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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

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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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

SEC. 2. DEFINITIONS.

In this Act:

(1) Except as inconsistent with the provisions of this Act, the term ''Assistant Secretary'' means the Assistant Secretary for Mental Health and Substance Use Disorders.

(2) The term ''evidence-based'' means the conscientious, systematic, explicit, and judicious appraisal and use of external, current, reliable, and valid research findings as the basis for making deci-

sions about the effectiveness and efficacy of a program, intervention, or treatment.

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

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

(a) IN GENERAL.—There shall be in the Department of Health and Human Services an official to be known as the Assistant Secretary for Mental Health and Substance Use Disorders, who shall—

(1) report directly to the Secretary;

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

(3) be selected from among individuals who—

(A)(i) have a doctoral degree in medicine or osteopathic medicine and clinical and research experience in psychiatry;

(ii) graduated from an Accreditation Council for Graduate Medical Education-accredited psychiatric residency program; and

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

(B) have a doctoral degree in psychology with—

(i) clinical and research experience regarding mental illness and substance use disorders; and

(ii) an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders.

(b) DUTIES.—The Assistant Secretary shall—

(1) promote, evaluate, organize, integrate, and coordinate research, treatment, and services across departments, agencies, organizations, and individuals with respect to the problems of individuals suffering from substance use disorders or mental illness;

(2) carry out any functions within the Department of Health and Human Services—

(A) to improve the treatment of, and related services to, individuals with respect to substance use disorders or mental illness;

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

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

nesses and individuals with a substance use disorder;

(D) to ensure that grant programs of the Department adhere to scientific standards with an emphasis on secondary prevention and tertiary prevention for individuals with serious mental illness or substance use disorders; and

(E) to develop and implement initiatives to encourage individuals to pursue careers (especially in underserved areas and populations) as psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and other licensed mental health professionals specializing in the diagnosis, evaluation, and treatment of individuals with severe mental illness, including individuals—

(i) who are vulnerable to crises, psychotic episodes, or suicidal rumination;

(ii) whose deterioration can be rapid; or

(iii) who require more frequent contact or integration of a variety of services by the treating mental health professional;

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

uation, knowledge dissemination, and public information functions that are required for the implementation of mental health programs, including block grants, treatments, and data collection;

(4) conduct and coordinate demonstration projects, evaluations, and service system assessments and other activities necessary to improve the availability and quality of treatment, prevention, and related services related to substance use disorders and mental illness;

(5) within the Department of Health and Human Services, oversee and coordinate all programs and activities relating to—

(A) the prevention of, or treatment or rehabilitation for, mental health or substance use disorders;

(B) parity in health insurance benefits and conditions relating to mental health and substance use disorder; or

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

(6) across the Federal Government, in conjunction with the Interagency Serious Mental Illness Coordinating Committee under section 501A—

(A) review all programs and activities relating to the prevention of, or treatment or rehabilitation for, mental illness or substance use disorders;

(B) identify any such programs and activities that are duplicative;

(C) identify any such programs and activities that are not evidence-based, effective, or efficient; and

(D) formulate recommendations for expanding, coordinating, eliminating, and improving programs and activities identified pursuant to subparagraph (B) or (C) and merging such programs and activities into other, successful programs and activities;

(7) identify evidence-based best practices across the Federal Government for treatment and services for those with mental health and substance use disorders by reviewing practices for efficiency, effectiveness, quality, coordination, and cost effectiveness;

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

(9) not later than one year after the date of enactment of the Helping Families in Mental Health Crisis Act of 2015, submit to the Congress a report

containing a nationwide strategy to increase the psychiatric workforce and recruit medical professionals for the treatment of individuals with serious mental illness and substance use disorders.

(c) NATIONWIDE STRATEGY.—The Assistant Secretary shall ensure that the nationwide strategy in the report under subsection (b)(9) is designed—

(1) to encourage and incentivize students enrolled in an accredited medical or osteopathic medical school to enter the specialty of psychiatry;

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

(3) to promote appropriate Federal administrative and fiscal mechanisms that support—

(A) evidence-based collaborative care models; and

(B) the necessary psychiatric workforce capacity for these models, including psychiatrists (including child and adolescent psychiatrists), psychologists, psychiatric nurse practitioners, clinical social workers, and mental health, peer-support specialists;

(4) to increase access to child and adolescent psychiatric services in order to promote early intervention for prevention and mitigation of mental illness; and

(5) to identify populations and locations that are the most underserved by mental health professionals and the most in need of psychiatrists (including child and adolescent psychiatrists), psychologists, psychiatric nurse practitioners, clinical social workers, and mental health, peer-support specialists.

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

(1) the integration of mental health, substance use, and physical health services for the purpose of diagnosing, preventing, treating, or providing rehabilitation for mental illness or substance use disorders, including any such services provided through the justice system (including departments of correction) or other entities other than the Department of Health and Human Services;

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

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

(3) workforce development for—

(A) appropriate treatment of serious mental illness or substance use disorders; and

(B) research activities that advance scientific and clinical understandings of these disorders, including the development and implementation of a continuing nationwide strategy to increase the psychiatric workforce with psychiatrists, child and adolescent psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and mental health peer support specialists.

(e) REQUIREMENTS AND RESTRICTIONS ON AUTHORITY TO AWARD GRANTS.—In awarding any grant or financial assistance, the Assistant Secretary, and any agency or official within the Office of the Assistant Secretary, shall comply with the following:

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

(2) Any program to be funded shall be demonstrated—

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

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

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

(4) An application for the grant or financial assistance shall include, as applicable, a scientific justification based on previously demonstrated models, the number of individuals to be served, the population to be targeted, what objective outcomes measures will be used, and details on how the program or activity to be funded can be replicated and by whom.

(5) Applicants shall be evaluated and selected through a blind, peer-review process by expert mental health care providers with professional experience in mental health research or treatment and where appropriate or necessary professional experience related to substance abuse and other areas of expertise

appropriate to the grant or other financial assistance.

(6) No member of a peer-review group conducting a blind, peer-review process, as required by paragraph (5), may be related to anyone who may be applying for the type of award being reviewed, may be a current grant applicant, or may have a financial or employment interested in selecting whom to receive the award.

(7) Award recipients may be periodically reviewed and audited at the discretion of the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States to ensure that—

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

(B) Federal funds are being used as required by the conditions of the award and by applicable guidelines of the NMHPL.

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

(f) DEFINITIONS.—In this section:

(1) The term ''secondary prevention'' means prevention that is designed to prevent a disease or condition from occurring among individuals or a subpopulation determined to be at risk for the disease or condition.

(2) The term ''tertiary prevention'' means prevention that is designed to reduce or minimize the consequences of a disease or condition among individuals showing symptoms of the disease or condition.

SEC. 102. TRANSFER OF SAMHSA AUTHORITIES.

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

(1) as of the day before the date of enactment of this Act, were vested in the Administrator of the Substance Abuse and Mental Health Services Administration; and

(2) are not terminated by this Act.

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

Services Administration to the Office of the Assistant Secretary.

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

(1) in the title heading, by striking "**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION**" and inserting "**MENTAL HEALTH AND SUBSTANCE USE DISORDERS**";

(2) by amending section 501(a) to read as follows:

"(a) ASSISTANT SECRETARY.—The Assistant Secretary for Mental Health and Substance Use Disorders shall have the duties and authorities vested in the Assistant Secretary by this title in addition to the duties and authorities vested in the Assistant Secretary by section 501 of the Helping Families in Mental Health Crisis Act of 2015 and other provisions of law.";

(3) by amending section 501(c) to read as follows:

"(c) DEPUTY ASSISTANT SECRETARY.—The Assistant Secretary, with the approval of the Secretary, may appoint a Deputy Assistant Secretary and may employ and prescribe the functions of such officers and employees, in-

cluding attorneys, as are necessary to administer the activities to be carried out under this title.'';

(4) by striking subsection (o) (relating to authorization of appropriations);

(5) by striking ''Administrator of the Substance Abuse and Mental Health Services Administration'' each place it appears and inserting ''Assistant Secretary for Mental Health and Substance Use Disorders'';

(6) by striking ''Administrator'' each place it appears and inserting ''Assistant Secretary'', except where the term ''Administrator'' appears within the term—

(A) Associate Administrator;

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

(C) Administrator of the Centers for Medicare & Medicaid Services; or

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

(7) by striking ''Substance Abuse and Mental Health Services Administration'' each place it appears and inserting ''Office of the Assistant Secretary'';

(8) in section 502, by striking ''Administration or Center'' each place it appears and inserting ''Office or Center'';

(9) in section 502, by striking ''Administration's'' and inserting ''Office of the Assistant Secretary's''; and

(10) by striking the term ''Administration'' each place it appears and inserting ''Office of the Assistant Secretary'', except in the heading of section 520G(b) and where the term ''Administration'' appears with the term—

(A) Health Resources and Services Administration; or

(B) National Highway Traffic Safety Administration.

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

(1) any reference in statute, regulation, or guidance to the Administrator of the Substance Abuse and Mental Health Services Administration shall be construed to be a reference to the Assistant Secretary for Mental Health and Substance Use Disorders; and

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

SEC. 103. REPORTS.

(a) REPORT ON INVESTIGATIONS REGARDING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.—

(1) IN GENERAL.—Not later than 180 days after the enactment of this Act, and annually thereafter, the Administrator of the Centers for Medicare & Medicaid Services, in collaboration with the Assistant Secretary of Labor of the Employee Benefits Security Administration and the Secretary of the Treasury, and in consultation with the Assistant Secretary for Mental Health and Substance Use Disorders, shall submit to the Congress a report—

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

Equity Act of 2008 (subtitle B of title V of division C of Public Law 110–343); and

(B) summarizing the results of such investigations.

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

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

(B) The benefit classification or classifications examined by each investigation.

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

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

(3) LIMITATION.—Individually identifiable information shall be excluded from reports under paragraph (1) consistent with Federal privacy protections.

(b) REPORT ON BEST PRACTICES FOR PEER-SUPPORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFICATION.—

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

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

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

(B) training and certifying peer-support specialists.

(2) PEER-SUPPORT SPECIALIST DEFINED.—In this subsection, the term ''peer-support specialist'' means an individual who—

(A) uses his or her lived experience of recovery from mental illness or substance abuse, plus skills learned in formal training, to facilitate support groups, and to work on a one-on-one basis, with individuals with a serious mental illness or a substance use disorder, in consultation with and under the supervision of a licensed mental health or substance use treatment professional;

(B) has been an active participant in mental health or substance use treatment for at least the preceding 2 years;

(C) does not provide direct medical services; and

(D) does not perform services outside of his or her area of training, expertise, competence, or scope of practice.

(3) CONTENTS.—Each report under this subsection shall include information on best practices and standards with regard to the following:

(A) Hours of formal work or volunteer experience related to mental health and substance use issues.

(B) Types of peer specialist exams required.

(C) Code of ethics.

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

(i) psychopharmacology;

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

(iii) ethics;

(iv) scope of practice;

(v) crisis intervention;

(vi) identification and treatment of mental health disorders;

(vii) State confidentiality laws;

(viii) Federal privacy protections, including under the Health Insurance Portability and Accountability Act of 1996; and

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

(E) Requirements to explain what, where, when, and how to accurately complete all required documentation activities.

(F) Required or recommended skill sets, including—

(i) identifying consumer risk indicators, including individual stressors, triggers, and indicators of escalating symptoms;

(ii) explaining basic de-escalation techniques;

(iii) explaining basic suicide prevention concepts and techniques;

(iv) identifying indicators that the consumer may be experiencing abuse or neglect;

(v) identifying and responding appropriately to personal stressors, triggers, and indicators;

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

(vii) explaining the typical process that should be followed to access or participate in community mental health and related services; and

(viii) identifying circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.

(G) Requirements for continuing education credits annually.

(c) REPORT ON THE STATE OF THE STATES IN MENTAL HEALTH AND SUBSTANCE USE TREATMENT.—

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

(A) A detailed report on how Federal mental health and substance use treatment funds are used in each State including:

(i) The numbers of individuals with serious mental illness or substance use disorders who are served with Federal funds.

(ii) The types of programs made available to individuals with serious mental illness or substance use disorders.

(B) A summary of best practice models in the States highlighting programs that are cost effective, provide evidence-based care, increase access to care, integrate physical, psychiatric, psychological, and behavioral medicine, and improve outcomes for individuals with mental illness or substance use disorders.

(C) A statistical report of outcome measures in each State, including—

(i) rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency psychiatric hospitalizations, and emergency room boarding; and

(ii) for those with mental illness, arrests, incarcerations, victimization, homelessness, joblessness, employment, and enrollment in educational or vocational programs.

(D) Outcome measures on State-assisted outpatient treatment programs, including—

(i) rates of keeping treatment appointments and compliance with prescribed medications;

(ii) participants' perceived effectiveness of the program;

(iii) rates of the programs helping those with serious mental illness gain control over their lives;

(iv) alcohol and drug abuse rates;

(v) incarceration and arrest rates;

(vi) violence against persons or property;

(vii) homelessness; and

(viii) total treatment costs for compliance with the program.

(E) STATE AND COUNTIES WITH ASSISTED OUTPATIENT TREATMENT PROGRAMS.—For States and counties with assisted outpatient treatment programs, the information reported under this subsection shall include a comparison of the outcomes of individuals with serious mental illness who participated in the programs versus the outcomes of individuals who did not

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

(F) STATES AND COUNTIES WITHOUT AOT PROGRAMS.—For States and counties without assisted outpatient treatment programs, the information reported under this subsection shall include data on individuals with mental illness who—

(i) have a history of violence, incarceration, and arrests;

(ii) have a history of emergency psychiatric hospitalizations;

(iii) are substantially unlikely to participate in treatment on their own;

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

(v) have a history of mental illness or condition that is likely to substantially deteriorate if the individual is not provided with timely treatment; and

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

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

(2) DEFINITION.—In this subsection, the term ''emergency room boarding'' means the practice of admitting patients to an emergency department and holding them in the department until inpatient psychiatric beds become available.

(d) REPORTING COMPLIANCE STUDY.—

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

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

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

of the Protecting Access to Medicare Act of 2014 (Public Law 113–93), as amended by section 505.

(2) SCOPE.—In preparing the report under subsection (a), the Institute of Medicine (or, if applicable, other appropriate entity) shall examine licensing, certification, service definitions, claims payment, billing codes, and financial auditing requirements used by the Office of Management and Budget, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Inspector General of the Department of Health and Human Services, State Medicaid agencies, State departments of health, State departments of education, and State and local juvenile justice and social service agencies to—

(A) establish an estimate of the combined nationwide cost of complying with such requirements, in terms of both administrative funding and staff time;

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

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

(C) make administrative and statutory recommendations to Congress (which recommendations may include a uniform methodology) to reduce the paperwork burden experienced by centers and clinics described in subparagraph (A) or (B) of paragraph (1).

SEC. 104. ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.

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

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

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

''(4) the Assistant Secretary for Mental Health and Substance Use Disorders;''.

TITLE II—GRANT REFORM AND RESTRUCTURING

SEC. 201. NATIONAL MENTAL HEALTH POLICY LABORATORY.

(a) IN GENERAL.—

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

shall establish, within the Office of the Assistant Secretary, the National Mental Health Policy Laboratory (in this section referred to as the ''NMHPL''), to be headed by a Director.

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

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

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

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

(D) establish standards for the appointment of scientific peer-review panels to evaluate grant applications; and

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

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

(A) shall give preference to models that improve—

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

(ii) the coordination among such providers and the justice and corrections system; and

(iii) the cost effectiveness, quality, effectiveness, and efficiency of health care services furnished to individuals with serious mental illness, in mental health crisis, or at risk to themselves, their families, and the general public; and

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

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

(4) DEADLINE FOR BEGINNING IMPLEMENTATION.—The Director of the NMHPL shall begin implementation of the duties described in this subsection not later than January 1, 2018.

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

(A) representatives of the National Institute of Mental Health on organization, hiring decisions, and operations, initially and on an ongoing basis;

(B) other appropriate Federal agencies;

(C) clinical and analytical experts with expertise in medicine, psychiatric and clinical psychological care, health care management, education, corrections health care, and mental health court systems; and

(D) other individuals and agencies as determined appropriate by the Assistant Secretary.

(b) STANDARDS FOR GRANT PROGRAMS.—

(1) IN GENERAL.—The Director of the NMHPL shall set standards for grant programs administered by the Assistant Secretary, and the Assistant Secretary shall comply with such standards, including standards for—

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

(B) the extent to which the grant plan submitted by the grantee as part of its application must explain how the grantee will help to provide comprehensive community mental health or substance use services to adults with serious mental illness and children with serious emotional disturbances;

(C) the extent to which the grantee must identify priorities, as well as strategies and performance indicators to address those priorities for the duration of the grant;

(D) the extent to which the grantee must submit statements on the extent to which the grantee is meeting annual program priorities with quantifiable, objective, and scientific targets, measures, and outcomes;

(E) the extent to which grantees are expected to collaborate with other child-serving

systems such as child welfare, education, juvenile justice, and primary care systems;

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

(G) the extent to which the grantee must use evidence-based practices and the extent to which those evidence-based practices must be used with respect to a population similar to the population for which the evidence-based practices were shown to be effective; and

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

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

(A) shall make the standards under paragraph (1), and the Director's findings on compliance by the Assistant Secretary and grantees with such standards, available to the public in a timely fashion; and

(B) may establish requirements for States and other entities receiving funds through grants under programs established or amended by this Act and under other mental health programs under the Public Health Service Act, including under a block grant under part B of

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

(c) STAFFING.—

(1) COMPOSITION.—In selecting the staff of the NMHPL, the Director of the NMHPL, in consultation with the Director of the National Institute of Mental Health, shall ensure the following:

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

(i) have a doctoral degree in medicine or osteopathic medicine and clinical and research experience in psychiatry;

(ii) have graduated from an Accreditation Council for Graduate Medical Education-accredited psychiatric residency program; and

(iii) have an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders.

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

(i) clinical and research experience regarding mental illness and substance use disorders; and

(ii) an understanding of biological, psychosocial, and pharmaceutical treatments of mental illness and substance use disorders.

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

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

(2) CONGRESSIONAL APPOINTMENTS.—At least 20 percent, or two, whichever is greater, of the members of the staff of the NMHPL shall be appointed by Congress.

(d) REPORT ON QUALITY OF CARE.—Not later than 1 year after the date of enactment of this Act, and every 2 years thereafter, the Director of the NMHPL shall submit to the Congress a report on the quality of care furnished through grant programs administered by the Assistant Secretary under the respective services delivery

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

(1) reduced rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency psychiatric hospitalizations, emergency room boarding, incarceration, crime, arrest, victimization, homelessness, and joblessness;

(2) rates of employment and enrollment in educational and vocational programs; and

(3) such other criteria as the Director may determine.

(e) DEFINITION.—In this section, the term ''emergency room boarding'' means the practice of admitting patients to an emergency department and holding them in the department until inpatient psychiatric beds become available.

SEC. 202. INNOVATION GRANTS.

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

(1) enhancing the screening, diagnosis, and treatment of mental illness and serious mental illness; or

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

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

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

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

(2) not less than one-third shall be awarded for screening, diagnosis, treatment, or services, as described in subsection (a), for individuals (or subpopulations of individuals) who are below the age of 18 when activities funded through the grant award are initiated.

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

(e) TERMINATION.—The Assistant Secretary may terminate any award under this section upon a determination that—

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

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

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

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

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

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

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

amounts are authorized to be used to carry out this section.

SEC. 203. DEMONSTRATION GRANTS.

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

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

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

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

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

(1) not less than half shall be awarded for screening, diagnosis, intervention, and treatment, as described in subsection (a), for individuals (or subpopulations of individuals) who are below the age of 26 when activities funded through the grant award are initiated;

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

(3) no amounts shall be made available for primary prevention; and

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

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

(e) TERMINATION.—The Assistant Secretary may terminate any award under this section upon a determination that—

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

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

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

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

results of programs and activities funded through the award; and

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

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

SEC. 204. EARLY CHILDHOOD INTERVENTION AND TREATMENT.

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

(1) grants to eligible entities to initiate and undertake, for eligible children, early childhood intervention and treatment programs, and specialized preschool and elementary school programs, with the goal of preventing chronic and serious mental illness;

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

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

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

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means a nonprofit institution that—

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

(B) provides services that include early childhood intervention and specialized preschool and elementary school programs focused on children whose primary need is a social or emotional disability (in addition to any learning disability).

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

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

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

(C) who could benefit from early childhood intervention and specialized preschool or elementary school programs with the goal of preventing or treating chronic and serious mental illness.

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

(d) USE OF FUNDS FOR EARLY CHILDHOOD INTERVENTION AND TREATMENT PROGRAMS.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) to carry out the following activities:

(1) Deliver (or facilitate) for eligible children treatment and education, early childhood intervention, and specialized preschool and elementary school programs, including the provision of medically based child care and early education services.

(2) Treat and educate eligible children, including startup, curricula development, operating and capital needs, staff and equipment, assessment and intervention services, administration and medication

requirements, enrollment costs, collaboration with primary care physicians and psychiatrists, other related services to meet emergency needs of children, and communication with families and medical professionals concerning the children.

(3) Develop and implement other strategies to address identified treatment and educational needs of eligible children that have reliable and valid evaluation modalities built into assess outcomes based on sound scientific metrics as determined by the NMHPL.

(e) USE OF FUNDS FOR LONGITUDINAL STUDY.—In conducting a study on longitudinal outcomes through a grant under subsection (a)(2), an eligible entity shall include an analysis of—

(1) the individuals treated and educated;

(2) the success of such treatment and education in avoiding the onset of serious mental illness or the preparation of such children for the care and management of serious mental illness;

(3) any evidence-based best practices generally applicable as a result of such treatment and educational techniques used with such children; and

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

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

(g) AMOUNT OF AWARDS.—

(1) AMOUNTS FOR EARLY CHILDHOOD INTERVENTION AND TREATMENT PROGRAMS.—The amount of an award to an eligible entity under subsection (a)(1) shall be not more than $600,000 per fiscal year.

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

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

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

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

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

(j) DEFINITIONS.—In this section:

(1) The term ''emergency room boarding'' means the practice of admitting patients to an emergency department and holding them in the department until inpatient psychiatric beds become available.

(2) The term ''primary prevention'' means prevention that is designed to prevent a disease or condition from occurring among the general population without regard to identifying the presence of risk factors or symptoms in the population.

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

SEC. 205. EXTENSION OF ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

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

(1) in subsection (e), by striking ''and 2018'' and inserting ''2018, 2019, and 2020''; and

(2) in subsection (g)—

(A) in paragraph (1), by striking ''2018'' and inserting ''2020'';

(B) in paragraph (2)—

(i) by striking ''$15,000,000'' and inserting ''$20,000,000''; and

(ii) by striking ''2018'' and inserting ''2020''; and

(C) by adding at the end the following:

''(3) ALLOCATION.—Of the funds made available to carry out this section for a fiscal year, the Secretary shall allocate—

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

''(B) 80 percent of such funds for new assisted outpatient treatment programs.''.

SEC. 206. BLOCK GRANTS.

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

''(c) BEST PRACTICES IN CLINICAL CARE MODELS.—The Secretary, acting through the Director of the National Institute of Mental Health, shall obligate 5 percent of the amounts appropriated for a fiscal year under subsection (a) for translating evidence-based (as defined in section 2 of the Helping Families in Mental Health Crisis Act of 2015) interventions and best available science into systems of care, such as through models including—

''(1) the Recovery After an Initial Schizophrenia Episode research project of the National Institute of Mental Health; and

''(2) the North American Prodrome Longitudinal Study.''.

(b) ADMINISTRATION OF BLOCK GRANTS BY ASSISTANT SECRETARY.—Section 1911(a) of the Public Health Service Act (42 U.S.C. 300x) is amended by striking ''acting through the Director of the Center for Mental Health Services'' and inserting ''acting through the Assistant Secretary for Mental Health and Substance Use Disorders''.

(c) ADDITIONAL PROGRAM REQUIREMENTS.—

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

(A) by striking ''The plan provides'' and inserting:

''(A) The plan provides'';

(B) in the subparagraph (A) inserted by paragraph (1), in the second sentence, by striking ''health and mental health services'' and inserting ''integrated physical and mental health services'';

(C) in such subparagraph (A), by striking ''The plan shall include'' through the period at the end and inserting ''The plan shall integrate and coordinate services to maximize the efficiency, effectiveness, quality, coordination, and cost effectiveness of those services and programs to produce the best possible outcomes for those with serious mental illness.''; and

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

''(B) The plan shall include a separate description of case management services and provide for activities leading to reduction of rates of suicides, suicide attempts, substance abuse,

overdose deaths, emergency hospitalizations, incarceration, crimes, arrest, victimization, homelessness, joblessness, medication nonadherence, and education and vocational programs drop outs. The plan must also include a detailed list of services available for eligible patients (as defined in subsection (d)(3)) in each county or county equivalent, including assisted outpatient treatment.''.

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

(A) by striking ''The plan contains an estimate of'' and inserting the following: ''The plan contains—

''(A) an estimate of'';

(B) in subparagraph (A), as inserted by paragraph (1), by inserting '', including reductions in homelessness, emergency hospitalization, incarceration, and unemployment for eligible patients (as defined in subsection (d)(3)),'' after ''targets'';

(C) in such subparagraph, by striking the period at the end and inserting ''; and''; and

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

''(B) an agreement by the State to report to the National Mental Health Policy Laboratory such data as may be required by the Secretary concerning—

''(i) comprehensive community mental health services in the State; and

''(ii) public health outcomes for persons with serious mental illness in the State, including rates of suicides, suicide attempts, substance abuse, overdose deaths, emergency hospitalizations, incarceration, crimes, arrest, victimization, homelessness, joblessness, medication nonadherence, and education and vocational programs drop outs.''.

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

(A) in paragraph (1)—

(i) by striking ''Except as provided'' and inserting:

''(A) Except as provided''; and

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

''(B) For eligible patients receiving treatment through funds awarded under a grant under section 1911, a State shall include in the State plan for the first year beginning after the date of the enactment of this subparagraph and each subsequent year, a de-individualized report, containing information that is open source and de-identified, on the services provided to those individuals, including—

''(i) outcomes and the overall cost of such treatment provided; and

''(ii) county or county equivalent level data on such patient population, including overall costs and raw number data on rates of involuntary inpatient and outpatient commitment orders, suicides, suicide attempts, substance abuse, overdose deaths, emergency hospitalizations, incarceration, crimes, arrest, victimization, homelessness, joblessness, medication non-adherence, and education and vocational programs drop outs.''; and

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

"(3) DEFINITION.—In this subsection, the term 'eligible patient' means an adult mentally ill person who—

"(A) may have a history of violence, incarceration, or medically unnecessary hospitalizations;

"(B) without supervision and treatment, may be a danger to self or others in the community;

"(C) is substantially unlikely to voluntarily participate in treatment;

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

"(E) with a history of mental illness or condition that is likely to substantially deteriorate if the person is not provided with timely treatment;

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

''(G) is likely to improve in mental health and reduce the symptoms of serious mental illness when in treatment.''.

(4) TREATMENT UNDER STATE LAW.—

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

''(e) ASSISTED OUTPATIENT TREATMENT UNDER STATE LAW.—

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

''(A) requires such patient to obtain outpatient mental health treatment while the patient is living in a community; and

''(B) is designed to improve access and adherence by such patient to intensive behavioral health services in order to—

''(i) avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior; and

''(ii) provide such patient with the opportunity to live in a less restrictive alternative to incarceration or involuntary hospitalization.

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

''(f) TREATMENT STANDARD UNDER STATE LAW.—

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

''(A) the State involved has in effect a law under which, if a State court finds by clear and convincing evidence that an individual, as a result of mental illness, is a danger to self, is a danger to others, is persistently or acutely disabled, or is gravely disabled and in need of treatment, and is either unwilling or unable to accept voluntary treatment, the court must order the individual to undergo inpatient or outpatient treatment; or

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

vidual with a mental illness to undergo inpatient or outpatient treatment, the law was in effect on the date of enactment of the Helping Families in Mental Health Crisis Act of 2015, and the Secretary finds that the law requires a State court to order such treatment across all or a sufficient range of the type of circumstances described in subparagraph (A).

''(2) DEFINITION.—For purposes of paragraph (1), the term 'persistently or acutely disabled' refers to a serious mental illness that meets all the following criteria:

''(A) If not treated, the illness has a substantial probability of causing the individual to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality.

''(B) The illness substantially impairs the individual's capacity to make an informed decision regarding treatment, and this impairment causes the individual to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an

understanding of the alternatives to the particular treatment offered after the advantages, disadvantages, and alternatives are explained to that individual.

''(C) The illness has a reasonable prospect of being treatable by outpatient, inpatient, or combined inpatient and outpatient treatment.''.

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

(i) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (d)''; and

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

''(d) INCREASE FOR CERTAIN STATES.—With respect to fiscal year 2016 and each subsequent fiscal year, in the case of a State that has in effect a law described in subsection (e)(1) or subparagraph (A) or (B) of subsection (f)(1), the amount of the allotment of a State under section 1911 shall be for such fiscal year the amount that would otherwise be determined, without application of this subsection, for such State for such fiscal year, increased by 2 percent.''.

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

"(g) EXPANSION OF MODELS.—

"(1) IN GENERAL.—Taking into account the results of evaluations under section 201(a)(2)(C) of the Helping Families in Mental Health Crisis Act of 2015, the Assistant Secretary may, by rule, as part of the program of block grants under this subpart, provide for expanded use across the Nation of evidence-based service delivery models by providers funded under such block grants, so long as—

"(A) the Assistant Secretary for Mental Health and Substance Use Disorders (in this subsection referred to as the 'Assistant Secretary') determines that such expansion will—

"(i) result in more effective use of funds under such block grants without reducing the quality of care; or

"(ii) improve the quality of patient care without significantly increasing spending;

''(B) the Director of the National Institute of Mental Health determines that such expansion would improve the quality of patient care; and

''(C) the Assistant Secretary determines that the change will—

''(i) significantly reduce severity and duration of symptoms of mental illness;

''(ii) reduce rates of suicide, suicide attempts, substance abuse, overdose, emergency hospitalizations, emergency room boarding, incarceration, crime, arrest, victimization, homelessness, or joblessness; or

''(iii) significantly improve the quality of patient care and mental health crisis outcomes without significantly increasing spending.

''(2) CONGRESSIONAL REVIEW.—Any rule promulgated pursuant to paragraph (1) is deemed to be a major rule subject to congressional review and disapproval under chapter 8 of title 5, United States Code.

''(3) DEFINITION.—In this subsection, the term 'emergency room boarding' means the practice of admitting patients to an emergency department and

holding them in the department until inpatient psychiatric beds become available.''.

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

''(d) PERIOD FOR EXPENDITURE OF GRANT FUNDS.—In implementing a plan submitted under section 1912(a), a State receiving grant funds under section 1911 may make such funds available to providers of services described in subsection (b) for the provision of services without fiscal year limitation.''.

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

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

fined in section 2 of the Helping Families in Mental Health Crisis Act of 2015) assertive outreach and engagement services targeting individuals that are homeless, have co-occurring disorders, or have a history of treatment failure. The Assistant Secretary for Mental Health and Substance Use Disorders shall work with the Director of the National Institute of Mental Health to develop a list of such evidence-based (as defined in section 2 of the Helping Families in Mental Health Crisis Act of 2015) assertive outreach and engagement services, as well as criteria to be used to assess the scope and effectiveness of such approaches. These programs may include assistant outpatient treatment programs under State law where State courts may order a treatment plan for an eligible patient that requires—

''(1) such patient to obtain outpatient mental health treatment while the patient is living in the community; and

''(2) a design to improve access and adherence by such patient to intensive mental health services.''.

SEC. 207. WORKFORCE DEVELOPMENT.

(a) TELEPSYCHIATRY AND PRIMARY CARE PHYSICIAN TRAINING GRANT PROGRAM.—

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

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

(2) TRAINING PROGRAM FOR CERTAIN PRIMARY CARE PHYSICIANS.—For purposes of paragraph (1), the purpose described in this paragraph, with respect to a grant awarded to a State under the grant program, is for the State to establish a training program to train primary care physicians in—

(A) valid and reliable behavioral-health screening tools for violence and suicide risk, early signs of serious mental illness, and untreated substance abuse, including any standardized behavioral-health screening tools that are determined appropriate by the Assistant Secretary;

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

(C) establishment of recommended intervention and treatment protocols for individuals in mental health crisis, especially for individuals

whose illness makes them less receptive to mental health services; and

(D) implementing the evidence-based collaborative care model of integrated medical-behavioral health care in their practices.

(3) PAYMENTS FOR MENTAL HEALTH SERVICES PROVIDED BY CERTAIN PRIMARY CARE PHYSICIANS.—

(A) IN GENERAL.—For purposes of paragraph (1), the purpose described in this paragraph, with respect to a grant awarded to a State under the grant program, is for the State to provide, in accordance with this paragraph, in the case of a primary care physician who participates in the training program of the State establish pursuant to paragraph (2), payments to the primary care physician for services furnished by the primary care physician.

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

(i) the nature and quality of services rendered;

(ii) the patients' health outcome;

(iii) the geographical location where services were provided;

(iv) the acuteness of the patient's medical condition;

(v) the duration of services provided;

(vi) the feasibility of replicating the payment model in other locations nationwide; and

(vii) proper triage and enduring linkage to appropriate treatment provider for subspecialty care in child or forensic issues; family crisis intervention; drug or alcohol rehabilitation; management of suicidal or violent behavior risk, and treatment for serious mental illness.

(4) TELEHEALTH SERVICES FOR MENTAL HEALTH DISORDERS.—

(A) IN GENERAL.—For purposes of paragraph (1), the purpose described in this paragraph, with respect to a grant awarded to a State under the grant program, is for the State to provide, in the case of an individual furnished items and services by a primary care physician during an office visit, for payment for

a consultation provided by a psychiatrist or psychologist to such physician with respect to such individual through the use of qualified telehealth technology for the identification, diagnosis, mitigation, or treatment of a mental health disorder if such consultation occurs not later than the first business day that follows such visit.

(B) QUALIFIED TELEHEALTH TECHNOLOGY.—For purposes of subparagraph (A), the term ''qualified telehealth technology'', with respect to the provision of items and services to a patient by a health care provider, includes the use of interactive audio, audio-only telephone conversation, video, or other telecommunications technology by a health care provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient.

(5) ELIGIBLE STATE.—

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

submitted to the Assistant Secretary an application under subparagraph (B) and has been selected under subparagraph (D).

(B) APPLICATION.—A State seeking to participate in the grant program under this subsection shall submit to the Assistant Secretary, at such time and in such format as the Assistant Secretary requires, an application that includes such information, provisions, and assurances as the Assistant Secretary may require.

(C) MATCHING REQUIREMENT.—The Assistant Secretary may not make a grant under the grant program unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purposes described in this subsection, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount equal to not less than 20 percent of Federal funds provided in the grant.

(D) SELECTION.—A State shall be determined eligible for the grant program by the Assistant Secretary on a competitive basis among States with applications meeting the require-

ments of subparagraphs (B) and (C). In selecting State applications for the grant program, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of grants awarded under the grant program.

(6) TARGET POPULATION.—In seeking a grant under this subsection, a State shall demonstrate how the grant will improve care for individuals with co-occurring behavioral health and physical health conditions, vulnerable populations, socially isolated populations, rural populations, and other populations who have limited access to qualified mental health providers.

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

(8) PUBLIC AVAILABILITY OF FINDINGS AND CONCLUSIONS.—Subject to Federal privacy protections with respect to individually identifiable information, the Assistant Secretary shall make the findings and conclusions resulting from the grant program under this subsection available to the public.

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

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

(10) REPORTS.—

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

(i) An evaluation of the grant program outcomes, including a summary of activities carried out with the grant and the results achieved through those activities.

(ii) Recommendations on how to improve access to mental health services at grantee locations.

(iii) An assessment of access to mental health services under the program.

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

cluding inpatient, emergency and ambulatory care).

(v) Recommendations on congressional action to improve the grant.

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

(B) REPORT.—Not later than December 31, 2018, the Assistant Secretary and the National Mental Health Policy Laboratory shall submit to Congress and make available to the public a report on the findings of the evaluation under subparagraph (A) and also a policy outline on how Congress can expand the grant program to the national level.

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

''(q)(1) In this subsection, the term 'federally qualified community behavioral health clinic' means—

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

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

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

''(2) For purposes of this section, a health care professional volunteer at an entity described in subsection (g)(4) or a federally qualified community behavioral health clinic shall, in providing health care services eligible for funding under section 330 or subpart I of part B of title XIX to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (5)(C). The preceding sentence is subject to the provisions of this subsection.

''(3) In providing a health care service to an individual, a health care professional shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) or at a federally qualified community behavioral health clinic if the following conditions are met:

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

''(B) The center or entity is sponsoring the health care professional volunteer pursuant to paragraph (4)(B).

''(C) The health care professional does not receive any compensation for the service from the individual or from any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care professional may receive repayment from the entity described in subsection (g)(4) or the center for reasonable expenses incurred by the health care professional in the provision of the service to the individual.

''(D) Before the service is provided, the health care professional or the center or entity described in subsection (g)(4) posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care professional is limited pursuant to this subsection.

''(E) At the time the service is provided, the health care professional is licensed or certified in accordance with applicable law regarding the provision of the service.

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

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

''(A) The first sentence of paragraph (2) applies in lieu of the first sentence of subsection (g)(1)(A).

''(B) With respect to an entity described in subsection (g)(4) or a federally qualified community behavioral health clinic, a health care professional is not a health professional volunteer at such center unless the center sponsors the health care professional. For purposes of this subsection, the center shall be considered to be sponsoring the health care professional if—

''(i) with respect to the health care professional, the center submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

''(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care professional is deemed to be an employee of the Public Health Service.

''(C) In the case of a health care professional who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such center, this subsection applies to the health care professional (with respect to services described in paragraph (2)) for any cause of action arising from an act or omission of the health care professional occurring on or after the date on which the Secretary makes such determination.

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

''(5)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection for health professional volunteers at entities described in subsection (g)(4).

''(B) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of health care professional volunteers, will be paid

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

''(C) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

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

''(B) Effective on the date of the enactment of this subsection—

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (4)(B); and

''(ii) reports under paragraph (5)(B) may be submitted to the Congress.''.

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

"PART K—MINORITY FELLOWSHIP PROGRAM

"SEC. 597. FELLOWSHIPS.

''(a) IN GENERAL.—The Secretary shall maintain a program, to be known as the Minority Fellowship Program, under which the Secretary awards fellowships, which may include stipends, for the purposes of—

''(1) increasing behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations;

''(2) improving the quality of mental and substance use disorder prevention and treatment delivered to ethnic minorities; and

''(3) increasing the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental health or substance use services to underserved minority populations.

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

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

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $6,000,000 for each of fiscal years 2016 through 2020.''.

(d) NATIONAL HEALTH SERVICE CORPS.—

(1) DEFINITIONS.—

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

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

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

children and adolescents)'' after ''population group''.

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

(2) ELIGIBILITY TO PARTICIPATE IN LOAN REPAYMENT PROGRAM.—Section 338A(b)(1)(B) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(B)) is amended by inserting '', including any physician child and adolescent psychiatry residency or fellowship training program'' after ''be enrolled in an approved graduate training program in medicine, osteopathic medicine, dentistry, behavioral and mental health, or other health profession''.

(e) CRISIS INTERVENTION GRANTS FOR POLICE OFFICERS AND FIRST RESPONDERS.—

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

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

(A) to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness; and

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

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

SEC. 208. AUTHORIZED GRANTS AND PROGRAMS.

(a) CHILDREN'S RECOVERY FROM TRAUMA.—Section 582 of the Public Health Service Act (42 U.S.C. 290hh–1) is amended—

(1) in subsection (a), by striking ''developing programs'' and all that follows and inserting the following: ''developing and maintaining programs that provide for—

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

section as the 'NCTSI'), which includes a coordinating center, that focuses on the mental, behavioral, and biological aspects of psychological trauma response; and

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

(2) in subsection (b)—

(A) by striking ''subsection (a) related'' and inserting ''subsection (a)(2) (related'';

(B) by striking ''treating disorders associated with psychological trauma'' and inserting ''treating mental, behavioral, and biological disorders associated with psychological trauma)'';

and

(C) by striking ''mental health agencies and programs that have established clinical and basic research'' and inserting ''universities, hospitals, mental health agencies, and other programs that have established clinical expertise and research'';

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

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

''(c) CHILD OUTCOME DATA.—The NCTSI coordinating center shall collect, analyze, and report NCTSI-wide child treatment process and outcome data regarding the early identification and delivery of evidence-based (as defined in section 2 of the Helping Families in Mental Health Crisis Act of 2015) treatment and services for children and families served by the NCTSI grantees.

''(d) TRAINING.—The NCTSI coordinating center shall facilitate the coordination of training initiatives in evidence-based (as defined in section 2 of the Helping Families in Mental Health Crisis Act of 2015) and trauma-informed treatments, interventions, and practices offered to NCTSI grantees, providers, and partners.

''(e) DISSEMINATION.—The NCTSI coordinating center shall, as appropriate, collaborate with the Secretary in the dissemination of evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders.

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

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

(5) in subsection (g) (as so redesignated), by striking ''with respect to centers of excellence are distributed equitably among the regions of the country'' and inserting ''are distributed equitably among the regions of the United States'';

(6) in subsection (i) (as so redesignated), by striking ''recipient may not exceed 5 years'' and inserting ''recipient shall not be less than 4 years, but shall not exceed 5 years''; and

(7) in subsection (j) (as so redesignated), by striking ''$50,000,000'' and all that follows through ''2006'' and inserting ''$45,713,000 for each of fiscal years 2014 through 2018''.

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

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

with serious mental illness, and social media companies to assist secondary school students and postsecondary students in—

(A) reducing the stigma associated with serious mental illness;

(B) understanding how to assist an individual who is demonstrating signs of a serious mental illness; and

(C) understanding the importance of seeking treatment from a physician, clinical psychologist, or licensed mental health professional when a student believes the student may be suffering from a serious mental illness or behavioral health disorder.

(2) DATA COLLECTION.—The Secretary of Education shall—

(A) evaluate the program under subsection (a) on public health to determine whether the program has made an impact on public health, including mortality rates of persons with serious mental illness, prevalence of serious mental illness, physician and clinical psychological visits, emergency room visits; and

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

(3) SECONDARY SCHOOL DEFINED.—For purposes of this section, the term ''secondary school'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(c) GARRETT LEE SMITH REAUTHORIZATION.—

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

''SEC. 520C. SUICIDE PREVENTION TECHNICAL ASSISTANCE CENTER.

''(a) PROGRAM AUTHORIZED.—The Assistant Secretary for Mental Health and Substance Use Disorders shall award a grant for the operation and maintenance of a research, training, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian tribes, tribal organizations, institutions of higher education, public organizations, or private nonprofit organizations concerning the

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

''(b) RESPONSIBILITIES OF THE CENTER.—The center operated and maintained under subsection (a) shall—

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

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

''(3) study the costs and effectiveness of statewide and tribal suicide early intervention and prevention strategies in order to provide information concerning relevant issues of importance to State, tribal, and national policymakers;

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

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

''(6) ensure the surveillance of suicidal behaviors and nonfatal suicidal attempts;

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

''(8) promote the sharing of data regarding suicide with Federal agencies involved with suicide early intervention and prevention, and State-sponsored statewide and tribal suicide early intervention and prevention strategies for the purpose of identifying previously unknown mental health causes and associated risk factors for suicide among all ages particularly among groups that are at high risk for suicide;

''(9) evaluate and disseminate outcomes and best practices of mental health and substance use disorder services at institutions of higher education; and

''(10) conduct other activities determined appropriate by the Secretary.

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

to be appropriated $4,957,000 for each of the fiscal years 2016 through 2020.''.

(2) YOUTH SUICIDE INTERVENTION AND PREVENTION STRATEGIES.—Section 520E of the Public Health Service Act (42 U.S.C. 290bb–36) is amended to read as follows:

''SEC. 520E. YOUTH SUICIDE EARLY INTERVENTION AND PREVENTION STRATEGIES.

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

''(1) develop and implement State-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations;

''(2) support public organizations and private nonprofit organizations actively involved in State-sponsored statewide or tribal youth suicide early intervention and prevention strategies and in the development and continuation of State-sponsored statewide youth suicide early intervention and prevention strategies;

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

''(4) collect and analyze data on State-sponsored statewide or tribal youth suicide early intervention and prevention services that can be used to monitor the effectiveness of such services and for research, technical assistance, and policy development; and

''(5) assist eligible entities, through State-sponsored statewide or tribal youth suicide early intervention and prevention strategies, in achieving targets for youth suicide reductions under title V of the Social Security Act.

''(b) ELIGIBLE ENTITY.—

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

''(A) a State;

''(B) a public organization or private nonprofit organization designated by a State to develop or direct the State-sponsored statewide youth suicide early intervention and prevention strategy; or

"(C) a federally recognized Indian tribe or tribal organization (as defined in the Indian Self-Determination and Education Assistance Act) or an urban Indian organization (as defined in the Indian Health Care Improvement Act) that is actively involved in the development and continuation of a tribal youth suicide early intervention and prevention strategy.

"(2) LIMITATION.—In carrying out this section, the Secretary shall ensure that a State does not receive more than one grant or cooperative agreement under this section at any one time. For purposes of the preceding sentence, a State shall be considered to have received a grant or cooperative agreement if the eligible entity involved is the State or an entity designated by the State under paragraph (1)(B). Nothing in this paragraph shall be construed to apply to entities described in paragraph (1)(C).

"(c) PREFERENCE.—In providing assistance under a grant or cooperative agreement under this section, an eligible entity shall give preference to public organizations, private nonprofit organizations, political subdivisions, institutions of higher education, and tribal organizations actively involved with the State-sponsored statewide or tribal

youth suicide early intervention and prevention strategy that—

''(1) provide early intervention and assessment services, including screening programs, to youth who are at risk for mental or emotional disorders that may lead to a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations;

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

''(3) employ or include in their applications a commitment to evaluate youth suicide early intervention and prevention practices and strategies adapted to the local community;

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

''(5) provide immediate support and information resources to families of youth who are at risk for suicide;

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

''(7) offer appropriate postsuicide intervention services, care, and information to families, friends, schools, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations of youth who recently completed suicide;

''(8) offer continuous and up-to-date information and awareness campaigns that target parents, family members, child care professionals, community care providers, and the general public and highlight the risk factors associated with youth suicide and the life-saving help and care available from early intervention and prevention services;

''(9) ensure that information and awareness campaigns on youth suicide risk factors, and early intervention and prevention services, use effective communication mechanisms that are targeted to and reach youth, families, schools, educational institutions, and youth organizations;

''(10) provide a timely response system to ensure that child-serving professionals and providers are properly trained in youth suicide early interven-

tion and prevention strategies and that child-serving professionals and providers involved in early intervention and prevention services are properly trained in effectively identifying youth who are at risk for suicide;

''(11) provide continuous training activities for child care professionals and community care providers on the latest youth suicide early intervention and prevention services practices and strategies;

''(12) conduct annual self-evaluations of outcomes and activities, including consulting with interested families and advocacy organizations;

''(13) provide services in areas or regions with rates of youth suicide that exceed the national average as determined by the Centers for Disease Control and Prevention; and

''(14) obtain informed written consent from a parent or legal guardian of an at-risk child before involving the child in a youth suicide early intervention and prevention program.

''(d) REQUIREMENT FOR DIRECT SERVICES.—Not less than 85 percent of grant funds received under this section shall be used to provide direct services, of which not less than 5 percent shall be used for activities authorized under subsection (a)(3).

''(e) CONSULTATION AND POLICY DEVELOPMENT.—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall collaborate with the Secretary of Education and relevant Federal agencies and suicide working groups responsible for early intervention and prevention services relating to youth suicide.

''(2) CONSULTATION.—In carrying out this section, the Secretary shall consult with—

''(A) State and local agencies, including agencies responsible for early intervention and prevention services under title XIX of the Social Security Act, the State Children's Health Insurance Program under title XXI of the Social Security Act, and programs funded by grants under title V of the Social Security Act;

''(B) local and national organizations that serve youth at risk for suicide and their families;

''(C) relevant national medical and other health and education specialty organizations;

''(D) youth who are at risk for suicide, who have survived suicide attempts, or who are currently receiving care from early intervention services;

"(E) families and friends of youth who are at risk for suicide, who have survived suicide attempts, who are currently receiving care from early intervention and prevention services, or who have completed suicide;

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

"(G) third-party payers, managed care organizations, and related commercial industries.

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

"(A) coordinate and collaborate on policy development at the Federal level with the relevant Department of Health and Human Services agencies and suicide working groups; and

"(B) consult on policy development at the Federal level with the private sector, including consumer, medical, suicide prevention advocacy groups, and other health and education professional-based organizations, with respect to State-sponsored statewide or tribal youth suicide early intervention and prevention strategies.

''(f) RULE OF CONSTRUCTION; RELIGIOUS AND MORAL ACCOMMODATION.—Nothing in this section shall be construed to require suicide assessment, early intervention, or treatment services for youth whose parents or legal guardians object based on the parents' or legal guardians' religious beliefs or moral objections.

''(g) EVALUATIONS AND REPORT.—

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

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

''(A) the evaluations conducted under paragraph (1); and

''(B) an evaluation conducted by the Secretary to analyze the effectiveness and efficacy of the activities conducted with grants, collaborations, and consultations under this section.

''(h) RULE OF CONSTRUCTION; STUDENT MEDICATION.—Nothing in this section shall be construed to allow school personnel to require that a student obtain any medication as a condition of attending school or receiving services.

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

''(j) PARENTAL CONSENT.—States and entities receiving funding under this section shall obtain prior written, informed consent from the child's parent or legal guardian for assessment services, school-sponsored programs, and treatment involving medication related to youth suicide conducted in elementary and secondary schools. The requirement of the preceding sentence does not apply in the following cases:

''(1) In an emergency, where it is necessary to protect the immediate health and safety of the student or other students.

''(2) Other instances, as defined by the State, where parental consent cannot reasonably be obtained.

''(k) RELATION TO EDUCATION PROVISIONS.—Nothing in this section shall be construed to supersede section 444 of the General Education Provisions Act, including

the requirement of prior parental consent for the disclosure of any education records. Nothing in this section shall be construed to modify or affect parental notification requirements for programs authorized under the Elementary and Secondary Education Act of 1965 (as amended by the No Child Left Behind Act of 2001; Public Law 107–110).

''(l) DEFINITIONS.—In this section:

''(1) EARLY INTERVENTION.—The term 'early intervention' means a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

''(2) EDUCATIONAL INSTITUTION; INSTITUTION OF HIGHER EDUCATION; SCHOOL.—The term—

''(A) 'educational institution' means a school or institution of higher education;

''(B) 'institution of higher education' has the meaning given such term in section 101 of the Higher Education Act of 1965; and

''(C) 'school' means an elementary or secondary school (as such terms are defined in section 9101 of the Elementary and Secondary Education Act of 1965).

''(3) PREVENTION.—The term 'prevention' means a strategy or approach that reduces the likelihood or risk of onset, or delays the onset, of adverse

health problems that have been known to lead to suicide.

''(4) YOUTH.—The term 'youth' means individuals who are between 10 and 26 years of age.

''(m) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $29,738,000 for each of the fiscal years 2016 through 2020.''.

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

(A) by amending the section heading to read as follows: ''**SUICIDE PREVENTION FOR YOUTH**''; and

(B) by striking subsection (n) and inserting the following:

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

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

"SEC. 520E–2. MENTAL HEALTH AND SUBSTANCE USE DISORDERS SERVICES ON CAMPUS.

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

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

''(1) The provision of mental health and substance use disorder services to students, including prevention, promotion of mental health, voluntary screening, early intervention, voluntary assessment, treatment, and management of mental health and substance use disorder issues.

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

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

''(4) The employment of appropriately trained staff, including administrative staff.

''(5) The provision of training to students, faculty, and staff to respond effectively to students with mental health and substance use disorders.

''(6) The creation of a networking infrastructure to link colleges and universities with providers who can treat mental health and substance use disorders.

''(7) Developing, supporting, evaluating, and disseminating evidence-based and emerging best practices.

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

''(1) college counseling centers;

''(2) college and university psychological service centers;

''(3) mental health centers;

''(4) psychology training clinics;

''(5) institution of higher education supported, evidence-based, mental health and substance use disorder programs; or

''(6) any other entity that provides mental health and substance use disorder services at an institution of higher education.

''(d) APPLICATION.—To be eligible to receive a grant under this section, an institution of higher education shall prepare and submit to the Secretary an application at such time and in such manner as the Secretary may require. At a minimum, such application shall include the following:

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

''(2) A description of Federal, State, local, private, and institutional resources currently available to address the needs described in paragraph (1) at the institution of higher education.

''(3) A description of the outreach strategies of the institution of higher education for promoting access to services, including a proposed plan for reaching those students most in need of mental health services.

''(4) A plan, when applicable, to meet the specific mental health and substance use disorder needs of veterans attending institutions of higher education.

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

groups and other public and private entities in carrying out the program under the grant.

''(6) A plan to evaluate program outcomes, including a description of the proposed use of funds, the program objectives, and how the objectives will be met.

''(7) An assurance that the institution will submit a report to the Secretary each fiscal year concerning the activities carried out with the grant and the results achieved through those activities.

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

''(1) demonstrate the greatest need for new or additional mental and substance use disorder services, in part by providing information on current ratios of students to mental health and substance use disorder health professionals; and

''(2) demonstrate the greatest potential for replication.

''(f) REQUIREMENT OF MATCHING FUNDS.—

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

available (directly or through donations from public or private entities) non-Federal contributions in an amount that is not less than $1 for each $1 of Federal funds provided under the grant, toward the costs of activities carried out with the grant (as described in subsection (b)) and other activities by the institution to reduce student mental health and substance use disorders.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under paragraph (1) may be in cash or in kind. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(3) WAIVER.—The Secretary may waive the application of paragraph (1) with respect to an institution of higher education if the Secretary determines that extraordinary need at the institution justifies the waiver.

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

Congress a report on such results that includes the following:

''(1) An evaluation of the grant program outcomes, including a summary of activities carried out with the grant and the results achieved through those activities.

''(2) Recommendations on how to improve access to mental health and substance use disorder services at institutions of higher education, including efforts to reduce the incidence of suicide and substance use disorders.

''(h) DEFINITIONS.—In this section:

''(1) The term 'evidence-based' has the meaning given to such term in section 2 of the Helping Families in Mental Health Crisis Act of 2015.

''(2) The term 'institution of higher education' has the meaning given such term in section 101 of the Higher Education Act of 1965.

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

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

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

"SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.

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

"(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night;

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

"(3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans' suicide prevention hotline.

"(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $8,000,000 for each of fiscal years 2016 through 2020.".

TITLE III—INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

SEC. 301. INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

Title V of the Public Health Service Act, as amended by section 101, is further amended by inserting after section 501 of such Act the following:

"SEC. 501A. INTERAGENCY SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE.

''(a) ESTABLISHMENT.—The Assistant Secretary for Mental Health and Substance Use Disorders (in this section referred to as the 'Assistant Secretary') shall establish a committee, to be known as the Interagency Serious Mental Illness Coordinating Committee (in this section referred to as the 'Committee'), to assist the Assistant Secretary in carrying out the Assistant Secretary's duties.

''(b) RESPONSIBILITIES.—The Committee shall—

''(1) develop and annually update a summary of advances in serious mental illness research related to causes, prevention, treatment, early screening, diagnosis or rule out, intervention, and access to services and supports for individuals with serious mental illness;

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

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

''(4) make recommendations to the Assistant Secretary regarding public participation in decisions relating to serious mental illness;

''(5) develop and annually update a strategic plan for advancing—

''(A) public utilization of effective mental health services; and

''(B) compliance with treatment;

''(6) develop and annually update a strategic plan for the conduct of, and support for, serious mental illness research, including proposed budgetary requirements; and

''(7) submit to the Congress such strategic plan and any updates to such plan.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Committee shall be composed of—

"(A) the Assistant Secretary for Mental Health and Substance Use Disorders (or the Assistant Secretary's designee), who shall serve as the Chair of the Committee;

"(B) the Director of the National Institute of Mental Health (or the Director's designee);

"(C) the Attorney General of the United States (or the Attorney General's designee);

"(D) the Director of the Centers for Disease Control and Prevention (or the Director's designee);

"(E) the Director of the National Institutes of Health (or the Director's designee);

"(F) the directors of such national research institutes of the National Institutes of Health as the Assistant Secretary for Mental Health and Substance Use Disorders determines appropriate (or their designees);

"(G) a member of the United States Interagency Council on Homelessness;

"(H) representatives, appointed by the Assistant Secretary, of Federal agencies that are outside of the Department of Health and Human Services and serve individuals with serious mental illness, including representatives of

the Bureau of Indian Affairs, the Department of Defense, the Department of Education, the Department of Housing and Urban Development, the Department of Labor, the Department of Veterans Affairs, and the Social Security Administration;

''(I) 4 members, of which—

''(i) 1 shall be appointed by the Speaker of the House of Representatives;

''(ii) 1 shall be appointed by the minority leader of the House of Representatives;

''(iii) 1 shall be appointed by the majority leader of the Senate; and

''(iv) 1 shall be appointed by the minority leader of the Senate; and

''(J) the additional members appointed under paragraph (2).

''(2) ADDITIONAL MEMBERS.—Not fewer than 14 members of the Committee, or ⅓ of the total membership of the Committee, whichever is greater, shall be composed of non-Federal public members to be appointed by the Assistant Secretary, of which—

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

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

"(B) at least one such member shall be a parent or legal guardian of an individual with a history of serious mental illness who has either attempted suicide or is incarcerated for violence committed while experiencing a serious mental illness;

"(C) at least one such member shall be a representative of a leading research, advocacy, and service organization for individuals with serious mental illness;

"(D) at least one such member shall be—

"(i) a licensed psychiatrist with experience treating serious mental illness; or

"(ii) a licensed clinical psychologist with experience treating serious mental illness;

"(E) at least one member shall be a licensed mental health counselor or psychotherapist;

"(F) at least one member shall be a licensed clinical social worker;

"(G) at least one member shall be a licensed psychiatric nurse or nurse practitioner;

"(H) at least one member shall be a mental health professional with a significant focus in his or her practice working with children and adolescents;

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

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

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

"(L) at least one member shall be a judge with experiences applying assisted outpatient treatment;

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

''(N) at least one member shall be a corrections officer.

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

''(1) analyzing the efficiency, effectiveness, quality, coordination, and cost effectiveness of Federal programs and activities relating to the prevention of, or treatment or rehabilitation for, mental health or substance use disorders, including an accounting of the costs of such programs and activities, with administrative costs disaggregated from the costs of services and care provided;

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

''(A) reduced rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, incarceration, crime, arrest, victimization, homelessness, and joblessness;

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

''(C) such other criteria as may be determined by the Assistant Secretary;

''(3) formulating recommendations for the coordination and improvement of Federal programs and activities described in paragraph (2);

''(4) identifying any such programs and activities that are duplicative; and

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

''(e) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following provisions shall apply with respect to the Committee:

''(1) The Assistant Secretary shall provide such administrative support to the Committee as may be necessary for the Committee to carry out its responsibilities.

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

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

''(3) The Committee shall meet at the call of the chair or upon the request of the Assistant Secretary. The Committee shall meet not fewer than 2 times each year.

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

''(f) SUBCOMMITTEES; ESTABLISHMENT AND MEMBERSHIP.—In carrying out its functions, the Committee may establish subcommittees and convene workshops and conferences. Such subcommittees shall be composed of Committee members and may hold such meetings as are necessary to enable the subcommittees to carry out their duties.''.

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.

(a) CAREGIVER ACCESS TO INFORMATION.—In applying section 164.502(g) of title 45, Code of Federal Regulations, to an individual with serious mental illness an exception for disclosure of specific limited protected health information shall be provided if all of the following criteria are met for the disclosure by a physician (as defined in paragraphs (1) and (2) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) or other licensed mental health or health care professional to an identified responsible caregiver:

(1) Such disclosure is for information limited to the diagnoses, treatment plans, appointment scheduling, medications, and medication-related instructions, but not including any personal psychotherapy notes.

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

(3) The information to be disclosed will be beneficial to the treatment of the individual if that individual has a co-occurring acute or chronic medical illness.

(4) The information to be disclosed is necessary for the continuity of treatment of the medical condition or mental illness of the individual.

(5) The absence of such information or treatment will contribute to a worsening prognosis or an acute medical condition.

(6) The individual by nature of the severe mental illness has or has had a diminished capacity to fully understand or follow a treatment plan for their medical condition or may become gravely disabled in absence of treatment.

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

(c) AGE OF MAJORITY.—In applying section 164.502(g) of title 45, Code of Federal Regulations, notwithstanding any other provision of law, an unemancipated minor shall be an individual under the age of 18 years.

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

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

(1) COVERED ENTITY.—The term ''covered entity'' has the meaning given such term in section 106.103 of title 45, Code of Federal Regulations.

(2) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' has the meaning given such term in section 106.103 of title 45, Code of Federal Regulations.

(3) CAREGIVER.—The term ''caregiver'' means, with respect to an individual with a serious mental illness—

(A) an immediate family member of such individual;

(B) an individual who assumes primary responsibility for providing a basic need of such individual;

(C) a personal representative of the individual as determined by the law of the State in which such individual resides;

(D) can establish a longstanding involvement and is responsible with the individual with a serious mental illness and the health care of the individual; and

(E) excludes an individual with a documented history of abuse.

(4) INDIVIDUAL WITH A SERIOUS MENTAL ILLNESS.—The term ''individual with a serious mental illness'' means, with respect to the disclosure to a caregiver of protected health information of an individual, an individual who—

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

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

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

(ii) results in functional impairment of the individual that substantially interferes with or limits one or more major life activities of the individual.

Such term includes an individual with autism spectrum disorder or other developmental disability if such individual has a co-occurring mental illness.

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

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

''(k) DISCLOSURES TO CAREGIVERS.—

''(1) IN GENERAL.—With respect to a student who is 18 years of age or older, an educational agency or institution may disclose to the caregiver of the student, without regard to whether the student has explicitly provided consent to the agency or institution for the disclosure of the student's education record, the education record of such student if a physician (as defined in paragraphs (1) and (2) of section 1861(r) of the Social Security Act), psychologist, or other recognized mental health professional or paraprofessional acting in his or her professional or paraprofessional capacity, or assisting in that capacity reasonably believes such disclosure to the caregiver is necessary to protect the health, safety,

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

''(2) DEFINITIONS.—In this subsection:

''(A) CAREGIVER.—The term 'caregiver' means, with respect to a student, a family member or immediate past legal guardian who assumes a primary responsibility for providing a basic need of such student (such as a family member or past legal guardian of the student who has assumed the responsibility of co-signing a loan with the student).

''(B) EDUCATION RECORD.—Notwithstanding subsection (a)(4)(B), the term 'education record' shall include a record described in clause (iv) of such subsection.''.

SEC. 403. CONFIDENTIALITY OF RECORDS.

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

(1) in paragraph (1), by striking ''; or'' and inserting a semicolon;

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

(3) after paragraph (2), by inserting the following:

''(3) within accountable care organizations described in section 1899 of the Social Security Act (42 U.S.C. 1395jjj), health information exchanges (as defined for purposes of section 3013), health homes (as defined in section 1945(h)(3) of such Act 42 U.S.C. 1396w–4(h)(3)), or other integrated care arrangements (in existence before, on, or after the date of the enactment of this paragraph) involving the interchange of electronic health records (as defined in section 13400 of division A of Public Law 111–5) (42 U.S.C. 17921(5)) containing information described in subsection (a) for purposes of attaining interoperability, improving care coordination, reducing health care costs, and securing or providing patient safety.''.

TITLE V—MEDICARE AND MEDICAID REFORMS

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

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

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended

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

''(78) not prohibit payment under the plan for a mental health service or primary care service furnished to an individual at a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act or a federally qualified health center (as defined in section 1861(aa)(3)) for which payment would otherwise be payable under the plan, with respect to such individual, if such service were not a same-day qualifying service (as defined in subsection (ll));''.

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

''(ll) SAME-DAY QUALIFYING SERVICES DEFINED.—For purposes of subsection (a)(78), the term 'same-day qualifying service' means—

''(1) a primary care service furnished to an individual by a provider at a facility on the same day a mental health service is furnished to such individual by such provider (or another provider) at the facility; and

''(2) a mental health service furnished to an individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility.''.

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

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ''effective'' and inserting ''(A) effective''; and

(ii) by inserting before the semicolon at the end the following: '', (B) qualified inpatient psychiatric hospital services (as defined in subsection (h)(3)) for individuals over 21 years of age and under 65 years of age, and (C) psychiatric residential treatment facility services (as defined in subsection (h)(4)) for individuals over 21 years of age and under 65 years of age''; and

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

ices described in subparagraphs (B) and (C) of paragraph (16) for individuals described in such subparagraphs)'' after ''patient in an institution for mental diseases''; and

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

''(3) For purposes of subsection (a)(16)(B), the term 'qualified inpatient psychiatric hospital services' means, with respect to individuals described in such subsection, services described in subparagraphs (A) and (B) of paragraph (1) that are furnished in an acute care psychiatric unit in a State-operated psychiatric hospital or a psychiatric hospital (as defined section 1861(f)) if such unit or hospital, as applicable, has a facilitywide average (determined on an annual basis) length of stay of less than 30 days.

''(4) For purposes of subsection (a)(16)(C), the term 'psychiatric residential treatment facility services' means, with respect to individuals described in such subsection, services described in subparagraphs (A) and (B) of paragraph (1) that are furnished in a psychiatric residential treatment facility (as defined in section 484.353 of title 42, Code of Federal Regulations, as in effect on December 9, 2013).''.

(c) REPORT.—

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

(A) The amount of funds expended annually by States on short-term, acute inpatient psychiatric hospital care.

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

(C) The reduction in the amount of funds described in subparagraph (A) that is attributable to the amendments made by subsection (b).

(D) The reduction in the amount of funds described in subparagraph (B) that is attributable to the amendment made by such subsection.

(E) The total amount of the reductions described in subparagraphs (C) and (D).

(2) DEFINITION OF SHORT-TERM, ACUTE INPATIENT PSYCHIATRIC HOSPITAL CARE.—For purposes of paragraph (1), the term ''short-term, acute inpatient psychiatric hospital care'' means care that is provided in either—

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

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

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

(d) EFFECTIVE DATE.—

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

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

(2) CERTIFICATION OF NO INCREASED SPENDING.—The amendments made by this section shall not be effective unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the inclusion of qualified inpatient psychiatric hospital services and psychiatric residential treatment facility services (as those terms are defined in section 1905(h) of the Social Security Act (42 U.S.C. 1396d(h))) furnished to nonelderly adults as medical assistance under section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by subsection (a), would not result in any increase in net program spending under title XIX of such Act.

(3) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first

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

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

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

(1) in clause (i)(I), by striking ''in the categories'' and inserting ''in the categories and classes of drugs specified in subclauses (II) and (IV) of clause (iv) and in other categories'';

(2) in clause (i)(II), by inserting '', for categories and classes of drugs other than the categories and classes of drugs specified in subclauses (II) and (IV) of clause (iv),'' before ''exceptions'';

(3) in clause (ii)(I), by inserting at the end the following new sentence: ''For purposes of the previous sentence, the categories and classes of drugs

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

(4) in clause (iv), in the matter preceding subclause (I), by inserting ''(and in the case of categories and classes of drugs specified in subclauses (II) and (IV), before, on, and after the Secretary establishes such criteria)'' after ''clause (ii)(II)''.

(b) COVERAGE OF PRESCRIPTION DRUGS USED TO TREAT MENTAL HEALTH DISORDERS UNDER MEDICAID.—

(1) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1396r–8(d)) is amended by adding at the end the following new paragraph:

''(8) ACCESS TO MENTAL HEALTH DRUGS.—With respect to covered outpatient drugs used for the treatment of a mental health disorder, including major depression, bipolar (manic-depressive) disorder, panic disorder, obsessive-compulsive disorder, schizophrenia, and schizoaffective disorder, a State shall not exclude from coverage or otherwise restrict access to such drugs other than pursuant to a prior authorization program that is consistent with paragraph (5).''.

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

''(9) COVERAGE OF PRESCRIPTION DRUGS USED TO TREAT MENTAL HEALTH DISORDERS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require coverage of all covered outpatient drugs used for the treatment of a mental health disorder, in accordance with section 1927(d)(8).''.

SEC. 503. ELIMINATION OF 190-DAY LIFETIME LIMIT ON COVERAGE OF INPATIENT PSYCHIATRIC HOSPITAL SERVICES UNDER MEDICARE.

(a) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by adding ''or'' at the end;

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

(C) by striking paragraph (3); and

(2) in subsection (c), by striking ''or in determining the 190-day limit under subsection (b)(3)''.

(b) EFFECTIVE DATE; CERTIFICATION OF NO INCREASED SPENDING.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 2016.

(2) CERTIFICATION OF NO INCREASED SPENDING.—The amendments made by subsection (a) shall not be effective unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such amendments will not result in any increase in net Federal expenditures under title XVIII of the Social Security Act.

SEC. 504. MODIFICATIONS TO MEDICARE DISCHARGE PLANNING REQUIREMENTS.

Section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)) is amended—

(1) in paragraph (1), by inserting ''and, in the case of a psychiatric hospital or a psychiatric unit (as described in the matter following clause (v) of section 1886(d)(1)(B)), if it also meets the guidelines and standards established by the Secretary under paragraph (3)'' before the period at the end; and

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

''(3) The Secretary shall develop guidelines and standards, in addition to those developed under paragraph (2), for the discharge planning process of a psychiatric hospital or a psychiatric unit (as described in the matter following clause (v) of section 1886(d)(1)(B)) in order to ensure a timely and smooth transition to the most appropriate type of and setting for posthospital or rehabilitative care. The Secretary shall issue final regulations implementing such guidelines and standards not later than 24 months after the date of the enactment of this paragraph. The guidelines and standards shall include the following:

''(A) The hospital or unit must identify the types of services needed upon discharge for the patients being treated by the hospital or unit.

''(B) The hospital or unit must—

''(i) identify organizations that offer community services to the community that is served by the hospital or unit and the types of services provided by the organizations; and

''(ii) must make demonstrated efforts to establish connections, relationships, and partnerships with such organizations.

''(C) The hospital or unit must arrange (with the participation of the patient and of any other individuals selected by the patient for such purpose) for the development and implementation of a discharge plan for the patient as part of the patient's overall treatment plan from admission to discharge. Such discharge plan shall meet the requirements described in subparagraphs (G) and (H) of paragraph (2).

''(D) The hospital or unit shall coordinate with the patient (or assist the patient with) the referral for posthospital or rehabilitative care and as part of that referral the hospital or unit shall include transmitting to the receiving organization, in a timely manner, appropriate information about the care furnished to the patient by the hospital or unit and recommendations for posthospital or rehabilitative care to be furnished to the patient by the organization.''.

SEC. 505. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES.

Section 223 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 128 Stat. 1077) is amended to read as follows:

"SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES.

"(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

"(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

"(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

"(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

"(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services

on the basis of a patient's ability to pay or a place of residence.

"(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

"(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

"(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

"(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, In-

dian Health Service youth regional treatment centers, State-licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

''(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

''(v) Inpatient acute care hospitals and hospital outpatient clinics.

''(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

''(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

''(ii) Screening, assessment, and diagnosis, including risk assessment.

"(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

"(iv) Outpatient mental health and substance use services.

"(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

"(vi) Targeted case management.

"(vii) Psychiatric rehabilitation services.

"(viii) Peer support and counselor services and family supports.

"(ix) Intensive, community-based mental health care for members of the Armed Forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

"(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes

data, quality data, and such other data as the Secretary requires.

"(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

"(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic partici-

pating in a demonstration program under subsection (d).

''(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

''(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other nonambulatory services, as determined by the Secretary; and

''(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

''(c) PLANNING GRANTS.—

''(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

''(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

''(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

''(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

''(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

''(d) DEMONSTRATION PROGRAMS.—

''(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

''(2) APPLICATION REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

''(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

''(i) The target Medicaid population to be served under the demonstration program.

''(ii) A list of participating certified community behavioral health clinics.

''(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

''(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

''(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

''(vi) Such other information as the Secretary may require relating to the demonstration program including with respect

to determining the soundness of the proposed prospective payment system.

''(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Not more than 10 States shall be selected for 4-year demonstration programs under this subsection.

''(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

''(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

''(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

''(iii) will improve availability of, access to, and participation in assisted out-

patient mental health treatment in the State; or

''(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

''(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

''(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of,

section 1903 of the Social Security Act (42 U.S.C. 1396b).

''(B) FEDERAL MATCHING PERCENTAGE.—The Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished—

''(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

''(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

''(C) LIMITATIONS.—

''(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

''(I) that are described in the demonstration program application in accordance with paragraph (2)(B)(iv);

"(II) for which payment is available under the State Medicaid program; and

"(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

"(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

"(I) for inpatient care, residential treatment, room and board expenses, or any other nonambulatory services, as determined by the Secretary; or

"(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

"(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be

necessary to conduct demonstration programs in accordance with the requirements of this subsection.

''(7) ANNUAL REPORTS.—

''(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

''(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

''(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration

State that are not participating in the demonstration program; and

"(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

"(B) RECOMMENDATIONS.—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

"(e) DEFINITIONS.—In this section:

"(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms 'Federally-qualified health center services', 'Federally-qualified health center', 'rural health clinic services', and 'rural health clinic' have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

"(2) ENHANCED FMAP.—The term 'enhanced FMAP' has the meaning given that term in section

2105(b) of the Social Security Act (42 U.S.C. 1397dd(b)) but without regard to the second and third sentences of that section.

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

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(f) FUNDING.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

''(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014; and

''(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016.

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.''.

TITLE VI—RESEARCH BY NATIONAL INSTITUTE OF MENTAL HEALTH

SEC. 601. INCREASE IN FUNDING FOR CERTAIN RESEARCH.

Section 402A(a) of the Public Health Service Act (42 U.S.C. 282a(a)) is amended by adding at the end the following:

''(3) FUNDING FOR THE BRAIN INITIATIVE AT THE NATIONAL INSTITUTE OF MENTAL HEALTH.—

''(A) FUNDING.—In addition to amounts made available pursuant to paragraphs (1) and (2), there are authorized to be appropriated to the National Institute of Mental Health for the purpose described in subparagraph (B)(ii) $40,000,000 for each of fiscal years 2016 through 2020.

''(B) PURPOSES.—Amounts appropriated pursuant to subparagraph (A) shall be used exclusively for the purpose of conducting or supporting—

''(i) research on the determinants of self- and other directed-violence in mental illness, including studies directed at reducing the risk of self harm, suicide, and interpersonal violence; or

''(ii) brain research through the Brain Research through Advancing Innovative Neurotechnologies Initiative.''.

TITLE VII—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

SEC. 701. EXTENSION OF HEALTH INFORMATION TECHNOLOGY ASSISTANCE FOR BEHAVIORAL AND MENTAL HEALTH AND SUBSTANCE ABUSE.

Section 3000(3) of the Public Health Service Act (42 U.S.C. 300jj(3)) is amended by inserting before ''and any other category'' the following: ''behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i)), a substance abuse professional, a psychiatric hospital (as defined in section 1861(f) of the Social Security Act), a community mental health center meeting the criteria specified in section 1913(c), a residential or outpatient mental health or substance use treatment facility,''.

SEC. 702. EXTENSION OF ELIGIBILITY FOR MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE.

(a) PAYMENT INCENTIVES FOR ELIGIBLE PROFESSIONALS UNDER MEDICARE.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (a)(7)—

(A) in subparagraph (E), by adding at the end the following new clause:

''(iv) ADDITIONAL ELIGIBLE PROFESSIONAL.—The term 'additional eligible professional' means a clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)).''; and

(B) by adding at the end the following new subparagraph:

''(F) APPLICATION TO ADDITIONAL ELIGIBLE PROFESSIONALS.—The Secretary shall apply the provisions of this paragraph with respect to an additional eligible professional in the same manner as such provisions apply to an eligible professional, except in applying subparagraph (A)—

''(i) in clause (i), the reference to 2015 shall be deemed a reference to 2020;

''(ii) in clause (ii), the references to 2015, 2016, and 2017 shall be deemed references to 2020, 2021, and 2022, respectively; and

"(iii) in clause (iii), the reference to 2018 shall be deemed a reference to 2023."; and

(2) in subsection (o)—

(A) in paragraph (5), by adding at the end the following new subparagraph:

"(D) ADDITIONAL ELIGIBLE PROFESSIONAL.—The term 'additional eligible professional' means a clinical psychologist providing qualified psychologist services (as defined in section 1861(ii))."; and

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

"(6) APPLICATION TO ADDITIONAL ELIGIBLE PROFESSIONALS.—The Secretary shall apply the provisions of this subsection with respect to an additional eligible professional in the same manner as such provisions apply to an eligible professional, except in applying—

"(A) paragraph (1)(A)(ii), the reference to 2016 shall be deemed a reference to 2021;

"(B) paragraph (1)(B)(ii), the references to 2011 and 2012 shall be deemed references to 2016 and 2017, respectively;

"(C) paragraph (1)(B)(iii), the references to 2013 shall be deemed references to 2018;

"(D) paragraph (1)(B)(v), the references to 2014 shall be deemed references to 2019; and

"(E) paragraph (1)(E), the reference to 2011 shall be deemed a reference to 2016.".

(b) ELIGIBLE HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(1) in subsection (b)(3)(B)(ix), by adding at the end the following new subclause:

"(V) The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital (as defined in subsection (n)(6)(C)) in the same manner as such provisions apply to an eligible hospital, except in applying—

"(aa) subclause (I), the references to 2015, 2016, and 2017 shall be deemed references to 2020, 2021, and 2022, respectively; and

"(bb) subclause (III), the reference to 2015 shall be

deemed a reference to 2020.''; and

(2) in subsection (n)—

(A) in paragraph (6), by adding at the end the following new subparagraph:

''(C) ADDITIONAL ELIGIBLE HOSPITAL.—The term 'additional eligible hospital' means an inpatient hospital that is a psychiatric hospital (as defined in section 1861(f)).''; and

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

''(7) APPLICATION TO ADDITIONAL ELIGIBLE HOSPITALS.—The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital in the same manner as such provisions apply to an eligible hospital, except in applying—

''(A) paragraph (2)(E)(ii), the references to 2013 and 2015 shall be deemed references to 2018 and 2020, respectively; and

''(B) paragraph (2)(G)(i), the reference to 2011 shall be deemed a reference to 2016.''.

(c) MEDICAID PROVIDERS.—Section 1903(t) of the Social Security Act (42 U.S.C. 1396b(t)) is amended—

(1) in paragraph (2)(B)—

(A) in clause (i), by striking ", or" at the end and inserting a semicolon;

(B) in clause (ii), by striking the period at the end and inserting a semicolon; and

(C) by inserting after clause (ii) the following new clauses:

"(iii) a public hospital that is principally a psychiatric hospital (as defined in section 1861(f));

"(iv) a private hospital that is principally a psychiatric hospital (as defined in section 1861(f)) and that has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title;

"(v) a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act; or

"(vi) a residential or outpatient mental health or substance use treatment facility that—

"(I) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accredita-

tion of Rehabilitation Facilities, the Council on Accreditation, or any other national accrediting agency recognized by the Secretary; and

''(II) has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title.''; and

(2) in paragraph (3)(B)—

(A) in clause (iv), by striking ''; and'' at the end and inserting a semicolon;

(B) in clause (v), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(vi) clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)), if such clinical psychologist is practicing in an outpatient clinic that—

''(I) is led by a clinical psychologist; and

''(II) is not otherwise receiving payment under paragraph (1) as a Medicaid provider described in paragraph (2)(B).''.

(d) MEDICARE ADVANTAGE ORGANIZATIONS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (l)—

(A) in paragraph (1)—

(i) by inserting ''or additional eligible professionals (as described in paragraph (9))'' after ''paragraph (2)''; and

(ii) by inserting ''and additional eligible professionals'' before ''under such sections'';

(B) in paragraph (3)(B)—

(i) in clause (i) in the matter preceding subclause (I), by inserting ''or an additional eligible professional described in paragraph (9)'' after ''paragraph (2)''; and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting ''or an additional eligible professional described in paragraph (9)'' after ''paragraph (2)''; and

(II) in subclause (I), by inserting ''or an additional eligible professional,

respectively,'' after ''eligible professional'';

(C) in paragraph (3)(C), by inserting ''and additional eligible professionals'' after ''all eligible professionals'';

(D) in paragraph (4)(D), by adding at the end the following new sentence: ''In the case that a qualifying MA organization attests that not all additional eligible professionals of the organization are meaningful EHR users with respect to an applicable year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such additional eligible professionals of the organization that are not meaningful EHR users for such year.'';

(E) in paragraph (6)(A), by inserting ''and, as applicable, each additional eligible professional described in paragraph (9)'' after ''paragraph (2)'';

(F) in paragraph (6)(B), by inserting ''and, as applicable, each additional eligible hospital described in paragraph (9)'' after ''subsection (m)(1)'';

(G) in paragraph (7)(A), by inserting ''and, as applicable, additional eligible professionals'' after ''eligible professionals'';

(H) in paragraph (7)(B), by inserting ''and, as applicable, additional eligible professionals'' after ''eligible professionals'';

(I) in paragraph (8)(B), by inserting ''and additional eligible professionals described in paragraph (9)'' after ''paragraph (2)''; and

(J) by adding at the end the following new paragraph:

''(9) ADDITIONAL ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible professional described in this paragraph is an additional eligible professional (as defined for purposes of section 1848(o)) who—

''(A)(i) is employed by the organization; or

''(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

''(II) furnishes at least 80 percent of the professional services of the additional eligible

professional covered under this title to enrollees of the organization; and

''(B) furnishes, on average, at least 20 hours per week of patient care services.''; and

(2) in subsection (m)—

(A) in paragraph (1)—

(i) by inserting ''or additional eligible hospitals (as described in paragraph (7))'' after ''paragraph (2)''; and

(ii) by inserting ''and additional eligible hospitals'' before ''under such sections'';

(B) in paragraph (3)(A)(i), by inserting ''or additional eligible hospital'' after ''eligible hospital'';

(C) in paragraph (3)(A)(ii), by inserting ''or an additional eligible hospital'' after ''eligible hospital'' in each place it occurs;

(D) in paragraph (3)(B)—

(i) in clause (i), by inserting ''or an additional eligible hospital described in paragraph (7)'' after ''paragraph (2)''; and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting ''or an addi-

tional eligible hospital described in paragraph (7)'' after ''paragraph (2)''; and

(II) in subclause (I), by inserting ''or an additional eligible hospital, respectively,'' after ''eligible hospital'';

(E) in paragraph (4)(A), by inserting ''or one or more additional eligible hospitals (as defined in section 1886(n)), as appropriate,'' after ''section 1886(n)(6)(A))'';

(F) in paragraph (4)(D), by adding at the end the following new sentence: ''In the case that a qualifying MA organization attests that not all additional eligible hospitals of the organization are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on the methodology specified by the Secretary, taking into account the proportion of such additional eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.'';

(G) in paragraph (5)(A), by inserting ''and, as applicable, each additional eligible hos-

pital described in paragraph (7)'' after ''paragraph (2)'';

(H) in paragraph (5)(B), by inserting ''and additional eligible hospitals, as applicable,'' after ''eligible hospitals'';

(I) in paragraph (6)(B), by inserting ''and additional eligible hospitals described in paragraph (7)'' after ''paragraph (2)''; and

(J) by adding at the end the following new paragraph:

''(7) ADDITIONAL ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible hospital described in this paragraph is an additional eligible hospital (as defined in section 1886(n)(6)(C)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.''.

TITLE VIII—SAMHSA REAUTHORIZATION AND REFORMS

Subtitle A—Organization and General Authorities

SEC. 801. IN GENERAL.

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

(1) in subsection (h), by inserting at the end the following: ''For any such peer-review group reviewing a proposal or grant related to mental illness, no fewer than half of the members of the group shall have a medical degree, or a corresponding doctoral degree in psychology and clinical experience.''; and

(2) in subsection (l)—

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

(B) in paragraph (3), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(4) At least 60 days before awarding a grant, cooperative agreement, or contract, the Assistant Secretary shall give written notice of the award to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.''.

SEC. 802. ADVISORY COUNCILS.

Paragraph (3) of section 502(b) of the Public Health Service Act (42 U.S.C. 290aa–1(b)) is amended by adding at the end the following:

''(C) No fewer than half of the members of an advisory council shall be mental health care providers with—

''(i) experience in mental health research or treatment; and

''(ii) expertise in the fields on which they are advising.

''(D) None of the appointed members may have at any point been a recipient of any grant, or participated in any program, about which the members are to advise.

''(E) None of the appointed members may be related to anyone who has been a recipient of any grant, or participated in any program, about which the members are to advise.

''(F) None of the appointed members may have a financial interest in any grant or program with respect to which they advise, or receive funding separately through the Office of Assistant Secretary.

''(G) Each advisory committee must include at least one member of the National Institute of Mental Health and one member from any Federal agency that has a program serving a similar population.''.

SEC. 803. PEER REVIEW.

Section 504 of the Public Health Service Act (42 U.S.C. 290aa–3) is amended—

(1) by adding at the end of subsection (b) the following: ''At least half of the members of any peer-review group established under subsection (a) shall have a degree in medicine, or a corresponding doctoral degree in psychology, or be a licensed mental health professional. Before awarding a grant, cooperative agreement, or contract, the Secretary shall provide a list of the members of the peer-review group responsible for reviewing the award to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.''; and

(2) by adding at the end the following:

''(e) SCIENTIFIC CONTROLS AND STANDARDS.—Peer review under this section shall ensure that any research concerning an intervention is based on scientific controls and standards indicating whether the intervention reduces symptoms, improves medical or behavioral outcomes, and improves social functioning.''.

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.

Section 105(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)) is amended—

(1) in paragraph (9), by striking ''and'' at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(11) agree to refrain, during any period for which funding is provided to the system under this part, from—

''(A) lobbying or retaining a lobbyist for the purpose of influencing a Federal, State, or local governmental entity or officer; and

''(B) counseling an individual with a serious mental illness who lacks insight into their condition on refusing medical treatment or act-

ing against the wishes of such individual's caregiver;''.

SEC. 812. ENSURING THAT CAREGIVERS OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS HAVE ACCESS TO THE PROTECTED HEALTH INFORMATION OF SUCH INDIVIDUALS.

Section 105(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)), as amended by section 811, is further amended by adding at the end the following:

''(12) ensure that caregivers (as defined in section 201 of the Helping Families in Mental Health Crisis Act of 2015) of individuals with serious mental illness (as defined in such section 201) have access to the protected health information of such individuals consistent with such section 201;''.

SEC. 813. PROTECTION AND ADVOCACY ACTIVITIES TO FOCUS EXCLUSIVELY ON SAFEGUARDING RIGHTS TO BE FREE FROM ABUSE AND NEGLECT.

(a) PURPOSES.—Section 101(b) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10801(b)) is amended—

(1) in paragraph (1), by inserting ''to be free from abuse and neglect'' before ''are protected''; and

(2) in paragraph (2)(A), by inserting ''to be free from abuse and neglect'' before ''through activities to ensure''.

(b) ALLOTMENTS.—Section 103(2)(A) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10803(2)(A)) is amended by inserting ''to be free from abuse and neglect'' before the semicolon.

(c) USE OF ALLOTMENTS.—Section 104(a)(1) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10804(a)(1)) is amended—

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

(2) in subparagraph (B), by striking the semicolon at the end and inserting ''to be free from abuse and neglect; and''; and

(3) by adding at the end the following:

''(C) the protection and advocacy activities of such an agency or organization shall be exclusively focused on safeguarding the rights of individuals with mental illness to be free from abuse and neglect.''.

(d) SYSTEM REQUIREMENTS.—Section 105 of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805), as amended by sections 811 and 812, is further amended—

(1) in subsection (a)—

(A) in the matter before paragraph (1), by inserting ''to be free from abuse and neglect'' before ''shall'';

(B) in paragraph (6)(A), by inserting ''to be free from abuse and neglect'' before the semicolon; and

(C) by adding at the end the following:

''(13) be exclusively focused on safeguarding the rights of individuals with mental illness to be free from abuse and neglect; and''; and

(2) in subsection (c)(1)(A), by inserting ''to be free from abuse and neglect'' before ''shall have a governing authority''.

(e) APPLICATIONS.—Section 111(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10821(a)) is amended—

(1) in paragraph (1), by inserting ''to be free from abuse and neglect'' before the semicolon;

(2) in paragraph (3), by striking ''and'' at the end;

(3) by redesignating paragraph (4) as paragraph (5); and

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

''(4) assurances that such system, and any State agency or nonprofit organization with which such system may enter into a contract under section 10804(a), will be exclusively focused on safeguarding the rights of individuals with mental illness to be free from abuse and neglect; and''.

(f) REPORTS BY SECRETARY.—Section 114(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10824(a)) is amended—

(1) in paragraph (1) in the matter before subparagraph (A), by inserting ''to be free from abuse and neglect'' before ''supported with payments'';

(2) in paragraph (2)(A), by inserting ''to be free from abuse and neglect'' before ''supported with payments''; and

(3) in paragraph (4), by inserting ''to be free from abuse and neglect'' before ''and a description''.

SEC. 814. REPORTING.

(a) PUBLIC AVAILABILITY OF REPORTS.—Section 105(a)(7) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)(7)) is amended by striking ''is located a report'' and inserting ''is located, and make publicly available, a report''.

(b) DETAILED ACCOUNTING.—Section 114(a) of the Protection and Advocacy for Individuals with Mental Ill-

ness Act (42 U.S.C. 10824(a)), as amended, is further amended—

(1) in paragraph (3), by striking ''and'' at the end;

(2) in paragraph (4), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(5) a detailed accounting, for each system funded under this title, of how funds are spent, disaggregated according to whether the funds were received from the Federal Government, the State government, a local government, or a private entity.''.

SEC. 815. GRIEVANCE PROCEDURE.

Section 105 of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805), as amended, is further amended by adding at the end the following:

''(d) GRIEVANCE PROCEDURE.—The Assistant Secretary shall establish an independent grievance procedure for the types of claims to be adjudicated, at the request of persons described in subsection (a)(9), through a system's grievance procedure established under such subsection.''.

SEC. 816. EVIDENCE-BASED TREATMENT FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Section 105(a) of the Protection and Advocacy for Individuals with Mental Illness Act (42 U.S.C. 10805(a)), as amended by sections 811, 812, and 813, is further amended by adding at the end the following:

''(14) ensure that individuals with serious mental illness have access to and can obtain evidence-based treatment for their 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.

Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States, in consultation with the Assistant Secretary for Mental Health and Substance Use Disorders, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, shall submit to Congress a report detailing the extent to which covered group health plans (or health insurance coverage offered in connection with such plans), including Medicaid managed care plans under section 1903 of the Social Security Act (42 U.S.C. 1396b), comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

2008 (subtitle B of title V of division C of Public Law 110–343) (in this section referred to as the ''law''), including—

(1) how nonquantitative treatment limitations, including medical necessity criteria, of covered group health plans comply with the law;

(2) how the responsible Federal departments and agencies ensure that plans comply with the law; and

(3) how proper enforcement, education, and coordination activities within responsible Federal departments and agencies can be used to ensure full compliance with the law, including educational activities directed to State insurance commissioners.

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