. Reschenthaler	Yea
Ms. Scanlon	Nay	Mrs. Fischbach	Yea
Mr. Morelle	Nay		
Mr. DeSaulnier	Nay		
Ms. Ross	Nay		
Mr. Neguse	Nay		
Mr. McGovern, Chairman	Nay		

Rules Committee record vote No. 242

Motion by Ms. Ross to report the rule. Adopted: 9–4

Majority Members	Vote	Minority Members	Vote
Mrs. Torres	Yea	Mr. Cole	Nay
Mr. Perlmutter	Yea	Mr. Burgess	Nay
Mr. Raskin	Yea	Mr. Reschenthaler	Nay
Ms. Scanlon	Yea	Mrs. Fischbach	Nay
Mr. Morelle	Yea		
Mr. DeSaulnier	Yea		
Ms. Ross	Yea		
Mr. Neguse	Yea		

Majority Members	Vote	Minority Members	Vote
Mr. McGovern, Chairman	Yea		

SUMMARY OF THE AMENDMENT TO H.R. 4176 IN PART A CONSIDERED AS ADOPTED

1. Maloney, Carolyn (NY): Adds a finding and makes technical and conforming changes to the bill.

SUMMARY OF THE AMENDMENTS TO H.R. 4176 IN PART B MADE IN ORDER

1. Jackson Lee (TX): Requires a report to Congress from the Comptroller General about the impact of the implementation of this Act on the provision of services to persons according to their gender identity, sexual orientation, and variations in sex characteristics. (10 minutes)

2. Maloney, Sean (NY): Clarifies that when applicable, federal surveys should gather information from a knowledgeable proxy of a deceased LGBTQI+ individual. (10 minutes)

3. Tlaib (MI): Requires agencies collecting information through a covered survey to establish data standards and protocols for anonymizing data collected and destroying personally-identifiable information at the appropriate time, which cannot be later than 3 years after the date that the information was collected. (10 minutes)

SUMMARY OF THE AMENDMENT TO H.R. 5585 IN PART C MADE IN ORDER

1. Eshoo (CA), Guthrie (KY): Clarifies organizational structure of offices within ARPA–H, limits the amount of administrative funding that may be used to operate ARPA–H to 15%, removes the requirement of Senate confirmation of Director, and clarifies ARPA–H's leasing authority. (10 minutes)

SUMMARY OF THE AMENDMENT TO H.R. 7666 IN PART D CONSIDERED AS ADOPTED

1. Pallone (NJ), McMorris Rodgers (WA): Makes technical changes and adds provisions from H.R. 7233 as reported out of the Committee on Energy and Commerce. Includes provisions to increase transparency of pharmacy benefit managers for plan sponsors related to prescription drug spending and requires NIH to examine the effects of modern technology and multimedia on youth.

SUMMARY OF THE AMENDMENTS TO H.R. 7666 IN PART E MADE IN ORDER

1. Bera (CA), Fitzpatrick (PA): Adds the House passed Helping Emergency Responders Overcome (HERO) Act, which establishes a series of programs relating to the behavioral health of law enforcement officers, first responders, 9–1–1 operators, and other public safety officers and health care providers. (10 minutes)

2. Davis, Rodney (IL), Bilirakis (FL), O'Halleran (AZ), Wagner (MO), Kuster (NH): Adds the text of HR 2355, the Opioid Prescription Verification Act of 2021, which encourages the expanded use of electronic prescribing for opioids similar to the mandate for

Medicare Part D opioid prescriptions under current law. Incentivize states to maintain and fully utilize prescription drug monitoring programs (PDMP) and requires the U.S. Department of Health and Human Services (HHS) to work with the CDC, DEA, and FDA to offer materials and guidance to pharmacists on how to verify the identity patients to help facilitate safe and responsible opioid prescriptions. (10 minutes)

3. Dean (PA), Spartz (IN), Scanlon (PA), Fitzpatrick (PA): Increases the time limit for health care providers to use and hold long-acting injectable (LAI) buprenorphine, if received through a specialty pharmacy, from 14 to 60 days. (10 minutes)

4. Demings (FL): Requires a report on the available mental health and stress related resources or programs that are available to law enforcement officers. The report shall include additional legislative tools and authorities that may be helpful or necessary to assist in assessing, monitoring, and improving the mental health of law enforcement officers. (10 minutes)

5. Feenstra (IA): Requires the Behavioral Health Crisis Coordinating Office to include the Veterans Crisis Line as an entity to provide rapid post-crisis follow-up care. (10 minutes)

6. Ferguson (GA), Burgess (TX), Pappas (NH), Carter, Buddy (GA), Costa (CA), Fitzpatrick (PA), McBath (GA): Requires the Department of Health and Human Services (HHS) to develop best practices for establishing behavioral intervention teams in educational settings. (10 minutes)

7. Gottheimer (NJ): Includes veterans as an eligible group for mental health and substance abuse care. (10 minutes)

8. Griffith (VA): Sets January 1, 2024 as date of applicability for Sec. 262 to allow states time to review and update state law, if desired. (10 minutes)

9. Joyce, David (OH): Requires the Department of Defense to carry out a two-year pilot program aimed at preventing suicides amongst active duty members of the Armed Forces by predownloading resources onto smart devices issued to members of the Armed Forces and to provide training on the use of these resources. (10 minutes)

10. Katko (NY), Napolitano (CA), Beyer (VA), Raskin (MD), Cárdenas (CA), Fitzpatrick (PA): Adds the House-passed Suicide Prevention Lifeline Improvement Act, which includes enhanced funding for the National Suicide Prevention Lifeline, authorization for HHS to develop and implement an enhanced quality assurance plan for the suicide prevention hotline, improved data sharing with the CDC, and a pilot program for innovative technologies for suicide prevention. (10 minutes)

11. Kim (NJ), Davids (KS): Adds the text of the Synthetic Opioid Danger Awareness Act, which requires HHS to conduct a public education campaign about synthetic opioids (including fentanyl and its analogues), disseminate information about synthetic opioids to health care providers, and develop a training guide and webinar for first responders and other individuals at high risk of exposure to synthetic opioids that details measures to prevent exposure. (10 minutes)

12. McKinley (WV), Dingell (MI): Amends the Controlled Substances Act to clarify the process for registrants to exercise due diligence upon discovering a suspicious order. (10 minutes)

13. Moore (WI): Add appropriate state, local, and tribal public officials administering programs that serve low-income pregnant and postpartum individuals to the list of entities that the Secretary should consult with in operating and maintaining the maternal mental health hotline. (10 minutes)

14. Napolitano (CA), Katko (NY): Revises Project AWARE, which is administered by the Substance Abuse and Mental Health Services Administration, to provide comprehensive school-based mental health services, including screening, treatment, and outreach programs. (10 minutes)

15. Pressley (MA): Requires HHS to administer a report to study rates of suicidal behaviors among children and adolescents with chronic illnesses, including substance use disorders, autoimmune disorders and heritable blood disorders and to submit a report to Congress on findings. (10 minutes)

16. Reschenthaler (PA), Morelle (NY), Wild (PA), Dean (PA): Requires a study to determine the true costs of untreated serious mental illness on families, health care systems, public housing, and law enforcement in America. (10 minutes)

17. Trone (MD), Armstrong (ND), Sherrill (NJ): Authorizes State Opioid Response (SOR) Grants and Tribal Opioid Response (TOR) Grants for 5 years at $1.75 billion per year, with a 5% set-aside for TOR. (10 minutes)

PART A—TEXT OF AMENDMENT TO H.R. 4176 CONSIDERED AS ADOPTED

Page 2, after line 2, insert the following:

> (5) The integrity of the Federal statistical system relies on the ability of agencies to determine the content of their statistical surveys based on considerations of relevance, timeliness, accuracy, objectivity, and ability to maintain confidentiality.

Page 2, line 9, insert "for statistical purposes" after "survey".

Page 2, beginning on line 11, strike "existing data sets to determine in which data sets" and insert "covered surveys to determine in which surveys".

Page 2, line 24 insert "for any survey identified in paragraph (1)" after "sex characteristics".

Page 3, strike lines 13 through 16 and insert the following:

> (2) WAIVER.—The statistical official (as described in section 314 of title 5, United States Code) of each agency, or the head of the agency, for any agency that does not have a statistical official, may waive the requirement under paragraph (1), on a case-by-case basis, if the standards and policies in subsection (c) can not be met, or if adding such information to the survey would impair the ability of the agency to preserve the utility, accuracy, or objectivity of the survey while also generating relevant evidence about the LGBTQI+ community.

Page 3, beginning on line 22, strike "(d) APPLICABILITY.—" and all that follows through "(1) CONSTRUCTION.—" and insert "(d) CONSTRUCTION.—".

Page 4, strike lines 3 through 9.

Page 4, line 13, after "any individual" insert the following: ", or that is inconsistent with disclosure limitations established in any other law".

Page 5, line 16, strike "observation or".

PART B—TEXT OF AMENDMENTS TO H.R. 4176 MADE IN ORDER

1. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE JACKSON LEE OF TEXAS OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 4, after line 9, insert the following (and redesignate the subsequent subsections accordingly):

(e) REPORT.— Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall provide a report to Congress on the implementation of the requirements of this Act by agencies, including how the implementation of such requirements by agencies affected the provision of services to persons according to the gender identity, sexual orientation, and variations in sex characteristics of the persons.

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2. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE MALONEY OF NEW YORK OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 4, line 22, insert after "proxy" the following: "(including a proxy of a deceased individual, if applicable)".

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3. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE TLAIB OF MICHIGAN OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 2, line 20, insert after "confidentiality" the following: ", including protocols for anonymizing data collected and destroying personally-identifiable information at the appropriate time and not later than three years after the date on which the information is collected".

PART C—TEXT OF AMENDMENT TO H.R. 5585 MADE IN ORDER

1. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE ESHOO OF CALIFORNIA OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 3, line 13, strike "There is established" and insert the following:

(1) IN GENERAL.—There is established

Page 3, after line 23, insert the following:

(2) ORGANIZATION.—

(A) IN GENERAL.—There shall be within ARPA–H—

(i) an Office of the Director;

(ii) not more than 6 program offices; and

(iii) such special project offices as the Director may establish.

(B) PROGRAM OFFICES DEDICATED TO RESEARCH AND DEVELOPMENT.—Not fewer than two-thirds of the program offices of ARPA–H shall be exclusively dedicated to research and development.

Page 6, line 16, strike "with the advice and consent of the Senate,".

Page 14, strike line 19, and all that follows through page 16, line 6, and insert the following:

"(3) UTILIZATION OF LEASE FUNDS.—The Director shall deposit amounts of cash consideration received for a lease entered into under this subsection in the 'Advanced Research

Projects Agency for Health' account as discretionary offsetting collections, and such amounts shall be available only to the extent and in the amounts provided in advance in appropriations Acts—

"(A) to cover the full costs to ARPA–H in connection with the lease;

"(B) for maintenance, capital revitalization, and improvements of the real property assets and related personal property under the jurisdiction of the Director; and

"(C) for maintenance, capital revitalization, and improvements of the real property assets and related personal property at the respective center or facility of ARPA–H engaged in the lease, subject to the concurrence of the Director.".

Page 26, lines 15 through 19, amend paragraph (3) to read as follows:

"(3) not award any grants, cooperative agreements, contracts, prizes, and other transactions to nondomestic recipients organized under the laws of a covered foreign country (as defined in section 119C of the National Security Act of 1947); and

Page 34, lines 23 and 24, strike "There is authorized" and insert the following:

(1) IN GENERAL.—To carry out this section, there is authorized

Page 35, after line 2 (but before the close quotation mark and second period) insert the following:

(2) ADMINISTRATIVE EXPENSES.—Not more than 15 percent of the amounts made available to carry out this section for any fiscal year may be used for administrative expenses to operate ARPA–H.

PART D—TEXT OF AMENDMENT TO H.R. 7666 CONSIDERED AS ADOPTED

Amend section 263 to read as follows:

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 (as defined under section 1861(r) of the Social Security Act), the practitioner meets one or 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, or 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 Association, 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, the ACCME, or the Commission on Dental Accreditation.

"(v) The physician graduated in good standing from an accredited school of allopathic medicine, 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—

"(I) 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; 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 use 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 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 (iv) and (v) of paragraph (1)(A) or 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.".

Page 150, after line 5, insert the following:

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 of fiscal years 2023 through 2027".

At the end of title IV, add the following new subtitle:

Subtitle D—Media and Mental Health

SEC. 431. STUDY ON THE EFFECTS OF SMARTPHONE AND SOCIAL MEDIA USE ON 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 underserved 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 of children and adolescents within

such cognitive areas as language development, executive functioning, attention, creative problem 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 experts as needed, shall develop a research agenda on the health and developmental 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 of 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.".

At the end of the bill, add the following new titles:

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 bene-

ficiary 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.

PART E—TEXT OF AMENDMENTS TO H.R. 7666 MADE IN ORDER

1. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE BERA OF CALIFORNIA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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).

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2. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE DAVIS OF ILLINOIS OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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".

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3. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE DEAN OF PENNSYLVANIA OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

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".

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4. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE DEMINGS OF FLORIDA OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

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.

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5. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE FEENSTRA OF IOWA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 5, after line 21, insert the following new subparagraph (and redesignate the subsequent subparagraphs accordingly):

"(B) the Veterans Crisis Line;

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6. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE FERGUSON OF GEORGIA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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 ongoing treatment recommendations.

"(5) The term 'violence risk assessment' means a broad determination of the potential risk of violence based on evidence-based literature.".

7. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE GOTTHEIMER OF NEW JERSEY OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 9, line 22, insert "veterans," after "minorities,".

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8. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE GRIFFITH OF VIRGINIA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

Page 130, after line 3, insert the following:

(c) APPLICABILITY.—The amendments made by this section shall not apply until January 1, 2024.

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9. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE JOYCE OF OHIO OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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.

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10. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE KATKO OF NEW YORK OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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).

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11. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE KIM OF NEW JERSEY OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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.

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12. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE MCKINLEY OF WEST VIRGINIA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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 pro-

mulgate 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.

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13. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE MOORE OF WISCONSIN OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

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.".

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14. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE NAPOLITANO OF CALIFORNIA OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

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".

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15. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE PRESSLEY OF MASSACHUSETTS OR HER DESIGNEE, DEBATABLE FOR 10 MINUTES

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.

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16. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE RESCHENTHALER OF PENNSYLVANIA OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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.

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17. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE TRONE OF MARYLAND OR HIS DESIGNEE, DEBATABLE FOR 10 MINUTES

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 sum-

mary 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.".

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