

114TH CONGRESS
1ST SESSION

H. R. 2646

To make available needed psychiatric, psychological, and supportive services for individuals with mental illness and families in mental health crisis, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 2015

Mr. MURPHY of Pennsylvania (for himself, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. BUCHANAN, Mr. DIAZ-BALART, Mr. BILIRAKIS, Mr. DOLD, Mr. GUINTA, Mrs. MIMI WALTERS of California, Mr. BRENDAN F. BOYLE of Pennsylvania, Mrs. ELLMERS of North Carolina, Mr. DENHAM, Mr. VARGAS, Mrs. MILLER of Michigan, Mr. HASTINGS, Mr. CALVERT, Mr. NUNES, Mr. HUNTER, Mr. BLUMENAUER, and Ms. SINEMA) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To make available needed psychiatric, psychological, and supportive services for individuals with mental illness and families in mental health crisis, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Helping Families in Mental Health Crisis Act of 2015”.

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

- Sec. 1. Short title; table of contents.
 Sec. 2. Definitions.

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH AND
 SUBSTANCE USE DISORDERS

- Sec. 101. Assistant Secretary for Mental Health and Substance Use Disorders.
 Sec. 102. Transfer of SAMHSA authorities.
 Sec. 103. Reports.
 Sec. 104. Advisory Council on Graduate Medical Education.

TITLE II—GRANT REFORM AND RESTRUCTURING

- Sec. 201. National mental health policy laboratory.
 Sec. 202. Innovation grants.
 Sec. 203. Demonstration grants.
 Sec. 204. Early childhood intervention and treatment.
 Sec. 205. Extension of assisted outpatient treatment grant program for individuals with serious mental illness.
 Sec. 206. Block grants.
 Sec. 207. Workforce development.
 Sec. 208. Authorized grants and programs.

TITLE III—INTERAGENCY SERIOUS MENTAL ILLNESS
 COORDINATING COMMITTEE

- Sec. 301. Interagency Serious Mental Illness Coordinating Committee.

TITLE IV—HIPAA AND FERPA CAREGIVERS

- Sec. 401. Promoting appropriate treatment for mentally ill individuals by treating their caregivers as personal representatives for purposes of HIPAA privacy regulations.
 Sec. 402. Caregivers permitted access to certain education records under FERPA.
 Sec. 403. Confidentiality of records.

TITLE V—MEDICARE AND MEDICAID REFORMS

- Sec. 501. Enhanced Medicaid coverage relating to certain mental health services.
 Sec. 502. Access to mental health prescription drugs under Medicare and Medicaid.
 Sec. 503. Elimination of 190-day lifetime limit on coverage of inpatient psychiatric hospital services under Medicare.
 Sec. 504. Modifications to Medicare discharge planning requirements.
 Sec. 505. Demonstration programs to improve community mental health services.

TITLE VI—RESEARCH BY NATIONAL INSTITUTE OF MENTAL
 HEALTH

- Sec. 601. Increase in funding for certain research.

TITLE VII—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

- Sec. 701. Extension of health information technology assistance for behavioral and mental health and substance abuse.
- Sec. 702. Extension of eligibility for Medicare and Medicaid health information technology implementation assistance.

TITLE VIII—SAMHSA REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

- Sec. 801. In general.
- Sec. 802. Advisory councils.
- Sec. 803. Peer review.

Subtitle B—Protection and Advocacy for Individuals With Mental Illness

- Sec. 811. Prohibition against lobbying by systems accepting Federal funds to protect and advocate the rights of individuals with mental illness.
- Sec. 812. Ensuring that caregivers of individuals with serious mental illness have access to the protected health information of such individuals.
- Sec. 813. Protection and advocacy activities to focus exclusively on safeguarding rights to be free from abuse and neglect.
- Sec. 814. Reporting.
- Sec. 815. Grievance procedure.
- Sec. 816. Evidence-based treatment for individuals with serious mental illness.

TITLE IX—REPORTING

- Sec. 901. GAO study on preventing discriminatory coverage limitations for individuals with serious mental illness and substance use disorders.

1 **SEC. 2. DEFINITIONS.**

2 In this Act:

3 (1) Except as inconsistent with the provisions
 4 of this Act, the term “Assistant Secretary” means
 5 the Assistant Secretary for Mental Health and Sub-
 6 stance Use Disorders.

7 (2) The term “evidence-based” means the con-
 8 scientious, systematic, explicit, and judicious ap-
 9 praisal and use of external, current, reliable, and
 10 valid research findings as the basis for making deci-

1 sions about the effectiveness and efficacy of a pro-
2 gram, intervention, or treatment.

3 **TITLE I—ASSISTANT SECRETARY**
4 **FOR MENTAL HEALTH AND**
5 **SUBSTANCE USE DISORDERS**

6 **SEC. 101. ASSISTANT SECRETARY FOR MENTAL HEALTH**
7 **AND SUBSTANCE USE DISORDERS.**

8 (a) IN GENERAL.—There shall be in the Department
9 of Health and Human Services an official to be known
10 as the Assistant Secretary for Mental Health and Sub-
11 stance Use Disorders, who shall—

12 (1) report directly to the Secretary;

13 (2) be appointed by the Secretary of Health
14 and Human Services, by and with the advice and
15 consent of the Senate; and

16 (3) be selected from among individuals who—

17 (A)(i) have a doctoral degree in medicine
18 or osteopathic medicine and clinical and re-
19 search experience in psychiatry;

20 (ii) graduated from an Accreditation Coun-
21 cil for Graduate Medical Education-accredited
22 psychiatric residency program; and

23 (iii) have an understanding of biological,
24 psychosocial, and pharmaceutical treatments of
25 mental illness and substance use disorders; or

1 (B) have a doctoral degree in psychology
2 with—

3 (i) clinical and research experience re-
4 garding mental illness and substance use
5 disorders; and

6 (ii) an understanding of biological,
7 psychosocial, and pharmaceutical treat-
8 ments of mental illness and substance use
9 disorders.

10 (b) DUTIES.—The Assistant Secretary shall—

11 (1) promote, evaluate, organize, integrate, and
12 coordinate research, treatment, and services across
13 departments, agencies, organizations, and individ-
14 uals with respect to the problems of individuals suf-
15 fering from substance use disorders or mental ill-
16 ness;

17 (2) carry out any functions within the Depart-
18 ment of Health and Human Services—

19 (A) to improve the treatment of, and re-
20 lated services to, individuals with respect to
21 substance use disorders or mental illness;

22 (B) to improve secondary prevention or
23 tertiary prevention services for such individuals;

24 (C) to ensure access to effective, evidence-
25 based treatment for individuals with mental ill-

1 nesses and individuals with a substance use dis-
2 order;

3 (D) to ensure that grant programs of the
4 Department adhere to scientific standards with
5 an emphasis on secondary prevention and ter-
6 tiary prevention for individuals with serious
7 mental illness or substance use disorders; and

8 (E) to develop and implement initiatives to
9 encourage individuals to pursue careers (espe-
10 cially in underserved areas and populations) as
11 psychiatrists, psychologists, psychiatric nurse
12 practitioners, clinical social workers, and other
13 licensed mental health professionals specializing
14 in the diagnosis, evaluation, and treatment of
15 individuals with severe mental illness, including
16 individuals—

17 (i) who are vulnerable to crises, psy-
18 chotic episodes, or suicidal rumination;

19 (ii) whose deterioration can be rapid;

20 or

21 (iii) who require more frequent con-
22 tact or integration of a variety of services
23 by the treating mental health professional;

24 (3) carry out the administrative and financial
25 management, policy development and planning, eval-

1 uation, knowledge dissemination, and public infor-
2 mation functions that are required for the implemen-
3 tation of mental health programs, including block
4 grants, treatments, and data collection;

5 (4) conduct and coordinate demonstration
6 projects, evaluations, and service system assessments
7 and other activities necessary to improve the avail-
8 ability and quality of treatment, prevention, and re-
9 lated services related to substance use disorders and
10 mental illness;

11 (5) within the Department of Health and
12 Human Services, oversee and coordinate all pro-
13 grams and activities relating to—

14 (A) the prevention of, or treatment or re-
15 habilitation for, mental health or substance use
16 disorders;

17 (B) parity in health insurance benefits and
18 conditions relating to mental health and sub-
19 stance use disorder; or

20 (C) the reduction of homelessness among
21 individuals with mental illness;

22 (6) across the Federal Government, in conjunc-
23 tion with the Interagency Serious Mental Illness Co-
24 ordinating Committee under section 501A—

1 (A) review all programs and activities re-
2 relating to the prevention of, or treatment or re-
3 habilitation for, mental illness or substance use
4 disorders;

5 (B) identify any such programs and activi-
6 ties that are duplicative;

7 (C) identify any such programs and activi-
8 ties that are not evidence-based, effective, or ef-
9 ficient; and

10 (D) formulate recommendations for ex-
11 panding, coordinating, eliminating, and improv-
12 ing programs and activities identified pursuant
13 to subparagraph (B) or (C) and merging such
14 programs and activities into other, successful
15 programs and activities;

16 (7) identify evidence-based best practices across
17 the Federal Government for treatment and services
18 for those with mental health and substance use dis-
19 orders by reviewing practices for efficiency, effective-
20 ness, quality, coordination, and cost effectiveness;

21 (8) be the head of and supervise the National
22 Mental Health Policy Laboratory; and

23 (9) not later than one year after the date of en-
24 actment of the Helping Families in Mental Health
25 Crisis Act of 2015, submit to the Congress a report

1 containing a nationwide strategy to increase the psy-
2 chiatric workforce and recruit medical professionals
3 for the treatment of individuals with serious mental
4 illness and substance use disorders.

5 (c) NATIONWIDE STRATEGY.—The Assistant Sec-
6 retary shall ensure that the nationwide strategy in the re-
7 port under subsection (b)(9) is designed—

8 (1) to encourage and incentivize students en-
9 rolled in an accredited medical or osteopathic med-
10 ical school to enter the specialty of psychiatry;

11 (2) to promote greater research-oriented psy-
12 chiatrist residency training on evidence-based service
13 delivery models for individuals with serious mental
14 illness or substance use disorders;

15 (3) to promote appropriate Federal administra-
16 tive and fiscal mechanisms that support—

17 (A) evidence-based collaborative care mod-
18 els; and

19 (B) the necessary psychiatric workforce ca-
20 pacity for these models, including psychiatrists
21 (including child and adolescent psychiatrists),
22 psychologists, psychiatric nurse practitioners,
23 clinical social workers, and mental health, peer-
24 support specialists;

1 (4) to increase access to child and adolescent
2 psychiatric services in order to promote early inter-
3 vention for prevention and mitigation of mental ill-
4 ness; and

5 (5) to identify populations and locations that
6 are the most underserved by mental health profes-
7 sionals and the most in need of psychiatrists (includ-
8 ing child and adolescent psychiatrists), psychologists,
9 psychiatric nurse practitioners, clinical social work-
10 ers, and mental health, peer-support specialists.

11 (d) PRIORITIZATION OF INTEGRATION OF SERVICES,
12 EARLY DIAGNOSIS, INTERVENTION, AND WORKFORCE
13 DEVELOPMENT.—In carrying out the duties described in
14 subsection (b), the Assistant Secretary shall prioritize—

15 (1) the integration of mental health, substance
16 use, and physical health services for the purpose of
17 diagnosing, preventing, treating, or providing reha-
18 bilitation for mental illness or substance use dis-
19 orders, including any such services provided through
20 the justice system (including departments of correc-
21 tion) or other entities other than the Department of
22 Health and Human Services;

23 (2) crisis intervention for, early diagnosis and
24 intervention services for the prevention of, and treat-

1 ment and rehabilitation for, serious mental illness or
2 substance use disorders; and

3 (3) workforce development for—

4 (A) appropriate treatment of serious men-
5 tal illness or substance use disorders; and

6 (B) research activities that advance sci-
7 entific and clinical understandings of these dis-
8 orders, including the development and imple-
9 mentation of a continuing nationwide strategy
10 to increase the psychiatric workforce with psy-
11 chiatrists, child and adolescent psychiatrists,
12 psychologists, psychiatric nurse practitioners,
13 clinical social workers, and mental health peer
14 support specialists.

15 (e) REQUIREMENTS AND RESTRICTIONS ON AUTHOR-
16 ITY TO AWARD GRANTS.—In awarding any grant or fi-
17 nancial assistance, the Assistant Secretary, and any agen-
18 cy or official within the Office of the Assistant Secretary,
19 shall comply with the following:

20 (1) The grant or financial assistance shall be
21 for activities consisting of, or based upon, applied
22 scientific research.

23 (2) Any program to be funded shall be dem-
24 onstrated—

1 (A) in the case of an ongoing program, to
2 be effective; and

3 (B) in the case of a new program, to have
4 the prospect of being effective.

5 (3) The programs and activities to be funded
6 shall use evidence-based best practices or emerging
7 evidence-based best practices that are translational
8 and can be expanded or replicated to other States,
9 local communities, agencies, or through the Medicaid
10 program under title XIX of the Social Security Act.

11 (4) An application for the grant or financial as-
12 sistance shall include, as applicable, a scientific jus-
13 tification based on previously demonstrated models,
14 the number of individuals to be served, the popu-
15 lation to be targeted, what objective outcomes meas-
16 ures will be used, and details on how the program
17 or activity to be funded can be replicated and by
18 whom.

19 (5) Applicants shall be evaluated and selected
20 through a blind, peer-review process by expert men-
21 tal health care providers with professional experience
22 in mental health research or treatment and where
23 appropriate or necessary professional experience re-
24 lated to substance abuse and other areas of expertise

1 appropriate to the grant or other financial assist-
2 ance.

3 (6) No member of a peer-review group con-
4 ducting a blind, peer-review process, as required by
5 paragraph (5), may be related to anyone who may
6 be applying for the type of award being reviewed,
7 may be a current grant applicant, or may have a fi-
8 nancial or employment interest in selecting whom
9 to receive the award.

10 (7) Award recipients may be periodically re-
11 viewed and audited at the discretion of the Inspector
12 General of the Department of Health and Human
13 Services or the Comptroller General of the United
14 States to ensure that—

15 (A) the best scientific method for both
16 services and data collection is being followed;
17 and

18 (B) Federal funds are being used as re-
19 quired by the conditions of the award and by
20 applicable guidelines of the NMHPL.

21 (8) Award recipients that fail an audit or fail
22 to provide information pursuant to an audit shall
23 have their awards terminated.

24 (f) DEFINITIONS.—In this section:

1 (1) The term “secondary prevention” means
2 prevention that is designed to prevent a disease or
3 condition from occurring among individuals or a
4 subpopulation determined to be at risk for the dis-
5 ease or condition.

6 (2) The term “tertiary prevention” means pre-
7 vention that is designed to reduce or minimize the
8 consequences of a disease or condition among indi-
9 viduals showing symptoms of the disease or condi-
10 tion.

11 **SEC. 102. TRANSFER OF SAMHSA AUTHORITIES.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall delegate to the Assistant Secretary
14 all duties and authorities that—

15 (1) as of the day before the date of enactment
16 of this Act, were vested in the Administrator of the
17 Substance Abuse and Mental Health Services Ad-
18 ministration; and

19 (2) are not terminated by this Act.

20 (b) TRANSITION.—This section and the amendments
21 made by this section apply beginning on the day that is
22 6 months after the date of enactment of this Act. As of
23 such day, the Secretary of Health and Human Services
24 shall provide for the transfer of the personnel, assets, and
25 obligations of the Substance Abuse and Mental Health

1 Services Administration to the Office of the Assistant Sec-
2 retary.

3 (c) CONFORMING AMENDMENTS.—Title V of the
4 Public Health Service Act (42 U.S.C. 290aa et seq.) is
5 amended—

6 (1) in the title heading, by striking “**SUB-**
7 **STANCE ABUSE AND MENTAL HEALTH**
8 **SERVICES ADMINISTRATION**” and insert-
9 ing “**MENTAL HEALTH AND SUBSTANCE**
10 **USE DISORDERS**”;

11 (2) by amending section 501(a) to read as fol-
12 lows:

13 “(a) ASSISTANT SECRETARY.—The Assistant Sec-
14 retary for Mental Health and Substance Use Disorders
15 shall have the duties and authorities vested in the Assist-
16 ant Secretary by this title in addition to the duties and
17 authorities vested in the Assistant Secretary by section
18 501 of the Helping Families in Mental Health Crisis Act
19 of 2015 and other provisions of law.”;

20 (3) by amending section 501(c) to read as fol-
21 lows:

22 “(c) DEPUTY ASSISTANT SECRETARY.—The Assist-
23 ant Secretary, with the approval of the Secretary, may ap-
24 point a Deputy Assistant Secretary and may employ and
25 prescribe the functions of such officers and employees, in-

1 cluding attorneys, as are necessary to administer the ac-
2 tivities to be carried out under this title.”;

3 (4) by striking subsection (o) (relating to au-
4 thorization of appropriations);

5 (5) by striking “Administrator of the Substance
6 Abuse and Mental Health Services Administration”
7 each place it appears and inserting “Assistant Sec-
8 retary for Mental Health and Substance Use Dis-
9 orders”;

10 (6) by striking “Administrator” each place it
11 appears and inserting “Assistant Secretary”, except
12 where the term “Administrator” appears within the
13 term—

14 (A) Associate Administrator;

15 (B) Administrator of the Health Resources
16 and Services Administration;

17 (C) Administrator of the Centers for Medi-
18 care & Medicaid Services; or

19 (D) Administrator of the Office of Juvenile
20 Justice and Delinquency Prevention;

21 (7) by striking “Substance Abuse and Mental
22 Health Services Administration” each place it ap-
23 pears and inserting “Office of the Assistant Sec-
24 retary”;

1 (8) in section 502, by striking “Administration
2 or Center” each place it appears and inserting “Of-
3 fice or Center”;

4 (9) in section 502, by striking “Administra-
5 tion’s” and inserting “Office of the Assistant Sec-
6 retary’s”; and

7 (10) by striking the term “Administration”
8 each place it appears and inserting “Office of the
9 Assistant Secretary”, except in the heading of sec-
10 tion 520G(b) and where the term “Administration”
11 appears with the term—

12 (A) Health Resources and Services Admin-
13 istration; or

14 (B) National Highway Traffic Safety Ad-
15 ministration.

16 (d) REFERENCES.—After executing subsection (a),
17 subsection (b), and the amendments made by subsection
18 (c)—

19 (1) any reference in statute, regulation, or guid-
20 ance to the Administrator of the Substance Abuse
21 and Mental Health Services Administration shall be
22 construed to be a reference to the Assistant Sec-
23 retary for Mental Health and Substance Use Dis-
24 orders; and

1 (2) any reference in statute, regulation, or guid-
2 ance to the Substance Abuse and Mental Health
3 Services Administration shall be construed to be a
4 reference to the Office of the Assistant Secretary.

5 **SEC. 103. REPORTS.**

6 (a) REPORT ON INVESTIGATIONS REGARDING PAR-
7 ITY IN MENTAL HEALTH AND SUBSTANCE USE DIS-
8 ORDER BENEFITS.—

9 (1) IN GENERAL.—Not later than 180 days
10 after the enactment of this Act, and annually there-
11 after, the Administrator of the Centers for Medicare
12 & Medicaid Services, in collaboration with the As-
13 sistant Secretary of Labor of the Employee Benefits
14 Security Administration and the Secretary of the
15 Treasury, and in consultation with the Assistant
16 Secretary for Mental Health and Substance Use
17 Disorders, shall submit to the Congress a report—

18 (A) identifying Federal investigations con-
19 ducted or completed during the preceding 12-
20 month period regarding compliance with parity
21 in mental health and substance use disorder
22 benefits, including benefits provided to persons
23 with serious mental illness and substance use
24 disorders, under the Paul Wellstone and Pete
25 Domenici Mental Health Parity and Addiction

1 Equity Act of 2008 (subtitle B of title V of di-
2 vision C of Public Law 110–343); and

3 (B) summarizing the results of such inves-
4 tigations.

5 (2) CONTENTS.—Subject to paragraph (3),
6 each report under paragraph (1) shall include the
7 following information:

8 (A) The number of investigations opened
9 and closed during the covered reporting period.

10 (B) The benefit classification or classifica-
11 tions examined by each investigation.

12 (C) The subject matter or subject matters
13 of each investigation, including quantitative and
14 nonquantitative treatment limitations.

15 (D) A summary of the basis of the final
16 decision rendered for each investigation.

17 (3) LIMITATION.—Individually identifiable in-
18 formation shall be excluded from reports under
19 paragraph (1) consistent with Federal privacy pro-
20 tections.

21 (b) REPORT ON BEST PRACTICES FOR PEER-SUP-
22 PORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFI-
23 CATION.—

24 (1) IN GENERAL.—Not later than 1 year after
25 the date of enactment of this Act, and biannually

1 thereafter, the Assistant Secretary shall submit to
2 the Congress and make publicly available a report on
3 best practices and professional standards in States
4 for—

5 (A) establishing and operating health care
6 programs using peer-support specialists; and

7 (B) training and certifying peer-support
8 specialists.

9 (2) PEER-SUPPORT SPECIALIST DEFINED.—In
10 this subsection, the term “peer-support specialist”
11 means an individual who—

12 (A) uses his or her lived experience of re-
13 covery from mental illness or substance abuse,
14 plus skills learned in formal training, to facili-
15 tate support groups, and to work on a one-on-
16 one basis, with individuals with a serious men-
17 tal illness or a substance use disorder, in con-
18 sultation with and under the supervision of a li-
19 censed mental health or substance use treat-
20 ment professional;

21 (B) has been an active participant in men-
22 tal health or substance use treatment for at
23 least the preceding 2 years;

24 (C) does not provide direct medical serv-
25 ices; and

1 (D) does not perform services outside of
2 his or her area of training, expertise, com-
3 petence, or scope of practice.

4 (3) CONTENTS.—Each report under this sub-
5 section shall include information on best practices
6 and standards with regard to the following:

7 (A) Hours of formal work or volunteer ex-
8 perience related to mental health and substance
9 use issues.

10 (B) Types of peer specialist exams re-
11 quired.

12 (C) Code of ethics.

13 (D) Additional training required prior to
14 certification, including in areas such as—

15 (i) psychopharmacology;

16 (ii) integrating physical medicine and
17 mental health supportive services;

18 (iii) ethics;

19 (iv) scope of practice;

20 (v) crisis intervention;

21 (vi) identification and treatment of
22 mental health disorders;

23 (vii) State confidentiality laws;

1 (viii) Federal privacy protections, in-
2 cluding under the Health Insurance Port-
3 ability and Accountability Act of 1996; and

4 (ix) other areas as determined by the
5 Assistant Secretary.

6 (E) Requirements to explain what, where,
7 when, and how to accurately complete all re-
8 quired documentation activities.

9 (F) Required or recommended skill sets,
10 including—

11 (i) identifying consumer risk indica-
12 tors, including individual stressors, trig-
13 gers, and indicators of escalating symp-
14 toms;

15 (ii) explaining basic de-escalation
16 techniques;

17 (iii) explaining basic suicide preven-
18 tion concepts and techniques;

19 (iv) identifying indicators that the
20 consumer may be experiencing abuse or ne-
21 glect;

22 (v) identifying and responding appro-
23 priately to personal stressors, triggers, and
24 indicators;

1 (vi) identifying the consumer's current
2 stage of change or recovery;

3 (vii) explaining the typical process
4 that should be followed to access or partici-
5 pate in community mental health and re-
6 lated services; and

7 (viii) identifying circumstances when
8 it is appropriate to request assistance from
9 other professionals to help meet the con-
10 sumer's recovery goals.

11 (G) Requirements for continuing education
12 credits annually.

13 (c) REPORT ON THE STATE OF THE STATES IN MEN-
14 TAL HEALTH AND SUBSTANCE USE TREATMENT.—

15 (1) IN GENERAL.—Not later than 1 year after
16 the date of enactment of this Act, and not less than
17 every 2 years thereafter, the Assistant Secretary
18 shall submit to the Congress and make available to
19 the public a report on the state of the States in
20 mental health and substance use treatment, includ-
21 ing the following:

22 (A) A detailed report on how Federal men-
23 tal health and substance use treatment funds
24 are used in each State including:

1 (i) The numbers of individuals with
2 serious mental illness or substance use dis-
3 orders who are served with Federal funds.

4 (ii) The types of programs made avail-
5 able to individuals with serious mental ill-
6 ness or substance use disorders.

7 (B) A summary of best practice models in
8 the States highlighting programs that are cost
9 effective, provide evidence-based care, increase
10 access to care, integrate physical, psychiatric,
11 psychological, and behavioral medicine, and im-
12 prove outcomes for individuals with mental ill-
13 ness or substance use disorders.

14 (C) A statistical report of outcome meas-
15 ures in each State, including—

16 (i) rates of suicide, suicide attempts,
17 substance abuse, overdose, overdose
18 deaths, emergency psychiatric hospitaliza-
19 tions, and emergency room boarding; and

20 (ii) for those with mental illness, ar-
21 rests, incarcerations, victimization, home-
22 lessness, joblessness, employment, and en-
23 rollment in educational or vocational pro-
24 grams.

- 1 (D) Outcome measures on State-assisted
2 outpatient treatment programs, including—
- 3 (i) rates of keeping treatment ap-
4 pointments and compliance with prescribed
5 medications;
 - 6 (ii) participants' perceived effective-
7 ness of the program;
 - 8 (iii) rates of the programs helping
9 those with serious mental illness gain con-
10 trol over their lives;
 - 11 (iv) alcohol and drug abuse rates;
 - 12 (v) incarceration and arrest rates;
 - 13 (vi) violence against persons or prop-
14 erty;
 - 15 (vii) homelessness; and
 - 16 (viii) total treatment costs for compli-
17 ance with the program.

18 (E) STATE AND COUNTIES WITH ASSISTED
19 OUTPATIENT TREATMENT PROGRAMS.—For
20 States and counties with assisted outpatient
21 treatment programs, the information reported
22 under this subsection shall include a compari-
23 son of the outcomes of individuals with serious
24 mental illness who participated in the programs
25 versus the outcomes of individuals who did not

1 participate but were eligible to do so by nature
2 of their history.

3 (F) STATES AND COUNTIES WITHOUT AOT
4 PROGRAMS.—For States and counties without
5 assisted outpatient treatment programs, the in-
6 formation reported under this subsection shall
7 include data on individuals with mental illness
8 who—

9 (i) have a history of violence, incarcer-
10 ation, and arrests;

11 (ii) have a history of emergency psy-
12 chiatric hospitalizations;

13 (iii) are substantially unlikely to par-
14 ticipate in treatment on their own;

15 (iv) may be unable for reasons other
16 than indigence, to provide for any of their
17 basic needs such as food, clothing, shelter,
18 health or safety;

19 (v) have a history of mental illness or
20 condition that is likely to substantially de-
21 teriorate if the individual is not provided
22 with timely treatment; and

23 (vi) due to their mental illness, have a
24 lack of capacity to fully understand or lack
25 judgment, or diminished capacity to make

1 informed decisions, regarding their need
2 for treatment, care, or supervision.

3 (2) DEFINITION.—In this subsection, the term
4 “emergency room boarding” means the practice of
5 admitting patients to an emergency department and
6 holding them in the department until inpatient psy-
7 chiatric beds become available.

8 (d) REPORTING COMPLIANCE STUDY.—

9 (1) IN GENERAL.—The Assistant Secretary for
10 Mental Health and Substance Use Disorders shall
11 enter into an arrangement with the Institute of
12 Medicine of the National Academies (or, if the Insti-
13 tute declines, another appropriate entity) under
14 which, not later than 12 months after the date of
15 enactment of this Act, the Institute will submit to
16 the appropriate committees of Congress a report
17 that evaluates the combined paperwork burden of—

18 (A) community mental health centers
19 meeting the criteria specified in section 1913(c)
20 of the Public Health Service Act (42 U.S.C.
21 300x–2), including such centers meeting such
22 criteria as in effect on the day before the date
23 of enactment of this Act; and

24 (B) federally qualified community mental
25 health clinics certified pursuant to section 223

1 of the Protecting Access to Medicare Act of
2 2014 (Public Law 113–93), as amended by sec-
3 tion 505.

4 (2) SCOPE.—In preparing the report under sub-
5 section (a), the Institute of Medicine (or, if applica-
6 ble, other appropriate entity) shall examine licens-
7 ing, certification, service definitions, claims payment,
8 billing codes, and financial auditing requirements
9 used by the Office of Management and Budget, the
10 Centers for Medicare & Medicaid Services, the
11 Health Resources and Services Administration, the
12 Substance Abuse and Mental Health Services Ad-
13 ministration, the Office of the Inspector General of
14 the Department of Health and Human Services,
15 State Medicaid agencies, State departments of
16 health, State departments of education, and State
17 and local juvenile justice and social service agencies
18 to—

19 (A) establish an estimate of the combined
20 nationwide cost of complying with such require-
21 ments, in terms of both administrative funding
22 and staff time;

23 (B) establish an estimate of the per capita
24 cost to each center or clinic described in sub-
25 paragraph (A) or (B) of paragraph (1) to com-

1 ply with such requirements, in terms of both
2 administrative funding and staff time; and

3 (C) make administrative and statutory rec-
4 ommendations to Congress (which recommenda-
5 tions may include a uniform methodology) to
6 reduce the paperwork burden experienced by
7 centers and clinics described in subparagraph
8 (A) or (B) of paragraph (1).

9 **SEC. 104. ADVISORY COUNCIL ON GRADUATE MEDICAL**
10 **EDUCATION.**

11 Section 762(b) of the Public Health Service Act (42
12 U.S.C. 294o(b)) is amended—

13 (1) by redesignating paragraphs (4) through
14 (6) as paragraphs (5) through (7), respectively; and

15 (2) by inserting after paragraph (3) the fol-
16 lowing:

17 “(4) the Assistant Secretary for Mental Health
18 and Substance Use Disorders;”.

19 **TITLE II—GRANT REFORM AND**
20 **RESTRUCTURING**

21 **SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORA-**
22 **TORY.**

23 (a) IN GENERAL.—

24 (1) ESTABLISHMENT.—The Assistant Secretary
25 for Mental Health and Substance Use Disorders

1 shall establish, within the Office of the Assistant
2 Secretary, the National Mental Health Policy Lab-
3 oratory (in this section referred to as the
4 “NMHPL”), to be headed by a Director.

5 (2) DUTIES.—The Director of the NMHPL
6 shall—

7 (A) identify, coordinate, and implement
8 policy changes and other trends likely to have
9 the most significant impact on mental health
10 services and monitor their impact;

11 (B) collect information from grantees
12 under programs established or amended by this
13 Act and under other mental health programs
14 under the Public Health Service Act, including
15 grantees that are States receiving funds under
16 a block grant under part B of title XIX of the
17 Public Health Service Act (42 U.S.C. 300x et
18 seq.);

19 (C) evaluate and disseminate to such
20 grantees evidence-based practices and services
21 delivery models using the best available science
22 shown to be cost-effective while enhancing the
23 quality of care furnished to individuals;

1 (D) establish standards for the appoint-
2 ment of scientific peer-review panels to evaluate
3 grant applications; and

4 (E) establish standards for grant programs
5 under subsection (b).

6 (3) EVIDENCE-BASED PRACTICES AND SERVICE
7 DELIVERY MODELS.—In selecting evidence-based
8 best practices and service delivery models for evalua-
9 tion and dissemination under paragraph (2)(C), the
10 Director of the NMHPL—

11 (A) shall give preference to models that
12 improve—

13 (i) the coordination between mental
14 health and physical health providers;

15 (ii) the coordination among such pro-
16 viders and the justice and corrections sys-
17 tem; and

18 (iii) the cost effectiveness, quality, ef-
19 fectiveness, and efficiency of health care
20 services furnished to individuals with seri-
21 ous mental illness, in mental health crisis,
22 or at risk to themselves, their families, and
23 the general public; and

24 (B) may include clinical protocols and
25 practices used in the Recovery After Initial

1 Schizophrenia Episode (RAISE) project and the
2 North American Prodrome Longitudinal Study
3 (NAPLS) of the National Institute of Mental
4 Health.

5 (4) DEADLINE FOR BEGINNING IMPLEMENTA-
6 TION.—The Director of the NMHPL shall begin im-
7 plementation of the duties described in this sub-
8 section not later than January 1, 2018.

9 (5) CONSULTATION.—In carrying out the duties
10 under this subsection, the Director of the NMHPL
11 shall consult with—

12 (A) representatives of the National Insti-
13 tute of Mental Health on organization, hiring
14 decisions, and operations, initially and on an
15 ongoing basis;

16 (B) other appropriate Federal agencies;

17 (C) clinical and analytical experts with ex-
18 pertise in medicine, psychiatric and clinical psy-
19 chological care, health care management, edu-
20 cation, corrections health care, and mental
21 health court systems; and

22 (D) other individuals and agencies as de-
23 termined appropriate by the Assistant Sec-
24 retary.

25 (b) STANDARDS FOR GRANT PROGRAMS.—

1 (1) IN GENERAL.—The Director of the
2 NMHPL shall set standards for grant programs ad-
3 ministered by the Assistant Secretary, and the As-
4 sistant Secretary shall comply with such standards,
5 including standards for—

6 (A) the extent to which the grantee must
7 have the capacity to implement the award;

8 (B) the extent to which the grant plan sub-
9 mitted by the grantee as part of its application
10 must explain how the grantee will help to pro-
11 vide comprehensive community mental health or
12 substance use services to adults with serious
13 mental illness and children with serious emo-
14 tional disturbances;

15 (C) the extent to which the grantee must
16 identify priorities, as well as strategies and per-
17 formance indicators to address those priorities
18 for the duration of the grant;

19 (D) the extent to which the grantee must
20 submit statements on the extent to which the
21 grantee is meeting annual program priorities
22 with quantifiable, objective, and scientific tar-
23 gets, measures, and outcomes;

24 (E) the extent to which grantees are ex-
25 pected to collaborate with other child-serving

1 systems such as child welfare, education, juve-
2 nile justice, and primary care systems;

3 (F) the extent to which the grantee must
4 collect and report data;

5 (G) the extent to which the grantee must
6 use evidence-based practices and the extent to
7 which those evidence-based practices must be
8 used with respect to a population similar to the
9 population for which the evidence-based prac-
10 tices were shown to be effective; and

11 (H) the extent to which a grantee, when
12 possible, must have a control group.

13 (2) PUBLIC DISCLOSURE OF RESULTS.—The
14 Director of the NMHPL—

15 (A) shall make the standards under para-
16 graph (1), and the Director’s findings on com-
17 pliance by the Assistant Secretary and grantees
18 with such standards, available to the public in
19 a timely fashion; and

20 (B) may establish requirements for States
21 and other entities receiving funds through
22 grants under programs established or amended
23 by this Act and under other mental health pro-
24 grams under the Public Health Service Act, in-
25 cluding under a block grant under part B of

1 title XIX of the Public Health Service Act (42
2 U.S.C. 300x et seq.), to collect information on
3 evidence-based best practices and services deliv-
4 ery models selected under section 101(c)(2), as
5 the Assistant Secretary determines necessary to
6 monitor and evaluate such models.

7 (c) STAFFING.—

8 (1) COMPOSITION.—In selecting the staff of the
9 NMHPL, the Director of the NMHPL, in consulta-
10 tion with the Director of the National Institute of
11 Mental Health, shall ensure the following:

12 (A) At least 20 percent of the staff shall—

13 (i) have a doctoral degree in medicine
14 or osteopathic medicine and clinical and re-
15 search experience in psychiatry;

16 (ii) have graduated from an Accredi-
17 tation Council for Graduate Medical Edu-
18 cation-accredited psychiatric residency pro-
19 gram; and

20 (iii) have an understanding of biologi-
21 cal, psychosocial, and pharmaceutical
22 treatments of mental illness and substance
23 use disorders.

24 (B) At least 20 percent of the staff shall
25 have a doctoral degree in psychology with—

1 (i) clinical and research experience re-
2 garding mental illness and substance use
3 disorders; and

4 (ii) an understanding of biological,
5 psychosocial, and pharmaceutical treat-
6 ments of mental illness and substance use
7 disorders.

8 (C) At least 20 percent of the staff shall
9 be professionals or academics with clinical or
10 research expertise in substance use disorders
11 and treatment.

12 (D) At least 20 percent of the staff shall
13 be professionals or academics with expertise in
14 research design and methodologies.

15 (2) CONGRESSIONAL APPOINTMENTS.—At least
16 20 percent, or two, whichever is greater, of the
17 members of the staff of the NMHPL shall be ap-
18 pointed by Congress.

19 (d) REPORT ON QUALITY OF CARE.—Not later than
20 1 year after the date of enactment of this Act, and every
21 2 years thereafter, the Director of the NMHPL shall sub-
22 mit to the Congress a report on the quality of care fur-
23 nished through grant programs administered by the As-
24 sistant Secretary under the respective services delivery

1 models, including measurement of patient-level outcomes
2 and public health outcomes such as—

3 (1) reduced rates of suicide, suicide attempts,
4 substance abuse, overdose, overdose deaths, emer-
5 gency psychiatric hospitalizations, emergency room
6 boarding, incarceration, crime, arrest, victimization,
7 homelessness, and joblessness;

8 (2) rates of employment and enrollment in edu-
9 cational and vocational programs; and

10 (3) such other criteria as the Director may de-
11 termine.

12 (e) DEFINITION.—In this section, the term “emer-
13 gency room boarding” means the practice of admitting pa-
14 tients to an emergency department and holding them in
15 the department until inpatient psychiatric beds become
16 available.

17 **SEC. 202. INNOVATION GRANTS.**

18 (a) IN GENERAL.—The Assistant Secretary shall
19 award grants to State and local governments, educational
20 institutions, and nonprofit organizations for expanding a
21 model that has been scientifically demonstrated to show
22 promise, but would benefit from further applied research,
23 for—

1 (1) enhancing the screening, diagnosis, and
2 treatment of mental illness and serious mental ill-
3 ness; or

4 (2) integrating or coordinating physical, mental
5 health, and substance use services.

6 (b) DURATION.—A grant under this section shall be
7 for a period of not more than 2 years.

8 (c) LIMITATIONS.—Of the amounts made available
9 for carrying out this section for a fiscal year—

10 (1) not more than one-third shall be awarded
11 for use for primary prevention; and

12 (2) not less than one-third shall be awarded for
13 screening, diagnosis, treatment, or services, as de-
14 scribed in subsection (a), for individuals (or sub-
15 populations of individuals) who are below the age of
16 18 when activities funded through the grant award
17 are initiated.

18 (d) GUIDELINES.—As a condition on receipt of an
19 award under this section, an applicant shall agree to ad-
20 here to guidelines issued by the National Mental Health
21 Policy Laboratory on research designs and data collection.

22 (e) TERMINATION.—The Assistant Secretary may
23 terminate any award under this section upon a determina-
24 tion that—

1 (1) the recipient is not providing information
2 requested by the National Mental Health Policy
3 Laboratory or the Assistant Secretary in connection
4 with the award; or

5 (2) there is a clear failure in the effectiveness
6 of the recipient's programs or activities funded
7 through the award.

8 (f) REPORTING.—As a condition on receipt of an
9 award under this section, an applicant shall agree—

10 (1) to report to the National Mental Health
11 Policy Laboratory and the Assistant Secretary the
12 results of programs and activities funded through
13 the award; and

14 (2) to include in such reporting any relevant
15 data requested by the National Mental Health Policy
16 Laboratory and the Assistant Secretary.

17 (g) DEFINITION.—In this section, the term “primary
18 prevention” means prevention that is designed to prevent
19 a disease or condition from occurring among the general
20 population without regard to identifying the presence of
21 risk factors or symptoms in the population.

22 (h) FUNDING.—Of the amounts made available to
23 carry out sections 501, 509, 516, and 520A of the Public
24 Health Service Act for a fiscal year, 5 percent of such

1 amounts are authorized to be used to carry out this sec-
2 tion.

3 **SEC. 203. DEMONSTRATION GRANTS.**

4 (a) GRANTS.—The Assistant Secretary shall award
5 grants to States, counties, local governments, educational
6 institutions, and private nonprofit organizations for the
7 expansion, replication, or scaling of evidence-based pro-
8 grams across a wider area to enhance effective screening,
9 early diagnosis, intervention, and treatment with respect
10 to mental illness and serious mental illness, primarily by—

11 (1) applied delivery of care, including training
12 staff in effective evidence-based treatment; and

13 (2) integrating models of care across specialties
14 and jurisdictions.

15 (b) DURATION.—A grant under this section shall be
16 for a period of not less than 2 years and not more than
17 5 years.

18 (c) LIMITATIONS.—Of the amounts made available
19 for carrying out this section for a fiscal year—

20 (1) not less than half shall be awarded for
21 screening, diagnosis, intervention, and treatment, as
22 described in subsection (a), for individuals (or sub-
23 populations of individuals) who are below the age of
24 26 when activities funded through the grant award
25 are initiated;

1 (2) no amounts shall be made available for any
2 program or project that is not evidence-based;

3 (3) no amounts shall be made available for pri-
4 mary prevention; and

5 (4) no amounts shall be made available solely
6 for the purpose of expanding facilities or increasing
7 staff at an existing program.

8 (d) GUIDELINES.—As a condition on receipt of an
9 award under this section, an applicant shall agree to ad-
10 here to guidelines issued by the National Mental Health
11 Policy Laboratory on research designs and data collection.

12 (e) TERMINATION.—The Assistant Secretary may
13 terminate any award under this section upon a determina-
14 tion that—

15 (1) the recipient is not providing information
16 requested by the National Mental Health Policy
17 Laboratory or the Assistant Secretary in connection
18 with the award; or

19 (2) there is a clear failure in the effectiveness
20 of the recipient's programs or activities funded
21 through the award.

22 (f) REPORTING.—As a condition on receipt of an
23 award under this section, an applicant shall agree—

24 (1) to report to the National Mental Health
25 Policy Laboratory and the Assistant Secretary the

1 results of programs and activities funded through
2 the award; and

3 (2) to include in such reporting any relevant
4 data requested by the National Mental Health Policy
5 Laboratory and the Assistant Secretary.

6 (g) FUNDING.—Of the amounts made available to
7 carry out sections 501, 509, 516, and 520A of the Public
8 Health Service Act for a fiscal year, 10 percent of such
9 amounts are authorized to be used to carry out this sec-
10 tion.

11 **SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREAT-**
12 **MENT.**

13 (a) GRANTS.—The Director of the National Mental
14 Health Policy Laboratory (in this section referred to as
15 the “NMHPL”) shall award—

16 (1) grants to eligible entities to initiate and un-
17 dertake, for eligible children, early childhood inter-
18 vention and treatment programs, and specialized
19 preschool and elementary school programs, with the
20 goal of preventing chronic and serious mental illness;

21 (2) grants to not more than 3 eligible entities
22 for studying the longitudinal outcomes of programs
23 funded under paragraph (1) on eligible children who
24 were treated 5 or more years prior to the enactment
25 of this Act; and

1 (3) ensure that programs and activities funded
2 through grants under this subsection are based on
3 a sound scientific model that shows evidence and
4 promise and can be replicated in other settings.

5 (b) ELIGIBLE ENTITIES AND CHILDREN.—In this
6 section:

7 (1) ELIGIBLE ENTITY.—The term “eligible enti-
8 ty” means a nonprofit institution that—

9 (A) is duly accredited by State mental
10 health and education agencies, as applicable, for
11 the treatment and education of children from 1
12 to 10 years of age; and

13 (B) provides services that include early
14 childhood intervention and specialized preschool
15 and elementary school programs focused on
16 children whose primary need is a social or emo-
17 tional disability (in addition to any learning dis-
18 ability).

19 (2) ELIGIBLE CHILD.—The term “eligible
20 child” means a child who is at least 0 years old and
21 not more than 12 years old—

22 (A) whose primary need is a social and
23 emotional disability (in addition to any learning
24 disability);

1 (B) who is at risk of developing serious
2 mental illness and/or may show early signs of
3 mental illness; and

4 (C) who could benefit from early childhood
5 intervention and specialized preschool or ele-
6 mentary school programs with the goal of pre-
7 venting or treating chronic and serious mental
8 illness.

9 (c) APPLICATION.—An eligible entity seeking a grant
10 under subsection (a) shall submit to the Secretary an ap-
11 plication at such time, in such manner, and containing
12 such information as the Secretary may require.

13 (d) USE OF FUNDS FOR EARLY CHILDHOOD INTER-
14 VENTION AND TREATMENT PROGRAMS.—An eligible enti-
15 ty shall use amounts awarded under a grant under sub-
16 section (a)(1) to carry out the following activities:

17 (1) Deliver (or facilitate) for eligible children
18 treatment and education, early childhood interven-
19 tion, and specialized preschool and elementary school
20 programs, including the provision of medically based
21 child care and early education services.

22 (2) Treat and educate eligible children, includ-
23 ing startup, curricula development, operating and
24 capital needs, staff and equipment, assessment and
25 intervention services, administration and medication

1 requirements, enrollment costs, collaboration with
2 primary care physicians and psychiatrists, other re-
3 lated services to meet emergency needs of children,
4 and communication with families and medical pro-
5 fessionals concerning the children.

6 (3) Develop and implement other strategies to
7 address identified treatment and educational needs
8 of eligible children that have reliable and valid eval-
9 uation modalities built into assess outcomes based
10 on sound scientific metrics as determined by the
11 NMHPL.

12 (e) USE OF FUNDS FOR LONGITUDINAL STUDY.—In
13 conducting a study on longitudinal outcomes through a
14 grant under subsection (a)(2), an eligible entity shall in-
15 clude an analysis of—

16 (1) the individuals treated and educated;

17 (2) the success of such treatment and education
18 in avoiding the onset of serious mental illness or the
19 preparation of such children for the care and man-
20 agement of serious mental illness;

21 (3) any evidence-based best practices generally
22 applicable as a result of such treatment and edu-
23 cational techniques used with such children; and

24 (4) the ability of programs to be replicated as
25 a best practice model of intervention.

1 (f) REQUIREMENTS.—In carrying out this section,
2 the Secretary shall ensure that each entity receiving a
3 grant under subsection (a) maintains a written agreement
4 with the Secretary, and provides regular written reports,
5 as required by the Secretary, regarding the quality, effi-
6 ciency, and effectiveness of intervention and treatment for
7 eligible children preventing or treating the development
8 and onset of serious mental illness.

9 (g) AMOUNT OF AWARDS.—

10 (1) AMOUNTS FOR EARLY CHILDHOOD INTER-
11 VENTION AND TREATMENT PROGRAMS.—The
12 amount of an award to an eligible entity under sub-
13 section (a)(1) shall be not more than \$600,000 per
14 fiscal year.

15 (2) AMOUNTS FOR LONGITUDINAL STUDY.—
16 The total amount of an award to an eligible entity
17 under subsection (a)(2) (for one or more fiscal
18 years) shall be not less than \$1,000,000 and not
19 greater than \$2,000,000.

20 (h) PROJECT TERMS.—The period of a grant—

21 (1) for awards under subsection (a)(1), shall be
22 not less than 3 fiscal years and not more than 10
23 fiscal years; and

24 (2) for awards under subsection (a)(2), shall be
25 not more than 5 fiscal years.

1 (i) MATCHING FUNDS.—The Director of the
2 NMHPL may not award a grant under this section to an
3 eligible entity unless the eligible entity agrees, with respect
4 to the costs to be incurred by the eligible entity in carrying
5 out the activities described in subparagraph (D), to make
6 available non-Federal contributions (in cash or in kind)
7 toward such costs in an amount equal to not less than
8 10 percent of Federal funds provided in the grant.

9 (j) DEFINITIONS.—In this section:

10 (1) The term “emergency room boarding”
11 means the practice of admitting patients to an emer-
12 gency department and holding them in the depart-
13 ment until inpatient psychiatric beds become avail-
14 able.

15 (2) The term “primary prevention” means pre-
16 vention that is designed to prevent a disease or con-
17 dition from occurring among the general population
18 without regard to identifying the presence of risk
19 factors or symptoms in the population.

20 (k) FUNDING.—Of the amounts made available to
21 carry out part E of title V of the Public Health Service
22 Act (42 U.S.C. 290ff et seq.) for each of fiscal years 2016
23 through 2021, not more than 5 percent of such amounts
24 are authorized to be appropriated to carry out this section.

1 **SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREAT-**
2 **MENT GRANT PROGRAM FOR INDIVIDUALS**
3 **WITH SERIOUS MENTAL ILLNESS.**

4 Section 224 of the Protecting Access to Medicare Act
5 of 2014 (42 U.S.C. 290aa note) is amended—

6 (1) in subsection (e), by striking “and 2018”
7 and inserting “2018, 2019, and 2020”; and

8 (2) in subsection (g)—

9 (A) in paragraph (1), by striking “2018”
10 and inserting “2020”;

11 (B) in paragraph (2)—

12 (i) by striking “\$15,000,000” and in-
13 serting “\$20,000,000”; and

14 (ii) by striking “2018” and inserting
15 “2020”; and

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

17 “(3) ALLOCATION.—Of the funds made avail-
18 able to carry out this section for a fiscal year, the
19 Secretary shall allocate—

20 “(A) 20 percent of such funds for existing
21 assisted outpatient treatment programs; and

22 “(B) 80 percent of such funds for new as-
23 sisted outpatient treatment programs.”.

1 **SEC. 206. BLOCK GRANTS.**

2 (a) BEST PRACTICES IN CLINICAL CARE MODELS.—
3 Section 1920 of the Public Health Service Act (42 U.S.C.
4 300x–9) is amended by adding at the end the following:

5 “(c) BEST PRACTICES IN CLINICAL CARE MOD-
6 ELS.—The Secretary, acting through the Director of the
7 National Institute of Mental Health, shall obligate 5 per-
8 cent of the amounts appropriated for a fiscal year under
9 subsection (a) for translating evidence-based (as defined
10 in section 2 of the Helping Families in Mental Health Cri-
11 sis Act of 2015) interventions and best available science
12 into systems of care, such as through models including—

13 “(1) the Recovery After an Initial Schizo-
14 phrenia Episode research project of the National In-
15 stitute of Mental Health; and

16 “(2) the North American Prodrome Longitu-
17 dinal Study.”.

18 (b) ADMINISTRATION OF BLOCK GRANTS BY ASSIST-
19 ANT SECRETARY.—Section 1911(a) of the Public Health
20 Service Act (42 U.S.C. 300x) is amended by striking “act-
21 ing through the Director of the Center for Mental Health
22 Services” and inserting “acting through the Assistant Sec-
23 retary for Mental Health and Substance Use Disorders”.

24 (c) ADDITIONAL PROGRAM REQUIREMENTS.—

1 (1) INTEGRATED SERVICES.—Subsection (b)(1)
2 of section 1912 of the Public Health Service Act (42
3 U.S.C. 300x-1(b)(1)) is amended—

4 (A) by striking “The plan provides” and
5 inserting:

6 “(A) The plan provides”;

7 (B) in the subparagraph (A) inserted by
8 paragraph (1), in the second sentence, by strik-
9 ing “health and mental health services” and in-
10 sserting “integrated physical and mental health
11 services”;

12 (C) in such subparagraph (A), by striking
13 “The plan shall include” through the period at
14 the end and inserting “The plan shall integrate
15 and coordinate services to maximize the effi-
16 ciency, effectiveness, quality, coordination, and
17 cost effectiveness of those services and pro-
18 grams to produce the best possible outcomes for
19 those with serious mental illness.”; and

20 (D) by adding at the end the following new
21 subparagraph:

22 “(B) The plan shall include a separate de-
23 scription of case management services and pro-
24 vide for activities leading to reduction of rates
25 of suicides, suicide attempts, substance abuse,

1 overdose deaths, emergency hospitalizations, in-
2 carceration, crimes, arrest, victimization, home-
3 lessness, joblessness, medication nonadherence,
4 and education and vocational programs drop
5 outs. The plan must also include a detailed list
6 of services available for eligible patients (as de-
7 fined in subsection (d)(3)) in each county or
8 county equivalent, including assisted outpatient
9 treatment.”.

10 (2) DATA COLLECTION SYSTEM.—Subsection
11 (b)(2) of section 1912 of the Public Health Service
12 Act (42 U.S.C. 300x-1(b)(2)) is amended—

13 (A) by striking “The plan contains an esti-
14 mate of” and inserting the following: “The plan
15 contains—

16 “(A) an estimate of”;

17 (B) in subparagraph (A), as inserted by
18 paragraph (1), by inserting “, including reduc-
19 tions in homelessness, emergency hospitaliza-
20 tion, incarceration, and unemployment for eligi-
21 ble patients (as defined in subsection (d)(3)),”
22 after “targets”;

23 (C) in such subparagraph, by striking the
24 period at the end and inserting “; and”; and

1 (D) by adding at the end the following new
2 subparagraph:

3 “(B) an agreement by the State to report
4 to the National Mental Health Policy Labora-
5 tory such data as may be required by the Sec-
6 retary concerning—

7 “(i) comprehensive community mental
8 health services in the State; and

9 “(ii) public health outcomes for per-
10 sons with serious mental illness in the
11 State, including rates of suicides, suicide
12 attempts, substance abuse, overdose
13 deaths, emergency hospitalizations, incar-
14 ceration, crimes, arrest, victimization,
15 homelessness, joblessness, medication non-
16 adherence, and education and vocational
17 programs drop outs.”.

18 (3) IMPLEMENTATION OF PLAN.—Subsection
19 (d) of section 1912 of the Public Health Service Act
20 (42 U.S.C. 300x–1(d)) is amended—

21 (A) in paragraph (1)—

22 (i) by striking “Except as provided”
23 and inserting:

24 “(A) Except as provided”; and

1 (ii) by adding at the end the following
2 new subparagraph:

3 “(B) For eligible patients receiving treat-
4 ment through funds awarded under a grant
5 under section 1911, a State shall include in the
6 State plan for the first year beginning after the
7 date of the enactment of this subparagraph and
8 each subsequent year, a de-individualized re-
9 port, containing information that is open source
10 and de-identified, on the services provided to
11 those individuals, including—

12 “(i) outcomes and the overall cost of
13 such treatment provided; and

14 “(ii) county or county equivalent level
15 data on such patient population, including
16 overall costs and raw number data on rates
17 of involuntary inpatient and outpatient
18 commitment orders, suicides, suicide at-
19 tempts, substance abuse, overdose deaths,
20 emergency hospitalizations, incarceration,
21 crimes, arrest, victimization, homelessness,
22 joblessness, medication non-adherence, and
23 education and vocational programs drop
24 outs.”; and

1 (B) by adding at the end the following new
2 paragraph:

3 “(3) DEFINITION.—In this subsection, the term
4 ‘eligible patient’ means an adult mentally ill person
5 who—

6 “(A) may have a history of violence, incar-
7 ceration, or medically unnecessary hospitaliza-
8 tions;

9 “(B) without supervision and treatment,
10 may be a danger to self or others in the com-
11 munity;

12 “(C) is substantially unlikely to voluntarily
13 participate in treatment;

14 “(D) may be unable, for reasons other
15 than indigence, to provide for any of the basic
16 needs of such person, such as food, clothing,
17 shelter, health, or safety;

18 “(E) with a history of mental illness or
19 condition that is likely to substantially deterio-
20 rate if the person is not provided with timely
21 treatment;

22 “(F) due to mental illness, lacks capacity
23 to fully understand or lacks judgment to make
24 informed decisions regarding his or her need for
25 treatment, care, or supervision; and

1 “(G) is likely to improve in mental health
2 and reduce the symptoms of serious mental ill-
3 ness when in treatment.”.

4 (4) TREATMENT UNDER STATE LAW.—

5 (A) IN GENERAL.—Section 1912 of the
6 Public Health Service Act (42 U.S.C. 300x-1)
7 is amended by adding at the end the following
8 new subsections:

9 “(e) ASSISTED OUTPATIENT TREATMENT UNDER
10 STATE LAW.—

11 “(1) IN GENERAL.—A funding agreement for a
12 grant under section 1911 is that the State involved
13 has in effect a law under which a State court may
14 order a treatment plan for an eligible patient that—

15 “(A) requires such patient to obtain out-
16 patient mental health treatment while the pa-
17 tient is living in a community; and

18 “(B) is designed to improve access and ad-
19 herence by such patient to intensive behavioral
20 health services in order to—

21 “(i) avert relapse, repeated hos-
22 pitalizations, arrest, incarceration, suicide,
23 property destruction, and violent behavior;
24 and

1 “(ii) provide such patient with the op-
2 portunity to live in a less restrictive alter-
3 native to incarceration or involuntary hos-
4 pitalization.

5 “(2) CERTIFICATION OF STATE COMPLIANCE.—
6 A funding agreement described in paragraph (1) is
7 effective only if the Assistant Secretary for Mental
8 Health and Substance Use Disorders reviews the
9 State law and certifies that it satisfies the criteria
10 specified in such paragraph.

11 “(f) TREATMENT STANDARD UNDER STATE LAW.—

12 “(1) IN GENERAL.—A funding agreement for a
13 grant under section 1911 is that—

14 “(A) the State involved has in effect a law
15 under which, if a State court finds by clear and
16 convincing evidence that an individual, as a re-
17 sult of mental illness, is a danger to self, is a
18 danger to others, is persistently or acutely dis-
19 abled, or is gravely disabled and in need of
20 treatment, and is either unwilling or unable to
21 accept voluntary treatment, the court must
22 order the individual to undergo inpatient or
23 outpatient treatment; or

24 “(B) the State involved has in effect a law
25 under which a State court must order an indi-

1 vidual with a mental illness to undergo inpa-
2 tient or outpatient treatment, the law was in ef-
3 fect on the date of enactment of the Helping
4 Families in Mental Health Crisis Act of 2015,
5 and the Secretary finds that the law requires a
6 State court to order such treatment across all
7 or a sufficient range of the type of cir-
8 cumstances described in subparagraph (A).

9 “(2) DEFINITION.—For purposes of paragraph
10 (1), the term ‘persistently or acutely disabled’ refers
11 to a serious mental illness that meets all the fol-
12 lowing criteria:

13 “(A) If not treated, the illness has a sub-
14 stantial probability of causing the individual to
15 suffer or continue to suffer severe and abnor-
16 mal mental, emotional, or physical harm that
17 significantly impairs judgment, reason, behav-
18 ior, or capacity to recognize reality.

19 “(B) The illness substantially impairs the
20 individual’s capacity to make an informed deci-
21 sion regarding treatment, and this impairment
22 causes the individual to be incapable of under-
23 standing and expressing an understanding of
24 the advantages and disadvantages of accepting
25 treatment and understanding and expressing an

1 understanding of the alternatives to the par-
2 ticular treatment offered after the advantages,
3 disadvantages, and alternatives are explained to
4 that individual.

5 “(C) The illness has a reasonable prospect
6 of being treatable by outpatient, inpatient, or
7 combined inpatient and outpatient treatment.”.

8 (B) FUNDING INCREASE.—Section 1918 of
9 the Public Health Service Act (42 U.S.C. 300x–
10 7) is amended—

11 (i) in subsection (a)(1), by striking
12 “subsection (b)” and inserting “sub-
13 sections (b) and (d)”;

14 (ii) by adding at the end the following
15 new subsection:

16 “(d) INCREASE FOR CERTAIN STATES.—With respect
17 to fiscal year 2016 and each subsequent fiscal year, in the
18 case of a State that has in effect a law described in sub-
19 section (e)(1) or subparagraph (A) or (B) of subsection
20 (f)(1), the amount of the allotment of a State under sec-
21 tion 1911 shall be for such fiscal year the amount that
22 would otherwise be determined, without application of this
23 subsection, for such State for such fiscal year, increased
24 by 2 percent.”.

1 (5) EVIDENCE-BASED SERVICES DELIVERY
2 MODELS.—Section 1912 of the Public Health Serv-
3 ice Act (42 U.S.C. 300x-1), as amended by para-
4 graph (4), is further amended by adding at the end
5 the following new subsection:

6 “(g) EXPANSION OF MODELS.—

7 “(1) IN GENERAL.—Taking into account the re-
8 sults of evaluations under section 201(a)(2)(C) of
9 the Helping Families in Mental Health Crisis Act of
10 2015, the Assistant Secretary may, by rule, as part
11 of the program of block grants under this subpart,
12 provide for expanded use across the Nation of evi-
13 dence-based service delivery models by providers
14 funded under such block grants, so long as—

15 “(A) the Assistant Secretary for Mental
16 Health and Substance Use Disorders (in this
17 subsection referred to as the ‘Assistant Sec-
18 retary’) determines that such expansion will—

19 “(i) result in more effective use of
20 funds under such block grants without re-
21 ducing the quality of care; or

22 “(ii) improve the quality of patient
23 care without significantly increasing spend-
24 ing;

1 “(B) the Director of the National Institute
2 of Mental Health determines that such expansion
3 would improve the quality of patient care;
4 and

5 “(C) the Assistant Secretary determines
6 that the change will—

7 “(i) significantly reduce severity and
8 duration of symptoms of mental illness;

9 “(ii) reduce rates of suicide, suicide
10 attempts, substance abuse, overdose, emergency
11 hospitalizations, emergency room
12 boarding, incarceration, crime, arrest, vic-
13 timization, homelessness, or joblessness; or

14 “(iii) significantly improve the quality
15 of patient care and mental health crisis
16 outcomes without significantly increasing
17 spending.

18 “(2) CONGRESSIONAL REVIEW.—Any rule pro-
19 mulgated pursuant to paragraph (1) is deemed to be
20 a major rule subject to congressional review and dis-
21 approval under chapter 8 of title 5, United States
22 Code.

23 “(3) DEFINITION.—In this subsection, the term
24 ‘emergency room boarding’ means the practice of ad-
25 mitting patients to an emergency department and

1 holding them in the department until inpatient psy-
2 chiatric beds become available.”.

3 (d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—
4 Section 1913 of the Public Health Service Act (42 U.S.C.
5 300x-2), as amended, is further amended by adding at
6 the end the following:

7 “(d) PERIOD FOR EXPENDITURE OF GRANT
8 FUNDS.—In implementing a plan submitted under section
9 1912(a), a State receiving grant funds under section 1911
10 may make such funds available to providers of services de-
11 scribed in subsection (b) for the provision of services with-
12 out fiscal year limitation.”.

13 (e) ACTIVE OUTREACH AND ENGAGEMENT.—Section
14 1915 of the Public Health Service Act (42 U.S.C. 300x-
15 4) is amended by adding at the end of the following:

16 “(c) ACTIVE OUTREACH AND ENGAGEMENT TO PER-
17 SONS WITH SERIOUS MENTAL ILLNESS.—A funding
18 agreement for a grant under section 1911 is that the State
19 involved has in effect active programs, including assisted
20 outpatient treatment, to engage persons with serious men-
21 tal illness who are substantially unlikely to voluntarily
22 seek treatment, in comprehensive services in order to avert
23 relapse, repeated hospitalizations, arrest, incarceration,
24 and suicide to provide the patient with the opportunity
25 to live in the community through evidence-based (as de-

1 fined in section 2 of the Helping Families in Mental
2 Health Crisis Act of 2015) assertive outreach and engage-
3 ment services targeting individuals that are homeless, have
4 co-occurring disorders, or have a history of treatment fail-
5 ure. The Assistant Secretary for Mental Health and Sub-
6 stance Use Disorders shall work with the Director of the
7 National Institute of Mental Health to develop a list of
8 such evidence-based (as defined in section 2 of the Helping
9 Families in Mental Health Crisis Act of 2015) assertive
10 outreach and engagement services, as well as criteria to
11 be used to assess the scope and effectiveness of such ap-
12 proaches. These programs may include assistant out-
13 patient treatment programs under State law where State
14 courts may order a treatment plan for an eligible patient
15 that requires—

16 “(1) such patient to obtain outpatient mental
17 health treatment while the patient is living in the
18 community; and

19 “(2) a design to improve access and adherence
20 by such patient to intensive mental health services.”.

21 **SEC. 207. WORKFORCE DEVELOPMENT.**

22 (a) **TELEPSYCHIATRY AND PRIMARY CARE PHYSI-**
23 **CIAN TRAINING GRANT PROGRAM.—**

24 (1) **IN GENERAL.—**The Assistant Secretary of
25 Mental Health and Substance Use Disorders (in this

1 subsection referred to as the “Assistant Secretary”)
2 shall establish a grant program (in this subsection
3 referred to as the “grant program”) under which the
4 Assistant Secretary shall award to 10 eligible States
5 (as described in paragraph (5)) grants for carrying
6 out all of the purposes described in paragraphs (2),
7 (3), and (4).

8 (2) TRAINING PROGRAM FOR CERTAIN PRIMARY
9 CARE PHYSICIANS.—For purposes of paragraph (1),
10 the purpose described in this paragraph, with re-
11 spect to a grant awarded to a State under the grant
12 program, is for the State to establish a training pro-
13 gram to train primary care physicians in—

14 (A) valid and reliable behavioral-health
15 screening tools for violence and suicide risk,
16 early signs of serious mental illness, and un-
17 treated substance abuse, including any stand-
18 ardized behavioral-health screening tools that
19 are determined appropriate by the Assistant
20 Secretary;

21 (B) implementing the use of behavioral-
22 health screening tools in their practices;

23 (C) establishment of recommended inter-
24 vention and treatment protocols for individuals
25 in mental health crisis, especially for individuals

1 whose illness makes them less receptive to men-
2 tal health services; and

3 (D) implementing the evidence-based col-
4 laborative care model of integrated medical-be-
5 havioral health care in their practices.

6 (3) PAYMENTS FOR MENTAL HEALTH SERVICES
7 PROVIDED BY CERTAIN PRIMARY CARE PHYSI-
8 CIANS.—

9 (A) IN GENERAL.—For purposes of para-
10 graph (1), the purpose described in this para-
11 graph, with respect to a grant awarded to a
12 State under the grant program, is for the State
13 to provide, in accordance with this paragraph,
14 in the case of a primary care physician who
15 participates in the training program of the
16 State establish pursuant to paragraph (2), pay-
17 ments to the primary care physician for services
18 furnished by the primary care physician.

19 (B) CONSIDERATIONS.—The Assistant
20 Secretary, in determining the structure, quality,
21 and form of payment under subparagraph (A)
22 shall seek to find innovative payment systems
23 which may take into account—

24 (i) the nature and quality of services
25 rendered;

- 1 (ii) the patients' health outcome;
- 2 (iii) the geographical location where
- 3 services were provided;
- 4 (iv) the acuteness of the patient's
- 5 medical condition;
- 6 (v) the duration of services provided;
- 7 (vi) the feasibility of replicating the
- 8 payment model in other locations nation-
- 9 wide; and
- 10 (vii) proper triage and enduring link-
- 11 age to appropriate treatment provider for
- 12 subspecialty care in child or forensic
- 13 issues; family crisis intervention; drug or
- 14 alcohol rehabilitation; management of sui-
- 15 cidal or violent behavior risk, and treat-
- 16 ment for serious mental illness.

17 (4) TELEHEALTH SERVICES FOR MENTAL
18 HEALTH DISORDERS.—

19 (A) IN GENERAL.—For purposes of para-

20 graph (1), the purpose described in this para-

21 graph, with respect to a grant awarded to a

22 State under the grant program, is for the State

23 to provide, in the case of an individual fur-

24 nished items and services by a primary care

25 physician during an office visit, for payment for

1 a consultation provided by a psychiatrist or psy-
2 chologist to such physician with respect to such
3 individual through the use of qualified tele-
4 health technology for the identification, diag-
5 nosis, mitigation, or treatment of a mental
6 health disorder if such consultation occurs not
7 later than the first business day that follows
8 such visit.

9 (B) QUALIFIED TELEHEALTH TECH-
10 NOLOGY.—For purposes of subparagraph (A),
11 the term “qualified telehealth technology”, with
12 respect to the provision of items and services to
13 a patient by a health care provider, includes the
14 use of interactive audio, audio-only telephone
15 conversation, video, or other telecommuni-
16 cations technology by a health care provider to
17 deliver health care services within the scope of
18 the provider’s practice at a site other than the
19 site where the patient is located, including the
20 use of electronic media for consultation relating
21 to the health care diagnosis or treatment of the
22 patient.

23 (5) ELIGIBLE STATE.—

24 (A) IN GENERAL.—For purposes of this
25 subsection, an eligible State is a State that has

1 submitted to the Assistant Secretary an appli-
2 cation under subparagraph (B) and has been
3 selected under subparagraph (D).

4 (B) APPLICATION.—A State seeking to
5 participate in the grant program under this
6 subsection shall submit to the Assistant Sec-
7 retary, at such time and in such format as the
8 Assistant Secretary requires, an application
9 that includes such information, provisions, and
10 assurances as the Assistant Secretary may re-
11 quire.

12 (C) MATCHING REQUIREMENT.—The As-
13 sistant Secretary may not make a grant under
14 the grant program unless the State involved
15 agrees, with respect to the costs to be incurred
16 by the State in carrying out the purposes de-
17 scribed in this subsection, to make available
18 non-Federal contributions (in cash or in kind)
19 toward such costs in an amount equal to not
20 less than 20 percent of Federal funds provided
21 in the grant.

22 (D) SELECTION.—A State shall be deter-
23 mined eligible for the grant program by the As-
24 sistant Secretary on a competitive basis among
25 States with applications meeting the require-

1 ments of subparagraphs (B) and (C). In select-
2 ing State applications for the grant program,
3 the Secretary shall seek to achieve an appro-
4 priate national balance in the geographic dis-
5 tribution of grants awarded under the grant
6 program.

7 (6) TARGET POPULATION.—In seeking a grant
8 under this subsection, a State shall demonstrate how
9 the grant will improve care for individuals with co-
10 occurring behavioral health and physical health con-
11 ditions, vulnerable populations, socially isolated pop-
12 ulations, rural populations, and other populations
13 who have limited access to qualified mental health
14 providers.

15 (7) LENGTH OF GRANT PROGRAM.—The grant
16 program under this subsection shall be conducted for
17 a period of 3 consecutive years.

18 (8) PUBLIC AVAILABILITY OF FINDINGS AND
19 CONCLUSIONS.—Subject to Federal privacy protec-
20 tions with respect to individually identifiable infor-
21 mation, the Assistant Secretary shall make the find-
22 ings and conclusions resulting from the grant pro-
23 gram under this subsection available to the public.

24 (9) AUTHORIZATION OF APPROPRIATIONS.—Out
25 of any funds in the Treasury not otherwise appro-

1 priated, there is authorized to be appropriated to
2 carry out this subsection, \$3,000,000 for each of the
3 fiscal years 2016 through 2020.

4 (10) REPORTS.—

5 (A) REPORTS.—For each fiscal year that
6 grants are awarded under this subsection, the
7 Assistant Secretary and the National Mental
8 Health Policy Laboratory shall conduct a study
9 on the results of the grants and submit to the
10 Congress a report on such results that includes
11 the following:

12 (i) An evaluation of the grant pro-
13 gram outcomes, including a summary of
14 activities carried out with the grant and
15 the results achieved through those activi-
16 ties.

17 (ii) Recommendations on how to im-
18 prove access to mental health services at
19 grantee locations.

20 (iii) An assessment of access to men-
21 tal health services under the program.

22 (iv) An assessment of the impact of
23 the demonstration project on the costs of
24 the full range of mental health services (in-

1 cluding inpatient, emergency and ambula-
2 tory care).

3 (v) Recommendations on congres-
4 sional action to improve the grant.

5 (vi) Recommendations to improve
6 training of primary care physicians.

7 (B) REPORT.—Not later than December
8 31, 2018, the Assistant Secretary and the Na-
9 tional Mental Health Policy Laboratory shall
10 submit to Congress and make available to the
11 public a report on the findings of the evaluation
12 under subparagraph (A) and also a policy out-
13 line on how Congress can expand the grant pro-
14 gram to the national level.

15 (b) LIABILITY PROTECTIONS FOR HEALTH CARE
16 PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH
17 CENTERS AND FEDERALLY QUALIFIED COMMUNITY BE-
18 HAVIORAL HEALTH CLINICS.—Section 224 of the Public
19 Health Service Act (42 U.S.C. 233) is amended by adding
20 at the end the following:

21 “(q)(1) In this subsection, the term ‘federally quali-
22 fied community behavioral health clinic’ means—

23 “(A) a federally qualified community behavioral
24 health clinic with a certification in effect under sec-

1 tion 223 of the Protecting Access to Medicare Act
2 of 2014; or

3 “(B) a community mental health center meeting
4 the criteria specified in section 1913(c) of this Act.

5 “(2) For purposes of this section, a health care pro-
6 fessional volunteer at an entity described in subsection
7 (g)(4) or a federally qualified community behavioral health
8 clinic shall, in providing health care services eligible for
9 funding under section 330 or subpart I of part B of title
10 XIX to an individual, be deemed to be an employee of the
11 Public Health Service for a calendar year that begins dur-
12 ing a fiscal year for which a transfer was made under
13 paragraph (5)(C). The preceding sentence is subject to the
14 provisions of this subsection.

15 “(3) In providing a health care service to an indi-
16 vidual, a health care professional shall for purposes of this
17 subsection be considered to be a health professional volun-
18 teer at an entity described in subsection (g)(4) or at a
19 federally qualified community behavioral health clinic if
20 the following conditions are met:

21 “(A) The service is provided to the individual at
22 the facilities of an entity described in subsection
23 (g)(4), at a federally qualified community behavioral
24 health clinic, or through offsite programs or events
25 carried out by the center.

1 “(B) The center or entity is sponsoring the
2 health care professional volunteer pursuant to para-
3 graph (4)(B).

4 “(C) The health care professional does not re-
5 ceive any compensation for the service from the indi-
6 vidual or from any third-party payer (including re-
7 imbursement under any insurance policy or health
8 plan, or under any Federal or State health benefits
9 program), except that the health care professional
10 may receive repayment from the entity described in
11 subsection (g)(4) or the center for reasonable ex-
12 penses incurred by the health care professional in
13 the provision of the service to the individual.

14 “(D) Before the service is provided, the health
15 care professional or the center or entity described in
16 subsection (g)(4) posts a clear and conspicuous no-
17 tice at the site where the service is provided of the
18 extent to which the legal liability of the health care
19 professional is limited pursuant to this subsection.

20 “(E) At the time the service is provided, the
21 health care professional is licensed or certified in ac-
22 cordance with applicable law regarding the provision
23 of the service.

24 “(4) Subsection (g) (other than paragraphs (3) and
25 (5)) and subsections (h), (i), and (l) apply to a health care

1 professional for purposes of this subsection to the same
2 extent and in the same manner as such subsections apply
3 to an officer, governing board member, employee, or con-
4 tractor of an entity described in subsection (g)(4), subject
5 to paragraph (5) and subject to the following:

6 “(A) The first sentence of paragraph (2) ap-
7 plies in lieu of the first sentence of subsection
8 (g)(1)(A).

9 “(B) With respect to an entity described in sub-
10 section (g)(4) or a federally qualified community be-
11 havioral health clinic, a health care professional is
12 not a health professional volunteer at such center
13 unless the center sponsors the health care profes-
14 sional. For purposes of this subsection, the center
15 shall be considered to be sponsoring the health care
16 professional if—

17 “(i) with respect to the health care profes-
18 sional, the center submits to the Secretary an
19 application meeting the requirements of sub-
20 section (g)(1)(D); and

21 “(ii) the Secretary, pursuant to subsection
22 (g)(1)(E), determines that the health care pro-
23 fessional is deemed to be an employee of the
24 Public Health Service.

1 “(C) In the case of a health care professional
2 who is determined by the Secretary pursuant to sub-
3 section (g)(1)(E) to be a health professional volun-
4 teer at such center, this subsection applies to the
5 health care professional (with respect to services de-
6 scribed in paragraph (2)) for any cause of action
7 arising from an act or omission of the health care
8 professional occurring on or after the date on which
9 the Secretary makes such determination.

10 “(D) Subsection (g)(1)(F) applies to a health
11 professional volunteer for purposes of this subsection
12 only to the extent that, in providing health services
13 to an individual, each of the conditions specified in
14 paragraph (3) is met.

15 “(5)(A) Amounts in the fund established under sub-
16 section (k)(2) shall be available for transfer under sub-
17 paragraph (C) for purposes of carrying out this subsection
18 for health professional volunteers at entities described in
19 subsection (g)(4).

20 “(B) Not later than May 1 of each fiscal year, the
21 Attorney General, in consultation with the Secretary, shall
22 submit to the Congress a report providing an estimate of
23 the amount of claims (together with related fees and ex-
24 penses of witnesses) that, by reason of the acts or omis-
25 sions of health care professional volunteers, will be paid

1 pursuant to this subsection during the calendar year that
2 begins in the following fiscal year. Subsection (k)(1)(B)
3 applies to the estimate under the preceding sentence re-
4 garding health care professional volunteers to the same
5 extent and in the same manner as such subsection applies
6 to the estimate under such subsection regarding officers,
7 governing board members, employees, and contractors of
8 entities described in subsection (g)(4).

9 “(C) Not later than December 31 of each fiscal year,
10 the Secretary shall transfer from the fund under sub-
11 section (k)(2) to the appropriate accounts in the Treasury
12 an amount equal to the estimate made under subpara-
13 graph (B) for the calendar year beginning in such fiscal
14 year, subject to the extent of amounts in the fund.

15 “(6)(A) This subsection takes effect on October 1,
16 2017, except as provided in subparagraph (B).

17 “(B) Effective on the date of the enactment of this
18 subsection—

19 “(i) the Secretary may issue regulations for car-
20 rying out this subsection, and the Secretary may ac-
21 cept and consider applications submitted pursuant to
22 paragraph (4)(B); and

23 “(ii) reports under paragraph (5)(B) may be
24 submitted to the Congress.”.

1 (c) MINORITY FELLOWSHIP PROGRAM.—Title V of
2 the Public Health Service Act (42 U.S.C. 290aa et seq.),
3 as amended, is further amended by adding at the end the
4 following:

5 **“PART K—MINORITY FELLOWSHIP PROGRAM**

6 **“SEC. 597. FELLOWSHIPS.**

7 “(a) IN GENERAL.—The Secretary shall maintain a
8 program, to be known as the Minority Fellowship Pro-
9 gram, under which the Secretary awards fellowships,
10 which may include stipends, for the purposes of—

11 “(1) increasing behavioral health practitioners’
12 knowledge of issues related to prevention, treatment,
13 and recovery support for mental and substance use
14 disorders among racial and ethnic minority popu-
15 lations;

16 “(2) improving the quality of mental and sub-
17 stance use disorder prevention and treatment deliv-
18 ered to ethnic minorities; and

19 “(3) increasing the number of culturally com-
20 petent behavioral health professionals who teach, ad-
21 minister, conduct services research, and provide di-
22 rect mental health or substance use services to un-
23 derserved minority populations.

24 “(b) TRAINING COVERED.—The fellowships under
25 subsection (a) shall be for postbaccalaureate training (in-

1 cluding for master’s and doctoral degrees) for mental
2 health professionals, including in the fields of psychiatry,
3 nursing, social work, psychology, marriage and family
4 therapy, and substance use and addiction counseling.

5 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there are authorized to be appro-
7 priated \$6,000,000 for each of fiscal years 2016 through
8 2020.”.

9 (d) NATIONAL HEALTH SERVICE CORPS.—

10 (1) DEFINITIONS.—

11 (A) PRIMARY HEALTH SERVICES.—Section
12 331(a)(3)(D) of the Public Health Service Act
13 (42 U.S.C. 254d(a)(3)) is amended by inserting
14 “(including pediatric mental health subspecialty
15 services)” after “pediatrics”.

16 (B) BEHAVIORAL AND MENTAL HEALTH
17 PROFESSIONALS.—Clause (i) of section
18 331(a)(3)(E)(i) of the Public Health Service
19 Act (42 U.S.C. 254d(a)(3)(E)(i)) is amended
20 by inserting “(and pediatric subspecialists
21 thereof)” before the period at the end.

22 (C) HEALTH PROFESSIONAL SHORTAGE
23 AREA.—Section 332(a)(1) of the Public Health
24 Service Act is amended by inserting “(including

1 children and adolescents)” after “population
2 group”.

3 (D) MEDICAL FACILITY.—Section
4 332(a)(2)(A) of the Public Health Service Act
5 is amended by inserting “medical residency or
6 fellowship training site for training in child and
7 adolescent psychiatry,” before “facility operated
8 by a city or county health department,”.

9 (2) ELIGIBILITY TO PARTICIPATE IN LOAN RE-
10 PAYMENT PROGRAM.—Section 338A(b)(1)(B) of the
11 Public Health Service Act (42 U.S.C. 254I-
12 1(b)(1)(B)) is amended by inserting “, including any
13 physician child and adolescent psychiatry residency
14 or fellowship training program” after “be enrolled in
15 an approved graduate training program in medicine,
16 osteopathic medicine, dentistry, behavioral and men-
17 tal health, or other health profession”.

18 (e) CRISIS INTERVENTION GRANTS FOR POLICE OF-
19 FICERS AND FIRST RESPONDERS.—

20 (1) GRANTS.—The Assistant Secretary may
21 award grants to provide specialized training to law
22 enforcement officers, corrections officers, para-
23 medics, emergency medical services workers, and
24 other first responders (including village public safety
25 officers (as defined in section 247 of the Indian Arts

1 and Crafts Amendments Act of 2010 (42 U.S.C.
2 3796dd note)))—

3 (A) to recognize individuals who have men-
4 tal illness and how to properly intervene with
5 individuals with mental illness; and

6 (B) to establish programs that enhance the
7 ability of law enforcement agencies to address
8 the mental health, behavioral, and substance
9 use problems of individuals encountered in the
10 line of duty.

11 (2) FUNDING.—Of the amounts made available
12 to carry out sections 501, 509, 516, and 520A of the
13 Public Health Service Act for a fiscal year, 5 per-
14 cent of such amounts are authorized to be used to
15 carry out this subsection.

16 **SEC. 208. AUTHORIZED GRANTS AND PROGRAMS.**

17 (a) CHILDREN’S RECOVERY FROM TRAUMA.—Sec-
18 tion 582 of the Public Health Service Act (42 U.S.C.
19 290hh–1) is amended—

20 (1) in subsection (a), by striking “developing
21 programs” and all that follows and inserting the fol-
22 lowing: “developing and maintaining programs that
23 provide for—

24 “(1) the continued operation of the National
25 Child Traumatic Stress Initiative (referred to in this

1 section as the ‘NCTSI’), which includes a coordi-
2 nating center, that focuses on the mental, behav-
3 ioral, and biological aspects of psychological trauma
4 response; and

5 “(2) the development of knowledge with regard
6 to evidence-based (as defined in section 2 of the
7 Helping Families in Mental Health Crisis Act of
8 2015) practices for identifying and treating mental,
9 behavioral, and biological disorders of children and
10 youth resulting from witnessing or experiencing a
11 traumatic event.”;

12 (2) in subsection (b)—

13 (A) by striking “subsection (a) related”
14 and inserting “subsection (a)(2) (related”;

15 (B) by striking “treating disorders associ-
16 ated with psychological trauma” and inserting
17 “treating mental, behavioral, and biological dis-
18 orders associated with psychological trauma”);
19 and

20 (C) by striking “mental health agencies
21 and programs that have established clinical and
22 basic research” and inserting “universities, hos-
23 pitals, mental health agencies, and other pro-
24 grams that have established clinical expertise
25 and research”;

1 (3) by redesignating subsections (c) through (g)
2 as subsections (g) through (k), respectively;

3 (4) by inserting after subsection (b), the fol-
4 lowing:

5 “(c) CHILD OUTCOME DATA.—The NCTSI coordi-
6 nating center shall collect, analyze, and report NCTSI-
7 wide child treatment process and outcome data regarding
8 the early identification and delivery of evidence-based (as
9 defined in section 2 of the Helping Families in Mental
10 Health Crisis Act of 2015) treatment and services for chil-
11 dren and families served by the NCTSI grantees.

12 “(d) TRAINING.—The NCTSI coordinating center
13 shall facilitate the coordination of training initiatives in
14 evidence-based (as defined in section 2 of the Helping
15 Families in Mental Health Crisis Act of 2015) and trau-
16 ma-informed treatments, interventions, and practices of-
17 fered to NCTSI grantees, providers, and partners.

18 “(e) DISSEMINATION.—The NCTSI coordinating
19 center shall, as appropriate, collaborate with the Secretary
20 in the dissemination of evidence-based and trauma-in-
21 formed interventions, treatments, products, and other re-
22 sources to appropriate stakeholders.

23 “(f) REVIEW.—The Secretary shall, consistent with
24 the peer-review process, ensure that NCTSI applications
25 are reviewed by appropriate experts in the field as part

1 of a consensus review process. The Secretary shall include
2 review criteria related to expertise and experience in child
3 trauma and evidence-based (as defined in section 2 of the
4 Helping Families in Mental Health Crisis Act of 2015)
5 practices.”;

6 (5) in subsection (g) (as so redesignated), by
7 striking “with respect to centers of excellence are
8 distributed equitably among the regions of the coun-
9 try” and inserting “are distributed equitably among
10 the regions of the United States”;

11 (6) in subsection (i) (as so redesignated), by
12 striking “recipient may not exceed 5 years” and in-
13 sserting “recipient shall not be less than 4 years, but
14 shall not exceed 5 years”; and

15 (7) in subsection (j) (as so redesignated), by
16 striking “\$50,000,000” and all that follows through
17 “2006” and inserting “\$45,713,000 for each of fis-
18 cal years 2014 through 2018”.

19 (b) REDUCING THE STIGMA OF SERIOUS MENTAL
20 ILLNESS.—

21 (1) IN GENERAL.—The Secretary of Education,
22 along with the Assistant Secretary for Mental
23 Health and Substance Use Disorders, shall organize
24 a national awareness campaign involving public
25 health organizations, advocacy groups for persons

1 with serious mental illness, and social media compa-
2 nies to assist secondary school students and postsec-
3 ondary students in—

4 (A) reducing the stigma associated with se-
5 rious mental illness;

6 (B) understanding how to assist an indi-
7 vidual who is demonstrating signs of a serious
8 mental illness; and

9 (C) understanding the importance of seek-
10 ing treatment from a physician, clinical psychol-
11 ogist, or licensed mental health professional
12 when a student believes the student may be suf-
13 fering from a serious mental illness or behav-
14 ioral health disorder.

15 (2) DATA COLLECTION.—The Secretary of Edu-
16 cation shall—

17 (A) evaluate the program under subsection
18 (a) on public health to determine whether the
19 program has made an impact on public health,
20 including mortality rates of persons with seri-
21 ous mental illness, prevalence of serious mental
22 illness, physician and clinical psychological vis-
23 its, emergency room visits; and

1 (B) submit a report on the evaluation to
2 the National Mental Health Policy Laboratory
3 created by title I of this Act.

4 (3) SECONDARY SCHOOL DEFINED.—For pur-
5 poses of this section, the term “secondary school”
6 has the meaning given the term in section 9101 of
7 the Elementary and Secondary Education Act of
8 1965 (20 U.S.C. 7801).

9 (c) GARRETT LEE SMITH REAUTHORIZATION.—

10 (1) SUICIDE PREVENTION TECHNICAL ASSIST-
11 ANCE CENTER.—Section 520C of the Public Health
12 Service Act (42 U.S.C. 290bb–34) is amended to
13 read as follows:

14 **“SEC. 520C. SUICIDE PREVENTION TECHNICAL ASSISTANCE**
15 **CENTER.**

16 “(a) PROGRAM AUTHORIZED.—The Assistant Sec-
17 retary for Mental Health and Substance Use Disorders
18 shall award a grant for the operation and maintenance
19 of a research, training, and technical assistance resource
20 center to provide appropriate information, training, and
21 technical assistance to States, political subdivisions of
22 States, federally recognized Indian tribes, tribal organiza-
23 tions, institutions of higher education, public organiza-
24 tions, or private nonprofit organizations concerning the

1 prevention of suicide among all ages, particularly among
2 groups that are at high risk for suicide.

3 “(b) RESPONSIBILITIES OF THE CENTER.—The cen-
4 ter operated and maintained under subsection (a) shall—

5 “(1) assist in the development or continuation
6 of statewide and tribal suicide early intervention and
7 prevention strategies for all ages, particularly among
8 groups that are at high risk for suicide;

9 “(2) ensure the surveillance of suicide early
10 intervention and prevention strategies for all ages,
11 particularly among groups that are at high risk for
12 suicide;

13 “(3) study the costs and effectiveness of state-
14 wide and tribal suicide early intervention and pre-
15 vention strategies in order to provide information
16 concerning relevant issues of importance to State,
17 tribal, and national policymakers;

18 “(4) further identify and understand causes
19 and associated risk factors for suicide for all ages,
20 particularly among groups that are at high risk for
21 suicide;

22 “(5) analyze the efficacy of new and existing
23 suicide early intervention and prevention techniques
24 and technology for all ages, particularly among
25 groups that are at high risk for suicide;

1 “(6) ensure the surveillance of suicidal behav-
2 iors and nonfatal suicidal attempts;

3 “(7) study the effectiveness of State-sponsored
4 statewide and tribal suicide early intervention and
5 prevention strategies for all ages particularly among
6 groups that are at high risk for suicide on the over-
7 all wellness and health promotion strategies related
8 to suicide attempts;

9 “(8) promote the sharing of data regarding sui-
10 cide with Federal agencies involved with suicide
11 early intervention and prevention, and State-spon-
12 sored statewide and tribal suicide early intervention
13 and prevention strategies for the purpose of identi-
14 fying previously unknown mental health causes and
15 associated risk factors for suicide among all ages
16 particularly among groups that are at high risk for
17 suicide;

18 “(9) evaluate and disseminate outcomes and
19 best practices of mental health and substance use
20 disorder services at institutions of higher education;
21 and

22 “(10) conduct other activities determined ap-
23 propriate by the Secretary.

24 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
25 purpose of carrying out this section, there are authorized

1 to be appropriated \$4,957,000 for each of the fiscal years
2 2016 through 2020.”.

3 (2) YOUTH SUICIDE INTERVENTION AND PRE-
4 VENTION STRATEGIES.—Section 520E of the Public
5 Health Service Act (42 U.S.C. 290bb–36) is amend-
6 ed to read as follows:

7 **“SEC. 520E. YOUTH SUICIDE EARLY INTERVENTION AND**
8 **PREVENTION STRATEGIES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Assistant Secretary, shall award grants or cooperative
11 agreements to eligible entities to—

12 “(1) develop and implement State-sponsored
13 statewide or tribal youth suicide early intervention
14 and prevention strategies in schools, educational in-
15 stitutions, juvenile justice systems, substance use
16 disorder programs, mental health programs, foster
17 care systems, and other child and youth support or-
18 ganizations;

19 “(2) support public organizations and private
20 nonprofit organizations actively involved in State-
21 sponsored statewide or tribal youth suicide early
22 intervention and prevention strategies and in the de-
23 velopment and continuation of State-sponsored
24 statewide youth suicide early intervention and pre-
25 vention strategies;

1 “(3) provide grants to institutions of higher
2 education to coordinate the implementation of State-
3 sponsored or tribal youth suicide early intervention
4 and prevention strategies;

5 “(4) collect and analyze data on State-spon-
6 sored statewide or tribal youth suicide early inter-
7 vention and prevention services that can be used to
8 monitor the effectiveness of such services and for re-
9 search, technical assistance, and policy development;
10 and

11 “(5) assist eligible entities, through State-spon-
12 sored statewide or tribal youth suicide early inter-
13 vention and prevention strategies, in achieving tar-
14 gets for youth suicide reductions under title V of the
15 Social Security Act.

16 “(b) ELIGIBLE ENTITY.—

17 “(1) DEFINITION.—In this section, the term
18 ‘eligible entity’ means—

19 “(A) a State;

20 “(B) a public organization or private non-
21 profit organization designated by a State to de-
22 velop or direct the State-sponsored statewide
23 youth suicide early intervention and prevention
24 strategy; or

1 “(C) a federally recognized Indian tribe or
2 tribal organization (as defined in the Indian
3 Self-Determination and Education Assistance
4 Act) or an urban Indian organization (as de-
5 fined in the Indian Health Care Improvement
6 Act) that is actively involved in the development
7 and continuation of a tribal youth suicide early
8 intervention and prevention strategy.

9 “(2) LIMITATION.—In carrying out this section,
10 the Secretary shall ensure that a State does not re-
11 ceive more than one grant or cooperative agreement
12 under this section at any one time. For purposes of
13 the preceding sentence, a State shall be considered
14 to have received a grant or cooperative agreement if
15 the eligible entity involved is the State or an entity
16 designated by the State under paragraph (1)(B).
17 Nothing in this paragraph shall be construed to
18 apply to entities described in paragraph (1)(C).

19 “(c) PREFERENCE.—In providing assistance under a
20 grant or cooperative agreement under this section, an eli-
21 gible entity shall give preference to public organizations,
22 private nonprofit organizations, political subdivisions, in-
23 stitutions of higher education, and tribal organizations ac-
24 tively involved with the State-sponsored statewide or tribal

1 youth suicide early intervention and prevention strategy
2 that—

3 “(1) provide early intervention and assessment
4 services, including screening programs, to youth who
5 are at risk for mental or emotional disorders that
6 may lead to a suicide attempt, and that are inte-
7 grated with school systems, educational institutions,
8 juvenile justice systems, substance use disorder pro-
9 grams, mental health programs, foster care systems,
10 and other child and youth support organizations;

11 “(2) demonstrate collaboration among early
12 intervention and prevention services or certify that
13 entities will engage in future collaboration;

14 “(3) employ or include in their applications a
15 commitment to evaluate youth suicide early interven-
16 tion and prevention practices and strategies adapted
17 to the local community;

18 “(4) provide timely referrals for appropriate
19 community-based mental health care and treatment
20 of youth who are at risk for suicide in child-serving
21 settings and agencies;

22 “(5) provide immediate support and informa-
23 tion resources to families of youth who are at risk
24 for suicide;

1 “(6) offer access to services and care to youth
2 with diverse linguistic and cultural backgrounds;

3 “(7) offer appropriate postsuicide intervention
4 services, care, and information to families, friends,
5 schools, educational institutions, juvenile justice sys-
6 tems, substance use disorder programs, mental
7 health programs, foster care systems, and other
8 child and youth support organizations of youth who
9 recently completed suicide;

10 “(8) offer continuous and up-to-date informa-
11 tion and awareness campaigns that target parents,
12 family members, child care professionals, community
13 care providers, and the general public and highlight
14 the risk factors associated with youth suicide and
15 the life-saving help and care available from early
16 intervention and prevention services;

17 “(9) ensure that information and awareness
18 campaigns on youth suicide risk factors, and early
19 intervention and prevention services, use effective
20 communication mechanisms that are targeted to and
21 reach youth, families, schools, educational institu-
22 tions, and youth organizations;

23 “(10) provide a timely response system to en-
24 sure that child-serving professionals and providers
25 are properly trained in youth suicide early interven-

1 tion and prevention strategies and that child-serving
2 professionals and providers involved in early inter-
3 vention and prevention services are properly trained
4 in effectively identifying youth who are at risk for
5 suicide;

6 “(11) provide continuous training activities for
7 child care professionals and community care pro-
8 viders on the latest youth suicide early intervention
9 and prevention services practices and strategies;

10 “(12) conduct annual self-evaluations of out-
11 comes and activities, including consulting with inter-
12 ested families and advocacy organizations;

13 “(13) provide services in areas or regions with
14 rates of youth suicide that exceed the national aver-
15 age as determined by the Centers for Disease Con-
16 trol and Prevention; and

17 “(14) obtain informed written consent from a
18 parent or legal guardian of an at-risk child before
19 involving the child in a youth suicide early interven-
20 tion and prevention program.

21 “(d) REQUIREMENT FOR DIRECT SERVICES.—Not
22 less than 85 percent of grant funds received under this
23 section shall be used to provide direct services, of which
24 not less than 5 percent shall be used for activities author-
25 ized under subsection (a)(3).

1 “(e) CONSULTATION AND POLICY DEVELOPMENT.—

2 “(1) IN GENERAL.—In carrying out this sec-
3 tion, the Secretary shall collaborate with the Sec-
4 retary of Education and relevant Federal agencies
5 and suicide working groups responsible for early
6 intervention and prevention services relating to
7 youth suicide.

8 “(2) CONSULTATION.—In carrying out this sec-
9 tion, the Secretary shall consult with—

10 “(A) State and local agencies, including
11 agencies responsible for early intervention and
12 prevention services under title XIX of the So-
13 cial Security Act, the State Children’s Health
14 Insurance Program under title XXI of the So-
15 cial Security Act, and programs funded by
16 grants under title V of the Social Security Act;

17 “(B) local and national organizations that
18 serve youth at risk for suicide and their fami-
19 lies;

20 “(C) relevant national medical and other
21 health and education specialty organizations;

22 “(D) youth who are at risk for suicide,
23 who have survived suicide attempts, or who are
24 currently receiving care from early intervention
25 services;

1 “(E) families and friends of youth who are
2 at risk for suicide, who have survived suicide at-
3 tempts, who are currently receiving care from
4 early intervention and prevention services, or
5 who have completed suicide;

6 “(F) qualified professionals who possess
7 the specialized knowledge, skills, experience,
8 and relevant attributes needed to serve youth at
9 risk for suicide and their families; and

10 “(G) third-party payers, managed care or-
11 ganizations, and related commercial industries.

12 “(3) POLICY DEVELOPMENT.—In carrying out
13 this section, the Secretary shall—

14 “(A) coordinate and collaborate on policy
15 development at the Federal level with the rel-
16 evant Department of Health and Human Serv-
17 ices agencies and suicide working groups; and

18 “(B) consult on policy development at the
19 Federal level with the private sector, including
20 consumer, medical, suicide prevention advocacy
21 groups, and other health and education profes-
22 sional-based organizations, with respect to
23 State-sponsored statewide or tribal youth sui-
24 cide early intervention and prevention strate-
25 gies.

1 “(f) RULE OF CONSTRUCTION; RELIGIOUS AND
2 MORAL ACCOMMODATION.—Nothing in this section shall
3 be construed to require suicide assessment, early interven-
4 tion, or treatment services for youth whose parents or
5 legal guardians object based on the parents’ or legal
6 guardians’ religious beliefs or moral objections.

7 “(g) EVALUATIONS AND REPORT.—

8 “(1) EVALUATIONS BY ELIGIBLE ENTITIES.—
9 Not later than 18 months after receiving a grant or
10 cooperative agreement under this section, an eligible
11 entity shall submit to the Secretary the results of an
12 evaluation to be conducted by the entity concerning
13 the effectiveness of the activities carried out under
14 the grant or agreement.

15 “(2) REPORT.—Not later than 2 years after the
16 date of enactment of this section, the Secretary shall
17 submit to the appropriate committees of Congress a
18 report concerning the results of—

19 “(A) the evaluations conducted under
20 paragraph (1); and

21 “(B) an evaluation conducted by the Sec-
22 retary to analyze the effectiveness and efficacy
23 of the activities conducted with grants, collabo-
24 rations, and consultations under this section.

1 “(h) RULE OF CONSTRUCTION; STUDENT MEDICA-
2 TION.—Nothing in this section shall be construed to allow
3 school personnel to require that a student obtain any
4 medication as a condition of attending school or receiving
5 services.

6 “(i) PROHIBITION.—Funds appropriated to carry out
7 this section, section 527, or section 529 shall not be used
8 to pay for or refer for abortion.

9 “(j) PARENTAL CONSENT.—States and entities re-
10 ceiving funding under this section shall obtain prior writ-
11 ten, informed consent from the child’s parent or legal
12 guardian for assessment services, school-sponsored pro-
13 grams, and treatment involving medication related to
14 youth suicide conducted in elementary and secondary
15 schools. The requirement of the preceding sentence does
16 not apply in the following cases:

17 “(1) In an emergency, where it is necessary to
18 protect the immediate health and safety of the stu-
19 dent or other students.

20 “(2) Other instances, as defined by the State,
21 where parental consent cannot reasonably be ob-
22 tained.

23 “(k) RELATION TO EDUCATION PROVISIONS.—Noth-
24 ing in this section shall be construed to supersede section
25 444 of the General Education Provisions Act, including

1 the requirement of prior parental consent for the disclo-
2 sure of any education records. Nothing in this section shall
3 be construed to modify or affect parental notification re-
4 quirements for programs authorized under the Elementary
5 and Secondary Education Act of 1965 (as amended by the
6 No Child Left Behind Act of 2001; Public Law 107–110).

7 “(1) DEFINITIONS.—In this section:

8 “(1) EARLY INTERVENTION.—The term ‘early
9 intervention’ means a strategy or approach that is
10 intended to prevent an outcome or to alter the
11 course of an existing condition.

12 “(2) EDUCATIONAL INSTITUTION; INSTITUTION
13 OF HIGHER EDUCATION; SCHOOL.—The term—

14 “(A) ‘educational institution’ means a
15 school or institution of higher education;

16 “(B) ‘institution of higher education’ has
17 the meaning given such term in section 101 of
18 the Higher Education Act of 1965; and

19 “(C) ‘school’ means an elementary or sec-
20 ondary school (as such terms are defined in sec-
21 tion 9101 of the Elementary and Secondary
22 Education Act of 1965).

23 “(3) PREVENTION.—The term ‘prevention’
24 means a strategy or approach that reduces the likeli-
25 hood or risk of onset, or delays the onset, of adverse

1 health problems that have been known to lead to sui-
2 cide.

3 “(4) YOUTH.—The term ‘youth’ means individ-
4 uals who are between 10 and 26 years of age.

5 “(m) AUTHORIZATION OF APPROPRIATIONS.—For
6 the purpose of carrying out this section, there are author-
7 ized to be appropriated \$29,738,000 for each of the fiscal
8 years 2016 through 2020.”.

9 (3) SUICIDE PREVENTION FOR YOUTH.—Sec-
10 tion 520E–1 of the Public Health Service Act (42
11 U.S.C. 290bb–36a) is amended—

12 (A) by amending the section heading to
13 read as follows: “**SUICIDE PREVENTION FOR**
14 **YOUTH**”; and

15 (B) by striking subsection (n) and insert-
16 ing the following:

17 “(n) AUTHORIZATION OF APPROPRIATIONS.—For the
18 purpose of carrying out this section, there is authorized
19 to be appropriated such sums as may be necessary for
20 each of fiscal years 2016 through 2020.”.

21 (4) MENTAL HEALTH AND SUBSTANCE USE
22 DISORDERS SERVICES AND OUTREACH ON CAM-
23 PUS.—Section 520E–2 of the Public Health Service
24 Act (42 U.S.C. 290bb–36b) is amended to read as
25 follows:

1 **“SEC. 520E-2. MENTAL HEALTH AND SUBSTANCE USE DIS-**
2 **ORDERS SERVICES ON CAMPUS.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Center for Mental Health Services and
5 in consultation with the Secretary of Education, shall
6 award grants on a competitive basis to institutions of
7 higher education to enhance services for students with
8 mental health or substance use disorders and to develop
9 best practices for the delivery of such services.

10 “(b) USES OF FUNDS.—Amounts received under a
11 grant under this section shall be used for 1 or more of
12 the following activities:

13 “(1) The provision of mental health and sub-
14 stance use disorder services to students, including
15 prevention, promotion of mental health, voluntary
16 screening, early intervention, voluntary assessment,
17 treatment, and management of mental health and
18 substance use disorder issues.

19 “(2) The provision of outreach services to notify
20 students about the existence of mental health and
21 substance use disorder services.

22 “(3) Educating students, families, faculty, staff,
23 and communities to increase awareness of mental
24 health and substance use disorders.

25 “(4) The employment of appropriately trained
26 staff, including administrative staff.

1 “(5) The provision of training to students, fac-
2 ulty, and staff to respond effectively to students with
3 mental health and substance use disorders.

4 “(6) The creation of a networking infrastruc-
5 ture to link colleges and universities with providers
6 who can treat mental health and substance use dis-
7 orders.

8 “(7) Developing, supporting, evaluating, and
9 disseminating evidence-based and emerging best
10 practices.

11 “(c) IMPLEMENTATION OF ACTIVITIES USING GRANT
12 FUNDS.—An institution of higher education that receives
13 a grant under this section may carry out activities under
14 the grant through—

15 “(1) college counseling centers;

16 “(2) college and university psychological service
17 centers;

18 “(3) mental health centers;

19 “(4) psychology training clinics;

20 “(5) institution of higher education supported,
21 evidence-based, mental health and substance use dis-
22 order programs; or

23 “(6) any other entity that provides mental
24 health and substance use disorder services at an in-
25 stitution of higher education.

1 “(d) APPLICATION.—To be eligible to receive a grant
2 under this section, an institution of higher education shall
3 prepare and submit to the Secretary an application at
4 such time and in such manner as the Secretary may re-
5 quire. At a minimum, such application shall include the
6 following:

7 “(1) A description of identified mental health
8 and substance use disorder needs of students at the
9 institution of higher education.

10 “(2) A description of Federal, State, local, pri-
11 vate, and institutional resources currently available
12 to address the needs described in paragraph (1) at
13 the institution of higher education.

14 “(3) A description of the outreach strategies of
15 the institution of higher education for promoting ac-
16 cess to services, including a proposed plan for reach-
17 ing those students most in need of mental health
18 services.

19 “(4) A plan, when applicable, to meet the spe-
20 cific mental health and substance use disorder needs
21 of veterans attending institutions of higher edu-
22 cation.

23 “(5) A plan to seek input from community
24 mental health providers, when available, community

1 groups and other public and private entities in car-
2 rying out the program under the grant.

3 “(6) A plan to evaluate program outcomes, in-
4 cluding a description of the proposed use of funds,
5 the program objectives, and how the objectives will
6 be met.

7 “(7) An assurance that the institution will sub-
8 mit a report to the Secretary each fiscal year con-
9 cerning the activities carried out with the grant and
10 the results achieved through those activities.

11 “(e) SPECIAL CONSIDERATIONS.—In awarding
12 grants under this section, the Secretary shall give special
13 consideration to applications that describe programs to be
14 carried out under the grant that—

15 “(1) demonstrate the greatest need for new or
16 additional mental and substance use disorder serv-
17 ices, in part by providing information on current ra-
18 tios of students to mental health and substance use
19 disorder health professionals; and

20 “(2) demonstrate the greatest potential for rep-
21 lication.

22 “(f) REQUIREMENT OF MATCHING FUNDS.—

23 “(1) IN GENERAL.—The Secretary may make a
24 grant under this section to an institution of higher
25 education only if the institution agrees to make

1 available (directly or through donations from public
2 or private entities) non-Federal contributions in an
3 amount that is not less than \$1 for each \$1 of Fed-
4 eral funds provided under the grant, toward the
5 costs of activities carried out with the grant (as de-
6 scribed in subsection (b)) and other activities by the
7 institution to reduce student mental health and sub-
8 stance use disorders.

9 “(2) DETERMINATION OF AMOUNT CONTRIB-
10 UTED.—Non-Federal contributions required under
11 paragraph (1) may be in cash or in kind. Amounts
12 provided by the Federal Government, or services as-
13 sisted or subsidized to any significant extent by the
14 Federal Government, may not be included in deter-
15 mining the amount of such non-Federal contribu-
16 tions.

17 “(3) WAIVER.—The Secretary may waive the
18 application of paragraph (1) with respect to an insti-
19 tution of higher education if the Secretary deter-
20 mines that extraordinary need at the institution jus-
21 tifies the waiver.

22 “(g) REPORTS.—For each fiscal year that grants are
23 awarded under this section, the Secretary shall conduct
24 a study on the results of the grants and submit to the

1 Congress a report on such results that includes the fol-
2 lowing:

3 “(1) An evaluation of the grant program out-
4 comes, including a summary of activities carried out
5 with the grant and the results achieved through
6 those activities.

7 “(2) Recommendations on how to improve ac-
8 cess to mental health and substance use disorder
9 services at institutions of higher education, including
10 efforts to reduce the incidence of suicide and sub-
11 stance use disorders.

12 “(h) DEFINITIONS.—In this section:

13 “(1) The term ‘evidence-based’ has the meaning
14 given to such term in section 2 of the Helping Fami-
15 lies in Mental Health Crisis Act of 2015.

16 “(2) The term ‘institution of higher education’
17 has the meaning given such term in section 101 of
18 the Higher Education Act of 1965.

19 “(i) AUTHORIZATION OF APPROPRIATIONS.—For the
20 purpose of carrying out this section, there are authorized
21 to be appropriated \$4,975,000 for each of fiscal years
22 2016 through 2020.”.

23 “(5) SUICIDE LIFELINE.—Subpart 3 of part B
24 of title V of the Public Health Service Act is amend-

1 ed by inserting after section 520E–2 of such Act (42
2 U.S.C. 290bb–36b), as amended, the following:

3 **“SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE**
4 **PROGRAM.**

5 “(a) IN GENERAL.—The Secretary shall maintain the
6 National Suicide Prevention Lifeline program, including
7 by—

8 “(1) coordinating a network of crisis centers
9 across the United States for providing suicide pre-
10 vention and crisis intervention services to individuals
11 seeking help at any time, day or night;

12 “(2) maintaining a suicide prevention hotline to
13 link callers to local emergency, mental health, and
14 social services resources; and

15 “(3) consulting with the Secretary of Veterans
16 Affairs to ensure that veterans calling the suicide
17 prevention hotline have access to a specialized vet-
18 erans’ suicide prevention hotline.

19 “(b) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this section, there are authorized to be appro-
21 priated \$8,000,000 for each of fiscal years 2016 through
22 2020.”.

1 **TITLE III—INTERAGENCY SERI-**
2 **OUS MENTAL ILLNESS CO-**
3 **ORDINATING COMMITTEE**

4 **SEC. 301. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
5 **ORDINATING COMMITTEE.**

6 Title V of the Public Health Service Act, as amended
7 by section 101, is further amended by inserting after sec-
8 tion 501 of such Act the following:

9 **“SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS CO-**
10 **ORDINATING COMMITTEE.**

11 “(a) ESTABLISHMENT.—The Assistant Secretary for
12 Mental Health and Substance Use Disorders (in this sec-
13 tion referred to as the ‘Assistant Secretary’) shall estab-
14 lish a committee, to be known as the Interagency Serious
15 Mental Illness Coordinating Committee (in this section re-
16 ferred to as the ‘Committee’), to assist the Assistant Sec-
17 retary in carrying out the Assistant Secretary’s duties.

18 “(b) RESPONSIBILITIES.—The Committee shall—

19 “(1) develop and annually update a summary of
20 advances in serious mental illness research related to
21 causes, prevention, treatment, early screening, diag-
22 nosis or rule out, intervention, and access to services
23 and supports for individuals with serious mental ill-
24 ness;

1 “(2) monitor Federal activities with respect to
2 serious mental illness;

3 “(3) make recommendations to the Assistant
4 Secretary regarding any appropriate changes to such
5 activities, including recommendations to the Director
6 of NIH with respect to the strategic plan developed
7 under paragraph (5);

8 “(4) make recommendations to the Assistant
9 Secretary regarding public participation in decisions
10 relating to serious mental illness;

11 “(5) develop and annually update a strategic
12 plan for advancing—

13 “(A) public utilization of effective mental
14 health services; and

15 “(B) compliance with treatment;

16 “(6) develop and annually update a strategic
17 plan for the conduct of, and support for, serious
18 mental illness research, including proposed budg-
19 etary requirements; and

20 “(7) submit to the Congress such strategic plan
21 and any updates to such plan.

22 “(c) MEMBERSHIP.—

23 “(1) IN GENERAL.—The Committee shall be
24 composed of—

1 “(A) the Assistant Secretary for Mental
2 Health and Substance Use Disorders (or the
3 Assistant Secretary’s designee), who shall serve
4 as the Chair of the Committee;

5 “(B) the Director of the National Institute
6 of Mental Health (or the Director’s designee);

7 “(C) the Attorney General of the United
8 States (or the Attorney General’s designee);

9 “(D) the Director of the Centers for Dis-
10 ease Control and Prevention (or the Director’s
11 designee);

12 “(E) the Director of the National Insti-
13 tutes of Health (or the Director’s designee);

14 “(F) the directors of such national re-
15 search institutes of the National Institutes of
16 Health as the Assistant Secretary for Mental
17 Health and Substance Use Disorders deter-
18 mines appropriate (or their designees);

19 “(G) a member of the United States Inter-
20 agency Council on Homelessness;

21 “(H) representatives, appointed by the As-
22 sistant Secretary, of Federal agencies that are
23 outside of the Department of Health and
24 Human Services and serve individuals with seri-
25 ous mental illness, including representatives of

1 the Bureau of Indian Affairs, the Department
2 of Defense, the Department of Education, the
3 Department of Housing and Urban Develop-
4 ment, the Department of Labor, the Depart-
5 ment of Veterans Affairs, and the Social Secu-
6 rity Administration;

7 “(I) 4 members, of which—

8 “(i) 1 shall be appointed by the
9 Speaker of the House of Representatives;

10 “(ii) 1 shall be appointed by the mi-
11 nority leader of the House of Representa-
12 tives;

13 “(iii) 1 shall be appointed by the ma-
14 jority leader of the Senate; and

15 “(iv) 1 shall be appointed by the mi-
16 nority leader of the Senate; and

17 “(J) the additional members appointed
18 under paragraph (2).

19 “(2) ADDITIONAL MEMBERS.—Not fewer than
20 14 members of the Committee, or $\frac{1}{3}$ of the total
21 membership of the Committee, whichever is greater,
22 shall be composed of non-Federal public members to
23 be appointed by the Assistant Secretary, of which—

24 “(A) at least one such member shall be an
25 individual in recovery from a diagnosis of seri-

1 ous mental illness who has benefitted from and
2 is receiving medical treatment under the care of
3 a licensed mental health professional;

4 “(B) at least one such member shall be a
5 parent or legal guardian of an individual with
6 a history of serious mental illness who has ei-
7 ther attempted suicide or is incarcerated for vi-
8 olence committed while experiencing a serious
9 mental illness;

10 “(C) at least one such member shall be a
11 representative of a leading research, advocacy,
12 and service organization for individuals with se-
13 rious mental illness;

14 “(D) at least one such member shall be—

15 “(i) a licensed psychiatrist with expe-
16 rience treating serious mental illness; or

17 “(ii) a licensed clinical psychologist
18 with experience treating serious mental ill-
19 ness;

20 “(E) at least one member shall be a li-
21 censed mental health counselor or
22 psychotherapist;

23 “(F) at least one member shall be a li-
24 censed clinical social worker;

1 “(G) at least one member shall be a li-
2 censed psychiatric nurse or nurse practitioner;

3 “(H) at least one member shall be a men-
4 tal health professional with a significant focus
5 in his or her practice working with children and
6 adolescents;

7 “(I) at least one member shall be a mental
8 health professional who spends a significant
9 concentration of his or her professional time or
10 leadership practicing community mental health;

11 “(J) at least one member shall be a mental
12 health professional with substantial experience
13 working with mentally ill individuals who have
14 a history of violence or suicide;

15 “(K) at least one such member shall be a
16 State certified mental health peer specialist;

17 “(L) at least one member shall be a judge
18 with experiences applying assisted outpatient
19 treatment;

20 “(M) at least one member shall be a law
21 enforcement officer with extensive experience in
22 interfacing with psychiatric and psychological
23 disorders or individuals in mental health crisis;
24 and

1 “(N) at least one member shall be a cor-
2 rections officer.

3 “(d) REPORTS TO CONGRESS.—Not later than 1 year
4 after the date of enactment of this Act, and every 2 years
5 thereafter, the Committee shall submit a report to the
6 Congress—

7 “(1) analyzing the efficiency, effectiveness,
8 quality, coordination, and cost effectiveness of Fed-
9 eral programs and activities relating to the preven-
10 tion of, or treatment or rehabilitation for, mental
11 health or substance use disorders, including an ac-
12 counting of the costs of such programs and activi-
13 ties, with administrative costs disaggregated from
14 the costs of services and care provided;

15 “(2) evaluating the impact on public health of
16 projects addressing priority mental health needs of
17 regional and national significance under sections
18 501, 509, 516, and 520A including measurement of
19 public health outcomes such as—

20 “(A) reduced rates of suicide, suicide at-
21 tempts, substance abuse, overdose, overdose
22 deaths, emergency hospitalizations, emergency
23 room boarding, incarceration, crime, arrest, vic-
24 timization, homelessness, and joblessness;

1 “(B) increased rates of employment and
2 enrollment in educational and vocational pro-
3 grams; and

4 “(C) such other criteria as may be deter-
5 mined by the Assistant Secretary;

6 “(3) formulating recommendations for the co-
7 ordination and improvement of Federal programs
8 and activities described in paragraph (2);

9 “(4) identifying any such programs and activi-
10 ties that are duplicative; and

11 “(5) summarizing all recommendations made,
12 activities carried out, and results achieved pursuant
13 to the workforce development strategy under section
14 501(b)(9) of the Public Health Service Act, as
15 amended by section 101.

16 “(e) ADMINISTRATIVE SUPPORT; TERMS OF SERV-
17 ICE; OTHER PROVISIONS.—The following provisions shall
18 apply with respect to the Committee:

19 “(1) The Assistant Secretary shall provide such
20 administrative support to the Committee as may be
21 necessary for the Committee to carry out its respon-
22 sibilities.

23 “(2) Members of the Committee appointed
24 under subsection (c)(2) shall serve for a term of 4
25 years, and may be reappointed for one or more addi-

1 tional 4-year terms. Any member appointed to fill a
2 vacancy for an unexpired term shall be appointed for
3 the remainder of such term. A member may serve
4 after the expiration of the member's term until a
5 successor has taken office.

6 “(3) The Committee shall meet at the call of
7 the chair or upon the request of the Assistant Sec-
8 retary. The Committee shall meet not fewer than 2
9 times each year.

10 “(4) All meetings of the Committee shall be
11 public and shall include appropriate time periods for
12 questions and presentations by the public.

13 “(f) SUBCOMMITTEES; ESTABLISHMENT AND MEM-
14 BERSHIP.—In carrying out its functions, the Committee
15 may establish subcommittees and convene workshops and
16 conferences. Such subcommittees shall be composed of
17 Committee members and may hold such meetings as are
18 necessary to enable the subcommittees to carry out their
19 duties.”.

1 **TITLE IV—HIPAA AND FERPA**
2 **CAREGIVERS**

3 **SEC. 401. PROMOTING APPROPRIATE TREATMENT FOR**
4 **MENTALLY ILL INDIVIDUALS BY TREATING**
5 **THEIR CAREGIVERS AS PERSONAL REP-**
6 **RESENTATIVES FOR PURPOSES OF HIPAA**
7 **PRIVACY REGULATIONS.**

8 (a) CAREGIVER ACCESS TO INFORMATION.—In ap-
9 plying section 164.502(g) of title 45, Code of Federal Reg-
10 ulations, to an individual with serious mental illness an
11 exception for disclosure of specific limited protected health
12 information shall be provided if all of the following criteria
13 are met for the disclosure by a physician (as defined in
14 paragraphs (1) and (2) of section 1861(r) of the Social
15 Security Act (42 U.S.C. 1395x(r))) or other licensed men-
16 tal health or health care professional to an identified re-
17 sponsible caregiver:

18 (1) Such disclosure is for information limited to
19 the diagnoses, treatment plans, appointment sched-
20 uling, medications, and medication-related instruc-
21 tions, but not including any personal psychotherapy
22 notes.

23 (2) Such disclosure is necessary to protect the
24 health, safety, or welfare of the individual or general
25 public.

1 (3) The information to be disclosed will be ben-
2 eficial to the treatment of the individual if that indi-
3 vidual has a co-occurring acute or chronic medical
4 illness.

5 (4) The information to be disclosed is necessary
6 for the continuity of treatment of the medical condi-
7 tion or mental illness of the individual.

8 (5) The absence of such information or treat-
9 ment will contribute to a worsening prognosis or an
10 acute medical condition.

11 (6) The individual by nature of the severe men-
12 tal illness has or has had a diminished capacity to
13 fully understand or follow a treatment plan for their
14 medical condition or may become gravely disabled in
15 absence of treatment.

16 (b) TRAINING.—In applying section 164.530 of title
17 45, Code of Federal Regulations, the training described
18 in paragraph (b)(1) of such section shall include training
19 with respect to the disclosure of information to a caregiver
20 of an individual pursuant to subsection (a).

21 (c) AGE OF MAJORITY.—In applying section
22 164.502(g) of title 45, Code of Federal Regulations, not-
23 withstanding any other provision of law, an
24 unemancipated minor shall be an individual under the age
25 of 18 years.

1 (d) PROVIDER ACCESS TO INFORMATION.—Health
2 care providers may listen to information or review medical
3 history provided by family members or other caregivers
4 who may have concerns about the health and well-being
5 of the patient, so the health care provider can factor that
6 information into the patient’s care.

7 (e) DEFINITIONS.—For purposes of this section:

8 (1) COVERED ENTITY.—The term “covered en-
9 tity” has the meaning given such term in section
10 106.103 of title 45, Code of Federal Regulations.

11 (2) PROTECTED HEALTH INFORMATION.—The
12 term “protected health information” has the mean-
13 ing given such term in section 106.103 of title 45,
14 Code of Federal Regulations.

15 (3) CAREGIVER.—The term “caregiver” means,
16 with respect to an individual with a serious mental
17 illness—

18 (A) an immediate family member of such
19 individual;

20 (B) an individual who assumes primary re-
21 sponsibility for providing a basic need of such
22 individual;

23 (C) a personal representative of the indi-
24 vidual as determined by the law of the State in
25 which such individual resides;

1 (D) can establish a longstanding involve-
2 ment and is responsible with the individual with
3 a serious mental illness and the health care of
4 the individual; and

5 (E) excludes an individual with a docu-
6 mented history of abuse.

7 (4) INDIVIDUAL WITH A SERIOUS MENTAL ILL-
8 NESS.—The term “individual with a serious mental
9 illness” means, with respect to the disclosure to a
10 caregiver of protected health information of an indi-
11 vidual, an individual who—

12 (A) is 18 years of age or older; and

13 (B) has, within one year before the date of
14 the disclosure, been evaluated, diagnosed, or
15 treated for a mental, behavioral, or emotional
16 disorder that—

17 (i) is determined by a physician to be
18 of sufficient duration to meet diagnostic
19 criteria specified within the Diagnostic and
20 Statistical Manual of Mental Disorders;
21 and

22 (ii) results in functional impairment
23 of the individual that substantially inter-
24 feres with or limits one or more major life
25 activities of the individual.

1 Such term includes an individual with autism
2 spectrum disorder or other developmental dis-
3 ability if such individual has a co-occurring
4 mental illness.

5 **SEC. 402. CAREGIVERS PERMITTED ACCESS TO CERTAIN**
6 **EDUCATION RECORDS UNDER FERPA.**

7 Section 444 of the General Education Provisions Act
8 (20 U.S.C. 1232g) is amended by adding at the end the
9 following new subsection:

10 “(k) DISCLOSURES TO CAREGIVERS.—

11 “(1) IN GENERAL.—With respect to a student
12 who is 18 years of age or older, an educational agen-
13 cy or institution may disclose to the caregiver of the
14 student, without regard to whether the student has
15 explicitly provided consent to the agency or institu-
16 tion for the disclosure of the student’s education
17 record, the education record of such student if a
18 physician (as defined in paragraphs (1) and (2) of
19 section 1861(r) of the Social Security Act), psycholo-
20 gist, or other recognized mental health professional
21 or paraprofessional acting in his or her professional
22 or paraprofessional capacity, or assisting in that ca-
23 pacity reasonably believes such disclosure to the
24 caregiver is necessary to protect the health, safety,

1 or welfare of such student or the safety of one or
2 more other individuals.

3 “(2) DEFINITIONS.—In this subsection:

4 “(A) CAREGIVER.—The term ‘caregiver’
5 means, with respect to a student, a family
6 member or immediate past legal guardian who
7 assumes a primary responsibility for providing
8 a basic need of such student (such as a family
9 member or past legal guardian of the student
10 who has assumed the responsibility of co-sign-
11 ing a loan with the student).

12 “(B) EDUCATION RECORD.—Notwith-
13 standing subsection (a)(4)(B), the term ‘edu-
14 cation record’ shall include a record described
15 in clause (iv) of such subsection.”.

16 **SEC. 403. CONFIDENTIALITY OF RECORDS.**

17 Section 543(e) of the Public Health Service Act (42
18 U.S.C. 290dd–2(e)) is amended—

19 (1) in paragraph (1), by striking “; or” and in-
20 serting a semicolon;

21 (2) in paragraph (2), by striking the period and
22 inserting “; or”; and

23 (3) after paragraph (2), by inserting the fol-
24 lowing:

1 “(3) within accountable care organizations de-
 2 scribed in section 1899 of the Social Security Act
 3 (42 U.S.C. 1395jjj), health information exchanges
 4 (as defined for purposes of section 3013), health
 5 homes (as defined in section 1945(h)(3) of such Act
 6 42 U.S.C. 1396w-4(h)(3)), or other integrated care
 7 arrangements (in existence before, on, or after the
 8 date of the enactment of this paragraph) involving
 9 the interchange of electronic health records (as de-
 10 fined in section 13400 of division A of Public Law
 11 111-5) (42 U.S.C. 17921(5)) containing information
 12 described in subsection (a) for purposes of attaining
 13 interoperability, improving care coordination, reduc-
 14 ing health care costs, and securing or providing pa-
 15 tient safety.”.

16 **TITLE V—MEDICARE AND**
 17 **MEDICAID REFORMS**

18 **SEC. 501. ENHANCED MEDICAID COVERAGE RELATING TO**
 19 **CERTAIN MENTAL HEALTH SERVICES.**

20 (a) MEDICAID COVERAGE OF MENTAL HEALTH
 21 SERVICES AND PRIMARY CARE SERVICES FURNISHED ON
 22 THE SAME DAY.—

23 (1) IN GENERAL.—Section 1902(a) of the So-
 24 cial Security Act (42 U.S.C. 1396a(a)) is amended

1 by inserting after paragraph (77) the following new
2 paragraph:

3 “(78) not prohibit payment under the plan for
4 a mental health service or primary care service fur-
5 nished to an individual at a community mental
6 health center meeting the criteria specified in section
7 1913(e) of the Public Health Service Act or a feder-
8 ally qualified health center (as defined in section
9 1861(aa)(3)) for which payment would otherwise be
10 payable under the plan, with respect to such indi-
11 vidual, if such service were not a same-day quali-
12 fying service (as defined in subsection (ll));”.

13 (2) SAME-DAY QUALIFYING SERVICES DE-
14 FINED.—Section 1902 of the Social Security Act (42
15 U.S.C. 1396a) is amended by adding at the end the
16 following new subsection:

17 “(ll) SAME-DAY QUALIFYING SERVICES DEFINED.—
18 For purposes of subsection (a)(78), the term ‘same-day
19 qualifying service’ means—

20 “(1) a primary care service furnished to an in-
21 dividual by a provider at a facility on the same day
22 a mental health service is furnished to such indi-
23 vidual by such provider (or another provider) at the
24 facility; and

1 “(2) a mental health service furnished to an in-
2 dividual by a provider at a facility on the same day
3 a primary care service is furnished to such individual
4 by such provider (or another provider) at the facil-
5 ity.”.

6 (b) STATE OPTION TO PROVIDE MEDICAL ASSIST-
7 ANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES
8 TO NONELDERLY ADULTS.—Section 1905 of the Social
9 Security Act (42 U.S.C. 1396d) is amended—

10 (1) in subsection (a)—

11 (A) in paragraph (16)—

12 (i) by striking “effective” and insert-
13 ing “(A) effective”; and

14 (ii) by inserting before the semicolon
15 at the end the following: “, (B) qualified
16 inpatient psychiatric hospital services (as
17 defined in subsection (h)(3)) for individ-
18 uals over 21 years of age and under 65
19 years of age, and (C) psychiatric residen-
20 tial treatment facility services (as defined
21 in subsection (h)(4)) for individuals over
22 21 years of age and under 65 years of
23 age”; and

24 (B) in the subdivision (B) that follows
25 paragraph (29), by inserting “(other than serv-

1 ices described in subparagraphs (B) and (C) of
2 paragraph (16) for individuals described in such
3 subparagraphs)” after “patient in an institution
4 for mental diseases”; and

5 (2) in subsection (h), by adding at the end the
6 following new paragraphs:

7 “(3) For purposes of subsection (a)(16)(B), the term
8 ‘qualified inpatient psychiatric hospital services’ means,
9 with respect to individuals described in such subsection,
10 services described in subparagraphs (A) and (B) of para-
11 graph (1) that are furnished in an acute care psychiatric
12 unit in a State-operated psychiatric hospital or a psy-
13 chiatric hospital (as defined section 1861(f)) if such unit
14 or hospital, as applicable, has a facilitywide average (de-
15 termined on an annual basis) length of stay of less than
16 30 days.

17 “(4) For purposes of subsection (a)(16)(C), the term
18 ‘psychiatric residential treatment facility services’ means,
19 with respect to individuals described in such subsection,
20 services described in subparagraphs (A) and (B) of para-
21 graph (1) that are furnished in a psychiatric residential
22 treatment facility (as defined in section 484.353 of title
23 42, Code of Federal Regulations, as in effect on December
24 9, 2013).”.

25 (c) REPORT.—

1 (1) IN GENERAL.—The Assistant Secretary for
2 Mental Health and Substance Use Disorders shall
3 report on the impact of the amendments made by
4 subsection (b) on the funds made available by States
5 for inpatient psychiatric hospital care and for com-
6 munity-based mental health services. Such study
7 shall include an assessment of each of the following:

8 (A) The amount of funds expended annu-
9 ally by States on short-term, acute inpatient
10 psychiatric hospital care.

11 (B) The amount of funds expended annu-
12 ally on short-term, acute inpatient psychiatric
13 hospital care through disproportionate share
14 hospital payments under section 1923 of the
15 Social Security Act (42 U.S.C. 1396r–4).

16 (C) The reduction in the amount of funds
17 described in subparagraph (A) that is attrib-
18 utable to the amendments made by subsection
19 (b).

20 (D) The reduction in the amount of funds
21 described in subparagraph (B) that is attrib-
22 utable to the amendment made by such sub-
23 section.

24 (E) The total amount of the reductions de-
25 scribed in subparagraphs (C) and (D).

1 (2) DEFINITION OF SHORT-TERM, ACUTE INPA-
2 TIENT PSYCHIATRIC HOSPITAL CARE.—For purposes
3 of paragraph (1), the term “short-term, acute inpa-
4 tient psychiatric hospital care” means care that is
5 provided in either—

6 (A) an acute-care psychiatric unit with an
7 average annual length of stay of fewer than 30
8 days that is operated within a psychiatric hos-
9 pital operated by a State; or

10 (B) a psychiatric hospital with an average
11 annual length of stay of fewer than 30 days.

12 (3) REPORT.—Not later than two years after
13 the date of the enactment of this Act, such Assistant
14 Secretary shall submit a report to Congress on the
15 results of the study described in paragraph (1), in-
16 cluding recommendations with respect to strategies
17 that can be used to reinvest in community-based
18 mental health services funds equal to the total
19 amount of the reductions described in paragraph
20 (1)(E).

21 (d) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Subject to paragraphs (2)
23 and (3), the amendments made by this section shall
24 apply to items and services furnished after the first

1 day of the first calendar year that begins after the
2 date of the enactment of this section.

3 (2) CERTIFICATION OF NO INCREASED SPEND-
4 ING.—The amendments made by this section shall
5 not be effective unless the Chief Actuary of the Cen-
6 ters for Medicare & Medicaid Services certifies that
7 the inclusion of qualified inpatient psychiatric hos-
8 pital services and psychiatric residential treatment
9 facility services (as those terms are defined in sec-
10 tion 1905(h) of the Social Security Act (42 U.S.C.
11 1396d(h))) furnished to nonelderly adults as medical
12 assistance under section 1905(a) of the Social Secu-
13 rity Act (42 U.S.C. 1396d(a)), as amended by sub-
14 section (a), would not result in any increase in net
15 program spending under title XIX of such Act.

16 (3) EXCEPTION FOR STATE LEGISLATION.—In
17 the case of a State plan under title XIX of the So-
18 cial Security Act, which the Secretary of Health and
19 Human Services determines requires State legisla-
20 tion in order for the respective plan to meet any re-
21 quirement imposed by amendments made by this
22 section, the respective plan shall not be regarded as
23 failing to comply with the requirements of such title
24 solely on the basis of its failure to meet such an ad-
25 ditional requirement before the first day of the first

1 calendar quarter beginning after the close of the
2 first regular session of the State legislature that be-
3 gins after the date of enactment of this section. For
4 purposes of the previous sentence, in the case of a
5 State that has a 2-year legislative session, each year
6 of the session shall be considered to be a separate
7 regular session of the State legislature.

8 **SEC. 502. ACCESS TO MENTAL HEALTH PRESCRIPTION**
9 **DRUGS UNDER MEDICARE AND MEDICAID.**

10 (a) COVERAGE OF PRESCRIPTION DRUGS USED TO
11 TREAT MENTAL HEALTH DISORDERS UNDER MEDI-
12 CARE.—Section 1860D–4(b)(3)(G) of the Social Security
13 Act (42 U.S.C. 1395w–104(b)(3)(G)) is amended—

14 (1) in clause (i)(I), by striking “in the cat-
15 egories” and inserting “in the categories and classes
16 of drugs specified in subclauses (II) and (IV) of
17 clause (iv) and in other categories”;

18 (2) in clause (i)(II), by inserting “, for cat-
19 egories and classes of drugs other than the cat-
20 egories and classes of drugs specified in subclauses
21 (II) and (IV) of clause (iv),” before “exceptions”;

22 (3) in clause (ii)(I), by inserting at the end the
23 following new sentence: “For purposes of the pre-
24 vious sentence, the categories and classes of drugs

1 specified in subclauses (II) and (IV) of clause (iv)
2 shall be deemed to be of clinical concern.”; and

3 (4) in clause (iv), in the matter preceding sub-
4 clause (I), by inserting “(and in the case of cat-
5 egories and classes of drugs specified in subclauses
6 (II) and (IV), before, on, and after the Secretary es-
7 tablishes such criteria)” after “clause (ii)(II)”.

8 (b) COVERAGE OF PRESCRIPTION DRUGS USED TO
9 TREAT MENTAL HEALTH DISORDERS UNDER MED-
10 ICAID.—

11 (1) IN GENERAL.—Section 1927(d) of the So-
12 cial Security Act (42 U.S.C. 1396r–8(d)) is amend-
13 ed by adding at the end the following new para-
14 graph:

15 “(8) ACCESS TO MENTAL HEALTH DRUGS.—
16 With respect to covered outpatient drugs used for
17 the treatment of a mental health disorder, including
18 major depression, bipolar (manic-depressive) dis-
19 order, panic disorder, obsessive-compulsive disorder,
20 schizophrenia, and schizoaffective disorder, a State
21 shall not exclude from coverage or otherwise restrict
22 access to such drugs other than pursuant to a prior
23 authorization program that is consistent with para-
24 graph (5).”.

1 (2) MEDICAID MANAGED CARE ORGANIZA-
2 TIONS.—Section 1932(b) of the Social Security Act
3 (42 U.S.C. 1396u–2(b)) is amended by adding at
4 the end the following new paragraph:

5 “(9) COVERAGE OF PRESCRIPTION DRUGS USED
6 TO TREAT MENTAL HEALTH DISORDERS.—Each con-
7 tract with a managed care entity under section
8 1903(m) or under section 1905(t)(3) shall require
9 coverage of all covered outpatient drugs used for the
10 treatment of a mental health disorder, in accordance
11 with section 1927(d)(8).”.

12 **SEC. 503. ELIMINATION OF 190-DAY LIFETIME LIMIT ON**
13 **COVERAGE OF INPATIENT PSYCHIATRIC HOS-**
14 **PITAL SERVICES UNDER MEDICARE.**

15 (a) IN GENERAL.—Section 1812 of the Social Secu-
16 rity Act (42 U.S.C. 1395d) is amended—

17 (1) in subsection (b)—

18 (A) in paragraph (1), by adding “or” at
19 the end;

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

22 (C) by striking paragraph (3); and

23 (2) in subsection (c), by striking “or in deter-
24 mining the 190-day limit under subsection (b)(3)”.

1 (b) EFFECTIVE DATE; CERTIFICATION OF NO IN-
2 CREASED SPENDING.—

3 (1) IN GENERAL.—Subject to paragraph (2),
4 the amendments made by subsection (a) shall apply
5 to items and services furnished on or after January
6 1, 2016.

7 (2) CERTIFICATION OF NO INCREASED SPEND-
8 ING.—The amendments made by subsection (a) shall
9 not be effective unless the Chief Actuary of the Cen-
10 ters for Medicare & Medicaid Services certifies that
11 such amendments will not result in any increase in
12 net Federal expenditures under title XVIII of the
13 Social Security Act.

14 **SEC. 504. MODIFICATIONS TO MEDICARE DISCHARGE PLAN-**
15 **NING REQUIREMENTS.**

16 Section 1861(ee) of the Social Security Act (42
17 U.S.C. 1395x(ee)) is amended—

18 (1) in paragraph (1), by inserting “and, in the
19 case of a psychiatric hospital or a psychiatric unit
20 (as described in the matter following clause (v) of
21 section 1886(d)(1)(B)), if it also meets the guide-
22 lines and standards established by the Secretary
23 under paragraph (3)” before the period at the end;
24 and

1 (2) by adding at the end the following new
2 paragraph:

3 “(3) The Secretary shall develop guidelines and
4 standards, in addition to those developed under paragraph
5 (2), for the discharge planning process of a psychiatric
6 hospital or a psychiatric unit (as described in the matter
7 following clause (v) of section 1886(d)(1)(B)) in order to
8 ensure a timely and smooth transition to the most appro-
9 priate type of and setting for posthospital or rehabilitative
10 care. The Secretary shall issue final regulations imple-
11 menting such guidelines and standards not later than 24
12 months after the date of the enactment of this paragraph.
13 The guidelines and standards shall include the following:

14 “(A) The hospital or unit must identify the
15 types of services needed upon discharge for the pa-
16 tients being treated by the hospital or unit.

17 “(B) The hospital or unit must—

18 “(i) identify organizations that offer com-
19 munity services to the community that is served
20 by the hospital or unit and the types of services
21 provided by the organizations; and

22 “(ii) must make demonstrated efforts to
23 establish connections, relationships, and part-
24 nerships with such organizations.

1 “(C) The hospital or unit must arrange (with
2 the participation of the patient and of any other in-
3 dividuals selected by the patient for such purpose)
4 for the development and implementation of a dis-
5 charge plan for the patient as part of the patient’s
6 overall treatment plan from admission to discharge.
7 Such discharge plan shall meet the requirements de-
8 scribed in subparagraphs (G) and (H) of paragraph
9 (2).

10 “(D) The hospital or unit shall coordinate with
11 the patient (or assist the patient with) the referral
12 for posthospital or rehabilitative care and as part of
13 that referral the hospital or unit shall include trans-
14 mitting to the receiving organization, in a timely
15 manner, appropriate information about the care fur-
16 nished to the patient by the hospital or unit and rec-
17 ommendations for posthospital or rehabilitative care
18 to be furnished to the patient by the organization.”.

19 **SEC. 505. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
20 **MUNITY MENTAL HEALTH SERVICES.**

21 Section 223 of the Protecting Access to Medicare Act
22 of 2014 (Public Law 113–93; 128 Stat. 1077) is amended
23 to read as follows:

1 **“SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
2 **MUNITY MENTAL HEALTH SERVICES.**

3 “(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-
4 IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-
5 ONSTRATION PROGRAMS.—

6 “(1) PUBLICATION.—Not later than September
7 1, 2015, the Secretary shall publish criteria for a
8 clinic to be certified by a State as a certified com-
9 munity behavioral health clinic for purposes of par-
10 ticipating in a demonstration program conducted
11 under subsection (d).

12 “(2) REQUIREMENTS.—The criteria published
13 under this subsection shall include criteria with re-
14 spect to the following:

15 “(A) STAFFING.—Staffing requirements,
16 including criteria that staff have diverse dis-
17 ciplinary backgrounds, have necessary State-re-
18 quired license and accreditation, and are cul-
19 turally and linguistically trained to serve the
20 needs of the clinic’s patient population.

21 “(B) AVAILABILITY AND ACCESSIBILITY OF
22 SERVICES.—Availability and accessibility of
23 services, including crisis management services
24 that are available and accessible 24 hours a
25 day, the use of a sliding scale for payment, and
26 no rejection for services or limiting of services

1 on the basis of a patient’s ability to pay or a
2 place of residence.

3 “(C) CARE COORDINATION.—Care coordi-
4 nation, including requirements to coordinate
5 care across settings and providers to ensure
6 seamless transitions for patients across the full
7 spectrum of health services including acute,
8 chronic, and behavioral health needs. Care co-
9 ordination requirements shall include partner-
10 ships or formal contracts with the following:

11 “(i) Federally-qualified health centers
12 (and as applicable, rural health clinics) to
13 provide Federally-qualified health center
14 services (and as applicable, rural health
15 clinic services) to the extent such services
16 are not provided directly through the cer-
17 tified community behavioral health clinic.

18 “(ii) Inpatient psychiatric facilities
19 and substance use detoxification, post-de-
20 toxification step-down services, and resi-
21 dential programs.

22 “(iii) Other community or regional
23 services, supports, and providers, including
24 schools, child welfare agencies, juvenile and
25 criminal justice agencies and facilities, In-

1 dian Health Service youth regional treat-
2 ment centers, State-licensed and nationally
3 accredited child placing agencies for thera-
4 peutic foster care service, and other social
5 and human services.

6 “(iv) Department of Veterans Affairs
7 medical centers, independent outpatient
8 clinics, drop-in centers, and other facilities
9 of the Department as defined in section
10 1801 of title 38, United States Code.

11 “(v) Inpatient acute care hospitals
12 and hospital outpatient clinics.

13 “(D) SCOPE OF SERVICES.—Provision (in
14 a manner reflecting person-centered care) of the
15 following services which, if not available directly
16 through the certified community behavioral
17 health clinic, are provided or referred through
18 formal relationships with other providers:

19 “(i) Crisis mental health services, in-
20 cluding 24-hour mobile crisis teams, emer-
21 gency crisis intervention services, and cri-
22 sis stabilization.

23 “(ii) Screening, assessment, and diag-
24 nosis, including risk assessment.

1 “(iii) Patient-centered treatment plan-
2 ning or similar processes, including risk as-
3 sessment and crisis planning.

4 “(iv) Outpatient mental health and
5 substance use services.

6 “(v) Outpatient clinic primary care
7 screening and monitoring of key health in-
8 dicators and health risk.

9 “(vi) Targeted case management.

10 “(vii) Psychiatric rehabilitation serv-
11 ices.

12 “(viii) Peer support and counselor
13 services and family supports.

14 “(ix) Intensive, community-based
15 mental health care for members of the
16 Armed Forces and veterans, particularly
17 those members and veterans located in
18 rural areas, provided the care is consistent
19 with minimum clinical mental health guide-
20 lines promulgated by the Veterans Health
21 Administration including clinical guidelines
22 contained in the Uniform Mental Health
23 Services Handbook of such Administration.

24 “(E) QUALITY AND OTHER REPORTING.—

25 Reporting of encounter data, clinical outcomes

1 data, quality data, and such other data as the
2 Secretary requires.

3 “(F) ORGANIZATIONAL AUTHORITY.—Cri-
4 teria that a clinic be a non-profit or part of a
5 local government behavioral health authority or
6 operated under the authority of the Indian
7 Health Service, an Indian tribe or tribal organi-
8 zation pursuant to a contract, grant, coopera-
9 tive agreement, or compact with the Indian
10 Health Service pursuant to the Indian Self-De-
11 termination Act (25 U.S.C. 450 et seq.), or an
12 urban Indian organization pursuant to a grant
13 or contract with the Indian Health Service
14 under title V of the Indian Health Care Im-
15 provement Act (25 U.S.C. 1601 et seq.).

16 “(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE
17 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-
18 TION PROGRAMS.—

19 “(1) IN GENERAL.—Not later than September
20 1, 2015, the Secretary, through the Administrator of
21 the Centers for Medicare & Medicaid Services, shall
22 issue guidance for the establishment of a prospective
23 payment system that shall only apply to medical as-
24 sistance for mental health services furnished by a
25 certified community behavioral health clinic partici-

1 pating in a demonstration program under subsection
2 (d).

3 “(2) REQUIREMENTS.—The guidance issued by
4 the Secretary under paragraph (1) shall provide
5 that—

6 “(A) no payment shall be made for inpa-
7 tient care, residential treatment, room and
8 board expenses, or any other nonambulatory
9 services, as determined by the Secretary; and

10 “(B) no payment shall be made to satellite
11 facilities of certified community behavioral
12 health clinics if such facilities are established
13 after the date of enactment of this Act.

14 “(c) PLANNING GRANTS.—

15 “(1) IN GENERAL.—Not later than January 1,
16 2016, the Secretary shall award planning grants to
17 States for the purpose of developing proposals to
18 participate in time-limited demonstration programs
19 described in subsection (d).

20 “(2) USE OF FUNDS.—A State awarded a plan-
21 ning grant under this subsection shall—

22 “(A) solicit input with respect to the devel-
23 opment of such a demonstration program from
24 patients, providers, and other stakeholders;

1 “(B) certify clinics as certified community
2 behavioral health clinics for purposes of partici-
3 pating in a demonstration program conducted
4 under subsection (d); and

5 “(C) establish a prospective payment sys-
6 tem for mental health services furnished by a
7 certified community behavioral health clinic
8 participating in a demonstration program under
9 subsection (d) in accordance with the guidance
10 issued under subsection (b).

11 “(d) DEMONSTRATION PROGRAMS.—

12 “(1) IN GENERAL.—Not later than September
13 1, 2017, the Secretary shall select States to partici-
14 pate in demonstration programs that are developed
15 through planning grants awarded under subsection
16 (c), meet the requirements of this subsection, and
17 represent a diverse selection of geographic areas, in-
18 cluding rural and underserved areas.

19 “(2) APPLICATION REQUIREMENTS.—

20 “(A) IN GENERAL.—The Secretary shall
21 solicit applications to participate in demonstra-
22 tion programs under this subsection solely from
23 States awarded planning grants under sub-
24 section (c).

1 “(B) REQUIRED INFORMATION.—An appli-
2 cation for a demonstration program under this
3 subsection shall include the following:

4 “(i) The target Medicaid population
5 to be served under the demonstration pro-
6 gram.

7 “(ii) A list of participating certified
8 community behavioral health clinics.

9 “(iii) Verification that the State has
10 certified a participating clinic as a certified
11 community behavioral health clinic in ac-
12 cordance with the requirements of sub-
13 section (b).

14 “(iv) A description of the scope of the
15 mental health services available under the
16 State Medicaid program that will be paid
17 for under the prospective payment system
18 tested in the demonstration program.

19 “(v) Verification that the State has
20 agreed to pay for such services at the rate
21 established under the prospective payment
22 system.

23 “(vi) Such other information as the
24 Secretary may require relating to the dem-
25 onstration program including with respect

1 to determining the soundness of the pro-
2 posed prospective payment system.

3 “(3) NUMBER AND LENGTH OF DEMONSTRA-
4 TION PROGRAMS.—Not more than 10 States shall be
5 selected for 4-year demonstration programs under
6 this subsection.

7 “(4) REQUIREMENTS FOR SELECTING DEM-
8 ONSTRATION PROGRAMS.—

9 “(A) IN GENERAL.—The Secretary shall
10 give preference to selecting demonstration pro-
11 grams where participating certified community
12 behavioral health clinics—

13 “(i) provide the most complete scope
14 of services described in subsection
15 (a)(2)(D) to individuals eligible for medical
16 assistance under the State Medicaid pro-
17 gram;

18 “(ii) will improve availability of, ac-
19 cess to, and participation in, services de-
20 scribed in subsection (a)(2)(D) to individ-
21 uals eligible for medical assistance under
22 the State Medicaid program;

23 “(iii) will improve availability of, ac-
24 cess to, and participation in assisted out-

1 patient mental health treatment in the
2 State; or

3 “(iv) demonstrate the potential to ex-
4 pand available mental health services in a
5 demonstration area and increase the qual-
6 ity of such services without increasing net
7 Federal spending.

8 “(5) PAYMENT FOR MEDICAL ASSISTANCE FOR
9 MENTAL HEALTH SERVICES PROVIDED BY CER-
10 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-
11 ICS.—

12 “(A) IN GENERAL.—The Secretary shall
13 pay a State participating in a demonstration
14 program under this subsection the Federal
15 matching percentage specified in subparagraph
16 (B) for amounts expended by the State to pro-
17 vide medical assistance for mental health serv-
18 ices described in the demonstration program ap-
19 plication in accordance with paragraph
20 (2)(B)(iv) that are provided by certified com-
21 munity behavioral health clinics to individuals
22 who are enrolled in the State Medicaid pro-
23 gram. Payments to States made under this
24 paragraph shall be considered to have been
25 under, and are subject to the requirements of,

1 section 1903 of the Social Security Act (42
2 U.S.C. 1396b).

3 “(B) FEDERAL MATCHING PERCENTAGE.—
4 The Federal matching percentage specified in
5 this subparagraph is with respect to medical as-
6 sistance described in subparagraph (A) that is
7 furnished—

8 “(i) to a newly eligible individual de-
9 scribed in paragraph (2) of section 1905(y)
10 of the Social Security Act (42 U.S.C.
11 1396d(y)), the matching rate applicable
12 under paragraph (1) of that section; and

13 “(ii) to an individual who is not a
14 newly eligible individual (as so described)
15 but who is eligible for medical assistance
16 under the State Medicaid program, the en-
17 hanced FMAP applicable to the State.

18 “(C) LIMITATIONS.—

19 “(i) IN GENERAL.—Payments shall be
20 made under this paragraph to a State only
21 for mental health services—

22 “(I) that are described in the
23 demonstration program application in
24 accordance with paragraph (2)(B)(iv);

1 “(II) for which payment is avail-
2 able under the State Medicaid pro-
3 gram; and

4 “(III) that are provided to an in-
5 dividual who is eligible for medical as-
6 sistance under the State Medicaid
7 program.

8 “(ii) PROHIBITED PAYMENTS.—No
9 payment shall be made under this para-
10 graph—

11 “(I) for inpatient care, residen-
12 tial treatment, room and board ex-
13 penses, or any other nonambulatory
14 services, as determined by the Sec-
15 retary; or

16 “(II) with respect to payments
17 made to satellite facilities of certified
18 community behavioral health clinics if
19 such facilities are established after the
20 date of enactment of this Act.

21 “(6) WAIVER OF STATEWIDENESS REQUIRE-
22 MENT.—The Secretary shall waive section
23 1902(a)(1) of the Social Security Act (42 U.S.C.
24 1396a(a)(1)) (relating to statewideness) as may be

1 necessary to conduct demonstration programs in ac-
2 cordance with the requirements of this subsection.

3 “(7) ANNUAL REPORTS.—

4 “(A) IN GENERAL.—Not later than 1 year
5 after the date on which the first State is se-
6 lected for a demonstration program under this
7 subsection, and annually thereafter, the Sec-
8 retary shall submit to Congress an annual re-
9 port on the use of funds provided under all
10 demonstration programs conducted under this
11 subsection. Each such report shall include—

12 “(i) an assessment of access to com-
13 munity-based mental health services under
14 the Medicaid program in the area or areas
15 of a State targeted by a demonstration
16 program compared to other areas of the
17 State;

18 “(ii) an assessment of the quality and
19 scope of services provided by certified com-
20 munity behavioral health clinics compared
21 to community-based mental health services
22 provided in States not participating in a
23 demonstration program under this sub-
24 section and in areas of a demonstration

1 State that are not participating in the
2 demonstration program; and

3 “(iii) an assessment of the impact of
4 the demonstration programs on the Fed-
5 eral and State costs of a full range of men-
6 tal health services (including inpatient,
7 emergency and ambulatory services).

8 “(B) RECOMMENDATIONS.—Not later than
9 December 31, 2021, the Secretary shall submit
10 to Congress recommendations concerning
11 whether the demonstration programs under this
12 section should be continued, expanded, modi-
13 fied, or terminated.

14 “(e) DEFINITIONS.—In this section:

15 “(1) FEDERALLY-QUALIFIED HEALTH CENTER
16 SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;
17 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH
18 CLINIC.—The terms ‘Federally-qualified health cen-
19 ter services’, ‘Federally-qualified health center’,
20 ‘rural health clinic services’, and ‘rural health clinic’
21 have the meanings given those terms in section
22 1905(l) of the Social Security Act (42 U.S.C.
23 1396d(1)).

24 “(2) ENHANCED FMAP.—The term ‘enhanced
25 FMAP’ has the meaning given that term in section

1 2105(b) of the Social Security Act (42 U.S.C.
2 1397dd(b)) but without regard to the second and
3 third sentences of that section.

4 “(3) SECRETARY.—The term ‘Secretary’ means
5 the Secretary of Health and Human Services.

6 “(4) STATE.—The term ‘State’ has the mean-
7 ing given such term for purposes of title XIX of the
8 Social Security Act (42 U.S.C. 1396 et seq.).

9 “(f) FUNDING.—

10 “(1) IN GENERAL.—Out of any funds in the
11 Treasury not otherwise appropriated, there is appro-
12 priated to the Secretary—

13 “(A) for purposes of carrying out sub-
14 sections (a), (b), and (d)(7), \$2,000,000 for fis-
15 cal year 2014; and

16 “(B) for purposes of awarding planning
17 grants under subsection (c), \$25,000,000 for
18 fiscal year 2016.

19 “(2) AVAILABILITY.—Funds appropriated
20 under paragraph (1) shall remain available until ex-
21 pended.”.

1 **TITLE VI—RESEARCH BY NA-**
2 **TIONAL INSTITUTE OF MEN-**
3 **TAL HEALTH**

4 **SEC. 601. INCREASE IN FUNDING FOR CERTAIN RESEARCH.**

5 Section 402A(a) of the Public Health Service Act (42
6 U.S.C. 282a(a)) is amended by adding at the end the fol-
7 lowing:

8 “(3) FUNDING FOR THE BRAIN INITIATIVE AT
9 THE NATIONAL INSTITUTE OF MENTAL HEALTH.—

10 “(A) FUNDING.—In addition to amounts
11 made available pursuant to paragraphs (1) and
12 (2), there are authorized to be appropriated to
13 the National Institute of Mental Health for the
14 purpose described in subparagraph (B)(ii)
15 \$40,000,000 for each of fiscal years 2016
16 through 2020.

17 “(B) PURPOSES.—Amounts appropriated
18 pursuant to subparagraph (A) shall be used ex-
19 clusively for the purpose of conducting or sup-
20 porting—

21 “(i) research on the determinants of
22 self- and other directed-violence in mental
23 illness, including studies directed at reduc-
24 ing the risk of self harm, suicide, and
25 interpersonal violence; or

1 “(ii) brain research through the Brain
2 Research through Advancing Innovative
3 Neurotechnologies Initiative.”.

4 **TITLE VII—BEHAVIORAL**
5 **HEALTH INFORMATION TECH-**
6 **NOLOGY**

7 **SEC. 701. EXTENSION OF HEALTH INFORMATION TECH-**
8 **NOLOGY ASSISTANCE FOR BEHAVIORAL AND**
9 **MENTAL HEALTH AND SUBSTANCE ABUSE.**

10 Section 3000(3) of the Public Health Service Act (42
11 U.S.C. 300jj(3)) is amended by inserting before “and any
12 other category” the following: “behavioral and mental
13 health professionals (as defined in section
14 331(a)(3)(E)(i)), a substance abuse professional, a psy-
15 chiatric hospital (as defined in section 1861(f) of the So-
16 cial Security Act), a community mental health center
17 meeting the criteria specified in section 1913(c), a residen-
18 tial or outpatient mental health or substance use treat-
19 ment facility,”.

20 **SEC. 702. EXTENSION OF ELIGIBILITY FOR MEDICARE AND**
21 **MEDICAID HEALTH INFORMATION TECH-**
22 **NOLOGY IMPLEMENTATION ASSISTANCE.**

23 (a) **PAYMENT INCENTIVES FOR ELIGIBLE PROFES-**
24 **SIONALS UNDER MEDICARE.**—Section 1848 of the Social
25 Security Act (42 U.S.C. 1395w-4) is amended—

1 (1) in subsection (a)(7)—

2 (A) in subparagraph (E), by adding at the
3 end the following new clause:

4 “(iv) ADDITIONAL ELIGIBLE PROFES-
5 SIONAL.—The term ‘additional eligible pro-
6 fessional’ means a clinical psychologist pro-
7 viding qualified psychologist services (as
8 defined in section 1861(ii)).”; and

9 (B) by adding at the end the following new
10 subparagraph:

11 “(F) APPLICATION TO ADDITIONAL ELIGI-
12 BLE PROFESSIONALS.—The Secretary shall
13 apply the provisions of this paragraph with re-
14 spect to an additional eligible professional in
15 the same manner as such provisions apply to an
16 eligible professional, except in applying sub-
17 paragraph (A)—

18 “(i) in clause (i), the reference to
19 2015 shall be deemed a reference to 2020;

20 “(ii) in clause (ii), the references to
21 2015, 2016, and 2017 shall be deemed ref-
22 erences to 2020, 2021, and 2022, respec-
23 tively; and

1 “(iii) in clause (iii), the reference to
2 2018 shall be deemed a reference to
3 2023.”; and

4 (2) in subsection (o)—

5 (A) in paragraph (5), by adding at the end
6 the following new subparagraph:

7 “(D) ADDITIONAL ELIGIBLE PROFES-
8 SIONAL.—The term ‘additional eligible profes-
9 sional’ means a clinical psychologist providing
10 qualified psychologist services (as defined in
11 section 1861(ii)).”; and

12 (B) by adding at the end the following new
13 paragraph:

14 “(6) APPLICATION TO ADDITIONAL ELIGIBLE
15 PROFESSIONALS.—The Secretary shall apply the
16 provisions of this subsection with respect to an addi-
17 tional eligible professional in the same manner as
18 such provisions apply to an eligible professional, ex-
19 cept in applying—

20 “(A) paragraph (1)(A)(ii), the reference to
21 2016 shall be deemed a reference to 2021;

22 “(B) paragraph (1)(B)(ii), the references
23 to 2011 and 2012 shall be deemed references to
24 2016 and 2017, respectively;

1 “(C) paragraph (1)(B)(iii), the references
2 to 2013 shall be deemed references to 2018;

3 “(D) paragraph (1)(B)(v), the references
4 to 2014 shall be deemed references to 2019;
5 and

6 “(E) paragraph (1)(E), the reference to
7 2011 shall be deemed a reference to 2016.”.

8 (b) ELIGIBLE HOSPITALS.—Section 1886 of the So-
9 cial Security Act (42 U.S.C. 1395ww) is amended—

10 (1) in subsection (b)(3)(B)(ix), by adding at the
11 end the following new subclause:

12 “(V) The Secretary shall apply
13 the provisions of this subsection with
14 respect to an additional eligible hos-
15 pital (as defined in subsection
16 (n)(6)(C)) in the same manner as
17 such provisions apply to an eligible
18 hospital, except in applying—

19 “(aa) subclause (I), the ref-
20 erences to 2015, 2016, and 2017
21 shall be deemed references to
22 2020, 2021, and 2022, respec-
23 tively; and

24 “(bb) subclause (III), the
25 reference to 2015 shall be

1 deemed a reference to 2020.”;

2 and

3 (2) in subsection (n)—

4 (A) in paragraph (6), by adding at the end
5 the following new subparagraph:

6 “(C) ADDITIONAL ELIGIBLE HOSPITAL.—

7 The term ‘additional eligible hospital’ means an
8 inpatient hospital that is a psychiatric hospital
9 (as defined in section 1861(f)).”; and

10 (B) by adding at the end the following new
11 paragraph:

12 “(7) APPLICATION TO ADDITIONAL ELIGIBLE
13 HOSPITALS.—The Secretary shall apply the provi-
14 sions of this subsection with respect to an additional
15 eligible hospital in the same manner as such provi-
16 sions apply to an eligible hospital, except in apply-
17 ing—

18 “(A) paragraph (2)(E)(ii), the references
19 to 2013 and 2015 shall be deemed references to
20 2018 and 2020, respectively; and

21 “(B) paragraph (2)(G)(i), the reference to
22 2011 shall be deemed a reference to 2016.”.

23 (c) MEDICAID PROVIDERS.—Section 1903(t) of the
24 Social Security Act (42 U.S.C. 1396b(t)) is amended—

25 (1) in paragraph (2)(B)—

1 (A) in clause (i), by striking “, or” at the
2 end and inserting a semicolon;

3 (B) in clause (ii), by striking the period at
4 the end and inserting a semicolon; and

5 (C) by inserting after clause (ii) the fol-
6 lowing new clauses:

7 “(iii) a public hospital that is principally a
8 psychiatric hospital (as defined in section
9 1861(f));

10 “(iv) a private hospital that is principally
11 a psychiatric hospital (as defined in section
12 1861(f)) and that has at least 10 percent of its
13 patient volume (as estimated in accordance with
14 a methodology established by the Secretary) at-
15 tributable to individuals receiving medical as-
16 sistance under this title;

17 “(v) a community mental health center
18 meeting the criteria specified in section 1913(c)
19 of the Public Health Service Act; or

20 “(vi) a residential or outpatient mental
21 health or substance use treatment facility
22 that—

23 “(I) is accredited by the Joint Com-
24 mission on Accreditation of Healthcare Or-
25 ganizations, the Commission on Accredita-

1 tion of Rehabilitation Facilities, the Coun-
2 cil on Accreditation, or any other national
3 accrediting agency recognized by the Sec-
4 retary; and

5 “(II) has at least 10 percent of its pa-
6 tient volume (as estimated in accordance
7 with a methodology established by the Sec-
8 retary) attributable to individuals receiving
9 medical assistance under this title.”; and

10 (2) in paragraph (3)(B)—

11 (A) in clause (iv), by striking “; and” at
12 the end and inserting a semicolon;

13 (B) in clause (v), by striking the period at
14 the end and inserting “; and”; and

15 (C) by adding at the end the following new
16 clause:

17 “(vi) clinical psychologist providing quali-
18 fied psychologist services (as defined in section
19 1861(ii)), if such clinical psychologist is prac-
20 ticing in an outpatient clinic that—

21 “(I) is led by a clinical psychologist;
22 and

23 “(II) is not otherwise receiving pay-
24 ment under paragraph (1) as a Medicaid
25 provider described in paragraph (2)(B).”.

1 (d) MEDICARE ADVANTAGE ORGANIZATIONS.—Sec-
2 tion 1853 of the Social Security Act (42 U.S.C. 1395w-
3 23) is amended—

4 (1) in subsection (l)—

5 (A) in paragraph (1)—

6 (i) by inserting “or additional eligible
7 professionals (as described in paragraph
8 (9))” after “paragraph (2)”; and

9 (ii) by inserting “and additional eligi-
10 ble professionals” before “under such sec-
11 tions”;

12 (B) in paragraph (3)(B)—

13 (i) in clause (i) in the matter pre-
14 ceding subclause (I), by inserting “or an
15 additional eligible professional described in
16 paragraph (9)” after “paragraph (2)”; and

17 (ii) in clause (ii)—

18 (I) in the matter preceding sub-
19 clause (I), by inserting “or an addi-
20 tional eligible professional described in
21 paragraph (9)” after “paragraph
22 (2)”; and

23 (II) in subclause (I), by inserting
24 “or an additional eligible professional,

1 respectively,” after “eligible profes-
2 sional”;

3 (C) in paragraph (3)(C), by inserting “and
4 additional eligible professionals” after “all eligi-
5 ble professionals”;

6 (D) in paragraph (4)(D), by adding at the
7 end the following new sentence: “In the case
8 that a qualifying MA organization attests that
9 not all additional eligible professionals of the
10 organization are meaningful EHR users with
11 respect to an applicable year, the Secretary
12 shall apply the payment adjustment under this
13 paragraph based on the proportion of all such
14 additional eligible professionals of the organiza-
15 tion that are not meaningful EHR users for
16 such year.”;

17 (E) in paragraph (6)(A), by inserting
18 “and, as applicable, each additional eligible pro-
19 fessional described in paragraph (9)” after
20 “paragraph (2)”;

21 (F) in paragraph (6)(B), by inserting
22 “and, as applicable, each additional eligible hos-
23 pital described in paragraph (9)” after “sub-
24 section (m)(1)”;

1 (G) in paragraph (7)(A), by inserting
2 “and, as applicable, additional eligible profes-
3 sionals” after “eligible professionals”;

4 (H) in paragraph (7)(B), by inserting
5 “and, as applicable, additional eligible profes-
6 sionals” after “eligible professionals”;

7 (I) in paragraph (8)(B), by inserting “and
8 additional eligible professionals described in
9 paragraph (9)” after “paragraph (2)”; and

10 (J) by adding at the end the following new
11 paragraph:

12 “(9) ADDITIONAL ELIGIBLE PROFESSIONAL DE-
13 SCRIBED.—With respect to a qualifying MA organi-
14 zation, an additional eligible professional described
15 in this paragraph is an additional eligible profes-
16 sional (as defined for purposes of section 1848(o))
17 who—

18 “(A)(i) is employed by the organization; or

19 “(ii)(I) is employed by, or is a partner of,
20 an entity that through contract with the organi-
21 zation furnishes at least 80 percent of the enti-
22 ty’s Medicare patient care services to enrollees
23 of such organization; and

24 “(II) furnishes at least 80 percent of the
25 professional services of the additional eligible

1 professional covered under this title to enrollees
2 of the organization; and

3 “(B) furnishes, on average, at least 20
4 hours per week of patient care services.”; and
5 (2) in subsection (m)—

6 (A) in paragraph (1)—

7 (i) by inserting “or additional eligible
8 hospitals (as described in paragraph (7))”
9 after “paragraph (2)”; and

10 (ii) by inserting “and additional eligi-
11 ble hospitals” before “under such sec-
12 tions”;

13 (B) in paragraph (3)(A)(i), by inserting
14 “or additional eligible hospital” after “eligible
15 hospital”;

16 (C) in paragraph (3)(A)(ii), by inserting
17 “or an additional eligible hospital” after “eligi-
18 ble hospital” in each place it occurs;

19 (D) in paragraph (3)(B)—

20 (i) in clause (i), by inserting “or an
21 additional eligible hospital described in
22 paragraph (7)” after “paragraph (2)”; and

23 (ii) in clause (ii)—

24 (I) in the matter preceding sub-
25 clause (I), by inserting “or an addi-

1 tional eligible hospital described in
2 paragraph (7)” after “paragraph
3 (2)”;

4 (II) in subclause (I), by inserting
5 “or an additional eligible hospital, re-
6 spectively,” after “eligible hospital”;

7 (E) in paragraph (4)(A), by inserting “or
8 one or more additional eligible hospitals (as de-
9 fined in section 1886(n)), as appropriate,” after
10 “section 1886(n)(6)(A)”;

11 (F) in paragraph (4)(D), by adding at the
12 end the following new sentence: “In the case
13 that a qualifying MA organization attests that
14 not all additional eligible hospitals of the orga-
15 nization are meaningful EHR users with re-
16 spect to an applicable period, the Secretary
17 shall apply the payment adjustment under this
18 paragraph based on the methodology specified
19 by the Secretary, taking into account the pro-
20 portion of such additional eligible hospitals, or
21 discharges from such hospitals, that are not
22 meaningful EHR users for such period.”;

23 (G) in paragraph (5)(A), by inserting
24 “and, as applicable, each additional eligible hos-

1 pital described in paragraph (7)” after “para-
2 graph (2)”;

3 (H) in paragraph (5)(B), by inserting
4 “and additional eligible hospitals, as applica-
5 ble,” after “eligible hospitals”;

6 (I) in paragraph (6)(B), by inserting “and
7 additional eligible hospitals described in para-
8 graph (7)” after “paragraph (2)”; and

9 (J) by adding at the end the following new
10 paragraph:

11 “(7) ADDITIONAL ELIGIBLE HOSPITAL DE-
12 SCRIBED.—With respect to a qualifying MA organi-
13 zation, an additional eligible hospital described in
14 this paragraph is an additional eligible hospital (as
15 defined in section 1886(n)(6)(C)) that is under com-
16 mon corporate governance with such organization
17 and serves individuals enrolled under an MA plan of-
18 fered by such organization.”.

19 **TITLE VIII—SAMHSA REAUTHOR-**
20 **IZATION AND REFORMS**

21 **Subtitle A—Organization and**
22 **General Authorities**

23 **SEC. 801. IN GENERAL.**

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

1 (1) in subsection (h), by inserting at the end
2 the following: “For any such peer-review group re-
3 viewing a proposal or grant related to mental illness,
4 no fewer than half of the members of the group shall
5 have a medical degree, or a corresponding doctoral
6 degree in psychology and clinical experience.”; and

7 (2) in subsection (l)—

8 (A) in paragraph (2), by striking “and” at
9 the end;

10 (B) in paragraph (3), by striking the pe-
11 riod at the end and inserting “; and”; and

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

13 “(4) At least 60 days before awarding a grant,
14 cooperative agreement, or contract, the Assistant
15 Secretary shall give written notice of the award to
16 the Committee on Energy and Commerce of the
17 House of Representatives and the Committee on
18 Health, Education, Labor, and Pensions of the Sen-
19 ate.”.

20 **SEC. 802. ADVISORY COUNCILS.**

21 Paragraph (3) of section 502(b) of the Public Health
22 Service Act (42 U.S.C. 290aa-1(b)) is amended by adding
23 at the end the following:

1 “(C) No fewer than half of the members of
2 an advisory council shall be mental health care
3 providers with—

4 “(i) experience in mental health re-
5 search or treatment; and

6 “(ii) expertise in the fields on which
7 they are advising.

8 “(D) None of the appointed members may
9 have at any point been a recipient of any grant,
10 or participated in any program, about which the
11 members are to advise.

12 “(E) None of the appointed members may
13 be related to anyone who has been a recipient
14 of any grant, or participated in any program,
15 about which the members are to advise.

16 “(F) None of the appointed members may
17 have a financial interest in any grant or pro-
18 gram with respect to which they advise, or re-
19 ceive funding separately through the Office of
20 Assistant Secretary.

21 “(G) Each advisory committee must in-
22 clude at least one member of the National Insti-
23 tute of Mental Health and one member from
24 any Federal agency that has a program serving
25 a similar population.”.

1 **SEC. 803. PEER REVIEW.**

2 Section 504 of the Public Health Service Act (42
3 U.S.C. 290aa-3) is amended—

4 (1) by adding at the end of subsection (b) the
5 following: “At least half of the members of any peer-
6 review group established under subsection (a) shall
7 have a degree in medicine, or a corresponding doc-
8 toral degree in psychology, or be a licensed mental
9 health professional. Before awarding a grant, coop-
10 erative agreement, or contract, the Secretary shall
11 provide a list of the members of the peer-review
12 group responsible for reviewing the award to the
13 Committee on Energy and Commerce of the House
14 of Representatives and the Committee on Health,
15 Education, Labor, and Pensions of the Senate.”;
16 and

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

18 “(e) **SCIENTIFIC CONTROLS AND STANDARDS.**—Peer
19 review under this section shall ensure that any research
20 concerning an intervention is based on scientific controls
21 and standards indicating whether the intervention reduces
22 symptoms, improves medical or behavioral outcomes, and
23 improves social functioning.”.

1 **Subtitle B—Protection and Advoca-**
2 **cacy for Individuals With Men-**
3 **tal Illness**

4 **SEC. 811. PROHIBITION AGAINST LOBBYING BY SYSTEMS**
5 **ACCEPTING FEDERAL FUNDS TO PROTECT**
6 **AND ADVOCATE THE RIGHTS OF INDIVID-**
7 **UALS WITH MENTAL ILLNESS.**

8 Section 105(a) of the Protection and Advocacy for
9 Individuals with Mental Illness Act (42 U.S.C. 10805(a))
10 is amended—

11 (1) in paragraph (9), by striking “and” at the
12 end;

13 (2) in paragraph (10), by striking the period at
14 the end and inserting a semicolon; and

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

16 “(11) agree to refrain, during any period for
17 which funding is provided to the system under this
18 part, from—

19 “(A) lobbying or retaining a lobbyist for
20 the purpose of influencing a Federal, State, or
21 local governmental entity or officer; and

22 “(B) counseling an individual with a seri-
23 ous mental illness who lacks insight into their
24 condition on refusing medical treatment or act-

1 ing against the wishes of such individual’s care-
2 giver;”.

3 **SEC. 812. ENSURING THAT CAREGIVERS OF INDIVIDUALS**
4 **WITH SERIOUS MENTAL ILLNESS HAVE AC-**
5 **CESS TO THE PROTECTED HEALTH INFORMA-**
6 **TION OF SUCH INDIVIDUALS.**

7 Section 105(a) of the Protection and Advocacy for
8 Individuals with Mental Illness Act (42 U.S.C. 10805(a)),
9 as amended by section 811, is further amended by adding
10 at the end the following:

11 “(12) ensure that caregivers (as defined in sec-
12 tion 201 of the Helping Families in Mental Health
13 Crisis Act of 2015) of individuals with serious men-
14 tal illness (as defined in such section 201) have ac-
15 cess to the protected health information of such indi-
16 viduals consistent with such section 201;”.

17 **SEC. 813. PROTECTION AND ADVOCACY ACTIVITIES TO**
18 **FOCUS EXCLUSIVELY ON SAFEGUARDING**
19 **RIGHTS TO BE FREE FROM ABUSE AND NE-**
20 **GLECT.**

21 (a) PURPOSES.—Section 101(b) of the Protection
22 and Advocacy for Individuals with Mental Illness Act (42
23 U.S.C. 10801(b)) is amended—

24 (1) in paragraph (1), by inserting “to be free
25 from abuse and neglect” before “are protected”; and

1 (2) in paragraph (2)(A), by inserting “to be
2 free from abuse and neglect” before “through activi-
3 ties to ensure”.

4 (b) ALLOTMENTS.—Section 103(2)(A) of the Protec-
5 tion and Advocacy for Individuals with Mental Illness Act
6 (42 U.S.C. 10803(2)(A)) is amended by inserting “to be
7 free from abuse and neglect” before the semicolon.

8 (c) USE OF ALLOTMENTS.—Section 104(a)(1) of the
9 Protection and Advocacy for Individuals with Mental Ill-
10 ness Act (42 U.S.C. 10804(a)(1)) is amended—

11 (1) in subparagraph (A), by striking “and” at
12 the end;

13 (2) in subparagraph (B), by striking the semi-
14 colon at the end and inserting “to be free from
15 abuse and neglect; and”; and

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

17 “(C) the protection and advocacy activities
18 of such an agency or organization shall be ex-
19 clusively focused on safeguarding the rights of
20 individuals with mental illness to be free from
21 abuse and neglect.”.

22 (d) SYSTEM REQUIREMENTS.—Section 105 of the
23 Protection and Advocacy for Individuals with Mental Ill-
24 ness Act (42 U.S.C. 10805), as amended by sections 811
25 and 812, is further amended—

1 (1) in subsection (a)—

2 (A) in the matter before paragraph (1), by
3 inserting “to be free from abuse and neglect”
4 before “shall”;

5 (B) in paragraph (6)(A), by inserting “to
6 be free from abuse and neglect” before the
7 semicolon; and

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

9 “(13) be exclusively focused on safeguarding
10 the rights of individuals with mental illness to be
11 free from abuse and neglect; and”;

12 (2) in subsection (c)(1)(A), by inserting “to be
13 free from abuse and neglect” before “shall have a
14 governing authority”.

15 (e) APPLICATIONS.—Section 111(a) of the Protection
16 and Advocacy for Individuals with Mental Illness Act (42
17 U.S.C. 10821(a)) is amended—

18 (1) in paragraph (1), by inserting “to be free
19 from abuse and neglect” before the semicolon;

20 (2) in paragraph (3), by striking “and” at the
21 end;

22 (3) by redesignating paragraph (4) as para-
23 graph (5); and

24 (4) by inserting after paragraph (3) the fol-
25 lowing:

1 “(4) assurances that such system, and any
2 State agency or nonprofit organization with which
3 such system may enter into a contract under section
4 10804(a), will be exclusively focused on safeguarding
5 the rights of individuals with mental illness to be
6 free from abuse and neglect; and”.

7 (f) **REPORTS BY SECRETARY.**—Section 114(a) of the
8 Protection and Advocacy for Individuals with Mental Ill-
9 ness Act (42 U.S.C. 10824(a)) is amended—

10 (1) in paragraph (1) in the matter before sub-
11 paragraph (A), by inserting “to be free from abuse
12 and neglect” before “supported with payments”;

13 (2) in paragraph (2)(A), by inserting “to be
14 free from abuse and neglect” before “supported with
15 payments”; and

16 (3) in paragraph (4), by inserting “to be free
17 from abuse and neglect” before “and a description”.

18 **SEC. 814. REPORTING.**

19 (a) **PUBLIC AVAILABILITY OF REPORTS.**—Section
20 105(a)(7) of the Protection and Advocacy for Individuals
21 with Mental Illness Act (42 U.S.C. 10805(a)(7)) is
22 amended by striking “is located a report” and inserting
23 “is located, and make publicly available, a report”.

24 (b) **DETAILED ACCOUNTING.**—Section 114(a) of the
25 Protection and Advocacy for Individuals with Mental Ill-

1 ness Act (42 U.S.C. 10824(a)), as amended, is further
2 amended—

3 (1) in paragraph (3), by striking “and” at the
4 end;

5 (2) in paragraph (4), by striking the period at
6 the end and inserting “; and”; and

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

8 “(5) a detailed accounting, for each system
9 funded under this title, of how funds are spent,
10 disaggregated according to whether the funds were
11 received from the Federal Government, the State
12 government, a local government, or a private enti-
13 ty.”.

14 **SEC. 815. GRIEVANCE PROCEDURE.**

15 Section 105 of the Protection and Advocacy for Indi-
16 viduals with Mental Illness Act (42 U.S.C. 10805), as
17 amended, is further amended by adding at the end the
18 following:

19 “(d) GRIEVANCE PROCEDURE.—The Assistant Sec-
20 retary shall establish an independent grievance procedure
21 for the types of claims to be adjudicated, at the request
22 of persons described in subsection (a)(9), through a sys-
23 tem’s grievance procedure established under such sub-
24 section.”.

1 **SEC. 816. EVIDENCE-BASED TREATMENT FOR INDIVIDUALS**
2 **WITH SERIOUS MENTAL ILLNESS.**

3 Section 105(a) of the Protection and Advocacy for
4 Individuals with Mental Illness Act (42 U.S.C. 10805(a)),
5 as amended by sections 811, 812, and 813, is further
6 amended by adding at the end the following:

7 “(14) ensure that individuals with serious men-
8 tal illness have access to and can obtain evidence-
9 based treatment for their serious mental illness.”.

10 **TITLE IX—REPORTING**

11 **SEC. 901. GAO STUDY ON PREVENTING DISCRIMINATORY**
12 **COVERAGE LIMITATIONS FOR INDIVIDUALS**
13 **WITH SERIOUS MENTAL ILLNESS AND SUB-**
14 **STANCE USE DISORDERS.**

15 Not later than 1 year after the date of the enactment
16 of this Act, the Comptroller General of the United States,
17 in consultation with the Assistant Secretary for Mental
18 Health and Substance Use Disorders, the Secretary of
19 Health and Human Services, the Secretary of Labor, and
20 the Secretary of the Treasury, shall submit to Congress
21 a report detailing the extent to which covered group health
22 plans (or health insurance coverage offered in connection
23 with such plans), including Medicaid managed care plans
24 under section 1903 of the Social Security Act (42 U.S.C.
25 1396b), comply with the Paul Wellstone and Pete Domen-
26 icki Mental Health Parity and Addiction Equity Act of

1 2008 (subtitle B of title V of division C of Public Law
2 110–343) (in this section referred to as the “law”), includ-
3 ing—

4 (1) how nonquantitative treatment limitations,
5 including medical necessity criteria, of covered group
6 health plans comply with the law;

7 (2) how the responsible Federal departments
8 and agencies ensure that plans comply with the law;
9 and

10 (3) how proper enforcement, education, and co-
11 ordination activities within responsible Federal de-
12 partments and agencies can be used to ensure full
13 compliance with the law, including educational ac-
14 tivities directed to State insurance commissioners.

○